UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

INDIANA PROTECTION AND ADVOCACY SERVICES COMMISSION, *et al.*,	)	
Plaintiffs,	)	
v.	)	No. 1:08-cv-01317 TWP-MJD
COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION,	)	
Defendant.	)	

Fourth Joint Status Report Following Effective Date of Private Settlement Agreement

The parties, by their counsel, as agreed to in paragraph 61(g) of their Private Settlement Agreement ("PSA"), file their status report.

1. Since the parties' last status report (Dkt. 604) they jointly retained Joel A. Dvoskin, Ph.D., to conduct an independent audit of the defendant's compliance with the private settlement agreement in this case.

2. Attached to this report as Exhibit 1 is Dr. Dvoskin's *Curriculum Vitae.*

3. From June 26-28, 2018, Dr. Dvoskin toured mental health units at Wabash Valley Correctional Facility, New Castle Correctional Facility, Pendleton Correctional Facility, and the Indiana Women's Prison. He also toured restricted housing units at Wabash Valley Correctional Facility and the Indiana Women's Prison.

4. Dr. Dvoskin's report is attached as Exhibit 2.

5. Dr. Dvoskin concludes that "[s]imply put, the Department and its contractor (Wexford) are in diligent compliance with all respects of the Settlement Agreement." (Ex. 2 at 13).

5. Dr. Dvoskin does, however, make recommendations concerning the private settlement agreement and recommendations outside of the settlement agreement. (*Id.* at 13-16).

6. Plaintiffs' counsel will be discussing these recommendations with defendant's counsel.

7. The parties believe that both sides are continuing to work to ensure that the terms of the private settlement agreement are met.

WHEREFORE, the parties file their Joint Status report.

For the plaintiffs:

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For the defendant:

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Curriculum Vitae (January 2017)

Joel A. Dvoskin, Ph.D., A.B.P.P.

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Web site: JoelDvoskin.com

EDUCATION:

Undergraduate: University of North Carolina at Chapel Hill; B.A. 1973;
Majors: English and Psychology;
Awards:
Order of the Old Well Honorary Society
Order of the Grail Honorary Society

Stockholm University, Stockholm, Sweden; Diploma, 1972;
Major: Social Science.

Graduate: University of Arizona, Tucson, Arizona;
M.A. in Clinical Psychology, 1978
Ph.D. in Clinical Psychology, 1981;

Dissertation: *Battered Women: An Epidemiological Study of Spousal Violence.*

Professional: University of Arizona College of Law, Tucson, Arizona (Doctoral Minor)

HONORS:

Diplomate in Forensic Psychology, American Board of Professional Psychology
Fellow, American Psychological Association
Fellow, American Psychology-Law Society
Peggy Richardson Award, National Coalition for the Mentally Ill in the Criminal Justice System
Amicus Award, American Academy of Psychiatry and the Law
Affiliate Member, International Criminal Investigative Analysis Fellowship
Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, April 14, 2005
President, Division 18 of the American Psychological Association (APA), Psychologists in Public Service (2000-2001)
President, American Psychology-Law Society, Division 41 of the American Psychological Association (2006-2007)
American Psychological Association, Division 18 Special Achievement Award
Served on APA Blue Ribbon Commission on Ethics Process (2016-17)
Arizona Psychological Association, Distinguished Contribution to the Science of Psychology Award, 2010
Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, March 30, 2011

ACADEMIC POSITIONS:

1996 - current
Asst. Professor (Clinical) - University of Arizona College of Medicine, Dept. of Psychiatry

1996 - 2001
Asst. Professor (Adjunct) - University of Arizona College of Law

2000 - 2005 (currently inactive)
Assistant Clinical Professor - Louisiana State University Medical Center

1986 - 1995 (currently inactive)
Assistant Clinical Professor - New York University Medical School, Dept. of Psychiatry

LICENSES:

Arizona Board of Psychologist Examiners, License #0931
New Mexico State Board of Psychologist Examiners, License #0904
Certificate of Professional Qualifications in Psychology (CPQ), CPQ #2,439
Interjurisdictional Practice Certificate, ASPPB, #2439

PROFESSIONAL EXPERIENCE:

January 2014 – April 2016
Chairman, (Nevada) Governor's Advisory Council on Behavioral Health and Wellness
Duties: Provide advice to Governor Brian Sandoval regarding public behavioral health; Chair statewide Advisory Council

September 1995 - Current
Full-time private practice of forensic psychology, providing expert testimony on civil and criminal matters, and consultation in the provision of mental health and criminal justice services, and workplace and community violence prevention programs.
Duties: Provide expert testimony, consultation, training, and public speaking services to federal, state, and local governmental agencies, corporations and attorneys, including the following areas:

- Forensic mental health evaluations
- Assessing and preventing the risk of violent behavior
- Assessment of suicide risk
- Treatment of Serious Mental Illness and Co-occurring Substance Use Disorders
- Police misconduct
- Conditions of confinement and hospitalization
- Architectural design of psychiatric, correctional, and secure psychiatric buildings
- Workplace violence prevention and crisis response
    - Working with labor organizations
    - Safely managing corporate layoffs
- Psychological autopsy – (Psychological investigation of equivocal death or suicide)
- Suicide prevention
- Mental health services in correctional and criminal justice settings
- Mental health services to juvenile correctional facilities
- Stalking
- Administration of public mental health and criminal justice services
- Conditions of confinement in sex offender treatment facilities
- Consultation to attorneys on cases involving mental health issues

November 2007 – May 2011
Federal Court Monitor over the Michigan Department of Corrections
Duties: Oversight of settlement agreement in *MPAS V. Caruso*

September 1995 – Current
Senior Psychologist, Threat Assessment Group, Inc., Newport Beach, California.
Duties: Provide consultation and training in workplace violence prevention and crisis management to governmental and corporate organizations.

September 1995 - Current
Associate, Park Dietz & Associates, Inc., Newport Beach, California.
Duties: Forensic psychological services and expert testimony

March 1995 - August 1995
Acting Commissioner, New York State Office of Mental Health.
Duties: Under the direct supervision of the Governor, served as C.E.O. of the largest agency of its kind in the United States, with an annual budget of more than $2.4 billion. The agency employed over 24,000 people and directly operated 29 institutions, including adult inpatient and outpatient psychiatric facilities, children's psychiatric hospitals, forensic hospitals and research institutes. The Office of Mental Health also licensed, regulated, financed, and oversaw more than 2,000 locally operated inpatient, emergency, outpatient, and residential programs in collaboration with 57 counties and New York City. Through an intergovernmental agreement, OMH provided psychiatric and mental health services to the NY State Department of Corrections.

November 1984 - March 1995
Director, Bureau of Forensic Services (1984-1988) and Associate Commissioner for Forensic Services (1988-1995), New York State Office of Mental Health.
Duties: Line authority for inpatient services at three large forensic hospitals and two regional forensic units, including services to civil, forensic and correctional patients; line authority for all mental health services in New York State prisons (serving more than 60,000 inmates), including 15 prison mental health units across New York; responsibility for innovative community forensic programs including suicide prevention in local jails, police mental health training, and mental health alternatives to incarceration.

December 1984 - July 1985
Acting Executive Director, Kirby Forensic Psychiatric Center.
Duties: Founding C.E.O. for new maximum security forensic psychiatric hospital in New York City.

July 1984 - November 1984
Acting Director, Office of Mental Health, Virginia Department of Mental Health and Mental Retardation (held concurrently with permanent position as Director of Forensic Services).
Duties: Supervision of budget and certification of all community mental health programs statewide; statewide policy development in all program areas related to mental health; Executive Secretary to Virginia Mental Health Advisory Council.

