Expert Report of Stuart Grassian, M.D.

***K.C., et al. v. Townsend, et al.*, Civil No. 6:09-CV-012-C (N.D. Tex.)**

Date: August 31, 2009

Signed: _____
Stuart Grassian

Expert Report of Stuart Grassian, M.D.

I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts, and was on the teaching staff of the Harvard Medical School continually from 1974 until 2002. My curriculum vitae is attached hereto.

1. Professional Experience Regarding Psychiatric Effects of Solitary Confinement

I have had extensive experience in evaluating the psychiatric effects of stringent conditions of confinement, and have served as an expert in a number of both individual and class-action lawsuits addressing this issue. My observations and conclusions regarding the psychiatric effects of such confinement have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis*, 844 F.2d 1310 (7th Cir. 1988), and *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995). I prepared a written declaration for *Madrid* describing the medical literature and historical experience concerning the psychiatric effects of restricted and isolated conditions of confinement as well as of other conditions of restricted environmental and social stimulation, and subsequently published the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration as paper entitled *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y (2006). This paper describes the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation, and more specifically, observations concerning the effects of segregated confinement on prisoners.

I have given lectures and seminars regarding the issue of the psychiatric effects of solitary confinement. Although I do not have a complete list of those lectures and seminars, they include, but are not limited to, lectures at Harvard Medical School-Beth Israel Hospital, Boston, the Federal Capital Defenders Habeas Unit and the Correctional Association of New York, as well as invited testimony before state legislative hearings in New York and Massachusetts. I have been retained as an expert in class-action lawsuits regarding solitary confinement issues in Massachusetts (2), New York (3), California (2), Kentucky, Michigan, Ohio, and Florida, as well as individual cases in other states, including California, Connecticut, Florida, Georgia, Maine, Massachusetts, New Mexico, New York, Pennsylvania, Texas, Virginia and the State of Washington. I have been retained and consulted by a variety of public advocacy groups, including the Legal Aid Society of New York, Prisoner's Legal Services of New York, the Center for Constitutional Rights, the Massachusetts Correctional Legal Services, the Massachusetts Civil Liberties Union, the National Prison Project of the American Civil Liberties Union, and the Department of Corrections of the State of Florida.

2. Professional Experience Regarding Psychiatric Effects of Strip Search Procedures

The second most important area of my forensic experience has been in evaluating the effects of various forms of sexual trauma. This has included testimony and research (the latter as Principal Investigator in a research project at Harvard Medical School/Beth Israel Hospital) regarding the effects of childhood sexual abuse, and substantial experience in evaluating the effects of other forms of sexual trauma.

I have had substantial clinical experience in evaluating and treating adolescent girls who have experienced emotional, sexual and/or physical trauma. I was for several years Director of the Adult and Adolescent Inpatient Unit at the New England Memorial Hospital, a teaching hospital of Harvard Medical School, where I taught and supervised as well as having an active clinical practice. Moreover, in parallel with my forensic work regarding sexual trauma, I have evaluated and testified regarding the effects of strip search procedures in several individual cases in Massachusetts, as well as class-action lawsuits in Massachusetts and New York. During the course of this work, I have evaluated a number of adolescent females who were subjected to strip searches. In some of these cases, the individual suffered severe psychiatric harm, including Post Traumatic Stress Disorder.[1]

3. Circumstances of Involvement in this Case

In the present case, I was retained by the ACLU and Dechert LLP to evaluate conditions at the Texas Youth Commission's Ron Jackson State Juvenile Correctional Complex in Brownwood, Texas ("TYC-Brownwood")—especially in regard to the use of solitary confinement (referred to there as "security housing"), strip search and related procedures, and concerns about the excessive use of force—and their effect upon the youths housed therein. For this purpose, I reviewed a number of pertinent documents produced by Defendants, a list of which is separately attached, and on July 20 and 21, 2009 I toured the Security Unit at the facility and interviewed 12 teenage girls currently confined at TYC-Brownwood. My professional fee for my work in this case is $300/hour, or $2500/day. A list of cases in which I have testified over the last four years is separately attached.

4. Observations and Opinions

In my opinion, TYC-Brownwood currently demonstrates grossly inadequate recognition of the potentially harmful effects of security housing, and it also continues to force girls to undress without privacy in security housing. The facility does so with an almost total disregard of these youths' past psychiatric histories, including but not limited to severe trauma, including sexual trauma.

[1] *See, e.g., Blackburn v. Snow*, 771 F.2d 556 (1st Cir. 1985).

The facility's disregard of the psychiatric illnesses virtually universal among the girls confined at the facility blinds its staff to the complex origins of the behavioral difficulties experienced by these girls. As a result, staff recurrently act from one paradigm, and one paradigm alone—the paradigm that if you punish unwanted behavior harshly, over and over again, the behavior will eventually improve. This is a brutal and entirely counterproductive response, one that can only worsen the emotional state of the girls so treated and lead to an increasingly sadistic and overly controlling attitude by staff. Psychiatric understanding of emotion and behavior is strikingly absent; there is thus a severe and very substantial departure from accepted clinical judgment and standards, a deviation that subjects the girls confined there to a substantial risk of serious psychiatric harm.

