IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARKELLE SETH, **Old North Carolina Highway 75** **Butner, N.C. 27509** **Plaintiff,** **vs.** **The DISTRICT OF COLUMBIA,** **Karl A. Racine, Attorney General** **Office of the Attorney General** **441 4th Street, N.W., Suite 630 South** **Washington, D.C. 20001** **The D.C. DEPARTMENT ON DISABILITY SERVICES,** **250 E Street, S.W.** **Washington, D.C. 20024, and** **ANDREW REESE, in his official capacity as Director of the D.C. Department on Disability Services,** **250 E Street, S.W.** **Washington, D.C. 20024** **Defendants.**	)	**CIVIL ACTION NO:**

AMENDED COMPLAINT

Markelle Seth, by and through his attorneys, brings this Amended Complaint against the District of Columbia; the D.C. Department on Disability Services ("DDS"); and Andrew Reese, in his official capacity as Director of DDS for violating Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12131 *et seq.* ("ADA"), Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) ("Section 504"), the D.C. Human Rights Act of 1997, D.C. Code § 2-1401.01 *et seq.* ("DCHRA"), and the Citizens with Intellectual Disabilities Civil Rights

Restoration Act of 2015, D.C. Code § 7-1301.01 *et seq*. ("CIDA").

I. INTRODUCTION

1. The District of Columbia, by and through DDS[1], the agency responsible for providing services to D.C. citizens with intellectual and developmental disabilities, has abandoned Markelle Seth ("Markelle")—a young man deemed eligible for Defendants' services and found by a judge of this Court to have "the auditory comprehension of a first-grade student"—leaving him to languish indefinitely in a federal prison in North Carolina in violation of state and federal law.

2. Markelle is a D.C. resident with intellectual disability[2] currently in federal prison despite not having been convicted of any crime and despite Defendants' obligation to provide him with services and treatment in the most integrated setting appropriate to his needs.

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[1] All references to DDS refer to DDS, its Director, Andrew Reese, and the District of Columbia. DDS is acting on behalf of the District of Columbia as the government agency charged with providing services for D.C. citizens with intellectual and developmental disabilities.

[2] Plaintiff uses the term "intellectual disability" in place of "mental retardation" except when directly quoting others or referencing names of organizations. Although the latter term appears in some evidence, case law, and statutory language, it is offensive to many persons and has been replaced by more sensitive and appropriate terminology. *See* Rosa's Law, Pub. L. No. 111-256, 124 Stat. 2643 (2010) (changing entries in the U.S. Code from "mental retardation" to "intellectual disability"); *Hall v. Florida*, 134 S. Ct. 1986, 1990 (2014) ("This opinion uses the term 'intellectual disability' to describe the identical phenomenon. This change in terminology is approved and used in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, one of the basic texts used by psychiatrists and other experts . . . ." (citations omitted)); Robert L. Schalock et al., *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 Intellectual & Developmental Disabilities 116 (2007). This complaint also uses person-first language, describing the person before the disability, consistent with D.C. Code § 2-632 (People First Respectful Language Modernization Act of 2006).

3. Markelle has now endured over four years of confinement in local and federal jails and prisons, despite Defendants' legal obligation to provide services and treatment to Markelle via civil commitment pursuant to the D.C. statute that governs situations exactly like this one, and corresponding federal law obligations to accommodate Markelle's intellectual disability in the most integrated setting appropriate. DDS's own prior director acknowledged, and continues to stand by, the agency's legal obligations in this case, noting that "the decision by DDS to allow Mr. Seth to languish and regress in federal custody rather than carry out its mission and mandate [is] inexplicable other than as a matter of discrimination." (Declaration of Laura L. Nuss ¶ 24 [hereinafter Nuss Decl.] (attached hereto as Exhibit 1).)

4. Indeed, DDS's *own* retained expert stated that Markelle can and should be returned to the District, where he can be placed in a supervisory program without posing a danger to himself or others. DDS—ignoring its own expert's recommendation—has reneged on its legal commitment to do so, despite having both the legal obligation and practical capacity to do so. Markelle does not seek to be released unsupervised in the District of Columbia. Rather, DDS is obligated to place him in a supervised program, which can and would effectively address the fact that, in the absence of such supervision, he could present a risk of engaging in sexually inappropriate behavior with minors.

5. Because of his disability, Markelle is entitled, under federal and D.C. law, to receive from Defendants supervised disability-related services in the most integrated setting appropriate for him in his home community. Defendants provide these services to District residents with mental illness but fail to do so for D.C. residents with intellectual disability. The District can provide these services in a manner consistent with the requirements of public safety as it is charged to do under law. Defendants' actions violate the ADA, Section 504, DCHRA,

and CIDA, and should be enjoined.

6. Defendants have within the District's Medicaid waiver system all the services necessary to safely and effectively serve Markelle in the community. Supporting individuals with intellectual and developmental disabilities ("I/DD") who have committed criminal offenses, including sexual offenses, is common practice throughout the United States.[3] People in Markelle's situation can live successfully in the community without presenting a harm to others, provided they receive appropriate training, treatment, and supervision, they can learn appropriate sexual behavior. In light of the development and implementation of safe and successful community-based treatment, services models and evidence-based practices, states across the country serve people with disabilities in the community. Defendants have available services sufficient to safely serve individuals with I/DD and complex behavioral needs, including problematic sexual behaviors. In addition to being a violation of state and federal law, Defendants' failure to meet its obligation to serve Markelle in this case flies in the face of decades of evidence-based research and successful practice in the field of disability services, finding that people with I/DD in institutional settings can be safely served in the community, even where they may present problematic behaviors. (*See* Thaler Decl. ¶¶ 3-4, 17, 19-20, 22, 26, 31; Declaration of Robert L. Denney ¶¶ 8, 10 [hereinafter Denney Decl.] (attached hereto as Exhibit 3); Nuss Decl. ¶¶ 16, 21.)

7. On October 3, 2014, when Markelle was twenty years old, he was charged in

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[3] For instance, in Pennsylvania alone, over 300 individuals with I/DD and a history of having committed a sexual offense are being successfully supported by provider agencies in the community throughout the Commonwealth. (Declaration of Nancy Thaler ¶ 26 [hereinafter Thaler Decl.] (attached hereto as Exhibit 2).)

Superior Court for the District of Columbia with sexual offenses involving children who lived in his household. Almost immediately, it became clear that Markelle, who had previously been found incompetent in a juvenile proceeding, had an intellectual disability and likely was not competent for trial. On October 16, 2014, the U.S. Attorney's Office simultaneously dismissed the Superior Court prosecution and initiated new charges in federal district court, styling the allegations to allege a federal offense, production of child pornography. Upon information and belief, the U.S. Attorney's Office later acknowledged that the move to federal court was made specifically in order to avoid a *Jackson* finding[4] being entered in D.C. Superior Court that would trigger the District of Columbia civil commitment process.

8. In federal court, as in Superior Court, it was quickly recognized that Markelle is an individual with intellectual disability and a series of evaluations ensued to determine his competency to stand trial. While those evaluations were pending, Markelle, through his counsel, applied to DDS for a determination of his eligibility for supervised disability-related services

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[4] A *Jackson* finding is a reference to a court's finding, pursuant to *Jackson v. Indiana*, 406 U.S. 715 (1972), that a defendant incompetent to stand trial, and unlikely to become competent, cannot be confined indefinitely. In *Jackson*, the Supreme Court held that a defendant committed solely on the basis of incompetency "cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." *Id.* at 738. Prior to this ruling, virtually all states allowed the automatic and indefinite commitment of incompetent defendants. The Court ruled that holding defendant Jackson (who had intellectual disability and was deaf) to a "more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses" deprived him of equal protection. *Id.* at 716. The Court also concluded that, "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Id.* at 738. Thus, the ruling identified the necessity of either initiating civil commitment or releasing a defendant whose competence is not likely to be restored. *Id.*

available through the District's Medicaid program. That request sought to ensure that, if Markelle were found by the court to be incompetent to stand trial and unlikely to be restored to competency, he would be eligible to be served in the most integrated setting appropriate in his community via the District of Columbia's civil commitment mechanism and in compliance with federal law, rather than remaining in prison without having been convicted of a crime.

9. In 2015, DDS began a comprehensive evaluation of Markelle. Based on his well-documented history of intellectual disability, he was found eligible for DDS's services. The agency next identified and referred him to an existing DDS service provider, which accepted him and began to develop a program to provide him with services and treatment in the community once his competency proceedings were concluded. DDS later retained an expert to determine if the recommended program could properly meet Markelle's needs while protecting the safety and security of the community. During that process, which extended through 2017, DDS repeatedly and unequivocally informed Markelle and his counsel, in writing and orally, that in accordance with its obligations under state and federal law it planned to commence civil commitment proceedings in order to provide him with supervised community-based services[5] through a selected provider, if and when this Court were to conclude that Markelle was incompetent to stand trial on the pending criminal charges and dangerous. (Nuss Decl. ¶¶ 6, 14, 18.)

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[5] CIDA defines "community-based services" as "non-residential specialized or generic services for the evaluation, care and habilitation of persons with intellectual disabilities, in a community setting, directed toward the intellectual, social, personal, physical, emotional or economic development of a person with an intellectual disability. Such services shall include, but not be limited to, diagnosis, evaluation, treatment, day care, training, education, sheltered employment, recreation, counseling of the person with an intellectual disability and his or her family, protective and other social and socio-legal services, information and referral, and transportation to assure delivery of services to persons of all ages who have intellectual disabilities." D.C. Code § 7-1301.03(5).

10. DDS was aware that if it did not move to take responsibility for Markelle, he would be subject to the federal civil commitment process and continued incarceration in the BOP, an outcome they indicated they agreed should be avoided. (E-mail from Mark D. Back, Gen. Counsel, DDS, to Lisa Greenman et al. (May 12, 2017, 16:03 EST) [hereinafter M.Back E-mail 1] (attached hereto as Exhibit 4).)

11. In recognition of its obligations under CIDA to provide supports and services for individuals with intellectual disability precisely in these circumstances, DDS identified an appropriate structure and plan for comprehensive supervised habilitative services in the community that would meet both Markelle's needs and the needs and interests of the community, including any danger that would be posed if Markelle were placed unsupervised into the community. DDS's expert issued a series of detailed reports containing a comprehensive plan to both serve and supervise Markelle outside of correctional facilities and within existing supervised programs with which DDS has contracted for services for other individuals with intellectual disability charged with sexual or other serious offenses, who may present a danger to the community if unsupervised.

12. In December 2016, based on multiple evaluations described below and a two-day evidentiary hearing, this Court found that Markelle was not competent to stand trial due to his intellectual disability and that there was no reasonable likelihood that he would ever become competent to stand trial. Following that finding, the Court was obligated, pursuant to 18 U.S.C. §§ 4246, 4248, to send Markelle back to BOP to determine (1) whether he was dangerous as a result of a mental condition and (2) whether his home state of D.C. would take responsibility for his care and custody. It was anticipated by all, including counsel for DDS, who had attended Markelle's competency hearing and each of the prior status conferences in federal district court,

that the answers to both of these questions was yes. At that point, pursuant to CIDA and its express acknowledgment of its obligations to Markelle, DDS should have begun civil commitment proceedings in the D.C. Superior Court.

13. Instead of following through on its commitment to Markelle, DDS reneged on its prior explicit commitments, ignored the recommendations of its own expert, and abdicated its legal responsibility to Markelle. As a result, Markelle remains incarcerated in a federal prison even though he has not been and cannot be convicted of the crime for which he was charged. Because DDS improperly refused to serve Markelle, the Warden of FMC Butner was required to file a certificate of dangerousness stating that "suitable arrangements for State placement are not available." As a result, the United States Attorney General filed a petition for *federal* civil commitment in the Eastern District of North Carolina which that court subsequently granted; as a result, Markelle faces indefinite incarceration in the Federal Bureau of Prisons ("BOP").

14. While Markelle was at Butner for his dangerousness study, DDS was fully aware of the likelihood that he would be found dangerous. Dangerousness was not a new fact or a surprise; it was in fact the premise and foundation for all of the planning that had been done for his DC commitment. (*See* Nuss Decl. ¶ 6.) Markelle's history and the allegations regarding his conduct with children were well known by DDS. (*See id*.) The mechanics of the federal civil commitment had been discussed with Markelle's criminal defense counsel and DDS was aware that the BOP would cooperate with DDS, as called for under the federal statute, when the District had finalized planning for Markelle's care and custody.

15. During his federal incarceration, Markelle has been confined almost continuously in either disciplinary segregation or administrative detention. Regardless of semantics, the experience for Markelle has been solitary confinement: confinement to his cell for a minimum of

22 hours each day, and frequently longer. Although in 2017 he periodically cycled back and forth between the prison's general population and confinement in such "segregation," records show that since early 2018, he has not been housed in general population at all. Markelle is in near-continuous solitary confinement because his intellectual disability—which includes poor executive functioning skills and impulsivity, among other challenges—makes it difficult for him to follow institutional rules, leading authorities to frequently discipline him by placing him in solitary confinement. (Declaration of Marisa C. Brown ¶¶ 37-39 [hereinafter Brown Decl.] (attached hereto as Exhibit 5); Denney Decl. ¶ 18.) Overall, he is unable to participate in any meaningful programming. For example, the "pet therapy" Markelle receives consists of him reaching through the food slot of his cell to pet dogs. (Denney Decl. ¶ 19.) Markelle also receives a weekly check-in from a mental health counselor, who speaks to him through the window on his cell door.

16. Markelle's experience in prison is predictable. It is well established that the problematic behavior of individuals with I/DD often worsens within the rigid confines of prison life. People with I/DD may have considerable difficulty understanding the purpose behind rules and the consequences for violating rules, and be frightened by the lack of supportive behavior from prison personnel. For those who cannot effectively communicate their dissatisfaction verbally, they may act out how they are feeling in ways that do not conform with the rules. For those who have experienced trauma, such as Markelle, this environment can be particularly destructive. (Thaler Decl. ¶ 23; Denney Decl. ¶ 9.)

17. Markelle is a young man who began life at three months of age removed from his family and placed in foster care. He has experienced abuse and abandonment, and the absence of positive role models or adult guidance. His intellectual disability limits his ability to understand

the world around him without professional guidance and supervision. Life in a correctional facility compounds his trauma, and will exacerbate his existing anxiety and intellectual disability stemming from abuse, head trauma and neglect. (Thaler Decl. ¶ 32.) If Markelle continues to be incarcerated, he will likely have continuing behavior problems resulting in increased levels of frustration or anger and a growing record of infractions, making it less likely that prison staff will ever agree to his release. Markelle is, thus, currently stuck in a Catch 22: the longer he remains in prison, the more harm he will experience and the more behavior problems he is likely to develop. (Thaler Decl. ¶ 34; Denney Decl. ¶ 9; Nuss Decl. ¶ 23.)

18. Should Markelle be provided rehabilitative services in the District, DDS and provider staff will be able to help him address these deficits in constructive ways, including via de-escalation techniques. His failure to advance in his social skills within the prison environment is not indicative of his potential for success within a community-based program that is tailored to his individual needs. (Denney Decl. ¶ 20.) Community settings can be much more easily individualized and designed to avoid triggers that may cause an individual's challenging behaviors. (Thaler Decl. ¶¶ 24-25.) In contrast, in the rigid prison environment, Markelle only has the opportunity to fail. (Brown Decl. ¶ 40.) This continued segregation is likely to have a negative long-term impact on Markelle's mental health and lead to the deterioration of his daily living skills. (*Id*. ¶¶ 37-38.) The vicious cycle Markelle is currently experiencing of triggers and punishments followed by triggers and more punishment is precisely what justifies prioritizing people in Markelle's situation for community placements rather than prisons. (Thaler Decl. ¶

33.) Butner's Federal Medical Center[6] is a prison first and cannot provide Markelle with what he needs, as the design, service provision, and staffing models of Butner virtually ensure his continued failure and incarceration by forcing him to remain in an environment in which he only has the opportunity to learn additional criminal style behaviors, rather than the pro-social behaviors required to effectively function in society. (Denney Decl. ¶¶ 9, 21.)

19. As a direct result of DDS's failure to initiate civil commitment proceedings in the District of Columbia where he could receive the supervised habilitative services to which he is entitled, Markelle now endures *federal* civil commitment—including regular solitary confinement—in a federal prison for the foreseeable future, if not for the rest of his life.

20. Authorities for the BOP have stated that they would send Markelle back to the District of Columbia, as they are required to do by federal statute, if the appropriate local agency were prepared to take responsibility for his supervised care and treatment.

21. DDS has both a mandate and the capacity to provide Markelle with the services and supports he needs to be supervised successfully in the community. (Brown Decl. ¶¶ 5, 22-24, 33-36, 41; Nuss Decl. ¶ 1.) DDS's own retained expert has recommended it do so in this case, and it has created specific plans for the supervised care and custody of Markelle. In other states throughout the country, people in Markelle's situation are routinely served in community-based settings. Community safety is achieved through very close supervision with 24-hour staff and few other residents. (Thaler Decl. ¶ 26; Denney Decl. ¶ 10.) Because the District is failing to fulfill its legal mandate to provide such services to Markelle, his civil rights are being violated,

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[6] Markelle was transferred to Federal Medical Center, Devens, on or around October 25, 2018, while counsel was finalizing this filing. Accordingly, all references to conditions in federal prison and FMC Butner include his current incarceration at FMC Devens.

his mental and physical health are being damaged, and his safety and future are at risk. (*See* Brown Decl., ¶ 41; Denney Decl. ¶¶ 9, 24; Nuss Decl. ¶ 24.)

22. Upon information and belief, the District of Columbia, through the Department of Behavioral Health, regularly provides community-based supervisory services to D.C. residents who are found not competent to stand trial due to mental illness, but fails to do so for those with intellectual disability, such as Markelle. D.C. law provides distinct mechanisms to civilly commit citizens who are found not competent to stand trial for one of two reasons: mental illness or intellectual disability. The District freely serves the former group, citizens found not competent to stand trial with a primary diagnosis of mental illness, pursuant to the Ervin Act, Mental Health Civil Commitment Act of 2002, D.C. Code § 21-501 *et seq.* ("Ervin Act"), which charges the District's Department of Behavioral Health with this responsibility. The Ervin Act's counterpart, CIDA, similarly charges DDS with providing services for citizens with intellectual disability found not competent to stand trial due to their intellectual disability. Despite having a statutory mandate to serve these citizens and the resources to do so, DDS has failed to act for Markelle. As explained in further detail below, although D.C. law provides, through the Ervin Act and CIDA, similar mechanisms to serve individuals found incompetent, the District's implementation of those laws through DBH and DDS provides actual commitment and services only for those diagnosed with mental illness who are provided for by DBH, and abandons those with intellectual disability who can only look to DDS.

23. DDS is expressly tasked with serving individuals who present a potential danger to the community if unsupervised, and DDS has been aware from the outset of its review that if he were not supervised, Markelle could present a risk to himself or others. Indeed, CIDA specifically provides that *only* individuals who present the highest level of risk (defendants

charged with a crime of violence or a sex offense) meet the criteria for civil commitment. The statute thus charges DDS with responsibility for a challenging population. The failure by DDS to fulfill its mandate as to individuals with intellectual disability, when similarly situated individuals with mental illness are provided with supervisory habilitative services, constitutes improper discrimination on the basis of disability under state and federal law.

24. Finally, the remedy sought here is appropriate because civil commitment is primarily a state, not a federal, function. Federal civil commitment exists only as a last resort for dangerous individuals for whom no state provision for care and custody exists. D.C. civil commitment allows for the provision of person-centered services and supports in the community, while federal civil commitment is akin to a lifelong prison sentence. Moreover, because DDS is able to care for and supervise Markelle, its failure to do so violates federal and D.C. law, and it cannot abdicate its responsibility to the federal government.

II. PARTIES

25. Plaintiff Markelle Seth is an individual with intellectual disability currently confined to federal custody after being found incompetent to stand trial and not capable of being returned to competency. Markelle is a resident of the District of Columbia.

26. Defendant District of Columbia is the jurisdiction that oversees DDS and the Department of Behavioral Health, both of which are city government agencies.

27. Defendant DDS is the D.C. government agency responsible for providing information, approval, placement, oversight and coordination, and funding for services to people with intellectual disability in the District.

28. Defendant Andrew Reese is the Director of DDS. In this role, Defendant Reese oversees the administration of the agency.

29. Whenever Plaintiff uses the word "Defendants" in this Amended Complaint, he means all Defendants, their agents, employees, and all those acting in concert with them or at their direction.

III. JURISDICTION AND VENUE

30. This Court has general jurisdiction over this matter pursuant to 28 U.S.C. § 1331 (federal question jurisdiction). This court has supplemental jurisdiction to consider state law claims under 28 U.S.C. § 1367.

31. Venue is proper in this Court pursuant to 28 U.S.C. § 1391.

IV. FACTS

A. Markelle Has Experienced Instability, Trauma, and Intellectual Disability.

32. Markelle was born in November 1993, and raised in the District. He was removed from his mother's care through neglect proceedings commenced in D.C. Superior Court when he was three months old. When the District's Child and Family Services Agency ("CFSA") took custody of Markelle, he weighed less than he did at his birth. He was then placed in St. Ann's Infant Home, an orphanage, rather than a family home. Markelle spent time in two separate foster care homes before he was placed with his father in 1997, at the age of three.

33. Markelle experienced childhood seizures from infancy until he was about six years old. Markelle had significant delays in reaching developmental milestones, including not being able to sit up on his own until age four and not being able to crawl until age five. He also had significant speech delays.

34. Markelle also experienced significant challenges in school. He was identified as having a disability and placed in special education classes during elementary school. He was

bullied by other students because of his disability. At some point during his attendance in a D.C. Public School, Markelle received an Individualized Education Program ("IEP") under the Individuals with Disabilities Education Act ("IDEA") that focused on supporting his learning activities across a broad array of areas, including math, reading, and writing, providing speech and language services, and behavioral supports.

35. For middle school and high school, Markelle was placed in Options Public Charter School ("Options"), a notoriously dysfunctional, segregated special education school in the District. In twelfth grade, Markelle's standardized testing scores reflected math skills at a fourth-grade level, reading skills at a second-grade level, and writing skills at a first-grade level.

36. The school deemed Markelle unable to earn a high school diploma and placed him on the certificate track. Although the federal IDEA entitled him to receive a full complement of special education services until he turned twenty-two, Options encouraged Markelle to leave school at age eighteen. This action deprived him of his full special educational entitlement. Markelle should have been eligible for DDS services upon his exit from school, but he was not offered such services until his counsel insisted upon them, following his arrest. Defendants washed their hands of all responsibility to assist Markelle and seek to continue to avoid their responsibility.

B. Markelle Is an Individual with Intellectual Disability.

37. As defined by the American Association on Intellectual and Developmental Disabilities ("AAIDD") and adopted by the District of Columbia, the definition of intellectual

disability has three prongs: (1) significantly impaired intellectual functioning;[7] (2) adaptive behavior deficits in conceptual, social, and/or practical skills; and (3) onset of the disability before age eighteen. AAIDD, *Definition of Intellectual Disability*, http://aaidd.org/intellectual-disability/definition (last visited Oct. 25, 2018); *see* D.C. Code § 7-1301.03(2), (15A).

38. In a letter dated March 20, 2015, DDS expressly found Markelle "eligible to receive services through the DDA service delivery system" as a person with intellectual disability.

39. Markelle receives federal Supplemental Security Income benefits based on his disability, and he has been evaluated and found eligible for services as an adult with intellectual disability by Defendant DDS. Multiple evaluations over many years have confirmed this diagnosis. In finding him incompetent for trial, *see infra* paras. 37-40, a judge of this Court found that Markelle's full scale IQ "hovers somewhere between fifty-three and sixty-five, landing at the bottom one percent of his age group regardless of where in that range it

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[7] An IQ of approximately 70–75 or lower demonstrates significant impairment of intellectual functioning. *See* AAIDD, *Intellectual Disability: Definition, Classification, and System of Supports* (11th ed. 2010) [hereinafter Classification Manual]; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013). The U.S. Supreme Court has rejected arbitrary cutoffs for IQ scores in making the intellectual disability determination, stating that "[i]ntellectual disability is a condition, not a number" and [c]ourts must recognize, as does the medical community, that the IQ test is imprecise," *Hall*, 134 S. Ct. at 2001, and the standard error of measurement "means that an individual's score is best understood as a range of scores on either side of the recorded score." *Id.* at 1995. Markelle's IQ score range of 53–65, *see supra* para. 31, unequivocally meets the first prong of the definition of intellectual disability.

falls."[8] Magistrate Judge Harvey's Report and Recommendation at 33, *United States v. Seth*, No. 14-mj-608 (BAH/GMH) (D.D.C. Dec. 1, 2016), Dkt. 75 [hereinafter Magistrate's Report] .

40. One component of Markelle's intellectual disability diagnosis is his poor executive functioning skills. Executive functioning refers to self-regulating and control functions of the brain that direct and organize behavior. Markelle experiences problems in self-inhibiting, self-monitoring, self-evaluating, flexible problem-solving, and self-awareness. (Brown Decl. ¶ 40.) Markelle's intellectual disability can, at times, also result in a short attention span, poor frustration tolerance, impulsivity, and challenges foreseeing consequences. (Denney Decl. ¶ 18.) In addition, some individuals with I/DD who exhibit inappropriate sexual behaviors, including Markelle, lack information about or opportunities for appropriate sexual expression and intimacy, lack social skills and information about appropriate sexual behavior, and misunderstand social boundaries and rules. At times, some individuals with I/DD may engage in sexual activity with individuals who are not of an appropriate age, which is known as "age discordant sex play." (Thaler Decl. ¶ 21.)

C. Markelle Was Arrested and Charged but This Court Determined Markelle is Not Competent to Stand Trial.

41. Markelle was arrested on October 2, 2014, and on October 3, 2014, he was charged in D.C. Superior Court with sex offenses involving children in his household. The impact of Markelle's disability on his competence quickly became obvious to the parties and the court, at which point the U.S. Attorney's Office, in an effort it later acknowledged was intended

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[8] Magistrate Judge Harvey's conclusions were adopted without objection from either party by Chief Judge Beryl Howell on December 22, 2016. Order, *United States v. Seth*, No. 14-mj-608 (BAH/GMH) (D.D.C. Dec. 22, 2016), Dkt. 77 [hereinafter Dec. 22, 2016 Order].

to avoid Superior Court competency and commitment proceedings, dismissed the Superior Court prosecution and began a new prosecution against Markelle in federal court. On October 15, 2014, a complaint was filed in the U.S. District Court for the District of Columbia charging Markelle with one count of production of child pornography for allegedly using his cell phone to videotape two children in his household engaging in sexual behavior with him, in violation of 18 U.S.C. § 2251(a).

42. Shortly following his arrest, competency proceedings were initiated due to Markelle's obvious intellectual disability. Although a criminal complaint was filed in federal district court, the government never proceeded to seek an indictment in the case.

43. Markelle was sent to a Federal Bureau of Prisons facility in New York for the competency evaluation. The BOP psychologist concluded he was incompetent to stand trial, which neither the defense nor prosecution disputed. In accordance with the federal statute, after being returned to the District, Markelle was next sent to a BOP facility in Butner, North Carolina, for an opinion on whether he could be "restored" to competence.

44. This series of transitions from the District to New York, back to the District, and then on to North Carolina was extremely hard for Markelle, who faces challenges to functioning successfully in a correctional environment under the best of circumstances. As described more fully herein, he spent virtually the entire period of the two BOP competency evaluations in solitary confinement.

45. Markelle was also physically harmed while in the District's custody during the interval between those evaluations. During a search of his cell at the D.C. Jail, Markelle protested and became upset when correctional officers touched his belongings. The officers responded with physical force and fractured his skull, which required sutures. Following

intervention from counsel, Markelle was moved to the Correctional Treatment Center. There he was provided special housing on a medical unit with older and physically unwell prisoners in an effort to keep him safe. His case manager, Charlene Reid, testified at Markelle's competency hearing that he behaved in a childlike way. She explained that the warden made an exception to the rules in order for Markelle to be allowed to have crayons to draw in a coloring book. May 16, 2016 Transcript of Competency Hearing – Day 1 at 29-34, *United States v. Seth*, No. 14-mj-608 (BAH/GMH) (D.D.C. June 7, 2016), Dkt. 67.

46. After a four-month incarceration at FMC Butner during which the BOP undertook to restore Markelle to competence, he was returned to the District. Following a contested evidentiary hearing, Magistrate Judge G. Michael Harvey decided that Markelle "lacks the capacity to understand, think through, and answer even the most basic questions about the legal process and the case against him." Magistrate's Report, *supra* para. 39, at 37. The Court concluded that due to "an incurable deficiency in oral comprehension and mental processing," Markelle is "incapable of being restored to competency for the foreseeable future." *Id.* at 39-40.

47. The court found Markelle "has consistently demonstrated that he has the auditory comprehension of a first grade student" and that "having [him] stand trial would be akin to putting a seven-year-old in the courtroom and expecting them to understand the language, ideas, and theories likely to be discussed." *Id.* at 39. During the hearing, Markelle was engrossed in coloring books, sticker books, word searches, and dot-to-dot activities. The Court noted that Markelle at times would "cover[] his ears as if to prevent himself from hearing testimony that he did not like, [behavior] that suggests he lacks a rational understanding of how to contribute to his defense and conduct himself in a courtroom." *Id.* at 26, 38.

48. After a two-day evidentiary hearing, during which both sides presented evidence

and experts, Magistrate Judge Harvey issued a Report and Recommendation on December 1, 2016, finding Markelle incompetent to stand trial and not restorable to competency in the foreseeable future.

49. On December 22, 2016, Chief Judge Beryl Howell issued an order adopting Magistrate Judge Harvey's Report and Recommendation. Chief Judge Howell also remanded Markelle into the Attorney General of the United States' custody pursuant to 18 U.S.C. § 4246, the federal civil commitment statute, for purposes of psychological examination to determine if Markelle's release would create a risk of substantial bodily injury or harm to another person. Markelle was transferred back to FMC Butner. Dec. 22, 2016 Order, *supra* note 7.

50. While federal law mandated that this Court order a dangerousness study following the finding that Markelle was not restorable, the ball was now in the District government's court: if, as planned and expected, DDS had advised the warden of FMC Butner that the District was prepared to provide a suitable placement for Markelle and take responsibility for his care and custody, no certificate of dangerousness would or could have been issued and Markelle would have been returned to the District of Columbia. D.C. Code § 4246(a).

