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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Victor Parsons; Shawn Jensen; Stephen Swartz; Dustin Brislan; Sonia Rodriguez; Christina Verduzco; Jackie Thomas; Jeremy Smith; Robert Gamez; Maryanne Chisholm; Desiree Licci; Joseph Hefner; Joshua Polson; and Charlotte Wells, on behalf of themselves and all others similarly situated; and Arizona Center for Disability Law,

Plaintiffs,

v.

Charles Ryan, Director, Arizona Department of Corrections; and Richard Pratt, Interim Division Director, Division of Health Services, Arizona Department of Corrections, in their official capacities,

Defendants.

No. CV 12-00601-PHX-NVW (MEA)

EXPERT REPORT OF ELDON VAIL

I. INTRODUCTION

1. I am a former corrections administrator with nearly thirty-five years of experience working in and administering adult institutions.

2. Before becoming a corrections administrator, I held various line and supervisory level positions in a number of prisons and juvenile facilities in Washington, in addition to serving as a Juvenile Parole Officer and pre-release supervisor. I have served as the Superintendent (Warden) of three adult institutions, including facilities with maximum-security inmates.

3. I served for seven years as the Deputy Secretary for the Washington State Department of Corrections (WDOC), responsible for the operation of prisons and community corrections. I briefly retired, but was asked by the former Governor of Washington, Chris Gregoire, to come out of retirement to serve as the Secretary of the Department of Corrections in the fall of 2007. I served as the Secretary for four years, until I retired in 2011. A complete copy of my resume, detailing my work experience, is attached as **Exhibit 1**.

4. My experience as a prison and corrections administrator included responsibility for, and a focus on, the mentally ill population and their custody, housing, and treatment. My opinions are based upon my substantial experience running correctional institutions and presiding over a statewide prison system for more than a decade, a system that successfully addressed the challenge created by the rapid influx of the mentally ill into the prison environment. In my thirty-five years of work in corrections, I have spent considerable time working to provide for the proper custody and care of the mentally ill sentenced to prison.

5. As the Superintendent of McNeil Island Corrections Center, and as a result of legislation, I was charged by the Secretary at the time, Chase Riveland, with designing and opening a new program for mentally ill inmates within the WDOC. I did so in collaboration with leaders from a number of departments from the University of Washington (UW) who informed the design and operation of the two units, one medium

security and one maximum security, devoted to this population.[1] That collaboration continued for nearly twenty years as UW staff came to assist the Department in improving our treatment of mentally ill inmates throughout the system, with a focus on moving them out of high security bed placement whenever possible. Like other states, Washington saw an influx of the mentally ill into the prison system, the result of the downsizing of mental hospitals that began in the 1980's. Political and agency leadership understood the need to provide treatment for this growing population and that simply housing them in a maximum-security environment was counter-productive. My charge was to lead the conversation about what changes needed to be made and what environment could be created within a prison to provide quality treatment to the mentally ill inmate population. For this program, we created a new job series, "Correctional Mental Health" workers. About two-thirds of the line staff were formerly correctional officers and the other third had little or no correctional experience but did have undergraduate or Master's degrees in psychology or other social services majors. The leadership of the program was also a hybrid of correctional and mental health staff, as well as psychiatrists and psychologists. This allowed the program to blend the two disciplines to make the program safe as well as effective in providing treatment to the mentally ill who were housed there. We provided psycho-educational treatment. Along with treatment from the primary clinicians, inmates were offered classes in areas such as anger management, symptom recognition, and medication management. The living unit itself was used as an environment to practice the skills being learned by the mentally ill inmates away from the pressures they can experience in a general population prison. We expected staff and inmates alike to model pro-social behavior. The design was proven effective. According to researchers at the UW, "[p]articipants were substantially less symptomatic when they left the program than when they entered . . . . there was a significant improvement in major infractions and use

[1] McNeil Island was a 1,700-bed facility with five medium security living units and one Intensive Management Unit (equivalent to the ADC's isolation unit), and a minimum-security unit outside the secure perimeter.

of expensive resources following program stays . . . . and, the pattern of work and school assignments is one of improvement."[2]

6. As Assistant Director for Prisons in Washington my responsibilities included oversight of mental health programs for all prisons in the State of Washington. Part of this assignment was to oversee the design of a capital project that more than doubled the size of Washington's largest program for the mentally ill in order to accommodate the growing number of mentally ill inmates arriving in Washington prisons. Taking what I had learned from my experience on McNeil Island, my primary focus was to design a housing continuum for the mentally ill that did not rely on over-classifying individuals as maximum security, and instead moved them through less restrictive levels of prison housing. We developed a design that allowed inmates to move through progressive custody levels from maximum to minimum and to avoid segregation whenever possible.

7. During my tenure as the Deputy Secretary, we created a specialized high security treatment unit for the mentally ill inmates who did end up in segregation separate and apart from a regular segregation unit, where the inmates could be safely housed without significant levels of isolation and also receive robust treatment from mental health professionals.

8. As Deputy Secretary and later as Secretary, I focused on providing proper treatment for the mentally ill in prison on a system-wide basis. The pioneering work of the McNeil program, and Washington's correctional programs for inmates placed in isolation, have been extensively studied and guided by researchers from the UW.[3]

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[2] D. Lovell, D. Allen, C. Johnson and R. Jemelka, *Evaluating the Effectiveness of Residential Treatment for Prisoners with Mental Illness*, Criminal Justice and Behavior, Vol. 28 February 2001, 83-104.

[3] For examples see, Lovell, *A Profile of Washington Inmates on Intensive Management Status*, University of Washington-Department of Corrections Behavioral Health Collaboration, October 2010, (unpublished, attached as Exhibit 3); Lovell, *Patterns of Disturbed Behavior in a Supermax Population*, Criminal Justice and Behavior, 2008, 985; D. Lovell and R. Jemelka, *Coping With Mental Illness in Prison*, Family and Community Health, 1998.

9. Most recently. I testified as an expert in the Eastern District Court of California in *Coleman v. Brown*, specifically addressing the issues of use of force and disciplinary procedures for mentally ill inmates.

10. Attached hereto as **Exhibit 1** is a true and correct copy of my resume. It details my work experience and lists the current cases for which I have been retained as an expert. My billing rate for work on this case is $150 per hour.

II. ASSIGNMENT

11. I have been retained by Plaintiffs to evaluate and offer my opinion regarding the policy and operational practices of the Arizona Department of Corrections (ADC) regarding the use of isolation units. I understand that the Court has defined the isolation sub-class in this case as "All prisoners who are now, or will in the future be, subjected by the ADC to isolation, defined as confinement in a cell for 22 hours or more each day or confinement in the following housing units: Eyman—SMU I; Eyman—Browning Unit; Florence—Central Unit; Florence—Kasson Unit; or Perryville—Lumley Special Management Area."[4]

12. The particular focus of my review has been on the conditions of confinement for inmates housed in isolation in the units identified in the Court's Order and on whether or not the inmates, especially mentally ill inmates, living in those units suffer serious harm or are subject to a substantial risk of serious harm.[5]

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[4] *See* Order, March 6, 2013, at 22 (Doc. 372).

[5] The defendants take issue with the use of the word "isolation" to describe the conditions under which many of the mentally ill live in the ADC. Within the corrections industry several different words are used to describe these living conditions. In addition to "isolation," some of the most frequently used terms are "segregation," "super-max," and "solitary confinement." I use the word "isolation" throughout this Report. It was the first word I learned to describe these conditions when I started working in corrections in 1974. The Defendants use it as well in their curriculum for *Understanding Mentally Ill Inmates* on page 54: "Also, staff should know that placing this inmate in isolation may actually worsen his psychosis due to isolation, boredom, and lack of stimuli." (ADC049856).

13. My work on this matter is ongoing. This report summarizes my current opinions given the available information I have reviewed to date. It is my understanding that a number of relevant documents requested by Plaintiffs' counsel have yet to be produced or were produced after the discovery cut-off date, and that some depositions of ADC personnel, including Defendants Ryan and Pratt, have not yet been taken. If additional information is produced, I reserve the right to modify or supplement my analyses and opinions accordingly.

III. FOUNDATION FOR EXPERT OPINION

14. I considered information from a variety of sources in the course of my work. This includes certain information provided by the parties; court filings submitted by the parties; certain deposition testimony; and other information I have obtained from public sources.

15. I was first contacted regarding this case in August 2012 by Plaintiffs' counsel. My work did not commence until June of 2013 when Plaintiffs' counsel provided me a number of documents for review, including but not limited to pleadings in this case, ADC policies, the declaration and deposition of Greg Fizer as well as several internal memos, reports, and logs regarding the operation of ADC. A complete list of the materials I reviewed in this matter is attached hereto as **Exhibit 2,** and may be referred to in footnotes and/or other references within this report.

16. In addition to the documents reviewed, I also conducted inspections and interviews in the isolation housing units located in three prisons where class members reside. The prisons were: Arizona State Prison Complex—Perryville on July 29, 2013, Arizona State Prison Complex—Florence on July 30 and 31, 2013, and Arizona State Prison Complex—Eyman on August 1 and 2, 2013. I was particularly interested in the conditions of confinement. I was able to view the physical design and condition of the living units, including cells, fixtures, shower areas, and recreation areas. During these tours, I spoke with well over 100 inmates, including 28 whom I interviewed in a

confidential setting, and the Named Plaintiffs in this action, who were currently housed in the isolation units that I inspected. Staff access was very limited and, when available, they frequently responded to my questions by stating, "read the policy."

IV. OPINIONS

17. ADC policy for isolating inmates is over-broad and fails to systematically take into account the needs of mentally ill inmates.

18. The conditions of confinement for inmates in isolation in ADC facilities results in extreme social isolation and other hardships that are both unnecessary and counter-productive to good prison security, as well as harmful for all inmates, but especially for the mentally ill.

19. ADC routinely and inappropriately uses chemical agents, such as Oleoresin Capsicum (OC) products, against mentally ill inmates without considering the impact on the inmate and the effective management of the inmate population.

20. My additional opinions are stated in the body of this report.

V. ADC'S CLASSIFICATION POLICY UNNECESSARILY ASSIGNS INMATES TO MAXIMUM CUSTODY

21. ADC policy on initial classification requires that all inmates serving a life sentence, those that have been validated as a gang member, and those sentenced to death are automatically assigned to maximum custody and are placed in an isolation unit.[6] In these cases, ADC policy ignores the individual's risk level and requires placement in maximum custody. While care must be taken in assigning custody levels and institutional placement to validated gang members or those with life sentences, in my experience it is not necessary, or even safe, for the individual prisoner to be placed in isolation when they

[6] ADC Department Order 801, Inmate Classification, 801.03 (describing "[n]on-discretionary overrides") (ADC013841).

can be successfully housed in lower custody levels. Many inmates with life sentences function quite well in close or medium custody.[7] Also, even though some inmates may belong to a gang, many are capable of not acting out while in the institution and can in fact be motivated to set their gang behavior aside while incarcerated if it means placement in a less severe prison environment than isolation. Many states have found that even inmates sentenced to death are capable of successful adjustment outside of isolation. Although free movement within the institution is rarely allowed, it is not uncommon that death row conditions of confinement are modified to allow routine and regular out of cell contact and some limited programming in small living units.[8] In order to avoid the known risks of harm associated with time spent in isolation, the risk factors of the individual inmate should control custody placement within ADC rather than unnecessary, mandatory policy overrides.

22. I found during my inspections and conversations with inmates housed in ADC isolation units that many had been automatically placed there simply because they had served time in ADC before and were released to the community from isolation status at the end of their previous incarceration.[9] This practice increases the risk that the individual prisoner will suffer unnecessarily from the conditions of confinement associated with isolation in the ADC prison system in situations when it is not needed for good prison security. In fact, this practice may well have the opposite effect. Punishment of an inmate for previous bad behavior that is not related to the current risk the inmate

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[7] I have also had success housing carefully chosen inmates with life sentences in minimum custody, although those minimum units were always inside a double fenced securely enclosed prison perimeter. My point here is that all inmates with life sentences are not the same and the individual risk associated with each prisoner needs to be considered in determining custody level placement.

[8] From my tours I observed many small living units that would be perfect for this kind of program within existing ADC facilities.

[9] The practice of releasing inmates from isolation directly to the community has been shown to be associated with an increased risk of recidivism. *See* David Lovell and Clark Johnson, *Felony and Violent Recidivism Among Supermax Prisoners in Washington State: A Pilot Study*, 2004.

represents may undermine the inmate's perception of the legitimate authority of prison officials, a critical ingredient in running a safe prison.[10]

23. Also, during my tours, I found many individuals housed in isolation for reasons even less serious than those described above. I talked to several inmates who were in isolation solely for their own protection, having been the victim of assault or threats by other inmates, or simply because they were awaiting transfer to a lower custody facility. This included some inmates who were already eligible for minimum security placement. Some of the inmates I interviewed had been waiting weeks or months for transfer. While they were waiting for their transfers, they were continuing to be subjected to the risk of harm associated with stays in isolation. Inmates who are victims or inmates ready to transfer to lower custody levels should not be housed in isolation except for very short periods of time, long enough to find them a safe bed in a less restricted living unit. Despite Director Ryan's claim that "ADC does not have a policy that allows detention beds or maximum custody beds to be filled based on a lack of bed space," that is exactly the practice that I witnessed.[11]

24. Based on my inspections of the ADC facilities, review of ADC policies and practices, and review of a number of custody files, it is my opinion that ADC over-uses isolation and that a significant portion of its current isolation population could be housed in a less restrictive environment, including units specifically designed for mentally ill prisoners with behavioral management issues.

25. The result is that the ADC houses about 8% of their population in isolation, a rate much higher than is found in other jurisdictions.[12] The risks of harm associated with

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[10] A.E. Bottoms, *Interpersonal Violence and Social Order in Prisons*, Crime and Justice, 1999.

[11] Plaintiff Dustin Brislan's First Set of Requests for Admission (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2) to Defendant Charles Ryan, and Defendant Charles Ryan's First Supplemental Answers Thereto, at Req. for Admis. No. 27 (p. 19, lines 13-15).

[12] J. Austin and E. Sparkman, *Colorado Department of Corrections Administrative Segregation and Classification Review*, National Institute of Corrections (Oct. 2011), at 17. For the ADC isolation figure, *see* Arizona Department of Corrections, "ADC Institutional Capacity

placement in isolation are well known and should be avoided or limited whenever it is safely possible to do so. ADC does not adopt this principle in policy or in practice.

VI. ADC ROUTINELY HOUSES MENTALLY ILL PRISONERS IN ISOLATION AND IGNORES THE RISK OF HARM.

26. ADC Director Ryan admits that placement in isolation "is determined by ADC's classification policy and by inmate behavior."[13] He goes on to say that "monitoring" for this population is enhanced. He further claims that special treatment areas are available for seriously mentally ill inmates at Florence and Eyman. No claim is even made regarding Perryville Special Management Area (SMA).[14] Based on my facility inspections, interviews, and documents reviews, it is my opinion that the conditions of confinement for mentally ill inmates in ADC's isolation units put them at serious risk of harm for no legitimate correctional purpose.

27. As an experienced corrections administrator, it is my opinion that housing mentally ill inmates in isolation is likely to exacerbate their mental illness and make management of the individual and of the entire institution much more difficult. For more than two decades, I worked closely with mental health staff and experts from the UW to understand the risks associated with confining mentally ill inmates in isolation. I have become familiar with the research and the evidence on the subject. There is broad consensus in the corrections and mental health community that placement of mentally ill inmates in isolation creates a significant risk of harm.

28. For example, in 2012 the American Psychiatric Association issued the following position statement:

> Prolonged segregation of adult inmates with serious mental

Committed Population," dated Oct. 31, 2013.

[13] Plaintiff Dustin Brislan's First Set of Requests for Admission (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2) to Defendant Charles Ryan, *and Defendant Charles Ryan's First Supplemental Answers Thereto*, at Req. for Admis. No. 1.

[14] *Id.*

> illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.[15]

29. Also, Dr. Craig Haney, writing about the harmful mental health effects of solitary confinement has said:

> There is not a single published study of solitary or supermax like-confinement....that failed to result in negative psychological effects. The damaging effects ranged in severity and included such clinically significant symptoms as hyper-tension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behavior.[16]

30. Writing a declaration for the court in another case, Dr. Haney has said:

> As I and many other researchers and knowledgeable mental health professionals have observed, segregated housing places prisoners at grave risk of psychological harm. This is especially true when prisoners are confined in especially harsh and deprived conditions for very long periods of time. There is widespread agreement that mentally ill prisoners areparticularly susceptible to this risk of harm. There are many studies of the effects of isolation in general that underscore the ways that it can undermine psychological well-being, and even more substantial evidence of its negative psychological effects in prison settings. This evidence comes from a variety of sources, including personal accounts, descriptive studies, and systematic research on solitary and supermax-type units. As I have noted in previously published reviews, the data that establish these

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[15] APA Official Actions, Position Statement on Segregation of Prisoners with Mental Illness (2012).

[16] Haney, C., Mental *Health Issues in Long Term Solitary and "Supermax" Confinement*, Crime & Deliquency, 49, 2003.

> harmful effects have been collected in studies conducted over a period of several decades, by researchers from several different continents with diverse backgrounds and a wide range of professional expertise.[17]

31. From my own training and experience in the corrections field, I understand what conditions of isolation can do to a person and the negative consequences that often result. In Arizona, inmates in isolation are confined to a small cell—with or without a cell partner—that is about the size of a small bathroom.[18] Human contact is limited to the few times that staff come to the front of the cell to provide a service, such as a meal or when mental health or medical staff are conducting rounds. Conversations with inmates in other cells is constrained, sometimes most dramatically, depending on the unit design. Recreation time, for most inmates the only time the inmate is let out of their cell, only occurs 3 days a week at best in an indoor or outdoor enclosure not much larger than the cell itself.[19] There is no clear pathway to tell the inmate what they need to do to earn their way out of isolation. Confined to a cell, with extreme amounts of idle time, sometimes with no TV or radio and a very uncertain and unpredictable future, it is no surprise that inmates begin to act out and find themselves in a spiral of behavior that will keep them in isolation for longer periods of time. This kind of environment puts great stress on the individual inmate that is not being alleviated or managed by the ADC staff. What group treatment, education, or jobs that exist are woefully inadequate to the volume of the need. Hopelessness and anger become the emotional range for the inmate and they become much more difficult to manage. The result is a prison environment in ADC that puts all inmates at risk of serious harm. It is my opinion that the incredibly high

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[17] Expert Declaration of Craig Haney, *Coleman v. Brown*, Doc. No. 4378, at No. 38 (E.D. Calif. Mar. 14, 2013).

[18] Defendants' Response to Plaintiff Wells' First Set of Interrogatories (6/26/13), Resp. to Interrogatory No. 10 (describing cell size at various facilities, with some as small as 8x6 or 9x5 feet).

[19] ADC Department Order 704.10, Inmate Exercise Enclosures, at 1.1 (ADC012693); ADC Department Order 804.01, Inmate Detention and Observation, at 1.2.6.5 (ADC107481).

incidences of self-harm on the isolation units recorded in ADC's incident reports are a direct product of this environment. Unfortunately, these incidents of self-harm sometimes result in actual suicides. In his deposition, Northern Region Operations Director, Carson McWilliams, acknowledges that 50% of the suicides that occur in the Arizona prison system take place in their protective custody units (which are isolation units).[20] He goes on to say that there is a higher rate of suicide in their isolation units.[21] According to the press releases on the ADC website, there have been nine suicides so far this year.[22] This number of suicides should be a cause for immediate concern by the responsible authorities.

32. It is also my opinion that mental health watch is being used in inappropriate ways in the system and this is at least partially driven by the fact that ADC is not providing alternatives to isolation for inmates with serious mental health issues. In some ways watch appears to be a default tool to deal with an inmate or inmates exhibiting mental health problems as opposed to treatment or care. During my inspections, I spoke with inmates who were on watch and inmates who had repeatedly been placed on watch. One inmate at Eyman whom I spoke with while in a watch cell could not tell me how long he had been there. Another inmate at that facility who hears voices told me he had spent fourteen days naked in a watch cell and was sprayed many times. Also at Eyman, I spoke with an inmate on watch who had been in prison for several years and was due to be released to the community in less than three months. He said he was depressed and often suicidal. He said there is no help for him while in watch or in the institution in general. When I asked him what real help would look like, he described the treatment he received while in the juvenile system as effective and helpful, treatment he did not believe he was receiving in the ADC. At Florence, I talked to an inmate who was on watch for a week.

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[20] McWilliams dep., 169:13-17 (Sept. 27, 2013).

[21] *Id.* at 170.

[22] *See* ADC News and Events, 2013 News Archive, http://www.azcorrections.gov/Minh_news_gov.asp.

He said that during the time he was on watch the only conversation he had with anyone was a brief check in each day with a mental health staff. At Perryville, I spoke with an inmate who said that while on watch status she had to pound on her door to get someone's attention. Another inmate at Perryville told me that while in watch you don't get respect from the staff and that the cells are dirty and insect infected.

33. Deposition testimony from the Defendants illustrates my concerns about the ADC's approach to managing inmates who may be self-destructive. Mr. McWilliams acknowledges the higher frequency of suicides for inmates in isolation in the ADC. In his deposition he also says:

> Q. Do the staff working in these units undergo extra training?
>
> A. No. I think all officers get the same training. You get the block at COTA, and then you get the annual refresher and regular training for line staff.[23]

34. After I left McNeil Island and went to the central office in Washington, every facility over which I had supervision had isolation units. I was frequently the final sign-off for who would stay or who would be released from these units. At one of my facilities, we were having a great deal of acting out by the inmates. Having had success at McNeil at managing the isolation population, I decided to re-assign one of my McNeil deputies to the prison with the problems to see what he could do to improve conditions. He went in and found that the inmates in the unit felt stuck, had very little to do, and were subjected to a great deal of staff disrespect rather than being managed professionally. Problems were being escalated instead of being resolved and use of force had become a daily occurrence. The deputy began to solve legitimate individual inmate problems and taught the staff that he expected them to do the same. He sought and brought in individual and congregate programs to the unit in partnership with some of the UW resources we had

[23] McWilliams dep., 169:13-17 (Sept. 27, 2013).

worked with on McNeil. He trained the staff in different approaches to manage the inmates. The result was a unit that calmed down and became the model for other isolations units in the Department. The other result was a book, *Total Confinement: Madness and Reason in the Maximum Security Prison*, written by an anthropologist attached to our collaboration with the UW.[24] In the book, the author documents our work with this very difficult population including our struggles, our successes, and our failures. It is difficult work, but it is not impossible work. In my experience, custody staff who are assigned, or better yet choose, to work with the mentally ill need intensive and specialized training to be successful at their jobs. Such intensive training will not only improve treatment outcomes, but also improve the overall conditions of confinement for the mentally ill. As custody staff learn more about the limitations of mentally ill inmates to respond to the typical prison environment, they evolve more effective techniques and daily routines better suited to that population. As noted above, that is not the practice at the ADC and is fundamental to why they are struggling to keep inmates from attempting to harm themselves.

35. There is no question that mentally ill inmates are regularly and routinely housed in isolation units within the ADC.[25] There is little evidence that the agency takes into consideration the potential harmful effects that the conditions of confinement in those units are having on all inmates, but especially the mentally ill, and the problems created in managing its facilities that result. Inmates need a coherent structure, living conditions that recognize the extreme stress social isolation creates, a staff that not only controls but respects them, and robust programs to help them learn what behaviors have brought them

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[24] Lorna A. Rhodes, *Total Confinement: Madness and Reason in the Maximum Security Prison*, University of California Press, 2004.