This is not to say that I have concluded that there are no helpful, sensitive staff at the facility. A few of the girls interviewed spoke of one or another staff member who was kind and trustworthy. But the overall tone, and the majority of interactions with staff, bespoke an excessive need for control, an excessive use of force, and a disregard and ignorance of the critical implications of the overwhelming psychiatric illness present at the facility.

These two major problems—the utter disregard of the psychiatric context, and the use of excessive and brutal force—are in fact extremely closely related. Any facility that deals with individuals manifesting disruptive behavior and psychiatric problems—whether a correctional facility or a psychiatric facility—must have a multidimensional, complex way of understanding behavior and its origins. When it only has a one-dimensional response—punishment quick and brutal and frequent—the only behavior which will improve is that which is rational, that which is based upon a rational calculus of reward and punishment. Such a one-dimensional paradigm might well be effective in dealing with emotionally cold, instrumental criminals, but such individuals are in fact exceedingly uncommon. Most prisoners, virtually all psychiatric patients, and virtually all of the girls at TYC-Brownwood, do not and cannot respond to such a rational calculus. Instead, their behavior is impulse-driven, chaotic, often out of their control as much as it is out of the control of the facility; simply punishing and punishing it is likely to make it worse. And meanwhile, the frustration and anger of the staff of such a facility will inevitably grow. If the only tool they have is punishment, and it does not work, they will become angry and want even more to punish. Any such facility will almost inevitably descend towards brutality and overcontrol. And the evidence indicates that TYC-Brownwood has not in any fundamental manner changed that culture of punishment and blindness.

5. Bases of Opinions

5.1 Lack of attention to psychosocial history and psychiatric status, and consequences of this inattention

Every girl whom we interviewed manifested severe psychiatric illness and a staggering history of trauma. They came from broken homes, had endured alcoholism

and drug abuse in their parents; they had suffered physical abuse, abandonment, and multiple episodes of sexual abuse and rape. Some had no family at all to return to. The psychiatric illness was striking—bipolar mood disorders and post traumatic stress disorder were most prevalent, and in most cases, were both present. These children had been and were being prescribed major psychiatric medications—antipsychotics, lithium, anticonvulsant mood stabilizers, antidepressants, sedatives, just about the full gamut of medications seen on an inpatient psychiatric unit. During the interviews, none of them was cold, unemotional, calculating. Each manifested emotional pain—often severe pain. Several cried during the interview. Indeed, the experience of interviewing these children was an emotionally exhausting one.

From those interviews, and from the brief conversations we were allowed to have with staff members of the facility, it became exceedingly clear that there is virtually no attention whatsoever paid to these psychiatric difficulties and traumatic histories. Upon inquiry, the staff of the Security Unit were explicit in declaring that they had no knowledge of the psychiatric history of any of the children who were housed in security; indeed, they did not even have the master files of the children on hand. And when inquiry was made of the unit psychologist as to whether there was any concern that, as a result of history of trauma, some of these girls might suffer severe reactions to strip search or to solitary confinement, the casual response was that while they had no knowledge of any child's psychiatric history, they were confident that at least 80 or 90 percent of the girls had a history of post traumatic stress disorder (PTSD) as a result of rape or sexual abuse, and that none of that made any difference anyway. Explicitly, the emotional background of the child was not relevant. If the procedure was to strip search, the girl was strip searched. If the policy was to isolate in security cells, that was what was done. Psychiatric history did not count, and in any event, it was unknown.

Yet even a rudimentary understanding of psychiatric illness should have clearly and emphatically led to the recognition that such punitive and physically intrusive responses by staff carry grave risks in these situations. There is in all of us a vital need to maintain some sense of personal integrity and control. Without those things, the individual is left utterly powerless, helpless, and debased. It is a breeding ground for self-destruction and suicide. Girls who have been severely abused—sexually, physically, or emotionally—characteristically become terrified in any situation in which their physical integrity is threatened, or in which they experience themselves as overpowered and powerless.

PTSD is intrinsically a disorder created by an experience of terror, powerlessness, and of utter humiliation. It is a condition inevitably creating a massive psychological vulnerability, and in order to begin a process of recovery, PTSD victims desperately need to feel a sense of control, of the inviolable integrity of their personal and physical being. When, instead, they experience continued helplessness, powerlessness, and humiliation, they will be deeply harmed. Their perception of self becomes degraded; their sense of hope is destroyed, and they come to experience a deep personal debasement, a self-loathing and hopelessness. Individuals experiencing such emotions are at great risk of self-harm and suicide.

One of the girls we interviewed, one of the many who had experienced sexual trauma, refused to take off her underwear in security unless her door was closed or the staff member turned her head away, and when this request was refused, she was forced to remain in handcuffs. A modest request for a bit of control, of dignity, was met with punishment; she was left utterly helpless and humiliated, worsening her already impaired sense of self-worth and worsening her depression.

Some of the referrals to security were a result of concern that the child might be "suicidal". One youngster asked to speak with a counselor, saying that she did not feel "safe" in her room. Without even asking her what she meant by "safe", staff referred her to security, where she was strip-searched and left in a barren cell with no one to talk with, nothing to distract her from her painful thoughts. Another wrote a letter to a friend, expressing only a passive suicidal wish, without any plan or thought that she would act on her wish that she was dead. Staff opened and read her letter, and instead of anyone trying to talk with her about her feelings, she was handcuffed and led away to security, where she was stripped and locked away in a barren cell with no one to talk with. It had become clear to her that there was no respect for her feelings; revealing anything was dangerous and foolish; it would just be used to further humiliate and disempower her.