51. Instead of advising the BOP that it was prepared to civilly commit Markelle and had a provider (Wholistic Services) lined up to serve Markelle in a highly structured and closely supervised community program developed in accordance with the recommendation of its own retained expert (Matthew Mason Ph.D.), and enforced by a DC Superior Court civil commitment order under CIDA, DDS sat on its hands. The agency said nothing, knowing the consequence of such silence would be issuance by the Warden of FMC Butner of a certificate of dangerousness based on there being no available state placement and a finding of dangerousness by BOP's expert, Dr. Kristina Lloyd, that was similarly both expected and inevitable. DDS had long

known the likelihood of both of these eventualities if they did not intervene to bring Markelle back to his home jurisdiction. It was specifically in order to avoid this outcome that DDS had agreed to move for commitment as soon as possible following a *Jackson* finding. (Nuss Decl. ¶¶ 6,18; M.Back E-mail 1, *supra* para. 10.)

52. Markelle remained at FMC Butner until, at his 18 U.S.C. § 4246 civil commitment hearing, he was found to be dangerous if released unsupervised. Prior to the § 4246 hearing, Markelle's counsel filed a motion to stay the proceedings pending resolution of the complaint filed in this lawsuit, as one of the elements required for federal civil commitment under § 4246—namely, whether suitable arrangements for State custody for Markelle are available in the District—was being actively litigated in this lawsuit. Judge Britt denied the motion to stay, finding that the availability of state placement options was not at issue in the § 4246 hearing. Order, *United States v. Seth*, Case No. 5:17-HC-02090-BR (E.D.N.C. May 17, 2018), Dkt. 30. At the May 24, 2018 federal civil commitment hearing, no evidence was presented regarding the availability of suitable state placement options, as Judge Britt had previously ruled that the government did not need to prove this element, nor was it at issue in this proceeding. Declining to make a broad ruling as to the availability of state placement, Judge Britt acknowledged the District's inaction and found that, "Upon the request of the Attorney General, the Court finds that the state placement is not available. This court finds, as I am only able to find, that the Attorney General has sent a letter to the District of Columbia requesting state placement and that letter has not been responded to." May 24, 2018 Competency Hearing at 46, *United States v. Seth*, Case No. 5:17-HC-02090-BR (E.D.N.C. June 7, 2018), Dkt. 34 [hereinafter 2018 Competency Hearing]. Markelle remains committed indefinitely to BOP custody.

D. DDS Initially Agreed, Pursuant to its State and Federal Legal Obligations, to Place Markelle in a Community-Based Program and Took Significant Steps in Furtherance of That Commitment.

53. In early 2015, prior to his "restoration" evaluation at Butner, Markelle's defense lawyers—anticipating that he would eventually be found incompetent and unrestorable and would then require civil commitment due to dangerousness if released unconditionally—applied to DDS to determine Markelle's eligibility. Counsel provided documentation concerning Markelle's disability, history of neglect, his multiple psychological evaluations, and his criminal charges, among other information. Counsel also explained in detail how the federal civil commitment process worked and how the District could, by doing its planning up front, minimize the time Markelle spent in an inappropriate and harmful prison setting. DDS's then-Director, Laura Nuss, acknowledged Markelle's eligibility for services and the agency's duty to provide them to him through the civil commitment process and in accordance with state and federal law. From the beginning of the agency's correspondence regarding Markelle, the agency was aware of the potential for a dangerousness finding and the public safety risks that could exist should Markelle be released to the community unsupervised. (E-mail from Laura Nuss, Director, DDS, to Lisa Greenman (Mar. 12, 2015, 17:11 EST) (attached hereto as Exhibit 6); *see* Nuss Decl. ¶ 6.)

54. On March 12, 2015, Director Nuss confirmed that a favorable eligibility determination was forthcoming and that DDS would proceed with civil commitment. *Id*. She wrote, "I encourage you to continue working with DDS and DDS/DDA[9] staff identified in the

[9] DDS is composed of two administrations that are tasked with overseeing and coordinating services for residents with disabilities through a network of private and non-profit providers:

emails below to develop a person-centered approach to supporting MS [Markelle Seth] in the context of the court proceedings and the formal commitment process. I am copying our General Counsel to ensure that we move forward together on MS's behalf." *Id*. Counsel for Markelle had expressly raised a concern that the sensitive nature of the criminal charges against Markelle and the appropriate consideration of public safety, and Director Nuss confirmed awareness of this: "We regularly work on forensic cases with the USAO and understand the process well." *Id*.

55. In further correspondence with DDS on March 12, 2015, counsel for Markelle again focused DDS attention on the public safety issues that were raised in Markelle's case: "We would like, ideally, to reach out to the USAO together with DDA and give them an understanding of what commitment would look like for MS — in particular, given their legitimate public safety interests, the degree of supervision and support that could be counted on. . . . I know that DDA generally prefers to avoid commitment, but in this situation I believe it's the only way to satisfy public safety concerns . . . ." (E-mail from Lisa Greenman to Laura Nuss, Director, DDS (Mar. 12, 2015, 18:38 EST) (attached hereto as Exhibit 7).)

56. On March 13, 2015, DDS's General Counsel, Mark Back, responded and acknowledged that DDS planned to move for civil commitment of Markelle *in order to remove him from federal prison*, writing in an email, "we will need to work together to get a suitable *Jackson* finding in order to move forward with commitment in the Habilitation Court." (E-mail from Mark D. Back, Gen. Counsel, DDS to Lisa Greenman (Mar. 13, 2015, 10:01 EST) [hereinafter M.Back E-mail 2] (attached hereto as Exhibit 8).)

57. On March 20, 2015, DDS sent a letter formally documenting that Markelle was

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Developmental Disabilities Administration ("DDA") and Rehabilitation Services Administration ("RSA").

eligible for its services based on his intellectual disability.

58. In April 2015, DDS sent a letter to Markelle stating that as soon as his competence status was resolved, DDS would initiate civil commitment proceedings in the District. In its April 17, 2015 letter, Musu Fofana, a Program Manager with DDS, acknowledged that:

a. Markelle is an individual with intellectual disability who is eligible to receive DDS services;

b. Markelle was determined to be incompetent to stand trial for the above-mentioned crimes; and

c. "once [DDS has] a *Jackson* finding from the federal court, DDS/DDA *will work with your attorneys and the federal authorities in filing for civil commitment* in the Mental Health and Habilitation Branch of the D.C. Superior Court's Family Division." Letter from Musu M. Fofana, Program Manager, DDS, to Markelle Seth (Apr. 17, 2015) (emphasis added) (attached hereto as Exhibit 9).

59. Given the prior correspondence and the applicable legal standards that require dangerousness as a prerequisite to commitment and that make commitment available only for a subset of the most dangerous crimes, when DDS agreed to seek civil commitment of Markelle here in the District, it was well aware of and prepared to account for the risks Markelle would present if placed into the community unsupervised. (Nuss Decl. ¶¶ 18, 20, 21.)

60. On April 23, 2015, two DDS case managers met with Markelle at the District's Correctional Treatment Facility to work on the person-centered plan that is part of DDS's process of developing an Individual Support Plan ("ISP"). DDS policy requires that an ISP: "1.

[s]upports the person to achieve individually defined outcomes and goals in the most integrated community setting appropriate to his or her needs; 2. [s]upports the person to exercise positive control over their life; 3. [e]nsures delivery of services in a manner reflecting personal preferences and choices and respecting what is important to and for the person; and 4. [s]upports the person's health and well-being."[10]

61. On July 13, 2015, DDS's then-Director Nuss and other DDS staff, including then-Deputy Director Holly Morrison and the agency's General Counsel, Mark Back, met to discuss Markelle's case. At that meeting, Director Nuss explained to Markelle's criminal defense counsel that DDS is accustomed to managing a wide range of behavioral challenges with its clients and it was prepared and equipped to address any issues presented by Markelle, including public safety issues, pursuant to its obligations under state and federal law.

62. Following that meeting, on August 6, 2015, DDS Deputy Director Morrison notified Markelle's counsel by email that DDS had identified a service provider, Benchmark Human Services ("Benchmark"), to serve Markelle and that DDS would be conducting a formal assessment to determine the parameters of a plan for Markelle. (E-mail from Holly Morrison, Deputy Director, DDA, to Lisa Greenman & Mark D. Back (DDS) (Aug. 6, 2015, 18:03 EST) (attached hereto as Exhibit 10).) DDS explained that Benchmark had a history of working successfully with complex and challenging DDS clients and had a proven track record of successfully serving in the community individuals with intellectual and other developmental

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[10] DDS/DDA, 2017-DDA-POL001, *Policy: Person Centered Planning Process and Individual Support Plans* 3 (2017), https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/2017-DDA-POL001%20Person%20Centered%20Planning%20Process%20and%20Individual%20Support%20Plans%20Policy.pdf.

disabilities whose behavior had brought them into contact with the criminal justice system, including individuals who presented dangerous sexual behaviors.

63. On August 12, 2015, DDS Deputy Director Morrison emailed Benchmark's President for Residential Services and asked him to arrange an assessment of Markelle. (E-mail from Holly Morrison, Deputy Director, DDA, to Lisa Greenman & Doug Beebe (Aug. 12, 2015, 20:12 EST) (attached hereto as Exhibit 11).)

64. From August 2015 through early 2017, first with Benchmark and later with Wholistic Services, which replaced Benchmark as the provider agency, DDS worked on developing a plan for Markelle's transition from the criminal justice system into the District's civil commitment system, which was expected to take place as soon as the issue of competency was resolved.

65. DDS, through Benchmark, its contractor, retained an expert, Dr. Matthew Mason, a licensed Psychologist and Board-Certified Behavior Analyst and an expert in developmental disabilities, to evaluate Markelle and decide on the components of a service plan that "will both meet his needs *and also account for concerns regarding the safety of others that are raised by the allegations* [in the criminal case]." Benchmark Human Services, *Draft Description of Services for Mr. Markelle Seth* 1 (2016) (emphasis added) [hereinafter Benchmark Service Plan] (attached hereto as Exhibit 12). Dr. Mason has extensive experience working with individuals with intellectual disability who present sexual behavior problems.

66. Dr. Mason's 2016 report explicitly addressed the potential risks of Markelle's receipt of community-based services. After interviewing Markelle and reviewing his history, Dr. Mason concluded that Markelle would be "responsive to and appropriate for placement in a highly structured and supervised [minimum of one-to-one, round-the-clock supervision]

community-based residential program," and determined specifically "that a more restrictive setting would not be necessary." *Id*. It was DDS's expert's professional opinion, based on years of experience addressing similar concerns with respect to individuals with intellectual and developmental disabilities, that Markelle's behavioral issues, whether sexual or otherwise, could be readily and safely managed in a community setting. Dr. Mason noted that "Benchmark has safely and successfully served individuals similar to and more behaviorally challenging than Mr. Seth in community settings with appropriate structure, staffing and programming." *Id.*

67. Dr. Mason's plan outlined various safety mechanisms that he recommended to be employed in a community residence for Markelle, but concluded that the most important feature of a plan would be that it have a high degree of engagement for Markelle:

> From Benchmark's experience working with individuals with profiles similar to Mr. Seth, it is clear that while the above safety precautions are necessary and appropriate, the most essential keys to a successful and safe experience for Mr. Seth will be engagement in activities that are meaningful to him, ensuring staff assigned to supervise him are well-trained and supported, providing high levels of supervision, as well as continuous oversight and evaluation of program services. Building with Mr. Seth's active involvement a home and a way of life that he is invested in will be the surest way to achieve success and meet the needs of both Mr. Seth and his community.

Id. at 4.

68. Dr. Mason's proposal also recommended that Markelle be provided with other services available in the community, including, in particular, sexuality education tailored to the needs of a person with his disability that is available through the DDA Health Initiative. The leadership of that program met with Markelle and indicated their ability and willingness to provide him services. (Brown Decl. ¶¶ 26, 29.)

69. Planning meetings to discuss services for Markelle and Dr. Mason's

recommendations were held in late 2015 and early 2016 at DDS's offices and included several DDS staff members, Dr. Mason, and Markelle's criminal defense counsel. Marisa Brown, director of the DDA Health Initiative at Georgetown University's Center for Child and Human Development participated as well. When Markelle's competency hearing in federal court was postponed from January to May 2016, DDS determined that remaining planning for services should also be postponed, to be resumed once there was a *Jackson* finding.

70. The determination that Markelle was unrestorable to competence was made on December 22, 2016, when Judge Howell adopted Judge Harvey's findings and held that Markelle could not restored to competence in the foreseeable future. Dec. 22, 2016 Order, *supra* note 7. At this point, although it was understood that Markelle would, by operation of statute, be sent to Butner for a dangerousness evaluation, Defendant DDS was expected to proceed with filing for civil commitment and finalizing a habilitation plan for Markelle. However, in the interim period, Defendant Reese had replaced Laura Nuss as Director of DDS. Instead of proceeding with a petition for civil commitment pursuant to its legal obligations, Defendant Reese requested that a new risk assessment of Markelle be prepared.

71. Defendant Reese retained Dr. Mason to prepare a new risk assessment of Markelle. On February 24, 2017, Dr. Mason issued a comprehensive report, finding that Markelle "can be safely and successfully supported in the community" in a "highly structured, closely supervised community based program" that would "provide for community safety while ensuring that Markelle has every opportunity to succeed and to avoid re-offending." Matthew Mason, *Risk Assessment Report for Markelle Seth* 15 (Feb. 24, 2017) (attached hereto as Exhibit 13). DDS provided a copy of this report to Markelle's criminal defense counsel.

72. Dr. Mason's 2017 report also addressed safety concerns, including Markelle's

behavior while he has been held in custody in correctional facilities. Dr. Mason found that "although numerous and frequent, Mr. Seth's problematic behaviors appeared relatively low in intensity and brief in duration." *Id*. at 6. He noted that prison staff described Markelle's behavioral outbursts as "immature and impulsive" and that Markelle responded well and generally quickly to "de-escalation strategies during these outbursts" and demonstrated remorse after he calmed down. *Id*. Dr. Mason noted that Markelle frequently reached out to others to assist with problem-solving and calming, which demonstrated his "interest in establishing supportive alliances." *Id*.

73. Dr. Mason reported that correctional facility staff described Markelle as "collaborative and outgoing" but also required a high degree of monitoring given his difficulty understanding and adhering to rules. *Id*. at 7. The correctional facility staff agreed that Markelle had difficulty following rules "not because he was a hardened criminal or oppositional in nature, but rather because he was immature, impulsive and had a strong desire for immediate gratification." *Id*. at 11. Staff described Markelle as "a likeable person with a sense of humor and playfulness." *Id*.

74. Dr. Mason further reported that Markelle was not preoccupied with children or "deviant" sexuality. *Id*. at 12. Prison staff noted that "although he was vulnerable to being taken advantage of by other inmates, he was not likely to try to take advantage of others, to attempt to develop relationships for the purposes of gaining sexual favor, or to otherwise act in a sexually predatory manner." *Id*.

75. Dr. Mason analyzed the results from the administration of a number of risk assessment instruments, including instruments designed to assess the risk of sexual violence. Dr. Mason found that Markelle's cognitive, behavioral and emotional characteristics were not

unusual, but instead are common in individuals with intellectual disability. Dr. Mason concluded that Markelle's prior and current behavior, including his sexual misconduct, was not based on an "underlying psychopathic condition." *Id*. at 14. Rather, such behaviors were "a function of inappropriate supervision" after having been placed in a position of caring for children, and "more opportunistic than predatory in nature, and influenced by his limitations in cognition and self-management." *Id*. Dr. Mason found that Markelle's sexual abuse charges stemmed, in part, "from a lack of supervision by responsive adults and from having been affirmatively placed in a position of caring for children." *Id*. at 15.

76. Dr. Mason recognized that Markelle would "need significant mentoring and supervision to function effectively in the community, especially with regards to following accepted norms of social behavior and engaging in safe sexual practices." *Id*. at 14. He found that Markelle did not appear to be "a flight risk . . . and his desire for social engagement, approval and need for supportive relationships are important compensatory strengths." *Id*.

77. Dr. Mason recommended the following criteria for a community-based placement for Markelle:

a. Markelle should be placed in a highly structured community-based residential program with "at least 1:1 staffing on a 24-hour basis" and with full and consistent daily schedule of employment and other meaningful activities. Staff assigned to Markelle should be thoroughly trained on his strengths and weaknesses, on the nature of his offenses, and on "non-negotiable safety practices." Markelle should "not live or work in areas with unsupervised access to children" and his behavior in the community must be monitored to prevent any unsupervised contact with minors.

b. Markelle should reside in a lower density neighborhood that promotes effective monitoring of exits.

c. DDS should develop comprehensive plans for Markelle that include behavioral management, crisis management, supportive psychiatric care, intensive counseling, psychosexual assessment and related sexual education, and self-management plans for Markelle.

d. Staff working with Markelle should be trained on the importance of using positive programming strategies to help address Markelle's social deficits and challenges in problem-solving that stem from his intellectual disability.

78. Dr. Mason stated that community supports for Markelle were appropriate and likely to be effective:

> Mr. Seth has demonstrated the capacity for establishing appropriate emotional ties, empathy and a desire to please others; these traits are indicators that he will be able to develop lasting, useful relationships with community-based staff and other supportive adults in his life.
>
> . . . .
>
> Based upon my extensive experience with many individuals with a variety of sexual behavioral problems, it is my opinion that Mr. Seth will respond well to supervision and supports. Mr. Seth's sociability, eagerness to please and willingness to create alliances with responsible adults are highly indicative that he will succeed if provided with appropriately designed supportive living and work environments that incorporate effective supervision.

Id. at 15.

79. Dr. Mason's recommendations, prepared at the request of Defendant DDS, were endorsed by a subsequent evaluation prepared by a second expert, Dr. Stephen Hart, who was retained by Markelle's lawyers. Dr. Hart is an internationally-renowned forensic psychologist

and researcher specializing in risk assessment, whose achievements include the development of some of the risk assessment tools used by BOP and other experts who evaluated Markelle.

80. In his June 18, 2017 report, which was provided to DDS, Dr. Hart reviewed both Dr. Lloyd's dangerousness study and Dr. Mason's report and recommendations. Report from Stephen D. Hart, Threat Assessment Specialist, Protect Int'l Risk and Safety Servs. Inc, to Lisa Greenman, re: *U.S. v. Markelle Seth* (June 18, 2017) (attached hereto as Exhibit 14). Dr. Hart rejected Dr. Lloyd's formulation and strongly endorsed the risk management plans proposed by Dr. Mason, noting Dr. Mason's expertise in intellectual disability and praising the individually tailored and workable nature of Dr. Mason's recommendations. He found that, consistent with best practices:

> the plans were based on a comprehensive assessment of risk factors; an individualized, integrative case formulation; identification of plausible scenarios; and attention to strategic, tactical, and logistical considerations. The plans also reflect a deep understanding of intellectual disability in general and the needs of Mr. Seth more specifically. Second, the management plans are remarkable or noteworthy for being feasible (i.e. available, accessible, and affordable), attentive to Mr. Seth's unique risk, need, and responsivity factors (i.e., appropriate), and consented to by Mr. Seth (i.e., acceptable).

Id. at 9-10.

81. Dr. Hart also discussed Markelle's history of behavior problems while held in various correctional facilities, noting that they were minor, connected to Markelle's intellectual disability, and a result of an inappropriate environment and a lack of trained staff. According to Dr. Hart, Markelle's institutional history involved:

> [I]ncidents that were primarily reactive in nature and minor in seriousness. Examples include minor rule violations (e.g., wearing the wrong clothes, not sharing a communal television with others) and problems dealing with interpersonal stress or conflict (e.g., rude or disruptive behavior when

> interacting with staff or fellow residents). Such incidents are expected when dealing with people with intellectual disability, especially when they are placed in closed living environments that lack the programs and trained staff to deal with their special needs (e.g., through contingency management, verbal de-escalation, and so forth).

Id. at 10.

82. Dr. Hart agreed with Dr. Mason's conclusion that Markelle's sexual misconduct was not consistent with an underlying psychopathic condition. Rather, Dr. Hart concluded that Markelle's actions were more likely attributable to "restricted opportunity for sexual contact with age appropriate peers, along with deficiencies in judgment and impulse control" and which were "exacerbated by a lack of appropriate intervention and supervision." *Id*. at 6-7.

83. Overall, both Dr. Mason's and Dr. Hart's recommendations were consistent with well-established, evidence-based practices regarding the elements required to provide appropriate services and treatment for individuals like Markelle in the community in a manner that allows for individual growth and community safety. (Thaler Decl. ¶¶ 28, 34.)

84. While BOP's expert, Dr. Lloyd, found, in contrast, that Markelle posed a public safety risk and could not return to the District, her determination ignored the comprehensive support plan and recommendations developed by DDS's expert regarding how Markelle could be safely served in the community upon return to D.C. and how D.C. has the appropriate capacity and experience to provide such services. Her evaluation was based on the assumption that Markelle would be returned to the community at large without supervision. The level of supervision recommended by Dr. Mason and Dr. Hart—and incorporated into Wholistic's proposed service plan—has proven successful

for hundreds of similar individuals in other states, but was not addressed in Dr. Lloyd's assessment. (Thaler Decl. ¶ 35.)

E. Per its Obligations under State and Federal Law to Serve Markelle in the Most Integrated Setting Appropriate, DDS Identified a Community-Based Provider Ready to Accept Markelle and Suitable for His and the Community's Needs.

85. While Markelle's competency proceedings were pending, Benchmark ceased operations in the District of Columbia. Wholistic Services, Inc. ("Wholistic")—a DDS-certified, D.C.-based provider of supportive services to individuals with intellectual and developmental disabilities, including supported living, behavioral supports, and supported employment—was therefore asked to assess Markelle for placement in its program. Wholistic conducted a comprehensive assessment of Markelle, and expressed its willingness and ability to provide an appropriate program to Markelle. In February 2017, Miatta Thomas, Chief Administrative Officer of Wholistic, informed DDS that Wholistic could provide services to Markelle to successfully support him and eventually help transition him into the community.

86. In August 2017, after DDS canceled planned group meetings to discuss Markelle's program, Wholistic provided DDS with a detailed Proposal for Transition, Safety and Support Services for Markelle ("Wholistic Proposal"), (attached hereto as Exhibit 15). Wholistic characterized its Proposal as a "draft" but also indicated that it was ready to be put it into final form, subject to review by DDS. In its Proposal, Wholistic stated that:

a. "Wholistic has safely and successfully served people similar to and more behaviorally challenging than Markelle in community settings with appropriate structure, staffing and programming." Wholistic Proposal at 7.

b. Wholistic has "a proven track record of successfully serving people with

intellectual and other developmental disabilities who have been involved in the criminal justice system, in particular people who have a history of dangerous sexual behaviors." *Id.* at 6.

c. Wholistic had taken into consideration the seriousness of the charges brought against Markelle and the risk that insufficient supervision could present. *Id.* at

87. Wholistic expressed confidence that it could account for this public safety risk, noting that Markelle would be subject to "a high level of supervision 24/7" in order to protect both Markelle and members of the community. *Id.* at 9.

88. Wholistic's Proposal addresses each of the recommendations and criteria identified by DDS's expert, Dr. Mason, for a successful supervised community-based placement for Markelle. Specifically, Wholistic proposed:

a. Training its staff related to Markelle's specific safety and crisis management needs, including training in essential strategies for supporting individuals with intellectual disability, in order to address Markelle's needs, as well as strategies to manage the risks that someone with Markelle's history and disabilities could pose to the community. *See id*. at 5-6, 8-9.

b. Placing Markelle in highly structured residential setting with at least 1:1 staffing on a 24-hour basis. Wholistic recognizes that increased staffing levels, such as a 2:1 supervision, may be necessary for up to the first year, and is ready to provide that level of supervision, if necessary. Wholistic notes that a residential placement with no more than one other housemate would be best for Markelle, given his history of multiple placements (foster care, homelessness) and his difficulties in institutional settings interacting with

others. *See id*. at 7-8.

c. Providing vocational services to Markelle, including a thorough evaluation of his skills and interests, and assistance with resume building, interview skills, and completing job applications. Wholistic indicates that if Markelle gains employment, staff would continue 1:1 supervision of him, and would coach Markelle and his employer and co-workers to ensure the safety of Markelle and others. *See id*.

d. Training staff to use a mentoring model to supervise Markelle, including demonstrating desired behaviors, using non-directive coaching strategies, and other methods, all within a framework of non-negotiable safety rules and limits. Wholistic states that Markelle would be fully informed of the supervision and safety requirements of his placement, and the consequences to him for violating those rules, including the potential for loss of community placement and liberty, and potentially incarceration. *See id*. at 8.

e. Developing a behavioral health and other professional services plan for Markelle. Wholistic identified a specific university-based program in Washington, D.C., with extensive expertise in the assessment and training related to sexual behavior, a psychiatrist to perform a psychiatric consultation for Markelle, and a psychologist to address Markelle's individual therapeutic needs and issues, including his history of abuse, the development of appropriate relationships, improving his self-management skills, and building his self-esteem. Wholistic also proposes retaining a registered nurse to monitor Markelle's medical care needs on a weekly basis. *See id.* at 9.

89. The plan proposed by Wholistic offers the necessary components of a successful service plan for Markelle, as agreed upon by experts in the field. It includes adequate supervision and training and assures community safety, while addressing potential crisis events such as elopements or behavioral incidents and providing Markelle with opportunities to grow, learn, and engage in meaningful activities. (Brown Decl. ¶¶ 34-35; Thaler Dec. ¶¶ 30, 31; Denney Decl. ¶¶ 8, 10, 25.) As of the date of this filing, Wholistic remains willing and able to provide the recommended supervisory services to Markelle.

F. DDS Reneged on Its Commitment and Obligation to Provide Markelle with Community-Based Supports and Services Pursuant to D.C.'s Civil Commitment Statute.

90. On April 22, 2016, Ms. Nuss departed DDS and Defendant Reese took over leadership of the agency as its Director.

91. Upon information and belief, DDS has decided not to provide community-based services and supports to Markelle via the civil commitment mechanism pursuant to its obligations under D.C. Code § 7-1301.01 *et seq*. This inaction constitutes not just an unfortunate reversal of circumstances for Markelle, but a violation of state and federal law.

92. As a result of DDS's violation of the law, on April 14, 2017, FMC Butner's warden filed a certificate of mental disease in Markelle's federal civil commitment case in the Eastern District of North Carolina, noting that "suitable arrangements for State custody are not available." Judge Britt held the following:

> Upon the request of the Attorney General, the Court finds that the state placement is not available. This court finds, as I am only able to find, that the Attorney General has sent a letter to the District of Columbia requesting state placement and that letter has not been responded to.

2018 Competency Hearing, *supra* para. 52, at 46. As Judge Britt had previously held that the availability of state placement options was not at issue in the absence of a District response, the Wholistic proposal and the availability or appropriateness of DDS services for Markelle was not considered or decided.

G. Markelle Struggles Within a Correctional Setting and Is Frequently Subjected to Solitary Confinement Due to His Intellectual Disability.

93. Markelle has been held at FMC Butner on two separate occasions. He was transferred to FMC Butner for the first time in April 2015 and spent four months there while the BOP endeavored to render him competent for trial, following which he was returned to the District of Columbia in September 2015. In January 2017, after this Court concluded that Markelle is neither competent to stand trial nor restorable to competency in the foreseeable future, Markelle was returned to FMC Butner, where he remains today.

94. Markelle, and other individuals like him who are awaiting civil commitment proceedings or who have already been civilly committed, are held at FMC Butner alongside incarcerated inmates who have been convicted and are serving their prison sentences in the facility, as well as inmates who are held in pretrial detention.

95. Because FMC Butner is a correctional institution, its inmates are expected to follow numerous rigid rules that govern every aspect of their daily lives. When inmates fail to follow institution rules, they are subjected to disciplinary measures that can include loss of privileges and/or disciplinary or administrative segregation in separate segregation areas.

96. Administrative and disciplinary segregation are essentially forms of solitary confinement. While in segregation, inmates are confined to their cells, except for short periods of time when they are allowed to leave their cells for recreation. Their interactions with other

inmates and staff are limited.

97. As a result of his intellectual disability, and in particular, his poor executive functioning skills, Markelle has struggled to comply with FMC Butner's rules, which do not contemplate the needs of individuals with intellectual and developmental disabilities. (Brown Decl. ¶¶ 39-40; Denney Decl. ¶ 18.) He has been disciplined for not following orders from correctional officers and staff, for talking back or being disrespectful to correctional officers and staff, and for singing loudly while listening to music using headphones. Markelle has also been disciplined for carrying a pop-tart back to his cell from the dining hall, failing to tuck in his clothes, wearing the wrong uniform shirt, refusing to buckle his belt, wearing earbuds in the prison hallways, and other similar behavior. Markelle has also gotten into several conflicts with other inmates at FMC Butner as a result of, for example, disputes over which television shows to watch when he has wanted to watch cartoons.

98. When Markelle has violated FMC Butner's rules, he has experienced a range of disciplinary consequences, including losing his phone privileges for months at a time, confiscation of his MP3 player and radio, and suspension of his commissary privileges.

99. Of utmost concern, Markelle has been placed in segregation on numerous occasions, even for apparently minor infractions, such as speaking disrespectfully to an officer. When confined in this manner, Markelle is locked alone in a cell for a minimum of 22 to 23 hours a day. When the institution is short-staffed he is not afforded the opportunity to leave the cell where he is confined at all. Each weekend he remains locked down for the full 48 hours. Markelle was in segregation for virtually the entirety of the four-month period of his restoration evaluation. *See* Magistrate's Report, *supra*, at 13. He has been in segregation for almost the entire period since he was returned to Butner in January 2017.

100. For an individual with an intellectual disability, such as Markelle, solitary confinement is recognized as being a particularly toxic setting that not only fails to provide equal access to programs, services and activities, but can cause additional long-lasting harm to his mental health and on his ability to perform daily living skills.[11] (Brown Decl. ¶¶ 37-38; Denney Decl. ¶¶ 22-24.)

101. FMC Butner does not have programs to meet Markelle's needs as an individual with intellectual disability and does not provide specific habilitation programming geared toward people with intellectual disability. (Brown Decl. ¶ 40; Denney Decl. ¶¶ 9, 22]. As DDS's own expert, Dr. Mason, made clear, Markelle has had difficulty following institutional rules and interacting properly with staff and other inmates because of challenges related to his intellectual disability.

102. It is well-established that the problematic behavior of individuals with I/DD often worsens within the rigid confines of prison life. People with I/DD may have considerable difficulty understanding the purpose behind rules and the consequences for violating rules and be frightened by the lack of supportive behavior from prison personnel. Those who cannot effectively communicate their dissatisfaction verbally may act out how they are feeling in ways that do not conform with the rules. For those who have experienced trauma, such as Markelle, this environment can be particularly destructive. (Thaler Decl. ¶ 23.)