[25] Declaration of Benjamin Shaw, filed Jan. 8, 2013, Doc. 321-1, para. 37; Plaintiff Dustin Brislan's First Set of Requests for Admission (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2) to Defendant Charles Ryan, and Defendant Charles Ryan's First Supplemental Answers Thereto, at Req. for Admis. Nos. 1-2; Shaw dep. 135:21- 137:2; 168:5-7; MH Levels Statistical Summary (4/15/13) (ADC083096-105); MH Levels Statistical Summary (7/23/12) (ADC027759-27768); MH Levels Statistical Summary (4/02/12) (ADC094442-51).

into segregation and what changes in conduct they need to make in order to get out and stay out. The ADC isolation units fail this challenge in every respect.

VII. PHYSICAL PLANT CONDITIONS OF CONFINEMENT IN ADC ISOLATION UNITS

36. From my tours and from a review of ADC policies, I found the conditions of confinement for inmates held in isolation in ADC to be shocking and sometimes deplorable. The problems endemic to those units are multiple—from physical plant design to routine maintenance and repair to their daily operational practices—add significant risk of harm to all prisoners, but especially prisoners with mental illness.

37. The size and construction of the isolation units in ADC differ a great deal from one to another.[26] The standards of the American Correctional Association (ACA), for a segregation cell require a minimum of 80 square feet.[27] Several of the cells I viewed during my tours did not meet this requirement. All of the isolation units at Florence fail to meet this standard:

Cell Block 1	54 square feet
Cell Block 2	40 square feet
Cell Blocks 3 & 4	54 square feet
Cell Blocks 5 & 7	72.96 square feet
Kasson	61.8 square feet

Cells at Perryville are 56 square feet.[28] The cell sizes referenced here are significantly smaller than the ACA standard—some as small as half the recommend size or only slightly larger—and add to the feeling of extreme isolation for those forced to live there.

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[26] All information regarding the size of ADC cells comes from Defendants' Response to Plaintiff Wells' First Set of Interrogatories at Response to Interrogatory No. 10.

[27] Standards for Adult Correctional Institutions, 4th Edition, American Correctional Association (2012), Standard No. 4-4141.

[28] According to Defendants' Response to Wells' First Set of Interrogatories, at Response to Interrogatory No. 10, the cell size at Perryville is 7 x 8 x 12.

Given that most inmates held in isolation in the ADC spend four days a week, 24 hours a day in their cells (the other 3 days, they are allowed 2 hours out for recreation, but it is frequently canceled), the lack of adequate space within the cell is important to consider when understanding the inmate's living conditions.

38. There is a dearth of natural light into ADC's isolation cells. A window directly to the outside from the cell, which is most common in isolations units around the country, rarely exists in cells in Arizona. Again, according to their own admissions, there are no windows in any of the cells at Eyman. At Florence, about half of the cells in CB 1 have windows to the outside; the rest do not. In CB 1 and CB 2, there is a vent-sized opening in the back of each cell that lets in a sliver of natural light, but since it is covered with only a metal grate, this opening also allows heat and cold directly into the cell. Inmates I interviewed during my inspection complained that their cells are intensely cold during the winter as a result. The cells at Kasson and CB 5 and 7 do have windows to the outside, but the narrow slits in the windows in CB 5 and 7 look only out to the concrete backside of the window in the cell adjacent. CB 3 and 4 do not have windows in their cells. What natural light does exist in many of the isolation units is either through filtered windows or skylights outside of the cell.

39. The unit design for isolation at Perryville is absolutely unique in my experience. There is no interior living unit or common area outside of the cells. Instead the cell doors open directly to the outdoors and give one the feeling of being trapped in a very small room in a dilapidated roadside motel. It was strange to witness and must be much more so to be confined in these units. This design produces a number of problems. For the inmates in the cells it exposes them to the intense heat of the summer or cold of the winter. For the staff, it exposes them to the same. We toured in the summer and it was very hot. These are the same cells used for suicide watch. I am concerned about the capacity of the officers assigned to monitor the inmates on suicide watch to properly conduct their duties. It would be very difficult for them to effectively conduct their duties when experiencing the intense heat of the Arizona sun. Fans that were set up to cool the

area were very loud and made it nearly impossible for me to actually talk to the inmates in those units. During my five-day inspection of Arizona prisons, I found one outdoor thermometer that registered 112 degrees in the shade.

40. The physical condition of many of the units I visited was very poor, despite the fact that multiple inmates told us they could tell a tour was about to come through because of the amount of clean-up work and painting that was being done prior to my arrival. Still, I saw several examples of chipped and peeling paint in the cells where inmates were living and in some common areas. It appeared as if there was a significant backlog of maintenance repairs. I saw leaking showers and toilets, some with visible rust that had eaten through the fixtures. An inmate at ASPC-Eyman showed me the constant leak at the base of his toilet that he had to sop up every day. Pieces of the toilet were coming loose as he went through his daily ritual of cleaning up the mess and trying to keep his cell clean and dry. Inmates showed me electrical problems that made the lights flicker in their cells. I saw broken windows and broken beds. In CB-4 there were several cells where I could see that water had been running down the cell walls, likely leaking from the roof, although some inmates believed it was sewer water. Traveling to the upper tiers in this cellblock, I could see that a substantial leak had been occurring for some time.

41. Of particular concern to me was the condition of several of the mattresses in the cells. After seeing one unmade bed in a cell with a mattress that was nearly in shreds, I asked other inmates to show me their mattresses. I saw several others in the same condition. Mattresses in the level of disrepair that I witnessed are a safety and security hazard and are likely a health hazard as well. First of all, mattresses in this condition would make for very easy places to hide contraband and would be difficult to properly search. Second, because the mattress covers were literally in shreds, I am concerned that bacteria, such as MRSA, could grow which would present a health hazard to the inmate. Last, the mattresses were ripped in long threads. Those threads could be torn from the mattresses and woven together to form a strong rope that could be used as a weapon of self-harm or used against another person.

42. Many of the showers I inspected had layers of built up soap and grime. Inmates often complained that the showers were not routinely cleaned. Some told me they refused showers and instead chose to try and keep clean in their small sinks (they called it a "bird-bath") rather than even try the dirty showers. Given the level of idleness of inmates in isolation, there is really no reason that the showers could not be thoroughly cleaned once or twice a day by the inmates themselves. It is demeaning to be expected to keep one's body clean in a space that is not kept clean itself. It reflects and communicates to the inmates a profound lack of care for their physical health and wellbeing, which is not conducive or motivating for inmates to want to participate in treatment for their mental illness.

43. It is a well-established axiom in corrections that facility cleanliness is fundamental to prison safety and security. The level of cleanliness and disrepair I saw in the Arizona isolation units I inspected show a profound disrespect for the inmates confined there and for the profession itself. Again, given the extreme idleness suffered by the inmates in these units, there is really no excuse for failing to put some of the inmates in isolation to work by keeping their facilities clean and in good repair. This can be safely done and often is in isolation units in other prisons around the country. While ADC staff told me that some inmates did work as porters, it is clear that the numbers were not sufficient. Inmates I spoke with on my inspection constantly complained of not having enough to do. An obvious, inexpensive, and effective solution would be to put more of them to work keeping the common areas of the living units cleaned.

44. On my first day of touring Florence, during a confidential interview in the visit room an inmate told me about a problem with roaches. The inmate guessed I was likely going to be in his unit the next day. He was right. He had shared my potential visit with others in the unit. By the time I arrived, several inmates had made a point of collecting roaches to show me. Some were in small jars; some were in the hands of the inmates and some wound up being confiscated by the custody staff before the inmates could show them to me. Later on that same day in another living unit, the lawyers I was

traveling with saw a mouse in the dayroom we were in. I was not quick enough to catch sight of it but the inmate that I was talking to at the cell front did and reacted strongly. He said mice were a constant problem in the unit he lived in and he showed me mouse droppings on the floor that I had previously missed. I kept my eyes and ears open after that, saw the droppings in other parts of the prison myself, and heard many other inmates tell me of problems with insects (including scorpions) and rodents in different living units.

45. I toured facilities in late July and early August and got a first-hand experience of the condition the inmates live in day in and day out. I previously mentioned that heat and cold could directly flow into the cells from the outdoors in CB 1 and 2, obviously a concern with the extreme temperatures in Arizona. Those units are supposed to be kept cool by the use of the swamp coolers. I did not find them to be effective. At the end of the tiers in CB 1, there were industrial size fans set up to blow air around. The noise they made was deafening and I had to raise my voice to be able to converse with the inmates who lived in the cells adjacent to the fans. As I moved to the middle portions of the tiers, I found that fans did not reach that far, the air was dead, and the temperature even more extreme. Inmates had consistent complaints (not just in CB 1 and 2 but in several of the other units as well) about the temperatures they are forced to live in. A couple of inmates shared with me that during the morning yard the very day we were visiting the entire group of inmates who were in the yard sat down and refused to return to the unit until they got a promise that the swamp coolers would be fixed. It is significant that inmates would be this organized and put themselves at risk of staging a group protest in order to alleviate the problem they were having with the heat in their living unit. Two days later when I was touring ASPC-Eyman, the warden accompanied me on the tour. I observed that whenever the warden was in the unit his subordinate staff always propped the doors of the unit open to the outside yard (and sometimes got him a chair to sit in). This was a very effective method of cooling off the living unit and the degree of temperature drop as a result of this practice was, I believe, a clear testament to how

extreme the temperatures are in those units on a daily basis. Despite the discomfort we were all experiencing, we could leave at the end of the day. The inmates could not.

46. As an experienced corrections administrator, I have learned that it is very dangerous to expose inmates on psychotropic medications to temperatures above 85 degrees. Many of the units I visited had many inmates on such medications and the temperatures very likely exceeded this threshold. The temperature data that have been made available to the plaintiffs confirms my perception as there are multiple temperature readings over 85 degrees in the different units; some had readings well over 90 degrees, and some readings were 100 degrees or higher.[29] From my training and experience, I know that these temperature levels are extremely dangerous to persons taking some psychotropic medications. Florence, which holds many mentally ill prisoners on psychotropic medications in their isolation units, according to Defendants, "does not track indoor temperatures."[30] As an experienced corrections administrator, it is unfathomable to me that temperatures are not tracked at this large prison and that dangerous levels are allowed with some frequency.

47. Inmates in the Arizona isolation units live in cramped conditions, often without a view to the outside of the cell and little natural light. They live in cells that have basic maintenance problems, with cell furnishings that are in disrepair and where common spaces are often not regularly cleaned. They live in those units in temperature of great extremes. It is my opinion that these unaddressed physical plant conditions are counter-productive for institutional security in general and put all inmates, but mentally ill inmates in particular, at risk of harm.

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[29] ASPC-Perryville, Daily Temperature Checks, ADC140513-60, ADC 140640-732, ADC140762, ADC140857; ASPC-Perryville, Lumley Unit, ADC141335-91; ASPC-Eyman-Browning, Daily Temperature Checks, ADC140213; ASPC-Eyman (untitled), Daily Temperature Checks, ADC140248-50, ADC140259-60, 140386-87.

[30] Defendants' First Supplemental Response to Plaintiff Sonia Rodriguez's First Set of Interrogatories, Response to No.1, at 30.

VIII. OPERATIONAL PRACTICES AND CONDITIONS OF CONFINEMENT IN ADC ISOLATION UNITS

48. Prolonged denial of outdoor exercise violates both domestic and international correctional standards, and is harmful to inmates' physical and mental well-being. The United Nations Standard Minimum Rules for the Treatment of Prisoners requires, "Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits."[31] The U.S. State Department created a handbook to provide embassy officials around the world with a basic understanding of international standards for correctional systems. That handbook states, "The prisoners should have access to recreation for no less than one hour per day."[32] The ACA has extensive standards on inmate recreation in prisons.[33] Those standards require, even for prisoners otherwise confined to their cell, "that inmates receive a minimum of one hour of exercise per day outside their cells, five days per week, unless safety or security considerations dictate otherwise."

49. While most isolation units I have seen or am aware of in other jurisdictions offer one hour of recreation each day from five to seven days a week, ADC policy requires that recreation be offered three times a week for two hours a day for a total of six hours a week.[34] On its face this policy increases the number of days inmates must spend in their cells. If an inmate gets one hour of recreation a day, then she/he gets to come out of the cell each day. If an inmate only gets it three days a week, then she/he must regularly remain in the cell for four full days each week. A constant complaint from the inmates I interviewed, verified by a review of the available documents, shows that recreations

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[31] *Standard Minimum Rules for the Treatment of Prisoners,* Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Standard 21(1).

[32] *A Practical Guide to Understanding and Evaluating Prison Systems*, United States Department of State, page 23.

[33] *Standards for Adult Correctional Institutions*, 4th edition, American Correctional Association (2012), Standard No. 4-4270.

[34] Perryville is an exception. They report that they offer recreation one hour a day, six days a week.

periods are frequently canceled. In reviewing some individual logs of inmates held in isolation while on the tour and viewing recreation records in the Individual Inmate Detention Records produced by the ADC since the tours,[35] I found that it was very common for inmates not to be offered six hours of recreation each week—at least one of the recreation periods within a week's time is frequently canceled. Since recreation is only offered three days a week to begin with (except for Perryville), the result is that in addition to inmates routinely spending twenty-four hours a day in their cells at least four days a week, when recreation is canceled even once a week, the amount of days and time spent continuously in the cell is increased exponentially. The reason given by ADC in their reports for the frequent recreation cancelations is most often "staff shortage."[36] Given that one third of an inmate's allowable time out of cell each week is eliminated each time a recreation period is canceled, ADC's regular and routine practice of canceling recreation adds to the extreme social isolation suffered by inmates held in those units. When inmates do get out for recreation, there is very little to do in the recreation cages. Defendants acknowledge as much when they say, "Defendant admits that for security purposes, exercise is limited to the use of a handball and calisthenics, with an emphasis on large muscle exercise, including walking, jogging in place, and isometrics."[37] The absence of meaningful group exercise for all but a few inmates further extends the experience of isolation beyond what is necessary for safety and security.

50. I have worked nearly 35 years in and around correctional institutions. I am very aware of protective equipment available to staff and the circumstances where it is necessary to wear such equipment. What I experienced in the ADC isolation units is

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[35] ADC 123536-123621, 136213-136317 and 139901-140087.

[36] ADC Reports regarding incidents that affected meals and-or recreation and occurred in isolation units at Eyman, Florence (ADC094500—094572) (includes Perryville documents); ASPC-Florence-Central Unit Information Reports regarding recreation cancellation (ADC084366-72).

[37] Plaintiff Dustin Brislan's First Set of Requests for Admission (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2) to Defendant Charles Ryan, *and Defendant Charles Ryan's First Supplemental Answers Thereto*, at Req. for Admis. No. 16 (p. 12).

different than what I experienced in my own state or in any other jurisdiction I have ever visited. ADC requires that stab proof vests and eye coverings be worn by all staff and visitors at all times when in any isolation unit. It is unnecessary and is an exaggerated response to a threat that does not routinely exist in those units. The mandatory wearing of such items sends a strong message to the inmate population about how they are perceived by the staff and serves to increase the social distance between the keepers and the kept. Inmates understand that all inmates are not the same, that real threats are rare and that the protective equipment is most always unnecessary. This practice also sends a strong message to the staff that all inmates in the units where this protective equipment is required must at all times be perceived as a threat. That is an exaggerated response to the actual level of threat presented by most of the inmates in the Arizona isolation units, and is counterproductive to good institution security as it is likely to push the staff out of the units as soon as possible in order to remove the protective gear. These practical disincentives created by ADC policy will keep officers from maximizing the opportunity to interact with inmates on the tiers. From my own experiences on the prison inspections, the vests are heavy and cumbersome, and make one want to get out of them as soon as possible. The protective helmets required at Eyman make it nearly impossible to converse with inmates in the cells even if a person's voice is raised. Every opportunity for routine human interaction is transformed into the inmate having to converse with a person more ready for combat than to have a normal conversation. While I have directed that this equipment be worn around certain inmates under certain circumstances,[38] to require it be worn every day for all non-inmates entering these units is counterproductive to good institution security, further alienates the inmate population and increases the experience of social isolation. In addition to their Enhanced Security Unit at Eyman, ADC has sufficient security hardware to keep staff safe in their existing facilities, including mobile plexi-

[38] For example, vests and spit helmets can be appropriate during a high security transport where there is a legitimate threat by a specific inmate. Those situations are rare and those inmates are well known to prison authorities.

glass shields that can be placed in front of an individual cell when a known risk by a specific inmate has been identified. It is important to note that whenever I visited inmates outside of the unit who were in the outdoor recreation cages, correctional officers and wardens alike immediately and frequently removed their protective gear, even though we were in as close proximity to the inmates as we were in the cell blocks. This is clear evidence that the equipment is not needed for staff safety and is used for no purpose other than to keep the inmates at a distance.

51. It is typical for those responsible for running isolation units to clearly describe to the inmate population what it will take for them to earn a promotion to a reduced custody placement. I found no coherent process in ADC that could be articulated by the inmates or staff. In my interviews with inmates, I asked them what they had to do in order to get out of isolation and the vast majority could not articulate it for me. I asked the staff, usually the wardens, if they had written material that described the programs for the inmates. With some uncertainty, they said they thought they did, but none was produced on my inspections. This absence of written material, apparently for both staff and inmates, suggests whatever process ADC has in place is of little importance. I have had the opportunity to review some related material that Plaintiffs' counsel received during discovery.[39] In summary, those documents tell the inmates to behave, work the programs available on closed circuit television and attend group sessions. They are very short on specific detail that an inmate could use to begin to understand what they need to do in order to be released from isolation. Universally the inmates I interviewed could not tell me what they were doing or what they needed to do to earn their way out of isolation.

52. I asked the inmates about the closed circuit TV programs and found it was often times necessary to have the money to buy your own TV in order to participate. Loaner programs apparently exist, but the facilities do not have the resources to match the

[39] *See* ADC 139519-139520 (Kasson) and 139521-139523 (Maximum Custody "Memo of Expectations," "Step Matrix," and "Mental Health and Behavioral Phase Matrix").

need. Even for those who had a TV and were participating, they did not understand if there was a connection between completing the TV programs and earning their way out of isolation. I have yet to see a schedule of the TV programs offered, although it is my understanding that it has been asked for in discovery. Inmates reported that the TV self-help programs, such as masonry and carpentry, were outdated and bore little relationship to the issues they believed they needed to deal with to improve their behavior.

53. I also asked the inmates about their participation in groups. Many inmates told me they wanted to get into groups but they could not get in. It was very rare that I found an inmate who was allowed to participate in more than one group a week. In viewing the available schedules for groups that are offered, it is very clear that the need again greatly outweighs the available resource. In the McWilliams deposition, he acknowledges this problem, "There's more inmates than we have staff to do the groups."[40] He then admits that the mentally ill held in ADC isolation units are put on waiting lists in order to receive proper group treatment for their mental illness.[41]

54. Based on my observations during the prison inspections, my interviews with prisoners allegedly in the programs, and subsequent document review, it is my opinion that there is a profound lack of a coherent program for the mentally ill in any of the isolation units. This finding is echoed in witness testimony. Dr. Pastor, designated by Corizon as its mental health expert for ADC, could not describe any mental health programming that occurs in the isolation units.[42] In her deposition in September of 2013, Dr. Taylor, ADC's mental health monitor, testified to a recent email from the Deputy Warden at Florence Central stating that the mental health programs were not being done.[43] During my inspection of the isolation units, I repeatedly heard from prisoners that they wanted to participate in groups but were told none were available. I also heard from many

[40] McWilliams dep., 114 (Sept. 27, 2013).
[41] *Id.* at 114:25-115:6.
[42] Pastor dep., 82, 189 (Oct. 4, 2013).
[43] Taylor dep., 160-61 (Sept. 5, 2013).

who thought groups might be starting, or who had been to one group in the week or two before my visit but the program had just started. Some prisoners remembered earlier efforts at group programming that had suddenly and inexplicably stopped. Others reported sporadic individual counseling sessions or requests for counseling that went unanswered. In none of the units I toured did I observe or hear about a coherent, structured and fully operational mental health program. Instead, the programs described to me appeared to be haphazard and intermittently administered. The absence of meaningful programs is a major obstacle to safely manage any inmate population, but especially the mentally ill. My experience and training has taught me that without regular, predictable and quality programs for the mentally ill offered by committed mental health professionals, my experience and training has taught me that mentally ill inmates will deteriorate and suffer, which is exactly what I believe is happening in the isolation units in the ADC. During my inspection, I repeatedly spoke with prisoners who were obviously suffering severe mental distress. Many spoke of the pain they experienced living in the isolation units. For individuals with mental illness the pain of being in extreme isolation often makes them more difficult to manage because of the behavioral problems created by isolation. As a result, the units themselves become more toxic and dangerous for all prisoners, regardless of their mental health status.

55. A common practice in prison isolation units is to check on the inmates every half hour. The specific American Correctional Association standards says:

> Written policy, procedure and practice require that all special Management inmates are personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; suicidal inmates are under continuing or continuous observation.[44]

[44] *Standards for Adult Correctional Institutions*, 4th edition, American Correctional Association (2012), Standard No. 4-4257.

This requirement is fundamental to the corrections profession and I have never been in an isolation unit in any jurisdiction where it was not observed. I have been unable to locate any such requirement in ADC policy. Their policy identifies the need for these welfare checks but does not describe a required frequency.[45] The lack of such a requirement for these checks is deeply disturbing. First, it puts the inmates in these units at great risk. If a medical emergency or a self-harm event occurs, staff discovery of the event might well be delayed. Second, the absence of these checks occurring on a frequent basis is one more example of the lack of another potential human contact for the inmates housed in isolation. During my tours, the lack of frequent checks was an item of concern reported by many inmates. Some said that the correctional staff only come around a couple of times a shift; others said they came around every hour or two. One inmate told me of it taking nearly an hour to get custody staff's attention for a medical problem and then another half hour for medical to respond. Another inmate told me of a similar event where it took 5 hours to get anyone's attention. Several inmates told me how they must make banging noises, sometimes as an individual and sometimes as a group, in order to get custody staff's attention when someone needs medical attention. This lack of frequent checks should be a great concern to ADC leadership. Failing to conduct welfare checks more frequently represents great risk for the prisoners in their custody. Failing to ensure regular and meaningful contact between staff and inmates increases the already extreme level of isolation in these units.

[45] ADC Department Order 804, Inmate Behavior Control, 1.10.1 (ADC107485); Deputy Warden of Florence Central Unit, Greg Fizer testified that the checks are required on the [redacted] but he could not locate it in policy either. He says he assumes that the checks are in the post orders. Fizer dep., October 29, 2012, pages 53-55. The post orders I received have been heavily redacted. Based on what I can discern, only [redacted] checks are required in the housing units. It is unclear if this Post Order applies to the isolation units. But in any case, it provides insufficient checks. ADC Post Orders, #12 Detention Unit Security Officer, #34 Yard Security Officer, #35 Housing Unit Floor Officer. ADC Post Order, Housing Unit Security Officer (5/9/12) (ADC107518-24).