The facility uses the term "security room" to refer to cells in the Security Unit. The term is somewhat cynical. The "room" is among the smallest and most barren solitary confinement cells that I have ever observed during my over 25 years of experience with maximum security prisons. The TYC-Brownwood security cells are approximately 45 square feet in area, entirely composed of concrete and cinder block except for the usual stainless steel sink/toilet combination. The "bed" is a simply a concrete shelf, on which may be placed a "mattress" that is about 1 1/2 inches thick. There is a very narrow window slot in the back of the cell. There is absolutely nothing else in the cell at all. And there is no opportunity for any distraction. There is no television or radio. Books are not provided in security. Educational materials are not provided. The Bible, being a book, is not provided. Nothing at all is provided. Many of the girls described these cells as filthy, often coated with blood, urine, or feces. Several thought they had acquired Staph skin infections while housed in security.

The only diversion is the opportunity to be led out of one's cell in the morning, handcuffed, to take a shower in a cage in the unit. The shower area was described as grimy and dirty, and there is a de facto penalty imposed for taking a shower—the blanket the girl had used the night before is taken away while she is in the shower, and it is not returned to her until nightfall. Some girls refused to take a shower because the cell was too cold and they felt they needed the blanket more than they needed to shower. There was no real choice offered; whichever decision the girl made, she would be left feeling dirty or mocked, and humiliated.

When we toured the unit in the afternoon, we found several girls lying on the floor of their cell, covered with a blanket and trying to sleep away the time. Many of the

girls we interviewed said that they had coped in a similar fashion—just trying to sleep away the misery and the endless time with nothing to do.

Girls on "suicide alert" (SA) in security experience additional burdens. After they remove all their clothes and underwear, they are required to wear only a "barrel" garment fastened together with velcro. The velcro tabs are worn and old, and can easily become unfastened, especially during any restraint maneuver. Thus girls on SA status are often rendered naked in front of male as well as female staff.

Current procedures for transporting girls to security can also trigger traumatic memories and images—memories of being grabbed, restrained, helpless and overpowered. Girls who are being compliant with staff are still handcuffed. Girls who ask to be able to walk to the security unit are still put into a van. Girls who have a history of sexual trauma sometimes ask that the male guards not grab their shoulders while accompanying them, but such requests are routinely refused.

Thus, in short, when a youth has a history of severe sexual abuse and reveals that pain—even a wish to die—the response generally is to restrain her, handcuff her, transport her by van to the security unit, where she is left half naked in a small barren, filthy, concrete cell, with absolutely nothing to distract her from her thoughts and memories. Even if the child is left in solitary for a relatively brief period of time—that is, hours rather than days—the whole process will still inevitably result in a reexperiencing of the traumatic experience of helplessness and debasement. Doing this to a child who is suicidal—who is already experiencing such feelings—is a clear violation of any reasonable standard of professional care.

5.2 Punitive responses to legitimate mental health requests

The blindness to mental health issues at TYC-Brownwood is staggering. Several girls described how difficult it is to get to see the psychiatrist about medication issues. One described that a medication that she was prescribed (an antipsychotic drug which often causes such side effects) made her so tired and dizzy that she fell three times while in the shower. She asked to see the psychiatrist so that the medication could be changed, but was told she could not—at least, for a month. And she was told she had no right to refuse the medication; if she did so, she would face punishment. She had no real choice; she had already put in her request to see the psychiatrist, so she refused the medication and was written up for it.

One girl who had been sexually abused asked that she be able to have a female counselor instead of the male to whom she had been assigned. The request was refused, without explanation. She explained that she could not talk about her history with a male. The response was to write her up for a disciplinary violation, for refusing to talk to her assigned counselor.

Some of the medication issues at the facility are truly grotesque. Sleeping meds are to be taken at 5:00 P.M., several hours before bedtime. There is no arrangement to

give them out later, and if a girl refuses, or tries to "cheek" the pill until closer to bedtime, she is punished. One girl was prescribed a very sedating medication in the morning, and despite her complaints about it and her request to see the psychiatrist so that this medication could be given her later in the day, her requests were refused. So she cheeked the pill, was discovered, and was shipped to security for it. Similarly, a girl with a bipolar mood disorder had done well on lithium, but at TYC-Brownwood, without explanation, she was prescribed valproate instead of lithium. Valproate did not agree with her; it made her agitated at night, unable to fall asleep. She asked to speak with the psychiatrist, but this did not happen, so she refused the valproate and was punished.

There were many complaints about the unavailability of the psychiatrist and the difficulty of having medications reviewed. One girl stated that she had asked to see the psychiatrist beginning in January 2009, and her caseworker told her that she had indeed put in those requests. But as of our visit in July she still had not been seen. Another, who had refused her medication because of severe side effects, was told after she stopped taking her medication that she now was no longer eligible to see the psychiatrist—only those girls taking medications would be given that opportunity. It was the perfect Catch-22: because the psychiatrist is not available, you must deal with the situation on your own and be punished for it; and now that you have done so, you no longer are even eligible to discuss your needs.

