EXHIBIT 2

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THERESA DOE, Parent and Legal Guardian for M.D., a Minor Plaintiff
v.
GRAYS HARBOR COUNTY,
A Municipality; Gerald Murphy, Greg Reynvaan,
And JOHN AND JANE E DOE,
In their individual capacity; Defendants

Louis J. Kraus, MD

Date of Report: May 23, 2017

I. Referral Source:

I was initially contacted by Nancy Talner, Senior Staff Attorney at ACLU of Washington and David Whedbee, attorney at Macdonald Hoague and Bayless, to complete a record review of MD and offer an opinion regarding his treatment at the Grays Harbor County Detention Center.

II. Qualifications:

1. I am Chief of Child and Adolescent Psychiatry at Rush University Medical Center in Chicago, IL. In that capacity, I supervise and train child and adolescent psychiatric fellows in various placements, including inpatient, residential treatment and outpatient programs for children, adolescents and young adults. I am currently the Psychiatric Director of the Sonja Shankman Orthogenic School (a residential treatment program for children and adolescents in need of support for profound emotional issues); the Director of the Autism Assessment Research, Treatment and Service Center at Rush University Medical Center; and the Medical Director of the Chicago Metropolitan Easter Seals Therapeutic School, a school providing a continuum of services for children with Autism. I also have a private practice where I assess and treat children and adolescents and provide therapy and psychopharmacological services.

2. I have worked with juveniles in correctional facilities for the past 26 years, including for 9 years from 1990 to 1999 as a treating psychiatrist at the Illinois Maximum Security Youth Center in Joliet Illinois. From 2003 to 2004 I was a consultant to the Civil Rights Division of the United States Department of Justice on a Civil Rights of Institutionalized Persons Act (CRIPA) investigation in Maryland. I also consulted with the American Civil Liberty Union of Illinois in a case challenging

conditions in the Cook County Juvenile Temporary Detention Facility, which resulted in a system-wide restructuring of mental health services in pre-trial detention, I have served as a consultant on various other correctional and juvenile justice matters.

3. I have been appointed to serve as a monitor in Consent Decrees in Federal Decrees involving reform and juvenile justice issues in Arizona and Illinois, both of which included reform to the use of solitary confinement against juveniles in those systems. In my role in Illinois, which is currently ongoing, I am assessing and restructuring the mental health programming of the Illinois Department of Juvenile Justice, C.R.J.V. Bishop, O 1:12-cv-07289 (ND III). In the Arizona case I assisted the Department of Justice from, 2005 to 2008 in restructuring the mental health, medical services and dental services in two state facilities. See Unite States v Arizona, NO. 2:04 cv-01926-EHC (D. Ariz).

4. I have also been involved in special education consulting and development of Individual Education Programs (IEPs) for the past 22 years. I am currently a consultant on special education issues to over 15 school districts in Illinois. I typically complete one or two evaluations each week, assist with developing IEPs and attend IEP meetings. I have testified regarding special education issues and due process hearings under the Individuals with Disabilities Act as well as in other civil cases.

5. I have authored a number of publications on treatment of juveniles in correctional settings. I am the primary author of the American Academy of Child and Adolescent Psychiatry (AACAP) Policy Statement on Solitary Confinement. I co-edited two monographs on juvenile justice reform for the AACAP, co-edited a book through Cambridge University Press entitled: "The Mental Health Needs of Young Offenders," and most recently edited a book, The Child and Adolescent Psychiatric Clinics of North America entitled: Adjudicated Youth, published in January of 2016. I also wrote the Practice Parameters for child and adolescent forensic evaluations for child and adolescent psychiatry, which was published in the Journal of Child and Adolescent Psychiatry.

6. I have served in a number of professional appointments in my field. From June 2014 to 2015, I served as the Chair Elect of the American Medical Association (AMA) Council on Science and Public Health and from 2015 to 2016, I serve as the Chair. From 2012 to May 2015, I was Chair of the American Psychiatric Association Council on Children, Adolescents and their families, which I had served in for 18 years. From October 2000 to October 2015, I was Chair of the AACAP Juvenile Justice Reform Committee and from 2011 to 2013 I was Chair of the AACAP Assembly.