56. It is not uncommon for inmates in prison to complain about the food. However, I have never heard the consistent level of food complaints that I heard from the inmates in ADC isolation units. The food is universally despised. The inmates are served a sack lunch in the morning that is supposed to provide them the first two meals of the day. This happens despite that fact that agency policy says, "When security precautions dictate, sack meals may be served."[46] Apparently, ADC believes that such security precautions in their isolation units require sack meals as a daily practice. Several inmates were determined to show me the contents of their sack and did so. It typically consists of six slices of bread, protein in the form of small sacks of peanut butter and/or what the inmates called "mystery meat," a ¾ ounce package of chips or popcorn, and a packet of mayonnaise and instant coffee. Inmates complained of losing weight as the sack provided for two of their meals each day. Some claimed they had lost 10, 20 or even 40 pounds, sometimes more. After hearing that complaint several times, I began to ask the inmates to show me their identification badge with a photo typically taken at the time of entrance to the Arizona prison system. The evidence of their weight loss was clear to me from comparing those photos to the way the inmate looks today. Some inmates even told me that they had to limit their exercise because it made them too hungry and there was not enough food. It is significant to note that ADC's policy reduces the caloric intake for inmates in isolation with the reason that this population is more "sedentary" than those in general population. For some inmates, this system clearly does not work. All inmates believe that it is absolutely necessary to have resources in the community to send them money so they can supplement their diet with purchases from the inmate canteen in order to avoid weight loss and near constant hunger. For those without such resources, they do without. Having witnessed the food offered by the state, I believe this universal belief to be absolutely correct. Finally, serving only two meals a day to the inmates in isolation, one in the morning and one in the evening, is one more limitation on the amount of human

[46] ADC Department Order 804, Inmate Behavior Control, 1.2.3.4 (ADC107480).

interaction they have with correctional staff that serve them the meals, again increasing the impact and experience of extreme social isolation.

57. There are some simple, inexpensive things that could be done, that are not done in the Arizona isolation units to alleviate some of the extreme isolation, idleness, and despair experienced by the inmates without creating additional security risks. One example is to increase the availability of phone calls. ADC inmates in isolation are only allowed one phone call a week. Calls to family are well known to be an effective protective factor in managing inmates. Other jurisdictions often make phones available in the recreation enclosures and do not have such a rigid restriction of one call a week. Another example would be to increase the availability of religious programs. The lack of access to a chaplain while held in isolation was a frequent comment by the inmates I interviewed. The inmates quite simply reported that they never saw a chaplain in the isolation units. In my experience, ensuring that inmates have access to chaplains in isolation units, including representatives of minority religions, is not only appropriate and lawful policy, it is also an excellent way to motivate inmates to stay out of trouble and find some strength to help them live through the difficult experience of isolation. I have had success bringing trusted volunteers into isolation units. Anything that can be done to increase human contact with inmates in isolation, including increasing expectations for contact with custody staff, will serve as a calming and settling influence for inmates.

58. Being segregated from the general population of a prison presents difficulties of some kind for most prisoners. But the units in ADC inflict a gratuitous level of isolation that I believe places prisoners at serious risk of harm. As I explained above, in Arizona the experience of isolation is exacerbated by extremely limited access to any out-of-cell time, including recreation. It is further exacerbated by extreme levels of social isolation with little human contact between prisoners and other prisoners or staff, almost non-existent programming, extremely limited phone calls and visits, and even limited access to religious counseling. The extreme idleness on these units is further increased by policies that severely limit property so that many prisoners report pacing

their cells and talking to themselves as routine, daily activities. There is also a profound lack of a coherent program to earn your way out of an isolation unit in ADC, including insufficient slots in the programs that do exist for the volume of need. Custody staff wear protective gear that is not necessary and do not check on the welfare of the inmates according to industry standard. The conditions in the ADC isolation units present a toxic combination of factors that create substantial risks for the prisoners housed there. As I describe below, I believe the conditions on these units increase the incidents of self-harm, lead to the use of suicide and mental health watch as a default practice for both staff and prisoners, and increase the lethality of these units. Unfortunately, the isolation practices and policies of ADC have made these painful and sometimes tragic outcomes entirely predictable.

IX. SUICIDE WATCH IN THE ADC AND THE INAPPROPRIATE AND ROUTINE USE OF OC AGAINST MENTALLY ILL INMATES

59. ADC Department Order 807, Inmate Suicide Prevention, Precautionary Watches and Maximum Behavioral Control Restraints describes a range of behavior that can cause an inmate to be placed in a watch cell, from being at serious risk of self-harm or suicide to being at imminent risk of self-harm or suicide. However, inmates report much different uses of the watch cells. They describe the use of watch cells by ADC as a mechanism for immediate and informal punishment and sometimes for retaliation. During my prison inspections, inmates told me about being put on watch status because: their regular assigned cell was dirty; they banged on their cell door; they mouthed off to staff; for refusing food trays; and they threw water on staff. I met one inmate who had recent surgery and had his mouth wired shut. Placing inmates in suicide watch cells for reasons other than to protect them from self-harm is inappropriate and has no justification in any correctional facility.

60. I inspected the suicide watch cells in every prison I visited. I found those cells to be beneath professional standards and to likely place the inmates housed in them

at an unnecessary risk of harm. At Florence, the beds in the watch cells could easily be moved and had been by the inmates that were being held there during my inspection. The ability to move the beds gives the inmate a tool to facilitate any serious attempt at self-harm. Cell furnishings in suicide watch cells should be fixed and stationary to prevent this possibility. All of the cells were much smaller than those typically designed and used to safely conduct suicide watches. When I asked the wardens if there was another area should an inmate need to be subjected to four or five point restraints, two of them told me that it happened in these cells. In my experience, the size of the cells I inspected would make it very difficult to safely restrain an inmate and greatly increase the potential for injury to the inmate being restrained and to the staff as well. A restraint room should have furniture that cannot be moved and sufficient floor space for four to six staff to be able to work. Typically one staff will be assigned each limb of the inmate, one staff may be assigned to make sure each limb is safely secured, and one medical staff should always be present. All of the suicide watch cells were located in cellblocks and not in or near a medical facility that is much more typical in prisons I have visited in other jurisdictions. As a result, nursing staff were not located in those units but instead simply came by on rounds.

61. At Perryville there were a number of women inmates being held on watch status. Male officers were supervising every one of them. Inmates on watch status are given very little clothing, usually just a suicide smock, which is a paper gown down to about the middle of the thigh. Inmates have to use the bathroom in full view of the officer assigned to do the watch wearing nothing but the smock. Absent an emergency situation, it is entirely inappropriate to have male officers conducting watches for female inmates. Some of the inmates I interviewed at Perryville complained about this practice and claimed it sometimes led to inappropriate behavior by both parties. I recommend this routine practice be stopped immediately.

62. In my training and experience, the use of chemical spray, including what is known as "OC" spray, against mentally ill inmates should be avoided whenever possible.

I have learned that using OC spray can and often does make it more difficult to manage the mentally ill, especially when the inmate is decompensating or in an acute mental health crisis. A psychotic or delusional inmate may actually be unable to respond to a custody order or command and the use of OC in such circumstances serves only to induce psychological harm and physical pain, akin to corporal punishment. The policy and practice regarding the use of OC in the ADC ignores this information, and ADC staff regularly and routinely use OC against the mentally ill, including those who are on "watch' status. This use of chemical spray often takes place in situations where the inmate is simply not following orders from custody staff and in other cases where the inmate is attempting self-harm.

63. ADC policy on use of force appropriately authorizes the use of force in order to: "Prevent suicide or serious self-inflicted injury."[47] In that same policy, staff are instructed to first use OC products if attempts at verbal intervention fail.[48] This direct instruction to staff is then followed regularly and routinely for inmates on watch status. The policy offers no further guidance regarding mentally ill inmates except to say, "In mental health care facilities, correctional staff shall notify and/or request intervention by Mental Health staff if the inmate or staff are not in imminent danger."[49] In all the reports generated and the interviews I conducted for inmates on watch status, I did not find one instance where this guidance is followed. The routine practice is to immediately spray an inmate who is disobedient or who begins to make even the most rudimentary self-harm gestures. Such a routine practice is completely inappropriate and unnecessary from a corrections standpoint.

64. All the use of force OC sprays that I reviewed for inmates on watch are not planned use of force by ADC's own policy definition and there is no video record required of what occurred. If cameras were posted in each suicide watch area it would

[47] ADC Department Order 804.04, Inmate Behavior Control, 1.1.2.2 (ADC 107490).
[48] ADC Department Order 804.04, Inmate Behavior Control, 1.2.1.2.1 (ADC107491).
[49] ADC Department Order 804.04, Inmate Behavior Control, 1.1.4 (ADC107491).

likely have a controlling effect on staff and inmates since they would know their behavior would be recorded for review by officials at a later date. Given the great frequency with which OC spray is used on inmates on watch status, cameras should be available or installed in watch cells areas to protect both the inmates and the staff.

65. The deposition testimony of a severely psychotic named plaintiff in this case, who I have met and interviewed, illustrates the inappropriate and unnecessary use of OC on mentally ill inmates. From the testimony during the inmate's deposition:[50]

> Q. And pepper spray's been used on you when you have failed to respond to the officers' calls so that they can see that you are awake, that you're alert, that your face is being shown, right?
>
> A. Yes, yes.

This inmate's disability is obvious and well known to even the most casual observer. The use of OC spray to wake up a sleeping inmate is completely inappropriate and uncalled for.

66. Records produced by Defendants show the use of OC spray as described above is common practice in ADC facilities. At Perryville. I read a Serious Incident Report (SIR) about an inmate who was banging her head and would not get off of the toilet.[51] At the same facility, I read another SIR where the inmate was destroying her helmet and would not submit to the application of handcuffs so she was sprayed.[52] These examples are not outliers. They are typical of the practice in ADC where OC spray is routinely used against the mentally ill on suicide watch.

67. The routine overuse of OC spray in ADC's isolation units is apparent in ADC's own records. I reviewed records from incident after incident in which the use of OC spray was profoundly disturbing, and more often than not, appeared to involve

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[50] Verduzco dep., 53:18-22 (Aug. 15, 2013).
[51] SIR # 13-08653, Lumley ([redacted]) (reviewed on-site).
[52] SIR # 13-08377, Lumley ([redacted]) (reviewed on-site).

prisoners with symptoms of mental illness. OC spray is routinely deployed with little or no apparent justification on inmates for such reasons as failing to return his food tray,[53] covering his light fixture with a blanket,[54] refusing to relinquish a blanket s/he had placed over her head,[55] refusing to surrender a suicide smock,[56] tampering with his colostomy bag,[57] refusing to come out from under his bunk,[58] refusing to take court ordered medication,[59] and tearing his suicide mattress.[60] In none of the cases was the inmate or the spraying officer at risk of imminent or serious harm. Rather, as discussed above, officers seemingly sprayed inmates solely because they refused to obey the officer's command. The volume of such incidents indicates to me that the use of chemical spray unnecessarily, and in contravention of ADC policy and because ADC policy is inadequate, is a frequent and regular occurrence in all ADC isolation units. Indeed, the Deputy Warden of Florence Central Unit, Greg Fizer, testified that chemical agents are used there "almost daily."[61]

68. Arizona has made the mistake of adopting OC spray as their first response in a use of force incident.[62] The logic of doing so usually rests on the erroneous assumption that OC spray does not cause injury to the victim. That assumption is wrong. OC spray inflicts intense physical pain. Depending upon the amount of spray used, that pain can last from thirty minutes to four hours. It inflames the tissues, burns the skin and makes it feel like it is on fire. It can cause temporary blindness as the eyes feel like they are bubbling and boiling. It restricts the airways and one can have difficulty breathing.

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[53] SIR # 201100103, SMU 1 (ADC089116), SIR # 201204945, Kasson (ADC089321).
[54] SIR # 201209956, SMU 1 (ADC089237).
[55] SIR # 201300585, Browning (ADC089258), SIR # 201101984, Lumley (ADC089354), SIR # 201110986, Lumley (ADC089363).
[56] SIR # 201204125, Browning (ADC089205).
[57] SIR # 201203694, Browning (ADC089203).
[58] SIR # 201114325, Browning (ADC089180).
[59] SIR # 201108721, SMU 1 (ADC089158), SIR # 201113031, Kasson (ADC089303), SIR # 201200401, Lumley (ADC089368).
[60] SIR # 201103500 (ADC089274).
[61] Fizer dep., 193.
[62] ADC Department Order 804.04, Inmate Behavior Control, 1.2.1.2 (ADC107491).

Some individuals feel like they are choking, which can lead to panic. It leaves no mark on the victim but it does inflict great pain. While it is a useful tactical tool in some circumstances where there is a real and imminent threat of loss of life or serious bodily harm, it is also not applicable in others, especially when used on distraught and disturbed inmates who are making either serious or symbolic gestures at harming themselves. In my experience mental health staff have cautioned against its use against the mentally ill because it can feed into the inmates' delusions and hallucinations and exacerbate their condition. The ADC needs to focus their efforts on legitimate clinical interventions prior to deciding it is necessary to use physical force on the mentally ill. They also need to have a more agile tactical response and not rely on OC spray as their first response. Depending on the situation, sometimes it is safer to simply go into the cell and use "hands on" physical force techniques to intervene and control a situation.

69. When touring the watch facilities at Eyman, I saw a table sitting next to the officers who were conducting the watches. On the table, in full view of every inmate held in that unit, were three canisters of OC spray. Whatever the intention of having these weapons so visible, the impact is one of fear and intimidation, hardly the best presentation to mentally inmates who are at risk for self-harm and/ or suicide. This startling evidence of the agency's overreliance on this singular use of force technique raises the issue of the impact on inmates in cells adjacent to an inmate who is being sprayed. Again, based on my training and education, including by mental health professionals over the years, observing the repeated use of OC in these units is likely to escalate the non-involved prisoners' level of fear and mistrust of correctional staff and make them even more difficult to manage.

X. ALTERNATE APPROACHES ARE READILY AVAILABLE AND IN PLACE IN OTHER JURISDICTIONS

70. Prison systems throughout the country have found that an overreliance on isolation is not necessary for good institution security or conducive to motivating inmates

to change their behavior, and it often inflicts serious harm on prisoners, especially those with mental illness. There are models that exist in many parts of the country that the ADC could study, adapt, and modify in order to effectively reduce their population of inmates held in isolation.

71. In Mississippi, the isolation population was reduced from 1,000 inmates to 300. The Director of the Mississippi system, Christopher Epps, who is also the current president of the American Correctional Association, reports that violence in his prisons has been reduced as his isolation population has come down. Speaking of what he learned from his experience of reducing the number of inmates in isolation in his prisons, Mr. Epps has said, "If you treat people like animals that is exactly how they will behave."[63]

72. The state of Maine reduced their population held in isolation by 60% without an increase in prison violence. An article in *The Crime Report* is especially illustrative for the ADC:

> In a matter of weeks this spring, Commissioner Ponte dramatically reformed the Maine State Prison's supermax the Special Management Unit or SMU. Like others across the country it had been plague by inmates "cutting up," by suicides and suicide attempts, hunger strikes, assaults on guards, guard assaults on inmates and in Maine's case, unexplained inmate deaths…Like its counterparts elsewhere, Maine's SMU had been increasingly accused of being a torture chamber, especially for the mentally ill… One immediate result is that the unit is calmer, and no great disruption has occurred from putting inmates back into the prison general population.[64]

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[63] Erica Goode, N.Y. Times, *Prisons Rethink Isolation, Saving Money, Lives and Sanity*, Mar. 10, 2012. Mr. Epps also testified before the U.S. Senate about Mississippi's reform of its solitary confinement practices. He said: "We needed a different approach," Mr. Epps told a committee of United States Senators last year. "Corrections professionals and the criminal justice system must be careful not to use administrative segregation in prison to manage those who we are mad at because this is an expensive option that takes away resources from . . . the services most needed to make a better society." Written Testimony of Christopher Epps, Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, U.S. Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights (June 19, 2012).

[64] The Crime Report, *Maine's Dramatic Reduction of Solitary Confinement*, July 20, 2011.

73. Similar reductions have occurred in the State of Virginia where their isolation population has been reduced by 62% through the implementation of a step-down program:

> First, prison officials evaluate inmates to identify the best candidates for success. These men are provided with classes and programs covering areas such as substance abuse, anger management, social skills development and problem-solving. Initially during group discussions, participants are confined adjacently in small cells; as they progress, they are handcuffed to desks and finally are permitted to take part without any restraints. Privileges to attend group meals and extended recreation periods are earned and serve as motivation.[65]

74. Before these more recent transitions in other jurisdictions, the State of Washington has worked for more than a decade to establish effective step down programs for inmates who repeatedly returned to isolation. We targeted the most recalcitrant inmates to see what we could do to offer them structured interventions that developed the internal skills and self-control necessary to help them live in general population. Our success with program outcomes was once again studied by researchers from the University of Washington.[66] Much has been learned in Washington from these initial efforts and their step down programs continue to operate and improve to this day.

XI. RECOMMENDATONS FOR CHANGE

75. In the name of safety and security, the ADC engages in multiple practices that are counterproductive to its stated aims and harmful to the prisoners in its custody. Overreliance on isolation as a primary means of control results in a harmful environment for all inmates, and especially those with mental illness. Moreover, the actual operations of those units—extreme levels of isolation and idleness, frequent use of peppers spray,

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[65] Patrick A. Hope and Adam P. Ebbin, Wash. Post, *Virginia Turns Away From Solitary Confinement*, Sept. 6, 2013.

[66] D. Lovell, *The Reintegration Program (RIP) at the Washington State Penitentiary: A Program Evaluation* (2009) (attached as Exhibit 4; internal memo by Lovell re: *CBCC ITP Evaluation*, July 20, 2010 (attached as Exhibit 5).

and unstable, infrequent, and incoherent "programming"—results in a correctional environment that exacerbates the already grave risks presented by ADC's over-use of isolation. A predictable and stable custody environment that would help mentally ill prisoners feel safe is essential to prepare inmates to be ready to engage in treatment. That environment does not currently exist within ADC. In order to produce change that will reduce the harmful impact of isolation, especially for the mentally ill, I recommend the following changes:

1. Change the current policies that define who is placed in isolation at reception. Very few inmates arriving in a prison system should be placed directly into isolation. No one should be placed in isolation simply because they are identified as a gang member, because they have a life sentence, a death sentence, or because they were last released to the community from that status.
2. Using criteria similar to what other states have done, review the population currently housed in ADC isolation to determine who can safely be classified to alternate housing locations and who should be diverted from isolation due to mental illness. Since the ADC clearly houses prisoners in isolation who do not require that level of security, re-invest the savings generated from predictable isolation unit closures to enhance programs for the mentally ill.
3. Screen inmates prior to placement in isolation units to divert seriously mentally ill individuals from placement in isolation units and create true mental health treatment units for prisoners who require greater security levels and behavior management. These programs must encourage and allow inmates to progress through reduced levels of custody. Authority and control of those units should be a partnership of custody and mental health staff. Have inmates involved in structured treatment activities throughout the day and appropriate levels of out-of-cell time. Select custody staff to work in those units who have the capacity and the desire to work with the

mentally ill and provide the staff with extensive training.

4. Create separation units that are not isolation units for those needing protection within the ADC.

5. For those inmates who cannot be immediately diverted from isolation, create an evidenced based and coherent step down program so the inmates know what they need to do in order to earn their way out. As stated above, there are models around the country that are in place and working that could be modified and adopted for ADC's use. Many of those programs are set up with the goal of moving inmates out of segregation quickly if the inmate fully participates and completes the individual program plan established for them.

6. For those inmates who cannot be diverted from isolation immediately, improve the conditions of confinement in those units by:

- Establish temperature controls so that inmates, and especially those on psychotropic medications, are not put at risk due to excessive heat.
- Require wellness checks, including assessment of both mental and physical health of inmates in isolation consistent with ACA standards at a minimum.
- Establish routine and regular cleaning and preventive maintenance schedules. Use inmate labor whenever possible.
- Investigate the insect and rodent problems in the isolation units and solve them.
- Reevaluate the two-meal sack lunch program for nutritional adequacy and have officers serve meals three times a day.
- Implement measures that decrease isolation and increase socialization for all inmates in isolation, including increasing phone access for prisoners, increasing contact visits, increasing staff interaction with prisoners, and where possible, increasing prisoner interaction with

other prisoners, e.g., through work and program activities.

- Improve access to recreation and recreation equipment, and allow for group recreation programs for all prisoners in isolation, not just those in particular programs or housing units. Offer recreation at least five days a week instead of three and allow for steady increases in out-of-cell time and congregate activities for all prisoners. Ensure that sufficient staff are present to run recreation. Implement a policy that discourages cancellation of recreation and provides for make-up sessions.
- Do not require staff and visitors to wear protective gear in isolation units except when there is a specific and articulated reason to do so.

7. Change ADC's policy and practice for inmates on suicide watch as well as the policy of using chemical spray on individuals with serious mental illness.

- Do not allow the use of OC spray against the mentally ill unless there is an imminent threat of death or serious bodily injury and only after meaningful clinical intervention has occurred.
- Make sure watch cells are properly equipped to provide a safe environment for the inmates.
- Install video cameras in watch cell areas to document when spray is used.

Executed on the 8th day of November 2013 in Olympia, WA.

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EXHIBIT 1

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WORK HISTORY

Nearly 35 years working in and administering adult and juvenile institutions, and probation and parole programs, starting at the entry level and rising to Department Secretary. Served as Superintendent of 3 adult institutions, maximum to minimum security, male and female. Served as Secretary for the Washington State Department of Corrections (WADOC) from 2007 until 2011.

▪ Secretary	WADOC	2007-2011
▪ Deputy Secretary	WADOC	1999-2006
▪ Assistant Deputy Secretary	WADOC	1997-1999
▪ Assistant Director for Prisons	WADOC	1994-1997
▪ Superintendent	McNeil Island Corrections Center	1992-1994
▪ Superintendent	WA. Corrections Center for Women	1989-1992
▪ Correctional Program Manager	WA. Corrections Center	1988
▪ Superintendent	Cedar Creek Corrections Center	1987
▪ Correctional Program Manager	Cedar Creek Corrections Center	1984-1987
▪ Juvenile Parole Officer	Division of Juvenile Rehabilitation	1984
▪ Correctional Unit Supervisor	Cedar Creek Corrections Center	1979-1983
▪ Juvenile Institution Counselor	Division of Juvenile Rehabilitation	1974-1979

SKILLS AND ABILITIES

- Ability to analyze complex situations, synthesize the information and find practical solutions that are acceptable to all parties.

- A history of work experience that demonstrates how a balance of strong security and robust inmate programs best improves institution and community safety.

- Leadership of a prison system with very little class action litigation based on practical knowledge that constitutional conditions are best achieved through negotiation with all parties and not through litigation.

- Extensive experience as a witness, both in deposition and at trial.

- Experience working with multiple Governors, legislators of both parties, criminal justice partners and constituent groups in the legislative and policymaking process.

- Skilled labor negotiator for over a decade. Served as chief negotiator with the Teamsters and the Washington Public Employees Association for Collective Bargaining Agreements. Chaired Labor Management meetings with Washington Federation of State Employees.

- Excellent public speaking and writing abilities.

HIGHLIGHTS OF CAREER ACCOMPLISHMENTS

- Reduced violence in adult prisons in Washington by over 30% during my tenure as Secretary and Deputy Secretary even though the prison population became much more violent and high risk during this same time period.

- Achieved dramatic reduction in escapes, including from minimum-security facilities.

- Increased partnerships with non-profits, law enforcement and community members in support of agency goals and improved community safety.

- Implemented and administered an extensive array of evidence based and promising programs:

    - Education, drug and alcohol, sex offender and cognitive treatment programs.
    - Implemented risk based sentencing via legislation and policy, reducing the prison populations of non-violent, low risk offenders, including the Drug Offender Sentencing Alternative and the Family and Offender Sentencing Alternative. http://www.doc.wa.gov/community/fosa/default.asp
    - Pioneered extensive family based programs resulting in reductions in use of force incidents and infractions and improved reentry outcomes for program participants.
    - Established Intensive Treatment Program for mentally ill inmates with behavioral problems.
    - Established step down programs for long-term segregation inmates resulting in significant reduction in program graduate returns to segregation. http://www.thenewstribune.com/2012/07/10/2210762/isolating-prisoners-less-common.html

- Initiated the Sustainable Prison Project; http://blogs.evergreen.edu/sustainableprisons/

- Administered the only state agency that bent the curve on health care costs while improving treatment outcomes.

- Focused the department on becoming a better asset to the community by expanding inmate and community supervision work programs.