The issue of appropriate medication management is inextricably bound up with the behavioral and disciplinary issues these girls face at TYC-Brownwood. Their psychiatric diagnoses—bipolar mood disorder, post traumatic stress disorder, attention deficit hyperactivity disorder—all are associated with excessive impulsivity and impaired behavioral control. TYC-Brownwood's failure to properly address these medication issues is a set-up, increasing the girls' impulsivity and the likelihood of misbehavior and punishment.

One of the girls interviewed described this problem. She refused a calming medication that was too sedating and was dispensed much too early in the day. Memories of her abuse oppressed her, but she had no one to talk with about them; she had not even seen her caseworker for months, and her privilege level was not high enough to allow her even to write about her feelings in a journal. So all the tension just built up, not dissipated by meds or by talking. The tension would mount until it would explode out, then she would lose privileges and not be able to progress to a higher privilege level. She felt utterly trapped and helpless.

In summary, the indifference to clinical concerns is quite rampant at the TYC-Brownwood. The children are left to feel that there is no real attention to their legitimate needs, no concern revealed in the policies and procedures at the facility—neither in regard to medication, counseling, or to mitigate the harsh and punitive responses of staff. In short, the children whom we interviewed revealed that the helplessness and fear that they had experienced during their lives was being relived and magnified by their experience at TYC-Brownwood.

5.3 Excessive use of force

The girls we interviewed described multiple incidents involving an excessive use of force by staff, as well as an exceedingly punitive response to even minor deviations from the rules. (This, again, is not to say that these girls were unable to find *some* examples of compassionate, respectful responses by some staff; however, such examples were decidedly in the minority.)

The interviews, as well as the document review, reveal an attitude of control for control's sake, even for trivial matters. For example, in late June 2009, one girl had a sock stolen by another. She asked a staff member if she could have another to replace it. Without reason or explanation, the staff member refused and then insisted that she put on her shoes without a sock for one of her feet. She objected, and asked why she then at least could not wear slides, which would not be so uncomfortable to wear without socks. As a result of this "resistance to authority," she was restrained, handcuffed, and sent to security to be isolated.

In May 2009, one girl failed to respond to a demand to remove the covers over her head. It was the middle of the night and she was asleep, so she had not heard the demand. There was no conversation; staff stormed into her room, pulled her forcefully from her bed, held her down, handcuffed her and sent her off to solitary.

A particularly intellectually curious and physically unaggressive youngster, while standing in line in late May 2009, mentioned something innocuous and interesting about DNA to a staff member near her. Another staff person farther down the line—apparently more rigid about no talking in line—responded by ordering that she be sent to security. When the girl asked why she was being sent to security for this, staff rushed her, threw her to the ground, and handcuffed her. She was thrown so forcefully to the ground that her chin smashed against the floor, causing a large laceration that bled profusely.

Another child had a long-standing phobia of heights, but despite this attempted to do a rope course, which would require her to slide down on a zip-line from a significant height. She panicked at the top and froze. The staff response was to threaten her with "escape" (a meaningless idea with her frozen at the top of this rope course) and then to punish her with 30 days restriction.

Many of the interviewees described the dilemma of living in an environment in which many of the rules are capricious and arbitrary, and in which different staff at different times respond in different ways to minor issues. There is an arbitrariness about it which leaves the youths feeling powerless and unsafe. Several also expressed a fear that doing anything to protest unfair treatment—filing a grievance, even speaking with the attorneys in this case—is likely to result in unfair harassment. One girl filed a grievance against a particular male staff member, only to have him read her grievance out loud to the whole dorm, intimidating and scaring her.

Interviewees described that you learn to either just stomach unfair treatment, or you get punished and harassed for speaking up against it. While walking outside to another building, a girl said "Hi" to a staff member she liked; in response, another staff member ordered her to solitary. Another girl was pepper sprayed just for giving out some cookies to some other girls.

Several girls described incidents in which another girl had physically attacked her, and she had defended herself. The policy in such incidents is apparently that *both* girls are sent to security, without any inquiry at all as to whether one of them was just acting in self-defense. Indeed, among the documents I reviewed, there is at least one in which a psychologist who was ostensibly screening a child who had been sent to security, actually *concluded* that the child had acted in self-defense, and then recommended placement in solitary. Why? No reason at all was given.

There is a policy that after a girl is referred to security she will be screened by a psychologist to ensure that there is no contraindication to security housing. I am unable to reach any conclusion as to whether such screenings *were* usually done in a timely fashion, but in any event, I could not find a single documented screening in which such a contraindication was found to exist. And this is not surprising—there are no *criteria* of what might constitute a contraindication, and the psychologist doing the assessment appears to have no information whatsoever regarding the child's psychiatric history.

6. Effects of Recent Policy Changes

The Defendants in this case have made policy changes since the filing of the lawsuit. But for the most part, those changes are only in embryonic form. For example, the Redirect Program (RDP) is intended to rectify the harsh prolonged solitary confinement that had previously been employed. Yet at the time of this writing, it is entirely unclear whether this program will have any meaningful effect. For one thing, it is clear that the facility does not yet know how to use it productively. While we were on tour of the Security Unit, there were two tiers of cells filled with girls in security housing—that is, in complete isolation. In contrast, the one tier devoted to this new RDP program had a total of exactly *one* girl confined there—and she had just arrived there that very day.