July 1983 - November 1984
Director of Forensic Services, Virginia Department of Mental Health and Mental Retardation.
Duties: Design and coordination of statewide delivery system of institutional and community treatment and evaluation of forensic patients; management of the contract for the University of Virginia Institute of Law, Psychiatry and Public Policy; departmental liaison to Virginia Dept. of Corrections and other criminal justice agencies; develop statewide plan for delivery of mental health services to D.O.C. inmates; statewide Task Force on Mental Health Services in Local Jails.

August 1982 - July 1983
Psychologist, Arizona Correctional Training Center, Tucson, Arizona.
Duties: Supervision of psychology department; direct clinical treatment and evaluation services.

April 1982 - July 1982
Acting Inmate Management Administrator, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct supervision of inmate records office; inmate classification and movement; correctional program (counseling) services; psychology department; hiring of all new correctional officers. (NOTE: During this period, I also maintained all duties of my permanent position as Psychologist (below).

October 1981 - July 1982
Psychologist, Arizona State Prison Complex, Florence, Arizona.
Duties: Supervision of Psychology Department for complex consisting of five prisons; direct clinical treatment and evaluation services.

November 1980 - October 1981
Psychology Associate, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct clinical treatment and evaluation services.

August 1980 - November 1980
Psychological consultant to the Massachusetts Department of Correction.
Duties: Consultation to Director of Health Services; direct clinical treatment and evaluation services at Walpole and Norfolk State Prisons.

January 1980 - November 1980
Psychologist (non-licensed) - Tri-Cities Community Mental Health Center, Malden, Massachusetts.
Duties: Pre-screened civil commitments for community mental health center.

August 1979 - August 1980
Pre-Doctoral Intern in Clinical Psychology, McLean Hospital, Belmont, Massachusetts; and Fellow in Clinical and Forensic Psychology, Harvard Medical School, Cambridge, Massachusetts, and Bridgewater (Massachusetts) State Hospital

1978-1979 Psychology Extern, Pima County (Arizona) Superior Court Clinic

1977-1978 Psychology Extern, Palo Verde Hospital, Tucson, Arizona

1976-1977 Psychology Extern, Arizona Youth Center (later Catalina Mountain School), Tucson, Arizona

1975-1976 National Institute of Mental Health Trainee

1973-1975 United States Peace Corps Volunteer, Senegal, West Africa

1970-1995 Coach, Dean Smith's Carolina Basketball School, Chapel Hill, N.C. (1-3 weeks each summer)

SELECTED CONSULTATION CLIENTS:

Federal Government -

National Institute of Mental Health
United States Secret Service
National Institute of Justice
National Institute of Corrections
Center for Mental Health Services
United States Department of Justice, Civil Rights Division
- Maricopa County (AZ) Jail
- Los Angeles County (CA) Jail
- Harrison County (MS) Adult Detention Center
- Los Angeles County (CA) Juvenile Hall
- Taycheeda State Prison for Women (Wisconsin)
- Huron Valley Women's Correctional Facility (Michigan)

Substance Abuse and Mental Health Administration
Department of Homeland Security – Office of Civil Rights
New Orleans Police Department (in collaboration with US Dept. of Justice)

State and Local Governments -

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Dist. of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Nebraska
Nevada
New Jersey
New Mexico
New York
North Carolina
Ohio
Oregon
Pennsylvania
Puerto Rico
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wyoming

International Clients -
Province of Ontario
Correctional Service of Canada
Province of British Columbia
England and Wales – National Offender Management Service Expert Advisory Panel

Selected Corporate Clients

Amazon
American Express
Amgen
Boise Cascade
Borden Foods
Chase Manhattan Bank
Corning, Incorporated
DaimlerChrysler Corporation
General Dynamics
Honeywell
Johnson and Johnson
Kraft Foods
The Law Firm of Akin Gump
Levi Strauss
Macy's
Motorola
NBA Players Association
National Basketball Assn.
National Semiconductor
Nationwide Insurance
Nordstrom
Oracle Corporation
Pillsbury
Ryman Hospitality
(Grand Ol' Opry)
Sony Corporation
State Farm Insurance
Texas Instruments
3M Corporation
United Auto Workers
University of Arizona
Visa
Warner-Lambert Pharmaceuticals
Pima (AZ) College

Professional Organization Clients –

American Psychological Association – Task Force on Preventing Gun Violence

American Psychological Association – Commission on Ethics Processes

American Psychiatric Association - Committee on Correctional Psychiatry

American Correctional Association

American Bar Association
ABA-APA Task Force on Mental Illness and the Death Penalty

National Basketball Association and NBA Players Association -
Rookie Transition Program (teaching life skills to NBA rookies)

NBA Players Association – Top 100 High School Basketball Camp

National Collegiate Athletic Association (NCAA) –
"First Team" Mentoring Program for elite High School Basketball Players

Federal Court Expert and Monitor –

Independent Expert to monitor a Federal Court settlement agreement at the Bernalillo County (N.M.) Detention Center in Albuquerque. (Completed)

Federal Court Monitor (one of two) of a settlement agreement regarding the Institute of Forensic Psychiatry at the Colorado Mental Health Institute – Pueblo. (Completed)

Federal Court Monitor (one of two) of a settlement agreement regarding the Forensic Unit at the Western State Hospital in Tacoma, Washington. (Completed)

Federal Court Monitor (one of two) of a statewide settlement agreement between the Michigan Protection and Advocacy Program and the Michigan Department of Corrections. (Completed)

Pro Bono consultation with the New Orleans Police Department and the US Department of Justice – Ethical Policing is Courageous (EPIC) program

Independent Expert to monitor settlement agreement regarding the transfer of incompetent defendants to State Hospital

Independent expert to monitor settlement agreement between Disability Rights Oregon and the Oregon Department of Corrections regarding the treatment of prisoners with serious mental illness

Architectural Consultations -

Dr. Dvoskin has served as design consultant for major renovations and new construction of a number of state, federal, and territorial psychiatric facilities during his long career. The following is a partial list of these projects:

New York - As part of his duties as Associate Commissioner of Mental Health for the state of New York, Dr. Dvoskin oversaw design of major renovations to Mid-Hudson Psychiatric Center, a 300 bed forensic psychiatric hospital in Middletown, NY. Completion of this project resulted in significant reductions in violent incidents at this facility.

Georgia - As part of a federal class action, plaintiffs and defendants agreed to ask Dr. Dvoskin to assess suicide hazards at six of Georgia's large state prisons, resulting in cost-effective, potentially life saving physical plant changes to rooms in which suicidal inmates were housed.

Louisiana - Again, at the request of plaintiffs and defendants, Dr. Dvoskin performed a comprehensive assessment of suicide hazards in the state's juvenile correctional facilities.

Puerto Rico - Dr. Dvoskin served as design consultant for a new correctional psychiatric center, which cost less than renovation of the existing building, which was the basis for a finding of unconstitutional conditions.

Michigan - Dr. Dvoskin assisted the state of Michigan, which was involved in constitutional litigation regarding its prison mental health system, in creating a MH care system within the Department of Mental Health. He also served as design consultant for new beds added to a state forensic psychiatric facility.

Maryland, Florida, and Maine - Dr. Dvoskin served as consultant to Commissioners of Mental Health, including consultation on the physical plants of forensic and civil psychiatric hospitals.

Delaware - Dr. Dvoskin served as design consultant for the new forensic wing of the state's psychiatric hospital.

Colorado - Dr. Dvoskin served as design consultant for the state's new forensic psychiatric hospital; a design which combines a sense of privacy and dignity among patients without sacrificing the visibility needed in order for staff to maintain safety.