- Improved efficiency in the agency by administrative consolidation, closing 3 high cost institutions and eliminating over 1,200 positions. Housed inmates at lowest possible custody levels, also resulting in reduced operating costs

- Successful settlement of the Jane Doe class action law suit, a PREA case regarding female offenders in the state's women's' prisons.

- Avoided class action lawsuit regarding religious rights of Native Americans. http://seattletimes.nwsource.com/html/opinion/2015464624_guest30galanda.html

- Led the nation's corrections directors to support fundamental change in the Interstate Compact as a result of the shooting of 4 police officers in Lakewood, WA.

- Dramatically improved media relations by being aggressively open with journalists, challenging them to learn the difficult work performed by corrections professionals on a daily basis.

- Long term collaboration with the University of Washington focusing on the mentally ill in prison and management of prisoners in and through solitary confinement.

EDUCATION AND OTHER BACKGROUND INFORMATION

- Post graduate work in Public Administration - The Evergreen State College, Washington - 1980 and 1981

- Bachelor of Arts - The Evergreen State College, Washington – 1973

- National Institute of Corrections and Washington State Criminal Justice Training Commission - various corrections and leadership training courses

- Member of the American Correctional Association

- Associate member, Association of State Correctional Administrators

- Guest Speaker, Trainer and Author for the National Institute of Corrections

- Commissioner, Washington State Criminal Justice Training Commission 2002-2006, 2008-2011

- Member, Sentencing Guidelines Commission 2007-2011

- Instructor for Correctional Leadership Development for the National Institute of Corrections (NIC)

- Advisory Panel Member, *Correctional Technology—A User's Guide*

- Author of *Going Beyond Administrative Efficiency—The Budget Crisis in the State of Washington*, published in Topics of Community Corrections by NIC

- Consultant for *Correctional Leadership Competencies for the 21st Century*, an NIC publication

- Consultant for Correctional Health Care Executive Curriculum Development, an NIC training program

- Co-chair with King County Prosecutor Dan Satterberg, *Examining the Tool Box: A Review of Supervision of Dangerous Mentally Ill Offenders* http://www.dbhds.virginia.gov/documents/Adm/080101-KingCountyReport.pdf

- Guest lecturer on solitary confinement at University of Montana Law School in 2012

CURRENT ACTIVITIES

- On retainer with Pioneer Human Services http://www.pioneerhumanservices.org/
- Serve on the Board of Advisors for Huy, a non-profit for supporting Native American Prisoners
- Retained as an expert witness in the following cases:
    - *Mitchell v. Cate*,
      No. 08-CV-1196 JAM EFB
      United States District Court, Eastern District of California,
      Declarations for the court March 4, 2013, May 15, 2013 and June 7, 2013
      Deposed on July 9, 2013
    - *Parsons, et al v. Ryan*,
      No. CV 12-06010 PHX-NVW
      United States District Court of Arizona
    - *Gifford v. State of Oregon*,
      No. 6:11-CV-06417-TC
      United States District Court, For the District of Oregon,
      Eugene Division,
      case settled 2013
    - *Ananachescu v. County of Clark*,
      No. 3:13-cv-05222-BHS
      United States District Court, Western District of Tacoma
    - *Coleman et al v. Brown, et al,*
      No. 2:90-cv-0520 LKK JMP P
      United State District Court, Eastern District of California,
      Declarations for the court, March 14, 2013 and May 29, 2013,
      Deposed on March 19, 2013 and June 27, 2013
      Testified on October 1, 2, 17 and 18, 2013
    - *Peoples v. Fischer*,
      No. 1:11-cv-02694-SAS
      United States District Court, Southern District of New York
    - *Dockery v. Epps*,
      No. 3:13-cv-326 TSL JMR
      United States District Court for the Southern District of Mississippi,
      Jackson Division
    - *C.B., et al v. Walnut Grove Correctional Authority et al*,
      No. 3:10-cv-663 DPS-FKB,
      United States District Court for the Southern District of Mississippi,
      Jackson Division
    - *Graves v. Arpaio,*
      No. CV-77-00479-PHX-NVW,
      United States District Court of Arizona

SAMPLE REFERENCES: contact information available upon request:

Chris Gregoire, former Governor, State of Washington
Tom McBride, Executive Secretary, Washington Association of Prosecuting Attorneys
Chase Riveland, Riveland Associates
Rowland Thompson, Executive Director, Allied Daily Newspapers

EXHIBIT 2

CONFIDENTIAL
Subject to Protective Order

Documents sent from plaintiffs' counsel to plaintiffs' witness Eldon Vail

Death Records

- [redacted]: ADC032045-185
- [redacted]: ADC061490-648, PLTF-PARSONS-002206-10
- [redacted]: ADC040693-1302
- [redacted]: ADC041302-459
- [redacted]: ADC061649-723, ADC067194-220
- [redacted]: ADC038909-9086
- [redacted]: ADC024880-929, ADC037377-514
- [redacted]: ADC039086-168
- [redacted]: ADC042032-349
- [redacted]: ADC042350-55
- [redacted]: ADC026255-415
- [redacted]: ADC025271-370, ADC039273-321, ADC042356-461
- [redacted]: ADC024516-61, ADC032292-405, ADC042462-606
- [redacted]: ADC061998-2260, PLTF-PARSONS-001958-63
- [redacted]: ADC026743-811, PLTF-PARSONS-001964-70
- [redacted]: ADC062287-357
- [redacted]: ADC039343-426, PLTF-PARSONS-001971-79
- [redacted]: ADC024930-48, ADC037515-685, ADC039445-644
- [redacted] ADC062358-405, PLTF-PARSONS-001901-04
- [redacted]: ADC026672-742, ADC033654-58, ADC037686-994, ADC062406-526, PLTF-PARSONS-002281-92
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- [redacted]: ADC062735-828
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- [redacted]: ADC024562-95, ADC034363-429, ADC063837-967
- [redacted]: ADC032879-937

- [redacted]: ADC044182-455
- [redacted]: ADC032938-3025, PLTF-PARSONS-001914-17
- [redacted]: ADC024598-716, ADC033684-88, ADC038394-434, ADC064610-839
- [redacted]: ADC026154-95, ADC034430-38, ADC064840-5029
- [redacted]: ADC025372-843
- [redacted]: ADC044456-840
- [redacted]: ADC033048-168
- [redacted]: ADC026957-7099, ADC033689-94, ADC044841-994
- [redacted]: ADC026416-671, ADC044995-5043, ADC065030-272
- [redacted]: ADC045044-537
- [redacted]: ADC026196-254
- [redacted]: ADC026930-55, PLTF-PARSONS-002293-303
- [redacted]: ADC047244-719, PLTF-PARSONS-002304-312
- [redacted]: ADC024949-88, ADC034462-615, PLTF-PARSONS-002313-18
- [redacted]: ADC024362-480, ADC033191-335, ADC038437-703
- [redacted]: ADC045579-6408
- [redacted]: ADC025110-39, ADC046409-42, PLTF-PARSONS-002319-25
- [redacted]: ADC046443-777
- [redacted]: ADC046918-46, ADC065370-599
- [redacted]: ADC024171-221, ADC034616-19, ADC065600-767
- [redacted]: ADC026072-153, ADC033699-709, ADC038704-06, ADC065768-896
- [redacted]: ADC065906-6204
- [redacted]: ADC066299-413
- [redacted]: ADC066492-743
- [redacted]: ADC066744-87, PLTF-PARSONS-001987-89
- [redacted]: ADC024481-515, ADC034620-79, ADC066788-7045
- [redacted]: ADC033537-638, PLTF-PARSONS-001941-42

Declarations

- Declaration of G. Fizer, 12/24/12 (Exhibit 4, Defendants' Response to Plaintiffs Motion for Class Certification)
- Declaration of B. Shaw, 12/21/12 (Exhibit 1, Defendants' Response to Plaintiffs Motion for Class Certification)

Department Orders and Director's Instructions

- ADC011582-92: DO 105 – Information Reporting
- ADC092398: DO105 Attachment – Incidents Requiring a Significant Incident Report
- ADC012120-45: DO 509 – Employee Training and Education
- ADC012447-68: DO 524 – Employee Assignments and Staffing
- ADC012628-34: DO 606 – Internal Inspections Program

- ADC012644-56: DO 701 – Inmate Accountability
- ADC082174-80: DO 703 – Security/Facility Inspections
- ADC012680-96: DO 704 – Inmate Regulations
- ADC012725-34: DO 708 – Searches
- ADC013837-59: DO 801 – Inmate Classification
- ADC048527-37: DO 802 – Inmate Grievance Procedure
- ADC013875-910: DO 803 – Inmate Disciplinary Procedure
- ADC013911-22: DO 804 – Inmate Behavior Control
- ADC107478-505: DO 804 – Inmate Behavior Control, updated 6/7/12 (restricted)
- ADC082205-26: DO 805 – Protective Custody
- ADC013941-66: DO 806 – Security Threat Groups (STGs)
- ADC013967-93: DO 807 – Inmate Suicide Prevention, Precautionary Watches, and Maximum Behavior Control Restraints
- ADC013994-014004: DO 809 - Earned Incentive Program
- ADC082227-35: DO 811 - Individual Inmate Assessments and Reviews
- ADC012938-62: DO 903 - Inmate Work Activities
- ADC082236-52: DO 904 - Inmate Religious Activities/Marriage Requests
- ADC013018-28: DO 906 - Inmate Recreation/Arts & Crafts
- ADC013029-74: DO 909 - Inmate Property
- ADC013075-98: DO 910 - Inmate Education and Resource Center Services
- ADC013099-136: DO 911 - Inmate Visitation
- ADC013137-41: DO 912 - Food Service
- ADC013142-65: DO 914 - Inmate Mail
- ADC013166-79: DO 915 - Inmate Phone Calls
- ADC013180-82: DO 916 – Staff-Inmate Communications
- ADC013210-17: DO 920 – Inmate Special Education Services
- ADC048543-73: DO 1101 - Inmate Access to Health Care
- ADC048574-97: DO 1103 – Inmate Mental Health Care, Treatment, and Programs
- ADC048608-12: DO 1105 – Inmate Mortality Review
- ADC082042-5: DI 145 - Strip Searches
- ADC082054-55: DI 300: 703 Monthly "GAR" Inspections
- ADC084421: DI 301: Modification of DO 912, Food Service

Depositions

- *ADC, Wexford, and Corizon Staff*
    - Deposition Transcript: Kathleen Campbell, RN, 9/11/13
    - Deposition Transcript: Kathleen Campbell, RN, 9/23/13
    - Deposition Transcript: Greg Fizer, 10/29/12
    - Deposition Transcript and Exhibits: Arthur Gross, 9/9/13
    - Deposition Transcript: Carson McWilliams, 9/27/13

- Deposition Transcript and Exhibits: Joseph Pastor, 10/4/13
- Deposition Transcript: Nicole Taylor, J.D., Ph. D., 9/5/13
- Deposition Transcript and Exhibits: Martin Winland, 9/18/13

- *Plaintiffs*
  - Deposition Transcript: Dustin Brislan, 8/8/13
  - Deposition Transcript: Robert Gamez, 8/6/13
  - Deposition Transcript: Joshua Polson, 8/23/13
  - Deposition Transcript: Sonia Rodriguez, 8/13/13
  - Deposition Transcript: Jeremy Smith, 8/20/13
  - Deposition Transcript: Jackie Thomas, 8/8/13
  - Deposition Transcript: Christina Verduzco, 8/15/13

Discovery Responses

- Dkt. 191: Defendant Ryan's First Supplemental Answers to Plaintiff Brislan's First Set of Requests for Admissions (Nos. 1-78) and First Set of Interrogatories (Nos. 1-2)
- Dkt. 491: Defendants Charles Ryan's Response to Plaintiff Christina Verduzco's First Set of Requests for Admission (Nos. 1-285) and First Set of Interrogatories (Nos. 1-2)
- Dkt. 527: Defendants' Response to Plaintiff Wells' First Set of Interrogatories, with Exhibits A-G
- Dkt. 538: Defendants' First Supplemental Response to Plaintiff Wells' First Set of Interrogatories
- Dkt. 570: Defendants' Response to Plaintiff Rodriguez's First Set of Interrogatories
- Dkt. 642: Defendant Ryan's Response to Plaintiff Gamez's First Set of Interrogatories and Requests for Admission
- Dkt. 686: Defendants' First Supplemental Response to Plaintiff Sonia Rodriguez's First Set of Interrogatories

Executive Reports

- *Dry Cell Watches*
  - ADC108139-207: All Units – 1/1/12 to 6/10/13
- *Executive Reports*
  - ADC110442-14357: Executive Reports – 2011 to 2013-06-13
- *Inmate Disciplinary Reports*
  - ADC091830-75: Eyman Inmate Disciplinary Report, 2/1/13 to 5/29/13
  - ADC091877-95: Florence Inmate Disciplinary Report, 2/1/13 to 5/29/13
  - ADC091904-45: Perryville Inmate Disciplinary Report, 2/1/13 to 5/29/13
- *Medical*
  - ADC108208-9790: All Units – 1/1/12 to 6/10/13
- *Suicides Attempted*
  - ADC094578: All units – printed 6/13/13
- *Suicide Watches*
  - ADC110442-4376: All units – 1/1/12 to 6/13/13

- *Use of Force Reports*
    - ADC089116-260: Eyman: SMU I and Browning – 2011-1-1 to 2013-2-6
    - ADC089261-352: Florence: Central and CB1-CB5, CB7, CBK – 2011-1-1 to 2013-2-6
    - ADC089353-379: Perryville: SMU I and Browning – 2011-1-1 to 2013-2-6

Grievances

- ADC016217-8164: Plaintiffs' medical grievance files
- ADC023557-4169: Plaintiffs' Non-medical grievance files
- ADC074296-366: Grievance appeal logs, January 2011 to January 2013
- ADC089380-91: Grievance appeals, non-medical, conditions – 2011-1-1 to 2013-4-24
- ADC089392-442: Grievance appeals, non-medical – 2011-1-1 to 2012-12-21

Master Files (non-named plaintiffs)

- [redacted] – Master File: ADC162660-865
- [redacted] – Master File: ADC162866-3257
- [redacted] – Master File: ADC163258-447
- [redacted] – Master File: ADC163448-885
- [redacted] – Master File: ADC138007-27
- [redacted] – Master File: ADC138778-86
- [redacted] – Master File: ADC138787-866
- [redacted] – Master File: ADC138867-963
- [redacted] – Master File: ADC138964-9078
- [redacted] – Master File: ADC139079-135
- [redacted] – Master File: ADC139635-682
- [redacted] – Master File: ADC139136-64
- [redacted] - Master File: ADC139165-304
- [redacted] – Master File: ADC139305-449
- [redacted] – Master File: ADC138028-176
- [redacted] – Master File: ADC139683-94
- [redacted] – Master File: ADC139450-79

Medical Files (non-named plaintiffs)

- [redacted]: WEX000001-131
- [redacted]: ADC145972-6069
- [redacted]: ADC146070-393
- [redacted]: ADC146394-918
- [redacted]: ADC146919-7126
- [redacted]: ADC147127-513
- [redacted]: ADC147514-8098
- [redacted]: ADC148099-459

- [redacted]: ADC148460-628
- [redacted]: ADC148629-9079
- [redacted]: ADC149080-766
- [redacted]: ADC149767-815
- [redacted]: ADC149816-887
- [redacted]: ADC149888-50069
- [redacted]: ADC150070-1259
- [redacted]: ADC151260-02
- [redacted]: ADC151603-992
- [redacted]: ADC151993-2080
- [redacted]: ADC152081-370
- [redacted]: ADC152371-3326

Meeting Minutes

- ADC076324-417: Florence, Management Meeting/Deputy Warden's Meeting Minutes, 2011
- ADC076418-529: Florence, Management Meeting/Deputy Warden's Meeting Minutes, 2012
- ADC076530-46: Florence, Management Meeting/Deputy Warden's Meeting Minutes, January to February 2013
- ADC076547-615: Florence-Central, Deputy Warden Team Management Meeting Minutes, 2011
- ADC076616-67: Florence-Central, Deputy Warden Team Management Meeting Minutes, 2012
- ADC076668-75: Florence-Central, Deputy Warden Team Management Meeting Minutes, January to February 2013
- ADC077039-60: Perryville, Weekly Executive Team Meeting Minutes, January-March 2011
- ADC077274-76: Perryville, Weekly Executive Team Meeting Minutes, March 2011
- ADC083106-311: Eyman, Executive Staff Meeting Minutes, March 2011 to April 2012
- ADC083312-66: Eyman-Browning, Management Meeting Minutes, 2012
- ADC083367-455: Eyman-SMU 1, Special Management Meeting Minutes, 2012
- ADC083456-667: Perryville, Weekly Executive Team Meeting Minutes, March 2011 to March 2013

Miscellaneous

- ADC027724-58: Powerpoint presentation, ADC mental health programs in isolation units
- ADC027733: Photographs of recreation enclosures for mental health units
- ADC027751: Eyman-SMU 1 diagram showing location of mental health recreation enclosures
- ADC027759-68: Mental health levels statistical summary, dated July 23, 2012
- ADC031959-2044: Mental Health Technical Manual
- ADC040610-91: Classification Technical Manual (revised October 28, 2010)
- ADC040692: Replacement Page for ADC's Classification Technical Manual, dated April 13, 2012
- ADC048345: Fancy Significant Incident Report
- ADC048379-410: Fancy Use of Force Checklist and Witness Sheets

- ADC048411-32: Holbrook Significant Incident Report
- ADC049045-77: Wexford Vacancy Reports, dated September and November 2012
- ADC049646-81: Inmate Suicide Prevention Training
- ADC049803-65: Training, Understanding Mentally Ill Inmates
- ADC050861-67: Memorandum to Charles Ryan from Robert Patton and Richard Pratt dated April 30, 2012, entitled "Increase of Mental Health for Max Custody"
- ADC050868-80: ADC Medical and Mental Health Score Inmate Distribution
    - ADC050868: Mental health levels statistical summary, dated 6/30/10
    - ADC050869-72: Mental health levels statistical summary, dated 8/9/11
- ADC055572-73: SMI Segregated Population, dated December 7, 2012
- ADC074367-80: Eyman DO 703 Report, April 2011
- ADC074402-09: Florence DO 703 Report, April 2011
- ADC083096-105: Mental health levels statistical summary, dated April 15, 2013
- ADC084366-72: ASPC-Florence-Central Unit Information Reports re Cancelled Recreation
- ADC091667-823: Eyman-Browning Correctional Service Log
- ADC093734-958: Mental health details reports, dated 4/26/13
- ADC094392-499: Mental health statistical summaries for 2011, 2012, and 2013
- ADC094500-72: ADC reports regarding missed meals
- ADC094573: Diagram of ASPC-Eyman-Browning Unit Typical Wing Layout
- ADC094576-77: Recreation Enclosures Dimensions Memo, dated 4/29/13
- ADC117064-74: May 2013 Monthly Staffing Reports
- ADC121167-77: June 2013 Monthly Staffing Reports
- ADC139481: Inmate Outcount, Perryville SMA, dated 7/18/13
- ADC139482-83: Weekly Programming for WTU, dated 7/1/13
- ADC139516-18: ASPC-Eyman-Browning Unit Activity Schedule, dated 8/1/13
- ADC139519-20: Kasson Mental Health Program
- ADC139521-23: Maximum Custody Step Matrix
- ADC139524: Perryville SMA mental health group schedules
- ADC139525-28: Mental health programming schedule, July and August 2013
- ADC140132-48: Governor's Briefing on ADC Mental Health Initiatives and Suicide Prevention Strategies, dated 5/22/13
- ADC140185-512: ASPC-Eyman Temperature Logs
- ADC140513-2832: ASPC-Perryville Temperature Logs
- ADC153777-93: Corizon Contract Staffing Percentage Report, dated 7/29/13
- ADC153834-35: Corizon Health Needs Requests (HNR) Appointment Report, July 2013
- PLTF-PARSONS-030686-96: Inmate Death Notifications and Email from Charles Ryan dated 10/11/13

Monitoring (Compliance) Reports

- *Eyman*

- ADC028093-97: Eyman Compliance Report dated 8/13/12
- ADC034917-5203: Eyman Compliance Report, September 2012
- ADC067241-539: Eyman Compliance Report, October 2012
- ADC052305-421: Eyman Compliance Report, November 2012
- ADC069206-99: Eyman Compliance Report, December 2012
- ADC070023-135: Eyman Compliance Report, January 2013
- ADC084391-98: Eyman Compliance Report, February 2013
- ADC088727-41: Eyman Compliance Report, March 2013
- ADC088814-45: Eyman Compliance Report, April 2013
- ADC117651-84: Eyman Compliance Report, May 2013
- ADC117927-951: Eyman Compliance Report, June 2013
- ADC137754-66: Eyman Quarterly Compliance Report, June 2013
- ADC137201-28: Eyman Compliance Report, July 2013
- ADC137465-96: Eyman Compliance Report, August 2013
- ADC154049-94: Eyman Compliance Report, September 2013

- *Florence*
  - ADC028098-110: Florence Compliance Report dated 8/13/12
  - ADC035204-95: Florence Compliance Report, September 2012
  - ADC067540-690: Florence Compliance Report, October 2012
  - ADC052422-564: Florence Compliance Report, November 2012
  - ADC069300-401: Florence Compliance Report, December 2012
  - ADC070136-270: Florence Compliance Report, January 2013
  - ADC084399-406: Florence Compliance Report, February 2013
  - ADC088742-55: Florence Compliance Report, March 2013
  - ADC088846-91: Florence Compliance Report, April 2013
  - ADC117685-717: Florence Compliance Report, May 2013
  - ADC117952-84: Florence Compliance Report, June 2013
  - ADC137767-79: Florence Quarterly Compliance Report, June 2013
  - ADC137229-67: Florence Compliance Report, July 2013
  - ADC137497-524: Florence Compliance Report, August 2013
  - ADC154095-146: Florence Compliance Report, September 2013
- *Perryville*
  - ADC028130-38: Perryville Compliance Report dated 8/13/12
  - ADC035459-619: Perryville Compliance Report, September 2012
  - ADC068031-239: Perryville Compliance Report, October 2012
  - ADC052718-839: Perryville Compliance Report, November 2012
  - ADC069514-97: Perryville Compliance Report, December 2012
  - ADC070399-510: Perryville Compliance Report, January 2013
  - ADC084407-16: Perryville Compliance Report, February 2013
  - ADC088763-70: Perryville Compliance Report, March 2013
  - ADC088914-53: Perryville Compliance Report, April 2013
  - ADC117738-65: Perryville Compliance Report, May 2013

- ADC118003-25: Perryville Compliance Report, June 2013
- ADC137793-805: Perryville Quarterly Compliance Report, June 2013
- ADC137289-315: Perryville Compliance Report, July 2013
- ADC137555-82: Perryville Compliance Report, August 2013
- ADC154182-518: Perryville Compliance Report, September 2013

- ADC138773: Segregated Inmates Compliance Sheet, blank
- ADC139857-79: Draft MGAR User Guide (used at training on 9/19/13)

Named Plaintiff Master Files

- ADC022704-3099: Brislan Master File
- ADC137871-81: Brislan Master File, Updated
- ADC020695-1192: Gamez Master File
- ADC127405-24: Polson Master File
- ADC018792-9563: Rodriguez Master File
- ADC022356-504 and ADC023100-379: Smith Master File
- ADC022145-355: Thomas Master File
- ADC137947-70: Thomas Master File, Updated
- ADC019564-20121: Verduzco Master File