In order for the RDP program to have any meaningful chance of working, there has to be a fundamental change in the culture of the facility—a richer and more complex understanding of behavior, a much greater attention to the psychiatric burdens and needs of the youths confined at TYC-Brownwood. As long as the culture remains one of harsh overcontrol and blindness to mental health issues, RDP will fail.

Indeed, it is supposed to be the only program for long-term confinement of a youth in the security housing unit. The utter isolation and deprivation of the security cells is *supposed* now to be limited to approximately three to five days or so at most. But what happens if a girl so harshly and punitively treated is worse, not better, after those three days? According to the security unit staff, she can be sent right back.

There is a kind of cynicism apparent regarding these changes. The RDP program is almost invisible, while harsh solitary confinement is still very frequent. There is apparently no plan to make this unit more psychiatrically informed. And it does not appear that there is a deeply held commitment to eliminating the harsh and punitive nature of the institution. Indeed, one girl reported to us that she was told by a staff member that pretty soon everything would go back to the way it used to be—including the strip searching of everyone sent to security.

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EDUCATION, TRAINING, FACULTY POSITIONS.

1963-1967 Harvard Club Scholar, Harvard University, Cambridge, MA

1967 B.A. Cum Laude, Harvard University, Cambridge, MA

1967-1969 NIMH Fellow in Sociology, Brandeis University, Waltham, MA

1969 M.A., Sociology, Brandeis University, Waltham, MA

1970 NSF Fellow in Psychiatry, Bellevue Hospital, NY

1973 M.D., New York University School of Medicine, NY

1973-1974 Intern (Medicine), New York University Medical Center, NY

1974-1977 Resident in Psychiatry, Beth Israel Hospital, Boston, MA.
Teaching Fellow in Psychiatry, Harvard Medical School.

1977-2003 Clinical Instructor in Psychiatry, Harvard Medical School.

1978-1980 Assistant Clinical Professor of Psychiatry, Tufts University School of Medicine.

1982-1986 Suffolk University Law School; J.D. 1986; Daniel Fern Award.

1986 Bar Examination completed; entry into Massachusetts Bar.(remain on “retired” status through present.)

LICENSURE.

1974- Massachusetts Medical License #37749.

BOARD CERTIFICATIONS

1979 Diplomate, American Board of Psychiatry and Neurology (ABPN) in Psychiatry.

1994 Diplomate Certification, ABPN, Added Qualifications in Addiction Psychiatry.

1996 Diplomate Certification, ABPN, Added Qualifications in Forensic Psychiatry

MAJOR PROFESSIONAL ACTIVITIES

1977 - Private practice in Psychiatry: Cambridge, MA (1977-1979), Chestnut Hill, MA (1979-), Stoneham, MA (1980-2003)

1977-1978 Clinical Director, Inpatient Service, Dorchester Mental Health Center, Boston, MA

1978-1980 Director, Inpatient Service, WestRosPark Mental Health Center, Boston, MA

1979-1983 Medical Staff, Lecturer, Glover Memorial Hospital, Needham, MA

1980-1994 Attending Psychiatrist, Adult & Adolescent Inpatient Services, New England Memorial Hospital, Stoneham, MA

1980-1983 Director, Adult & Adolescent Inpatient Services, Department of Psychiatry, New England Memorial Hospital, Stoneham, MA

1983-1994 Attending Psychiatrist, Addictions Treatment Unit, New England Memorial Hospital, Stoneham, MA

1987-1993 Supervising Psychiatrist, Outpatient Department, New England Memorial Hospital, Stoneham, MA

1992-1994 Psychiatric Director, Partnership Recovery Center, Melrose-Wakefield Hospital, Melrose, MA (Day treatment program for Addiction rehabilitation)

CONSULTATIONS, AFFILIATIONS, BOARD MEMBERSHIPS

1979- Massachusetts Correctional Legal Services. (Psychiatric Effects of Solitary Confinement, Psychiatric Effects of Strip Search Procedures)

1980- Massachusetts Civil Liberties Union. (Psychiatric Effects of Strip Search Procedures, Psychiatric Effects of Solitary Confinement)

1993- Massachusetts Department of Corrections, Stress Management Unit. (Occupational Stress among Correctional Staff)

1993-4 Board of Trustees, New England Memorial Hospital, Stoneham, MA.

1995 Consultation to Psychiatric Expert/Special Master; Madrid v Gomez Federal District Court, Northern District, CA #C-90-3094TEH. (Psychiatric Effects of Solitary Confinement)

1995- Consultant to Massachusetts Professional Recovery Committee, and to Substance Abuse Rehabilitation Program of the Massachusetts Board of Registration in Nursing. (Addictive Disorders, Impaired professionals)

1997 Botech Corporation, Cambridge, MA. (Effects of Solitary Confinement)

1998 Psychiatric Expert in Compliance Monitoring; Eng v Coombe Federal District Court, Western District, NY, CIV #80-385-S. (Effects of Solitary Confinement)

2000-2 The Desisto School, Lenox MA

2001- Consultant, Florida Department of Corrections. (Solitary Confinement and Mental Health Issues in Florida State Prisons.)