Washington, DC - Dr. Dvoskin served as consultant to two Federal Receivers, then to the Commissioner of Mental Health, in a variety of areas. These included an assessment of the number of beds needed, then to assist in a Capital Plan for the entire DC Mental Health System. Dr. Dvoskin served as design consultant for the creation of a brand new Saint Elizabeths Hospital, to replace the entire civil and forensic hospital campus. The design of this facility, which is now under construction, included an innovative consumer advisory panel, facilitated by Dr. Dvoskin, which had input into every phase of the project's design.

North Carolina – Consultant to architectural renovation of forensic unit at Broughton State Hospital.

North Carolina – Consultant to Disability Rights North Carolina to assess safety and security of new Central Regional Hospital.

Harris County, Texas – Consultant to the Harris County Sheriff's Office on the construction of a new jail in Houston, Texas.

Miami–Dade County, Florida – Consultant on the capital renovation and program development for a new community forensic facility for Miami and Dade County, Florida.

Oregon Department of Corrections – Consultant to creation of large correctional complex, including mental health unit, in Junction City, Oregon.

Idaho Department of Corrections – Consultant to creation of a 300-bed mental health unit.

Missouri Department of Mental Health – Architectural Design Consultant on 300-bed Secure Forensic Hospital to replace existing buildings at the Fulton State Hospital (currently under construction)

Oregon Department of Corrections – Architectural improvements to Secure Mental Health Treatment Unit at Oregon State Penitentiary

BOARD MEMBERSHIPS:

Editorial Boards (former)	Journal of the American Academy of Psychiatry and the Law
	Journal of Mental Health Administration
	Behavioral Sciences and the Law
	Journal of Aggression, Maltreatment, and Trauma (former)
	Psychological Services (former)
	Journal of Threat Assessment (former)
	Law and Human Behavior
Research Advisory Board	United States Secret Service (former)

Advisory Board	National Center for State Courts, Institute on Mental Disability and the Law (former)
Member	White House Panel on the Future of African-American Males –1995
Member	American Bar Association Task Force on Capital Punishment and Mental Disability – Completed 2005
Member	American Psychological Association Task Force on Reducing Gun Violence – 2013
Member	American Psychological Association Blue Ribbon Commission on Ethics Processes -- 2016

PUBLICATIONS:

Gilfoyle N & Dvoskin JA (2017)
APA's Amicus Curiae Program: Bringing psychological research to judicial decisions. *American Psychologist*.

Brodsky, SL, Dvoskin JA, & Neal TMS (2017)
Temptations for the Expert Witness. *Journal of the American Academy of Psychiatry and the Law*. Vol 45(4): 460-463

Morgan RD, Van Horn SA, and Dvoskin JA (2017)
Correctional Settings and Prisoners' Rights. In: Gold L and Frierson R (Eds.) *Textbook of Forensic Psychiatry*, American Psychiatric Publishing: Washington DC.

Mucha Z, with Dvoskin J and MacYoung M (2016)
Emotional Abuse: A manual for self-defense. Chicago: Zak Mucha

Maloney MP, Metzner JL & Dvoskin JA. (2015)
Screening and Assessments, Chapter 3.1. In: Trestman RL, Appelbaum KL, Metzner JL (Eds.), *The Oxford Textbook of Correctional Psychiatry*, New York: Oxford University Press

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Report on threat assessment in the workplace. Heilbrun, K. (in press). In K. Heilbrun, D. DeMatteo, S. Brooks Holliday, and C. LaDuke (Eds.), *Forensic mental health assessment: A casebook (2nd edition)*. New York: Oxford.

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"When specialized measures cannot be used." In K. Heilbrun, D. DeMatteo, S. Brooks Holliday, and C. LaDuke (Eds.), *Forensic mental health assessment: A casebook (2nd edition)*. New York: Oxford.

O'Keefe, ML, Klebe, KJ, Metzner J, Dvoskin, JA, Fellner, J, & Stucker A. (2013)

A Longitudinal Study of Administrative Segregation. *Journal of the American Academy of Psychiatry and the Law. Volume* 41:49–60, 2013.

Dvoskin, JA, Skeem, JL, Novaco RW, and Douglas KS. (Editors) (2011)
Using Social Science To Reduce Violent Offending. New York: Oxford University Press. (Winner of the 2012 Book Award of the American Psychology-Law Society)

Kane, AW & Dvoskin, JA. (2011).
Evaluation for Personal Injury Claims. New York: Oxford University Press.

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Correctional Psychology. In Weiner, I. & Craighead W.E. (Eds.) *Corsini Encyclopedia of Psychology* (Vol. 1: pp 417-420). Wiley: New York.

Ruiz A, Dvoskin JA, Scott CL, Metzner JL. (2010)
Manual of Forms and Guidelines for Correctional Mental Health. American Psychiatric Publishing: Washington, DC

Heilbrun, K., Dvoskin, J and Heilbrun, A. (2009).
"Toward Preventing Future Tragedies: Mass Killings on College Campuses, Public Health, and Threat/Risk Assessment." *Psychological Injury and Law*. Vol 2(2), Oct 2008, 93-99.

Dvoskin, JA and Guy, LS (2008)
"On Being an Expert Witness: It's not about you." *Psychiatry, Psychology and Law*. Vol 15(2), Oct 2008, 202-212.

Dvoskin, JA (2008)
Commentary on Elger's "Medical Ethics in Correctional Healthcare." *Journal of Clinical Ethics*. Vol. 19, No. 3, 256-259.

Dvoskin. JA. (2008)
Book Review: School Violence and Primary Prevention, by Thomas Miller (Ed.). *Journal of the American Medical Association*.

Dvoskin JA, Bopp J, and Dvoskin JL (2008)
Institutionalization and Deinstitutionalization. In Cutler, B (ed.) *Encyclopedia of Psychology and Law*. Sage Publications: Thousand Oaks, CA.

Dvoskin, JA; Spiers EM, and Brodsky, S (2007)
Correctional Psychology: Law, ethics, and practice. In Goldstein, Alan M. (Ed). *Forensic psychology: Emerging topics and expanding roles*. (pp. 605-632). Hoboken, NJ, US: John Wiley & Sons Inc. xix, 819 pp.

McDermott, B.E., Dvoskin, J. and Quanbeck, C. (In press.)

Psychopathy: Towards a more reasoned understanding of the relationship to aggressive behavior. *Forensic Psychiatry Research Trends*

Spiers EM, Pitt SE & Dvoskin JD (2006)
Psychiatric Intake Screening. In Puisis M. (Ed.) *Clinical Practice in Correctional Medicine*. Philadelphia: Elsevier.

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Commentary: The Physicians Torture Report. *Correctional Mental Health Report*. Kingston, NJ. Volume 8, No. 1.

Schlank A & Dvoskin JA (2006).
Similar Statutes, Different Treatment Needs -- A Comparison of SVP and Mentally Ill Populations. In Schlank, A. (Ed.) *The Sexual Predator, Volume 3*: New York, NY: Civic Research Institute.

Metzner JL & Dvoskin JA. (2006)
Controversies Concerning Supermax Confinement and Mental Illness. *Psychiatric Clinics of North America*. Philadelphia: Elsevier. Volume 29, No. 3.

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Two Sides to Every Story: The Need for Objectivity and Evidence. *Journal of the American Academy of Psychiatry and the Law*. Vol. 33, No. 4, 482-483.

Dvoskin JA, Spiers EM, & Brodsky SL. (In press.)
Correctional Psychology: Law, Ethics, and Practice. In Goldstein AM (Ed.), Forensic *Psychology: Emerging Topics and Expanding Roles*. Hoboken, NJ. John Wiley & Sons.

Peters RH, Matthews CO & Dvoskin, JA (2005)
Treatment in prisons and jails. In Lowinson JH, Ruiz P, Millman RB, & Langrod JG (eds.) *Substance Abuse: A Comprehensive Textbook – Third Edition*. Baltimore, MD: Williams & Wilkins Publishers. Pages 707-722.