Named Plaintiff Medical Records

- *Brislan*
  - ADC008296-537: Brislan Medical Records, 1/26/10 to 3/8/12
  - ADC016217-499: Brislan Medical Grievances
  - ADC018105-141: Brislan Medical Grievances
  - ADC073455-798: Brislan Medical Records, 3/9/12 to 2/12/13
  - ADC074276-79: Brislan Medical Grievances
  - ADC107525-602: Brislan Medical Records, Maricopa County Jail, 2000
  - ADC122075-3237: Brislan Medical Records, 3/1/13 to 7/15/13
  - ADC123238-51: Brislan Medical Records, ORC, Rx August 2013
- *Gamez*
  - ADC000287-1258: Gamez Medical Records, 10/17/97 to 3/15/12
  - ADC017495-879: Gamez Medical Grievances
  - ADC018005-45: Gamez Medical Grievances
  - ADC071394-573: Gamez Medical Records, 3/6/12 to 2/12/13
  - ADC074441-577: Gamez Medical Records, University Medical Center
  - ADC122219-89: Gamez Medical Records, 3/1/13 to 7/15/13
- *Polson*
  - ADC005959-6574: Polson Medical Records, 8/2/04 to 5/16/06, 5/30/06 to 8/30/06, 9/30/06 to 4/10/07, 2/21/08 to 3/8/12
  - ADC017218-485: Polson Medical Grievances

- ADC017954-83: Polson Medical Grievances
- ADC071742-93: Polson Medical Records, 3/9/12 to 2/12/13
- ADC074973-74: Polson Medical Records, John C. Lincoln
- ADC074975: Polson Medical Records, Phoenix Baptist
- ADC107603-72: Polson Medical Records, Maricopa County Jail, 2002
- ADC122338-70: Polson Medical Records, 3/1/13 to 7/15/13
- ADC131368-405: Polson Medical Records, 3/8/12 to 10/23/12

- *Rodriguez*
  - ADC008538-10121: Rodriguez Medical Records, 3/9/1994 to 3/28/03, 6/10/09 to 3/16/12
  - ADC017916-17: Rodriguez Medical Grievances
  - ADC073890-4120: Rodriguez Medical Records, 3/9/12 to 2/12/13
  - ADC074976-6190: Rodriguez Medical Records, Maricopa Medical Center
  - ADC076191-218: West Valley Hospital
  - ADC107672-959: Rodriguez Medical Records, Maricopa County Jail, 2007
  - ADC123384-89: Rodriguez Medical Records, 2/10/13 to 2/28/13
  - ADC122371-464: Rodriguez Medical Records, 3/1/13 to 7/15/13
- *Smith*
  - ADC007145-439: Smith Medical Records, 3/17/08 to 3/15/12
  - ADC017984-8004: Smith Medical Grievances
  - ADC074121-213: Smith Medical Records, 3/16/12 to 2/12/13
  - ADC076219: Smith Medical Records, Recovery Innovations
  - ADC117587-630: Smith Medical Records, Maricopa County Jail
  - ADC127369-75: Smith Medical Records, Rx and CIPS
  - ADC127376-81: Smith Medical Records, 2/10/13 to 2/28/13
- *Thomas*
  - ADC007440-8295: Thomas Medical Records, 11/3/06 to 3/8/12
  - ADC017918: Thomas Medical Grievances
  - ADC070949-1360: Thomas Medical Records, 3/9/12 to 2/12/13
  - ADC074273-75: Thomas Medical Grievances
- *Verduzco*
  - ADC002289-4373: Verduzco Medical Records, 5/10/06 to 3/19/12
  - ADC121331-2074: Verduzco Medical Records, Arizona State Hospital, 2006
  - ADC122720-3780: Verduzco Medical Grievances, 3/1/12 to 7/15/13
  - ADC123390-400: Verduzco Medical Records, 2/10/13 to 2/28/13
  - ADC136885-901: Verduzco Medical Records from Expert Tours

Named Plaintiff – Other

- *Brislan*
  - Individual Detention Records, ADC139904-38
- *Gamez*

- Individual Detention Records, ADC139939-40027

- *Polson*
  - Individual Detention Records, ADC136213-54
- *Rodriguez*
  - Individual Detention Records, ADC136255-314
- *Smith*
  - Individual Detention Records, ADC140028-87
- *Swartz*
  - Individual Detention Records, ADC136316-17
- *Thomas*
  - Individual Detention Records, ADC139901-03
- *Verduzco*
  - Individual Detention Records, ADC123484-3621

No Bates Range

- ADC Locator Codes – Confidential
- Browne, Angela, "Prisons Within Prisons: The Use of Segregation in the United States", *Federal Sentencing Reporter*, Vol. 24, No. 1, October 2011
- List of SIRs with Prisoner Names and ID Numbers

Nutrition

- ADC077368-403: Diet Reference Manual
- ADC077955-77: Food Services Technical Manual
- ADC078656-59: ADC Menus Nutritional Content and Statement of Nutritional Adequacy
- ADC078703-45: Weekly Menu Cycles

Pleadings

- Dkt. 1: Plaintiffs' Class Action Complaint for Injunctive and Declaratory Relief
- Dkt. 372: Order

Post Orders

- *Eyman*
  - ADC088634: Eyman PO – Mental Health Emergencies
  - ADC088637-38: Eyman PO – Mental Health SMI Designation
  - ADC088646-48: Eyman PO – Emergency Response Plan
  - ADC088655: Eyman PO – Watch Swallow for Psychotropic Medication
  - ADC088663-69: Eyman PO – Detention Unit Security Officer (restricted)
  - ADC088671-77: Eyman PO – Housing Unit Security Officer (restricted)
  - ADC088678-82: Eyman PO – Yard Security Officer (restricted)

- ADC107506-12: Eyman PO-12 – Detention Unit Security Officer, updated 5/19/12 (restricted)
- ADC107513-17: Eyman PO-34 – Yard Security Officer, updated 5/19/12 (restricted)
- ADC107518-24: Eyman PO-35 – Housing Unit Security Officer, updated 5/19/12 (restricted)
-

- *Florence*
  - ADC029012-13: PO-07-69 – Florence PO: Detention Status - Protective Segregation and Administrative Detention
  - ADC029054: PO-07-81 - Florence HS PO: Mental Health Emergencies
  - ADC029115-16: PO-07-124 - Florence HS PO: Health Checks for Max Security Inmates Central Unit
  - ADC029117-18: PO-07-125 - Florence HS PO: Detention Checks – CB-K, Wing 3
- *Perryville*
  - ADC029139: PO-11-0102B - Perryville HS PO: Health Needs Request Submittal and Pick Up in CDU and SMA Units

Tour Photos

- *Eyman*
  - ADC153327-44 - Photos - Eyman (Stewart Tour) – 7/16/13 (redacted)
  - ADC153345-52 - Photos - Eyman (Cohen Tour) – 7/17/13
  - ADC153353-54 - Photos - Eyman (Cohen Tour) – 7/18/13
  - ADC153355-91 - Photos - Eyman (Haney Tour) – 7/23/13 (redacted)
  - ADC153392-406 - Photos - Eyman (Vail Tour) – 8/1/13 (redacted)
  - ADC153407-20 - Photos - Eyman (Vail Tour) – 8/2/13 (redacted)
  - ADC153421-34 - Photos - Eyman (Williams Tour) – 8/15/13 (redacted)
- *Florence*
  - ADC154422-46 - Photos - Florence (Haney Tour) – 7/19/13 (redacted)
  - ADC154447-77 - Photos - Florence (Haney Tour) – 7/22/13 (redacted)
  - ADC154478-505 - Photos - Florence (Stewart Tour) – 7/15/13 (redacted)
  - ADC154506-33 - Photos - Florence (Vail Tour) – 7/31/13 (redacted)
  - ADC154534-47 - Photos - Florence (Williams Tour) – 8/14/13 (redacted)
- *Perryville*
  - ADC163886-99 - Photos - Perryville (Haney Tour) – 7/18/13 (redacted)
  - ADC163900-09 - Photos - Perryville (Stewart Tour) – 7/18/13 (redacted)
  - ADC163910-25 - Photos – Perryville (Vail Tour) – 7/29/13 (redacted)
  - ADC163926-36 - Photos - Perryville (Williams Tour) – 8/16/13 (redacted)

EXHIBIT 3

A Profile of Washington Inmates on Intensive Management Status

David Lovell

University of Washington-Department of Corrections Behavioral Health Collaboration

October, 2010

Executive Summary

This description covers 520 inmates on Intensive Management Status (IMS) at two different points in time—2000 and 2006—referred to as the *index IMS assignment* from which infraction rates and return to IMS are calculated. To assist in planning policies and programs, the following topics are covered:

- General characteristics of IMS vs. general population (GP) inmates;
- Security threat group involvement;
- Mental health issues;
- Assaults on staff;
- Return to IMS;
- Policy directions.

General Characteristics. Intensive Management Status is the assignment of inmates to extended administrative segregation to reduce serious threats to institutional security or to the safety of inmates and staff. Many differences between IMS and GP offenders are predictable:

- Leaving aside sex offenders, 71% of IMS inmates are serving terms of homicide or violent offenses against persons, vs. 42% of GP inmates;
- Half of IMS inmates are serving terms of 10 years or more, vs. 33% among GP inmates.
- The average annual infraction rate among IMS inmates was 6.8 per year, compared to 1 per year for general population inmates;
- IMS inmates are similar in racial classification to GP inmates, but a rising percentage—14% in 2000, 23% in 2006—are identified as Hispanic, vs. 10% of GP inmates, reflecting increasing activity of Latino gangs in Washington's prisons.

Despite these unsurprising patterns, there was great variation among IMS inmates in length of prison and IMS terms and rates of prison misbehavior. The average length of the IMS term decreased between 2000 and 2006, from 26 months to 21 months.

STG Involvement. Over half of IMS inmates have been identified as STG-affiliated. White supremacists predominated in 2000 (37% of all STG members on IMS); between then and 2006, the Latino share of STG affiliates among IMS STG members rose from 18% to 39%, with a concomitant decline in the share of white supremacists.

- Among IMS inmates, STG affiliates and non-affiliates showed similar infraction rates;
- Non-affiliates were more likely to show increased infraction rates after IMS assignment (25% vs. 18%), and served longer IMS terms: 28 months vs. 20 months.

Mental Illness. *Serious mental illness* (SMI) is defined as a major thought or mood disorder that significantly impairs functioning, causes substantial pain or disability, and requires continuing

treatment. Given the vagaries of mental health diagnosis and documentation in DOC records, a variety of sources must be used to provide reliable estimates of rates of serious mental illness.

- A sample of IMU residents in 2000 found 20% with documented evidence of SMI;
- A systematic survey of all prisoners in 2002 identified 17% of IMU residents as SMI.

For the 2006 IMS group, data from OBTS covered the entire population but were limited to two useful indicators: (1) assessment by a mental health professional as seriously mentally ill; (2) diagnosis with one of a group of severe illnesses. Those meeting either indicator were counted as showing *mental health problems;* those meeting both criteria were counted as *SMI.*

- Excluding inmates at SOU, 18% of IMS inmates in 2006 were counted as SMI.
- Inmates with mental health problems had longer IMS terms (21 months vs. 12 months). This discrepancy is only partly accounted for by their higher rates of infractions on IMS.
- STG affiliates showed higher rates of mental illness than expected: excluding people at SOU, mental health problems were found in 25% of IMS STG cases.

Several federal court rulings have required prison systems in other states to avoid long-term placement of SMI offenders in the equivalent of IMUs. The *Madrid v. Gomez* court in California also excluded persons with borderline personality disorders, brain damage or mental retardation, or impulse-ridden personalities. This description evokes the offenders—not necessarily SMI, but with repetitive patterns of disruptive, irrational, or egregious conduct in a variety of prison settings—who, in Washington, are called *behaviorally disturbed.*

- As noted above, a detailed sample of IMU residents in 2000 documented strong evidence of SMI in 20% of cases.
- With the addition of clinical symptom ratings in interviews, OBTS records of psychotic episodes or self-injury, and evidence of development disability or traumatic brain injury, the percentage of IMU residents with mental health-related issues—a broader concept than mental illness, including those called behaviorally disturbed—rose to 45%.
- Both the 2000 study and patterns of behavior found in the current study raise questions about the effectiveness of the IMU regime in deterring disruptive behavior among offenders with mental health problems.

Staff Assaults. There were 158 IMS offenders (30%) who had assaulted staff: 356 incidents, 23 aggravated. Of inmates who assaulted staff after the index term, 95% returned to IMS.

- Only one-quarter of inmates with previous staff assaults did so again after IMS, but this rate was twice that of those with no previous staff assaults.

We may infer that IMS deters staff assaults only if the correlation between previous and subsequent assaults is explained in terms of an underlying predisposition.

- STG members assaulted staff at a slightly lower rate than other IMS inmates.

- IMS inmates with mental health problems, however, were far more likely to commit staff assaults: 40%, compared to 18% of other inmates.

If sanctions are less likely to deter offenders with mental illness, this factor may explain their disproportionate representation on IMS, as well as their proclivity for infractions on IMS.

Return to IMS. *IMS Recidivism* is defined as return to IMS within 3 years of release from the index term in 2000 or 2006. Overall, offenders returned to IMS at a rate of 55%, but the rate increased from 49% for the 2000 group to 60% for the 2006 group.

- The length of the IMS term made no difference to recidivism when other variables such as STG membership were taken into account.
- Inmates with mental health problems returned to IMS at about the same rate as others..
- Recidivism rates were higher among STG offenders (66%), especially members of Latino STGs (70%); the increasing presence of Latino STG members, therefore, may explain the increase in recidivism between the 2000 and 2006 groups.
- Among STG affiliates, Norteños returned to IMS at the high rate of 80%, probably because they were relatively low in number and subject to attack on sight by their rivals.

Return to IMS differs from recidivism in the community in that no set of official record variables has been found that predicts IMS recidivism with reasonable accuracy. The apparent success of IMS stepdown programs at WSP and CBCC, however, suggests that there are causes of IMS recidivism that may be addressed by intervention. These factors are not regularly assessed or documented in official records.

Policy Directions. Most offenders affiliated with STGs are unlikely to reject an allegiance central to their identity. They may be encouraged to modify their behavior, however, by programs that help them recognize an interest in freedom that outweighs the short-term gains of violence and racketeering.

- The effectiveness of incapacitation and deterrence through IMS is limited by the continuing influx of new gang members.
- Behavioral incentives and offender change programs in general population, IMU-based stepdown programs, and transfers to less intense settings may all be used, depending on circumstances, to reduce levels of violence associated with STG affiliation.

Legal and ethical concerns about protection from harm, as well as the evident failure of IMS to deter misbehavior by inmates with mental health problems, suggest that the Department should formalize policies and procedures to divert inmates with mental illness from IMS.

- Diversion from IMS requires mental health professionals to assess clinical status and needs of mentally ill inmates at administrative segregation hearings.
- Diversion also requires reliable systems for identifying inmates with mental illness and safe alternative programs for those whose behavior warrants maximum custody.

Introduction

Intensive Management Status (IMS) may be defined as the assignment of inmates to extended administrative segregation, a preventive measure to address substantial threats to institutional security or to the safety of inmates or staff. This description of IMS inmates in Washington is intended to help the Department address policy issues about the use of IMS to control security threat groups (STGs), rates of mental illness in IMS, and the problem of "behaviorally disturbed" inmates. At this point, no systematic data are available about another major challenge facing DOC, the use of IMS for protective custody.

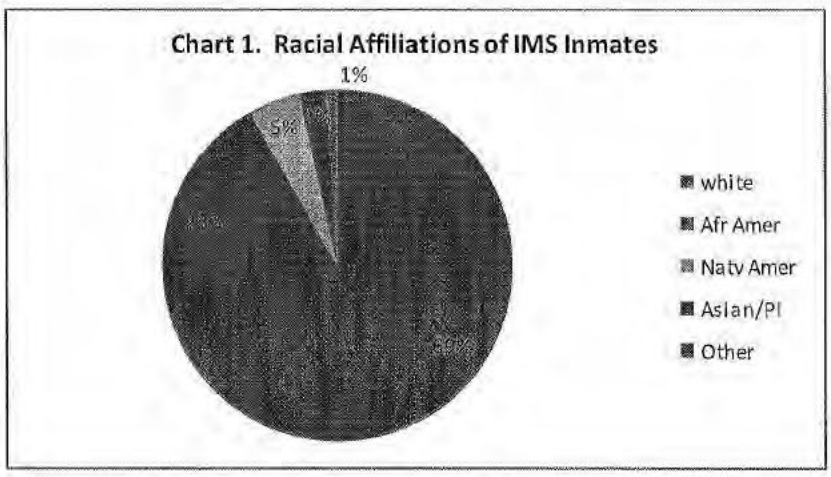
This profile relies on DOC's administrative datasets, in particular the offender tracking data in OMNI and mental health data collected from OBTS, to describe two groups of IMS inmates:

- IMS inmates identified and described in studies conducted in 2000 (N=227);
- Inmates on IMS as of January 1, 2006 (N=293);[1]

The *index IMS* assignment is the term an inmate was serving when, in 2000 or 2006, he appeared in a snapshot of all IMS inmates. The index assignment is the point that defines two distinct *cohorts* and from which previous IMS assignments and return to IMS are measured.

Demographics and Criminal History

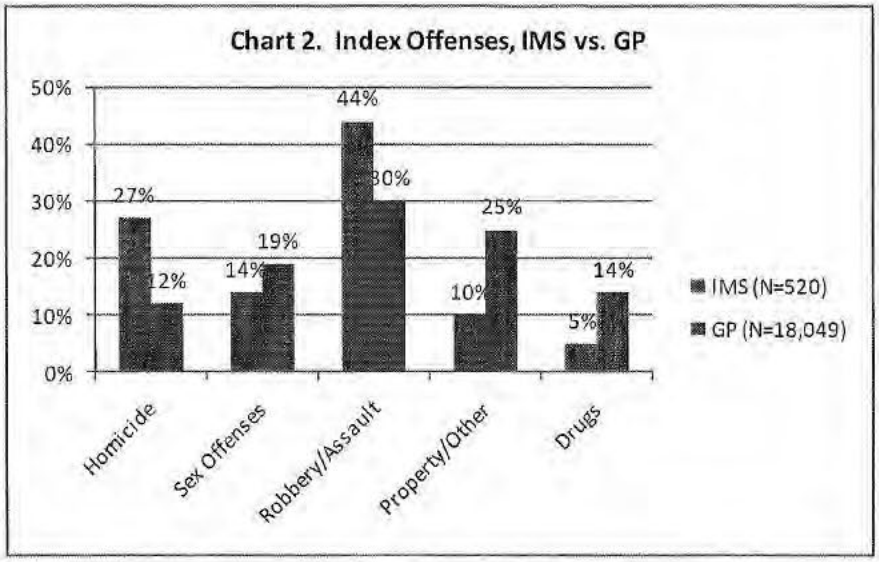
IMS inmates are roughly comparable to general population (GP) inmates in racial classification..

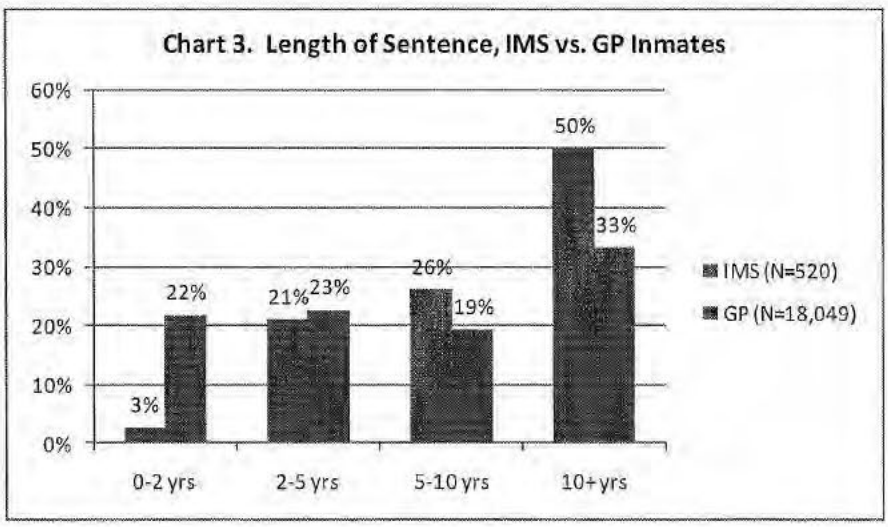


Among IMS inmates, 14% were identified as Hispanic in 2000 and 23% in 2006, compared to 10% among GP inmates (2008).

[1] Because 11 inmates were in both cohorts, this analysis actually covers 509 different individuals, but 520 IMS cases, who are referred to throughout this report as "inmates" to simplify the presentation.

Given the purpose of IMS, it is not surprising that, as in our past studies, it was found that IMS inmates have been convicted of more violent crimes, serve longer sentences, and have much higher rates of infractions.





Leaving aside sex offenders, who are under-represented on IMS, 71% of IMS inmates are serving terms of homicide or violent offenses against persons, vs. 42% of GP inmates. There were 5 IMS inmates under sentence of death, and 41 (8%) serving terms of life without parole.

Diversity. Although of course IMS inmates have more violent records, longer prison terms, and higher infraction rates than GP inmates, it is critical to acknowledge the wide variation among IMS inmates. Because there is no typical IMS offender, DOC faces the challenge of making

programs and policies consistently serve the principal security objectives of IMS while bringing about change among inmates with diverse histories, capabilities, and attitudes.

Table 1. Variability Among IMS Inmates*

Statistic	Prison Term (years)	Index IMS Term (months)	Annual Major Infraction Rate**
Mean	9.3	24	4.0
Median	8.3	17	2.6
Standard Deviation	5.8	21	5.0
Minimum	0.4	1	0.0
Maximum	35.7	192	52.5

*The maximum prison term reflects those inmates sentenced to life without parole, whose prison terms are presumed to end when they reach 75 years of age.

**The average among GP inmates was measured at 1 per year in an earlier study.

Variability among IMS inmates is shown by the broad range from minimum to maximum values, high standard deviations, and the differences between the means and the medians, reflecting the influence of a small number of inmates on the extreme high end of each variable.

Infractions, IMS Terms, and Release to the Community. The average length of an IMS term decreased from 2000 to 2006, from 26 months to 21 months.

- The number of IMS assignments per inmate ranged from 1 to 11, with an average of 2.3.
- The average annual infraction rate before the index IMS assignment was 6.8;
- In 68% of cases, infraction rates went down after the index IMS term; in 21% of cases, infraction rates went up after the index IMS term; the remaining 11% maintained approximately the same rate.

The most common or significant infractions—comprising almost two-thirds of the 15,000 infractions committed by these 520 inmates—were divided into categories:

- *Violent*, following DOC's criteria for violent incidents;
- *Racket-related*, consisting of STG activities and possession of controlled substances;
- *Disobedient*, such as refusing orders and endangering safety;
- *Disturbed*, consisting of threatening, throwing objects, setting fires, and flooding;\

Over 300 inmates were infracted for fighting, averaging 2.5 incidents apiece; inmates infracted for threatening, an equally prevalent infraction, were even more repetitious, averaging 4.5 incidents apiece. Infractions classified as disobedient were the most common, comprising over 5,000 incidents, partly because so many types of infractions were included under this heading. There were 6 inmates infracted for an infraction labeled "homicide," which covers both attempted and successful deadly assaults: though not for lack of effort by the perpetrators, in these instances the victim did not die. Assaults on staff were singled out for separate analysis, presented below after discussions of security threat groups and mental illness.

Release to the Community. If prisoners with violent records re-enter society directly from IMU, we may be concerned that long-term isolation would render them even less able to cope with the behavior of others. These concerns were supported by a UW study showing that IMU offenders released directly to the community re-offended sooner and at higher rates than comparable IMS offenders with three months or more in less restrictive settings before release.[2]

- Of 250 IMS offenders in this study who had been released from prison, there were 66 (26%) released directly from IMU.
- Given discussions of this problem and the UW study's preliminary findings during 2003-2006,, it was surprising to find that the percentage released directly to the community *increased* between the 2000 and 2006 cohorts, from 19% to 33%.

