EXHIBIT 1

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Expert Report of Joel A. Dvoskin, Ph.D., ABPP

May 25, 2022

Introduction

I was contacted on March 4, 2022 by Lauren Bonds, Legal Director of the National Police Accountability Project, asking if I was available to serve as a potential expert in regard to a matter involving delays in competency evaluation and restoration in Kansas.

I am being paid my usual rate of $600 per hour for all time spent on this case.

Referral questions

- What are the consequences of long waiting lists for admission to Larned State Hospital (Larned) for people who are awaiting competency evaluation or restoration treatment?
- Are there things that the state could do now to reduce wait times?

Summary of Findings

Based on my review of the materials listed below, it is my professional opinion that the State of Kansas is harming people who are awaiting competency evaluation and/or restoration treatment by forcing them to remain in jail pending admission to Larned. Currently, approximately 150 presumptively innocent defendants are enduring wait times of approximately 11 months for a forensic bed at Larned. It is particularly egregious that 23 of these defendants are merely awaiting a competency evaluation. For all these people, their legal procedural rights, including their right to a speedy trial, have been denied for no reason other than the fact that someone has alleged them to be incompetent to stand trial. Except in very rare cases, evaluation of competency does not require inpatient hospitalization, and their inability to be evaluated could easily and quickly be remedied by contracting with community providers to conduct these evaluations in jail or in the community. Likewise, long jail stays awaiting a treatment bed significantly harm the individuals

on the wait list who are awaiting competency restoration treatment. 11 months waiting for a treatment bed is an egregiously long period of time, and far longer than the wait times experienced by people in other states. Based on my experience and knowledge of the psychological impact of long jail stays for those with serious mental illness, these wait times are likely resulting in severely harmful conditions of confinement that exacerbate, rather than mitigate, active psychosis.

For these reasons, as explained in detail below, I conclude that the long wait times for beds at Larned are having a deeply harmful impact on people who are awaiting competency evaluations and restoration treatment, and that the State of Kansas has not taken affirmative, necessary steps that would help bring the wait times back under control.

Credentials

I earned a Ph.D. in Clinical Psychology in 1981, from the University of Arizona. I am licensed as a psychologist in Arizona. I am currently an Assistant Clinical Professor at the University of Arizona College of Medicine in the Department of Psychiatry. From 2000 through 2005, I was an Assistant Clinical Professor at the Louisiana State University Medical Center. I have also served as a faculty member at the New York University Medical School and the University of Arizona College of Law.

I am a Fellow of the American Psychological Association and the American Psychology-Law Society. I am certified by the American Board of Professional Psychology in Forensic Psychology and hold a Certificate of Qualification in Psychology and an Interjurisdictional Practice Certificate from the Association of State and Provincial Psychology Boards. I have been President of two divisions of the American Psychological Association – Division 18 (Division of Public Service Psychology) and Division 41 (American Psychology-Law Society).

In 1984-85, I founded the Kirby Forensic Psychiatric Center (Kirby) in New York City, a maximum-security psychiatric hospital in New York City, and served as its Acting Executive Director (CEO) from November 1984 until September 1985. As a forensic psychiatric hospital, Kirby provided treatment for patients who had been found incompetent to stand trial or not guilty by reason of insanity. For more than a decade, I served as Director of Forensic Services and Associate Commissioner for the New York State Office of Mental Health, where I was responsible for forensic and prison mental health services throughout the State of New York. In

that role I directly supervised the CEOs of 3 freestanding forensic psychiatric hospitals, each of which served patients who had been found incompetent to stand trial, and forensic units in 3 other state hospitals. My office also supervised all insanity acquittees being supervised by the New York State Office of Mental Health, in hospitals and in the community. In addition, my office developed the first statewide suicide prevention program for local jails and a statewide program to train police officers in how to deal with people with serious mental illness or in emotional crisis. Both programs were requested, shared, and adopted by jurisdictions throughout the United States.

In 1995, I became Acting Commissioner of Mental Health for the State of New York. In that role, I directly supervised 31 civil, forensic, and children's psychiatric hospitals and the licensing of all outpatient mental health programs and agencies in New York.

I served for several years as the Chair of the Governor's Advisory Council on Behavior Health for the State of Nevada. In that role I chaired a Council that helped to improve crisis services to Nevadans with and without serious mental illness and provided advice to Governor Sandoval on issues related to behavioral health across the state.

I have published numerous articles in professional journals on the relationship between psychology and law, especially areas in which the mental health and criminal justice systems interact. Many of these articles deal with the provision of mental health services in criminal and juvenile justice settings. I have published articles on assessing and mitigating the risk of interpersonal violence and suicide, especially for people who have serious mental illnesses and/or co-occurring substance use disorders. My peer reviewed publications are listed in my *curriculum vitae,* which is attached.