7. I was on the Board of Directors of the National Commission of Correctional Health Care (NCCHC) from 1997 to 2003. I was appointed chairman of the NCCHC Committee on Juvenile Healthcare from 1999 to 2003. I served as vice-chairman of

the same committee in 1998. This is a major accrediting agency in the U.S. for prisons and jails.

8. I obtained my Doctorate of Medicine Degree, MD, from The Chicago Medical School in 1987 and my Bachelor of Science degree, BS, from Syracuse University in 1983. I append a copy of my curriculum vitae to this report.

III. Record Review:

I. M.D. is currently a 16-year old. Over the past 4 years, he was detained numerous times in the Grays Harbor Juvenile detention facility. Most of the placements were for probation violations. During his placements at the Grays Harbor Juvenile detention facility, M.D. was placed numerous times in solitary confinement. As is typical in many facilities, solitary confinement has other names. Here it was referred to as 24, 48, or 72-hour Lock, Padded Room, room confinement, room restriction, room lock, or isolation. Based on document review, the majority if not all, of solitary confinement used for M.D., was for punitive versus any possible therapeutic benefit. Rationales for placement in confinement were secondary to such things as talking back, passing notes, yelling, using profanity and for the most part, nonthreatening behaviors.

Between the years of 2013 and 2016, M.D, was placed in solitary confinement over 40 times. In aggregate, this totaled over 75 days of placement in solitary confinement.

Most notably while in solitary confinement, M.D. was only given peanut butter and jelly sandwiches to eat.

On March 28, 2016, M.D.'s placement in solitary confinement was in the news. Honorable David L. Edwards, Superior Court Judge, presiding judge in a Grays Harbor Juvenile Court notified Mr. Reyvnaan and Mr. Murphy that they were being reprimanded. Judge Edwards noted, "a detainee at the juvenile facility was put into solitary confinement for an extended period of time and restricted of food and bedding." He then added, "This type of discipline is unacceptable and will not be tolerated." The judge sanctioned and reprimanded both Mr. Reyvnaan and Mr. Murphy. However, M.D. was not released from solitary confinement until April 27, 2016. On April 27th MD was released from the detention facility, between 2013 and 2016, M.D's confinements at the facility were for 30 days, although he had one 60-day placement and one 120-day placement. He also had several placements that were for fewer days. There are numerous examples of M.D's placement in solitary confinement for relatively minimal rule violations. There were some placements where it wasn't clear there was a rule violation. For example, on November 20, 2013 he was placed on a "24-hour Lock" for talking to another youth. Another example was on July 22, 2014. M.D. was placed in a 24-hour Room lock because water had spilled and pooled under the door of his room. As a result of this 24-hour Room lock, his family visit was cancelled. There are numerous other placements in solitary confinement for relatively minor violations. Many of the placements in solitary

confinement in 2013 and 2014 were "24-hour Locks." In 2015, the placements were referred to as a 23/1 for such things as being told to change his attitude and yelling profanities. Another example of solitary confinement was on March 29, 2015, when he was placed in a 24-hour Room lock for kicking over a backpack. On April 1, 2015 and for having numerous solitary confinements, M.D. was placed in the "Padded Room" for being disruptive. He refused verbal commands to be quite and swore at a staff member. It had been noted that placement in the "Padded Room" was unwarranted as being disruptive does not qualify for this placement. There was no description of risk of harm or other reason to be placed in this room. The room had been described as a somewhat foul smelling damp room that has a certain fecal smell to it. In addition to being dirty, there was a description of food and blood spatters on the walls and floor. At one point, the Plaintiff had requested permission to clean the grate. Staff asked if he would "eat the feces." Reportedly staff laughed at him when he said no and stated that in that case they would not allow him to clean the grate." On one description, the toilet is essentially a grate in the floor with dried pieces of feces left on it.