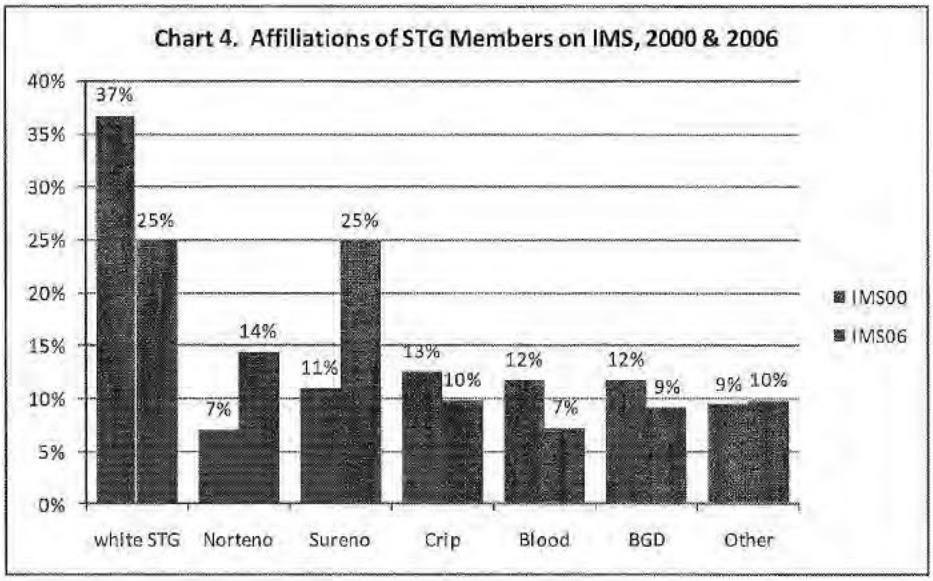
One obstacle to transitioning IMS offenders through less restrictive settings is the risk they pose in general population, and some factors may have changed between 2000 and 2006. In the next two sections, we consider the risks associated with STG status and mental illness.

Security Threat Group Involvement

Security threat group (STG) activities are a major source of violence in prisons. Just over half of IMS inmates were identified as active STG members:

- Among IMS inmates in 2000, 57% have been identified as active STG members;
- Among IMS inmates in 2006, 52% have been identified;
- The apparent decrease may only reflect the longer period for intelligence collection about the 2000 group;
- Among IMS inmates affiliated with STGs, the percentage active in Latino groups increased dramatically between 2000 and 2006, with a concomitant reduction in the predominance of white supremacists among active STG members on IMS.

[2] Lovell, D., Johnson, L.C., & Cain, K.C.. 2007. Recidivism of Supermax Prisoners in Washington State. *Crime and Delinquency,* 53(4): 633-656.



STG Involvement, Infractions, and IMS Terms. Given the attention drawn by the behavior of inmates identified as active in STGs, some observations were unexpected:

- Affiliated and non-affiliated IMS inmates showed no difference in annual infraction rates.
- STG-affiliated inmates were *more* likely to improve their infraction rates after their index IMS assignments:
    - Among affiliates, 73% showed lower rates, 18% higher;
    - Among non-affiliates, 60% showed lower rates, 25% higher.
- STG-affiliated inmates had shorter average index IMS stays:: 20 months vs. 28 months for non-affiliates, but averaged more IMS terms: 2.6 vs. 2.

In addition to STG involvement, mental illness—which is more highly concentrated among non-STG affiliates—also affects outcomes such as length of stay and infraction rates.

Mental Health Issues in IMS Inmates

The concept of *serious mental illness* (SMI) is intended to capture those prisoners for whom mental health treatment is medically necessary by virtue of the obligation to protect persons from harm while they are wards of the state. These are the critical elements in DOC's definition of mental illness, following the standard set in Ohio as part of a federal court consent decree:

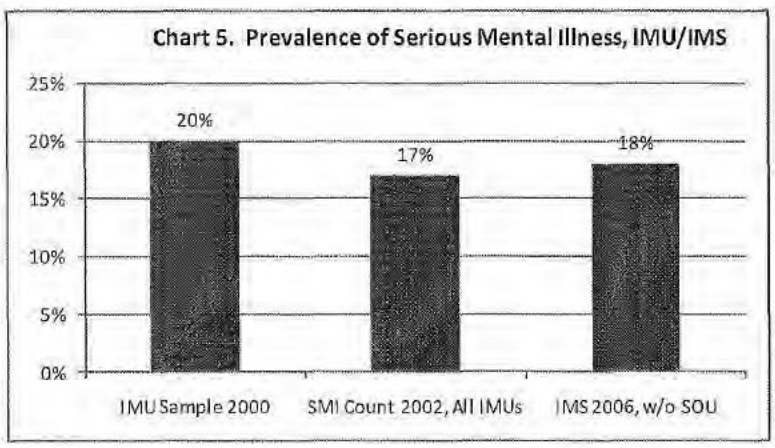
- Major thought or mood disorder, causing
- Significant impairment of functioning in prison (judgment, behavior, capacity to recognize reality), and

- Substantial pain or disability, so that
- Continuing treatment is necessary.

Counting SMI. Identification of inmates as SMI has been problematic for a variety of reasons: insufficient psychiatric staffing at key facilities such as the reception center and WSP; different understandings of SMI among mental health professionals; reliance on contract psychiatrists who do not always document diagnosis in DOC records; unreliable entry and updating of electronic records; and contention about ascribing SMI to offenders with severe behavior problems. In 1998, the UW collaborated with DOC, DSHS, and the Washington Institute for Mental Health Research and Training to document SMI among offenders who had been released as part of a large-scale community transition study which has served as a baseline for subsequent program evaluation efforts. A variety of indicators were combined in an algorithm that has since been refined in subsequent studies: a random sample of IMU residents in UW's 2000 study, and a 2003 study that identified all inmates with SMI as of June, 2002 and found rates of 10% among all prisoners, 13% among residents of major institutions.[3] Because the current study of IMS residents was limited to electronic records, mental health status was measured only for the 2006 cohort because, by then, two relatively useful indicators were commonly documented:

1. Certification of Serious Mental Illness by a mental health professional, recorded in the OBTS DT86 screen ("Interview Confirms SMI"); or
2. Diagnosis of Schizophrenia, Schizoaffective Disorder, Psychosis unspecified, Bipolar Disorder, Major Depression, Organic Thought or Mood Disorder, or Borderline Personality Disorder (these diagnoses are selected because treatment is usually medically necessary).

Inmates meeting either indicator are described in this report as showing *mental health problems* or as *mental health cases*; those meeting both criteria are classified as *SMI*. Chart 5 presents rates of SMI, conservatively defined, in the 2000 IMU sample, the IMU inmates in the 2003 prevalence study, and the 2006 IMS cohort (excluding inmates at SOU).



[3] Lovell, D. 2003. Identification of offenders with serious mental illness in Washington Department of Corrections facilities. Olympia, WA: Department of Corrections.

These estimates are not fully comparable because of differences in population and sources of evidence; furthermore, the 2000 and 2006 estimates are likely both to miss some undocumented SMI inmates and count others (false positives) whom a more detailed examination would exclude. Nevertheless, the rough similarity of the estimates provides a measure of the presence in IMUs of offenders for whom DOC is obligated to provide medically necessary treatment.

SMI, Disturbed Offenders, and IMS Policy. Several federal court rulings—*Madrid v Gomez* (California) and *Jones'El v Berge* (Wisconsin) have found it a constitutional violation to assign prisoners with serious mental illness to their states' supermax facilities. The *Madrid* court also listed further factors, highlighted below, that characterize prisoners who, in Washington, are often labeled *behaviorally disturbed*:

> Such inmates consist of the already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities, or a history of prior psychiatric problems or chronic depression. For these inmates, placing them in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk is high enough, and the consequences serious enough, that we have no hesitancy in finding that the risk is plainly "unreasonable." ... Such inmates are not required to endure the horrific suffering of a serious mental illness or major exacerbation of an existing mental illness before obtaining relief.

Most DOC staff can identify the prisoners to whom the concept *behaviorally disturbed* applies: those who have shuttled back and forth between prisons and between disciplinary and treatment settings, disrupting living units, and engaging in desperate or egregious behavior for incomprehensible or seemingly trivial reasons. While the term is sometimes used to distinguish "behavioral" inmates from those with mental illness, many of them are eventually recognized as mentally ill. Nevertheless, *disturbed* is not a clinical term; it refers not to an underlying disposition but to a pattern of behavior, conditioned by prison settings, which has defied understanding and intervention.

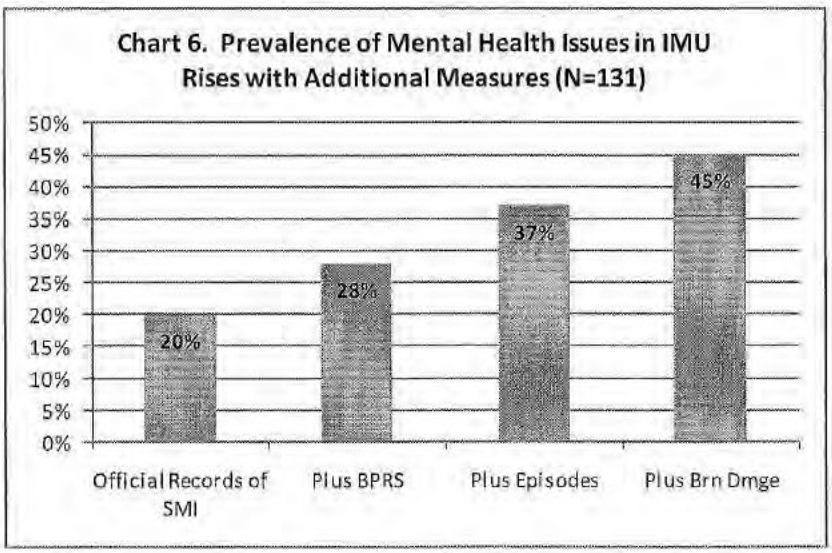
Our 2000 study included a 40% random sample of IMU inmates who were interviewed and whose charts were reviewed. Table 2 summarizes the prevalence of indicators of psychological disturbance similar to those described in the *Madrid* ruling:

- Serious Mental Illness, defined operationally by DOC classification, diagnosis, medications, and housing records;
- Marked or severe psychiatric symptoms shown in interviews, measured by BPRS scores;
- Psychotic or self-injurious episodes described in OBTS and medical chart notes;
- Indications of brain damage in medical charts.

Chart 6 displays the rising prevalence of mental health issues with the addition of each indicator. These four measures have been presented roughly in descending order, in terms of the reliability of the evidence we were able to gather and their relationship to serious mental illness. Taken together, they point to a high rate of mental health issues.

Table 2. Forms of Disturbance or Impairment in IMU Residents (N=131)

Measure	Number	Percent
Official record evidence of SMI	26	20%
BPRS Symptoms	19	15%
Self-Injury or Psychotic Episodes	32	24%
Brain Damage	36	30%



In addition to legal and ethical concerns, one may question whether housing either mentally ill or behaviorally disturbed prisoners is compatible with the mission of Intensive Management: to contain inmates committed to violence, rackets, or organized power struggles with authorities and other groups of prisoners. The commitment to organized power struggles with prison authorities has been explicit in our interviews with IMS prisoners associated with STGs, especially white supremacist groups, but many non-affiliated inmates have also chosen violent or exploitative prison careers. In addition to a high degree of surveillance and physical security, IMUs attempt to control behavior through a combination of incentives and disincentives that presume that IMS prisoners will improve their behavior in order to gain more freedom or avoid further restrictions and long-term isolation. Our studies have cast doubt on the effectiveness of this regime for both inmates with serious mental illness and the behaviorally disturbed.[4]

Rates of mental illness were significantly lower among STG members, but still high:

[4] Lovell, D. 2008. Patterns of disturbed behavior in a Supermax population. *Criminal Justice and Behavior,* 35(8), 985-204.

- With SOU inmates removed, the respective percentages of mental health problems were 25% among STG affiliates and 36% among non-affiliates.
- Even with the stricter standard of *SMI*, requiring both certification and a qualifying diagnosis, over 14% of STG members, not in SOU, were mentally ill.

From these findings one may infer either (1) that the qualifications for STG membership are relatively low, requiring a less organized, willful set of aptitudes than one might have expected; or (2) that impulsive or disorganized STG members are more likely than others to incur IMS.

Inmates with mental health problems generally spend longer time on IMS:

- Mental health cases spent far more time in their index IMS term (21 months vs. 12 months), and more total IMS time: 50 months vs. 23 months.
- Inmates with mental health problems also committed *infractions on IMS* at almost 3 times the rate of the non-mentally ill (4 vs. 1.4 per year). Although, for obvious reasons, this factor is highly correlated with longer IMS stays, it does not completely explain the longer stays of inmates with mental illness.
- IMS inmates classified as SMI were less likely than those without mental illness to lower their infraction rates after the index IMS assignment (51% vs. 68%).

We have distinguished between serious mental illness and mental health problems, more broadly defined. Many of those with mental health problems who don't meet criteria for SMI would qualify as disturbed. In either case, there is a high proportion of IMS offenders whose behavior hasn't responded well to sanctions. The next section goes into detail about a behavior that poses the question of the deterrent function of IMS in its most acute form: assaults by inmates on staff.

Assaults on Staff

We found that 30% of IMS offenders have assaulted staff. Whatever the numerical significance of this rate, prevention of staff assault—for reasons so obvious it would be insulting to state them—looms large among objectives of the IMS institution.

There were 158 offenders (30%) who assaulted staff: 356 incidents, 23 of them aggravated. There is a clear relationship between staff assault and IMS assignment:

- Of 53 offenders who committed staff assault after their index IMS term, 45 (85%) returned to IMS.

It is less clear, however, whether IMS deters future staff assaults. Of those who committed staff assault, half did so before their first IMS assignment, half afterwards. Table 2 compares post-index staff assaults for inmates with and without previous staff assaults.

Table 2. Relationship of Pre-IMS to Post-IMS Staff Assaults

		Previous Staff Assault		
		Yes	No	Total
Post-Index Staff Assault	Yes	25 26%	54 13%	79 15%
	No	73 74%	368 87%	441 85%
	Total	98 100%	422 100%	520 100%

Note. N=520; χ^2=9.978, df=1, p=.002, odds ratio=2.33.

- Offenders with a previous staff assault were twice as likely to commit assaults after IMS.
- On the other hand, only one-quarter of those with previous staff assaults committed new ones after their index IMS assignment.

If we assume that some inmates are intrinsically more prone than others to custodial assault, then the higher rate of post-index assaults among previous offenders may be explained by that fact. If this explanation is accepted, then the lower rate *after* IMS suggests that IMS may deter future assaults. This explanation requires that we identify a condition or disposition that inclines inmates to assault staff. How is this behavior related to the two main topics of this report: STG involvement and mental illness?

- Among IMS inmates there is no significant relationship between STG involvement—not even white supremacist allegiance—and staff assault. Indeed, the rate of staff assault is slightly lower, though not significantly so, among STG members.
- Inmates with mental health problems, however, did commit far more than their share of staff assaults: 42% of SMI inmates and 40% of the broader group with mental health problems assaulted staff, compared to 18% of other inmates..
- Aggravated staff assaults were comparatively rare (21 offenders, 23 incidents), and no more common among inmates with mental illness than among others.[5]

If mental illness, broadly defined, qualifies as a condition or disposition that inclines inmates to commit staff assaults, how susceptible is this behavior to deterrence?

- Prisoners with mental illness comprised 36% of the 2006 cohort and over half of those with staff assaults before their index IMS assignment;

[5] These statistics only cover IMS inmates; in the whole inmate population, one might well find that staff assault is directly related to STG involvement, or more weakly related to mental illness.

- Of 13 previous assaulters with new assaults after the index IMS term, 11 (85%) were mental health cases.

Table 3. Mental Illness and New Staff Assaults After IMS Among Offenders with Previous Staff Assaults

		Mental Health Problems		
		Yes	No	Total
Post-Index Staff Assault	Yes	11	2	13 27%
	No	14	22	36 73%
	Total	25	24	49

Note. N=49 offenders with previous staff assaults in 2006 cohort; χ^2=8, p=.005, odds ratio=8.6.

Evidently, IMS offenders who assault staff are less likely to be deterred by the prospect of renewed solitary confinement if they are mentally ill. The numbers, however, are low; furthermore, among the mentally ill as among all IMS inmates, a substantial majority—61% among those with mental health problems, 82% among others—have committed no staff assaults. Moreover, as we shall see in the next section, inmates with mental illness appear no more likely than others to return to IMS once released. For these reasons, the greater proclivity for staff assaults among inmates with mental illness doesn't wholly explain their disproportionate presence on IMS.

The legal constraints on the use of IMS for inmates with serious mental illness (and, perhaps, those with irrationally impulsive tendencies) have been described. The challenge of living up to the principle embodied in these constraints—not to harm the mentally ill by subjecting them to prolonged solitary confinement—is at its highest with staff assaults. On the other hand, if IMS assignment is a weaker deterrent to staff assault among the mentally ill, the Department has all the more reason to find more creative ways of addressing the relationship between mental illness and this major institutional safety issue.

Return to IMS

In this analysis, *IMS Recidivism* is defined as return to IMS status within 3 years of release from the index term in 2000 or 2006.

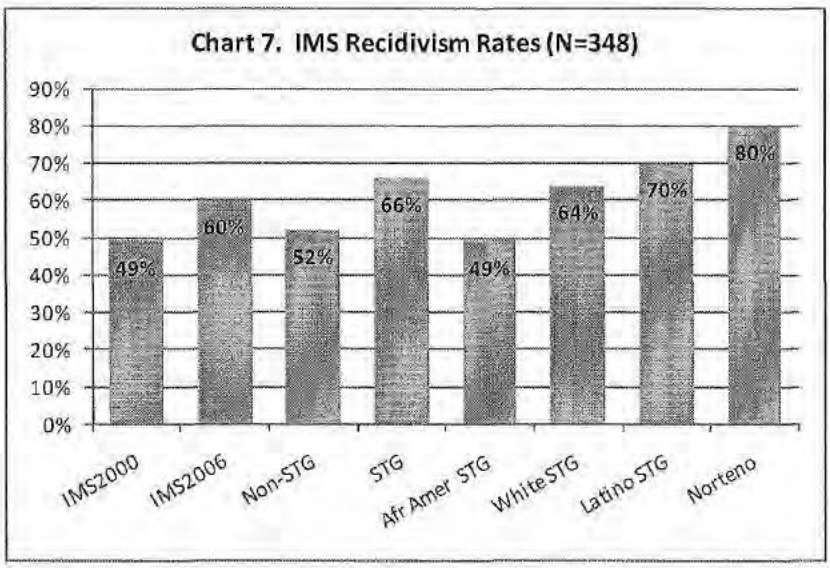
- Of 520 inmates, 169 were removed from analysis because they left prison within 3 years without return to IMS.

- An additional 3 inmates were removed from analysis because they had not been released from their index IMS term, leaving a total of 348 cases for recidivism analysis.
- The overall rate of IMS recidivism—return to IMS within 3 years—was 55%.

SMI and Recidivism. Because comprehensive data on the two primary mental illness measures were available only for the 2006 cohort, the association between mental illness and IMS recidivism is analyzed only for this cohort..

- In the 2006 cohort, mentally ill inmates—broadly or narrowly defined—and others showed the same rate of IMS recidivism (60%).
- IMS inmates at SOU were less likely to return to IMS than others (7 out of 16, 43%) but the numbers are too low to permit interpretation.

Because no significant association between mental illness and IMS recidivism was found in the 2006 cohort—despite higher rates of staff assault among the mentally ill—subsequent analysis uses the entire sample of 348 cases and omits mental illness.



Factors Associated with Recidivism. Comparative rates of IMS Recidivism for various groups of IMS inmates are displayed in Chart 7. Noteworthy in this chart is the increased rate of IMS recidivism between the 2000 and 2006 cohorts, and the high rate of IMS recidivism among Latino STG affiliates, especially Norteños. It was noted earlier that between 2000 and 2006, the proportion of Latino STG members rose by 20 points, from 18% of all STG members on IMS to 39%. The proclivity of these offenders for returning to IMS may well explain the increase in IMS recidivism between 2000 and 2006.

- The especially high rate among Norteños may be due to the intense rivalry between the two Latino groups for "control of the yard," with orders to attack on sight. Since there

are over twice as many Sureños as Norteños, the practice of assigning both fight participants to IMS, if gang-affiliated, leaves Norteños disproportionately likely to incur IMS: an equation well understood by their rivals.

Prediction of recidivism. One policy issue requiring assessment of recidivism is the duration of the initial IMS assignment, now set at 6 months. Would it make any difference to IMS recidivism if this presumptive term were shortened or lengthened?

- Very few inmates (3%) served 4 months or less. Those who served less than 6 months or 6-12 months returned at a rate of 50%; those who served longer terms at 60%.
- The duration of the IMS term made no contribution to predicting IMS recidivism when other relevant factors were included such as STG affiliation, previous IMS terms, and types of infractions.

If the length of IMS stay doesn't affect recidivism, what does? In the case of recidivism in the community, reasonably accurate probabilities can be derived from a limited set of official record variables: age at first offense and release from prison, number of past misdemeanors and past felonies, types of past offenses (e.g., drug offenses), low vs. high infraction rates, mental health and treatment status. The following measures were compiled to assess whether similarly accurate probabilities could be derived from correctional records:

- Past infraction rates, categories of common infractions, and custodial assault;
- Number of IMS assignments, length of index assignment, cumulative IMS time;
- STG status;
- Whether the index offense was violent;
- Demographic characteristics such as age and racial or ethnic classification.

Exploratory analysis was conducted on variables associated with IMS recidivism, selecting those with the highest contributions to logistic regression equations, testing for spurious correlations, and recoding variables to increase predictive power. The results were not encouraging.

- Predictive accuracy was assessed through ROC analysis, in which a score of 0.5 represents random prediction, 1.0 perfect. Straining ingenuity to analyze available variables, the best equation produced a mediocre ROC of 0.703, an insufficient improvement over chance to warrant policy or programmatic use of this set of variables.
- Furthermore, the variables included in the best equation were repetitive (three variables for STG affiliation) or theoretically mysterious: for example, violent index offenses and previous involvement in rackets were included as factors that *reduced* the probability of recidivism, probably as an artifact of the weakness of the prediction model.
- Custodial assault did contribute to predicting IMS recidivism, but only when assaults committed after the index IMS assignment were included. In that case, however,

custodial assaults are a *reason* for IMS assignment, not a factor that would assist advance prediction of who was likely to return to IMS.

The failure to generate a set of reliable IMS predictors, by means of the official record variables available for this study, does not mean IMS recidivism has no patterns. If not, there would be no place to intervene; results of stepdown programs, however, demonstrate the promise of systematic efforts to help IMS inmates redirect their attitudes and goals and test prosocial behaviors in safe social situations. Therefore, if interventions are to be guided by risk factors for recidivism, we would have to develop reliable indicators of the unmeasured attitudes and habits which, among the diversity of inmates in IMS, distinguish those most likely to continue endangering themselves or others.

Policy Directions

It has been said that three main groups of offenders comprise those on IMS: inmates with mental illness, STG affiliates, and inmates needing protection. These groups are not exclusive: some STG affiliates are mentally ill, and both mental illness and STG involvement may provide reasons to seek protection. The self-protection motive is often disguised, and violence against staff or other inmates may be a means of obtaining protection without admitting as much. Partly for this reason, official record data are lacking on protective custody issues among IMS inmates. Concluding, suggestions, therefore, are limited to STG and mental illness issues in IMS.