I have served as an expert witness, consultant, mediator, and/or independent expert on cases dealing with waiting lists for transfer of incompetent defendants to psychiatric hospitals in Pennsylvania, Louisiana, Colorado, Mississippi, Alabama, Utah, and Florida. I have served as a monitor or independent expert regarding federal court settlement agreements and consent decrees in Washington, New Mexico, Michigan, and Colorado, and, in September, I will begin to serve as a Federal Court-appointed Monitor in a class action in Montana.

I served as design consultant for psychiatric hospital architectural projects at the St. Elizabeths Hospital, Fulton (MO) State Hospital, Colorado Mental Health Institute-Pueblo, and most recently the new high-security patient building at the Hawaii State Hospital.

Records Reviewed[1]

- Proponent Testimony of Scott Bruner, Deputy Secretary for Hospitals and Facilities for KDADS, in support of HB 2697 – February 17, 2022
- Waitlist to admission to Larned State Hospital
- Letter from Sharon Brett of the ACLU Kansas requesting documents, dated December 7, 2021
- Letter from Secretary Laura Howard to Sheriff Jay T. Armbrister, dated December 14, 2021
- Letter from Jeffrey Heiman (Stevens Brand Law Firm) to Kayla DeLoach, dated January 25, 2022
- Letter from Kayla DeLoach of the ACLU Kansas to the Douglas County Sheriff's Office dated December 17, 2021, requesting records
- Copy of Waitlist stats from KD 030722.xlsx
- DGSO records production, including emails between Chanda Wilder (KDADS) to Kevin Bellinger (Douglas County S.O.)
- Jackson Overstreet, 61 Kansas sheriffs call for changes to Larned state hospital admin, process, KAKE.com, November 4, 2021, https://www.kake.com/story/45125959/61-kansas-sheriffs-call-for-changes-to-larned-statehospital-admin-process.
- KAKE News, Kansas sheriffs send letter to governor asking for changes to KDADS, Larned State Hospital, KAKE.com, November 3, 2021, https://www.kake.com/story/45120737/kansas-sheriffssend-letter-to-governor-asking-for-changes-to-kdads-larned-state-hospital.
- (Kansas) HB 2508

[1] This following list includes the documents upon which my opinion is based. In addition, I also reviewed a draft of the complaint that the potential plaintiffs intended to submit to the court.

- Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T., Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review, *Arch Gen Psychiatry*, 2005, vol. 62 (pg. 975-983)
- Kane JM, Schooler NR, Marcy P, Correll CU, Brunette MF, Mueser KT, Rosenhack RA, Addington J, Robinson J, Penn DL & Robinson DG (2015) The RAISE Early Treatment Program for First-Episode Psychosis: Background, rationale, and study design. Journal of Clinical Psychiatry, Vol 76(3) March 2015, 240-246 https://doi.org/10.4088/JCP.14m09289

Expert Opinions

Introduction

Delaying the transfer of an incompetent defendant to a psychiatric hospital and keeping them in jail causes them great harm and ironically wastes large amounts of tax dollars. For as long as they await transfer, they are prevented from receiving effective competency restoration services. By allowing inmates to languish in stressful and often frightening jails, the symptoms of mental illnesses are likely to get worse, in many cases adding considerable time and hospital days to the process of restoring competency. During this period of delay, defendants have little or no ability to demonstrate their innocence of charges. They are precluded from entering into plea bargains. As a result, the criminal process to which they are entitled grinds to a halt.

For defendants whose charges are minor (*e.g.*, misdemeanors or low-level felonies), they may remain locked up in jail much longer than they would have had they pled or been found guilty. The long periods of waiting in jail also delay a finding of non-restorability, which under state and federal law should result in release or civil commitment to a psychiatric hospital.

For many reasons, Kansas currently forces hundreds of presumptively innocent defendants to remain in jail for many months simply because they are awaiting competency evaluation or restoration, thereby denying them their rights to treatment, non-discrimination, and a speedy trial. These delays also cause harm to the jails that are ill-equipped to safely house and treat people with serious mental illness. Most jail settings cannot provide sufficient treatment services to a high-needs population. Even worse, detainees with serious mental illness are disproportionately likely

to be housed in segregation or restricted housing, which can exacerbate symptoms of mental illness.

The size of Kansas' waiting list and the average length of time each person spends on the waiting list is significantly worse than that of other states, even states with much larger populations. While the reasons for these delays may seem complicated, there are a number of steps that can be taken by the Kansas Department of Aging and Disabilities (KDADS) that would alleviate the problem significantly. Larned has for some time been operating at significantly below its funded capacity. KDADS also appears to have limited admission of all competency patients to one hospital (Larned) and to one specific part of that hospital, apparently without regard to each individual's clinical needs, risk of violence, and risk of flight. KDADS apparently presumed that competency evaluations require inpatient admission, which is not the case. Indeed, many states allow competency evaluations to be done wherever the defendant happens to be, treating inpatient admission as a rare exception for specific reasons.