During the month of April 2015, M.D. was placed in solitary confinement on 6 occasions. In May he was placed on 4 occasions in solitary confinement. He had repeated placements in June and July as well. On July 12, 2015, M.D. was given a 48-hour Room confinement due to his bad attitude. There were numerous other examples of solitary confinement going into the fall of 2015. On February 21, 2016 there was an incident where M.D. was placed in solitary confinement for over a month, which included 8 days in the "Padded Room." Most of the issue had to do with banging and yelling and trying to involve other youth to participate in banging and yelling. There was no sense of violent physical behavior which occurred as a result.

Most notably, while in solitary confinement (Isolation in the Padded Room), M.D. was only given peanut butter and jelly sandwiches to eat. The staff was specifically instructed to not give milk or any snacks. Even though the Grays Harbor County Juvenile Detention Center Policy Manual specifically describes in their policy to give nutritional meals, this was clearly violated. Essentially, M.D. was given non-nutritional meals and limited food as a punishment. He was essentially being starved.

Even after Judge Edwards confirmed on March 28, 2016 about M.D.'s placement in solitary for this extended period of time and his restriction of food and bedding and the reprimand given, M.D. remained in solitary confinement.

The Grays Harbor Juvenile Detention Center Policy Manual was reviewed. Within the Procedures, they state they will respect and protect the civil and legal rights of all youth. They will serve each case with appropriate concern for the youth's welfare. They will promote mutual respect within the profession and to the improvement of its quality of service. Described in their policy manual 12.5 the youth are responsible for cleaning their rooms on a daily basis, at no point to do

state they will restrict the youth's ability to clean their room or require them to eat excrement. In Chapter 10, under Medical/Mental Health Services they reported that "Youth that are in crisis or experiencing issues related to mental health problems will be referred to mental health treatment service providers." One would assume that placement into a "Padded Room" for an extended period of time, would by definition include youth suffering from some type of acute mental health problem. There was a single mental health assessment regarding acute risk of harm to self. M.D. had o further mental health treatment. Since release, M.D. has been diagnosed with an Anxiety Disorder. He also has a Substance Use Disorder. M.D. ic currently on Venlafaxine (an antidepressant) and Hydroxyzine (an antihistamine) that may be helpful for anxiety).

IV. Opinion:

1. My opinions are based on the review of the available information with the caveat that I have not evaluated M.D. or assessed the facility. Nonetheless, I can comment on the conditions on which he was held through his numerous placements between 2013 and 2016, based on the information provided to me through the Washington ACLU, including Policies and Procedures and the Grays Harbor Juvenile Detention Facility Policy Manual, and M.D.'s detention records, as well as filings for the case at hand. My view of this, as well as the impact the research has shown on the child placed in this type of isolation.

2. In my view, what M.D, has been subjected to during this period is solitary confinement. He was isolated the great majority of the day, he was not allowed to be educated and in some situations, barely fed, certainly not in any type of nutritional way. The idea of only serving a child a peanut butter and jelly sandwich, with nothing more than water, no snacks or other nutrients is inhumane and in my opinion, torturous in nature.

3. Research has shown that youth that are in correctional facilities have a 60 to 70 percent likelihood of having underlying severe mental health issues. (Teplin et al.) Many of these children have underlying learning disabilities and other deficits impacting their basic educational needs. To isolate them from the general population and their typical day-to-day activities, will only worsen underlying mental health issues, in particular increase the likelihood of depression and anxiety symptomatology. Youth, not uncommonly will develop a progressive lack of trust with adults and have more difficulty being able to work with them as time progresses. M.D.'s behavior certainly seems consistent with this. The types of terminology used by the facility in my opinion, are synonymous with using the term solitary confinement.

4. The youth was placed in solitary confinement. No youth should be placed in solitary confinement. If a youth is placed in solitary confinement, they should be evaluated by mental health to determine whether or not there could be a mental health origin to the struggles which were occurring. The evaluation should not just address if they are suicidal. Most certainly if it is a repetitive process or as in one for

M.D., which resulted in him being placed in a "Padded Room" most certainly should have had mental health interventions, as this type of placement is typically when one is at acute harm to self or others.