103. Markelle is a young man who began life at three months of age removed from his

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[11] In a landmark decision, the court in *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995) concluded that for vulnerable prisoners, including those with intellectual disability, pre-existing mental illness and brain damage, "placing them in the SHU [Solitary Housing Unit] is the mental equivalent of putting an asthmatic in a place with little air to breathe." *Id*. at 1265.

family and placed in foster care. He has experienced abuse and abandonment, the absence of positive role models or adult guidance. His intellectual disability limits his ability to understand the world around him without professional guidance and supervision. Life in a correctional facility has likely compounded his trauma, and exacerbated his existing anxiety and related mental illness stemming from abuse, head trauma and neglect.[12] (Thaler Decl. ¶ 32.) If Markelle continues to be incarcerated, he will likely have continuing behavior problems resulting in increased levels of frustration or anger and a growing record of infractions, making it less likely that prison staff will ever agree to his release. The longer Markelle remains in prison, the more harm he will experience and the more behavior problems he is likely to develop. (Thaler Decl. ¶ 34.)

104. Within this highly restrictive setting, Markelle is unable to maintain consistent communications with his legal team, as his legal calls are not permitted with regularity and are routinely monitored by BOP staff. Legal calls at FMC Butner occurred in Markelle's counselor's office. Markelle's counselor listens to his legal calls and intercedes to reprimand Markelle for discussing issues with his attorneys that she feels are "non-legal" including discussions regarding his pending disciplinary hearings and his resulting confinement in the Solitary Housing Unit.

105. Dr. Mason recommended positive, non-directive programming strategies for Markelle. Specifically, he noted:

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[12] Markelle's counsel sought permission from FMC Butner for a psychologist to evaluate the harm to Markelle from solitary confinement. But FMC Butner has refused access. (Mot. Requesting An Order to BOP Directing Expert Access to Fed. Med. Ctr. Butner to Interview Pl., Sept. 4, 2018, Dkt. 24.)

> [T]he most essential keys to a successful and safe experience for Mr. Seth will be engagement in activities that are meaningful to him, ensuring staff assigned to supervise him are well-trained and supported, providing high levels of supervision, as well as continuous oversight and evaluation of program services. Building with Mr. Seth's active involvement a home and a way of life that he is invested in will be the surest way to achieve success and meet the needs of both Mr. Seth and his community.

Benchmark Service Plan, *supra* para. 65, at 4. This type of skills acquisition and behavior support is not present at FMC Butner and is not possible to achieve in such a setting.

106. Community settings can be much more easily individualized and designed to avoid triggers that may cause an individual's challenging behaviors. (Thaler Decl. ¶¶ 24-25.) In contrast, in the rigid prison environment, Markelle only has the opportunity to fail. (Brown Decl.¶ 40.) This continued segregation is likely to have a negative long-term impact on Markelle's mental health and lead to the deterioration of his daily living skills. (Brown Decl. ¶ 37-38.) The vicious cycle Markelle is currently experiencing at Butner of triggers and punishments followed by triggers and more punishment is precisely what justifies prioritizing people in Markelle's situation for community placements rather than prisons. (Thaler Decl. ¶ 33; Denney Decl. ¶¶ 18-22.)

107. In addition to the conditions of his confinement within the institution, Markelle's confinement at FMC Butner has placed him far away from his family and circle of support in the District of Columbia. Because Markelle's family, and in particular his father, with whom he maintains a close relationship, is financially unable to travel from the District to North Carolina, they are unable to see and interact with Markelle and provide him with additional support that could help lead to his re-integration into the community.

108. In sum, FMC Butner cannot provide the community-based and personalized services through which Markelle may be rehabilitated and to which Markelle is legally entitled.

(Denney Decl. ¶¶ 9, 22, 24.)

H. DDS Would be Able to Serve Markelle Without Undue Hardship .

109. As a result of the *Evans v. Bowser*, No. 1:76-cv-00293-ESH (D.D.C.) class action lawsuit filed in 1976 to remedy the constitutionally deficient level of care, treatment, education, and training provided to residents of Forest Haven—the District's former institution for people with intellectual and developmental disabilities—the institution closed in 1991 and the D.C. government[13] was charged with developing a quality support services delivery system for District residents with intellectual and developmental disabilities. (Brown Decl. ¶¶ 10, 11d, 31.) Since 1991, the District has provided residents with intellectual and developmental disabilities services in small, community-based programs. DDS's mission statement notes that it seeks to "provide innovative high quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces and communities in every neighborhood in the District of Columbia." *DDS Mission Statement*, Dep't on Disability Servs., https://dds.dc.gov/page/dds-mission-statement (last visited Oct. 25, 2018). DDS states that it is committed to person-centered service planning and delivery and community integration.

110. Defendant's Developmental Disabilities Administration (DDA) is comprised of an integrated network of service divisions charged with a continual planning process that considers changes in service needs and provides ongoing support through their technical assistance to community-based service providers. DDA has well-established systems that are inter-related with their network of contracted, community-based, disability service providers to

[13] The agency responsible for this work at the time was known as the Mental Retardation and Developmental Disabilities Administration. In 2006, this agency was replaced with DDS.

ensure appropriate service planning that provides safeguards for the individual with a disability, the staff that support the individual, and the community into which the individual is integrated. (Brown Decl. ¶¶ 19, 23.)

111. DDA is designed to serve, and does serve, many individuals whose intensive needs would present risk to their own safety or the safety of the community if they were not appropriately supported and supervised. DDA is able to serve individuals whose challenges include physically aggressive behaviors, risk of absconding, and intensive medical and mental health needs. While most individuals served by DDA do not require round-the-clock or one-to-one supervision, DDA can and does provide this level of service to a significant number of individuals. (Brown Decl. ¶ 24; Nuss Decl. ¶¶ 3, 5, 15, 19, 21.]

112. DDA's service planning for individuals with complex needs is dynamic and ongoing. When problems arise, there are a range of mechanisms for responding, including crisis management, changing the service plan, or changing the service site to a setting that is more restrictive, whether temporarily or long-term. And, in those cases in which it becomes necessary, out of state residential programs and institutions that further limit an individual's liberty and access to the community can be and are accessed by DDA. DDA has the ability to manage behavioral and other challenges through a continuum of care that ranges from less intensive to more intensive and from less restrictive to more restrictive. By design, there is no person with I/DD whose needs cannot be accommodated, because DDA has a virtually unlimited ability to select the environment and staffing level required by the individual's needs. (Brown Decl. ¶ 24; Thaler Decl. ¶¶ 31, 36; Nuss Decl. ¶ 3.)

113. Upon information and belief, in coordination with DBH, DDS provides supervised community-based services to individuals with co-existing diagnoses of mental illness

and intellectual disability who have faced similar criminal charges and whose behavioral challenges and corresponding risks are at least equivalent to those posed by Markelle's intellectual disability and associated behavioral issues. The proposal from Wholistic Services, Inc. identifies two such individuals whom it successfully serves and who have been successfully served in the community for many years. One was found incompetent in connection with a charge of murder and the other was found incompetent on charges involving sexual contact with children. Both are diagnosed with a serious mental illness as well as intellectual disability. A mental illness diagnosis allows DBH to step in and coordinate services in conjunction with DDS, whereas DDS alone is charged with providing services to individuals with only an intellectual disability diagnosis. However, DDS refuses to provide such services to individuals, such as Markelle, who have only a diagnosis of intellectual disability. As noted above, DDS's own expert has found that DDS can treat and serve Markelle, and DDS committed to doing so following the *Jackson* determination.

114. Upon information and belief, DDS has the capacity to plan and monitor individualized services for Markelle and has contracted with providers who are capable of executing DDS's plans. It is impossible to guarantee outcomes, but the provider network in the District of Columbia, and DDS in particular, is well-prepared to address, and has a track record of serving, individuals who present risks similar to and greater than Markelle. (Brown Decl. ¶ 23; Thaler Decl. ¶¶ 3, 29, 36; Nuss Decl. ¶¶ 4, 18, 21.)

115. Upon information and belief, Defendant District of Columbia, through the Department of Behavioral Health, and pursuant to the Ervin Act, regularly provides community-based services to D.C. residents with mental illness who have been found incompetent, but is refusing to serve Markelle through the Department on Disability Services, pursuant to CIDA.

116. Upon information and belief, in just the last fiscal year, 40 Ervin Act petitions seeking civil commitment of incompetent defendants with mental illness were filed through the Department of Behavioral Health, and many of those individuals are currently being served in the community by the District. The contrast with filings for citizens with intellectual disabilities is stark. In the last *seven* years, only two petitions seeking commitment to DDS for individuals with intellectual disability under D.C. Code 7-1303.04(b-1), the CIDA provision for post-*Jackson* defendants, have been filed, and both of these were initiated under unusual circumstances.

117. Upon information and belief, in 2011, an experienced DDS staff member indicated that, notwithstanding the 2002 amendments, DDS did not intend to exercise any longer its authority to commit and serve incompetent individuals with intellectual disability. The legislative history of the 2002 amendments reflects an expectation that one to two individuals per year would be subject to a post-*Jackson* commitment to DDS, Kathy Patterson, Chairperson, Committee on the Judiciary, *Bill 14-616, the "Civil Commitment of Citizens with Mental Retardation Amendment Act of 2002"* 17-19, Council of the District of Columbia, (June 3, 2002), http://lims.dccouncil.us/Download/329/B14-0616-COMMITTEEREPORT.pdf [hereinafter D.C. Council Report]; however, DDS has only filed petitions for commitment of two individuals in the past seven years.

118. In effect, the District has returned to functioning as it did prior to the 2002 amendment (and its predecessor emergency legislation), when the Ervin Act was available for civil commitment of incompetent defendants with mental illness but there was no parallel provision under which incompetent defendants with intellectual disability (but without a serious mental illness diagnosis) could be committed and served. The statute that was passed by the

Council to accomplish this express goal—to serve people in exactly Markelle Seth's position—is being ignored rather than implemented by DDS. The District thus deprives individuals with intellectual disability of access to needed services, while individuals with mental illness are petitioned for commitment and served by the Department of Behavioral Health.

119. The unusual circumstances of the two petitions for commitment by DDS filed since 2011 under D.C. Code 7-1303.04(b-1) reinforce the claim that DDS is no longer willing to move to commit and serve individuals with intellectual disabilities who have been found incompetent. One of those cases was filed after May 1, 2018 (the date Markelle's Complaint was filed) and, upon information and belief, that petition was filed by the Office of the Attorney General, in the name of the D.C. Attorney General, over DDS's objections. In the other case, filed in 2014, the respondent, who had severe disabilities, was already a DDS client at the time he was charged with the offense for which he was found incompetent. Thus, upon information and belief, with the exception of two unusual cases, between 2011 and the present DDS has not moved for civil commitment of any incompetent defendant.

120. Only Defendants know how many individuals with intellectual disability the District has failed to serve as a result of DDS's refusal to implement CIDA. However, based on the estimate in 2002 that CIDA would result in one to two incompetent individuals with intellectual disability per year being civilly committed and served by DDS, DDS has failed to meet its obligations to between six and 13 people in the last seven years alone, in addition to Markelle.

121. Although Defendant District of Columbia has the legal authority and obligation, financial ability and appropriate programming to provide community-based services for incompetent defendants with intellectual disability, they have discriminated against Markelle by

ignoring the authority and responsibility imposed by the D.C. Council in CIDA.

122. DDS's failure to exercise its authority and responsibility under CIDA flies in the face of D.C. Code § 7-1304.01, which, as its legislative history makes clear, was designed precisely for situations like Markelle's. As such, there is no legitimate reason for DDS not to file a civil commitment petition in Markelle's case as a means of complying with its obligations under state and federal law to serve and treat Markelle in the most integrated setting appropriate to his needs.

V. LEGAL FRAMEWORK

A. By Failing to Provide Markelle with Services and Treatment in the Most Integrated Setting Appropriate for Him, Defendants Have Violated Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

123. Congress enacted the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq*. ("ADA"), to provide a clear and comprehensive mandate for the elimination of discrimination against people with disabilities and to provide strong and consistent standards for identifying and addressing such discrimination. 42 U.S.C. § 12101(b)(1), (2). The ADA is based on Congress's findings that: (1) "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem," *id.* § 12101(a)(2); (2) "individuals with disabilities continually encounter various forms of discrimination, including . . . relegation to lesser services, programs, activities, benefits, jobs, or other opportunities," *id.* § 12101(a)(5); and (3) "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . . and access to public services," *id.* § 12101(a)(3).

124. In relevant part, the ADA defines a "disability" as "a physical or mental impairment that substantially limits one or more major life activities." 42 U.S.C. § 12102(1)(A). The ADA defines "major life activities" as including "learning, reading, concentrating, thinking, [and] communicating," as well as major bodily functions, such as brain function. *Id.* § 12102(2)(A), (B). The regulations implementing Title II of the ADA make clear that intellectual disability "will virtually always be found to impose a substantial limitation on a major life activity." 28 C.F.R. § 35.108(d)(2)(ii), (iii)(C). Markelle has a disability as defined in the ADA, and is entitled to the protections of the ADA.

125. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Title II applies to all services, programs, and activities of public entities. *See id.* Defendants are public entities and must comply with Title II of the ADA.

126. Congress directed the Attorney General of the United States to promulgate regulations enforcing Title II of the ADA and to provide guidance on their content. 42 U.S.C. § 12134. The regulations specify that it is unlawful discrimination for a public entity to: (1) "[a]fford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others," 28 C.F.R. § 35.130(b)(1)(ii); (2) "[p]rovide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others," *id.* § 35.130(b)(1)(iii); (3) fail to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities," *id*. § 35.130(d) ("the integration mandate"),

which the Attorney General has defined as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible," 28 C.F.R. pt. 35, App. B; or (4) "utilize criteria or methods of administration . . . [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities." *Id.* § 35.130(b)(3)(ii).

B. The District Has Intentionally Discriminated Against Markelle by Treating Him Differently from Individuals with Mental Illness.

127. The Defendants' failure to serve Markelle, while serving individuals with mental illness, constitutes disparate treatment of Markelle on the basis of his intellectual disability. The multiple individuals with mental illness whom the District has served whose alleged conduct was similar to the allegations against Markelle, DDS's desire "to leave as small a footprint as possible[;]" DDS's plan to pursue a parallel DC civil commitment despite its awareness that Markelle had a pending federal civil commitment; and DDS's ultimate refusal to civilly commit Markelle combine to create a strong inference that DDS's ultimate failure to serve Markelle was not because of the charges against Markelle or his potential dangerousness but was because of discrimination against Markelle due to his intellectual disability.

128. Evidence of the Defendants' disparate treatment of Markelle on the basis of intellectual disability includes:

a. Upon information and belief, in the last fiscal year (October 1, 2017 through September 30, 2018), the District filed 40 petitions for civil commitment under the Ervin Act following a *Jackson* finding that a criminal defendant was not competent to stand trial (and not likely to become competent) as a result of mental illness. By contrast, in the last seven years, the District filed only two petitions

for DDS commitment following a *Jackson* finding of incompetence based on intellectual disability. Upon information and belief, these two petitions involved extenuating circumstances that forced the District to overcome its usual resistance to serving individuals with intellectual disability in Markelle's circumstances.

b. Upon information and belief DDS avoids serving people with intellectual disability who have been involved in the criminal justice system by: (i) refusing to evaluate such individuals for habilitation services; (ii) determining them ineligible for habilitation services based on subjective criteria or based on the District's incorrect assertion that federally incarcerated individuals with intellectual disability, unlike individuals with mental illness, are no longer residents of the District; and/or (iii) refusing to move to civilly commit such individuals.

c. The District was well aware of any danger posed by Markelle in 2015, 2016, and 2017, as reflected, inter alia, in its experts' reports, well before the North Carolina federal court concluded that Markelle would be dangerous if returned unsupervised to the District. (Nuss Decl. ¶ 6.)

d. Upon information and belief, and based on publicly available data regarding the budget for DDS, budget allocations to DDS to fulfill its mandate have increased every year since 2016. Gov't of the District of Columbia, *A Fair Shot: FY 2019 Proposed Budget and Financial Plan*, Vol. 4, Pt. III (Mar. 21, 2018), https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/DC_OCFO_FY19_Budget_V4_WEB_0.pdf. Accordingly, there is no budgetary reason for DDS to have refused to serve Markelle. (Nuss Decl. ¶ 5.)

e. Upon information and belief, at no time during the period relevant to Markelle's

case has there been a waiting list for DDS services. Accordingly, lack of programmatic capacity cannot be a legitimate reason for DDS to refuse to serve Markelle. (*Id*.)

f. In correspondence with counsel for Markelle on March 13, 2015, DDS's General Counsel described a conversation with Assistant General Counsel for DDS Richard Williams about how best to obtain a suitable *Jackson* finding "in order to move forward with commitment in the Habilitation Court." M.Back E-mail 2, *supra* para 58. He then asked Markelle's counsel to: "please reach back out" to his colleague "to discuss. We would like to leave as small a footprint as possible on this matter." *Id*. Upon information and belief, this statement reflects both DDS's willingness in 2015 to civilly commit Markelle and its simultaneous preference that others remain unaware of this action regarding Markelle's case, evidencing DDS's bias against serving individuals with intellectual disability.

g. As late as 2017, *after* the Attorney General had commenced the civil commitment process in the Eastern District of North Carolina, the DDS General Counsel emailed Markelle's counsel about ongoing planning for Markelle's civil commitment by DDS in the District of Columbia. "Mr. Seth has a [sic] status in his DC federal case (by videophone) on July 21st and a hearing in the NC federal case on September 26th. It is possible to move up the various court dates if we have the planning piece in place and the idea is to get MS out of confinement as soon as possible within the timing realities of the two commitment processes." M.Back E-mail 1, *supra* para. 10.

129. These facts create a strong inference that the District's different treatment of

Markelle, who has an intellectual disability, compared to its treatment of similarly situated individuals with mental illness is based on his disability and based solely on his disability.

C. The District's Policies Have a Discriminatory Disparate Impact on Individuals with Intellectual Disability.

130. The Defendants' specific practice of regularly seeking civil commitment in the District of Columbia for individuals with mental illness while not doing so for individuals with intellectual disability also constitutes unlawful disparate impact discrimination.[14] *See supra* para. 104(a). Even if the Defendants' decision-making in relation to individuals charged with sexual offenses involving minors were facially neutral, the Defendants' practices have had a disparate (and therefore unlawful) impact. *See id.*

a. Upon information and belief, in just the last fiscal year, 40 individuals with mental illness who were incompetent for trial were the subject of petitions for commitment under the Ervin Act by DBH. While some of those cases have not yet been resolved, of the 19 that have been, five individuals received inpatient commitments and 14 received outpatient commitments in the community. In contrast, upon information and belief, there have been only two new petitions filed under the post-*Jackson* provision of CIDA in the last seven years.

b. Although DDS does serve some individuals in the community who were

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[14] Here, "individuals with mental illness" also includes individuals with a dual diagnosis of both mental illness and intellectual disability. This is in contrast to individuals diagnosed *solely* with intellectual disability, like Markelle. A dual diagnosis allows the District to assume responsibility through the Department of Behavioral Health, while a diagnosis of intellectual disability alone relegates individuals to the care and custody of the Department on Disability Services.

previously found incompetent to stand trial on serious charges, or who had other criminal justice system involvement, most of those individuals have come to DDS through another District agency, such as DBH or CFSA, under circumstances that would not permit DDS to reject serving them. For example, efforts to reduce the census at St. Elizabeth's Hospital resulted in DBH clients with both mental illness and intellectual disability being moved to the community to receive services from DDS in the community. (Nuss Decl. ¶¶ 14, 15.)

c. Upon information and belief, there are as few as two instances in the last seven years in which the District sought civil commitment for an individual found to be incompetent based primarily on intellectual disability. In one of those instances, the individual already was receiving services from DDS at the time of the criminal charge. In the other instance, DDS initially was unwilling to seek civil commitment and the Office of the Attorney General overruled DDS and filed for commitment itself. The small number of these cases and manner in which the District responds to them, compared with the manner in which the District addresses similarly situated individuals with mental illness, demonstrate the bias that the District has against individuals with intellectual disability.

D. The District Has Failed to Reasonably Modify its Policies, Procedures and Practices to Accommodate Markelle.

131. The Defendants' failure to place Markelle in an appropriately supervised program in the District of Columbia also constitutes an unlawful failure to reasonably modify its policies, procedures, and practices to accommodate him. A failure to reasonably modify occurs when (1) the plaintiff has a disability for the purposes of the Rehabilitation Act" or the ADA; (2) the

public entity "had notice of his disability"; and (3) the public entity denied his request for a reasonable modification of its policies, procedures or practices necessary to accommodate his disability. All of these criteria have been met here:

a. Plaintiff alleges at paragraphs 33 to 40 above that he was determined to have intellectual disability within the meaning of the Rehabilitation Act and ADA;

b. Plaintiff alleges at paragraphs 53 to 89 above that since at least March 2015, Defendants have had notice of Plaintiff's disability and his request for appropriately supervised habilitation services.

c. Plaintiff alleges at paragraphs 85 to 89 above that Wholistic could provide appropriately supervised habilitation services. Implementation of Wholistic's proposal is reasonable on its face, particularly in light of the services available through the District's services system and in light of the services the District makes available to similarly situated individuals with mental illness.

d. Plaintiff alleges at paragraphs 90 to 92 above that, notwithstanding Wholistic's formal proposal (which expressly addresses issues of dangerousness and public safety), and the fact that Defendants would serve Markelle if he had a mental illness, Defendants have denied Plaintiff's request for reasonable accommodation.

e. Although it is not Plaintiff's burden to so prove, upon information and belief, providing the services proposed by Wholistic, in accordance with the District's own experts' recommendations, would not pose an undue burden (or hardship) or fundamental alteration for the District, nor create a direct threat to the health or safety of others.

E. The District Refuses to Serve Markelle in the Most Integrated Setting Appropriate for Him.

132. The Supreme Court has held that discrimination prohibited under Title II of the ADA includes the unnecessary isolation or segregation of persons with disabilities. In *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), the Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate, as determined by treatment professionals; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. *Id.* at 607. The Supreme Court explained that its holding "reflects two evident judgments." *Id.* at 600. First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id*. at 601.

a. As alleged above in paragraphs 71-89 and 109-122, appropriately supervised community based services are appropriate for Markelle;

b. In fact, Defendant DDS so determined in March 2015. *See* paragraphs 53 to 89.

c. Each of the Defendants' own experts has determined that supervised community-based services available to the District are appropriate for Markelle;

d. The subsequent decision by DDS not to provide services to Markelle in a community-based setting, in contradiction to its own experts' recommendations,

is not sufficient to satisfy the *Olmstead* standard, that community based services are not "appropriate." First, DDS has articulated no finding that such services are not appropriate for Markelle and has provided no explanation for its change in position. Second, the determination of whether a community-based setting is appropriate for an individual with a disability is an objective standard not within the discretion of the agency's non-medical staff. Third, Plaintiff alleges that DDS's change in position is based on improper assumptions about and bias against individuals with intellectual disability or other impermissible factors separate from the genuine appropriateness of serving Markelle.

e. As alleged in paragraphs 53 to 89 and 93 to 108, Markelle does not oppose a supervised community-based program.

f. As alleged in paragraphs 109 to 122, Defendants have the ability to place Markelle in a supervised community-based program without their experiencing undue hardship, or fundamental alteration, or his posing a direct threat.

133. Congress specifically authorized individuals who believe their Title II ADA rights are being violated to bring an action in a United States District Court. 42 U.S.C. § 12133 (incorporating the remedies and enforcement procedures available under Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.*, which includes a private right of action).

134. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) ("Section 504") provides: "No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." *Id.*

135. An individual with a disability is any person who has a disability as defined in § 12102 of the ADA, as described above. 29 U.S.C. § 705. Defendants' programs, services, and activities receive Federal financial assistance. Accordingly, Defendants are subject to the nondiscrimination requirements of Section 504.

136. Congress directed that Title II of the ADA be interpreted in a manner consistent with Section 504, 42 U.S.C. §§ 12134(b), 12201(a), and the courts have followed this directive. *See, e.g.*, *Yeskey v. Pa. Dep't of Corr.*, 118 F.3d 168, 170 (3d Cir. 1997), *aff'd sub nom*. *Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206 (1998).

F. By Treating Markelle Differently from Similarly Situated Individuals with Mental Illness, Failing to Reasonably Modify Policies to Accommodate Markelle, and Failing to Provide Markelle with Services and Treatment in the Most Integrated Setting Appropriate, Defendants Have Violated the D.C. Human Rights Act of 1977.

137. The D.C. Human Rights Act of 1977, D.C. Code § 2-1401.01 *et seq.* ("DCHRA"), defines "disability" identically to the ADA. *Id.* § 2-1401.02(5A).

138. Discriminating on the basis of disability is proscribed by the DCHRA. *Id.* § 2-1401.01. The DCHRA provides: "Every individual shall have an equal opportunity to participate fully in the economic, cultural and intellectual life of the District and to have an equal opportunity to participate in all aspects of life, including, but not limited to, in employment, in places of public accommodation, resort or amusement, in educational institutions, in public service, and in housing and commercial space accommodations." *Id*. § 2-1402.01.

139. The DCHRA further notes, "it shall be an unlawful discriminatory practice for a District government agency or office to limit or refuse to provide any facility, service, program, or benefit to any individual on the basis of an individual's actual or perceived . . . disability." *Id*.

§ 2-1402.73.

140. The statute provides for a private right of action and damages. *Id*. § 2-1403.16. "The D.C. courts have always looked to cases from the federal courts in interpreting the D.C. Human Rights Act, and have followed, wherever applicable, precedents from the federal courts' treatment of comparable civil rights statutes." *Paralyzed Veterans of Am. v. Ellerbe Becket Architects & Eng'rs, P.C.*, 950 F. Supp. 393, 405 (D.D.C. 1996).

G. By Failing to Petition for Markelle's Civil Commitment in Order to Provide Him with Services and Treatment in the Most Integrated Setting Appropriate, Defendants Have Violated D.C.'s Citizens with Intellectual Disabilities Civil Rights Restoration Act of 2015.

141. In 2002, the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, (renamed in 2012 to D.C.'s Citizens with Intellectual Disabilities Civil Rights Restoration Act of 2015, D.C. Code § 7-1301.01 *et seq.* ("CIDA")), was amended to establish a civil commitment procedure for individuals with intellectual disability who have been charged with a violent crime or sex offense but found incompetent to stand trial to achieve the "*dual goals* of protecting public safety *while also safeguarding individual civil liberties and developing appropriate treatment programs.*"[15] D.C. Council Report, *supra* para. 117, at 9-10 (emphasis added). The D.C. Council Committee Report for CIDA stated that the legislation "is modeled after the Ervin Act provisions that govern civil commitment in the context of individuals who have been found incompetent to stand trial due to mental illness," since the Ervin Act does not

[15] The Disability Services Reform Amendment Act of 2018, D.C. Act 22-277, which amends CIDA, was enacted on March 12, 2018. This bill eliminates civil commitment for most individuals with intellectual disability moving forward, but keeps intact the current procedures regarding individuals like Markelle who are found incompetent to stand trial in criminal cases.

address those who are found incompetent due to intellectual disability. *See* D.C. Council Report, *supra* para. 117, at 4.

142. The Ervin Act, originally passed in 1964, was updated in 2002 to ensure that individuals with mental illness receive treatment in the least restrictive, most integrated setting appropriate. The Act was also amended to provide for regular review of an individual's commitment to ensure restrictions are lifted as soon as possible. The District's Department of Behavioral Health is responsible for providing services to D.C. residents with mental illness who are subject to the Ervin Act.

143. CIDA was amended after two separate incidents in which individuals with intellectual disability were charged with violent offenses, were deemed incompetent to stand trial without the possibility of restoration of competence, and were not eligible for civil commitment under the Ervin Act because they did not have mental illness. Both individuals continue to receive services successfully in the community from DDS.

144. The CIDA legislation is the result of many years of efforts by the D.C. Council, in conjunction with advocates from the D.C. disability and civil rights communities, to ensure that individuals in Markelle's situation receive needed supports and services in the least restrictive setting while simultaneously employing safeguards to preserve public safety in a way that provides the greatest possible protection of their civil rights.[16] Indeed, the Council Report

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[16] In the 2002 D.C. Council Committee Report for the law, Chairperson of the Committee on the Judiciary Kathy Patterson noted that the new iteration of the bill "emphasize[s] a civil rather than criminal approach to the issue." D.C. Council Report, *supra* para. 117, at 9. The Report recounts the testimony of various community members, which included sex educators and civil and disability rights advocacy groups. The input from the collective testimony included the following points that were later incorporated into the statute: (1) intellectual disability is not causally related to violence; (2) though the individual's disability does not

explicitly describes these "dual goals" in explaining the purpose of the law and how it was developed. D.C. Council Report, *supra* para. 117, at 9-10.

i. Purpose of D.C.'s Citizens with Intellectual Disabilities Act

145. The law's Statement of Purpose requires that any treatment, supports, and services must be provided in the least restrictive setting in a manner that is individually tailored and geared toward maximal community integration:

> [T]he design and delivery of care and habilitation services for persons with intellectual disabilities shall be directed by the principles of normalization, and therefore: (1) Community-based services and residential facilities that are least restrictive to the personal liberty of the individual shall be established for persons with intellectual disability at each stage of life development; (2) The use of institutionalization shall be abated to the greatest extent possible; (3) Whenever care in an institution or residential facility is required, it shall be in the least restrictive setting; and (4) Persons placed in institutions shall be transferred to community or home environments whenever possible, consistent with professional diagnoses and recommendations.

D.C. Code § 7-1301.02(b).

146. CIDA defines "least restrictive alternative" as

> that living and/or habilitation arrangement which least inhibits a person's independence and right to liberty. It shall include, but not be limited to, arrangements which move an individual from: (A) More to less structured living; (B) Larger to smaller facilities; (C) Larger to smaller living units;

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change over time, individuals with intellectual disability benefit from sex education and other behavioral supports that teach about appropriate sexual conduct; (3) the legislation should not be enacted without a study of similar legislation throughout the country and a close examination of best practices, such as in the states of Washington and Vermont; (4) the legislation must focus on plans that target behavior and provide appropriate treatment options; and (5) any treatment plans created by the legislation should be individualized and tailored to the needs of the specific person.

> (D) Group to individual residences; (E) Segregated from the community to integrated with community living and programming; and/or (F) Dependent to independent living.

Id. § 7-1301.03(16); *see also id.* § 7-1305.03.

147. CIDA further provides that an individual subject to civil commitment under the statute "shall be provided with the least restrictive and most normal living conditions possible consistent with preventing the person from causing injury to others . . . . Individuals shall be taught skills that help them learn how to effectively utilize their environment and how to make choices necessary for daily living and . . . refrain from committing crimes of violence or sex offenses." *Id.* § 7-1305.02. The statute also provides for an annual court hearing to review the individual's commitment in the event it is no longer appropriate, *id.* § 7-1304.11(a-1), a private right of action, *id.* § 7-1305.13, and damages, *id.* § 7-1305.14. Sovereign immunity does not bar an action under CIDA. *Id.* § 7-1305.13(c).

ii. CIDA's Application to Individuals with Intellectual Disability Charged with a Crime

148. In line with CIDA's requirements, all of DDS's services for individuals who are civilly committed are provided in the least restrictive setting. Although Markelle would require intensive, 24-hour supports, civil commitment under D.C. law would allow him to receive these services in his home community in the most integrated setting appropriate for his needs.