Metzner JL and Dvoskin JA (2004) Psychiatry in Correctional Settings, in *Textbook of Forensic Psychiatry*. Robert R. Simon MD and Lisa H. Gold, MD (editors). Washington, DC: American Psychiatric Publishing, Inc.

Dvoskin JA and Spiers EM (2004) On the Role of correctional Officers in Prison Mental Health Care. *Psychiatric Quarterly*.

Dvoskin JA and Spiers EM (2003) Commentary: In Search of Common Ground, *Journal of the American Academy of Psychiatry and the Law*. Vol. 31, No. 2. 184-188.

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Mental health professionals as institutional consultants and problem-solvers. In Fagan, T, and Ax, R (Eds) *Correctional Mental Health Handbook*. Thousand Oaks, CA: Sage Publications.

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The structure of correctional mental health services. In Rosner, R. (ed.), *Principles and Practice of Forensic Psychiatry, Second Edition*. London: Arnold Publishing.

Dvoskin, J.A. (2002)
Knowledge is Not Power – Knowledge is Obligation. *Journal of the American Academy of Psychiatry and the Law*. Vol. 30, No. 4.

Dvoskin JA, Radomski SJ, Bennett C, Olin JA, Hawkins RL, Dotson LA, Drewnicky IN. (2002)
Architectural design of a secure forensic state psychiatric hospital. *Behavioral Sciences and the Law, Vol. 20, No. 5.* Pages 481-493.

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Commentary: Behavioral Health Professionals in Class Action Litigation -- Some Thoughts on the Lawyer's Perspective. *Journal of the American Academy of Psychiatry and the Law*. 30:1

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Coggins MH, Pynchon MR, Dvoskin JA (1993) Integrating research and practice in federal law enforcement: Secret Service applications of behavioral science expertise to protect the President. *Behavioral Sciences & the Law*, Volume 16, Issue 1, pp. 51 - 70

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Powell v. Coughlin and the Application of the Professional Judgment Rule to Prison Mental Health. *Mental and Physical Disability Law Reporter*. Vol. 19, No. 1

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Dvoskin, Joel A. and Horn, Martin F. (1994)
Parole Mental Health Evaluations. *Community Corrections Report*. July/August 1994

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Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community. *Hospital and Community Psychiatry*. Vol. 45, No. 7. Pp. 679-684.

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Intermediate Care Programs for Inmates with Psychiatric Disorders. *Bulletin of the American Academy of Psychiatry and the Law*. Volume 22, Number 1.

Dvoskin, Joel A. (1994)

The Structure of Prison Mental Health Services. In Rosner, Richard (Editor), *Principals and Practice of Forensic Psychiatry*. New York: Chapman and Hall.

Cohen, Fred and Dvoskin, Joel A. (1993)
Therapeutic Jurisprudence and Corrections: A glimpse. *New York Law School Journal of Human Rights*. Vol.X.

Dvoskin, Joel A., Smith, Hal, and Broaddus, Raymond (1993)
Creating a Mental Health Care Model. *Corrections Today*. Vol. 55, No. 7.

Dvoskin, Joel A., Steadman, Henry J. and Cocozza, Joseph J. (1993)
Introduction. In Steadman, Henry J. and Cocozza, Joseph J. (Editors), *Mental Illness in America's Prisons*. Seattle: National Coalition for the Mentally Ill in the Criminal Justice System.

Clear, Todd R., Byrne, James M. and Dvoskin, Joel A. (1993)
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August 4, 2018

Independent Audit Report in the Matter of *Indiana Protection and Advocacy Services Commission et al versus Commissioner, Indiana Department of Corrections*

Joel A. Dvoskin, Ph.D. ABPP (Forensic)

August 4, 2018

Introduction

In April 2018, I was contacted by John Dallas, Vice President of Operations for Wexford of Indiana, LLC. Wexford is the contractor that provides health and mental health services to the Indiana Department of Corrections (the Department). Mr. Dallas asked me to conduct tours of four Indiana Prisons (one of which is operated under contract with the GEO Group).

During my tours, the staff and leadership of Wexford and the Department were cordial and candid. At no time was I denied access to inmates, staff at all levels, and facility and leadership. While I reviewed the data produced by the Department and Wexford regarding compliance with the Settlement Agreement, I did not take their accuracy for granted, and confirmed the data with inmates and correction officers in each prison.

In this report, as agreed in my discussions with Mr. Dallas, I will provide two different kinds of observations. First, I will speak directly to the requirements of the Settlement Agreement. Second, as agreed with Mr. Dallas, I will provide suggestions for further improvement of the mental health services provided in the four prisons I toured. **I very much appreciate the openness displayed by the Department and Wexford in considering the additional suggestions, but they should in no way be deemed to represent departures from or non-compliance with the Settlement Agreement.**

Finally, I wish to thank the leadership of both Wexford and the Department for their kindness and hospitality. It was very clear to me that they shared the desire of the

plaintiffs to provide high quality mental health and psychiatric services to their inmates.

Sources of Information

During June 26-28, 2018, I visited four of Indiana's prisons, as follows:

June 26, 2018	Wabash Valley Prison
June 27, 2018	New Castle State Prison (operated by the GEO Group)
June 27, 2018	Indiana Reformatory
June 28, 2018	Indiana Women's Prison

For each prison, I was provided with recent data regarding the offering of out-of-cell therapeutic programming, including but not limited to structured groups and individual therapy. These reports included explanations of exceptions, i.e., those inmates who were not offered at least 10 hours of therapy each week, along with an explanation. I was also given a list of approximately 20 inmates in the State that remained in Restrictive Housing Units (RHU) despite being deemed to have a serious mental illness (SMI). Each of these exceptions was due to an overriding security concern and was approved at the highest levels of the Department. I was also provided with a copy of the Settlement Agreement and was given access to the relevant Departmental policies and procedures.

Prior to my visit, I was able to speak by telephone with Kenneth Falk, an attorney representing the plaintiffs. I also spoke with Mr. Dallas, representing Wexford, and Dr. Deanna Dwenger, who supervises the programs I was to assess.

At each prison, I first met with the Warden and members of the executive team. They explained to me the manner in which the prison was operated, with special attention to the relationship between custody, correctional programs, and mental health programs. I was provided a brief tour of each prison, before focusing on the RHU and the four mental health units. I was given complete and unfettered access to inmates and staff. Whenever I requested privacy, it was provided to me, whether I was talking with inmates, correctional officers, or other staff.

During these tours I looked to see if there were inmates with SMI who were not identified. Given the brevity of my conversations with each inmate, it was not possible to diagnose anyone; my goal was to see if anyone required evaluation by the mental health and psychiatric staff.

At the time the Settlement Agreement was signed, it appears that there was a large number of inmates with mental illness in restrictive housing. Because of the Settlement Agreement, this no longer appears to be the case. With the exception of a small number (approximately 20) of security exceptions, inmates with SMI are moved to various mental health units instead of restrictive housing, or

shortly after arriving there. When the Settlement Agreement was signed, many of the inmates in the four mental health units had been transferred from segregation. Today, as a result of the Settlement Agreement and the Department's enthusiastic adherence to it, many of the inmates now housed in the mental health programs were never in restricted housing or were there for a short time. This has allowed for the Department to continue loosening the restrictions placed on these inmates in the SNU and the IRT programs, and I predict that the same thing will happen, albeit to a lesser degree, in the New Castle Psychiatric Program.

In my opinion, the Settlement Agreement was exceptionally clear and well-written, which made my job of assessing compliance much easier. The definitions of SMI contained in the Settlement Agreement were, in my opinion, reasonable and consistent with modern psychiatric treatment of these conditions.