5. The use of solitary confinement, in association with no education and minimal mental health interventions, will likely increase recidivism.

6. Youth in correctional facilities need assistance with education, academically and otherwise so that they have some hope to complete their education upon release. The more they are isolated and have no education, the less likely it is that this will occur. The American Academy of Child and Adolescent Psychiatry (AACAP) has a Policy Statement on solitary confinement of juvenile offenders that has been in place since April of 2012. I was primary author of this policy statement. The American Medical Association (AMA) has a Policy Statement against the use of juvenile solitary confinement, in place since 2016. The National Commission of Correctional Healthcare (NCCHC), a major accrediting agency of jails and prisons across the United States, has a policy in place regarding being against solitary confinement of juveniles. They state, "Those in solitary confinement often experience sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs... correctional health professionals duty is to the clinical care, physical safety and psychological wellness of their patients. Correctional health professionals should not condone or participate in cruel, inhumane or degrading treatment of inmates."

Within the AACAP Policy Statement on solitary confinement, they define solitary confinement as the placement of an incarcerated individual in a locked room or cell with minimal to no contact with people other than staff of the correctional facility. It is used as a form of discipline or punishment. There is no benefit to solitary confinement. As is seen in this facility, solitary confinement for M.D, was used solely for the purpose of a punitive intervention. There was no benefit or therapeutic component to this. The potential psychiatric consequences of solitary confinement are well recognized and include depression, anxiety and psychosis. [2]

7. There are at times, acute medical or mental health reasons to separate someone and to watch them closely, perhaps in a medical wing, either just returning from or planning on going to a hospital, or perhaps with infectious diseases. These youth should be under the close watch of a physician and/or psychiatrist, dependent upon the situation at hand.

Solitary confinement is different from what is termed a "time out," which is typically some type of separation from the general population for one hour or less. This type of intervention has been quite effective in minimizing longer levels of isolation. This, in combination with appropriate mental health interventions and de-escalation techniques, have been remarkably successful in minimizing and

eliminating solitary confinement as I am observing in the State of Illinois, in a current consent decree.

The United Nations and the United Nations Rules for the Protection of Juveniles Deprived of Their Liberty established minimum standards for the protection of juveniles in correctional facilities (approved in December of 1990) and supported my many countries, specifically prohibit the solitary confinement of juvenile offenders. Section 67 of the Rule states, "All disciplinary measures constitute cruel or inhumane or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned."

8. It is my opinion that the regime M.D. was subjected to between 2013 to April of 2016 is solitary confinement. Based on the information provided, it appears that M.D. would typically spend either 23 or 24 hours a day within his cell, varying from a single day to weeks of solitary confinement.

9. Solitary confinement can be dangerous to anyone, but juveniles are a group particularly vulnerable to a substantial serious harm from solitary confinement because juveniles are still developing socially, psychologically and neurologically, they are especially susceptible to psychological harm when they are isolated from other people. Research suggests removing them from their regular routines, school, mental health, treatment and opportunities for interaction with peers can result in long-term lack of trust, hypervigilance and paranoia.

10. Solitary confinement negatively impacts juveniles by perpetuating, worsening, or precipitating mental health concerns, including but not limited to, Post Traumatic Stress Disorder, Psychosis, Anxiety Disorders, Major Depression, Hypervigilance, Agitation and a general lack of trust, suicidal ideations, suicidal intent, self-mutilation and suicidal behavior.

11. These mental health concerns can cause long-term harm. Solitary confinement can lead to chronic conditions like depression, which in teenagers can manifest as anger or as self-harm. (Suicide is the third leading cause of death in this age group.) In addition, children who experience depression/anxiety in their teenage years are at high risk of presenting with these diagnoses again. Damage associated with low self-esteem, vegetative features, hopelessness, associated with depression, can similarly be longstanding. Depression has a 10 to 15 percent mortality rate associated with it, and solitary confinement increases the risk of suicide substantially, compared to the general population.