149. CIDA provides that in the instance of an individual found incompetent in a criminal case, "the District shall have no more than 30 days from the date on which the finding is made that the person is incompetent and not likely to gain competence in the foreseeable future in which to file a petition . . . . For extraordinary cause shown, the Court may extend the period

of time within which the petition must be filed."[17] *Id.* § 7-1303.12a(a). Markelle was found incompetent by this court in December 2016.

150. Absent any extraordinary justification, DDS has refused to petition for Markelle's commitment for over a year and has indicated that it has no plans to do so in the foreseeable future. Unless DDS acts pursuant to its legal obligations, Markelle will remain incarcerated indefinitely in a setting in which he is subjected to solitary confinement, deprivation of privileges, and other disciplinary measures due to his disability in a prison setting that is inappropriate for the supports and treatment he requires.

H. Markelle's Federal Civil Commitment Does Not Excuse the Defendants' From Carrying Out Their Obligations.

151. Although civil commitment of incompetent defendants is typically a state function, as outlined above, federal law, 18 U.S.C. § 4246, provides that a federally charged defendant who is found incompetent to stand trial may be civilly committed by the federal government if, and only if, (1) he is found dangerous as a result of a mental condition, and (2) his home state refuses to take responsibility for his care and custody. Federal civil commitment results in confinement by the BOP in a federal prison hospital until the prison authorities determine that it is safe to release the individual.

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[17] The statute governing federal civil commitment, 18 U.S.C. § 4246(d), *see* discussion *infra* Section VI, also contemplates that the process of getting the state to take responsibility for a defendant found incompetent may be an ongoing process, noting that the Attorney General will have custody over the individual until the state "will assume such responsibility" and requiring the Attorney General to "continue periodically to exert all reasonable efforts to cause such a State to assume such responsibility for the person's custody, care, and treatment." 18 U.S.C. § 4246(d).

152. Federal law recognizes the strong preference for returning an individual to his/her own state for commitment. 18 U.S.C. § 4246(d) states:

> The Attorney General shall release the person to the appropriate official of the State in which the person is domiciled or was tried if such State will assume responsibility for his custody, care, and treatment. The Attorney General shall make all reasonable efforts to cause such a State to assume such responsibility. If, notwithstanding such efforts, neither such State will assume such responsibility, the Attorney General shall hospitalize the person for treatment in a suitable facility, until (1) such a State will assume such responsibility; or (2) the person's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another; whichever is earlier. The Attorney General shall continue periodically to exert all reasonable efforts to cause such a State to assume such responsibility for the person's custody, care, and treatment.

153. The BOP's evaluation concluded that Markelle "is currently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to the property of another." Because DDS has failed to petition for Markelle's commitment or indicate its willingness to accept responsibility for his care and custody, the BOP concluded that "suitable arrangements for State custody are not available," even though, as described above, they clearly are if only DDS would act to provide them. As a result, a petition for federal civil commitment was filed in the Eastern District of North Carolina on April 28, 2017.

154. The petition for federal civil commitment was granted on May 24, 2018. At this federal civil commitment hearing, no evidence was presented regarding the availability of suitable state placement options, as the court had previously ruled that the government did not need to prove this element, nor was it at issue in this proceeding. Declining to make a broad

ruling as to the availability of state placement, the court held that, "Upon the request of the Attorney General, the Court finds that the state placement is not available. This court finds, as I am only able to find, that the Attorney General has sent a letter to the District of Columbia requesting state placement and that letter has not been responded to." 2018 Competency Hearing, *supra* para. 52, at 46.

155. Pursuant to 18 U.S.C. § 4246(d), BOP can only retain custody of Markelle

> until (1) such a State will assume such responsibility; or (2) the person's mental condition is such that his release, or his conditional release under a prescribed regimen of medical, psychiatric, or psychological care or treatment would not create a substantial risk of bodily injury to another person or serious damage to property of another; whichever is earlier.

Currently, Markelle's release under a prescribed regimen of medical, psychiatric, or psychological care or treatment, such as that proposed by Wholistic, would not create a substantial risk of bodily injury to another person. Having no basis on which to decline to release Markelle, BOP will presumably do so as soon as Defendants authorized payment for those services.[18] Thus, neither the federal court's civil commitment decision nor the BOP's current custody of Markelle poses a barrier to the Defendants' exercise of their responsibility to serve Markelle in the community.

156. The circumstances here weigh overwhelmingly in favor of Markelle's civil commitment in the District: (1) DDS has authority and responsibility to petition for Markelle's civil commitment to provide him with supports and services in the most integrated setting

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[18] Indeed, in the absence of civil commitment by the District, BOP may already have an obligation to release Markelle because he has been prescribed a regimen of services that will avoid any substantial risk of harm to the public. Upon Markelle's release, he will be entitled to Wholistic's services, for which he has already been found eligible, and the District will have no ability to civilly commit or oversee the success of those services.

appropriate in his home state pursuant to CIDA; (2) DDS's *own expert* agrees that Markelle can and should be served in the community; and (3) a community-based provider in the District of Columbia with the capacity to do so has offered to serve Markelle.

157. By refusing to fulfill their legal obligation to petition for custody of Markelle and provide services to him in the most integrated setting appropriate to his needs, Defendants, the District of Columbia, DDS, and its Director, Andrew Reese, have caused Markelle to remain in federal prison at FMC Butner—often in solitary confinement—in violation of Title II of the ADA, 42 U.S.C. § 12131 *et seq.*, Section 504, 29 U.S.C. § 794(a), the DCHRA, D.C. Code § 2-1401.01 *et seq.*, and CIDA, D.C. Code § 7-1301.01 *et seq*. Defendants violated Markelle's rights from the time he was found not restorable to competency by refusing to serve him, and they have violated his rights every day since then. Every day that Defendants fail to fulfill their legal obligation to provide community-based services to Markelle in his home state is another day that he is forced to languish in federal prison indefinitely without having been convicted of a crime.

158. CIDA was passed as part of an intentional and deliberative effort to place responsibility on DDS for the exact scenario faced by Markelle. The law—explicitly concerned with the *dual* goals of protecting public safety while also safeguarding civil liberties and developing appropriate treatment programs—plainly requires DDS to provide Markelle with services in the most integrated setting appropriate to his needs in a way that simultaneously ensures public safety and the protection of his civil rights. Defendants' failure to fulfill their obligation under this law guarantees Markelle's continued placement in federal prison in violation of the ADA, Section 504, DCHRA, and CIDA.

VI. CAUSES OF ACTION

COUNT 1: VIOLATION OF THE AMERICANS WITH DISABILITIES ACT

159. The allegations of paragraphs 1 to 158 above are incorporated herein.

160. Markelle is a "qualified individual with a disability" as defined in the ADA, 42 U.S.C. § 12131(2); *see id.* § 12102(1). Markelle's intellectual disability substantially limits multiple major life activities, such as caring for oneself, learning, reading, concentrating and thinking, and DDS has determined him to be eligible for disability services. Moreover, with appropriately tailored support systems such as those described above, Markelle can be served in the community without posing a threat to the health or safety of others.

161. Defendant DDS is a public entity subject to the ADA. *Id.* § 12131(1).

162. By refusing to follow through on its determination that Markelle is eligible for DDS services and can reasonably be served in the community, and by failing to move to civilly commit Markelle, DDS is depriving him the benefits of its programs, activities, and services in violation of Title II of the ADA, *id.* § 12132.

163. Specifically, Defendants are, on the basis of his intellectual disability, excluding Markelle from participation in or denying him the benefits of the services, programs, or activities of the District, or subjecting him to discrimination, including by:

(i) Denying Markelle the opportunity to participate in or benefit from an aid, benefit, or service;

(ii) Affording Markelle an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Providing Markelle with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Providing different or separate aids, benefits, or services to Markelle than are provided to others unless such action is necessary to provide Markelle with aids, benefits, or services that are as effective as those provided to others;

(v) Otherwise limiting Markelle in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

See 28 C.F.R. § 35.130(a), (b)(1).

164. Defendants are intentionally treating Markelle differently from similarly situated individuals with mental illness on the basis of his intellectual disability. Upon information and belief, the District of Columbia regularly provides community-based supervisory services to D.C. residents who are found not competent to stand trial due to mental illness through the Department of Behavioral Health, but is failing to do so for those with intellectual disability, such as Markelle. Despite having both the resources to serve these citizens and a statutory mandate to do so, DDS has failed to act for Markelle.

165. In addition, Defendants are denying Markelle the opportunity to participate in services, programs, or activities that are not separate or different from those offered to others, *id*. § 35.130(b)(2), and utilizing criteria or methods of administration—

1. That have the effect of subjecting Markelle to discrimination on the basis of disability; or
2. That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to Markelle.

See id. § 35.130(b)(3)(i)-(ii).

166. DDS is also imposing or applying "eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying [a] service, program, or activity," without showing that "such criteria [are] necessary for the provision of the service, program, or activity being offered." *Id.* § 35.130(b)(8).

167. Finally, DDS is failing to "administer services, programs, and activities in the most integrated setting appropriate to [Markelle's] needs." *See id.* § 35.130(d); *id*. § 35.152(b)(2); *see also Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

168. In *Olmstead,* the Court determined "that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* at 607.

169. A state cannot escape its *Olmstead* responsibilities by simply claiming that it does not have a plan in place to serve individuals with disabilities in the most integrated setting appropriate to their needs. Rather, if such a plan is missing, the state must create one in order to comply with its ADA obligations. Interpreting *Olmstead* otherwise turns the law on its head and renders it meaningless as any state could easily evade responsibility by claiming that it does not have a plan to serve individuals in the community, relegating people with disabilities to segregated, institutional placements in clear violation of the law. This situation is precisely what *Olmstead* and the ADA seek to safeguard against.

170. As in *Olmstead*, numerous professionals, including DDS's own professionals, who have treated and evaluated Markelle, have concluded that he can and should be served in the community, Markelle wants to return to and be treated in the District, and there are community-based options available to him that can both meet his needs and provide for the community's security.

171. By refusing to serve Markelle, DDS leaves him in a federal prison facility—often in segregated housing—that is unable to provide the necessary treatment, safe facilities, and integrated services required by the ADA. *See supra* paras. 98-106.

172. Defendants have failed to comply with the nondiscrimination requirements of the ADA and the integration mandate of the ADA, based on Markelle's disability.

173. Community-based services for Markelle can be reasonably accommodated, taking into account the resources available to the District and the needs of others who are receiving disability services from the District. Defendants' actions in violation of the ADA were intentional.

174. Defendants' actions in refusing to serve Markelle are intentional and as a result of Defendants' violations of the ADA, Markelle has suffered harm.

175. Unless enjoined by the Court, Defendants will continue to violate the ADA rights of Markelle.

COUNT 2: VIOLATION OF SECTION 504 OF THE REHABILITATION ACT

176. The allegations of paragraphs 1 to 175 above are incorporated herein.

177. Markelle is a "qualified individual with a disability" as defined in Section 504, 29 U.S.C. § 794, *et seq*., Markelle's intellectual disability substantially limits multiple major life activities, such as caring for oneself, learning, reading, concentrating and thinking, and DDS has

determined him to be eligible for disability services.

178. Discrimination on the basis of disability is prohibited by Section 504: "No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." *Id.* § 794(a).

179. DDS and the District are recipients of Federal financial assistance.

180. As set forth above, Defendants have discriminated against Markelle solely because of his intellectual disability. In doing so, they have denied him the benefits of its federally funded programs.

181. Defendants' actions in refusing to serve Markelle are intentional and Markelle has suffered harm as a result.

COUNT 3: VIOLATION OF THE D.C. HUMAN RIGHTS ACT

182. The allegations of paragraphs 1 to 181 above are incorporated herein.

183. Markelle is an individual with a disability under the DCHRA, which defines "disability" identically to the ADA. D.C. Code § 2-1401.02(5A).

184. It is a violation of the DCHRA to discriminate on the basis of disability. *Id.* § 2-1401.01. The DCHRA provides: "Every individual shall have an equal opportunity to participate fully in the economic, cultural and intellectual life of the District and to have an equal opportunity to participate in all aspects of life, including, but not limited to, in employment, in places of public accommodation, resort or amusement, in educational institutions, in public service, and in housing and commercial space accommodations." *Id.* § 2-1402.01. The statute further notes that "it shall be an unlawful discriminatory practice for a District government

agency or office to limit or refuse to provide any facility, service, program, or benefit to any individual on the basis of an individual's actual or perceived . . . disability." *Id*. § 2-1402.73.

185. Defendants have discriminated against Markelle on the basis of his intellectual disability in violation of the DCHRA.

186. Community-based services for Markelle can be reasonably accommodated, taking into account the resources available to the District and the needs of others who are receiving disability services from the District. As a result of Defendants' violations of the DCHRA, Markelle has suffered harm.

187. Unless enjoined by the Court, Defendants will continue to violate the DCHRA rights of Markelle.

COUNT 4: VIOLATION OF THE CITIZENS WITH INTELLECTUAL DISABILITIES ACT

188. The allegations of paragraphs 1 to 187 above are incorporated herein.

189. Pursuant to the dual goals for which it was established, CIDA requires that the District petition for civil commitment for individuals with intellectual disability found incompetent to stand trial and not likely to gain competence in the foreseeable future in a criminal case within 30 days of such a finding absent a showing of extraordinary cause. *Id.* § 7-1303.12a(a). Once the person is committed, the statute requires that individuals with intellectual disability be

> provided with the least restrictive and most normal living conditions possible . . . . This standard shall apply to dress, grooming, movement, use of free time, and contact and communication with the community . . . . Individuals shall be taught skills that help them learn how to effectively utilize their environment and how to make choices necessary for daily living and . . . to refrain from committing crimes of violence or sex offenses.

Id. § 7-1305.02.

190. This Court issued a finding of incompetence to stand trial in December 2016. DDS has an obligation to petition for Markelle's civil commitment to provide him with supports and services in the most integrated setting appropriate in his home state. Instead, Markelle has been held in federal custody for over a year, frequently placed in solitary confinement and subjected to a number of other harsh conditions and deprivation of privileges at FMC Butner, an unnecessarily harsh, inappropriate, and restrictive treatment placement.

191. CIDA requires DDS to provide Markelle with treatment and supervision services in the community in the most integrated setting appropriate to his needs in a way that simultaneously ensures public safety and the protection of his civil rights. Defendants' failure to fulfill their obligation under this law guarantees Markelle's continued placement in federal prison in violation of the law.

VI. PRAYER FOR RELIEF

WHEREFORE, Markelle prays that judgment be entered in his favor and against Defendants as follows:

A. Declaring that the Defendants' actions described above constitute violations of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the D.C. Human Rights Act of 1997, and the Citizens with Intellectual Disabilities Civil Rights Restoration Act of 2015;

B. Granting preliminary and permanent injunctive relief requiring Defendants to promptly accept physical and legal custody of Markelle within a reasonable period of time, not to exceed thirty (30) days;

C. Awarding compensatory and punitive damages to Markelle including his out-of-

pocket losses, emotional damages, and other harms caused by the Defendants' discriminatory conduct, from the time that Defendants failed to meet their obligation to civilly commit Markelle to the present;

D. Awarding attorneys' fees and costs incurred in the prosecution of this action;

E. Granting such other and further relief as the Court may deem just and proper.

Respectfully submitted this 26th day of October, 2018.

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Exhibit 1

DECLARATION OF LAURA L. NUSS

I, Laura L. Nuss, declare under penalty of perjury that:

1. I have over 34 years of experience working in the field of services for people with intellectual and developmental disabilities ("IDD"). I have over 17 years' experience, including 8 and one-half years in the District of Columbia ("District"), working for and leading state government agencies, that oversee, fund, design and provide services for people with IDD. In this capacity, I have overseen the development of or supported a system of community services that can support all people with IDD, including people with complex needs and behavioral health needs. This included the design and development of a community system of supports in the District of Columbia. I also have been a direct provider and administrator of community services for people with IDD. Additionally, I have more than 3 years of experience working with states across the country on improving their IDD systems.

2. I have reviewed the Complaint and Exhibits in this case, including the Draft Description of Services prepared by Benchmark Human Services (Complaint Exhibit 2) and the Proposal for Transition, Safety & Support Services prepared by Wholistic Home and Community Based Services, Inc. (Complaint Exhibit 3, "Wholistic Proposal") for Markelle Seth. I have also reviewed Mr. Seth's Complaint against the District of Columbia; the D.C. Department on Disability Services; assessments completed by Matthew Mason, Ph.D., BCBA-D, LBA, Stephen D. Hart, Ph. D, Manuel E. Gutierrez, Psy.D., and Katrina P. Lloyd, Psy. D.; the Competency to Stand Trial Evaluation by Samantha E. Dimisa Ph.D.; the Neuropsychological examination report completed by Robert L. Denney, Psy.D., ABPP; the April 17, 2015 planning letter to Mr. Seth from Musu Fofana, Program Manager from the D.C. Dept. on Disability Services; and, the September 26, 2018 Declaration of Nancy Thaler.

3. Based on my decades of experience and expertise, including direct experience with the District's Department on Disability Services ("DDS") and the District's system of

community services for people with intellectual and developmental disabilities, it was and continues to be my expert opinion that the District can serve people with IDD and complex behavioral needs, including problematic sexual behaviors, such as Markelle Seth.

4. The District through DDS is already successfully serving people with the most complex needs, including those accused of or convicted with sexual offenses, in the community, the result of over a decade of dedicated, intentional, and collaborative work and investment by four successive Mayors, the D.C. City Council, DDS staff, families and self-advocates, the District's Department of Health Care Financing, the Department of Health, the DDS IDD Provider community, Georgetown University Center for Excellence, University Legal Services (the District's federally designated protection and advocacy agency), and The Quality Trust. DDS has the available service array through its IDD Home and Community-Based Services ("HCBS") Waiver program to successfully serve individuals with complex needs like Mr. Seth.

5. The DDS IDD HCBS Waiver is designed to serve individuals with extraordinary needs with no limits on the cost of overall service plan permitted as written, with the cost of those services shared by the federal government at a ratio roughly 70% federal to 30% local/District funds[1]. The DDS budget was sufficient to serve Mr. Seth in 2015/16 and has increased year over year in part to fund the required local match for the IDD HCBS Waiver program.[2] The District is required to provide services to all individuals who are eligible for services under the IDD HCBS Waiver if there is a funded "slot" available[3]. There was an

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[1] DC IDD HCBS Waiver (0307.R04.00): Appendix B-2 Individual Cost Limit, a. "No Cost Limit". https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8432

[2] Government of the District of Columbia FY 12019 Proposed Budget and Financial Plan, Volume 4-Agency Budget Chapters -Part III, March 21, 2018. DDS budget found at page E-177. (https://cfo.dc.gov/sites/default/files/dc/sites/ocfo/publication/attachments/DC_OCFO_FY19_Budget_V4_WEB_0.pdf .

[3] Eligibility for the DC IDD HCBS Waiver (0307.R04.00): Appendix B-1:b: "D.C. Official Code 7-761.05(1)(a) requires DDS to provide services and supports to people with intellectual disabilities in accordance with Chapter 13 of Title 7, which is the codification of D.C. Law 2-137, the Citizens with Intellectual Disabilities Constitutional Rights and Dignity Act of 1978, effective March 3, 1979, D.C. Official Code § 7-1301.01 et seq., as amended. Under D.C. Law 2-137, DDS provides services and supports to District residents with intellectual disabilities through the admission and commitment process by petition to the Family Court for certain residential services and by application to DDS. See D.C. Official Code 7-1301.03(2) and 7-1301.03 through 7-1303.06. In addition, eligibility for services is limited to adults with an intellectual disability under 29 DCMR § 1902.1(b), 63 DCR 10445 (August 12, 2016)." https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8432

available funded slot for Mr. Seth when he made application to and was found eligible for DDS services. There continue to be funded slots in the DDS IDD Waiver program. The District has not notified individuals or its stakeholders that it has implemented a waiting list for the IDD HCBS Waiver program.

6. Mr. Seth was found eligible for services from DDS in April 2015 when I was serving as the Director. Included in his application for services was clear evidence of the charges pending against Mr. Seth and preliminary evaluations sufficient to demonstrate his potential danger to the community if left unsupervised. In fact, there would be no need or basis for civil commitment in the absence of a dangerousness finding. DDS fully expected to assume responsibility for Mr. Seth pending the outcome of his competency status as a resident of the District with full knowledge of his complex support needs.

7. I offer the following information and opinions based on my significant expertise and experience, as described above, and included in my C.V., which is attached to this Declaration as Attachment 1. I am not being compensated for my work in this case.

Professional Experience

8. Since I resigned my Cabinet position as the Director of the District's Department on Disability Services in April 2016, I have provided consulting services to numerous state IDD agencies in policy development, research, and design of community services for individuals with IDD as the principal of the LNUSS Group. I have also served as a Subject Matter Expert for the Centers for Medicare and Medicaid Services (CMS) to provide consulting services to state IDD agencies in the design of HCBS Waiver programs, and for the Department of Labor, Office of Disability Employment Policy to provide consulting services to state agencies in the development of employment policy and services for people with disabilities. In addition, I have provided independent evaluation reviews for support coordination and quality improvement in *U.S. v. The State of Georgia et al.* I also serve as a Senior Program Analyst for New Editions Consulting, Inc. providing expert review and technical assistance support for the Centers for

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Medicare and Medicaid Services Home and Community-Based Services Settings Rule implementation contract since October 2017.

9. I have extensive knowledge of the operations and capabilities of DDS. I was the Deputy Director for DDS responsible for the Developmental Disabilities Administration ("DDA") from August 20, 2007 until my appointment as the Director of DDS in June 2010. I served as the Director of DDS until April 30, 2016 at which time I voluntarily resigned from this post. As the Deputy Director and Director, I was responsible for the administration of the District's system of community services for individuals with intellectual and developmental disabilities. This included all activities related to policy development, service design and standards, budget development, financial management, quality management, and the operation of the state's community-based service system for people with disabilities through the federally funded Medicaid Waiver programs, and service provision funded under the federally funded Intermediate Care Facilities for Person with Intellectual Disabilities (ICF/ID) program. I was one of two authors of the District's 2007 IDD Medicaid Waiver, and oversaw the renewal of that Waiver in 2012.

10. During my tenure with DDS, the District successfully underwent extensive infrastructure development and systems change to support the conclusion of the nation's oldest class action *Evans v. Bowser* in January 2017. This included significant improvements in the design and implementation of robust quality and risk management systems, and substantial investment in training and technical assistance made available to the IDD provider community. Another significant priority during this time was returning individuals to the District from out-of-state placements and transitioning individuals with IDD from the District's inpatient mental health facility, St. Elizabeth's Hospital, back into community settings with support from IDD providers.

11. From 2003 to 2007, I served as the Director of Strategic Leadership for the state of Connecticut's Department of Developmental Services providing services to approximately 15,000 children and adults with intellectual disabilities. In this position, I was responsible for the quality assurance, waiver operations, policy, staff development and information technology

units. During my tenure, I managed the design and implementation of two new HCBS Waiver programs and a new quality assurance review program to meet CMS HCBS quality standards and ensure the health and safety of people receiving services and the community. From 2002 to 2003, I served as a Regional Director for the Department with administrative responsibility for all public and privately-operated community and institutional ICF/IDD services for approximately 3,000 children and adults. The state of Connecticut worked closely with the courts on matters of competency to stand trial and provided services to individuals accused or convicted of sex offenses in both secured and non-secured community settings.

12. From 1999 to 2002, I served as the Branch Head for Operations and Fiscal Management for the state of North Carolina Developmental Disabilities Section. In this capacity I had administrative responsibility for Medicaid policy, HCBS Waiver management, waiting list management, fiscal policy and technical assistance for a system serving approximately 22,000 children and adults. The North Carolina DD Section worked closely with the Mental Health Section to successfully transition hundreds of individuals from inpatient mental health hospitals back into community-based service settings with support from IDD service providers, including those with complex needs and forensic histories.

13. Finally, I have 15 years of experience as a provider of services for people with IDD, including those with complex medical and behavioral health needs. I began my career providing services to individuals transitioning from an institution to the community in apartment settings and small group homes in 1984, first from Pennhurst State School and Hospital, until its closure in 1987 and then from the Embreeville State School and Hospital. Over the span of those 15 years, I took on management and administrative roles in two community non-profit organizations, overseeing the development and management of numerous community residential settings serving individuals with a wide variety of support needs, including those with criminal histories and complex behavior needs.

The District of Columbia Has the Capacity to Serve Individuals with IDD and Problematic Sexual Behaviors in its Community-Based System

14. When Mr. Seth made application for services from DDS, the Developmental Disabilities Administration within DDS was currently serving a few individuals who had a history of sexual offenses in community-based service settings in the District. DDA also had served for a number of years a few individuals who had been found not competent to stand trial who were committed to DDS. These individuals were primarily those who were already receiving services from DDA or who were under the care of the Children and Family Services Administration and were transitioned to DDA for adult services.

15. During my tenure with DDS, St. Elizabeth's Hospital transitioned to a new, smaller facility. As part of that transition, DDS worked closely with the Department of Mental Health to transition approximately 20 individuals who had been long-term patients of St. Elizabeth's Hospital, under civil or criminal commitment, back into the community with support from the IDD provider community. A number of these individuals had significant forensic histories and/or a history of violent behavior, including sexual offenses, requiring careful, person-centered planning to ensure a successful transition to a safe setting for the individual and their community. DDS has a history of working collaboratively with the Department of Mental Health to support individuals with a dual diagnosis of intellectual disability and a mental or behavioral health diagnosis, including those with the most complex and significant disabilities. This includes utilizing the District's mental health crisis intervention system and public and private psychiatric hospital systems for short-term stabilization and care.

16. Prior to 2007, the District's education system, Child and Family Services Administration and DDA frequently placed individuals with complex behavioral and medical needs in out-of-state residential settings as a result of the lack of expertise to serve such individuals by District service providers. During my tenure with DDS, as the IDD service delivery system strengthened, DDS successfully returned dozens of such individuals back to the District. The District's IDD service delivery system has demonstrated that it has the capacity to serve individuals with IDD and any number of co-occurring disorders and disabilities.

17. Although it is a last resort, DDA can also place individuals with intellectual disabilities in out-of-state placements when necessary to meet needs not within the expertise of DDA's local providers. During my tenure with DDS, DDA developed an out-of-state placement

specifically for one individual who could not be served by District IDD providers. This individual's needs were so complex they required the construction of a specially designed home, specialized staffing and staff training and private air transportation to the new home to succeed. Although Mr. Seth's records do not indicate that his needs are anywhere close to such complexity, DDA staff and leadership learned a great deal from that experience that it could bring to bear if Mr. Seth were to require an out-of-state placement. In addition, placements adequate to meet Mr. Seth's needs are widely available in nearby states, such as Pennsylvania.

18. I made the decision to direct DDS to proceed with commitment of Mr. Seth to DDS should he be found not competent to stand trial based on decades of experience, research in the field regarding the ability to serve individuals in the community with complex needs and harm in turn to individuals with IDD who are institutionalized, and first-hand experience with the District's IDD service delivery system. DDA had successfully served individuals with the same profile and history and had no reason to not do the same for Mr. Seth. I also understood that the District's Department of Behavioral Health routinely undertook civil commitment and provided services to individuals with mental illness in similar situations, and that individuals with intellectual disabilities deserved similar treatment.

19. Mr. Seth's eligibility package included sufficient information to make the determination that Mr. Seth could present a danger to the community if not appropriately supervised and provided therapeutic and clinical supports. As such, DDA proceeded with person-centered planning to identify an appropriate IDD community service provider and prepare for the necessary clinical and behavioral support systems. The IDD HCBS Waiver program allows for intensive supervision including the use of two staff (or more if needed) at all times for one service recipient, and includes behavioral support services and sex education services. DDS also maintained a contract with the Georgetown University Center for Child and Human Development to provide additional behavioral support consultation, and DDA maintained a Ph.D. behavioral psychologist on contract for additional consultative support.

20. The IDD HCBS Waiver program is not limited by an individual's potential service costs. In fact, as the DDS IDD HCBS Waiver program is constructed, the District is required to provide the level of support necessary as determined by the person-centered plan to

ensure the individual's, and community's, health and welfare. Any eligible person who makes application for HCBS Waiver services is required to be served by DDS unless DDS has a waiting list for services. DDS does not have a waiting list for services, and its budget continues to increase year over year to accommodate for new individuals seeking services.

21. I have reviewed the evaluation prepared by Matthew Mason, Ph.D. who would also be available to support Mr. Seth, his planning team and IDD community support providers. The plan developed by Wholistic is comprehensive and includes services from a psychiatrist, a therapist and behavior specialist in addition to intensive staff supervision. The District also has available crisis intervention services should that be necessary, although Mr. Seth's clinical profile suggests that well trained staff should be very successful in their own right. The District can also turn to out-of-state residential settings if in the future Mr. Seth displayed significant non-compliance. There are specialized programs such as the Deveraux Foundation and others that could effectively provide comprehensive supports should that future need arise.

Conclusion

22. The IDD HCBS Waiver has all the services and supports necessary to safely and effectively support, supervise and manage such individuals in the community, and the amount of services available are not limited. The service plan proposed by Wholistic includes those critical services and supports, and there is no waiting list for enrollment into the IDD HCBS Waiver program.

23. The evaluation completed by DDS' own retained behavioral psychologist, Dr. Mason (2017), noted that Mr. Seth's cognitive, behavioral and emotional traits have been repeatedly characterized as those of an immature child as opposed to those of a "hardened" offender, and his problematic behaviors displayed while incarcerated have appeared to be relatively low in intensity and brief in duration. Mr. Seth's history of abuse, neglect and abandonment combined with a lack of consistent intervention and support for his intellectual disability throughout his life obviously contributed to his offending behavior. Dr. Mason has worked in the District's IDD service delivery system for a number of years, including during my

tenure with DDS, and as such has direct knowledge of the capabilities of the DDS service delivery system. Given that knowledge, Dr. Mason provided his recommendation to DDS that with appropriate services in place, Mr. Seth can be safely and successfully supported in the community. I agree with Dr. Mason and Wholistic has designed a proposed program that addresses Dr. Mason's recommendations.

24. Based on my knowledge of the DDS IDD provider community and the IDD HCBS Waiver program, the decision by DDS to allow Mr. Seth to languish and regress in federal custody rather than carry out its mission and mandate remains inexplicable other than as a matter of discrimination and refusal to alter a usual way of working in order to accommodate an individual's needs. The evaluations have described Mr. Seth's difficulty with adapting to the prison environments as a result of his disabilities leading to repeated periods of solitary confinement. I agree with Nancy Thaler who observed that this illustrates the kind of vicious cycle of triggers and punishment followed by triggers and more punishment that justifies prioritizing people like Mr. Seth for community rather than institutional placement.