2001- Board of Advisors, Correctional Association of New York, (Mental Health Issues in New York State Prisons).

2002-4 Board of Directors, Massachusetts 9/11 Fund.

2002-4 American Boyschoir School, Princeton, NJ.

2002-3 Poly Prep School, Brooklyn, NY.

(Note: As a result of my experience with the effects of stringent conditions of confinement, I have had a large number of other affiliations and consultations, which have not been separately listed. The following is not a complete list: American Friends Service Committee, Amnesty International, The Capital Habeas Unit of the Defender Services Division of the United States Courts, The Center for Constitutional Rights, The Correctional Association of New York, Federal Public Defender - of E. Dist VA, of Tennessee, of the State of Washington, and of Washington, DC, The Legal Aid Society of New York, National Defenders Investigators Association, The National Prison Project of the ACLU, Prisoners Legal Services of Michigan, of New Mexico, and of New York, Public Defenders Office of Connecticut, and of Maine, etc.)

PROFESSIONAL SOCIETY/COMMITTEE/STAFF MEMBERSHIPS

1974-2003. Member, American Psychiatric Association &
Massachusetts Psychiatric Society

Committee Memberships.
Inpatient Psychiatry Committee (1981-1984)
Private Practice Committee (1992-1995)
Chair, Presidents Task Force on Managed Care (1993-1994)
Steering Committee, Managed Care Retreat (1993-1994)

1974-1977 Resident in Psychiatry, Beth Israel Hospital, Boston, MA.
Clinical Fellow in Psychiatry, Harvard Medical School.

1977-2003 Courtesy Staff, Beth Israel Hospital, Boston, MA
Assistant in Psychiatry (1977-1991)
Associate in Psychiatry (1991-2003)
Clinical Instructor in Psychiatry, Harvard Medical School.

1980-1999 Active Staff, Boston Regional Medical Center, Stoneham, MA

Committee Memberships
Credentials Committee (1986-1990)
Chair, Bylaws Committee (1987-1990)
Medical Staff Executive Committee (1989-1992)
Chief of Staff (1990-1992)
Board of Trustees (1990-1992)

1992 - Active/Courtesy Staff, Melrose-Wakefield Hospital, Melrose, MA

1993-2000 Psychiatric Network of Massachusetts
Committee Memberships
Steering Committee (1993-1994)
Chairman, Board of Directors (1994-1995)

AWARDS

2005. National Alliance for the Mentally Ill (NAMI). Exemplary Psychiatrist Award,
Presented at Annual Meeting, American Psychiatric Association, May 2005.

TEACHING APPOINTMENTS, PRESENTATIONS

1967 Teaching Fellow, Harvard Graduate School of Education, Cambridge, MA

1967-1969 Teaching Fellow, Department of Sociology, Brandeis University, Waltham, MA

1973 Clinical Fellow in Psychiatry, New York University Medical Center, New York, NY

1974-1977 Clinical Fellow in Psychiatry, Harvard Medical School, Boston, MA

1975-1976 Consultant and Lecturer, Human Resources Institute, Brookline, MA

1977-2003 Clinical Instructor, Department of Psychiatry, Harvard Medical School, Boston, MA

1978-80 Assistant Clinical Professor, Department of Psychiatry, Tufts University Medical Center, Boston, MA

1987 Faculty, Third International Conference on Restricted Environmental Stimulation, New York, NY: "Effect of REST In Solitary Confinement and Psychiatric Seclusion"

1987 Guest Lecturer, Suffolk University School of Law, Boston, MA: "Commitability and the Right to Refuse Treatment"

1988 Faculty, 32nd Institute on Hospital and Community Psychiatry, Boston, MA

1990 Massachusetts Bar Association Symposium, Boston, MA: "Drugs and Alcohol on Campus"

1992 - Faculty, American Academy of Psychiatry and Law, Boston, MA: "Effects of Childhood Sexual Abuse"

1993 Faculty, Massachusetts Department of Corrections Stress Unit, Statewide Seminar, MA: "Stress Awareness for Managers"

1993 Massachusetts Continuing Legal Education Seminar, Boston, MA: "Psychiatric Effects of Physical and Sexual Assault"

1994 Massachusetts Academy of Trial Attorneys Seminar, Boston, MA: "Psychiatric Evaluation of Victims of Violent Crime"

1994 Beth Israel Hospital/Harvard Medical School, Boston, MA: "Psychiatric Consequences of Solitary Confinement; "Effects of Sensory Deprivation and Social Isolation in a Vulnerable Population"

1994 Massachusetts Medical Society, Committee on Managed Care, Waltham, MA: "Ethics of Managed Care"

1994 Prison Psychiatric Group, Albany, NY: "Criminality and Mental Illness, Revisited: Disorders of Volition". (Lecture sponsored by Pfizer Pharmaceuticals)

1995 Suffolk University Advanced Legal Studies, Boston, MA: "Sexual Abuse: Memory, Truth and Proof"

1995 Massachusetts Association of Trial Attorneys Seminar, Boston, MA: "Premises Liability/Negligent Security: Psychiatric Testimony and the Role of the Psychiatric Expert"

1996 New England Society for the Study of Dissociation, McLean Hospital, Belmont, MA: "Impact of Forensic Issues on Treating Victims of Violence"