Key Requirements of the Settlement Agreement

1. Except in specifically delineated exceptional circumstances, no seriously mentally ill prisoners shall be placed in segregation/restrictive housing (including protective custody) if they are known to be seriously mentally ill prior to such placement, or if they become seriously mentally ill subsequent to such placement.

2. Otherwise, seriously mentally ill prisoners must be placed in a setting where they could receive at least 10 hours a week of therapeutic programming, not including the time spent out of cell for recreation, showers, or other purposes permitted generally to offenders not in the certified class. Therapeutic programming can include formal group therapy, individual therapy, therapeutic milieu activity, and other activity as determined by mental health professionals as part of an individualized treatment plan.

3. DOC will maintain sufficient staff to manage the mental health units … and to identify seriously mentally ill prisoners and divert them from placement In segregated/restrictive housing.

4. Prisoners will be allowed to attend group therapy sessions without restraints unless necessary for security reasons.

5. Prisoners will receive individual therapy provided by a mental health professional at least once a month.

6. The agreement also delineates certain exceptions to the DOC Disciplinary Code when mental health professionals determine that the incident in question was the result of the prisoner's mental illness.

7. During the time that the prisoner is confined (in a suicide-safer cell), the DOC is not required to provide the prisoner with the minimum adequate treatment noted above. In that event, consistent with DOC policy, mental health will monitor the prisoner and the prisoner will be provided appropriate mental health services and treatment. **(Please note, I strongly recommend to the parties that this section be changed. I will discuss this recommendation below.)**

Findings

Simply put, **the Department and Wexford are in full compliance with the substantive requirements of the Settlement Agreement**. **Moreover, the Department and Wexford have internalized these requirements and support them enthusiastically**. Overall, I found the leadership on both the DOC side and the Wexford side to be outstanding. Based on my observations, I truly believe that these conditions would continue to be met even if there were no Settlement Agreement. My specific findings will follow.

Wabash Valley Prison

At Wabash Valley, I met with the executive team, who seem very proud of the improvements in mental health care that have been achieved during the past few years. I observed good communication and cooperation between the custody staff and the mental health staff. Warden Brown, like the other three wardens I met, is impressive in regard to his leadership as well as his commitment to meeting the requirements of the Settlement Agreement. Officers are selected to work in the Special Needs Unit (SNU) based on their interpersonal skills and willingness to work with this population. The Warden assured me that if Wexford staff felt that an officer was inappropriate for this work, he or she would be moved to another assignment. According to both the prison's executive team and the Wexford leadership, this has not been a problem.

I talked to several inmates who were on the list of exceptions, meaning that they were housed in RHU despite their SMI due to security concerns.

One inmate made a series of serious allegations of mistreatment; however, they had been made in writing to and investigated by the prison administration, and they were not confirmed by other inmates. He reported to me that he has a very long history of severely self-injurious behavior. This inmate was one of the exceptions to the policy, and had reportedly been removed from the SNU and placed in RHU because he has been successfully encouraging other inmates to cut themselves.

I walked the RHU range and had confidential, cell-front conversations with a number of inmates. One inmate appeared to me to be exhibiting pressured speech,

possibly suggesting a need for additional evaluation and treatment. I referred him to Dr. Dauss, who quickly arranged for him to receive a psychiatric evaluation. Surprisingly, the RHU was relatively quiet and free of any unpleasant smells. Interactions between inmates and staff appeared respectful and calm.

The Settlement Agreement implied the necessity of identifying RHU inmates with serious mental illness, or those who had developed acute emotional problems after being sent to the RHU. The Department and Wexford have developed a reasonable, though minimal, system of "rounds" in RHU. This practice has become the standard of practice in many states, and consists of regular cell front visits, and the ability of clinicians or inmates to request private meetings out of cell. The frequency of these visits within IDOC is based upon the mental health designation of the inmates. Inmates at level A (no known mental illness) must be visited every thirty days. Inmates at levels B through E and visited at least once per week, and inmates with a designation of SMI are visited at last twice per week. In my opinion, this meets the minimum requirement of the Settlement Agreement. **However, in my opinion, the Department would be well served to visit every RHU inmate at least once per week.** (See below.) For example, in some other states, these "rounds in segregation occur as often as 5 days perweek.

The cell used for suicide watch did not have a toilet. Instead, there was a hole in the floor that can be flushed. I found this to be offensive, degrading, and humiliating. While it is not contrary to the Settlement Agreement, I recommend that the Department consider changing these conditions as explained below.

I toured the Special Needs Unit (SNU). As everyone is aware, the physical plant of the unit is not ideal for this purpose. However, I was impressed with the way that Department and Wexford staff have adapted to it to create a reasonably therapeutic program. In large part, this is due to the professionalism of the officers and therapists who work there. With only a very few and temporary exceptions, all inmates were offered at least the 10 hours of therapeutic programming that is required by the Settlement Agreement. Exceptions were based on security concerns that were temporary and were being addressed by the treatment team. Almost all of the inmates in the SNU are assigned inmate mentors, who are carefully selected and trained for this function.

The cell block in which the SNU is located consists of two levels of cells surrounding a large common area. The surfaces are entirely hard, creating a great deal of noise and echoing that creates a challenge for treatment groups. **I recommended to the Warden that he consider breaking up the space with upholstered "pony walls" that will allow for more than one group at a time, and will help alleviate the sound pollution and echo.** The unit housing the SNU was clean, free of unpleasant smells, and its showers were clean and completely free of mold.

The right side of the SNU was called the Assessment and Orientation (A&O) part of the program. Most inmates remain here for a relatively short time. While this side of

the SNU operates in an approximately similar manner as the other side, the inmates are supervised a bit more closely. Some inmates, especially those who have recently arrived n the SNU, are taken to group in handcuffs until they demonstrate the ability to behave safely.

The left side of the SNU was managed on a phase program. Inmates in the left side of the SNU were taken to the chow hall for meals. Some inmates at phases 4 and 5 were taken to group therapy in a different building. Inmates at phase 5 are allowed to have television in their cells. However, if they are not adequately involved in programming, they could be demoted to a lower lever and denied access to their televisions.

I was especially concerned that the Settlement Agreement discussed "milieu therapy," with no real definition of what that would encompass. My concern in reading the Settlement Agreement was that a prison could substitute unstructured time in the day room for truly therapeutic programs. This was not the case in the SNU. The therapists were actively involved in helping the inmates to learn how to socialize appropriately, and took special care to engage more solitary inmates with others as they played cards, board games, or simply engaged in conversation. **The manner in which this "milieu therapy" was conducted was appropriate and therapeutic, and very much conformed with the spirit of the Settlement Agreement.**

The therapists and correctional officers working in the SNU were outstanding. They engaged with the inmates in a professional and empathic manner. Moreover, they demonstrated an enthusiasm for the program that was inspiring.

An appropriate number of inmates were receiving involuntary medication, pursuant to the appropriate level of due process. **Although I am not a psychiatrist, I did not observe signs that large numbers of inmates were overmedicated**. People placed on involuntary medications are required to be seen 7 days after the first injection, and at clinically appropriate intervals (at least once every thirty days) thereafter.

<u>New Castle Correctional Facility</u>

New Castle C.F. is a unique facility of approximately 3200 inmates. It has the only protective custody unit in Indiana, and its general population is largely made up of sex offenders. The facility is operated by a contract with GEO, and sex offender treatment is provided by contract with Liberty Healthcare. Warden Butz explained that the dormitories are organized by types of inmates. For example, there is a dorm for incarcerated veterans, a sober housing dorm for people who are recovering from substance abuse, a dorm for inmates that are heavily involved in education, etc.