25. Providing appropriate, closely supervised, residential, vocational and therapeutic services in a community setting can be accomplished while assuring the safety of the community in the District and offer Mr. Seth the opportunity for rehabilitation and freedom from further and ongoing trauma.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 24th day of October, 2018.

Laura L. Nuss

Laura L. Nuss

Accomplished and visionary executive leader in government and non-profit administration with record of success in planning and executing organizational and systems-wide change. Advanced significant person-centered thinking and No Wrong Door grant initiatives from planning to implementation. Extensive experience in HCBS program design. implementation and management in multiple states to advance community integration, inclusion, employment and self-determination. Designed and managed quality assurance and improvement systems at the state and provider level, including critical incidents, mortality review, provider certification and monitoring, and risk analysis and management. Lifelong advocate in support of persons with developmental disabilities and their families skilled in expanding and improving stakeholder engagement and provider relations.

Education

- M.S., Community Systems Planning and Development
  The Pennsylvania State University, University Park, PA
- B.S., Administration of Justice
  The Pennsylvania State University, University Park, PA

Employment History

Senior Program Analyst, New Editions Consulting, Inc., Falls Church, VA (October 2017 to present)
Provides expert review and technical assistance support for the Centers for Medicare and Medicaid Services Home and Community-Based Services Settings Rule implementation contract. Reviews state documents, providing comments and feedback for CMS. Provides individual state TA in response to states' needs and with CMS approval. Develops and presents webinars and conference presentations on topic related to HCBS and the Settings rule.

Principal, LNUSS Group, Silver Spring, MD (May 2016 to present)
Technical assistance and consulting services in Medicaid policy, LTSS systems change, Olmstead compliance, person-centered thinking transformation, finance strategies and rate setting, stakeholder engagement, WIOA, inclusive employment and support strategies, and, quality and performance management for federal, state and local government and private organizations. Clients:

- Colorado Office of Community Living, Department of Health Care Policy and Finance
- D.C. Department on Disability Services
- Delaware Division of Developmental Disabilities Services
- DOJ Independent Reviewer
- Econsys: DOL/Office of Disability Employment Policy- Subject Matter Expert
- Foothold Technology, NY, NY- Senior Advisor
- Liberty Healthcare Corporation

- Maryland Developmental Disabilities Administration
- New Editions Consulting: CMS Technical Assistance Contract- Expert Consultant
- New Mexico Developmental Disabilities and Supports Division
- Ohio Department of Developmental Disabilities
- U.S. State Department, International Disabilities Rights Speaker Program
- Utah Disability Rights

Director, Department on Disability Services, Government of the District of Columbia, Washington, DC (June 2010 to April 2016)
Cabinet level appointment leading agency employing 400+ skilled and professional staff for Department encompassing the Developmental Disabilities Administration, combined Vocational Rehabilitation Services Administration and federal Disability Determination Division for the District.

- Created innovative information, performance, and quality management systems to support the *Plan for Compliance and Conclusion* of a 40-year-old federal class action (*Evans v. Bowser*), and ID/DD HCBS quality assurance requirements. Submitted final certifications resulting in successful conclusion of the case in January 2017.
- Implemented system-wide, multi-year Person-Centered Thinking and Employment First! initiatives for the public and private sector in advance of the 2014 HCBS Settings rules to support systems change to increase employment, community integration and choice outcomes. Ensured timely submission of STP and HCBS supporting amendments.
- Led cross-agency innovations in WIOA and No Wrong Door initiatives, braiding and blending resources and business process improvements. Designed and implemented cross-agency person-centered planning and thinking training and practices across No Wrong Door partners.
- Multiple systems change efforts led to jump from 48th to 8th in UCP inclusion rankings over an eight-year span.

Deputy Director, Department on Disability Services, Government of the District of Columbia, Washington, DC (August 2007 to May 2010)
Designed and implemented system and organizational reforms for a newly organized Developmental Disabilities Administration.

- Increased service recipients by 52% and budget by 300% in the HCBS waiver program with no increase to the local (state) budget through local and HCBS 1915(c) waiver program and finance revisions. Reduced reliance on ICF/IID model of care by 40%.
- Designed and implemented enhanced quality assurance and improvement systems for the IDD service system to meet CMS 1915 (c) HCBS waiver assurances. Transitioned provider monitoring/certification to private vendor to increase transparency and focus on outcome measures.
- Designed and implemented a new organizational structure and led system reform efforts to bring closure to an outstanding penalty phase of a federal class action litigation (*Evans v. Fenty*) and proceed to a *Plan for Compliance and Conclusion* in 2010.

- Designed and implemented innovated health care collaborations and initiatives with local Medical Schools and the UCEDD to increase medical provider capacity, improve skills of ID/DD service community, and enhance direct clinical services and medical professional education to improve health care services to persons with ID/DD.

Consultant, Premier Government Solutions, Mechanicsburg, PA. (January 2007 to August 2007)

- Researched and designed a 1915(c) renewal HCBS waiver application for the District of Columbia, Department on Disability Services.

Director of Strategic Leadership, Connecticut Department of Developmental Services, Hartford, CT (July 2003 to July 2007). Provided executive leadership in Medicaid operations, policy development, quality assurance, staff development and information management to drive system reform for $900M organization.

- Developed and implemented two new 1915 (c) HCBS waivers to promote self-direction and new individualized home and community-based services.
- Managed the design and implementation of a new quality assurance and improvement system for HCBS services and web-based information management system to support data driven decision-making.
- Designed a fiscal strategy to create a $40M waiting list initiative as part of effort to successfully settle pending WL/HCBS class action, and, led fee-for-service payment structure systems change.

Regional Director, Connecticut Department of Developmental Services, Bridgeport, CT (February 2002 to June 2003) Led all aspects of the regional ID/DD system providing public and private contracted services with an annual operating budget of $85M in support of more than 3,000 children and adults.

Branch Head, Operations and Fiscal Management, North Carolina State Developmental Disabilities Section, Raleigh, NC (1999 to 2002) Led fiscal and information system policy and planning, Medicaid policy, HCBS waiver management, waiting list management, and technical assistance for developmental disability services serving 22,000 children and adults with an operating budget of $850M.

Coordinator/Consultant, PIER-Consumer Family Satisfaction Team, Media, PA (1998 to1999)

Progressive Mid to Executive Non-Profit Management, Elwyn, Inc. and Barber Resources for Delaware Valley, Southeastern PA (1984 to 1998)

<u>Principal Investigator</u>

- *Level of Need and Resource Allocation: Independence Plus Initiative*, October 2003-September 2007, Centers for Medicare and Medicaid Services.
  In collaboration with the CT UCEDD, designed a level of need and risk assessment tool to establish individual budgets in self-directed HCBS services, meet the risk assessment

requirements for HCBS person-centered planning and support waiting list prioritization for services.

- *Quality Assurance and Improvement: Systems Change Grant,* October 2003- September 2007, Centers for Medicare and Medicaid Services.
  Designed a new quality assurance and improvement system for HCBS services, wrote an RFP for the supporting information management system and managed the development phase with the IT contractor.

Teaching Experience

Instructor, *Probation, Parole and Community Field Services,* Independent Learning Division, Penn State University, University Park, PA (1983 to 1994)

Affiliations

NASDDDS Alumni Member
NASDDDS Board Member 2009 – 2016, Board President 2015-2016
APSE Member
RCM of Washington, Inc., Board Member
Shared Horizons, Board Member

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MARKELLE SETH, **Plaintiff,**	)	
vs.	)	**CIVIL ACTION NO: 1:18-cv-01034**
The DISTRICT OF COLUMBIA,	)	
The D.C. DEPARTMENT ON DISABILITY SERVICES, and	)	
ANDREW REESE, in his official capacity as Director of the D.C. Department on Disability Services,	)	
Defendants.	)	

DECLARATION OF NANCY THALER

I, Nancy Thaler, declare under penalty of perjury that:

1. I have over 47 years of experience working in the field of services for people with intellectual and developmental disabilities ("IDD"). I have over 19 years' experience working for and leading state government agencies that oversee, fund, design, and provide services for people with IDD. In this capacity, I have overseen the development of a system of community services that can support all people with IDD, including people with complex needs and behavioral needs. I also have been a direct provider and administrator of services for people with IDD both in the community and in institutions. Additionally, I have more than 10 years of experience working with states across the country on improving their IDD systems.

2. I have reviewed the Complaint and Exhibits in this case, including the Draft Description of Services prepared by Benchmark Human Services (Complaint Exhibit 2) and the Proposal for Transition, Safety & Support Services prepared by Wholistic Home and Community Based Services, Inc. (Complaint Exhibit 3, "Wholistic Proposal") for Markelle Seth. I have also

reviewed Mr. Seth's Complaint against the District of Columbia; the D.C. Department on Disability Services; assessments completed by Matthew Mason, Ph.D., BCBA-D, LBA, Stephen D. Hart, Ph. D, Manuel E. Gutierrez, Psy.D., and Katrina P. Lloyd, Psy. D.; the Competency to Stand Trial Evaluation by Samantha E. Dimisa Ph.D.; the Neuropsychological examination report completed by Robert L. Denney, Psy.D., ABPP; the April 17, 2015 planning letter to Mr. Seth from Musu Fofana, Program Manager from the D.C. Dept. on Disability Services; a set of 2017 incident reports prepared by the Dept. of Justice's Federal Bureau of Prisons; and the August 4, 2017, letter from Laura L. Nuss, former Director of DDS regarding Mr. Seth.

3. Based on my decades of experience and expertise, it is my expert opinion that state systems, such as the Department on Disability Services ("DDS") system in the District of Columbia, can serve people with IDD and complex behavioral needs, including problematic sexual behaviors, such as Markelle Seth, in a fashion that allows them to live successfully in the community while simultaneously ensuring community safety.

4. States across the country are already serving people with the most complex needs in the community. The District of Columbia has available services sufficient to safely serve individuals with IDD with problematic sexual behaviors in the community. Yet, the District of Columbia has inexplicably decided to rely on the federal Bureau of Prisons to serve Markelle Seth even though it has community-based services available to meet his needs and the needs of his community. The District's decision in this case is contrary to decades of evidence-based research and successful practice in the field of disability services, to the District's own capabilities, and to its own goals for serving people with IDD in the community.

5. I offer the following information and opinions based upon my significant expertise and experience, as described above, and included in my C.V., which is attached to this Declaration as Attachment 1. I am not being compensated for my work in this case.

Professional Experience

6. I was, until September 7, 2018, the Deputy Secretary of the Office of Developmental Program ("ODP") in the Commonwealth of Pennsylvania, a position which I had held since June 2015. As the head of ODP, I was responsible for the administration of the state's system of community services and state-operated institutions, which serve more than 55,000 children and adults with IDD. As Deputy Secretary, I was responsible for all activities related to policy development, service design and standards, budget development, financial management, quality management, and the operation of the state's community-based service system for people with disabilities through four federally funded Medicaid Waiver programs, one Medicaid managed care program and the federally funded Intermediate Care Facilities for Person with Intellectual Disabilities (ICF/ID) program. It has long been a priority of the Commonwealth of Pennsylvania to expand community services to ensure that all people with disabilities, including people with complex behavioral needs and problematic sexual behaviors, are given the opportunity to receive the services they need to live safe and integrated lives in the community.

7. I previously held this same position – which was then called the Deputy Secretary for Pennsylvania's Office for Mental Retardation (OMR) – from 1993 to 2003. During that time period, I oversaw a significant expansion of community-based services in Pennsylvania, coupled with the transition of over 1,800 people with IDD from institutions to the community. We closed ten state-operated institutions: three very large facilities (serving 250 to 400 people) and seven large facilities (serving 50 to 100 people). We also transitioned to the community over 300 individuals from private institutions that subsequently closed. During my tenure as Deputy Secretary of OMR, there was a more than 58% reduction in the number of people with IDD served in institutions operated or funded by Pennsylvania. During this time, Pennsylvania also began the development of a statewide network of support for individuals with IDD and problematic behavior including sexual behavior, conducted training institutes on serving such individuals in the community, and developed a manual, training curriculum, and risk assessment tools designed to guide agencies and staff to serve individuals with IDD and problematic sexual

behaviors in the community.[1] These resources and training programs have been continually expanded with additional training programs provided on line and through training vendors. In addition, there are numerous clinical treatment centers that specialize in treatment and support to enable offenders to live successfully in the community.

8. From 1987 to 1993, prior to the appointment as the Deputy Secretary of OMR, I served in OMR as the Director of the Bureau of Community Programs. In that capacity, I administered the state's system of community services, including residential settings, vocational training, family support services and case management services for over 55,000 children and adults.

9. Before my return to state government in Pennsylvania, I served from 2007 to 2015 as the Executive Director of the National Association of State Directors of Developmental Disabilities Services ("NASDDDS"). NASDDDS is a national organization, founded in 1964, that promotes and assists states in developing effective, person-centered service delivery systems for people with IDD. All 50 states and the District of Columbia are currently members of NASDDDS. NASDDDS provides extensive technical assistance and resources to state agencies regarding best practices in serving individuals with IDD, including best practices for serving individuals accused or convicted of sex offenses, individuals leaving incarceration, and individuals who pose safety risks. NASDDDS tracks trends in states' delivery of IDD services and offers a forum for the development of significant state and federal policy initiatives. States often requested technical assistance from NASDDDS to help them design and implement changes in their services systems so that individuals in institutions could be offered the opportunity to receive services in the community.

10. I have extensive knowledge of the operations and capabilities of DDS. During my tenure, the NASDDDS staff and I worked with the District of Columbia on several projects. In 2007, I was asked by DDS to conduct a review of the District's developmental disability system from an administrative point of view, to determine whether the infrastructure of DDS was

[1] Safer Options Manual: A Road Map to Treatment and Community Safety: Pennsylvania's Office of Developmental Programs (2010 ed.).

adequate to operate a system of services that can be expected to achieve positive outcomes for the people it serves, including health and safety, participation in community life. The report was submitted as evidence in the *Evans v. Washington* case. On June 30, 2010 I provided testimony for the Council of the District of Columbia on the appointment of the Director of DDS. In 2011, Chas Moseley, the NASDDDS Associate Executive Director led a study under my supervision on the expansion of service eligibility for DDS and the Developmental Disabilities Council. The result was a report "Assessment and Analysis of the Service Needs of Washington, D.C. Residents with Intellectual and Developmental Disabilities." In 2015, the District of Columbia was enrolled in and received technical assistance from the NASDDDS federally funded Community of Practice (COP) for Supporting Families of Individuals with Intellectual and Developmental Disabilities.

11. I also have extensive expertise in designing and implementing systems to monitor the quality and safety of community-based services. When I was Deputy Secretary for OMR, I was responsible for designing and implementing a quality management system for ensuring that Pennsylvania's community service system met the needs of service recipients and their communities, kept them healthy and safe, and facilitated their integration in the community. From 2003 to 2005, I served in the United States Department of Health and Human Services as the Director for Quality Improvement at the Centers for Medicare and Medicaid Services ("CMS") Center for State and Medicaid Operations ("CSMO"). I was hired for this position because of my nationally-recognized work on designing and implementing a strong and effective quality management system for community services in Pennsylvania. In my position with CMS, I was responsible for the national quality-improvement strategy in the Medicaid Home and Community-Based Services ("HCBS") Waiver program. In that capacity, I oversaw the development of a new HCBS waiver application (still in effect today) that requires states to develop and report on key components of their quality assurance systems, including: provider qualifications, individual care planning, health and safety outcomes, and performance measures. In my most recent position as Deputy Secretary of ODP, I continued to oversee Pennsylvania's quality management system.

12. Finally, I have more than 16 years' experience as a provider of services for people with IDD, including individuals with complex medical and behavioral needs. I began my career in 1971 as a direct service professional providing daily supervision and training for children with IDD. I also supervised small residential settings and served as a facility administrator for a large (70+ beds) institution for people with IDD known as an Intermediate Care Facility ("ICF"). I first began providing services to individuals transitioning from an institution to the community in 1974, following an order by a federal district court requiring Pennsylvania to develop community placements for people transitioning from one of the state's institutions, the Pennhurst State School and Hospital. From 1974 to 1978, I served as a houseparent in a group home serving six individuals, three of whom were individuals transitioned from Pennhurst State Center. Over the next decade, including through the closure of Pennhurst in 1987, I took on supervisory and then administrative roles, overseeing the development and management of many community homes that served individuals transitioning from Pennhurst to the community.

13. During the last six years, I have provided testimony in litigation four times. In January 2018, I submitted an affidavit in *Pendleton et al. v. JEVS et al.* evaluating a service model known as Life Sharing, its value in supporting individuals to live in the community and the application of Department of Labor rules to the service model. In March 2016, I submitted a declaration in *United States v. Georgia* (N.D. Ga.) opining about the state of Georgia's ability to serve people with IDD in community-based settings pursuant to a settlement with the United States under the Americans with Disabilities Act and *Olmstead*. In November 2015, I testified in court regarding behavioral interventions for people with IDD and significant behavioral needs on behalf of the Commonwealth of Massachusetts in *Judge Rotenberg Center v. Massachusetts Department of Developmental Services* (Bristol County Probate Court). In May 2012, I submitted a declaration in *United States v. Virginia* (E.D. Va.), about whether a settlement agreement between the Commonwealth of Virginia and the U.S. Department of Justice to address the state's violations of the Americans with Disabilities Act and *Olmstead* met prevailing standards for state systems serving individuals with IDD in *United States v. Virginia* (E.D. Va).

People with IDD, Including People with Complex Behavioral Needs and Problematic Sexual Behaviors, Can Be Served Safely in the Community

14. Over the last fifty years, there has been a steady and significant increase in demand for community-based services for persons with IDD and their families. In the 1970s and 1980s, through the development of family support services, residential services, vocational training programs, recreational programs, and educational opportunities, many people with IDD transitioned from institutions and started becoming part of the community. Admissions to state institutions declined rapidly as, for more and more families, the concept of institutionalization was simply not considered for their children with disabilities. More and more evidence mounted that community living was, in fact, possible for all people, including people who were once believed to require institutional care or incarceration.

15. The federal government established the Medicaid HCBS Waiver program in 1981, making federal funding available to states for community-based services through the Medicaid program. Currently, the Medicaid HCBS waivers generally comprise the central package of services states and the District of Columbia use to serve individuals with IDD in their own communities.

16. Due to the significant development of community-based systems over the past several decades, even individuals with very significant support needs (including individuals who are non-verbal and need complete assistance with functions such as eating and bathing), complex medical conditions (such as those requiring feeding tubes and tracheostomy care) and challenging behaviors (such as aggression, self-injurious behavior, destructive behavior, or sexually inappropriate behavior) can live safely and successfully in the community with appropriate services and supports. Each of the 711,974 individuals who were served by HCBS services in 2013 had disabilities severe enough to be eligible for an institutional level of care, but these individuals instead were successfully served in the community with supportive services.

17. As evidenced through my own experience and confirmed by national data, individuals in the community have the same complex medical conditions, the same severity of disability and the same behavioral issues as individuals in institutions. In fact, based on my more

than 45 years of experience transitioning individuals from institutions to the community, every person with IDD currently in an institution, including Markelle Seth, could be served safely and successfully in the community if the right services and supports are put in place. National data reveals that today there are 1.23 million people with IDD receiving services – less than 20,000 are in state institutional settings. This drop in institutional census from a high in 1967 of over 194,000 individuals to less than 20,000 today combined with the fact that 14 states have no state-operated institutions at all, underscores the fact that everyone, regardless of their disabilities or presenting challenges, can be and are being supported in the community in the United States.[2]

18. The outcomes for individuals with IDD in community-based services are virtually always better than the outcomes for individuals in institutions or prisons. A recent report from the National Council on Disability surveying the research concluded that individuals in small community settings, such as in their own apartment, a host home, or a very small group home "exhibited the best-developed adaptive behavior and the least challenging behavior" compared to individuals who were institutionalized.[3]

19. Whereas, years ago, community-based treatment and services for individuals with IDD and problematic behavior including sexual behaviors were largely unavailable, extensive research and experience across the country have led to the development and widespread implementation of safe and successful community-based treatment and service models, and evidence-based practices, and expert providers of such services are now available in the District of Columbia and across the country.

20. Serving individuals in the community who have serious co-occurring psychiatric issues and significant behavioral needs is also common. Approximately 32.9% of individuals with IDD served by state agencies have a mental health disorder.[4] Individuals who have

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[2] Larson, S., In-Home & Residential Supports for Persons with Intellectual or Developmental Disabilities: Status and Trends Through 2016: Residential Information Systems Project Report University of Minnesota (2108), available at https://risp.umn.edu/sites/risp.umn.edu/files/2018-08/RISP2016_WEB.pdf.

[3] National Council on Disability, "Home and Community-Based Services: Creating Systems for Success at Home, at Work and in the Community" at 30 (Feb. 24, 2015), *available at* https://www.ncd.gov/publications/2015/02242015.

[4] Including Individuals with Intellectual/Developmental Disabilities and Co-Occurring Mental Illness Challenges that Must Be Addressed in Health Care Reform; NADD Position Statement 2013

challenging behaviors including aggression, self-injurious behavior, property destruction, compulsive overeating, and socially or sexually inappropriate behavior can be successfully served in the community. Supervision in residential living arrangements, in the District as well as elsewhere, is typically 24 hrs. a day, seven days a week and can include intensive 1:1 or higher levels of staffing. Specific behavioral supports can be designed around the individual's needs and specialized training and support for caregivers are all strategies that are routinely used in the community.

21. In my experience, and based on decades of research, individuals with IDD who exhibit inappropriate sexual behaviors often lack information about or opportunities for appropriate sexual expression and intimacy, lack social skills and information about appropriate sexual behavior, and misunderstand social boundaries and rules. In addition, individuals with intellectual and developmental disabilities are far more likely than non-disabled individuals to have themselves been the victim of sexual abuse. The US Dept. of Justice reports that individuals with IDD are seven times more likely to experience sexual abuse than people without disabilities.[5] In many cases, the experience of sexual abuse causes trauma and confusion about what is appropriate sexual behavior. Individuals who have been victims of sexual abuse may also imitate behavior, particularly when not treated for their own trauma. In some cases, individuals with IDD engage in sexual activity with individuals who are not of an appropriate age, which is sometimes called "age discordant sex play."

22. People with IDD who have committed sexual offenses can live successfully in the community, without presenting harm to others. They can learn appropriate sexual behavior. The keys to success are supervision, treatment and training.

23. Experience and research also confirm that an individual's challenging behaviors may improve once the individual is provided with appropriate supports in the community. [6] The

[5] Abused and Betrayed: Joseph Shapiro, National Public Radio 2018, *available at* https://www.npr.org/series/575502633/abused-and-betrayed.

[6] Lakin, C., University of Minnesota Research and Training Center on Community Living, Policy Research Brief, Outcomes of Deinstitutionalization for People with Intellectual and/or Developmental Disabilities: Third Decennial Review of U.S. Studies, 1977-2010, at 8-9, available at https://ici.umn.edu/products/prb/212/212.pdf.

individual's problem behaviors may be aggravated by the daily aspects of life in a prison or other institution: rigid routines that allow little personal control over the activities of daily life; adults mandated to eat, sleep, and move through a predetermined schedule that is created to manage groups of people; and the lack of stimulating activity, which results in boredom often stimulates rebellious and non-compliant behavior. People with IDD may have considerable difficulty understanding the purpose behind rules and the consequences for violating rules and be frightened by the lack of supportive behavior from prison personnel. People who cannot effectively communicate their dissatisfaction with words may simply act it out. Very often, institutional residents' behavior is a result of, or a reaction to, abuse or trauma they may have experienced.

24. Community settings can be easily individualized and designed to avoid the specific triggers that cause an individual's challenging behaviors, including those that are the result of previous experiences of abuse. In Pennsylvania, one population prioritized for community placement is people with the most significant behavioral needs, precisely because of how problematic the inflexible institutional or prison environment is for these individuals and how community settings can be more tailored to an individual's needs and triggers.

25. For example, discipline reports indicate that Mr. Seth has been punished with solitary confinement for conflicts arising because he was not able to watch his preferred television programs. While such a strong television preference may create a problem in an institutional setting, it is unlikely to arise in a community-based program such as that proposed by Wholistic because Mr. Seth would not be in a group setting sharing a television with many other residents. In addition, to the extent conflict did arise, Wholistic's trained staff have tools to de-escalate conflicts and teach positive social behaviors without resorting to isolation.

26. Supporting individuals with IDD who have committed criminal offenses in the community, including those who have committed sexual offenses, is common practice throughout the United States. In Pennsylvania alone, over 300 individuals with IDD and a history of having committed a sexual offense are being successfully supported by over ten different community provider agencies across the Commonwealth. The program model has two

equally important components: community safety and the person's growth and development through treatment and support services. Community safety is achieved through very close supervision which is typically living in a small home with no more than one or two other individuals and having staff present at all times. As early as the 1980s, a model for supporting and treating sex offenders with intellectual disabilities was developed in Lancaster County.[7]

Components of a Successful Program to Safely Serve Individuals with IDD and Problematic Sexual Behaviors in the Community

27. With over four decades of experience with deinstitutionalization, IDD professionals know how to successfully serve individuals with IDD and problematic sexual behaviors in the community.

28. Based on my over 45 years of experience and the success of programs in Pennsylvania, the most critical components of an effective treatment plan for an individual with IDD and problematic sexual behaviors such as those Markelle Seth has displayed are the following:

a. an experienced therapist within the treatment team
b. coordination with the criminal justice system if applicable
c. regular on-going staff training
d. knowledge of the offending cycle
e. supervision and safety plans
f. identification and addressing red flag behaviors, understanding thinking errors / cognitive distortions / triggers / targets and disclosure
g. mental health assessment and services appropriate to a diagnosed mental health disorder
h. a small residential setting with 24-hour staff supervision and no more than 2 housemates who are carefully screened to assure compatibility and safety; location to vulnerable populations must be evaluated

[7] Lancaster County Pennsylvania, Mentally Retarded Offenders Program, White and Wood 1986 The Prison Journal Volume: 66 issue: 1

i. the use of person-centered planning practices to assist the person in developing interests and skills, to maintain good health and wellness, to participate in community life in a way that is safe, to maintain connections to family members, to find a way to contribute to the community, preferably through employment
j. assessment of elopement potential with plan for deterrence, supervision and management
k. access to technology for communication, supervision and safety
l. crisis management plan

The District of Columbia Has the Capacity to Serve Individuals with IDD and Problematic Sexual Behaviors in its Community-Based System

29. The District of Columbia has the services available within its system to provide the necessary components of a successful service plan for a person with IDD and inappropriate sexual behaviors such as Mr. Seth.

30. The service plan proposed by Wholistic Home and Community Services is thoughtful and offers the necessary components of a successful service plan for an individual with IDD and problematic sexual behaviors such as Mr. Seth. Wholistic's plan includes services from a psychiatrist as well as a therapist and behavior specialist, and will provide sexuality education through the Georgetown University Center for Child and Human Development, the District's University Center for Excellence in Developmental Disabilities. Wholistic's plan includes 1:1 staffing in a single residence with no more than one additional resident. Given Mr. Seth's enjoyment of the company of other adults, the introduction of an additional resident is both prudent and supportable. The agency is prepared to provide 2:1 staffing in the initial months until they know Mr. Seth well and can reliably predict his behavior pattern. The daily interaction with Mr. Seth is based on a mentoring model which will provide him with respect as well as modeling for appropriate behavior. With the addition of a formal behavioral assessment and planned interventions, and a highly structured daily routine, Mr. Seth will be continually engaged in meaningful and appropriate activity through which he can grow and develop healthy behavior. Wholistic is prepared to hold certain privileges contingent on meeting behavior goals using an evidence-based approach that respects Mr. Seth's rights. The

Wholistic proposal offers a complete approach to supervision of Mr. Seth, assuring safety in the community and addressing crisis events such as elopements or behavioral incidents.

Conclusion

31. For the last 30 or more years, states have substantially improved their systems of services and evidence-based practices to serve individuals with IDD and problematic sexual behaviors. We now know from extensive research and national experience what it takes to effectively and safely serve such individuals in their communities. Pennsylvania and many other states serve numerous people with IDD and problematic sexual behaviors in the community through their Medicaid waiver programs. The District of Columbia has within its Medicaid waiver system all the services necessary to safely and effectively serve such individuals in the community. The service plan proposed by Wholistic Home Services includes the critical components necessary to serve such an individual including adequate supervision and training.

32. Mr. Seth is a young man who began life at three months of age removed from his family and placed in foster care. He has experienced abuse and abandonment, the absence of positive role models or adult guidance. His intellectual disability limits his ability to understand the world around him without professional guidance and supervision. Life in a correctional facility will compound his trauma, and will exacerbate his existing anxiety and related mental illness stemming from abuse, head trauma and neglect.

33. The evaluations of Dr. DiMisa (2014), Dr. Denney (2015), Dr. Lloyd, (2015, 2017) and Dr. Mason (2017) underscore Mr. Seth's significant limitations, his history of abuse and trauma and his inability to participate in his own defense. These evaluations also describe Mr. Seth's difficulty adjusting to the rigid and unforgiving demands of a prison environment and how infractions have been punished with extended solitary confinement and removal of privileges. This illustrates the kind of vicious cycle of triggers and punishment followed by triggers and more punishment that justifies prioritizing people like Mr. Seth for community rather than institutional placement.

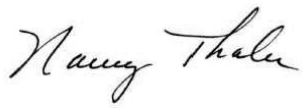
34. I agree with Dr. Hart's (2017) conclusion that if Mr. Seth continues to be incarcerated without appropriate services, he will likely have continuing behavior problems resulting in increased levels of frustration or anger and a growing record of infractions, making it less and less likely that prison staff will perceive him as compliant and agree to his release. In short, the longer Mr. Seth remains in prison, the more harm he will experience, the more behavior problems he is likely to develop, and the more difficult it will be for him to transition to the community. However, I also agree with Dr. Mason that a carefully designed and appropriately staffed community-based program focused on Mr. Seth's learning, behavioral and emotional needs has is highly likely to succeed in preventing his re-offending. Wholistic has developed a proposed program meeting all the criteria identified by Dr. Mason to achieve that goal.

35. Dr. Lloyd, a prison psychologist, opines that Mr. Seth would be a danger in the community. Her evaluation is based on the assumption that he would be returned to the community at large without supervision or control. However, according to the materials I have reviewed, Mr. Seth would not be unsupervised in the community and the terms of his liberty would be subject to a court order of civil commitment. Rather, the Wholistic proposal would have Wholistic determine the location of Mr. Seth's living facility and directly control it, supervise activities that Mr. Seth engages in 24 hours a day with staff supervision for all waking and sleeping hours. This level of constant supervision has proven to be successful for hundreds of similar offenders and will keep the community safe and Mr. Seth from reoffending.