1996 Harvard Medical School, Children's Hospital Family Violence Seminar, Boston, MA: "Trauma and Memory"

1996 Trauma and Memory: An International Research Conference, Durham, NH: "Factors Distinguishing True and False Memory of Childhood Sexual Abuse"

1996 Trauma and Memory: An International Research Conference, Durham, NH: "Memory of Sexual Abuse by a Parish Priest"

1997 Correctional Association of New York, NY: "Psychiatric Effects of Solitary Confinement".

1998 Massachusetts Board of Registration in Medicine and Northeastern University Conference, Substance Abuse and The Licensed Professional, Boston, MA: "Addictions and Compulsions: Disorders of Volition"

2000 Human Rights Watch and American Civil Liberties Union Foundation Conference. Washington, D.C. "Super-Maximum Security Confinement in the United States."

2003 Capital Habeus Unit Training Conference of the Defender Services Division of the United States Courts, San Antonio, TX. (lecture regarding death row confinement and its effects on post-conviction appeal process.)

2003 NAACP Legal Defense Fund Conference, Airlie, VA. 7/03. Lecture regarding mental health issues and solitary confinement of prisoners.

2005 Vera Institute. National Commission on Safety and Abuse in Prisons. Newark NJ, July 2005. Effects of Isolation.

2005. NAACP Legal Defense Fund, Airlie Conference, Va. July 2005. "'Volunteers' in Death Row".

2006 University of California at Davis, Symposium - The Neurobiology of Torture. "What is Known about the Neurobiological Effects of Solitary Confinement."

MEDIA, PUBLIC AFFAIRS PRESENTATIONS

1988 NBC-TV, Today Show "Small Group Confinement of Female Political Prisoners at the Federal Penitentiary in Lexington, KY"

1990 NPR-TV, News Interview Program: "Psychiatric Effects of Small Group Confinement"

1990 PBS-TV, Point of View "Through the Wire", Documentary regarding women confined for politically motivated crimes

1991 WBZ-TV, Boston, MA: Channel 4 Nightly News "Statute of Limitations on Cases of Childhood Sexual Abuse"

1992 Boston Globe, New York Times, etc.: "Effects of Childhood Sexual Abuse by a Catholic Priest"

1992 Boston Globe, New York Times, San Francisco Chronicle, Los Angeles Times, etc.: "Psychiatric Effects of Solitary Confinement"

1993 New England Cable News, Newton, MA: Commentator regarding insanity defense in Kenneth Sequin trial

1993 Massachusetts House of Representatives, Judiciary Committee testimony: Proposed change in Statute of Limitations in cases of childhood sexual abuse

1993 CBS-TV, 60 Minutes "Pelican Bay – Psychiatric Effects of Solitary Confinement in California's High-Tech Maximum Security Prison"

1993 New England Cable News, Newton, MA: News Night "False

Memory and Recovered Memory of Childhood Sexual Abuse"

1993 WCVB-TV, Boston, MA: Chronicle "Sentencing of Father Porter – The Effect on the Victims"

1994 WHDH-TV, Boston, MA: Boston Common "False Memory Syndrome".

1994 FOX-TV, Boston, MA: At Issue "Psychiatric Effects of Solitary Confinement"

1996 New England Cable News, Newton, MA: News Night "The Insanity Defense"

1998 ABC-TV, Nightline with Ted Koppel; Primetime Live "Crime and Punishment"

1998 WBZ-TV, Boston, MA: Channel 4 Nightly News "Perpetrators of Sexual Abuse: Dangers to the Community"

1999 ABC-TV, 20/20 "Effects of Solitary Confinement"

2003 Discovery Channel. "Mohammed Atta: Profile of a Terrorist".

2003 Invited Testimony, Joint Legislative Hearing, New York State Assembly, New York City, November 2003. "Disciplinary Confinement and Treatment of Prison Inmates with Serious Mental Illness."

2004 Invited Testimony, Massachusetts State Legislature. Joint Committee on Public Safety. "The Cost of Corrections".

MAJOR INTERESTS IN FORENSIC PSYCHIATRY

1. Psychiatric Effects of Solitary Confinement

Psychiatric expert in large number of cases including several large class action suits and other lawsuits in Federal and State Courts in California, Connecticut, Florida, Georgia, Massachusetts, Maine, New Mexico, New York State, Texas, Virginia, the State of Washington, and in Washington, D.C. Decisions in some of those cases, and my published findings, have been cited in Federal Appellate decisions, and have also generated significant national media interest. Issues have included: mental illness among inmates so confined; effect on ability to assist in inmate's own legal defense (both pretrial and postconviction); "volunteering" for execution; impact on inmate's ability to cooperate with government in debriefing and testifying.

Peer-Reviewed Medical Publications:

"Psychopathological Effects of Solitary Confinement", Am J Psychiatry 140:11, 1983.

"Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement", Intl J Law & Psychiatry 8:49, 1986.

Law Journals:

"Psychiatric Effects of Solitary Confinement", Washington Univ. Journal of Law & Policy Vol 22: pp. 325-383, 2007.

Book Chapter:

"Neuropsychiatric Effects of Solitary Confinement" in Ojeda, ed., The Trauma of Psychological Torture, Praeger, Westport Conn., 2008.