STG Involvement. The substantial expansion of IMS beds since 2000 has been matched by an increase in IMS placements, largely attributable to conflicts between Latino groups. The Department appears to recognize that it cannot manage STG-related violence through IMS alone.

- Due to external social factors, STG affiliation prevails in many neighborhoods and is established long before most inmates come to prison. Unless the Department pursues the costly policy of proliferating IMU beds, the influx of new affiliates with incentives to attack each other exceeds the rate at which they can be incapacitated through IMS.
- Reports from staff and administrators at WSP suggest that separating rival groups in different close custody quadrants helps reduce violence; such gains are precarious, however, since STG incentives may lead allied groups, e.g., different sets of Sureños, to attack each other.
- For many offenders, STG identity is so deeply rooted that a frontal assault—whether through sanctions or positive incentives—is unlikely to succeed: A gang unit detective asked, "what alternative can you offer to integrity?" And a stepdown program graduate declared, "I'm always going to have this. The gang is going to be in my heart, it's such a big part of my life. That doesn't mean I'm going to be gang-banging."

The last comment holds the key to the Department's strategy. Interviews with administrators, staff, and inmates indicate that a variety of techniques may encourage affiliated offenders to

refrain from STG-related rackets and violence without directly challenging their loyalty to their comrades. What is effective will depend on an inmate's affiliation (since rules vary among STGs), his status, and his sentence structure. To the limited extent that the interest of gangs in the well-being of their members outweighs their interest in exploiting them, they may support offender change programs.

> There have so many high-ranking guys from all the "cars" through this program that it's now accepted.

Some offenders can be brought to a new understanding of where their interests lie:

> Fighting for power in prison makes no sense; we should make freedom the goal.

For those serving long sentences, freedom may consist in transfers to settings with fewer restrictions and more options for personal development while in prison; for others, it may mean release to the community with enhanced prospects for remaining outside. Methods of strengthening members' interest in freedom, as opposed to the interests of those who exploit them, include incapacitation, deterrence, incentives for better behavior such as the level system in WSP close custody units, transfers to settings in which the pressure to participate is reduced, and IMU-based offender change programs—such as the promising IMS stepdown interventions mounted at WSP and CBCC.

Mental Illness. Legal and ethical concerns about protection from harm, as well as the evident failure of IMS to deter misbehavior by inmates with mental illness, indicate it is time for the Department to formalize policies to decrease the use of IMS for inmates with mental illness. The principle that IMS is a last resort—the exception, not the rule—should be embodied in procedures to divert those with serious mental health problems.

- Whether or not an inmate is mentally ill, if a dangerous situation develops on a living unit, prison authorities are perfectly justified, indeed obliged, to prevent injury. If the first response is to remove the apparent source or target of danger from general population, there is no point in second-guessing.
- Intervention should be focused, therefore, on the decision to formalize an emergency segregation action through hearings to assess the need for administrative segregation and, eventually, intensive management status. If an inmate has been classified as mentally ill, a mental health professional should participate and provide an assessment of the inmate's clinical status, the consequences of extended segregation, and steps needed to reduce the danger the inmate poses to himself or others.
- Diversion from IMS is not accomplished simply by writing policies and procedures, but by developing or expanding alternatives to IMS—such as Intensive Treatment programs for maximum custody inmates with mental illness.
- Diversion from IMS for those with mental illness requires that an inmate's clinical status *matters* in the IMS decision. If so, continuing efforts to systematize mental health evaluation and treatment are required so that an inmate's clinical status is *known* when housing and classification decisions are made.

EXHIBIT 4

The Reintegration Program (RIP) at Washington State Penitentiary:

A Program Evaluation

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Reintegration Program, Washington State Penitentiary
Executive Summary

The Reintegration Program at Washington State Penitentiary (RIP) was designed to promote a successful transition to general population of Intensive Management Status (IMS) offenders through a combination of incentives for appropriate behavior, programs to develop pro-social habits, and opportunities to practice social coping skills in a safe, but less restrictive, setting.

Program Approach. Social learning theory emphasizes the capacity of participants for rational reflection and treats behavior as a product of individual propensities, the institutional setting, and the way people understand their roles in that setting.

- As students of their own behavior, participants produced a Time-Line Self-Analysis that reviewed their prison records and analyzed choices at each juncture;
- Participants chose among a variety of courses that emphasized practical skills (Conflict Management, Communication Skill) and developing cognitive understanding and empathy (Victim Issues, Diversity in Prison).
- After Step 0, in which staff and program candidates evaluated their suitability for the program, participants moved through 6 steps: Steps 1-4 (RIP-In) took place in IMU, using cell front interviews and written materials; Steps 5 and 6 (RIP-Out) were held in a vacated wing of the old Unit 1 segregation unit, with a dayroom for group activities and the opportunity for participants to go to yard and chow with other offenders.

Program Implementation. Guided by the program approach, and in the absence of established recipes for treating supermax offenders, staff and administrators developed the program content and procedures from scratch. Implementation was delayed until mid-2006 by negotiations for resources and by the pace of physical renovation at WSP. State budget cuts in response to the global fiscal crisis led to the closing of the program in Spring of 2009.

- This study covers 116 participants enrolled during the program's 33 months, almost all of them serving time for non-sexual violent offenses such as robbery, assault, and homicide.
- Only 10% of participants were African American, vs. 19% in general population; but 28% were Hispanic, vs. 9% in general population.
- STG affiliations were reported for 70% of participants, 36% associated with Latino organizations (predominantly Sureño), and 20% white supremacist.

During the years of planning and program execution, RIP faced a series of challenges.

- There were two changes of leadership at WSP and at DOC;
- There was a complete turnover in program staff;

- Periodic closing of units and movements of offenders as part of facility reconstruction produced dramatic ups and downs in program participation;
- Staff and participants alike came under pressure from peers who distrusted the program.

Nevertheless, the program won intense commitment among the administrators and staff involved, and was appreciated by participants who were considered among the most dangerous and intransigent offenders at WSP.

Program Outcomes. An outcome analysis group consisted of 48 participants with at least 6 months of post-program exposure who were still in prison when data were collected in March of 2009. Of these, 24 were classified as program graduates, 24 as non-graduates.

- RIP participants were compared with a control group of 103 offenders drawn from a previous study of offenders on IMS, selected according to criteria of comparability with RIP participants (violent offense, STG membership, post-IMS exposure).
- RIP graduates averaged 9 months in their index IMS term, vs. 13 months for non-grads and 17 months for controls. Graduates had significantly lower previous annual infraction rates than non-graduates (4.95 vs. 9.17) but were comparable to controls (6.03).

The principal measure of program effectiveness was return to IMS.

- RIP graduates fared better than non-graduates: 3 out of 24 graduates returned, whereas 7 out of 24 non-grads returned and another 4 were retained on IMS.
- Overall, 23% of participants returned to IMS, vs. 37% of controls.
- The clearest outcome evidence compares RIP Grads to controls: 3 out of 24 RIP grads (12.5%) returned to IMS, vs. 37% of controls. The odds of success vs. failure were 4 times better for RIP grads than for controls.

Interpretation of Results. RIP was designed to test participants' commitment to living safely among others; furthermore, random assignment of participants to intervention and control groups wasn't feasible. For these reasons, statistical tests cannot tell us whether the results of the program are due to its clinical benefits rather than to selection of graduates through the testing process or other differences between RIP grads, non-grads, and controls.

- To address the issue of interpretation, we take into account comments such as, "Every single one of them in the past could and would have caused trouble. These were high-powered guys."
- The clinical benefits of the program are also supported by the ability of participants to describe specifically how it affected them and why it made a difference. Common themes included the availability of counselors, respect for individual differences, the relevance of mini-courses to their issues, and what they learned from a searching review of their past patterns.

Lessons Learned. The results and the response by staff and participants support the social learning approach to IMS offenders. Two specific design improvements are recommended for future stepdown programs:

- Provide participants with a more limited and focused set of choices among mini-courses to improve efficiency and consistency of the program's clinical focus;
- Build in from the beginning a post-program placement, support, and counseling component to help participants cope with peer pressure and other stresses in general population.

Program acceptance by staff and administrators outside the program was a challenge throughout the program's tenure.

- More widespread support might be generated by a broader effort to educate members of the prison community about the program's methods and objectives, e.g., make presentations at roll call, work with other unit managers on the role of the program within the institution;
- Stability would be enhanced by ensuring that staff are specifically selected for the program and securing a location and resources before launching it.

Because an IMS stepdown program addresses men who have caused trouble and injured staff and other inmates, staff are naturally going to be suspicious because it may seem that participants don't really deserve help. In addition to providing specific evidence of a program's safety benefits, it is important to be clear about the connection between genuine accountability and the program's premise of respect for the participants' capacity for rational choice.

Introduction

The Reintegration Program at Washington State Penitentiary (RIP) was designed to promote a successful transition to general population of Intensive Management Status (IMS) offenders through a combination of incentives for appropriate behavior, programs to develop pro-social habits, and opportunities to practice coping skills in a safe, but less restrictive, setting. After three years of planning and negotiating for space and resources, RIP enrolled its first participants in June, 2006. RIP was terminated in March, 2009, in response to severe cuts in state budgets brought on by the global financial crisis.

During the years of planning and program execution, RIP faced a series of challenges.

- There were two changes of leadership at WSP and at DOC;
- There was a complete turnover in program staff;
- Because the entire facility underwent major reconstruction, periodic opening and closing of Intensive Management Units (IMUs) and designated program space produced dramatic ups and downs in levels of program participation;
- Staff and participants alike came under pressure from peers who distrusted the program.

Nevertheless, the program won intense commitment among a small group of administrators and staff. It gained the grudging respect and finally gratitude of participants, who had been notoriously dangerous adherents and enforcers of the "convict code." And strong evidence of successful outcomes can be found in the data collected for this study:

- Of 24 participants who completed the program, only 3 (12.5%) returned to IMS status, vs. 38 of 103 (37%) in a comparable group of offenders on IMS just before the program began.

Interpretation of this surprisingly positive finding is complicated because the program was designed to test participants before graduation, and because random assignment of participants to control groups was not feasible with this maximum custody program. In this report, reflections on years of collaboration and discussion with administrators, staff, and participants will be used to shed light on this pioneering effort to change the relationship between the prison and some of its toughest residents.

Program Development

The need for the RIP program was identified by the IMU Process Improvement Team at its August 29, 2002 meeting in which the team adopted the objective of establishing an IMU step-down program. In subsequent discussions, Washington State Penitentiary was chosen as the program pilot site. At WSP, prospective program administrators and staff worked with IMU staff and administrators to define criteria and incentives for program participation and protocols

for moving participants through a level system like the IMU levels. As of February 2003, however, when we began working with the design team, little had been established about the program's approach to offender change.

Philosophical Approach. Applying the analysis of Toch and Adams in *Acting Out: Maladaptive Behavior in Confinement*, we suggested that the program adopt a social learning approach with several key features.

- The concept of a prison career emphasizes that actions cannot simply be explained by enduring individual attributes such as psychopathy. While people are in prison their lives follow a trajectory that reflects their changing dispositions, the way they fit or fail to fit their settings, and the expectations others have of them.
- Social learning depends on the participant's capacity for self-reflection which is exploited by three principal methods:
    1. Participants must become students of their own behavior. To this end, a "Time Line Self Analysis" component requires participants to review and consider the implications of choices they made at particular junctures in their prison careers.
    2. Intervention is voluntary and individualized.
    3. Because the social community affects how participants understand themselves, realism about what needs to change can best be established by analyzing behavior in small group settings, with others who live in the same community and are affected by what each member does.

The social learning approach always takes account of the institutional setting and the presence of others as well as individual traits and states. Its suitability to the situation of IMS offenders is illustrated by comments on a confidential Aggression Questionnaire:

> I observed that this questionnaire tends to lean towards finding out my propensity for violence in my relations with the people in my environment. Let me be frank. First, I live in a bad place (and may have to for some time). I've developed a socially unacceptable disposition & a temperament that I would describe as "flash forward." I easily get angry, &, depending on the circumstance, I have the capability to cool off quickly. This is unfortunately a dog eat dog environment—the "flash forward" temperament has served me well . . . It is important to recognize, I plan to change many of my actions & social rapport.

Using social relations in a small group setting as a laboratory for reflection and change suits the primary requirement of any IMS transition program: since IMS offenders have been removed from face-to-face social interaction, prudence suggests the need for a safe social environment in which social behavior can be tested before participants are transferred to general population.

Program Planning. Until the fall of 2003, discussions about the program revolved around criteria for program participation, in particular whether the program should be voluntary; the use of incentives for program participation; and whether some phases of the program would indeed be conducted outside the IMU. The decision not to coordinate program steps with existing IMU

levels allowed planners to disentangle program needs from IMU management principles. By the Spring of 2004, a team of staff and administrators had completed a detailed proposal that incorporated the social learning approach, and outlined program requirements as well as a series of mini-courses from which participants would choose. The creativity of staff had been unleashed, and initially skeptical IMU administrators had signed on to the effort. Two program stages were planned:

1. RIP-In, using cell front interviews and written materials, would take place while participants were still living in IMU;

2. RIP-Out, in which participants would live in a secure but more open setting with a dayroom for group activities and the opportunity to go to yard and chow with other offenders, was planned for part of Unit 1, which was to be vacated and renovated as part of the planned reconstruction of WSP.

During the next two years, program development slowed down while negotiations for resources and space proceeded. Program implementation was also delayed by hold-ups in WSP's ambitious capital construction program, which program developers planned to exploit for program resources as well as space. There is a chronic sense in prisons that resources are limited, as in other public services, and supporters believed that using staff positions freed up by closing units during periods of renovation would be more palatable than allocating new positions to the program.

Anticipated and actual changes in leadership at DOC and at WSP also played a role in the slow pace of program implementation. Initiatives are often delayed while mid-level administrators assess the attitudes and intentions of new leadership. A new Governor was elected in 2004, a new Secretary of Corrections was appointed early in 2005, and within a year a new Superintendent was appointed at WSP. By the time the program was launched in 2006, the correctional program manager who had led efforts to develop RIP had been reclassified and reassigned as part of efforts to cut costs and streamline administration.

Supporters understood that acceptance of the program by WSP staff would be tenuous until it had begun to show results. Some administrators and staff in IMU and segregation units had raised obstacles and advocated policies that would have undermined the program approach. Because their support was needed to carry out the program, efforts to sell the program focused primarily on this relatively small group. In retrospect, a broader effort to educate members of the WSP community about the program's methods and objectives might have gained it more widespread support; but one may be confident that at the time, program planners were fully occupied with keeping their heads above water.

Program Implementation

Applying the Social Learning Approach. When RIP began enrolling participants in June of 2006, it was not the only offender change program offered in the WSP IMU. Offenders assigned IMS were generally required to complete either Anger Management or a Cognitive Behavioral Change program. These programs were delivered by workbooks that residents completed in their cells; interaction with staff about content was available but not essential.

Like other IMS programs, RIP adopted a step system in which increasing opportunities were provided as participants completed each step: steps 0-4 were conducted in IMU, 5 and 6 in close custody. Otherwise, RIP departed substantially from existing prison program models both inside and outside IMU.

- Not only was RIP voluntary, there was a substantial preliminary process of engagement (Step 0) and a detailed written application, reviewed and revised, before a team decision about admission in which the candidate participated.
- Research presented in trainings indicated that programs have little effect on high-risk offenders unless sufficient contact hours are provided. Adequate intensity of treatment required hiring a core group of staff whose primary responsibility was the program.

By far the most important difference between RIP and other programs to which participants had been exposed, was its responsiveness to individual differences.

- Certain core requirements were common to all participants: Time-Line Self-Analysis, First Steps, and Behavior Management Plans for each new step. To assist in self-analysis, participants were given an individualized chronological time line of their prison careers including such official records as housing and custody changes, segregation, and infractions. By design, the content with which participants fulfilled the common requirements varied according to their individual histories and needs.
- A large variety of mini-courses were available, from which participants chose two at each step. These included not only skill-building courses such as Communication Skills, Emotional Management, Conflict Management, and Problem Solving, but courses designed to stimulate cognitive understanding and empathy, such as Victim Issues, Diversity in Prison, and Society and Government.

Responsivity is a well-established principle in correctional treatment. Within the social learning approach of RIP, it meant that the behavior of participants was not treated only as an expression of deficits, to be corrected by building new skills, but as a consequence of core principles of action around which their lives had been constructed.

> This program appealed to me because it wasn't just about what you gotta do to stay out of IMU.
>
> Anger is not my problem. I fight because I'm supposed to; it was the right thing to do.

> I'd always thought of myself as a nice guy, respectful, opening doors for ladies. But when I read my self-analysis, I understood that I'd lived my life as an immoral person, a dirt bag.

To engage participants at such a fundamental level, one must begin by respecting—which does not mean endorsing—their point of view.:

> While the focus is on behavior, to support motivation it is critical that we use the offender's own words to talk about issues, rather than insisting on his accepting our terms. (Anthony Coker, Manager, Correctional Service Canada, Violence Prevention Program, personal communication)

This approach requires empathy and commitment on the part of staff. As the program was put into place, staff training concerned not only such standard fare as building effective teams, but understanding the difference between the ethical framework that most staff take for granted and the worlds in which offenders had been formed. Six months into the program, staff said:

> The longer they stay in the program, the more responsive they become. It was the theory, it's about the offenders. We will be there, we have kept our promise.

The availability of staff was appreciated by participants, but frequent interaction also served to provide staff with richer information about the thinking and commitment of participants. The authenticity of participants' engagement with staff and their ability to match words with deeds was tested as the program proceeded. This did not mean that participants had to pretend that a sudden transformation had taken place in their identity.

> I'm not an inmate, I'm a convict. I follow the code. They talk to me about the trust issue: I don't.

> I'm always going to have this. The gang is going to be in my heart, it's such a big part of my life. That doesn't mean I'm going to be gang-banging.

Table 1. Participant Status as of March, 2009 (N=116)

Status	Number	Percent
Still in program	31	27%
Graduate	28	24%
Released from prison	3	3%
Transferred	7	6%
Withdrew	17	15%
Terminated	30	26%

Participant Characteristics. Here we present a quantitative profile of 116 offenders who participated in the program to varying degrees during its 33-month life. Mutual testing of participants and staff is illustrated by statistics on participant status when the program ended (Table 1). The hard-core IMS composition of RIP is demonstrated by participants' index offenses and gang affiliations. Like other IMS offenders, RIP participants had a considerably

higher proportion of violent index offenses than general population inmates. The absence of sex offenders among RIP participants suggests that they were less likely than other IMS offenders to have been placed on that status for protection. Furthermore, the vast majority of RIP participants had been identified as affiliated with Security Threat Groups (STGs).

Table 2. Index Offenses:
RIP Participants (N=116), IMS Offenders, and General Population Inmates

Offense Type	Number	Percent	IMS Pct (N=348)*	General Pop Pct (N=18,627)
Drug Offenses	7	6%	4%	12%
Property, Other Offenses	17	15%	12%	20%
Robbery, Assault, etc.	68	59%	44%	34%
Sex Offenses	0	0%	16%	21%
Homicide	24	21%	24%	14%

*Note: From a 2008 UW study of all offenders on IMS as of January 1, 2006.

Table 3. Security Threat Group Affiliation, RIP Participants (N=116)

Affiliation	Number	Percent
None	35	30%
White Supremacist	23	20%
Norteño	12	10%
Sureño	30	26%
Crip, Blood, BGD	13	11%
Other, Natv American	3	3%

IMS offenders in the previous UW study resembled general population offenders in racial classification. In RIP, there was a lower percentage of African Americans and a higher percentage of white inmates (Table 4).

- Among RIP participants, 28% identified themselves as Hispanic, vs. 9% in general population. As in previous studies, this difference reflects the influence of Latino gangs.
- A smaller number of RIP participants qualified for outcome analysis, which required that they had left the program at least six months before March of 2009, when outcome data

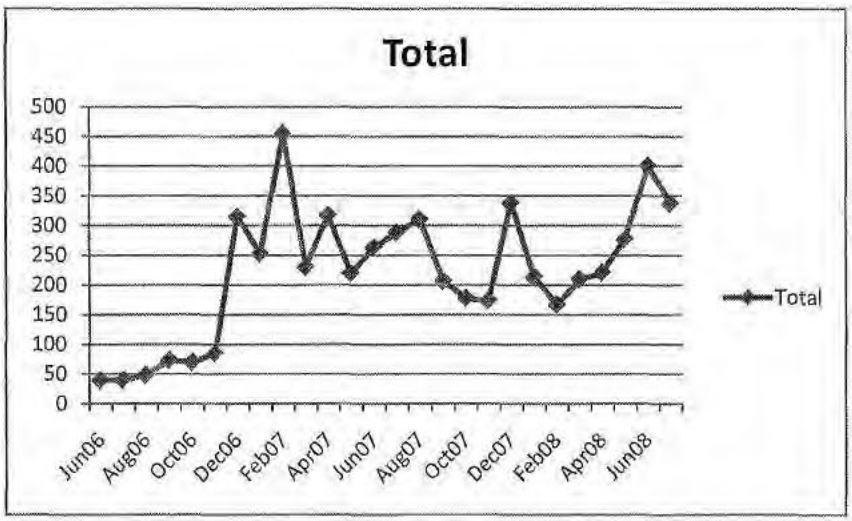
were collected. In that analysis, offenders identifying as Hispanic constituted less than 15% of outcome cases and 8% of program graduates, indicating that more Latino offenders joined the program in its later stages.

Table 4. Racial Classification, RIP Participants (N=116)

Classification	Number	Percent	General Pop Pct (N=18,627)
White	98	84%	71%
African American	11	10%	19%
Native American	5	4%	5%
Asian/Other	2	3%	5%

Program Vicissitudes. Program integrity was assessed by requiring staff to track their clinical encounters with participants: time spent at cell front, in individual interviews, or in group settings working with participants on their issues. Chart 1 demonstrates dramatic ups and downs in levels of program activity.

Chart 1. RIP Monthly Contact Hours, 2006 - 2008



The low number of contact hours in the early months reflects the six-month delay in the anticipated opening of Unit 1, which provided more opportunity for programming and was followed by a sharp increase in program delivery. At this point, however, there was a rapid turnover in program staff so that, by mid-2007, we found an almost entirely different group.

Although these staff were even more committed than the first group to the objectives and methods of the program, the transition caused disruptions in program delivery.

While the move to Unit 1 finally enabled the program to work as intended, it heightened conflicts that had been evident over months and years of program development.

- There were 50 beds in the wing of Unit 1 allocated to the program, occupied by less than a dozen RIP participants. These segregation beds were coveted by custody staff coping with a continuing increase in gang-related violence and other tensions.
- Furthermore, the newly visible use of half a dozen staff members for a small number of participants provided fuel for resentment on the part of non-program staff who already had reasons for suspicions about a program that appeared to offer benefits to some of the least popular prisoners at WSP.

Evidently, not all COs hid their feelings from participants:

> Unit 1 was cool, but so many people didn't believe in the program. We were under intense scrutiny, with people hoping that you do fail.

Nor were program staff exempted from criticism by peers:

> [When the program was discontinued,] people would come up to me and say, 'I'm glad we're getting rid of RIP, it's bullshit.' And I'd say, 'just what do you know about the program,' and they'd say, 'it's just bullshit They're not holding inmates accountable.'

The rapid turnover of staff after the first six months probably reflected a combination of administrative inexperience, emerging philosophical differences, and pressure from non-supportive peers. In the late summer and early fall of 2007, as part of the continuing revolution in the geography of WSP, the IMU was closed temporarily, with residents transferred to an older segregation unit. Early in 2008, recruitment was slowed by difficulty coordinating with the new IMU facility and rumors of the program's impending move to another location. When program integrity was compromised as a by-product of organizational and physical changes at WSP, some staff saw a lack of administrative commitment.