At New Castle, I met with the executive team. As was the case at Wabash Valley, they seemed very proud of the improvements in mental health care that have been

achieved during the past few years. Again, I observed good communication and cooperation between the custody staff and the mental health staff. Warden Butz is an extremely impressive leader with a strong commitment to meeting the requirements of the Settlement Agreement. Officers are selected to work in the Special Needs Unit (SNU) based on their interpersonal skills and willingness to work with this population. The Warden assured me that if Wexford staff felt that an officer was inappropriate for this work, he or she would be moved to another assignment. According to both the prison's executive team and the Wexford leadership, this has not been a problem.

According to the Warden, there are only 31 RHU beds at New Castle. I was particularly impressed by the Warden's statement, "We only lock people up when we are afraid of them." The Warden also reported, "We haven't done a cell extraction over two years."

Correctional officers who work in the "New Castle Psych" (NCP) program or in the RHU receive training as Certified Treatment Specialists (CTS.) While I did not review the entire training curriculum, the description of the training sounded appropriate.

Communication between mental health staff and correctional officers seems to work well. Observations by correctional officers are communicated orally or in writing to the mental health staff, who in turn document the observation in a progress note in the medical record. In addition, there are shift reports between custody and the mental health team.

As was the case at Wabash Valley and is explained below, the rooms used for seclusion or suicide watch are not equipped with toilets. Instead, there are flushable holes in the floor of the cell. (See below.)

The therapists and correction officers working in the NCP Program were outstanding. They engaged with the inmates in a professional and empathic manner. Moreover, they demonstrated an enthusiasm for the program that was inspiring.

An appropriate number of inmates were receiving involuntary medication, pursuant to the appropriate level of due process. Although I am not a psychiatrist, **I did not observe signs that large numbers of inmates were overmedicated.** People placed on involuntary medications are required to be seen 7 days after the first injection, and at clinically appropriate intervals (at least once every thirty days) thereafter.

The New Castle Psych Program (NCP) consists of 128 beds, divided into eight ranges of 16 beds each. The NCP houses those inmates with the most acute and severe mental health needs. Many of them had behaved in a manner that was dangerous to others. Pursuant to the Settlement Agreement, such inmates are no longer routinely housed in RHU. The NCP is a more therapeutic and less punitive alternative. Importantly, the same officers are assigned to the NCP every day, which contributes

to the teamwork with the mental health staff and decreases the likelihood of counter-therapeutic interactions.

While the Settlement Agreement only requires that 10 hours of therapeutic programming be offered, good correctional and mental health practice carefully monitors the number of hours that are received. **Thus, it is important to minimize the number of inmates who refuse to participate in treatment**. One particularly talented therapist, Ms. Heimann, has gained a reputation as the "refuser whisper." Through a combination of skill and empathy, she seems to be able to successfully encourage inmates to participate. I suggested to Dr. Dwenger that these skills can be taught to other therapists throughout the state, which would further enhance the rate of participation in the treatment that is offered.

I was also pleased to see that Ms. Heimann conducts a spirituality group. People with the most severe psychiatric disabilities have physical, cognitive, and emotional problems that are frequently the subject of psychiatric and mental health treatment. It is less common to find clinical attention to their spiritual needs. According to several inmates, this non-denominational group helps them to think about the meaning of their lives and their place in the world.

I noted that the restraint beds used in this program pose the possibility of a suicide risk, however, this risk is mitigated when the inmates are under constant supervision.

One inmate, with a history of chronic self-injury, reported that he was confined to the padded suicide watch cell for "months." He reported that he felt punished for harming himself, and complained that he was allowed only boxer shorts despite the fact that the suicide watch cell was cold. He reported that he requested crayons, a radio, and more therapy, but was denied while he was housed in the suicide watch cell. When I asked staff about these reports, custody staff reported that the suicide-resistant "smocks" could be torn apart and used as a ligature, which is why he was not allowed a smock. **I suggested that they consider buying a better quality smock and suicide-resistant blankets**, and mentioned several companies who provide these items.

Suicide watch is enhanced by the presence of inmate "companions," who are tasked with watching the suicidal inmate constantly. Unfortunately, these inmates are precluded from engaging in conversation with the suicidal inmates, making the word "companion" ironic and inaccurate. **So long as these inmates are well-trained, well supervised, and clearly told that they are not therapists, there is no good reason for them to silently stare at the inmates that the prison is trying to keep alive**.

The NCP Program offers the required number of hours of therapeutic programming. Although I was only briefly able to sit in on a group, based on inmate reports the quality of therapy appears good.

Indiana Reformatory

At the Indiana Reformatory (IR), I met with Warden Dusan Zatecky and the executive team. As was the case with the other facilities, **they seem very proud of the improvements in mental health care that have been achieved during the past few years.** Again, I observed good communication and cooperation between the custody staff and the mental health staff. There was a complete commitment, from the top down, to meeting the requirements of the Settlement Agreement. Officers are selected to work in the Indiana Reformatory Treatment Unit (IRT) based on their interpersonal skills and willingness to work with this population. I observed no problems with the behavior and demeanor of the correctional staff assigned to the IRT, and was again assured that such a problem would be quickly remedied if it arose.

At IR, I noted that Protective Custody (PC) inmates are housed in the Restrictive Housing Unit (RHU), as the facility does not have a PC unit. Most of the inmates who are deemed to be appropriate for PC are transferred to other institutions. Most of the time, these transfers are voluntary. However, when inmates are unwilling to explain the reason that they believe themselves to be at risk, they may be temporarily housed in the RHU, usually for less than 60 days.

The IRT is similar to the SNU at Wabash Valley in many ways. Inmates housed there can be classified at any custody level. The main difference between the two programs is that the disorders of the inmates housed in the IRT are deemed to be more likely to be primarily characterological rather than psychotic. The belief is that inmates with severe character disorders, even if they are legitimately classified as SMI, are likely to take advantage of the more debilitated inmates housed in the SNU. I think this is a reasonable belief, and this plan appears to be working well.

The IRT consists of 156 people in 194 beds. There are four different buildings, separated by the privilege phase the inmate has achieved. Some of the inmates in this program are transferred from the NCP program, while others are transferred directly from general population. When the program first opened, there was a problem with a prevalence of predatory inmates. The situation was dealt with, mainly through the use of appropriate clinical consequences.

While the IRT is housed in separate buildings, the program is "semi-integrated" with the general population, including a shared chow hall. This arrangement increases the chances that at least some inmates with serious mental illness will be able to eventually rejoin the general population.

Unit C1 consists of 24 cells and is quite restrictive. There are four inmate mentors who work with the inmates housed in these cells. The inmates are offered 10 hours per week of group activities as required by the Settlement Agreement; however, they come out in restraints that include an uncomfortable "black box" that prevents

inmates from freeing themselves from handcuffs. **In my opinion, the use of the black box is unnecessarily punitive and a strong disincentive for participating in treatment. I recommend that its use be discontinued unless an inmate has demonstrated an ability to get out of handcuffs or presents other compelling security concerns.** Luckily, it appears that this status is relatively short-term, as the length of stay in C1 was reported to average less than two months. Finally, for the inmates who did come out for group, their reports were generally positive about the quality of the groups. I was told that Bible study groups do not count as therapeutic program for the purposes of the Settlement Agreement. **I recommend that Bible study and other organized spiritual activities should count as therapeutic programs, as they are extremely valuable and therapeutic.**

There were several good things about the C1 unit. There are four inmate mentors who spend time talking with the C1 inmates. I met several of the mentors, and they appeared to be experienced, mature, and helpful. **I recommend that the Department consider carefully expanding this mentor program**. Mature, experienced inmates have credibility that is very different from that of officers and clinicians. Inmates in C1 also stated that the staff generally dealt with them in a fair and respectful manner.