36. It should also be noted that if for any reason Mr. Seth were to abscond from his placement, or if his behavior in the community were to reach a point where a higher level of restriction or even confinement were necessary to protect him or the safety of the community, DDS has access to a continuum of care that includes a continuum of restriction. Locally, there are crisis beds and hospital units where intervention can take place. And, should longer term restriction become necessary, DDS has the ability to place Mr. Seth in an out of state residential program or institution. Nothing in the extensive materials I have reviewed suggests a need for such a restrictive setting for Mr. Seth, but these options are available if necessary.

37. Placement into a properly located, well supervised, experienced community program, such as that proposed by Wholistic, will assure the safety of all members of the community at large and will offer Mr. Seth an opportunity to be free from abuse and trauma, and to be rehabilitated during his adult life.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 26th day of September, 2018.



Nancy Thaler

NANCY R. THALER

Education:

Misericordia University 2007
Honorary Doctor of Humane Letters, Honoria Causa

Villanova University 1988
Master of Human Organization Science
Major: Public Administration

La Salle College and Wharton School/University of Pennsylvania 1984
Social Science Agency Management Education and Development
Program for Executives

Misericordia University 1971
Bachelor of Arts
Major: Music

Experience:

Commonwealth of Pennsylvania 2015 – 2018
Harrisburg, Pennsylvania
Department of Public Welfare / Office of Developmental Programs
Appointed by Governor Tom Wolf 2015
As Deputy Secretary for Mental Retardation, administered Pennsylvania's system of community services and state-operated facilities for over 55,000 children and adults with disabilities.
Responsibilities included:

- Managing
  - a budget of $4 Billion in state and federal funds
  - 2,000 employees in administrative roles and in state institutions
  - organizational change involving significant expansion of the service system and the closing of six public institutions
- Strategic planning, policy, and developing legislative proposals
- Maintaining a working relationship with Federal funding agencies, including The Centers for Medicare and Medicaid Services, the Federal Department of Education and state departments and agencies
- Maintaining a working relationship with elected officials in the Pennsylvania State General Assembly and Congress
- Representing the Governor and the Secretary of the Department of Public Welfare to the public and the press

- Developing and maintaining a working relationship with consumers, families, advocacy groups, providers of service, and county governments, including involvement in planning and policy development
- Developing a Quality Management Program and a state-wide training program for service providers and employees in county government
- Representing the Commonwealth in state and federal litigation, providing testimony in trials and negotiating settlement agreements

National Association of State Directors of Developmental Disabilities Services — 2007 – 2015
Alexandria, Virginia

As Executive Director, Responsibilities Include:

- Working with the Board of Directors,
- Strategic planning
- Hiring, directing and evaluating personnel
- Managing the operating budget
- Direct the activities of the association

Liberty Healthcare Corporation — 2006 – 2007
Bala Cynwyd, Pennsylvania

As Vice President of Operations, responsibilities included:

- Consultation to government agencies and private organizations on Medicaid Waivers, organizational planning and operations, program design, policies and procedures, and Quality Management
- Expert Witness on behalf of state agencies related to waiting list litigation, Medicaid Waiver operations and institutional closings
- ICF/MR facility management

Northwestern Management Services Company — 2005 – 2006
Harrisburg, Pennsylvania

As Senior Advisor for MR Services, Quality and Development, Responsibilities included:

- Consultation to outside government agencies and private organizations on Medicaid Waivers, organizational planning and operations, program design, policies, procedures, and Quality Management.
- Direct technical assistance to NHS Human Services, an affiliate organization, on Mental Retardation/Developmental Disability program design, policies, operating procedures and training
- Direct technical assistance to NHS Human Services on quality

practices in foster care, juvenile justice, and behavioral health services.

Centers for Medicare and Medicaid Services (CMS)/ 2003 – 2005
Center for State and Medicaid Operations (CSMO)
Baltimore, Maryland

As Director for Quality Improvement, responsible for national quality-improvement strategy in the Medicaid Home and Community-Based Waiver Program serving over 750,000 individuals in 50 states and territories. Responsibilities included:

- Designing:
  - Requirements for the Home and Community Based Waiver Program
  - Protocol and procedures for federal oversight of state programs and assist in their implementation
  - New work flow processes for CMS review and approval of state applications and CMS review and renewal of state programs
- Directing:
  - Technical assistance to states
- Developing:
  - Policy analysis and recommendations for CMS officials

Commonwealth of Pennsylvania 1993 – 2003
Harrisburg, Pennsylvania

Department of Public Welfare / Office of Mental Retardation
Appointed by Governor Robert P. Casey 1993
Appointed by Governor Tom Ridge 1995
As Deputy Secretary for Mental Retardation, administered Pennsylvania's system of community services and state-operated facilities for over 80,000 children including birth – 3 Early Intervention Services and adults with disabilities.
Responsibilities included:

- Managing
  - a budget of $2 Billion in state and federal funds
  - 4,000 employees in administrative roles and in state institutions
  - organizational change involving significant expansion of the service system and the closing of six public institutions
- Strategic planning, policy, and developing legislative proposals
- Maintaining a working relationship with Federal funding agencies, including The Centers for Medicare and Medicaid Services, the Federal Department of Education, state departments and agencies
- Maintaining a working relationship with elected officials in the

Pennsylvania State General Assembly and Congress

- Representing the Governor and the Secretary of the Department of Public Welfare to the public and the press
- Developing and maintaining a working relationship with consumers, families, advocacy groups, providers of service, and county governments, including involvement in planning and policy development
- Developing a Quality Management Program and a state-wide training program for service providers and employees in county government
- Developing a web-based Information System with applications for client, financial, and quality management for over 10,000 users throughout the Commonwealth
- Representing the Commonwealth in state and federal litigation, providing testimony in trials and negotiating settlement agreements

Commonwealth of Pennsylvania 1986 – 1993
Harrisburg, Pennsylvania

Department of Public Welfare / Office of Mental Retardation
As Director of the Bureau of Community Programs, administered Pennsylvania's system of community services consisting of residential options, vocational training, family support services, early intervention, and case management services for 55,000 children and adults. Responsibilities included:

- Planning, policy development, licensing, resource allocation, and the implementation and evaluation of community services
- Supervising 80 professional staff in a central and four regional offices
- Providing direction to 45 County Mental Health/Mental Retardation Programs
- Managing a community services budget of over $500 Million
- Maintaining working relationships with statewide consumer, advocacy, and service provider organizations
- Representing the Office of Mental Retardation in meetings with elected officials and the public

Ken-Crest Services 1985-1987
Plymouth Meeting, Pennsylvania

As Director of Residential and Vocational Services, responsible for hiring and supervising directors, establishing a quality assurance program, planning and implementing new programs, and representing Ken-Crest to the public. Responsibilities included administering:

- Residential programs serving children and adults with disabilities,

including Intermediate Care Facilities for the Mentally Retarded and Community Living Programs in three counties in Delaware

- Vocational programs including two sheltered workshops and a supported employment program serving over 140 people

Ken-Crest Services 1981-1985
Plymouth Meeting, Pennsylvania

As Director of River Crest Center, supervised an Intermediate Care Facility for the Mentally Retarded serving 77 children and adults, and a vocational training program for 110 adults. Responsibilities included: managing daily operations - including a residential summer camp serving 140 children and adults - supervising staff, developing budgets, and representing River Crest to the community

Ken-Crest Services 1978-1981
Plymouth Meeting, Pennsylvania

As Director of the Community Living Program, supervised 15 group homes serving 50 individuals. Responsibilities included: supervising staff, overseeing daily operations, developing budgets, and representing Ken-Crest to the community

Ken-Crest Services 1974-1978
Philadelphia, Pennsylvania

As Program Manager/Houseparent, provided a home, with my husband, for six children and adolescents with developmental disabilities which included creating a home environment, caring for daily needs, managing medical care, attending parent-teacher meetings, and writing individual plans of instruction to encourage growth and development

Ken-Crest Services/River Crest 1972-1974
Mont Clare, Pennsylvania

As Childcare Worker, provided daily supervision and training to a group of teenage girls with developmental disabilities in a small private facility

Keystone Residence 1971-1972
Scranton, Pennsylvania

As Childcare Worker, provided supervision and developmental training to toddlers with developmental disabilities in a small private residential facility

Lackawanna Intermediate Unit 1971-1972
Scranton, Pennsylvania

As Special Education Teacher, taught general studies and music to children and adolescents with disabilities

Related Experience/Organizations:

2014 - present National Advisory Board of the College of Direct Support, a web-based learning management system managed by Elesvier, designed for people providing long term care in community-based settings.

2012 - present Board Member Parent to Parent USA, an organization dedicated to assisting parents of children with disabilities to meet other parents with like experiences in order to establish peer support.

2006 - 2012 Board Member of the Council on Quality and Leadership, a private accreditation body that provides training and consultation to organizations serving people with developmental disabilities.

2003 Participant at Invitational Conference to establish National Goals, State of Knowledge Research Agenda for Persons with Intellectual and Developmental Disabilities sponsored by nine federal agencies and 16 national organizations

2000-2003 Board Member of the Home and Community Based Services Network, a federal Health and Human Services initiative to promote high quality consumer-directed services in integrated settings in the states

1999-2001 President of the National Association of State Directors of Developmental Disabilities Services, Inc. (NASDDDS)

1995-2001 Board Member NASDDDS

1994-1996 Member of the National Steering Committee on Managed Care for Related Older Persons and Persons with Disabilities: National Academy for State Health Policy

1985-1987 President (and Board Member) of the Pennsylvania Association of Resources for People with Mental Retardation, a provider trade association

1981-1985 President (and Member) of the Montgomery County Mental Retardation Providers Association

1982-1984 Board Member Montgomery County ARC (Association for People with Mental Retardation)

1975-1978 Member of the Philadelphia Right to Education Task Force

Guest Lecturer/ Instructor:

2004 - present Lecturer: National Leadership Consortium, University of Delaware
2004 Guest Lecturer: University of Pennsylvania/Graduate School of Public Administration
2000-2004 Guest Speaker: Temple University Partners in Policy Making
2002-2003 Guest Lecturer: Penn State Human Services Program
2002 Guest Lecturer: Developmental Disabilities Lecture Series:
The Boggs Center of The University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School
1995 Instructor: The Summer Institute at McGill University - Montreal
1994 Retreat facilitator: New England State MR/DD Directors Retreat

Public Speaking:

Keynote speeches and presentations before numerous professional organizations at the local, state, and national level including:

- National Associations: American Association on Mental Retardation (AAMR); The Association for Persons with Severe Handicaps (TASH) The ARC of the United States; National Home and Community Based Services Conferences;
- Centers for Medicare and Medicaid Services
- State government agencies
- National advocacy, provider, and consumer organization events
- Television interviews both local and national

Publications:

The Role of the U.S. Department of Justice in Enforcing the ADA's Integration Mandate with Dan Berland — 2015
Impact Volume 28 No. 1 Winter 2015

NASDDDS: 50 Years of History — 2014
Future Directions in State Policy: The Path Ahead
National Association of State Directors of Developmental Disabilities Services

Shared Living Guide with Robin Cooper and Kara LeBeau 2011
National Association of State Directors of Developmental
Disabilities Services

The Role of State Developmental Disability Systems: *2010*
Evolving to meet the Needs of Those We Serve Autism Advocate
Second Edition 2010, Vol. 59, No. 2

Constructing the New Service Paradigm: 2009
Responding to Today's Challenges
(North Carolina Medical Journal
November/December Volume 70, Number 6)

Health Care Reform: Long-Term Services and Supports 2008
for Citizens with Developmental Disabilities with Dan Berland
And Charles Moseley
National Association of State Directors of Developmental
Disabilities Services

Managing in an Economic Downturn 2008
National Association of State Directors of Developmental
Disabilities Services

The Dangers of a Literal Interpretation 2004
(TASH Connections; Volume 31, Issue Numbers 5/6, May/June)

Measure for Measure: Person-Centered Quality Assurance: 2000
Balancing Individual Choice and Control with Personal Health and Safety:
A State Administrator's Perspective
with co-author Robert Gettings
(Wingspread Conference Proceedings)

Community Services Reporter 1996
Vouchers: A Funding Mechanism Worth Exploring
with co-author Marsha Blanco
(National Association of State Directors of Developmental Disabilities
Services; Vol. 3, No. 8)

Forward to Learning to Listen: Positive Approaches And 1995
People with Difficult Behavior by Herbert Lovett
(Brookes Publishing, Inc.)

Impact: Institute on Community Integration: 1993
Quality Enhancement: A Commitment in Pennsylvania

(University of Minnesota, Vol. 6, 2, Summer)

Awards/Recognition:

Bethesda Lutheran Communities Pool of Bethesda Award	2012
New Jersey Association of Community Providers (NJACP) Public Leadership Award	2012
Outstanding Ally Award Autistic Self Advocacy Network	2011
The Autistic Self Advocacy Network (ASAN) Outstanding Ally Award	2011
Doctor of Humane Letters, Honoria Causa College Misericordia	2004
Censoni Award of Excellence in Public Services National Association of State Directors of Developmental Disabilities Services (NASDDDS)	2003
Leadership Award American Association on Mental Retardation (AAMR)	2003
Promising Practice Designation Centers for Medicare and Medicaid Services for: Pennsylvania's Transformation of Supports for People with Mental Retardation Pennsylvania's Independent Monitoring for Quality	2003
Professional Service Award The Arc of Allegheny County, Pennsylvania	2001
Vincent J. Fitzpatrick Leadership Award: The Arc of Montgomery County, Pennsylvania	2001
Chairman's Award President's Committee on Mental Retardation	1998
Award for Contribution to Non-Aversive Behavioral Intervention The National Association for People with Severe Handicaps (TASH)	1992
Residential Service and Program Award The Arc of Montgomery County, Pennsylvania	1985

Exhibit 3

Declaration of Robert L. Denney

I, Robert L. Denney, declare as follows:

1. The facts contained in this Declaration are within my personal knowledge and if called upon to testify, I could and would testify competently thereto.

Introduction

2. I am a clinical psychologist with over 27 years of experience and added specialization in the areas of Forensic Psychology and Clinical Neuropsychology. I have extensive experience in the assessment of court-involved individuals with intellectual disability and particular knowledge of the federal civil commitment process and the care and custody of civilly committed persons in the federal system. I have particular expertise with respect to the assessment and treatment of persons in the custody of the federal Bureau of Prisons because, prior to retiring in 2011, I served for 20 years as a psychologist for the Federal Bureau of Prisons (BOP) at the United States Federal Medical Center for Federal Prisoners (USMCFP) in Springfield, Missouri. Like the Federal Medical Center (FMC) at Butner, USMCFP Springfield is a maximum security facility for sentenced male inmates, pretrial detainees, and civilly committed individuals. My responsibilities at USMCFP Springfield included forensic evaluations for the U.S. District courts on such issues as competency to stand trial, competency to waive death penalty appeals, sanity, mental condition and dangerousness in connection with proceedings for federal civil commitment, and the need for inpatient mental health treatment. In this capacity, I provided forensic psychological and neuropsychological evaluations, reports, and testimony to the U.S. District Courts throughout the United States and U.S. Territories.

3. After retiring from the BOP, I began a private practice in 2012. Since that time, I have been retained numerous times by federal prosecutors, most frequently in the context of capital prosecutions. In many of those cases, I have been asked to evaluate defendants' claims that they are ineligible for the death penalty because of a diagnosis of intellectual disability. I have also been retained by the Office of the United States Attorney for the District of Columbia regarding potential future dangerous in the context of potential community release after insanity acquittal. I have published within the scientific literature on the topic of the neurobiology of violence. Additional details concerning my experience and expertise are provided later in this Declaration and in my full curriculum vita, which is attached as Exhibit A.

4. I have been asked to provide in this Declaration my opinion about questions regarding Markelle Seth's civil commitment status in the BOP, the potential for Mr. Seth to be helped or harmed by such confinement, and whether Mr. Seth would be dangerous to himself or others if released to a highly structured community-based program in connection with civil commitment in the District of Columbia.

5. The opinions set forth in this declaration are informed by my experience evaluating Mr. Seth and testifying in his competency proceedings before Magistrate Judge G. Michael Harvey in Federal District court for the District of Columbia in May of 2016. My work as an expert in Mr. Seth's criminal case marked the first time I was retained to testify as an expert on behalf of a criminal defendant. In that proceeding, I concluded that Mr. Seth was incompetent and unlikely to become competent in the foreseeable future. I disagreed, and continue to disagree, with the opinion of the BOP's evaluator, Dr. Kristina Lloyd, that Mr. Seth -- who had previously been found incompetent by an earlier BOP evaluator -- had been rendered competent during his time at Butner. Magistrate Judge G. Michael Harvey found that Mr. Seth was incompetent in accordance with my conclusion.

6. For purposes of serving as an expert in Mr. Seth's competency proceeding, I conducted a comprehensive neuropsychological assessment and an evaluation of Mr. Seth's competence to stand trial. I reviewed Mr. Seth's medical records, school records, and court records going back to infancy; discovery materials provided by the prosecution relating to the charged offense; and records generated during Mr. Seth's incarceration at the DC Jail and Correctional Treatment Facility and in BOP facilities (primarily FMC Butner) pending trial. I also interviewed witnesses and listened to the testimony presented during the two-day evidentiary hearing.

7. In order to render the opinion I have been asked to provide in the current case concerning Mr. Seth's civil commitment, I have reviewed the following additional materials: dangerousness reports of BOP evaluators Kristina Lloyd (April 11, 2017) and Manuel Gutierrez (March 6, 2017); Bureau of Prisons medical records concerning Mr. Seth, including Psychology Data System records (January 2017 – September 2018); Bureau of Prisons disciplinary records concerning Mr. Seth (same); report of Matthew Mason (February 24, 2017); report of Stephen D. Hart (June 18, 2017); Proposal for Transition, Safety and Support Services of Wholistic Services, Inc.; Letter of Laura L. Nuss (August 4, 2017); and the civil complaint (May 1, 2018).

8. It is my professional opinion, which I hold with a reasonable degree of scientific certainty, that if released pursuant to a highly structured and closely supervised community based program such as the one described in Wholistic Services, Inc.'s proposal, Markelle Seth's potential risk of violence and sexual violence would be reasonably and effectively lowered such that he could function in the community. Mr. Seth does present risk, but the type of risk he presents is narrow and manageable: he should not have unsupervised contact with children. In my professional opinion, this can be safely and effectively managed in a community setting given the proposed safeguards. It does not require confinement in a federal prison hospital.

9. Confinement in the prison setting is harmful and damaging to Mr. Seth. This is evident from the fact that Mr. Seth has spent virtually his entire period of custody with the BOP locked in a cell between 22 and 24 hours a day on disciplinary segregation and administrative detention. Housing in this restrictive setting makes it virtually impossible for him to

participate in meaningful programming. The record reveals that he is in this status not due to particularly violent or aggressive behavior but due to repeated rule infractions, most of which are relatively minor in nature and relate to the immaturity and ineffective stress tolerance inherent with his Intellectual Disability. Such behaviors are disruptive in a correctional setting where conformity is required. Since it is a prison first, even the Federal Medical Center is not equipped to provide the individualized services Mr. Seth needs. So long as he remains in such a restrictive status, which appears to have been almost continuously, he cannot participate in any meaningful programming. Nor will Mr. Seth, in this setting, be able to demonstrate that he would not be dangerous if released conditionally, with appropriate support and supervision. While he remains in the BOP, Mr. Seth is stuck in a Catch-22. His disability will continue to get him into trouble. And although the types of trouble he experiences in the BOP are not good indicators of his ability to adjust to an individualized therapeutic environment like the one proposed for him in the District of Columbia, Mr. Seth will be unable to demonstrate sufficient good behavior to earn the chance for release to such a program. Thus, the design, service provision, and staffing models of the BOP virtually ensure continuing failure and continuing incarceration.

10. On the other hand, there is every reason to believe Mr. Seth would not pose a danger and would thrive if released to a program such as the one described by Dr. Mason and proposed by Wholistic Services, Inc. Although the BOP does not offer such a setting, individuals with Intellectual Disability who present the type of risk Mr. Seth presents are safely managed in community based treatment programs throughout the country.

Professional background

11. I am board certified in Forensic Psychology by the American Board of Professional Psychology. I am also board certified in Clinical Neuropsychology by the American Board of Professional Psychology. I am a fellow of the American Academy of Forensic Psychology and the American Academy of Clinical Neuropsychology. I am a past President (2009) and fellow of the National Academy of Neuropsychology, the largest organization of practicing neuropsychologists in the world. I am also a fellow of the American Psychological Association (Division 40: Society for Clinical Neuropsychology). I am licensed to practice psychology in Missouri (R0316) and Washington, D.C. (PSY1001323). I graduated with a Doctor of Psychology degree from the Forest Institute of Professional Psychology in 1991.

12. I completed my clinical internship at the United States Medical Center for Federal Prisoners (USMCFP) in Springfield, Missouri (with additional rotations at the Missouri Head Injury Rehabilitation Center and Cox Medical Center). USMCFP is a 1100 bed, maximum security, medical, surgical, and psychiatric hospital for sentenced male inmates and pretrial detainees. Immediately after my graduation in 1991, I was hired by the Federal Bureau of Prisons (BOP) to work as a forensic psychologist at USMCFP. In this role, I provided forensic psychological and neuropsychological evaluations, reports, and testimony to the U.S. District Courts throughout the United States and U.S. Territories. I taught didactic seminars on functional neuroanatomy, adult neuropathology, neuropsychological assessment,

identifying organic disorders, malingering organic mental illness, and psychoneuroimmunology to doctoral interns and post-doctoral fellows in an American Psychological Association approved clinical psychology internship program. I provided supervision of interns and post-doctoral fellows in the area of forensic evaluation with a neuropsychological emphasis. I also evaluated the mental status of sentenced federal prisoners upon referral from Bureau of Prisons facilities for their need of inpatient mental health treatment and performed crisis intervention and neuropsychological consultation as needed for mental health treatment and medical/surgical patients. When needed, I provided reports to the US District Court related to civil commitment procedures pertaining to sentenced prisoners who needed inpatient mental health treatment and either refused treatment or were not competent to consent to such treatment under 18 USC 4245. I participated in risk assessment panel evaluations and wrote risk assessment reports regarding the potential release and placement of men committed under 18 USC 4243 and 4246. In 2000, my role changed to neuropsychologist in the Medical and Surgical Units of USMCFP. In this setting, I continued to provide neuropsychological consultation services to the Forensic Service and continued to supervise clinical interns and post-doctoral fellows.

13. During my career with at USMCFP, I completed over 500 inpatient forensic evaluations for the U.S. District courts on such issues as competency to stand trial, competency to waive death penalty appeals, sanity, dangerousness, and need for inpatient mental health treatment. I performed well over 1000 additional psychological and neuropsychological examinations as part of my clinical practice with sentenced inmates. While at USMCFP, the Federal BOP requested I, along with three other forensic psychologists, develop a training manual for the many forensic psychologists within the BOP. This training manual was titled, *How to conduct a thorough and professional forensic evaluation: Training manual of the Federal Bureau of Prisons*.

14. I currently maintain a consulting practice for civil and criminal attorneys, judges, and the insurance industry, in addition to holding a neuropsychology staff position at the Missouri Memory Center and Neurology Clinic at Citizens Memorial Hospital, Bolivar, Missouri. I have recently been involved in 14 different murder cases, 12 of which were capital. In the majority of those cases I was retained by the U.S. Attorney's Office to address questions of death penalty eligibility (Atkins), competency to stand trial, criminal responsibility (*mens rea*), and mitigating issues.

15. I have testified as an expert witness related to forensic psychology and neuropsychology assessment well over 100 times.

16. From 1996 until August 2015, I was also a Professor at the Forest Institute of Professional Psychology in Springfield, Missouri. I ultimately achieved the rank of Professor by Distinction and Director of Neuropsychology at this American Psychological Association accredited doctoral program in clinical psychology. I taught the following courses over my tenure at Forest Institute: Forensic Psychology: Overview of Mental Health Case Law and Forensic Assessment; Forensic Psychology: Advanced Forensic Case Analysis and Report

Writing; Functional Neuroanatomy & Neuropathology; Neuropsychological Assessment I: Adult; Neuropsychological Intervention I: Adult Neuropathology & Remediation; Neuropsychological Intervention II: Child Neuropathology & Remediation; Advanced Neuropsychological Case Analysis & Report Writing; and Biopsychology.

17. I have presented throughout the U.S. on neurolitigation, the application of neuropsychological assessment to criminal and civil forensic matters, neuroanatomy, brain injury, malingering, and admissibility of scientific evidence. I have published over 50 peer reviewed papers and book chapters in the scientific literature on such subjects as neuropsychological evaluation of criminal defendants, malingering, evaluating psychological damages, trauma and violence, ethical issues, and professional licensure. I am on the editorial boards of The Clinical Neuropsychologist, Applied Neuropsychology, and Archives of Clinical Neuropsychology. I am co-editor of Clinical Neuropsychology in the Criminal Forensic Setting (2008; Guilford), co-author of Detection of Deception (2007; Professional Resource Press), co-author of Ethical Practice in Forensic Psychology: A Systematic Model for Decision Making (2006; APA), and co-editor of Detection of Response Bias in Forensic Neuropsychology (2002; Haworth). I believe I have published more peer reviewed papers and book chapters on the application of clinical neuropsychological assessment within the criminal forensic setting than any other author.

Mr. Seth's recent history and status at BOP

18. Mr. Seth was returned to FMC Butner on January 27, 2017 for a dangerousness evaluation pursuant to 18 USC 4246 and 4248. BOP records reveal that he has been in segregated housing status virtually the entire period since then. It appears his segregation is not due to serious violence but due to a series of immature impulsive incidents that are directly related to the nature of his disability – short attention span, poor frustration tolerance, impulsivity, inability to foresee consequences (e.g., numerous petty issues like conflicts over television programming; wearing earbuds where not allowed; wearing the wrong uniform or wearing the uniform incorrectly (not buckling his belt); not standing for the count; speaking disrespectfully to an officer; pushing or hitting an inmate who grabbed a bag of chips from him).

19. While under disciplinary segregation and administrative detention he remains in his cell on average 22 to 24 hours per day. When out of his cell, he is either at the shower or the recreation cage. He is not able to participate meaningfully in programming. Even the mental health support and pet therapy he is getting is provided at the door to his cell under most circumstances. The psychology and medical records suggest he was in either disciplinary segregation or administrative detention from February 2018 through the end of September 2018. PDS notes reveal brief counseling sessions through his cell door or at the recreation cage generally once a week. Mr. Seth received pet therapy once in March and once in April where he was allowed to reach through the food slot of his cell and pet the dogs. There was no indication in the medical record of him receiving skills training or any treatment that might actually benefit a man with Intellectual Disability. Over the last few

months, Mr. Seth has not received any regularly scheduled programming. He was in a vocational rehabilitation program briefly and started out doing well, but when staff needed to change him from one job to another job he did not adjust well and was removed from the program.

20. There is no indication that Mr. Seth will be allowed to re-engage in regular inmate life within the FMC within the foreseeable future. In his current living situation, he is not allowed to improve his social functioning or learn to engage in more productive social interactions, which for a man with very low IQ, would need to be learned by practicing with others rather than simply through education. His failure to advance in his social skills within this environment is not indicative of his potential for success within a community based program that is tailored to his particular needs.

21. To my knowledge, the BOP does not have programming that is specific to the needs of someone like Mr. Seth. There are sex offender treatment programs, but those programs would not be appropriate for a man with his low intellectual functioning. In the absence of appropriate programming, Mr. Seth only has the opportunity to learn additional criminal style behaviors rather than the pro-social behaviors needed to effectively function in society. Without appropriate programing, there is no suggestion that his functioning will ever improve; consequently, he would have little hope of ever getting out of prison.

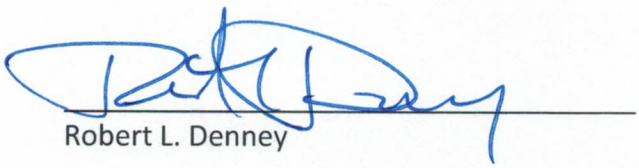
Conclusions

22. In my professional opinion, Mr. Seth's condition will not improve with continued housing within the BOP.

23. In my professional opinion, with continued housing within the BOP, Mr. Seth's condition is more likely to worsen over the course of time rather than improve in terms of potential risk of future violence and sexual violence upon release to the community.

24. In my professional opinion, the plan outlined by Dr. Mason and the service proposal prepared by Wholistic Services, Inc. would sufficiently decrease the risk of sexually violent behavior such that Mr. Seth could reside in the community.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 25th day of October, 2018.



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Board Certified in Forensic Psychology

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CURRICULUM VITA

CLINICAL WORK EXPERIENCE

01/2015—Present: Independent Practice in Clinical Neuropsychology
Neuropsychological Associates of Southwest Missouri
4350 S. National Avenue, Suite 116B
Springfield, Missouri 65810
Phone: (417) 881-1810
Fax (417) 888-728-5456
Position: Neuropsychological evaluation and consultation

01/2012—01/2015: Independent Practice in Clinical Neuropsychology
Forest Institute
2885 W. Battlefield Road
Springfield, Missouri 65807
Phone: (417) 823-3477
Fax (417) 888-728-5456
Position: Neuropsychological evaluation and consultation

2/2000—12/2011: U.S. Medical Center for Federal Prisoners
P.O. Box 4000
Springfield, Missouri 65801-4000
Position: Licensed Psychologist: Forensic Psychology, Clinical Neuropsychology, Behavioral Medicine, Medical and Surgical Units

Psychological and neuropsychological evaluations and treatment on the medical and surgical units of a 1000 bed maximum security prison-hospital. This work also included providing forensic evaluation services to the U.S. District Courts for individuals experiencing significant medical/neurological disability. Taught didactic seminars on functional neuroanatomy, adult neuropathology, neuropsychological assessment, identifying organic disorders, and malingering organic mental illness to doctoral interns and post-doctoral fellows in an American Psychological Association approved clinical psychology internship program. Provided supervision of psychology interns in the area of neuropsychological evaluation and behavioral medicine. Performed crisis intervention and neuropsychological consultation as needed for mental health treatment and forensic services.

12/91—2/2000: U.S. Medical Center for Federal Prisoners
Springfield, Missouri
Position: Licensed Psychologist, Clinical & Forensic Neuropsychology, Mental Health Evaluation Unit

Psychological and neuropsychological evaluations and expert testimony for U.S. District Courts; taught didactic seminars on functional neuroanatomy, adult neuropathology, neuropsychological assessment, identifying organic disorders, malingering organic mental illness, and over-viewing psychoneuroimmunology to doctoral interns and post-doctoral fellows in an American Psychological Association approved clinical psychology internship program. Provided supervision of interns and post-doctoral fellows in the area of forensic evaluation with a neuropsychological emphasis. Evaluated mental status of sentenced federal prisoners upon referral from Bureau of Prisons facilities for their need of inpatient mental health treatment. Performed crisis intervention and neuropsychological consultation as needed for mental health treatment and medical/surgical patients in a 1000 maximum security prison-hospital.