> Shutting down the IMU sunk us . . . Seg is more toxic, and it influenced our participants.
>
> [The Director] was never really given a chance to succeed.

When the program was closed, in the wake of budgetary calamity and yet another reorganization of spaces, the supporters of the program all believed, fairly or unfairly, that it really happened because the system at WSP just couldn't tolerate it.

Program Outcomes

A smaller outcome analysis group that permitted follow-up was generated from the 116 participants by removing those still in the program (31), those with less than six months of post-program exposure (35), and those released from prison (2).

- Of the 48 analysis cases, 21 graduated at Step 6; 3 who transferred earlier to other prisons with custody promotions were also treated as graduates for analysis purposes.

RIP Grads vs. Non-Grads. Not surprisingly, RIP graduates were enrolled in the program much longer than non-graduates (averaging 300 days vs. 129) and averaged over three times as many clinical contact hours (129 vs. 34). The disparity between the number of days in the program and clinical contact hours is partly explained by the brief nature of the primary cell-front form of interaction during RIP-In (Steps 0-4, in IMU).

- Participants averaged 9 hours of contact at each step from 0 through 4, vs. 43 at Step 6 and 49 at Step 6.
- Low contact hours at the IMU steps also reflect periods of delay when no RIP-Out program space was available.

The principal outcome measure is return to IMS. The 24 RIP Non-Grads included 4 who were never promoted from IMS; for purposes of this comparison, these were treated as failures along with 7 who subsequently returned to IMS.

Table 6. Failure Rates, RIP Grads vs. Non-Grads (N=48)

		Failure		
		New IMS or retained (4 cases)		
		Yes	No	Total
RIP Grad	Yes	3	21	24
		12.5%	87.5%	
	No	11	13	24
		46%	54%	
	Total	14	34	48
		29%	71%	

Note: Failure, Grads vs. Non-Grads: χ^2=6.45, df=1, p=.024; odds ratio=5.9

- Graduates averaged 9 months in their index IMS term, vs. 13 months for non-grads.
- Grads averaged 4.95 annual pre-IMS major infractions, vs. 9.17 for non-grads (both rates much higher than the 1 per year found in a previous study of general population inmates)
- A lower percentage of grads were classified as STG-involved (54% vs. 75%).

These differences suggest that non-graduates may have been more impulsive than graduates and therefore less likely to persevere in the program and remain out of trouble once released from IMS. That RIP graduates had shorter index IMS stays suggests that program completion, or the

behaviors and attitudes that supported it, may have contributed to an earlier favorable reclassification.

- One strength of the program was its ability to test the commitment of participants. By the same token, however, it is difficult to distinguish the contribution of the clinical benefits of the program from the contribution of pre-existing differences and the testing process.

RIP Grads vs. Controls. To provide a clearer test of effectiveness, we compared RIP graduates to a control group drawn from a previous UW study of 348 offenders on IMS as of January, 2006. Many of this group were seriously mentally ill; while offenders with major mental health issues were not excluded from RIP, the program was not suitable for seriously disorganized or psychotic inmates. Since almost all RIP participants had non-sexual violent index offenses, and two-thirds were STG involved, a number of cases were eliminated, in the following order, to render the control group equivalent to RIP participants:

- Those assigned Intensive Treatment Status at the special offender unit for mentally ill prisoners, n=53;
- Those still on IMS, n=21;
- Those cases with less than 180 days post-IMS exposure, n=67;
- A proportionate random sample of those with more than 731 days post-IMS exposure, n=29;
- Those subsequently enrolled in RIP, n=6;
- Those with sexual or non-violent offenses, n=45;
- A proportionate random sample of non-STG cases, n=17;
- Those with multiple indicators of flagrant mental illness, n=7.

The final control group totaled 103 IMS offenders. They averaged 17 months of post-IMS exposure, compared to 19 months for RIP Grads, indicating that RIP Grads had, if anything, a better chance of failure during the exposure period. Some differences are displayed in Table 7.

Table 7. RIP Grads (n=24) vs. Controls (n=103)

Variable	Grads	Controls
Index IMS Months (avg)	9	17
Pre-IMS Infraction Rate (yrly avg)	4.95	6.03
STG Involvement (%)*	54%	64%
African American (%)	8%	19%
Hispanic (%)*	8%	30%

*The rate of STG involvement among controls is equivalent to rates of STG involvement in RIP if both grads and non-grads are included; our final analysis compares all RIP cases to controls.

Though average infraction rates are higher among controls, the difference is not statistically significant. There is no obvious explanation for the major difference in IMS terms.

Table 8. New IMS, RIP Grads vs. Controls (N=127)

		New IMS		
		Yes	No	Total
RIP Grad	Yes	3	21	24
		12.5%	87.5%	
	No	38	65	103
		37%	63%	
	Total	41	86	127
		32%	68%	100%

Note: New IMS, Grads vs. Controls: χ^2=5.3, df=1, p=.028; odds ratio=4.1

Table 8 shows striking and significant differences in outcomes between RIP Grads and controls. The odds of success vs. failure were 7:1 for RIP Grads, 5:3 for controls. Based on the ratio of these odds, we may say that RIP Grads were four times as likely to succeed as controls.

Because differences between RIP Grads and Non-Grads appeared equally as strong as those between RIP Grads and controls, one may suspect that these results are due to the selection of graduates through the program testing process rather than to clinical changes produced by the program. To allay this suspicion, we compare the entire RIP group to controls. The 4 RIP non-graduates who had been classified as failures are excluded from this analysis because offenders retained on IMS were excluded from the control group.

Table 9. New IMS, RIP vs. Non-Grads (N=147)

		New IMS		
		Yes	No	Total
RIP	Yes	10	34	44
		23%	77%	
	No	38	65	103
		37%	63%	
	Total	48	99	147
		33%	67%	

Note: New IMS, RIP vs. Controls: χ2=2.81, df=1, p=.124 (.067 1-tailed); odds ratio=1.99

These results fall short of statistical significance because with such a low number of cases, the difference between groups is not large enough to establish a less than 5% probability that the results could have occurred by chance. We address below the underlying issue of what explains the positive findings. Meanwhile, it is worth noting that RIP participants, even if they failed to complete the program, were twice as likely to succeed as members of the control group. Furthermore, of the 48 RIP follow-up cases, only 5 were still on IMS when data were collected.

Implications

This final section has two objectives:

1. To explain why our positive findings results may credibly be attributed to the program rather than to uncontrolled differences between the program and the control group; and

2. To draw some lessons from the brief but eventful career of RIP at WSP.

Interpreting Results. Inherent limitations to research design in maximum custody studies mean that statistical findings, no matter how strong, cannot establish whether participants would have succeeded without the program,. In such a case, interpretation is aided by taking seriously how the people involved explain their own behavior. Many RIP participants were well known to staff because of frequently disruptive behavior or long-standing connections to security threat groups. About these men, one veteran staff member commented as follows:

> The group who graduated all behave well; even one of those who failed is much better now. Every single one of them in the past could and would have caused trouble. These were high-powered guys.

No doubt one of the factors that distinguished those who persevered from those who failed or dropped out was how fed up they were with the path they had taken. This theme was vividly expressed by a man in another stepdown program, featured in previous reports as a prime example of someone for whom IMS was designed:

> At some point you realize that if you keep going on like this you're going to spend the rest of your life in a cage, and that's just fucking retarded.

Minor collateral incentives (out of cell time, mirror in cell) had little influence on decisions to join or continue in the program. Rather, participants were moved by longer-term incentives such as the prospect of staying out of IMU, promotions in custody levels, and contact visits and other forms of reconnection with the world outside prison.

> My family wanted me to do it. I've been in, out, in, out. I thought, I'd give it a shot, at least I tried. They want for me to be placed in a different prison.

> What's respected is strength and violence; I was at the top of the food chain. I've tried to change in the past, but you can't crawl out from under your reputation. I'd like to change my reputation with staff . . . you can't beat DOC physically.

These men, however, had not previously succeeded in governing their moment-to-moment responses by a long-term perspective. A paradigm case of such a transformation was provided by

a man with STG ties and a well-established reputation as an enforcer; after leaving the IMU stage of the program, he was assaulted by another inmate in the yard. Instead of beating the other man to a pulp, as his reputation required, he defended himself by bear-hugging his assailant:

> I was thinking: just now, I didn't swing; will they look down upon me? But if I did I'd be losing out on everything: no completing the program, not being able to see my son, my Dad, my Mom who's in the hospital . .

Several months earlier, this man had described some effects of the program:

> It has been challenging: you gotta be honest . . . Now I'm more calm, think things over, pay attention to people's opinions.

The argument for attributing our positive findings to the influence of the program is strengthened by the ability of participants to describe specifically what made a difference to them:

> At first I thought it was a snitch program, but when I began meeting daily, I saw that it wasn't; they were more interested in what I was thinking. I did a lot of writing, bringing out aspects of myself I hadn't seen.
>
> Counselors talking to you every day; there's more interaction . . . The self-analysis helps you figure out a lot of things about yourself.
>
> Point one, it was individually suited; point two, the counselors were there whenever you needed them and they work hard for you; point three, the self analysis. This was the toughest part, it made you realize you're not a good person.
>
> There was a lot of one-on-one time . . . The program teaches you to stop and decide how you want to handle something.
>
> There was good information: communication skills, dealing with stress, victim issues—seeing the ripple effect of what you do, conflict management—things you can say if people get in your face.

When asked what was most important, several participants named the specific staff members with whom they worked during the final months of the program. The factor most difficult to control in any treatment program is the commitment and communication skills of staff. This objective is aided by the authority to recruit and select staff but also requires explicit discussion, in this process, of the rationale for the program approach and the attitudes it requires of staff.

In summary, the participants we interviewed supported the social learning approach of the program. Common themes included the availability of counselors, respect for individual differences, the relevance of mini-courses to their issues, and what they learned from a searching review of their past patterns.

Lessons Learned: Program Design. The enthusiasm and creativity of staff was reinforced by asking them to build the program, and most participants appreciated the difference between the program content and prepackaged courses such as anger management, cognitive behavioral change, and moral reconation training.

- Nevertheless, a more limited and focused set of choices among mini-courses would provide clearer structure and consistency while still respecting the individuality and diversity of participants.

In 2008, Step 7—follow-up on graduates in general population—was added to the program tracking system jointly managed by UW and program staff. Participants need to be prepared to counter the suspicions of former associates and resist the temptation to prove themselves by resuming previous roles. This challenge is particularly acute for men with STG affiliations who are returned to close custody:

> If you start treating other people better, you become the enemy. It turns out [the members of my group] weren't really my friends . . . I'm challenged every day . . . I have to walk away vs. bash their skull in and drag 'em in my house.

Others evidently fared better because they had higher status to begin with and were more accommodating, maintaining relations with former allies without joining in their projects.

> Those who were really my friends know how important it is for me to be the way I am today. I'm trying to stay out of trouble and they respect that.

Some participants were able to transition quickly to medium custody. This move aroused suspicions (what did you do to get that?), but also relieved pressure to maintain a reputation on mainline: "The whole helpfulness was coming to medium . . . you still need aftercare."

- Any program for IMS transition needs to build in post-IMS planning and support from the beginning.

Lessons Learned: Program Implementation. The sections on planning and implementation described a combination of challenges: resources, space, staff turnover, and resistance by staff not directly involved in the program. One veteran administrator, commenting about "a lack of knowledge about how to implement a program that valuable," made specific suggestions:

- Talk about the program at roll call;
- Make presentations at each of the living units;
- Ensure that staff are specifically selected for the program;
- Work with other unit managers on the role of the program within the institution;
- Secure a location and resources before launching a program.

This last recommendation will be particularly difficult to achieve over the next few years. Furthermore, specific programs are always at risk for accidental damage as a by-product of institution or system-wide decisions about how to match bodies to beds at various custody levels and how to construct living spaces that minimize physical risks for staff and prisoners at large.

Finally, a comment about program acceptance. It is common to defend treatment programs by arguing that good treatment is good custody; so common that one must wonder why this

argument isn't more effective. Part of the answer lies in specific evidence, such as that presented here, that a program improves safety and security by helping offenders change dangerous behavior. The paradox, however, is that participants accepted the program because its message was not about what the institution needed, but about respect: we're offering this program because we think it will meet needs you can recognize as yours—at least once we take the time to work through what matters to you. While it is natural to classify this approach as a form of "help," this term is misleading for two reasons. To offenders, it may suggest that staff know what's good for them, a suggestion unlikely to carry conviction with the kind of men who joined this program. To staff, it suggests that we want to do something good for these people; but what they have done to others makes it hard to think they have anything coming to them.

What is lost in this argument, of course, is the distinction between respecting a person's point of view and accepting what they do. The same battle was waged ten years ago, when Gary Jones, with respect as a watch-word, pushed through a new regime at WCC IMU that brought about dramatic reductions in violence, property damage, and cell extractions, amidst repeated warnings that reforms were undermining the principles by which dangerous men must be managed. Among the WCC innovations were periodic "walk-arounds," in which residents could speak with ranking institutional administrators, and sometimes got immediate relief when complaints were reasonable and readily addressed. This practice is now standard in all IMUs, and it may seem strange that it was once so controversial. Perhaps step-down programs for IMS inmates, likewise based on the principle of respect for their rational capacities, will someday seem an equally obvious matter of common sense.

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Neither this report nor the program it describes would have been possible without the dedication of administrators and staff at DOC. Steve Ramsey, Carla Schettler, Emily Tillotson, Charlie Bull, Tomas Wilson, and Mary Moss played key roles in the design and implementation of the program, and in helping us understand what was going on. The several dozen participants who spoke freely with us in interviews also deserve credit for their role in the program and in this report, although confidentiality rules prevent us from naming them.

EXHIBIT 5

July 20, 2010

TO: Sean Murphy, Dan Pacholke, Geri Newman, Tim Hunter

FROM: David Lovell

SUBJECT: CBCC ITP Evaluation

This memo covers 106 CBCC Intensive Transition Program (ITP) participants who had joined the program as of September, 2009. A more complete report and analysis will be completed later.

Comparison with WSP RIP. ITP resembles the RIP program at WSP in several critical respects. Both programs promoted personal change and institutional safety by helping offenders learn how to live safely in general population through a combination of counseling, offender change courses, incentives, and an opportunity to practice prosocial behavior in a secure social setting. Both programs included a trial period in a maximum security setting and proceed in steps—4 Phases for ITP, 6 Steps for RIP—with different combinations of interventions and increased responsibility at each level. ITP took from RIP the value of "high presence"—frequent interaction between participants and staff—as a critical part of intervention. Finally, both programs showed promising outcomes, with graduates returning to IMS at a far lower rate than control groups of IMS offenders. Furthermore, participants were able to describe what it was about the program that had helped them change, supporting an attribution of results to the program rather than to pre-existing differences between participants and controls. There were also, however, substantial differences between programs:

- While several of the CBCC courses, notably Self Repair and Commitment to Change, were developed by staff at CBCC, the program also used established interventions such as Moral Reconation Therapy and Getting It Right.
- ITP has been sustained with minimal dedicated staff FTE, due to substantial contributions of time and energy from administrators and staff. In addition to developing and facilitating many ITP courses, mental health professionals conducted assessments and provided an hour of individual counseling a week to each participant during Phases 1-3.
- CBCC ITP benefits from an ideal location, the old YOP facility, separate from general population with ample classroom space and three pods with graduated levels of custody.
- RIP participants moved through program steps at an individualized pace, whereas CBCC participants proceeded in small cohort groups of 5 or 6 with defined periods for each phase. RIP also included an extensive "timeline self analysis" that required participants to write a reflective description of their choices at critical junctures in their lives, including their prison careers. In these respects, the overall program at RIP was more individualized, although mental health counseling in ITP provides substantial individualized support.

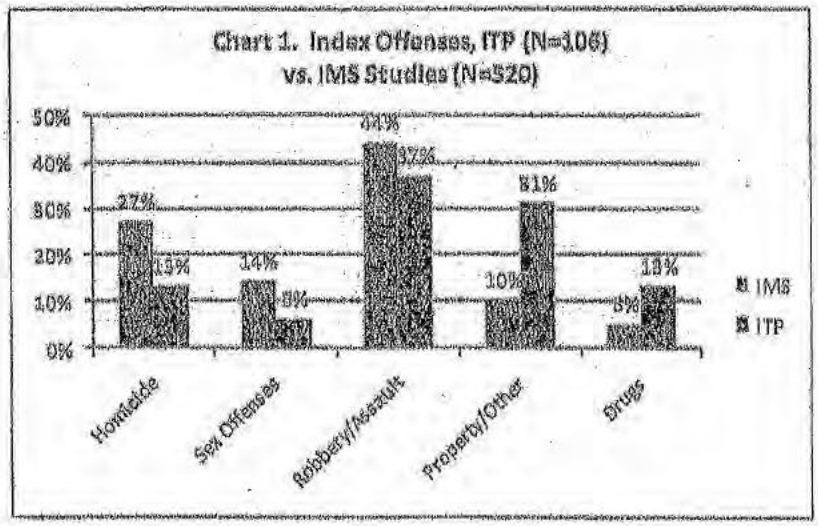
- Finally, all RIP participants were on IMS when they entered the program and retained that status well into the program. ITP, however, was designed also to divert offenders from IMS. Among ITP participants, 23% had never been on IMS in the current incarceration, and another 17% had completed their previous IMS long before program entry.

Description of ITP Participants. As of September, 2009, ITP had enrolled 106 participants. Of these, 13 were still in the program. Of the remaining 93 offenders, there were 59 (63%) who graduated, 14 (15%) transferred or released from prison, and 20 (22%) terminated.

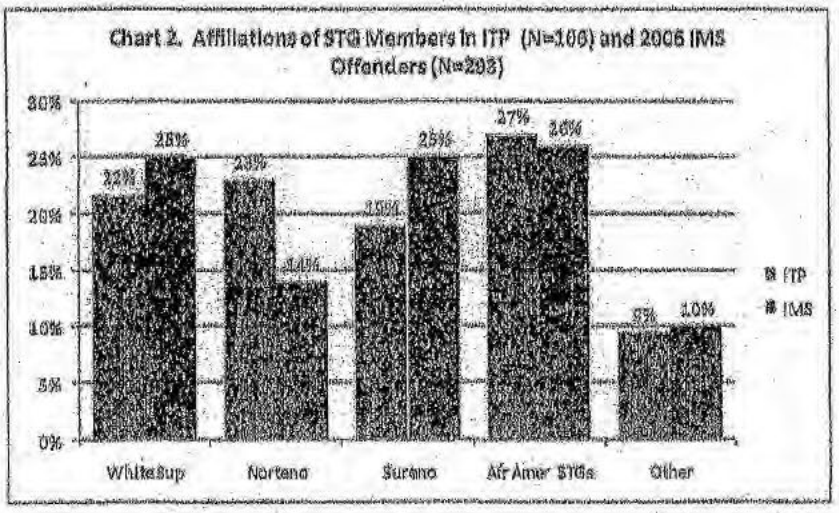
Program graduates averaged almost a year in the program; non-graduates, 8 months. A few participants were suspended and returned later, joining a later cohort at an earlier program phase.

ITP participants were similar in racial classification to general population offenders (about 70% white), but showed a much higher proportion with Hispanic origin (22% vs. 10%). Like IMS offenders in previous studies—referred to as Non-ITP IMS—ITP participants were younger than general population offenders, had longer sentences, had been convicted of more violent crimes, and showed much higher infraction rates (averaging 3.3 major infractions per year, vs. 1 per year among general population offenders).

- ITP participants had a less serious criminal record than IMS offenders generally. Their average sentence length, while long, was 150 months, vs. 220 months for non-ITP IMS. There were 3 (3%) serving terms of Life Without Parole, vs. 8% of Non-ITP IMS (an additional 5 non-ITP IMS were under a death sentence).



- As in the RIP program, ITP participants had a higher rate of STG membership at 70% than non-ITP IMS offenders (54%). Latino STG members, especially Nortenos, have been especially active in ITP.



Program Outcomes. The primary outcome measure was IMS recidivism, i.e., return to IMS status. For this purpose, 59 ITP participants with at least six months of follow-up in prison after leaving the program were compared to a control group from previous IMS studies.

- The 309 control cases were selected to match the ITP group in length of prison follow-up, rates of mental illness, and rates of STG membership (which is associated with a higher likelihood of return to IMS).
- Controls had higher average annual infraction rates than ITP participants (6.6 vs.5.2) but showed equal percentages in the more consequential general categories of low, medium, and high rate infractors.
- There were more controls with index violent (non-sex) offenses (76% vs. 54%), which—for reasons that have not been studied—is associated with a *lower* probability of IMS recidivism.

Although STG membership and previous infraction rates are associated with higher IMS recidivism, and index violent offenses with lower rates, a recent study of IMS recidivism shows that no combination of official record variables provides accurate predictions of IMS recidivism. It is reasonable to infer that recidivism is generated by unmeasured attitudes and habits, with which stepdown programs such as RIP and ITP have attempted to intervene. This inference would be supported by successful program outcomes.

Table 1 compares all ITP participants to controls, Table 2 ITP graduates to controls. Lower rates of recidivism for ITP participants were significant and striking, even more so with program graduates. The odds of success over failure were 6 times greater for program graduates than for controls.

Table 1. Return to IMS, ITP Participants vs. IMS Controls

		Return to IMS		
		Yes	No	Total
ITP	Yes	15	44	59
		25%	75%	
	No	142	167	309
		46%	54%	
	Total	157	211	368

χ^2=8.5, p=.002, odds ratio=2.5

Table 2. Return to IMS, ITP Graduates vs. IMS Controls

		Return to IMS		
		Yes	No	Total
ITP Grad	Yes	5	37	42
		12%	87.5%	
	No	142	167	309
		46%	54%	
	Total	147	204	351

χ^2=17.6, p=.000, odds ratio=6.3

Controls were followed up longer than ITP participants—the average time "at risk" before the study was completed was 24 months for ITP participants, 28 months for controls—but in both groups, 90% of those who recidivated did so in less than two years.

In light of the previous discussion of differences between ITP and RIP, it is worth noting that it was evidently much more difficult to graduate from the RIP program, and this factor may have affected the pattern of results.

- Half of the 48 subjects of the RIP outcome study had graduated from the program (including 4 who left the program early with favorable transfers), compared to 70% of ITP outcome study subjects.
- Among those who didn't complete the programs, RIP non-graduates failed at a lower rate than ITP non-graduates: 7 out of 24 (30%) vs. 10 out of 17 (59%).
- As a result of these countervailing differences, 75% of participants in both programs—whether graduates or not—had succeeded in avoiding return to IMS until the point that data were collected, averaging about two years.

Caution should be exercised about these comparative findings. Differences in policies and methods of maintaining program records make it difficult to assess the extent of systematic differences in the way that participants were tested and weeded out if they seemed unready for general population or unresponsive to staff efforts.

Next Steps. In any study without random assignment of subjects to participant and control groups—a design to which there are substantial ethical, practical, and political drawbacks in IMS studies—differences in outcomes do not establish that the program was responsible for the difference. This difficulty is particularly acute for IMS stepdown programs, which include the objective of testing the readiness of participants to live safely in general population. By design, therefore, those who succeed in the program have already shown themselves as more committed to change than those who fail or who never choose to participate.

To aid interpretation of results, one must assemble evidence that participants would have been less likely to succeed without the program. To make this case, it is important to rule out alternative explanations, and the comparability of control groups is part of that argument. The other part of the argument, to be developed in a more discursive report, analyzes the ability of participants and staff to describe how the program made a difference. This evidence will be equally as valuable as the results reported here when DOC applies the lessons of these promising programs to future program design and to broader concerns about how offenders are treated and how violence is controlled in Washington's prisons.