12. Solitary confinement of juveniles can also lead to long-term trust issues with adults, including paranoia and anger directed at others. This makes it difficult to create a trusting, therapeutic relationship and can lead to noncompliance with

treatment in the future making it hard for people to get the help they need to address the mental health concerns resulting from solitary confinement.

13. Medical research on adolescent brains shows that juveniles are more vulnerable to the risk of long-term harm. In the adolescent brain, the connections between the frontal lobe and the mid-brain have not fully developed. The mid-brain, which is the part of the brain responsible for the flight or fight response, is firing away. If an adolescent is traumatized in certain ways, it can cause certain changes in brain development and can create a higher risk of developing permanent psychiatric sequelae like paranoia and anxiety. Trauma, such as that induced by solitary confinement, especially prolonged, have a high likelihood of causing these permanent changes. Juveniles in jails (or detention centers) are vulnerable to substantial risk of serious harm from solitary confinement.

14. Juveniles with mental illness have increased risk of serious harm when placed in solitary confinement. People with mental illness already have deficits in their brain structure or biochemistry. They already have weakened defense mechanisms, are at a higher risk for mental health sequelae and are more susceptible to the significant trauma of social isolation. The trauma of social isolation can occur for those with mental illness will be more significant and longstanding than for those without a mental illness. A professional consensus is better reflected in longstanding U.S. accreditation standards for isolation in psychiatric hospitals. The Joint Commission, the most commonly used accreditation agency for psychiatric hospital systems, limits the use of seclusion to the least amount of time possible for the immediate protection of an individual, and situations where less restrictive interventions have been ineffective. These standards require that if a person is placed in seclusion of any kind, after one hour a physician must assess their wellbeing.

15. In conclusion, keeping a child incarcerated in the conditions that M.D. was held for a repetitive period over multiple years on and off, creates a significant risk of harm to the child. In my view, the appropriate de-escalation techniques, education and comprehensive mental health interventions will diminish and in my experience, eliminate the need for solitary confinement.

To clarify, a 23/1 or a 22/2 "isolation" for 24 hours, 48 hours or 72 hours, are all forms of solitary confinement. This could include such things as room restriction, a lock down administrative hold, a behavioral intervention or seclusion. They may have different names to them, but this is solitary confinement. For the same reasons you would never do this to a child in the community, you would never do this to a child who is in a juvenile detention facility.

Negative reinforcement of bad behavior does not decrease or stop bad behavior. It has no long-term benefit. Positive behavioral plans and appropriate de-escalation techniques will have a far more long lasting impact. This requires well trained staff and involvement of mental health.

It is possible in certain situations to have a behavioral dorm. These dorms have to have a positive behavior component, daily mental health interventions, educational involvement and quick progression and therapeutic benefit for youth. These types of dorms should never be used for punitive purposes.

16. The use of "time outs" which are typically one hour or less, can be remarkably helpful. This can often assist with intervening an acute issue at hand, such as using bad language or oppositional behavior and then be able to quickly reintroduce the youth to the general population. Again, to focus on a positive behavioral plan will assist with more consistent positive behavior.

The frequency, and at times length of solitary confinement for M.D., in my opinion can be very detrimental to M.D.'s underlying mental health with both short and long-term ramifications as described.

The dire restrictions placed on M.D. from March to April of 2016 where he was given peanut butter and jelly sandwiches three times a day and water, with nothing else, is at best torturous. I have never seen a process where they are essentially starving a youth and giving the, a poor nutritious diet to punish them.

This facility needs to closely look at their policies and procedures. They need to develop de-escalation techniques, better mental health interventions and a way to eliminate solitary confinement. They need to develop a consistent behavioral plan. Staff needs to have appropriate training and implementation. There needs to be collaborative work with mental health and security staff for appropriate interventions.

Louis J. Kraus, MD

References:

1) Archives General Psychiatry, 2002, December. 59(12)1133-43. Psychiatric Disorders in Youth in Juvenile Detention, Teplin LA, at el
2) Grassin, Stewart, (Psychiatric Effects of Solitary Confinement. Journal of Law and Policy.) (2006, 325-383.)