In my opinion, the severity of this problem is exacerbated by the fact that things are getting worse. According to Deputy Secretary Scott Bruner's testimony, for the years 2020-2021, the waiting list increased from 118 to 167 people who were in jails awaiting a bed at Larned. A 40% increase. During that same period, the amount of time that these defendants spent waiting increased from 270 days to 336 days, representing a 24% increase in just two years. Many other states have reported significant increases in numbers of defendants for whom competency evaluations have been requested; so in the absence of meaningful action by KDADS to address this problem, it is likely to persist.

As I was writing this report, I became aware of the passing of House Bill No. 2508, which offers courts and KDADS some additional freedoms regarding the location for competency assessment and restoration treatment. Depending how these freedoms are exercised, they might help KDADS to reduce the size of the waiting list and the average duration of wait times. Particularly useful is a change in the required number of evaluators, from two to one licensed physician or psychologist.

These arbitrary, self-imposed rules result in circumstances that would be comical if they were not so tragic, as evidenced by the following email from Chanda Wilder, legal assistant at KDADS, dated November 2, 2022. Responding to a jail's request to transfer a detainee with apparent mental health issues, Chanda Wilder wrote the following.

> *"There are a couple of things you could try: 1. Have him screened by the mental health center for an involuntary commitment for care and treatment case. If he met criteria he would then be admitted to OSH until he was stabilized, at which time he would be sent back to you to await admission for his competency evaluation. (This option would not affect his placement/admission for his criminal case) 2. You can request an expedited admission, our triage team would then review the information provided and determine whether or not he meets criteria to move to the top of our pending admissions list."*

To be clear, this is not a criticism of Chanda Wilder, who appears to be trying their best to help a jail employee to manage a ridiculous set of rules and circumstances in an effort to get help to a detainee. However, it is emblematic of the overarching problem: KDADS is not using the vast majority of resources at its disposal to quickly and effectively evaluate and treat individuals whose competency has been called into question by the court. If it is safe for the person to be housed at OSH (Osawatomie State Hospital), why not simply evaluate and restore the person to competency there?

There are two overarching ways that KDADS could alleviate its waiting list problem. First, it can contract with community providers for evaluation and treatment of incompetent defendants, especially those with misdemeanor or low-level felony charges. Second, KDADS can maximize the use of its hospital beds at Larned, and use the two state hospitals (Larned and Osawatomie State Hospital) in a more logical and efficient manner. These steps are clearly within the authority and ability of KDADS and would alleviate at least some of the waiting list problem.

Background

The Supreme Court's holding in *Dusky v. United States,* 362 U.S. 401 (1960) states that "[m]ental incapacity to proceed exists when, as a result of a mental disease or defect, a defendant presently lacks the capacity to understand the proceedings against him or to assist in his defense." The two most common reasons that defendants are found incompetent to proceed under this standard are: (1) acute psychosis, or (2) intellectual disabilities that are serious enough that a defendant appears unable to understand the nature of the charges or proceedings and/or defendant is unable to assist in his or her own defense.

The presence of a severe, acute, and often florid psychosis is by far the most common basis of incompetency under *Dusky*. Such disorders are often treatable in relatively short order -- and only if a defendant is: (1) examined by a psychiatrist or similarly qualified provider (*e.g.*, certified psychiatric nurse practitioner), (2) prescribed appropriate medication, usually an antipsychotic, if

needed, and (3) willing to take medication as prescribed. In addition, such individuals require other appropriate forms of treatment such as individual or group psychotherapy and milieu therapy that takes place in a truly therapeutic environment. It is also important that individuals be in a situation in which they feel safe, to prevent destabilization and/or regression.

A patient's willingness to take psychotropic medication as directed is often dependent upon the patient's setting. Even if incompetent defendants are willing to take medication, the lack of other forms of therapy and a therapeutic environment dramatically decreases the chances of successful treatment. However, in my experience, persons with acute and serious psychotic symptoms are very often unwilling to take such medications in jails for several reasons that will be explained in the following subsection.

After acute psychosis, the second most common reason for a finding of incompetence is an intellectual disability that is serious enough that a defendant appears unable to learn the nature of the charges or proceedings against him or her and/or the defendant is unable to assist in his or her own defense. In forensic hospitals across the United States, the standard of care for such persons includes observation, further assessment, and diagnosis designed to ascertain whether such disability is treatable or permanent. Until the defendant is transferred to a mental health facility so that this treatment can begin, it is difficult or impossible to ascertain whether competence is restorable. The standard of care also includes some form of educational intervention, wherein incompetent patients are taught, for example, the roles of the various players involved in a trial, the basic legal concepts that are likely to be discussed in a trial, and how to work with counsel. Such educational intervention has two purposes: (1) attempting to render the person competent so that he or she can quickly resume the journey through the criminal justice system; and (2) determining whether the disability that led to the finding of incompetence was due to ignorance (which is ameliorable) or a lack of capacity (which should lead to a timely finding that the person is not restorable). In cases of moderate or severe intellectual disability, the person is typically found unrestorable, moved to an appropriate facility or program, and their charges dismissed.