07/91—07/94: Independent contract--Missouri Rehabilitation Center
Mt. Vernon, Missouri
State funded head-injury rehabilitation hospital

Completed neuropsychological evaluations for the outpatient department, typically Missouri Department of Vocational Rehabilitation and insurance company referrals.

10/91—12/91: U.S. Medical Center for Federal Prisoners
Springfield, Missouri
Position: Clinical Psychologist, Behavioral Medicine

In charge of psychological services to medical and surgical patients. Duties included consultation to medicine, surgery, neurology, and orthopedics; working with contract psychiatrists to provide psychiatric services; assessment and therapy with dialysis, HIV/AIDS, hypertension, and respiratory rehabilitation; supervision of a doctoral intern during the Behavioral Medicine rotation in an American Psychological Association approved clinical psychology internship.

10/90—10/91: U.S. Medical Center for Federal Prisoners
Springfield, Missouri
Position: Doctoral Intern in Clinical Psychology

Rotations included mental health assessment and treatment, forensic assessment, and medical/surgical consultation and treatment. Also included was a six month, part-time rotation in Neuropsychological evaluation and treatment at the Missouri Rehabilitation Center and a six month, part-time rotation in adolescent drug and alcohol treatment at the Cox Medical Centers-North, Adolescent Treatment Center.

1989—1990: Forest Institute of Professional Psychology
1322 S. Campbell
Springfield, Missouri
Position: Administrative Assistant for the Forest Family Clinic (now Robert J. Murney Clinic), a community mental health center

TEACHING APPOINTMENTS

01/10—Present: Evangel University
1111 N. Glenstone Avenue
Springfield, Missouri
Position: Adjunct Professor
Course: Combined graduate and undergraduate Physiological Psychology

01/96—Present: School of Professional Psychology at Forest Institute
2885 W. Battlefield
Springfield, Missouri
Position: Professor by Distinction (Associate Professor 2002-2014, Adjunct Professor 1996-2002) and Director of Neuropsychology in this APA accredited clinical psychology (Psy.D.) program.

Doctoral level courses taught:
- Functional Neuroanatomy & Neuropathology
- Neuropsychological Assessment I: Adult
- Neuropsychological Intervention I: Adult Neuropathology & Remediation
- Neuropsychological Intervention II: Child Neuropathology & Remediation
- Advanced Neuropsychological Case Analysis & Report writing
- Biopsychology

Previous doctoral level courses taught (as Director of Forensic Psychology):
- Forensic Psychology: Overview of mental health case law and forensic assessment
- Forensic Psychology: Advanced forensic case analysis and report writing

08/94—12/96: Southwest Baptist University
Springfield Extension
Springfield, Missouri
Position: Adjunct Professor, Department of Behavioral Sciences
Undergraduate course taught: Elementary Statistics for the Behavioral Sciences

EDUCATION

Forest Institute of Professional Psychology, Springfield, Missouri
Doctor of Psychology (PSY.D.), Clinical Psychology, *Magna Cum Laude*, September 1991
Included Specialization Track in Clinical Neuropsychology
Research dissertation: *Hemispherical activation theory: Effects of repeated lateral orienting behavior on perceived sad affect among undergraduate dextrals*.

Forest Institute of Professional Psychology, Springfield, Missouri
Master of Arts (M.A.), Psychology, *Magna Cum Laude*, May 1989

Lutheran Bible Institute of Seattle
Issaquah, Washington
Bachelor of Youth Ministry (B.Ym.), June 1985

STATE LICENSURE

Licensed Psychologist in the state of Missouri: #R0316 (December 1992-currently active)

Licensed Psychologist in the state of Arizona: #1918 (December 1991-May 1993)

Certificate of Professional Qualification in Psychology (ASPPB): #4325 (July 11, 2013)

Interjurisdictional Practice Certificate (ASPPB): #4325 (July 11, 2013)

BOARD CERTIFICATION

Board Certified in Clinical Neuropsychology: American Board of Clinical Neuropsychology, an affiliate of the American Board of Professional Psychology (ABPP) (#5786, October 2003)

Board Certified in Forensic Psychology: American Board of Forensic Psychology, an affiliate of the American Board of Professional Psychology (ABPP) (#4814, March 1997)

PROFESSIONAL AFFILIATIONS

Fellow of the American Psychological Association, Division 40 – Clinical Neuropsychology (as of August 2012)

National Academy of Neuropsychology Executive Board member as Past-President (2010-2012)

President of the National Academy of Neuropsychology (2009)

President-Elect of the National Academy of Neuropsychology (2008)

Fellow of the National Academy of Neuropsychology (as of June 30, 2004)

National Academy of Neuropsychology Annual Conference Program Committee: Assistant Program Chair (2002), Program Co-Chair (2003), Program Chair (2004).

Fellow of the American Academy of Clinical Neuropsychology (as of October 2003)

Fellow of the American Academy of Forensic Psychology (as of March 1997)

Member of Division 41 of the American Psychological Association: American Psychology-Law Society

EDITORIAL BOARD ACTIVITY WITH PEER REVIEWED JOURNALS

Member of the Editorial Board for *The Clinical Neuropsychologist* (01/2011 – present)

Member of the Editorial Board for *Applied Neuropsychologist* (10/2010 – present)

Member of the Editorial Board for the *Archives of Clinical Neuropsychology* (01/2010 – present)

Member of the Editorial Board of the *Journal of Forensic Neuropsychology* (11/1997-7/2006)

Ad hoc reviewer for the *Journal of Head Trauma Rehabilitation*

Ad hoc reviewer for *Neuropsychology Review*

Ad hoc reviewer for *Psychological Reports: Perceptual and Motor Skills*

Ad hoc reviewer for *Professional Psychology: Research and Practice*

Ad hoc reviewer for *International Journal of Forensic Mental Health*

PUBLICATIONS

Peer Reviewed Journal Publications

Fazio, R. L., Sanders, James Forrest, & **Denney, R. L.** (2015). Comparison of Performance of the Test of Memory Malingering and Word Memory Test in a criminal forensic sample. *Archives of Clinical Neuropsychology, 30,* 293-301.

Armistead-Jehle, P., & **Denney, R. L.** (2015). The Detection of Feigned Impairment Using the WMT, MSVT, and NV-MSVT. *Applied Neuropsychology: Adult, 22,* 147-155.

Dunham, K., Shadi, S., Sofko, C. A., **Denney, R. L.**, & Calloway, J. (2014). Comparison of the

Repeatable Battery for the Assessment of Neuropsychological Status Effort Scale and Effort Index in a dementia sample. *Archives of Clinical Neuropsychology, 29,* 633-641.

Fazio, R.L., Dunham, K., Griswold, S., & **Denney, R. L.** (2013). An improved measure of handedness: The Fazio Laterality Inventory. *Applied Neuropsychology: Adult, 20,* 197-202.

Eng, K., Rolin, S., Fazio, R.L., O'Grady, M., Biddle, C., & **Denney, R. L.** (2013). Finger Tapping: Why can't we alternate hands? *Applied Neuropsychology, 20,* 187-191.

Hanson Misialek, L., Fazio, R. L., **Denney, R. L**., & Myers, W. G. (2013). Limited predictive accuracy of the Booklet Category Test in a criminal forensic sample. *Applied Neuropsychology, 20,* 77-82.

Fazio, R., Coenen, C., & **Denney, R. L.** (2012). The original instructions for the Edinburgh Handedness Inventory are misunderstood by a majority of participants. *Laterality: Asymmetries of Body, Brain and Cognition, 17*(1), 70-77.

Fazio, R. L., Pietz, C. P., & **Denney, R. L.** (2012). An estimate of the prevalence of autism-spectrum disorders in an incarcerated population. *Open Access Journal of Forensic Psychology,* 69-80. http://www.forensicpsychologyunbound.ws/ -- 2012: 69-80.

Dionysus, K. E., **Denney, R. L.**, & Halfaker, D. A. (2011). Detecting negative response bias with the Fake Bad Scale, Response Bias Scale, and Henry-Heilbronner Index of the Minnesota Multiphasic personality Inventory-2. *Archives of Clinical Neuropsychology, 26,* 81-88.

Heilbronner, R. L., Sweet, J. J., Morgan, J. E., Larrabee, G. J., Millis, S., & Conference Participants (**Denney, R. L.**) (2009). American Academy of Clinical Neuropsychology Consensus Conference Statement on the neuropsychological assessment of effort, response bias, and malingering. *The Clinical Neuropsychologist, 23*, 1093-1129.

D'Amato, C. P., & **Denney, R. L.** (2008). Diagnostic utility of the Rarely Missed Index (RMI) in detecting response bias in an adult male incarcerated Setting. *Archives of Clinical Neuropsychology, 23*, 553-561.

Downing, S. K., **Denney, R. L.**, Spray, B. J., Houston, C. M., & Halfaker, D. A. (2008). Examining the relationship between the Reconstructed Scales and the Fake Bad Scale of the MMPI-2. *The Clinical Neuropsychologist, 22*, 680-688.

Ardolf, B. R., **Denney, R. L**., & Houston, C. M. (2007). Base rates of negative response bias and Malingered Neurocognitive Dysfunction among criminal defendants referred for neuropsychological evaluation. *The Clinical Neuropsychologist, 21*, 899-916.

Gassen, M., Pietz, C. A., Spray, B. J., & **Denney, R. L.** (2007). Accuracy of Megargee's Criminal Offender Infrequency (Fc) Scale in Detecting Malingering Among Forensic

Examinees. *Criminal Justice and Behavior, 34*, 493-504.

Neller, D. J., **Denney, R. L.**, Pietz, C. A., & Thomlinson, R. P. (2006). The relationship between trauma and violence in a jail inmate sample. *The Journal of Interpersonal Violence, 21*, 1234-1241.

Neller, D. J., **Denney, R. L.**, Pietz, C. A., & Thomlinson, R. P. (2005). Testing the trauma model of violence. *Journal of Family Violence, 20(3)*, 151-159.

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Sullivan, J. P., & **Denney, R. L.** (2003). Constitutional and Judicial Foundations in Criminal Forensic Neuropsychology. *Journal of Forensic Neuropsychology, 3(4)*, 13-44.

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Tucillo, J. A., DeFilippis, N. A., **Denney, R. L.**, & Dsurney, J. (2002). Licensure requirements for interjurisdictional forensic evaluation. *Professional Psychology: Research and Practice, 33*, 377-383.

Denney, R. L., & Wynkoop, T. F. (2000). Clinical neuropsychology in a criminal forensic setting. *Journal of Head Trauma Rehabilitation, 15*(2), 804-828.

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Denney, R. L. (1999). A brief Symptom Validity Testing procedure for Logical Memory of the Wechsler Memory Scale-Revised which can demonstrate verbal memory in the face of claimed disability. *Journal of Forensic Neuropsychology, 1*(1), 5-26.

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Books and Book Chapters

Denney, R. L., Fazio, R. L., & Greiffenstein, M. F. (in press). Clinical neuropsychology in criminal forensics. In J. E. Morgan & J. H. Ricker (Eds.) (2nd ed), *Textbook of clinical neuropsychology*. NY: Taylor & Francis.

Fazio, R. & **Denney, R. L.** (in press). Assessment of the Neurophysiological and Neuropsychological Bases for Violence. In C. A. Pietz & C. A. Mattson (Eds.) *Offenders: Psychological constructs and evaluations*. NY: Oxford University Press.

Denney, R. L. (2012). Criminal forensic neuropsychology and assessment of competency. In G. J. Larrabee (Ed.), *Forensic Neuropsychology: A Scientific Approach* (2nd ed.) (pp 438-472). NY: Oxford University Press.

Denney, R. L. (2012). Criminal responsibility and other criminal forensic issues. In G. J. Larrabee (Ed.), *Forensic Neuropsychology: A Scientific Approach* (2nd ed.) (pp 473-500). NY: Oxford University Press.

DeJesus-Zayas, S. R., Buigas, R. & **Denney, R. L.** (2011). Evaluation of culturally diverse populations (pp. 248-265). In D. Faust (Ed.) *Coping with Psychiatric and Psychological Testimony* (6th ed.). NY: Oxford University Press.

Magaletta, P. R., Diamond, P. M., McLearen, A. M., & **Denney, R. L**. (2010). Traumatic brain injuries in correctional populations: Understanding and responding to an important need. In *Managing Specific Populations in Jails and Prisons*. Kingston, NJ: Civic Research Institute.

Denney, R. L. (2008). Evaluating Competency to Stand Trial and Sanity in the Face of Marked Amnesia and Claimed Psychosis. In J. E. Morgan & J. J. Sweet (Eds.). *Neuropsychology of Malingering Casebook*. New York: Taylor & Francis.

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Boyd, A. R., McLearen, A. M., Meyer, R. G., & **Denney, R. L.** (2007). *Detection of Deception*. Sarasota, FL: Professional Resource Press.

Bush, S. S., Connell, M. A., & **Denney, R. L.** (2006). *Ethical Issues in Forensic Psychology: Key Concepts and Resources*. Washington, DC: American Psychological Association.

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Denney, R. L. (2005). Ethical challenges in forensic neuropsychology, section 1. In S. Bush (ed.), *A Casebook of Ethical Challenges in Neuropsychology* (pp. 15-22). Philadelphia, PA: Psychology Press/Taylor & Francis.

Denney, R. L. (2005). Gambling, Money Laundering, Competency, Sanity, Neuropathology, and Intrigue. In R. L. Heilbronner (Ed.) *Forensic Neuropsychology Casebook* (pp. 305-325). NY: Guilford.

McLearen, A. M., Pietz, C. A., & **Denney, R. L.** (2004). Evaluation of psychological damages. In W. O'Donohue & E. Levensky (Eds.), *Forensic Psychology* (pp. 267-299). NY: Academic.

Hom, J., & **Denney, R. L.** (Eds.) (2002). *Detection of Response Bias in Forensic Neuropsychology*. West Hazleton, PA: Haworth Press.

Published Abstracts

Rolin, S. N., Biddle, C., Fazio, R., & **Denney, R. L.** (2013). Comparison between MMPI-2 and

MMPI-2-RF validity scale classification in a criminal population. *The Clinical Neuropsychologist, 27*, 597-598.

Dunham, K., Rolin, S., Sibson, J., Ogbeide, S., Glover, M., & **Denney, R. L.** (2012). Utility of the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) in differentiating between types of dementia*. Archives of Clinical Neuropsychology, 27*, 587.

Deneen, T., **Denney, R. L.,** Fisher, J., & Spray, B. (2012). The effectiveness of the MMPI-2-RF validity and cognitive/somatic scales in predicting symptom validity failure in TBI litigant tested for effort. *Archives of Clinical Neuropsychology, 27*, 642-643.

Dunham, K., Shadi, S., Sofko, C., & **Denney, R. L**. (2012). Preliminary look: Comparison of the Effort Index and Effort Scale on the RBANS. *Archives of Clinical Neuropsychology, 27*, 587.

Dunham, K., Warchol, A., Hunter, B., Shadi, S., **Denney, R. L.,** & Nichols, C. (2012). Comparison of the Reliable Digit Span and Age-Corrected Scaled Score on the WISC-IV as a measure of effort in children. *Archives of Clinical Neuropsychology, 27*, 587-588.

Rolin, S., Higgins, K, & **Denney, R. L**. (2012). Utility of the Response Bias Scale (RBS) of the MMPI-2-RF in relation to structured malingering criteria in a criminal population. *Archives of Clinical Neuropsychology, 27*, 643.

Biddle, C., Fazio, R., Willett, K., Rolin, S., O'Grady, M., & **Denney, R.** (2011). Motor dysfunction profiles in a simulated chronic pain sample. *Archives of Clinical Neuropsychology, 26,* 559.

England, D., **Denney, R.**, & Meyers, J. (2011). Differential diagnosis of TBI and PTSD using the Meyers Neuropsychological Battery. *Archives of Clinical Neuropsychology, 26,* 514.

Hanson Misialek, L., Fazio, R., **Denney, R.**, & Myers, W. (2011). Efficacy of embedded validity indices of the Booklet Category Test in a criminal forensic population. *Archives of Clinical Neuropsychology, 26,* 562.

Fazio, R., Griswold, S., & **Denney, R. L.** (2010, October). *Initial psychometric properties of the Fazio Laterality Inventory* [Abstract]. *Archives of Clinical Neuropsychology, 25,* 529.

Sanders, F., Bailey, C. M., **Denney, R. L.** & Marcopulos, B. A. (2009). Performance of the Test of Memory Malingering (TOMM) and the Word Memory Test (WMT) in criminal medical and psychiatric settings [Abstract]. *Archives of Clinical Neuropsychology, 24*, 537.

Barber, A. P., **Denney, R. L.**, & Deal, W. P. (2009). Validity of effort testing among individuals with mental retardation [Abstract]. *Archives of Clinical Neuropsychology, 24*, 537.

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Triebel, K. L., & **Denney, R. L.** (2005). Reliability of the Lees-Haley Take Bad Scale in a population of personal injury litigants [Abstract]. *Archives of Clinical Neuropsychology, 20*, 886.

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Denney, R. L. (1997). A forced-choice recognition test for detecting negative response bias on the Wechsler Memory Scale-Revised [Abstract]. *Archives of Clinical Neuropsychology, 12(4)*, 308.

Denney, R. L., & Scully, B. M. (1996). Exaggeration of neuropsychological impairment in Pick's Disease: A case study [Abstract]. *Archives of Clinical Neuropsychology, 11(5)*, 382.

Denney, R. L., & Wynkoop, T. F. (1995). Exaggeration of neuropsychological deficits in pretrial evaluation: A case presentation [Abstract]. *The Clinical Neuropsychologist, 9(3)*, 277.

Book and Test Reviews

Denney, R. L. (2011). Book Review: *Forgiveness, Reconciliation, and Restoration: Multidisciplinary Studies from a Pentecostal Perspective* by M. W. Mittelstadt & G. W. Sutton (Eds.) (2010). Pickwick Publications; Eugene, OR. *Encounter: Journal for Pentecostal Ministry,* Summer, Vol. 8.

Wynkoop, T. F., & **Denney, R. L.** (2005). Test Review: Green's Word Memory Test (WMT) for Windows. *Journal of Forensic Neuropsychology, 4,* 101-105.

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Denney, R. L. (2001). Book Review: *The Evaluation and Treatment of Mild Traumatic Brain Injury*, edited by Nils Varney and Richard Roberts. *The Journal of Psychiatry & Law, 29*, 195-198.

Wynkoop, T. F., & **Denney, R. L.** (2001). Test Reviews: Computerized Assessment of Response Bias (CARB), Word Memory Test (WMT), and Memory Complaints Inventory (MCI). *Journal of Forensic Neuropsychology, 2(1),* 71-77.

Denney, R. L. (1999). Test Review: Victoria Symptom Validity Test, Version 1.0. *Journal of Forensic Neuropsychology, 1(1)*, 89-95.

OTHER PUBLICATIONS

Denney, R. L. (2010). Authentic Professional Competence in Clinical Neuropsychology (2009 NAN Presidential Address). *Archives of Clinical Neuropsychology, 25*(5), 457-467.

Hearne, B. M. (2005). Up Front–Competency and brain injury: An interview with **Robert Denney, Psy.D.** Special Issue: Is that Legal? Brain Injury and the Law. *Premier Outlook: A periodical about brain injury, 5*(2), 11-19.

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PRESENTATIONS

Denney, R. L. (2014, March). *The Mysterious and Often Perplexing Nature of Mild TBI and Persistent Post-Concussion Syndrome*. Workshop presented on behalf of PsyBar, LLC, for the Custom Disability Solutions Group Reinsurance, South Portland, ME.

Denney, R. L. (2013, November). *Clinical Neuropsychology for the Forensic Psychologist*. Day long (7 CE Credit) workshop presented at Contemporary Issues in Forensic Psychology, Workshop Series of the American Academy of Forensic Psychology, Fort Lauderdale, Florida.

Denney, R. L. (2013, August). *Validity and Deception in Neuropsychological Evaluations*. Workshop presented on behalf of PsyBar, LLC, for The Standard Insurance Company, Portland, OR.

Greiffenstein, M. F. & **Denney, R. L.** (2013, June). *Forensic Neuropsychology: From Foundational Knowledge to Advanced Practice*. Three hour (3 CE Credit) workshop presented at the American Academy of Clinical Neuropsychology 11th Annual Conference, Chicago, Illinois.

Denney, R. L. (2013, April). *The Mysterious and Often Perplexing Nature of Mild TBI and Persistent Post-Concussion Syndrome*. Workshop presented on behalf of PsyBar, LLC, for the Prudential Insurance Company of America, Newark, NJ.

Denney, R. L. (2012, November). Moderator. *Forensic Grand Rounds*. Workshop presented at the 32nd Annual National Academy of Neuropsychology Conference, Nashville, TN.

Denney, R. L. (2012, June). *Validity and Deception in Neuropsychological Evaluations*. Workshop presented on behalf of PsyBar, LLC, for the Prudential Insurance Company of America, Newark, NJ.

Denney, R. L. (2012, February). *Foundations of Ethical Neuropsychological Assessment for the Criminal Courts*. Three hour (3 CE Credit) workshop presented at the 40th Annual Meeting of the International Neuropsychological Society, Montréal, Québec, Canada.

Denney, R. L. (2011, November). Moderator. *Forensic Grand Rounds*. Workshop presented at

the 31st Annual National Academy of Neuropsychology Conference, Marco Island, Florida.

Denney, R. L. (2010, October). Moderator. *Forensic Grand Rounds*. Workshop presented at the 30th Annual National Academy of Neuropsychology Conference, Vancouver, British Columbia, Canada.

Denney, R. L. (2010, May). *Clinical Neuropsychology for the Forensic Psychologist*. Day long (7 CE Credit) workshop presented at Contemporary Issues in Forensic Psychology, Workshop Series of the American Academy of Forensic Psychology, Kansas City, Missouri.

Denney, R. L. (2009, November). *NAN Presidential Address: Authentic Professional Competence in Clinical Neuropsychology*. Presidential Address given at the 29th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Denney, R. L. (2009, November). Moderator. *Forensic Grand Rounds*. Workshop presented at the 29th Annual National Academy of Neuropsychology Conference, New Orleans, Louisiana.

Denney, R. L. (2008, November). *Foundations of Neuropsychological Assessment for the Criminal Courts*. Three hour (3 CE Credit) workshop presented at the 28th Annual National Academy of Neuropsychology Conference, New York, New York.

Denney, R. L. (2008, November). Moderator. *Forensic Grand Rounds*. Workshop presented at the 28th Annual National Academy of Neuropsychology Conference, New York, New York.

Denney, R. L. (2008, June). *Foundations of Neuropsychological Assessment for the Criminal Courts*. Three hour (3 CE Credit) workshop presented at the American Academy of Clinical Neuropsychology 6th Annual Conference and Workshops, Boston, Massachusetts.

Denney, R. L. (2008, January). *Clinical Neuropsychology for the Forensic Psychologist*. Day long (7 CE Credit) workshop presented at Contemporary Issues in Forensic Psychology, Workshop Series of the American Academy of Forensic Psychology, San Antonio, Texas.

Denney, R. L. (2007, November). Moderator. *Forensic Grand Rounds*. Workshop presented at the 27th Annual National Academy of Neuropsychology Conference, Scottsdale, Arizona.

Denney, R. L. (2007, November). *Forensic Pre-Conference 2: Neuropsychological assessment in the criminal forensic arena: Competencies, sanity, & Ethics.* 2.5-hour (2.5 CE & CLE Credit) workshop presented at the 27th Annual National Academy of Neuropsychology Conference, Scottsdale, Arizona.

Denney, R. L. (2007, October). *Malingering detection and ethics in forensic psychological assessment*. 4.5 CE credit hour invited presentation at the Arkansas Psychological Association annual conference. Little Rock, Arkansas.

Denney, R. L. (2006, October). Moderator. *Forensic Grand Rounds*. Workshop presented at

the 26th Annual National Academy of Neuropsychology Conference, San Antonio, Texas.

Denney, R. L. (2006, June). *Matters of import in forensic neuropsychology: Can a panel of experts agree?* - Moderator: Jerry Sweet, Ph.D. Panel: Larry Binder, Ph.D., Robert L. Denney, Psy.D., Manfred Greiffenstein, Ph.D., Robert L. Heilbronner, Ph.D. 4th Annual conference of the American Academy of Clinical Neuropsychology (AACN), Philadelphia, PA.

Denney, R. L. (2005, October). Moderator. *Forensic Grand Rounds*. Workshop presented at the 25th Annual National Academy of Neuropsychology Conference, Tampa, Florida.

Denney, R. L., & Sullivan, J. P. (2005, June). *Constitutional/Judicial foundations for criminal forensic neuropsychology: Competency to confess and stand trial*. Three hour (3 CE Credit) workshop presented at the 2005 American Academy of Clinical Neuropsychology workshops and annual meeting, Minneapolis, Minnesota.

Sullivan, J. P., & **Denney, R. L.** (2005, June). *Rules of engagement – Considerations for the clinical neuropsychologist working in forensic areas*. Three hour (3 CE Credit) workshop presented at the 2005 American Academy of Clinical Neuropsychology workshops and annual meeting, Minneapolis, Minnesota.

Denney, R. L. (2005, February). *Criminal Forensic Neuropsychology: Ethical, Legal, & Practical Issues*. Day long (7 CE Credit) workshop presented at Contemporary Issues in Forensic Psychology, Workshop Series of the American Academy of Forensic Psychology, Dallas, Texas.

Denney, R. L. & Sullivan, J. P. (2004, November). *Constitutional and Judicial Foundations for Criminal Forensic Neuropsychology: Competency to Stand Trial and Confess*. 3-hour (3CE Credit) workshop presented at the 24th Annual National Academy of Neuropsychology Conference, Seattle, Washington.

Denney, R. L. (2004, November). Moderator. *Forensic Grand Rounds*. Workshop presented at the 24th Annual National Academy of Neuropsychology Conference, Seattle, Washington.

Denney, R. L. (2002, October). *Neuropsychological Assessment in the Criminal Forensic Arena: Competencies, Sanity, and Ethics.* 3-hour (3CE Credit) Workshop presented at the 22nd Annual National Academy of Neuropsychology Conference, Miami Beach, Florida.

Denney, R. L. (2002, May). *Forensic Issues: Assessment and Ethics*. Pre-conference workshop provided at the 12th Annual Mental Health in Corrections Symposium, Kansas City, Missouri.

Denney, R. L. (2002, April). *Forensic neuropsychology in criminal cases: Competency to stand trial and criminal responsibility.* Invited address presented at the UCSD School of Medicine's 12th Annual Nelson Butters' West Coast Neuropsychology Conference: Interface

between neuropsychology and law, La Jolla, California.

Denney, R. L. (2001, June). *Symptom exaggeration and malingering: Theory and detection strategies*. Presentation given during 11th Annual Mental Health in Corrections Symposium, Kansas City, Missouri.

Denney, R. L. (2001, June). *Recent trends in scientific admissibility of mental health testimony*. Presentation given during 11th Annual Mental Health in Corrections Symposium, Kansas City, Missouri.

Denney, R. L. (1998, October). *Assessing Civil Competencies*. Presentation given to psychology and rehabilitation staff at Cox Medical Centers-South, Springfield, Missouri.

Denney, R. L. (1998, August). *Assessing Feigned Cognitive Impairment*. Presentation given to Bureau of Prisons forensic psychologists, Washington, D.C.

Denney, R. L. Junk Science and Admissibility of Neuropsychological Evidence. Presentation given during *Neurolitigation: Analyzing Brain Injury Claims*. A program of Continuing Legal Education:
The State Bars of New Mexico and Arizona, Albuquerque, New Mexico. July 9, 1999.
The University of Denver School of Law, Denver, CO. June 25, 1999.
The George Mason University School of Law, Arlington, VA. June 10, 1999.
The State Bars of Nevada and Oregon, Caesar's Palace, Las Vegas, NV. May 22, 1999.
The State Bar of Kansas, University of Kansas, Kansas City, KS. April 24, 1999.
The State Bar of New Mexico, Albuquerque, New Mexico. August 8, 1998.

Denney, R. L. Clinical Neuroanatomy and Neuropathology. Presentation given during *Neurolitigation: Analyzing Brain Injury Claims*. A program of Continuing Legal Education:
The State Bars of New Mexico and Arizona, Albuquerque, New Mexico. July 9, 1999.
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The State Bar of Kansas, University of Kansas, Kansas City, KS. April 24, 1999.
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Denney, R. L. Neuroimaging: Radiological imaging techniques for the brain. Presentation given during *Neurolitigation: Analyzing Brain Injury Claims*. A program of Continuing Legal Education:
The State Bars of New Mexico and Arizona, Albuquerque, New Mexico. July 9, 1999.
The University of Denver School of Law, Denver, CO. June 25, 1999.
The George Mason University School of Law, Arlington, VA. June 10, 1999.

The State Bars of Nevada and Oregon, Caesar's Palace, Las Vegas, NV. May 22, 1999.

Denney, R. L. (1998, August). The Inadequate Evaluation. Presentation given during *Neurolitigation: Analyzing Brain Injury Claims*. A program of Continuing Legal Education of The State Bar of New Mexico, Albuquerque, New Mexico. August 8, 1998.

Denney, R. L. (1997, November). *Critical Issues in Criminal Forensic Neuropsychology: Competency to Stand Trial and Sanity Evaluations*. Two hour presentation at the 17th Annual Convention of the National Academy of Neuropsychology, Las Vegas, Nevada.

Reuterfors, D., Mrad, D., & **Denney, R. L.** (1997, February). *The impact of the Tarasoff decision and the Missouri Bradley v. Ray case on Missouri mental health practitioners' duty to warn and protect*. Presentation given to Ozark Area Psychological Association, Springfield, Missouri.

Denney, R. L. (1996, May). *Identifying feigned amnesia by using the Symptom Validity Testing Paradigm*. Symposium conducted at the Sixth Annual Mental Health in Corrections Symposium, Kansas City, Missouri.

POSTER PRESENTATIONS

Biddle, C., Fazio, R. L., & **Denney, R. L.** (2014, February). The effect of hand restraints on forensic neuropsychological evaluations. Poster presented at the 42nd Annual Meeting of the International Neuropsychological Society, Seattle, Washington.

Dunham, K. J., & **Denney, R. L.** (2014, February). *Introduction to a new profile analysis on the Medical Symptom Validity Test*. Poster presented at the 42nd Annual Meeting of the International Neuropsychological Society, Seattle, Washington.