2. Strip Search Procedures, Sexual and Physical Assault

Psychiatric expert in a number of strip search cases in Federal and Massachusetts state courts. Testimony has been cited by the Federal Appeals Court in Cole v Snow. Consulted in settlement of two class action suits.

Psychiatric expert in cases of rape, sexual and physical assault. Substantial experience in evaluating the effects of childhood sexual abuse, and the

processing over time of memories of that abuse. Evaluated approximately 100 victims of childhood sexual abuse, including many of the plaintiffs in the clergy sex abuse scandals in Massachusetts. Consulted to private schools around such issues.

Research and Presentations:

Principal Investigator, Beth Israel Hospital, Department of Psychiatry, Boston, MA.
"Psychiatric and Addictive Problems in Survivors of Childhood Sexual Abuse Perpetrated by Father Porter."

"Recovery of Memory of Childhood Sexual Abuse and Creation of False Memories; Can These Processes be Distinguished?".

3. Addictive Disorders

Testimony in a number of criminal and civil cases. My testimony in a highly publicized case, In re Cockrum, helped to establish that an individual who was otherwise highly competent, was not competent to act in his own behalf in appealing his murder conviction, as a result of an underlying addictive suicidal compulsion.

4. Civil Rights Issues

Expert in a number of cases regarding racial and sexual harassment in employment and housing situations, including cases brought by Civil Rights Division of the United States Department of Justice, and by Greater Boston Legal Services, and in strip search procedures by law enforcement and prison personnel.

(updated 7/25/08)

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August 4, 2009

TESTIMONY LIST, LAST FOUR YEARS

Washington v. Buraker, USDistCt, WDVa, 3:03CV106, deposition testimony, 11/05.

Testimony in 2006.

Finlan v. Verizon, NewEngland, Inc., Superior Court, Suffolk County, MA, No. 02-4616G. trial testimony, April 2006.

Washington v. Buraker, USDistCt, WDVa, 3:03CV106, trial testimony, 5/06.

Dicen v. A.I.M. Mutual Insurance, Suffolk, SS. Div of Industrial Accidents No. 6043-04, deposition testimony, June 2006.

Ajaj v. U.S., et al. USDistCt, Colorado, No. 03-cv-1959-MSK-PAC, deposition testimony, June 2006.

MB Management v. Carol Berry, Trial Court of MA, Housing Ct. Dept., Boston Div.
Docket #06-SP-00295; hearing testimony, August 2006.

Ogborn v. McDonalds Corporation, Commonwealth of Kentucky, 55th Judicial District, Bullitt County Circuit Court, No. 04-CI-00769. deposition testimony, October 2006.

Jama v. United States Immigration and Naturalization Service, et al., U.S. DistCt, New Jersey, No. 97-3093 (DRD). deposition testimony, November 2006 and January 2007..

Tennessee v. Leonard Smith, Circuit Court of Hamblen County, Post-Conviction Case No. 99-CR-310. hearing testimony, December 2006.

Testimony in 2007.

John Thompson v. Harry F. Connick, et al. U.S.Dist.Ct., E.D. La, New Orleans, Civ. No. 03-2045, trial testimony, February 2007.

Miniassian v. Agulian, Middlesex Sup. Ct., MA. Civ No. 02-0442. trial testimony, March 2007.

Ogborn v. McDonalds Corporation, Commonwealth of Kentucky, 55th Judicial District, Bullitt County Circuit Court, No. 04-CI-00769. trial testimony, October 2007.

USA v. LoPresti, EDNY Cr 07-273 (CBA), trial testimony, November 2007.

In Re Mary Jane D'Arcy. Massachusetts Division of Industrial Accidents. Board No. 33417-03; deposition testimony, December 2007.

Testimony in 2008.

Phillip Gardner v. State of New York, et al. U.S.Dist.Ct. S.D.N.Y., No. 04 CIV 4675; court hearing testimony, February 2008.

Anderson v. O'Brien, Plymouth Sup. Ct, MA., Civ.05-00767A. deposition testimony, July 2008.

Commonwealth vs.Husband, Middlesex Sup Ct, MA, trial testimony, October 2008.

Roberts v. Roberts, Middlesex Probate Court, MA, trial testimony, December 2008. deposition testimony, January 2009.

Testimony in 2009.

Johnson v. Guevara and City of Chicago, USDist Ct, ND Ill, Eastern Division, Civ. 05 C 1042, deposition testimony, February 2009; trial testimony, June 2009.

Documents Shared with Stuart Grassian, M.D., by Plaintiff's Counsel in *K.C. v. Townsend,* Civil Action No. 6:09-CV-012-C (N.D. Tex.):

1. Documents numbered TYC_000001 to TYC_005919
2. Documents numbered TYC_005920 to TYC_007919
3. Documents numbered TYC_008374 to TYC_009064
4. Disk numbered TYC_008685
5. Documents received from Defendants' counsel at the Deposition of Thomas Adamski (not Bates-stamped)
6. Index to above documents prepared by Plaintiff's counsel
7. Affidavit of Thomas Adamski, dated December 19, 2008
8. Affidavit of Thomas Adamski, dated May 8, 2009
9. Transcript of June 4, 2009 Deposition of Thomas Adamski
10. Additional Master and Security files of former TYC-Brownwood residents in the possession of Plaintiff's counsel