As discussed below, the long waitlist for evaluation and treatment beds at Larned is causing extreme harm to those who are awaiting bed space while incarcerated at county jails. Moreover, several solutions to the wait times are within KDADS's direct authority over their budget and operations.

Harms Caused by Keeping Incompetent Defendants in Jail

The vast majority of jails lack adequate psychiatric, psychological, social work, and nursing services, thereby decreasing the likelihood that prescribed medications are appropriate, effective, and preferred by the patient, which in turn reduces the likelihood that a patient will take them. Nurses' time is predominantly used in administering medications to the entire jail, leaving them little time to engage in meaningful two-way conversations with detainees. Such shortages also decrease the amount of time available to develop trust, and to explain and hopefully convince the patient of the value of taking psychotropic medication.

Few if any jails are able to create a therapeutic environment in which a detainee feels like a patient. The failure to create such a setting precludes the detainee from viewing the health and mental health care professionals as doctors/nurses who care about them. Indeed, many jails specifically avoid trying to create a therapeutic environment because they need to focus on maintaining security, which they rightly view as their primary objective.

Effective psychiatric treatment must be individualized. Jails, however, are almost universally run with three omnipresent watchwords: "firm, fair, and consistent." While these values may be excellent correctional goals, they are in direct conflict with the goals of individualized treatment of serious mental illnesses, which is the hallmark of good psychiatric and mental health care.

Jails are seldom perceived as safe places by inmates and detainees. Risks, such as those addressed by the Prison Rape Elimination Act, are real problems, and are exacerbated by sensational and ubiquitous portrayals of jails as places where rape and assault run rampant and unchecked. Inmates' understandable fears for their own safety can make them loathe to accept psychotropic medication, which will tranquilize them and leave them feeling less alert and less vigilant in the event that they need to defend themselves.

For these reasons and many others, the prevalence of suicidal and para-suicidal behaviors, as well as the risk of death by suicide, is dramatically higher in jails than in the general (community) population. Consider that the lifetime prevalence of suicide among people with schizophrenia is also much higher than the general population. Together, those risk factors combine to make jail an especially dangerous place for people with serious mental illnesses.

The stigma of mental illness that exists throughout our society is even worse in jails, where inmates, and even staff frequently refer to inmates with mental illness in insulting and demeaning terms. I have visited hundreds of correctional institutions; the large majority use some sort of idiosyncratic and offensive "nickname" (*e.g.*, "bugs," "crazies") to refer to inmates with serious mental illness. These insulting characterizations of inmates with mental illness contribute to their sense of despair and hopelessness.

Many jails are insensitive to the frequent minor disciplinary violations (*e.g.*, being out of place, failing to obey a direct order) that usually accompany psychosis, treating such infractions as if they were intentional rule violations. As a result, inmates with serious mental illness commonly comprise a disproportionate number of inmates in lockdown settings such as administrative or disciplinary (punitive) segregation or other forms of restricted housing.

Restricted housing (*i.e.*, segregation) poses a risk of psychological harm to inmates, and there is virtual unanimity among experts that segregation should be avoided for any inmate or detainee who suffers from acute symptoms of serious mental illness such as severe depression or psychosis. Further, restricted housing settings are also characterized by a higher rate of suicide than general population.

It is cruelly ironic that people charged with misdemeanor offenses may be detained in jail for far longer periods of time than the maximum sentence they could have received, and astronomically longer than the amount of time they would have remained in jail had they simply been allowed to plead guilty. In addition to denying the misdemeanor defendants a speedy trial, these delays also waste an astonishing amount of tax dollars (in the form of jail days and hospital days). These resources could have been used to provide the person with outstanding mental health care in the community, instead of making them worse by holding them in jail for months.

The purported reason for denying pretrial release to people with mental illnesses is the presumption that people with mental illness are, by definition, dangerous. This presumption is inaccurate and discriminatory; in fact, people with mental illness are far more likely to be victims of crime than perpetrators of crime. Further, a great deal of research over the past several decades has repeatedly shown that mental illness by itself has a very weak predictive relationship to violent crime—far less than other known criminogenic factors.

As a result of the factors enumerated above, psychotic pretrial detainees are likely to remain psychotic longer if housed in a jail than if housed in a modern, competently run psychiatric hospital. Accordingly, in virtually all jurisdictions, the standard of care for incompetent defendants who must remain in custody due to a significant risk to public safety is transfer to a state forensic psychiatric hospital, which provides a therapeutic environment, milieu, and other characteristics listed above. However, the standard of care does not prevent communities from treating incompetent defendants with outpatient or residential treatment when they do not pose a significant risk to public safety.