On a less happy note, the acoustics in this building are terrible. Unfortunately, I can't think of any good recommendation to fix this problem. On the other hand, the buzzer that signifies meals is extremely loud and unpleasant, and sounds very much like a fire alarm. Apparently, because of the noise and poor acoustics of the unit, it was felt that this type of signal was necessary. **I would recommend seeking a better solution for announcing meals.**

For inmates in C-1, the exercise areas are stark and barren of any equipment at all. Again, this is a disincentive for inmates to accept the recreation time, and increases boredom and anger. **I recommend at the facility consider installing some safe, basic exercise equipment in these outdoor exercise areas.**

Inmates in C1 are cuffed and shackled whenever they leave their cells. I understand why some inmates need to be restrained when they are in a particularly acute or violent state, however there are other ways to accomplish this. For example, the state of New York has developed a "Re-start Chair," which allows an inmate to freely and relatively comfortably participate in programs, with no ability to reach staff or other inmates.

The groups are led by likeable, enthusiastic, and competent counselors. A suggestion is to remind is counselors to avoid long, unfamiliar words and closed-end questions that allowed inmates to provide one-word answers without actually participating. **Amazingly, several inmates complained about the groups as being "too short." I can think of no greater compliment to group therapists**. That being said, **I do recommend some additional training for the people doing group therapy.**

There were some complaints from inmates that their dayroom recreation periods, especially in the evening. are sometimes cut with no reason being given. When I asked about this, staff usually gave a sensible and credible reason; however **I recommend spending a little more time explaining this to inmates, and perhaps making it up the next night.** When I suggested this to the custody supervisor, he stated, "I don't do give-backs." I did not have time to explore this response, and I'm not sure I understand it. If inmates are entitled to something, but can't receive it through no fault of their own (e.g., temporary staff shortage) why would it not be fair to make it up to them the next day?

On the same topic, out of cell time in phases 3 and 4 appear to be only 2-3 hours per day. Further, I was told that the number of hours does not increase when an inmate graduates from phase 3 to phase 4. **I recommend that the facility consider increasing the out of cell time in both phases 3 and 4, with phase 4 receiving more time than phase 3.**

Overall, I again found the leadership on both the DOC side and the Wexford side to be outstanding.

Indiana Women's Prison (IWP)

At IWP, I met with Warden Laurie Johnson and her executive team. Again, I found great communication between mental health and custody staff. There are three women's prisons in Indiana, but inmates in need of mental health services, including those covered by the Settlement Agreement, are transferred to IWP. The women's SNU is unique, in that the more secure area (similar to NCP) is housed in the same building as the SNU. This combination makes good sense, in light of the smaller number of women in the program.

The Restrictive Status Housing Unit (RSHU) consists of 25 beds. To the credit of the correctional officers assigned there, the unit was clean and quiet. On the other hand, it appeared that inmates have limited access to books and other safe diversions while housed in restrictive housing. One woman, for example, spoke only limited English, and wanted a book in Spanish that she could read to alleviate her boredom. Apparently, none of the mental health staff speaks Spanish, which poses a real problem for Spanish-speaking inmates with serious mental illness. In this woman's case, **this problem could be somewhat alleviated by using a translator and perhaps assigning a Spanish-speaking inmate mentor to spend some time with her.**

Officially, rounds in segregation follow departmental policy, in that inmates with a mental health designation of A are only required to be "rounded" by a mental health professional once per month. It appears that the actual performance is better than that. In fact, at IWP, all inmates in restricted housing are provided 10 hours per

week of out of cell time. **Nevertheless, I repeat my recommendation that policy should require that every inmate throughout IDOC in restricted housing should be rounded by a mental health professional at least once per week.**

I saw one woman who is receiving involuntary medication yet appears to be in severe and acute distress. The prisons have no ability to transfer anyone to the state hospital, and while this should be very rarely needed, here was a case that seemed to obviously require such a transfer. As a former state hospital administrator, I understand why departments of mental health are cautious about accepting correctional transfers into a limited number of state hospital beds. **I do, however, suggest that IDOC negotiate for a small number of beds at the state hospital, to be used only in the most extreme circumstances.**

Currently, the SNU houses 30 inmates in 46 beds. As was the case at IP, several general population inmates also lived there and serve as mentors. **Again, I was impressed by this program and suggest consideration of its expansion.**

The Warden explained that they hand-select the officers who were to be assigned to the SNU, and all of them receive CTS training, as described above. As was the case in the other facilities, I was consistently impressed with the professionalism, competence, and therapeutic orientation of the correctional officers assigned to the mental health units. This was especially true in IWP, where I observed a number of extremely skillful interventions.

Generally, I found the staff open and sensitive to the problems related to trauma, which are extremely prevalent especially (but certainly not exclusively) among women inmates. **However, I strongly recommend that all of the clinicians who work in Indiana's prisons receive additional training on trauma-informed therapies**. While I did not get a chance to review the CST curriculum, **I recommend reviewing it to ensure that trauma-related training is included in the training for officers who work in mental health and restrictive housing units.**

I met one inmate with a severe eating disorder. **Speaking with the staff, it became clear that they could profit from some additional sophisticated training on the treatment of eating disorders.**

Although it is perhaps tangential to the official purpose of my visit, I would be remiss if I did not mention the "Wee Ones" program that allows new mothers to remain with their babies for up to 30 months. The program is extremely well run, with excellent management and good support from the prison administration, which takes justifiable pride in the program. While not officially a mental health program, I can assure you that a program like this has immense emotional and behavioral value to these women inmates. **My only recommendation is to publish a description of the "Wee Ones" program so that it can be emulated by other prison systems**.

Findings and Recommendations regarding the Settlement Agreement

Simply put, the Department and its contractor (Wexford) are in diligent compliance with all aspects of the Settlement Agreement.

I do, however, recommend changes to item 56 of the Settlement Agreement, which reads, "During the time that the prisoner is confined (in a suicide-safer cell), the DOC is not required to provide the prisoner with the minimum adequate treatment noted above. Consistent with DOC policy, mental health will monitor a prisoner on suicide watch and the prisoner will be provided "appropriate mental health services and treatment."

While there is a vague mention of providing "appropriate mental health services and treatment" to inmates on suicide watch, in practice it appears that the quality and quantity of mental health treatment is actually lower when inmates are on suicide watch. **Ironically, suicidal inmates are in need of more, not less treatment during periods of suicidal crisis**.

There is a widespread belief in American corrections that inmates on suicide watch must be housed alone in a cell 24 hours per day until they are no longer deemed to be suicidal. This practice flies in the face of what we know about suicide prevention. There is no evidence whatsoever that being locked in a room alone is appropriate psychological treatment for suicidal ideation or behavior. **Further, as noted below, if the circumstances of suicide watch are perceived as punitive, it will dissuade truly suicidal inmates from coming forward and asking for help**. If therapeutic activities are adequately supervised, then there is no reason that a suicidal inmate cannot participate in some therapeutic activities, especially if they are being constantly watched by a staff member. I would suggest that the department adopt a presumption that inmates on suicide watch fully participate in treatment unless it is clinically determined that such participation would be counter-therapeutic or dangerous to the inmate or others.