Research has demonstrated that allowing patients to experience acute and untreated psychosis can have a long-term, and possibly permanent, negative effect on the trajectory of the person's illness; moreover, a long period of untreated psychosis is especially associated with worse long-term outcomes in people with first-episode psychosis.[2] [3] In other words, allowing people to get worse can make their treatment more challenging and expensive for the rest of their lives.

The above circumstances apply to all jails, even those few that have adequate psychiatric and mental health services. Unfortunately, the vast majority of American jails have grossly inadequate psychiatric and mental health services, causing inmates to decompensate even more rapidly. These exacerbations of serious mental illness can cause defendants to harm themselves, experience more severe hallucinations and delusions, and to disrupt the other inmates and detainees, who sometimes respond with violence toward the person with mental illness. In other words, because the jail environment is so harmful for people with psychoses, the longer a person remains in jail, the longer it will take to restore them to competency and mental health.

Jails Are Ill-Equipped to Safely House People with Serious Mental Illness

It has been my consistent experience that sheriffs, wardens, and jail administrators believe that they are ill-prepared to provide psychiatric care to people with serious mental illness, especially severe psychoses. Many of them resent the fact that they have been asked to be a primary provider

[2] See, for example, Kane JM, Schooler NR, Marcy P, Correll CU, Brunette MF, Mueser KT, Rosenhack RA, Addington J, Robinson J, Penn DL & Robinson DG (2015) The RAISE Early Treatment Program for First-Episode Psychosis: Background, rationale, and study design. Journal of Clinical Psychiatry, Vol 76(3) March 2015, 240-246.

[3] Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review, *Arch Gen Psychiatry*, 2005, vol. 62 (pg. 975-983).

of mental health and psychiatric services, in large part because the state hospitals and community mental health centers have lost funding and capacity over the last few decades. Sheriffs believe that their primary job is to hold people for trial in a safe environment. They are not mental health professionals and they do not pretend to be.

Despite the fact that courts have consistently upheld the duty of jails and prisons to provide treatment for serious psychiatric problems, the sad truth is that most jails fall woefully short of the minimal mental health services that are recommended by various professional organizations. Indeed, many jails provide no meaningful mental health treatment at all.

The Rights of the Accused

While incompetence to proceed to trial can rightly delay going to trial, this should be no longer than the time needed for active treatment to restore the person to competency. By housing psychotic inmates in jail instead of a treatment setting, pretrial detainees with psychotic symptoms are likely to be prevented from proceeding to trial for far longer than is reasonably necessary to restore their competency. For misdemeanor and low-level felony defendants, their period of pretrial detention and involuntary hospitalization is likely to dramatically exceed the amount of time they would have been incarcerated if they had been found guilty in a timely manner.

Problems and Potential Solutions

In Kansas, my review of the waiting lists that have been provided to me reveals that there are two problems which each have a different, but related, solution.

First, some of the detainees on the wait list are simply waiting for an evaluation to determine whether or not they are fit to proceed to trial. Waiting lists for evaluation are inexcusable, as these evaluations can be provided regardless of the person's location by contracting with forensic mental health professionals (FMHPs). The number of psychologists and psychiatrists who are willing to provide these evaluations is directly correlated with the amount of money they are offered for each evaluation. Considering the massive savings that have likely accrued because of Larned's reduced operating capacity, expense is no excuse. KDADS could immediately contract with more community mental health providers or expand its mobile evaluation units to reach communities that have fewer evaluation options locally.

Second, while many states are struggling with waiting lists for competency restoration, Kansas is an outlier. The number of people who are languishing in jail and the lengths of time they remain there are unacceptable. As many other states have discovered, the problem of competency waiting lists, while challenging, can be overcome. KDADS has the authority and ability to use its existing hospital resources more efficiently and to contract with community providers and agencies to expand community options aimed at keeping people with serious mental illness out of the criminal justice system. For example, defendants whose incompetence is solely the result of acute psychosis, and who pose no serious risk of harm to self or others, could be treated effectively and at greatly reduced public cost in existing community mental health settings.

The State argues that these waiting lists are the direct result of the COVID pandemic and an increase in competency cases. However, many other states have experienced increases in competency cases, and all 50 states have experienced the COVID pandemic. Despite the fact that these challenges exist, they are not an excuse for denying presumptively innocent Kansans their constitutional (*e.g.*, speedy trial) and statutory (*e.g.*, non-discrimination and reasonable accommodation for a disability) rights.

It is important to note that Larned has operated at a reduced capacity for a long time. Presumably, this means that a large amount of money that was budgeted for Larned has gone unspent. This creates a very large temporary pool of money that could be spent on non-recurring items such as signing bonus for understaffed positions, retention bonuses, renovation of mental health housing alternatives (*e.g.*, community residences, board and care homes, etc.). Those funds could also be spent on security enhancements to state hospital beds that are currently considered inappropriate for competency patients.

A Cautionary Note

One frequently proposed solution to the "waiting list problem" has been to create so-called competency restoration programs in jails. In most cases, these programs consist of poor psychiatric care with some perfunctory judicial education thrown in. The amount and quality of competency restoration programming is vastly inferior to that found in forensic psychiatric hospitals. In my opinion, in order for a jail-based competency restoration program to be adequate, it is necessary to approximate the staffing levels one would find in a state psychiatric hospital. Most states have found such programs prohibitively expensive. This observation is not meant to criticize jails;

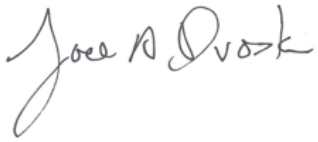
detention facilities simply were not designed and are grossly inadequate for treatment activities that meet the standard of care described above.

Summary

The current practice of forcing defendants to wait for many months in order to receive competency evaluations and/or restoration treatment is extremely harmful to these defendants and prevents them from receiving speedy trials. Often, they lose significantly more freedom than had they been found guilty of the alleged crime. Many jail days are wasted on people who pose no serious risk to public safety, and many expensive hospital days are wasted on people whose mental health needs could be much better met in their home communities. KDADS has the tools and resources to restore Larned to full capacity and to contract with community providers to ensure that evaluations are completed in a timely manner.

As always, these opinions are based on my education, professional experience, and the documents I have reviewed. If additional information is provided, I reserve the right to amend my opinions accordingly.

Respectfully submitted



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

APPENDIX A: *Curriculum Vitae* of Joel Dvoskin, Ph.D.

***CURRICULUM VITAE* (August 2020)**

Joel A. Dvoskin, Ph.D., ABPP

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EDUCATION:

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

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

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

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

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

HONORS:

Diplomate in Forensic Psychology, American Board of Professional Psychology

Fellow, American Psychological Association

Fellow, American Psychology-Law Society

National Coalition for the Mentally Ill in the Criminal Justice System, Peggy Richardson Award

American Academy of Psychiatry and the Law, *Amicus* Award

Affiliate Member, International Criminal Investigative Analysis Fellowship

Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, April 14, 2005

President, Division 18 of the American Psychological Association (APA), Psychologists in Public Service (2000-2001)

President, American Psychology-Law Society, Division 41 of the American Psychological Association (2006-2007)

American Psychological Association, Division 18 Special Achievement Award

Member, APA Blue Ribbon Commission on Ethics Process (2016-17)

Arizona Psychological Association, Distinguished Contribution to the Practice of Psychology Award, 2001

Arizona Psychological Association, Distinguished Contribution to the Science of Psychology Award, 2010

Distinguished Visiting Professor of Psychiatry, University of California, Davis School of Medicine and Napa State Hospital, March 30, 2011

Southern Arizona Psychological Association, Peter Attarian Award for Outstanding Contributions to the Profession of Psychology in Southern Arizona, 2014

Executive Office of the President of the United States, Member, Expert Panel to Develop a Strategic Action Plan for African-American Males, 1995

Arizona Psychological Association, Aaron H. and Matilda B. Canter Award for Distinguished Contributions to Professional Psychology, 2018

American Academy of Forensic Psychology Distinguished Contribution Award, 2020

American Psychological Association, Division 18 (Criminal Justice Section), Advocacy in Criminal Justice Psychology Award, 2021

ACADEMIC POSITIONS:

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

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

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

1986 - 1995 (currently inactive)
Assistant Clinical Professor - New York University Medical School

LICENSES:

Arizona Board of Psychologist Examiners, License #0931

New Mexico State Board of Psychologist Examiners, License #0904 (inactive)

Certificate of Professional Qualifications in Psychology (CPQ), CPQ #2,439 (inactive)

Interjurisdictional Practice Certificate, ASPPB, #2439

PROFESSIONAL EXPERIENCE:

(Planned) September 2022 – Ongoing

Monitor, Disability Rights Montana, Inc. v. Brian M. Gootkin, et al, case # CV-15-22-DWM, filed in the U.S. District Court for the District of Montana, Butte Division

Duties: Assess compliance by the Montana Department of Corrections with Settlement Agreement and report to parties and the Court.

May 2022 – Current
Co-founder and Partner, Heroes Active Bystandership Training

Duties: Manage company that provides training to state departments of corrections, local jails, and other industries. Support clients in their efforts to change organizational culture by teaching employees when and how to intervene to prevent harm such as mistakes, misconduct, and to enhance the wellness of fellow employees.

January 2020 – Current

Consultant, Training Instructor and Psychologist, Project ABLE (Active Bystandership for Law Enforcement), part of Georgetown Law's Innovative Policing Program

Duties: Assist in development of curriculum to train law enforcement officers to be active bystanders and intervene to prevent fellow officers from mistakes and misconduct, and to enhance the well-being of fellow officers; provide training to police trainers who will serve as ABLE instructors.