Please note, I was told by several staff members that the problem of malingered suicidal behavior is best solved by making sure that suicide watch is not a pleasant experience. Sadly, this belief is common among many correction institutions across the country. The belief is that unpleasant or even punitive conditions of suicide watch will decrease false claims of suicidality. Even if this is true, it will also have the same effect on people who are truly suicidal, thus inadvertently increasing the risk of suicide. Further, it doesn't work, as malingering continues to be a problem. It is worth considering <u>why</u> a person would feign suicidal intent. For example, if the inmate is seeking suicide watch due to fear of something or someone in their housing unit, it is no wonder that unpleasant conditions do not deter them from asking to be safely locked up. Finally, no clinician can reliably distinguish between

feigned and real suicidal intent; indeed, the two often co-exist. **In summary, people who claim to be suicidal need more treatment, not less, and conditions that are reasonably perceived to be punitive are inappropriate as part of a suicide prevention program.**

Throughout the system, I was impressed with the relatively low number of nonparticipants among inmates in the various mental health units. In large part, this appears to be due to the friendly and likable mental health staff who provide these programs, and the encouragement and support provided by many of the custody officers.

I was also pleased to hear of system-wide efforts by the Department to reduce the overall use of restrictive housing, both by reducing admissions to RHU and by reducing lengths of stay.

Recommendations Outside of the Settlement Agreement

It is interesting to note that the implementation of the Settlement Agreement has significantly changed the manner in which IDOC uses restrictive housing, at least as it applies to inmates with serious mental illness. As a result, these programs are no longer best understood as a way to get inmates out of restrictive housing. Basically they have become very appropriate ways to meet the mental health needs of inmates. I congratulate the parties for this achievement.

At New Castle and Wabash Valley, the cells used for suicide watch did not have toilets. Instead, there was a hole in the floor that can be flushed. I found this to be offensive, degrading, and likely to be experienced as punitive. I also believe it can inadvertently increase the risk of suicide. When the circumstances of suicide watch are reasonably perceived to be punitive, it decreases the likelihood that truly suicidal inmates will ask for the help they need. While it is not contrary to the Settlement Agreement, I recommend that the Department consider changing these conditions. **All of the cells used for suicide watch should be equipped with a secure toilet/sink combination unit.** Flushable holes in the floor are an anachronism; to my knowledge, no prison or psychiatric hospital built in this century has included such a cell. In my opinion, this practice is likely to cause inmates unnecessary humiliation and a feeling of shame that is unnecessary and counter-therapeutic. If an inmate attempts self-injury by banging his or her head against the sink/toilet, it would justify transferring them to a room equipped for top-of-bed restraints.

The restraint beds are equipped with metal rings to which restraints are attached. However, these rings are far enough off of the floor to allow an inmate to commit suicide by hanging. In my opinion, this precludes the use of these rooms for

seclusion, unless the inmate is under constant supervision by staff. To its credit, the Department has appropriately mitigated this risk by placing restrained inmates on constant observation. There are, however, much safer beds available for this purpose, where the restraints can be attached at floor level.

It was unclear to me how often the suicide prevention committees are meeting. This is an important function. In addition to reviewing the data on suicide deaths and attempts, this Committee should be tasked with proactively searching for physical spaces and practices that could be altered to reduce the risk of suicide even further. Examples would include creation of a "punch list" of suicide hazards to be used for cell inspections, such as identifying loose fixtures that might allow for the attachment of a ligature, and identifying sharp metal edges on beds and other furniture. Obviously, these inspections are especially important in cells used for suicide watch, mental health treatment, and restrictive housing. To cite another example, the committee might survey the correctional staff to look for ways to improve pre-service and inservice suicide prevention training.

The common area of the SNU at Wabash Valley is ill suited for groups, and virtually precludes conducting more than one group at a time. In many of California's prisons, they have created multiple group rooms by strategically placing upholstered "pony walls." This configuration works very well, and allows the California Department of Corrections and Rehabilitation to successfully conduct multiple groups at the same time. **I recommend that the Department consider altering the large day rooms at Wabash Valley SNU by adding upholstered "pony walls**," similar to those used in some California prisons.

When inmates with SMI appear to be making no progress, it would be good to conduct a formal case conference, including some of the most experienced and well-trained clinicians throughout the system. In some cases, these case conferences might include outside consultants with specialty skills such as the treatment of eating disorders.

In speaking with staff at each facility, it is clear that the rounds in segregation are more frequent than officially required by policy. For people with the lowest mental health needs rating (level A), there is an official requirement of mental health rounds in segregation once every 30 days, unless the inmate requests a visit. I realize this comports with ACA standards, but in my opinion it is not adequate. That being said, in my conversations with clinicians, **it appears that inmates in Restrictive Housing are visited by a mental health professional at least once a week. My recommendation is to make this a requirement by policy**. **I also recommend that the policy explicitly state that either an inmate or mental health staff member can request an audibly private meeting, as opposed to a cell-front visit.**

I also noted that the mental health codes (A-F) do not correlate to the designation of Seriously Mentally Ill (SMI). I am not certain, but I wonder if this discrepancy may

be confusing to inmates or staff. **If this is the case, my recommendation is to consider incorporating the SMI designation into the system of mental health codes.** On the other hand, if the dual system seems to be working well, there may be no need to change it.

I reviewed the seclusion and restraint policy, which looks good except for the designation of seclusion and restraint as "therapeutic." **There is nothing therapeutic about seclusion or restraint**, although it is sometimes necessary to protect inmates or staff. I would also suggest adding to the policy more specific rules regarding the frequency of staff observation for inmates in seclusion and restraint, and a revisiting of the roles of "companions" (See below).

I was especially pleased with one part of the suicide watch policy, which requires follow-up of any inmate who was on suicide watch at 24 hour, one week, two week, and one month intervals.

Suicide watch is enhanced by the presence of inmate "companions," who are tasked with watching a suicidal inmate constantly. Unfortunately, these inmates are precluded from engaging in conversation with the suicidal inmates, making the word "companion" ironic and inaccurate. **So long as these inmates are well trained, well supervised, and clearly told that they are not therapists, there is no good reason for them to silently stare at the inmates that they are trying to keep alive. Forced solitude is not a legitimate treatment for a suicidal crisis.**

I was a bit confused by the fact that "case plans" and "mental health treatment plans" were completely separate. Since I am not sure exactly how this is working, I refrain from making a specific recommendation. **However, it is important to make sure that these plans are either integrated or at least complementary.**

As noted earlier, **I was impressed with the "mentor" program**, which is sometimes a good way to encourage the most difficult inmates to consider participating in treatment programs. Often, experienced inmates have credibility that mental health and correctional professionals do not. If my understanding is correct, this program is not in place at NCP. Of course, these mentors must be carefully selected, trained, and supervised. If it is not already the case, **I suggest consideration of expanding this program.**

Generally, I found the staff open and sensitive to the problems related to trauma, which are extremely prevalent among all inmates. **However, I strongly recommend that all of the clinicians who work in Indiana's prisons receive additional training on trauma-informed therapies. While I did not get a chance to review the CST curriculum, I recommend reviewing it to ensure that trauma -related training is included in the training for officers who work in mental health and restrictive housing units.**

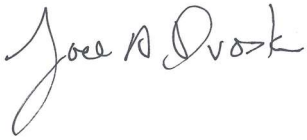
Summary and Conclusion

As stated above, the Department and Wexford are in full compliance with the substantive requirements of the Settlement Agreement. Moreover, the Department and Wexford have internalized these requirements and support them enthusiastically. Overall, I found the leadership on both the DOC side and the Wexford side to be outstanding. Based on my observations, I truly believe that these conditions will continue to be met even when there is no longer a Settlement Agreement.

I am very grateful to the leadership of IDOC, Wexford, as well as the staff and inmates at the 4 prisons I visited. They treated me with hospitality and respect, and responded to me questions with integrity and candor.

Finally, I want to congratulate the Plaintiffs, especially Mr. Falk, and the legal team and leadership of IDOC for the collaborative manner in which this case was resolved. The Settlement Agreement **was clear and reasonable, and has resulted in prisons that are safer and healthier for inmates and staff alike.**

Respectfully submitted,



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