September 1995 - Current

Full-time private practice of forensic psychology, providing expert testimony on civil and criminal matters, and consultation in the provision of mental health and criminal justice services, and workplace and community violence prevention programs.

Duties: Provide expert testimony, consultation, training, and public speaking services to federal, state, and local governmental agencies, corporations and attorneys, including the following areas:

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

August 2012 – Current

Pro Bono Consultant, New Orleans Police Department EPIC (Ethical

Policing is Courageous) Project

Duties: Assist in the development and delivery of a training program to teach police officers how to prevent misconduct by fellow officers

January 2014 – April 2016

Chairman, (Nevada) Governor's Advisory Council on Behavioral Health and Wellness

Duties: Provide advice to Governor Brian Sandoval regarding public behavioral health; Chair statewide Advisory Council

November 2007 – May 2011

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

September 1995 – Current

Senior Psychologist, Threat Assessment Group, Inc., Newport Beach, California.

Duties: Provide consultation and training in workplace violence prevention and crisis management to governmental and corporate organizations.

September 1995 - Current

Associate, Park Dietz & Associates, Inc., Newport Beach, California. **Duties**: Forensic psychological services and expert testimony

March 1995 - August 1995

Acting Commissioner, New York State Office of Mental Health.

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

November 1984 - March 1995

Director, Bureau of Forensic Services (1984-1988) and Associate Commissioner for Forensic Services (1988-1995), New York State Office of Mental Health.

Duties: Line authority for inpatient services at three large forensic hospitals and two regional forensic units, including services to civil, forensic and correctional patients; line authority for all mental health services in New York State prisons (serving more than 60,000 inmates), including 15 prison mental health units across New York; responsibility for innovative community forensic programs including suicide prevention in local jails, police mental health training, and mental health alternatives to incarceration.

December 1984 - July 1985

Acting Executive Director, Kirby Forensic Psychiatric Center.

Duties: Founding C.E.O. for new maximum security forensic psychiatric hospital in New York City.

July 1984 - November 1984

Acting Director, Office of Mental Health, Virginia Department of Mental Health and Mental Retardation (held concurrently with permanent position as Director of Forensic Services).

Duties: Supervision of budget and certification of all community mental health programs statewide; statewide policy development in all program areas related to mental health; Executive Secretary to Virginia Mental Health Advisory Council.

July 1983 - November 1984

Director of Forensic Services, Virginia Department of Mental Health and Mental Retardation.

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

August 1982 - July 1983

Psychologist, Arizona Correctional Training Center, Tucson, Arizona. **Duties:** Supervision of psychology department; direct clinical treatment and evaluation services.

April 1982 - July 1982

Acting Inmate Management Administrator, Arizona State Prison Complex, Florence, Arizona.

Duties: Direct supervision of inmate records office; inmate classification and movement; correctional program (counseling) services; psychology department; hiring of all new correctional officers. (NOTE: During this period, I also maintained all duties of my permanent position as Psychologist (below).

October 1981 - July 1982

Psychologist, Arizona State Prison Complex, Florence, Arizona

Duties: Supervision of Psychology Department for complex consisting of five prisons; direct clinical treatment and evaluation services.

November 1980 - October 1981

Psychology Associate, Arizona State Prison Complex, Florence, Arizona.

Duties: Direct clinical treatment and evaluation services.

August 1980 - November 1980

Psychological consultant to the Massachusetts Department of Correction.

Duties: Consultation to Director of Health Services; direct clinical treatment and evaluation services at Walpole and Norfolk State Prisons.

January 1980 - November 1980

Psychologist (non-licensed) - Tri-Cities Community Mental Health Center, Malden, Massachusetts.

Duties: Pre-screened civil commitments for community mental health center.

August 1979 - August 1980

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

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

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

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

1975-1976 National Institute of Mental Health Trainee

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

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

SELECTED CONSULTATION CLIENTS:

Federal Government and Federally Funded Protection and Advocacy Services -

National Institute of Mental Health

United States Secret Service

National Institute of Justice

National Institute of Corrections

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

United States Department of Justice, Civil Rights Division

Maricopa County (AZ) Jail

Los Angeles County (CA) Jail

Harrison County (MS) Adult Detention Center

Los Angeles County (CA) Juvenile Hall

Taycheeda State Prison for Women (Wisconsin)

Huron Valley Women's Correctional Facility (Michigan)

Substance Abuse and Mental Health Administration
National GAINS Center

Department of Homeland Security – Office of Civil Rights

New Orleans Police Department (in collaboration with US Dept. of Justice)

Disability Rights Florida

Disability Rights Oregon

Alabama Disability Advocates Program

Michigan Protection and Advocacy Services

Center for Public Representation

MacArthur Justice Center

Federal Multi-Agency Task Force on National Security Implications of Y2K

State, County, and Local Governments -

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

International Clients –

Province of Ontario

Correctional Service of Canada

Province of British Columbia

England and Wales – National Offender Management Service Expert Advisory Panel

American Samoa (Pago Pago)

Selected Corporate Clients –

Amazon

American Express

American Express

Amgen

Boise Cascade

Borden Foods

Chase Manhattan Bank

Corning, Inc.

DaimlerChryslet

General Dynamics

Honeywell

Johnson and Johnson

Kraft Foods

The Law Firm of Akin Gump

Sheppart Mullen Law Firm

Levi Strauss

Macy's

Motorola

NBA Players Association

National Basketball Association

National Semiconductor

Nationwide Insurance

Nordstrom

Oracle Corporation

Pillsbury

Ryman Hospitality (Grand 'Ol Opry")

Sony Corporation

State Farm Insurance

Texas Instruments

3M Corporation

United Auto Workers

University of Arizona

Visa

Pima College

Warner-Lambert Pharmaceuticals

Professional Organization Clients –

American Psychological Association – Task Force on Preventing Gun Violence

American Psychological Association – Commission on Ethics Processes

American Psychiatric Association - Committee on Correctional Psychiatry

American Correctional Association

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

Council of state Governments

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

NBA Players Association – Top 100 High School Basketball Camp

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

Federal Court Independent Expert and Monitor –

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

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

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

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

Independent Expert to monitor settlement agreement regarding the transfer of incompetent defendants to State Hospitals in Colorado

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

Architectural Consultations -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Missouri Department of Mental Health – Architectural Design Consultant on 300bed Secure Forensic Hospital to replace existing buildings at the Fulton State Hospital. This project was selected to receive the Distinguished Award for Architecture from the St. Louis Chapter of the American Institute of Architects.

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

Hawaii Department of Health -- Architectural Design Consultant for new forensic building at the Hawaii State Hospital

American Samoa – Served as design consultant for a new forensic psychiatric unit in Pago Pago

BOARD MEMBERSHIPS:

Board of Advisors	Georgetown Law School's Innovative Policing Program, Project ABLE (Active Bystandership for Law Enforcement)
Board of Advisors	Justice Initiative of the Meharry Medical College and the Fox Foundation
Board of Directors	Legislative Drafting Institute for Child Protection
Editorial Boards	*Journal of the American Academy of Psychiatry and Law (former)* *Journal of Mental Health Administration* *Behavioral Sciences and the Law* *Journal of Aggression, Maltreatment, and Trauma (former)* *Psychological Services (former)* *Journal of Threat Assessment (former)* *Law and Human Behavior*
Research Advisory Board	United States Secret Service (former)
Advisory Board	National Center for State Courts, Institute on Mental Disability and the Law (former)

Member	White House Panel on the Future of the African-American Male –1995
Member	American Bar Association Task Force on Capital Punishment and Mental Disability – Completed 2005
Member	American Psychological Association Task Force on Reducing Gun Violence – 2013
Member	American Psychological Association Blue Ribbon Commission on Ethics Processes -- 2016

UNITED STATES SUPREME COURT *AMICUS* BRIEFS

Consultation and assistance in preparation of *Amicus Curiae* briefs submitted to the United States Supreme Court:

Clark v. Arizona, 548 U.S. 735 (20060
Graham v. Florida, 560 U.S. 48 48 (2010)
Miller v. Alabama, 576 U.S. 460 (2012)
Moore v. Texas, 137 S. Ct. 1039 (2017)
Panetti v. Quarterman, 551 U.S. 930 (2007)
Roper v. Simmons, 543 U.S. 551 (2005)

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Preventing Suicide in Detention and Correctional Facilities. In: Woolredge J and Smith P (Eds.) *The Oxford Handbook of Prisons and Imprisonment*, Oxford University Press: New York, NY

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APA's Amicus Curiae Program: Bringing psychological research to judicial decisions. *American Psychologist*.

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

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The Structure of Correctional Mental Health Services. In: Rosner R and Scott CL (Eds.) Principles and Practice of Forensic Psychiatry, Taylor and Francis: Boca Raton, FL.

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

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

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

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

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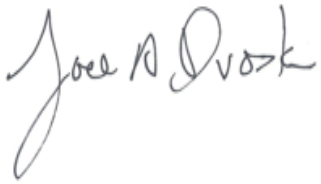
PROFESSIONAL AFFILIATIONS:

American Psychological Association (Fellow)
American Association of Correctional Psychologists
American Psychology - Law Society (Fellow)
American Correctional Association
National Association of State Mental Health Forensic Directors - Chairman 1986-1988
American Correctional Health Association
American Jail Association (former)

Appendix B: List of Cases

As of May 24, 2022, I have not testified in any court proceeding, at trial or by deposition, in the last 4 years.



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