Dunham, K. J., Rolin, S. N., Sibson, J. M., Ogbeide, S. A., & **Denney, R. L.** (2014, February). *Specificity for cognitively impaired individuals on the RBANS Effort Scale and Effort Index.* Poster presented at the 42nd Annual Meeting of the International Neuropsychological Society, Seattle, Washington.

Sofko, S., Dunham, K. J., Shadi, S., **Denney, R. L.**, & Fazio, R. L. (2014, February). *A rarely missed items index for the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).* Poster presented at the 42nd Annual Meeting of the International Neuropsychological Society, Seattle, Washington.

Dunham, K., Rolin, S., Sibson, J., Ogbeide, S., Glover, M., & **Denney, R. L.** (2012, November). *Utility of the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) in differentiating between types of dementia.* Poster presented at the 32nd Annual Conference of the National Academy of Neuropsychology, Nashville, Tennessee.

Deneen, T., **Denney, R. L.,** Fisher, J., & Spray, B. (2012, November). *The effectiveness of the MMPI-2-RF validity and cognitive/somatic scales in predicting symptom validity failure in TBI litigant tested for effort.* Poster presented at the 32nd Annual Conference of the National Academy of Neuropsychology, Nashville, Tennessee.

Dunham, K., Shadi, S., Sofko, C., & **Denney, R. L**. (2012, November). *Preliminary look: Comparison of the Effort Index and Effort Scale on the RBANS.* Poster presented at the 32nd Annual Conference of the National Academy of Neuropsychology, Nashville, Tennessee.

Dunham, K., Warchol, A., Hunter, B., Shadi, S., **Denney, R. L.,** & Nichols, C. (2012, November). *Comparison of the Reliable Digit Span and Age-Corrected Scaled Score on the WISC-IV as a measure of effort in children.* Poster presented at the 32nd Annual Conference of the National Academy of Neuropsychology, Nashville, Tennessee.

Rolin, S., Higgins, K, & **Denney, R. L.** (2012, November). *Utility of the Response Bias Scale (RBS) of the MMPI-2-RF in relation to structured malingering criteria in a criminal population.* Poster presented at the 32nd Annual Conference of the National Academy of Neuropsychology, Nashville, Tennessee.

Dunham, K., Warchol, A., & **Denney, R. L.** (2012, March). *Can We Trust Kids? A Review of Effort Measures in Pediatric Populations.* Poster presented at the 2012 conference of the Missouri Psychological Association, St. Louis, Missouri.

Dunham, K., Shadi, S., & **Denney, R. L.** (2012, March). *Review of the Use of Symptom Validity Measures for Neurocognitive Dementias.* Poster presented at the 2012 conference of the Missouri Psychological Association, St. Louis, Missouri.

Biddle, C., Fazio, R., Willett, K., Rolin, S., O'Grady, M., & **Denney, R.** (2011, November). *Motor dysfunction profiles in a simulated chronic pain sample.* Poster presented at the 31st Annual Conference of the National Academy of Neuropsychology, Marco Island, Florida.

England, D., **Denney, R.**, & Meyers, J. (2011, November). *Differential diagnosis of TBI and PTSD using the Meyers Neuropsychological Battery.* Poster presented at the 31st Annual Conference of the National Academy of Neuropsychology, Marco Island, Florida.

Hanson Misialek, L., Fazio, R., **Denney, R.**, & Myers, W. (2011, November). *Efficacy of embedded validity indices of the Booklet Category Test in a criminal forensic population*. Poster presented at the 31st Annual Conference of the National Academy of Neuropsychology, Marco Island, Florida.

Mack, J., Sparks, A., Dunham, K., & **Denney, R. L.** (2011, June). *Sensitivity of the Green Battery (WMT, MSVT, & NV-MSVT) to simulated dementia*. Poster presented at the 9th Annual AACN Conference & Workshops, Washington, DC.

Biddle, C., Willett, K., O'Grady, M., Rolin, S., Fazio, R., & **Denney, R. L.** (2011, June). *Finger Tapping: Why can't we alternate hands?* Poster presented at the 9th Annual AACN Conference & Workshops, Washington, DC.

Fazio, R., Griswold, S., & **Denney, R. L.** (2010, October). *Initial psychometric properties of the Fazio Laterality Inventory.* Poster presented at the 30th Annual Conference of the National Academy of Neuropsychology, Vancouver, British Columbia, Canada.

Umaki, T. M. & **Denney, R. L.** (2009, November). *Neurocognitive deficits associated with the hepatitis C virus among incarcerated men.* Poster presented at the 29th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Sanders, F., Bailey, C. M., **Denney, R. L.** & Marcopulos, B. A. (2009, November). *Performance of the Test of Memory Malingering (TOMM) and the Word Memory Test (WMT) in criminal medical and psychiatric settings*. Poster presented at the 29th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Barber, A. P., **Denney, R. L.**, & Deal, W. P. (2009, November). *Validity of effort testing among individuals with mental retardation*. Poster presented at the 29th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Triebel, K. L., **Denney, R. L.**, & Halfaker, D. (2009, November). *The utility of a short-Fake Bad Scale for detecting malingered neurocognitive dysfunction on the 370-item MMPI-2*. Poster presented at the 29th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Pipkin, S., **Denney, R. L.**, & Hartman, D. (2008, November). *Detecting exaggeration in neurocognitive functioning: Predicting Word Memory Test classification with the Structured Inventory of Malingered Symptomatology*. Poster presented at the 28th Annual Conference of the National Academy of Neuropsychology, New York, New York.

Denney, R. L., & Tyner, E. (2008, June). *Effectiveness of Reliable Digit Span at differentiating Definite Neurocognitive Dysfunction from good effort mild and moderate TBI among adult male criminals*. Poster presentation at the 6th Annual conference of the American Academy of Clinical Neuropsychology, Boston, Massachusetts.

Dionysus, K. E., **Denney, R. L.**, & Halfaker, D. (2008, June). *A comparison of the validity scales of the MMPI-2 and the RBS 28*. Poster presentation at the 6th Annual conference of the American Academy of Clinical Neuropsychology, Boston, Massachusetts.

Downing, S. K, **Denney, R. L.**, Spray, B. J., & Halfaker, D. A. (2007, November). *The performance of the MMPI-2 Reconstructed Scales among personal injury litigants feigning impairment.* Poster presented at the 27th Annual Conference of the National Academy of Neuropsychology, Scottsdale, Arizona.

Rosenstein, L. D., & **Denney, R. L.** (2007, June). *Initial development of the Feigning Low Intelligence Test (FLIT)*. Poster presentation at the 5th Annual conference of the American Academy of Clinical Neuropsychology, Denver, Colorado.

Sanders, J. F., & **Denney, R. L.** (2007, June). *A comparison of the Test of Memory Malingering and the Word Memory Test in a criminal forensic population*. Poster presentation at the 5th Annual conference of the American Academy of Clinical Neuropsychology, Denver, Colorado.

D'Amato, C. P., & **Denney, R. L.** (2007, February). *The Diagnostic Utility of the Rarely Missed Index in Detecting Response Bias in an Adult Male Incarcerated Setting*. Poster presented at the 35th Annual conference of the International Neuropsychology Society, Portland, Oregon.

Ardolf, B. R., **Denney, R. L.**, & Houston, C. M. (2005, October). *Base rates of malingered neurocognitive dysfunction among criminals*. Poster Presentation at the 25th Annual National Academy of Neuropsychology Conference, Tampa, FL.

Schnakenberg-Ott, S. D., **Denney, R. L.**, & Ryan, J. J. (2004, November). *Utility of WAIS-III Incidental Learning to detect negative response bias in a sample of civil and criminal litigants*. Poster presented at the 24th Annual National Academy of Neuropsychology Conference, Seattle, WA.

Collins-Johns, K., Powers, B. K., **Denney, R. L.**, Cannedy, R. C. (2002, May). *Comparison of Carlson Psychological Survey Chemical Abuse Scale and Substance Abuse Screening Inventory-3 in an Inmate Population*. Poster presented at the 12th Annual Mental Health in Corrections Symposium, Kansas City, Missouri.

Van Gaasbeek, J. K., **Denney, R. L.**, & Harmon, J. (2001, November) *Another look at an MMPI-2 neurocorrective factor in forensic cases: Utility of the Fake Bad Scale*. Poster presented at 21st Annual Conference of the National Academy of Neuropsychology, San Francisco, CA.

Cunic, T. L., & **Denney, R. L.** (2001, November). *Use of videotaped administrations as a method of establishing inter-rater reliability for the NCSE*. Poster presented at 21st Annual Conference of the National Academy of Neuropsychology, San Francisco, CA.

Burger, C. M., **Denney, R. L.**, & Lee, K. E.(2000, November). *The Kaufman Short Neuropsychological Assessment Procedure and the Halstead Reitan Neuropsychological Battery: A comparison using participants referred by Vocational Rehabilitation*. Poster presented at the 20th Annual Conference of the National Academy of Neuropsychology, Orlando, Florida.

Hughes, M., **Denney, R. L.**, & Cannedy, R. (2000, March) *Competency of juveniles to stand trial in criminal court*. Poster presented at the American Psychology-Law Society Biennial

2000 conference, New Orleans, Louisiana.

Denney, R. L., Feaster, T., Hughes, M., Estees, S., McKay, D., Mockenhaupt, S., Rooney, K., & Whisman, K. (1998, November) *Recognition items on the WMS-III as a forced-choice test of negative response bias*. Poster presented at the 18th Annual Conference of the National Academy of Neuropsychology, Washington, DC.

Denney, R. L. (1996, October). *A forced-choice recognition test for detecting negative response bias on the Wechsler Memory Scale-Revised*. Poster presented at the 16th Annual Conference of the National Academy of Neuropsychology, New Orleans, Louisiana.

Denney, R. L., & Scully, B. M. (1995, November). *Exaggeration of Neuropsychological Impairment in Pick's Disease: A Case Study*. Poster presented at the 15th Annual Conference of the National Academy of Neuropsychology, San Francisco, California.

Denney, R. L., & Wynkoop, T. F. (1995, August) *Exaggeration of Neuropsychological Deficits in Pretrial Evaluation: A Case Presentation*. Poster presented at the American Psychological Association 103rd Annual Convention, New York, New York.

Exhibit 4

From: **Back, Mark (DDS)** mark.back@dc.gov
Subject: Planning meeting for MS on May 22nd?
Date: May 12, 2017 at 4:03 PM
To: Lisa Greenman (greenmanlisa@gmail.com) greenmanlisa@gmail.com, Fofana, Musu (DDS) musu.fofana@dc.gov, Burrage, Theresa (DDS) theresa.burrage@dc.gov, Reaves, Jeremy (DDS) jeremy.reaves@dc.gov, VanHorn, Yolanda (DDS) yolanda.vanhorn@dc.gov
Cc: Morris, Thomas (DDS) thomas.morris@dc.gov, Woodland, Winslow (DDS) winslow.woodland@dc.gov, Williams, Richard (DDS) richard.williams@dc.gov

MB

The purpose of this email is to determine if we can get a meeting scheduled for the afternoon of May 22nd to discuss planning for Markelle Seth. Lisa Greenman, one of MS's attorneys, has already contacted Wholistic's Miatta Thomas and Georgetown's Matt Mason and they are available. So, are DDS staff available on May 22nd in the afternoon? If not, please work together to get a mutually agreeable date and time.

You should not need Richard Williams or me for these meetings but we are available should the need arise. The federal government already has filed a petition for commitment in the U.S. District Court for the Eastern Division of North Carolina and Richard is preparing a petition for his commitment in the MHab Court here in DC. Mr. Seth has a status in his DC federal case (by videophone) on July 21st and a hearing in the NC federal case on September 26th. It is possible to move up the various court dates if we have the planning piece in place and the idea is to get MS out of confinement as soon as possible within the timing realities of the two commitment processes.

Many thanks.

MDB

Mark D. Back
General Counsel
D.C. Department on Disability Services
One Independence Square
250 E Street, SW, 6th Floor
Washington, DC 20024
(202) 730-1592

Exhibit 5

DECLARATION of Marisa C. Brown MSN, RN

I, Marisa C. Brown, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. I am competent to testify to the matters set forth herein, and testify based on personal knowledge, information and belief.
2. I have thirty-four years of clinical and policy experience working in the District of Columbia with people who have intellectual and developmental disabilities (I/DD) and collaborating with the D.C. government and associated social service agencies that are responsible for meeting the needs of this population.
3. In August 2017, I retired as director of the DDA Health Initiative, a program funded by the D.C. government and based at Georgetown University's Center for Child and Human Development. The Center is part of the national network of University Centers for Excellence in Developmental Disabilities (UCEDDs), described below. The DDA Health Initiative works with individuals with I/DD and the District of Columbia's Developmental Disability Administration (DDA), a branch of the D.C. Department on Disability Services (DDS), to address intensive behavioral supports and complex medical and nursing care for DDA-supported individuals. Among many other things, the program addresses sexual behavior issues and provides sexuality education to individuals with I/DD. It was through this program that I came to be aware of Markelle Seth and his needs.
4. I have met individually with Markelle and participated in planning meetings about his needs with DDA officials and service providers. I have reviewed relevant medical, mental health and court records about Markelle including those relating to his infancy and early childhood. I also observed two days of testimony about Markelle at his federal court competency hearing, which included extensive testimony from two psychologists and others. I am therefore deeply familiar with Markelle's history and his current service needs, which include the problematic sexual behavior which led to his current court involvement.
5. Based on my extensive experience working with individuals with I/DD in the District of Columbia, my long-term collaborative work with both DDA and its network of community-based service providers, and my first-hand knowledge of Markelle's strengths and challenges, it is my professional opinion that Markelle can be safely and effectively served in the community through the existing system of care. Markelle does not present risks or problems that are unfamiliar to DDA or its service providers. Markelle's support and supervision needs are similar to those of people already being served and in fact less challenging than those presented by many who are already being served in the community. Indeed, people who present the very same issues Markelle presents are currently served in community-based programs throughout the country.
6. Having reviewed the recommendations of Dr. Matthew Mason, who was retained by DDA to assess Markelle and who succeeded me as director of the DDA Health Initiative, and the extraordinarily thorough proposal by Wholistic Services, Inc., an organization I know and hold in high regard, it is my professional opinion that the pieces are in place for Markelle to be safely integrated back into the community.

Education and Relevant Experience

7. My education includes a B.S.N. from Niagara University and a M.S.N. from George Mason University. While completing the requirements for my Master's degree, I participated as a fellow in the

federally funded Leadership Education in Neurodevelopmental Disabilities program at the Georgetown University Center for Child and Human Development.

8. My experience includes thirty-four years with the Georgetown University UCEDD, serving in a variety of roles, including that of a clinical nurse specialist, Project Coordinator, Senior Policy Associate for Family Engagement, Coordinator for Information and Dissemination of the UCEDD and Project Director.
9. I was a member of the faculty of Georgetown University (retired August 2017) and worked in Georgetown's Center for Child and Human Development, which is part of the national network of University Centers for Excellence in Developmental Disabilities (UCEDDs). UCEDDs are authorized by the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 and were originally authorized in 1963. These clinical centers exist in every state and territory and are affiliated with universities, allowing them to serve as liaisons between academia and the community. UCEDDs are a nationwide network of independent but interlinked centers, representing an expansive national resource for addressing issues, finding solutions, and advancing research related to the needs of individuals with I/DD and their families.
10. In my thirty-four-year affiliation with Georgetown University, I was frequently engaged with the D.C. government in joint efforts to effect reform within its disability services system, which had been under a federal lawsuit (*Evans v. Bowser*), filed in 1976, to close its institution (Forest Haven) for people with I/DD and to create a system of community-based services and supports in its place.
11. I have also collaborated directly with the D.C. government as it established the Department on Disability Services, Developmental Disability Administration which is charged with providing community-based supports to adults with I/DD. Those projects included:
    a. From 1991 to 1992, I served as a Clinical Nurse Specialist for an outreach mental health clinic funded by the D.C. Commission on Mental Health. I was responsible for nursing assessment and case management within an interdisciplinary team of mental health professionals to provide services to adults with intellectual disability and mental health diagnoses.
    b. From 1989 to 1993, I was funded by a federal grant in one of the earliest efforts to prepare communities to transition people with I/DD from institutional settings to the community. Working closely with D.C. officials, I assisted in the development and implementation of a curriculum for direct support professionals in the District of Columbia. Over four years, the basic curriculum was expanded to include specialty courses in positive behavioral supports (a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment) and the support of people with complex health needs. The course was taught to direct support professionals, including some of the staff of the District's institution for people with I/DD, Forest Haven. Throughout this period, I along with two other faculty colleagues, consulted closely with District administrators to create a joint initiative that was embraced by the burgeoning network of private providers who were opening group homes for the support of people with I/DD in the community.
    c. From 1994 to 2001, District funding shifted to an emphasis on person-centered planning, a process that allows individuals with I/DD to be engaged in the decision-making process about their own options, preferences, values, and financial

resources rather than allowing someone else to make decisions on their behalf without their input. I coordinated training designed to assure that individuals with I/DD and their families had increased opportunities for choice and control over their lives by building the capacity of the District's service delivery system to provide person-centered and culturally competent services and supports.

d. In 2005, I was chosen by the Mental Retardation and Developmental Disabilities Administration, now renamed the Developmental Disabilities Administration (DDA), to develop a system of training and technical assistance to support DDA to meet its regulatory and legal requirements pursuant to the *Evans* lawsuit, to evaluate the effectiveness of policies and procedures related to the delivery of health care and related services, and to establish frameworks for the delivery of culturally and linguistically competent services to diverse constituencies. This initiative focused on health and health-related issues that impact access to quality services and supports and, ultimately, the quality of life for people with I/DD. The goal of this initiative was to improve the health outcomes for adults with I/DD by addressing policies, practices, and resources for workforce development that affect change in the system of community-based services and supports. Through this work, I was awarded a grant which resulted in the establishment of the DDA Health Initiative.

e. I directed the DDA Health Initiative for twelve years, working very closely with the administrators of DDA and the executive and nursing leadership of the agencies with which DDA contracted to provide community-based services and supports. There were numerous instances over the course of those twelve years where I had to be intimately versed in how the DDA system worked so that I could assist DDA and the community-based service providers to solve problems and determine the best way to support people who were experiencing changes in their health status. As Director of the DDA Health Initiative, I was often alerted to "critical incidents"—events that created a serious risk of harm to health or safety—that arose within community residences and was called upon to provide technical assistance to identify short- and long- term solutions for their successful resolution. This assistance included issues related to the need for innovative behavioral supports, complex medical and nursing care issues, creating dementia-capable environments, and delicate end-of-life considerations.

12. In addition to my work with the DDA Health Initiative, I have experience addressing problematic sexual behaviors and providing sexuality education for individuals with I/DD and their families in other settings. For approximately four years, in the early 2000's, I provided instruction and consultation to Paul VI High School in Fairfax, VA for their students with I/DD in their Family Life class. This class provided instruction on human sexuality within the tenets of Catholic teaching and the classes were individualized in order to address any current issues facing students and teachers in the students' school and home life. This consultation also included annual meetings with the parents of the students.
13. My work in the field of I/DD also includes scholarship. I have written several articles, including in peer-reviewed journals, and chapters in nursing and medical texts related to nursing assessment, health planning and sexuality education for people with I/DD.

14. I am an active member of professional organizations focusing on I/DD. I am a member of the American Association on Intellectual and Developmental Disabilities and the Developmental Disabilities Nursing Association. I have presented educational sessions at each of their annual, national meetings, as well as presentations with the American Academy of Developmental Medicine and Dentistry.
15. I am a regional trainer with the National Task Group on Intellectual Disabilities and Dementia.
16. I have served on the human rights committees of two D.C.-based developmental disability service organizations and the Alexandria Community Services Board human rights committee where issues related to sexual behavior and appropriate community supports were discussed and recommendations offered.
17. I served as the Chair of the Virginia State Special Education Advisory Committee from 1992 to 1996 and Chair of the Fairfax County (VA) Special Education Advisory Committee from 1997 to 2000.
18. I am familiar with services provided to individuals with I/DD in areas beyond the District of Columbia. For the past four years I have served as a consultant to the Independent Reviewers for Georgia and Virginia who are both appointed by the U.S. Department of Justice to oversee those states' respective agreements to close most of their large institutions and create systems of community-based services for their citizens with I/DD. My responsibilities involve evaluating the adequacy of services to people with health care support needs to ensure that the supports outlined in their individual support plans are being implemented, and to ensure that nurses are following the mandates of their state nurse practice acts in providing assessment, planning, care and evaluation of the health status of people for whom they have been given responsibility.

The District of Columbia Service System for People with I/DD

19. DDA is comprised of an integrated network of service divisions charged with a continual planning process that considers changes in service needs and provides ongoing support through their technical assistance to community-based service providers. DDA is comprised of numerous divisions and units which are integrated to ensure the provision of high-quality services that adhere to the policies and procedures of the Administration. Though the units and divisions have changed over the years, I have experience with and knowledge about the following units and divisions: Service Planning and Coordination Division; Provider Resource Management Unit; Health and Wellness Unit; Quality Management Unit; Office of Rights and Advocacy; Quality Improvement Unit; and Office of Incident Management.
20. The Department on Disability Services has a robust system of training, known as the Training Institute (DDSTI). The DDSTI offers a four-tiered curriculum to those who provide services to persons served by DDA. The curriculum is designed to build conceptual understanding of best practices while using person-centered thinking tools to gain a deeper understanding of the people who receive support. Each staff member who comes in contact with a person with I/DD within the service system is expected to complete initial training and then maintain up-to-date training as the needs of the person changes. In my role as Georgetown University UCEDD faculty and Director of the DDA Health Initiative, I reviewed and provided content for the health and behavioral health related components of this training.
21. DDA also has a robust mechanism for ensuring provider compliance with all DDA policies and procedures via the Provider Certification Review (PCR). The PCR is the mechanism for annually determining if a provider is qualified to deliver the HCBS waiver service(s) for which it has been

enrolled. Providers who complete the PCR process with a less than satisfactory rating in a service(s) may not provide that HCBS waiver service(s) through the DDS/DDA.

22. The District routinely provides highly individualized services and supports to people, including those with serious mental illness (in addition to their intellectual disability), complex and chronic health conditions, and those who have had a history of sexually inappropriate behavior. For example, there is a small group of three to four men who previously lived at Forest Haven and have histories of sexually inappropriate behavior who were successfully transitioned to living in the community. When Forest Haven closed in 1991, these men were initially retained in a District-owned facility known as D.C. Village because the Community Services Board (now known as the DDA) was uncertain how to provide community-based services. However, a non-profit provider accepted responsibility for the provision of their services, and, to my knowledge, they continue to reside in the same home, located in a residential neighborhood in Northwest D.C., to this day.
23. Based on my thirty-four years of experience observing and participating in the provision of services to people with I/DD in DC, including those presenting significant risks and challenges, it is my opinion that DDA has well-established systems that are inter-related with their network of contracted, community-based, disability service providers to ensure appropriate service planning that provides safeguards for the individual with a disability, the staff that support the individual, and the community into which the individual is integrated.
24. DDA is designed to serve, and does serve, many individuals whose intensive needs would present risk to their own safety or the safety of the community if they were not appropriately supported and supervised. DDA is able to serve individuals whose challenges include physically aggressive behaviors, risk of absconding, intensive medical and mental health needs, etc. While most individuals served by DDA don't require round-the-clock or one-to-one supervision, DDA can and does provide this level of service to a significant number of individuals. In addition, service planning for individuals with complex needs is dynamic and ongoing. When problems arise, there are a range of mechanisms for responding, including crisis management, changing the service plan or even changing the service site to a setting that is more restrictive, whether temporarily or long-term. And, in those cases in which it becomes necessary, out of state residential programs and institutions that further limit an individual's liberty and access to the community can be and are accessed by DDA. DDA has the ability to manage behavioral and other challenges through a continuum of care that ranges from less intensive to more intensive and from less restrictive to more restrictive. By design, there is no person with I/DD whose needs cannot be accommodated, because DDA's has a virtually unlimited ability to select the environment and staffing level required by the individual's needs. This is not to say the system is perfect. It is not. But the system as it currently exists is entirely capable of meeting the needs of an individual like Markelle Seth.

Experience with Markelle Seth

25. I first became aware of Markelle Seth in 2015 when I received a phone call from Lisa Greenman, his criminal defense attorney, who explained she had been referred to me by the court-appointed monitor for the *Evans* case, Elizabeth Jones. Ms. Greenman was seeking information about services and supports provided in the District of Columbia for people with I/DD, with a specific focus on meeting the individual and public safety needs presented by a person alleged to have been involved in inappropriate sexual behavior with children.

26. Beginning in 2015, I began a series of meetings with Markelle while he was held at the Correctional Treatment Facility and the D.C. Jail. I was aware that Markelle had been found eligible for DDA services and that the agency was prepared to civilly commit him and provide him with community-based services once the court found him incompetent and therefore eligible to be civilly committed. I anticipated that my program would be supporting his adjustment. I therefore met with Markelle in order to have a first-hand understanding of his presentation and better understand his needs. I also brought with me a member of my staff, family educator Erica Thomas, who has extensive experience working with individuals with I/DD to address sexual behavior, including problematic sexual behavior, and providing sexuality education.
27. I also met with Markelle once when he was having a dental problem, in order to help him understand why, in spite of his fear of needles, it was critical that he allow the jail's dentist to numb him and remove a decayed tooth.
28. In my encounters with him, I observed Markelle to be open, receptive and eager to please. It was easy to establish rapport and he actively engaged with me and my staff, readily sharing his interests and his hopes. Markelle has a lively sense of humor and a playful manner and he is quick to smile and laugh. My interactions with him reinforce my opinion that Markelle would do well in a community setting where he will have the opportunity to develop relationships with the staff that support him, and have the opportunity to learn how to care for himself and his home. I am most impressed with the rapport he has developed with his attorney Lisa Greenman that has remained consistent and positive over time despite his long period of incarceration and isolation.
29. Between 2015 and 2017, I participated in planning meetings with DDA administrators and staff for the purpose of identifying the specific community-based services Markelle would need when released from his criminal case and civilly committed by the District. Markelle had already been found eligible for DDA services and these meetings focused on identifying the necessary elements of a community-based service plan. In addition, I spoke more informally with Andrew Reese (DDS Director) and Thomas J. Morris (then DDA's Acting Deputy Director) about Markelle's eventual transition to the community.
30. I also attended the competency hearing for Markelle that was held in federal district court on May 16 and 17, 2016, to gain a better understanding of Markelle, since, as indicated above, I anticipated that members of my team, the DDA Health Initiative, would be called upon to provide training and technical assistance to DDA staff and the staff of the community residential provider that would assume responsibility for providing his services and supports.
31. On July 27, 2017, I wrote a letter [attached here] to DDS Director Reese outlining my lengthy and substantial meetings with Markelle, my knowledge of his history, and the compelling reasons that, in my opinion, DDA and its network of providers would be able to safely and successfully support Markelle. I reminded Mr. Reese that the District had asserted in numerous court filings in the *Evans* law suit that they had the capacity and robust systems in place to serve people with I/DD and complex support needs. But most importantly, I reminded Mr. Reese that Markelle's situation provides an opportunity to serve someone with intellectual disability in need in a meaningful way.
32. I have reviewed the complaint and exhibits filed on Markelle Seth's behalf on May 1, 2018, in the United States District Court for the District of Columbia, and the reports of Dr. Matthew Mason and Dr. Stephen Hart. I have also reviewed court records concerning his early childhood and other medical and mental health records relating to Markelle.

Markelle Seth Can be Safely and Effectively Served in the Community by the District

33. It is my opinion that DDA has the capacity to provide appropriate services for Markelle that will assist him to grow as an individual and at the same time ensure the protection of community safety.
34. DDA is able to provide, through Wholistic or another provider, one-to-one staffing twenty-four hours per day. This is not an extraordinary level of support for the agency. There are a number of people for whom DDA provides this level of supervision to ensure their safety and the safety of the community. They include people with complex health support needs, advanced forms of dementia, high risk of falling, and significant behavioral support needs, including people with histories of sexual behavior problems such as sexual conduct toward children. It is not unusual for this type of staffing to be provided within the DDA system.
35. Markelle has already been found eligible to be served by DDA. Wholistic Services, or whatever agency is designated to be his provider, will hire staff who are trained according to DDA policy on all of the elements of his ISP and a behavioral support plan (if one is needed). Thirty days after the initiation of the ISP, his circle of support will be convened by his assigned case manager to review his progress toward his identified goals and to amend any goals and strategies as needed. This will also be an opportunity to ensure that all resources that are needed are in place. This process can be convened at any time that Markelle or anyone on his support team determines that changes are needed to the ISP.
36. In addition, should Markelle return to D.C. to receive services, part of his ISP could include the DDA Health Initiative providing him with sexuality education in order to teach him appropriate sexual behavior, something which he has never had the opportunity to learn. Erica Thomas, an educator with DDA who has extensive experience working on these issues as mentioned above, is available to provide these services to Markelle upon his return to D.C.
37. Markelle has had to spend much of his time at FMC Butner in solitary confinement due to his inability to conform to the environment of the prison. During his period of incarceration, Markelle has been deprived of the supports and services for which he has been found eligible as a person with intellectual disability. In fact, he is at high risk of deterioration of his skills related to activities of daily living. His long periods of isolation will also likely have a negative impact on his mental health.
38. A growing body of research reveals that even short stays in solitary confinement can have severe and long-lasting consequences for people with disabilities, particularly those with mental health conditions.
39. Given my numerous interactions with Markelle, my attendance at his competency hearing, and my review of his records, I believe that I have a good sense of who Markelle is and the kind of supports he needs to thrive in the community. Markelle presents as a highly resilient person. His strengths lie in his ability to engage with people and his interest in simple pleasures such as his books and cartoon shows. He can write simple sentences, and once wrote a letter to me. He was able to engage with some of the officers at D.C. Jail in a positive way. His case manager from the D.C. Correctional Treatment Facility testified that she treated him like a son, allowing him to pass the time sitting in her office and color pictures in a coloring book. She said the warden made an exception to the rules and allowed Markelle to have crayons. These characteristics demonstrate an inclination to form positive relationships with caring professionals and this is predictive of a good outcome once he is living in the community and offered the supports his disability requires. His numerous instances of infractions and behavior while in custody do not undermine this conclusion. Rather, these infractions include issues such as not tucking in the shirt of his prison uniform, throwing his ID card down the elevator shaft while at DC jail, and changing the TV set against the

expressed wishes of fellow inmates at Butner. These kinds of infractions are examples of his poor executive functioning skills.

40. Executive functioning refers to self-regulating and control functions of the brain that direct and organize behavior. Markelle experiences problems in the following areas: self-inhibiting, self-monitoring, self-evaluating, flexible problem-solving, and self-awareness. In a community setting, staff will be able to help Markelle address these deficits in constructive ways. Unfortunately, within the rigid confines of federal prison, Markelle only has the opportunity to fail.
41. As described above, my extensive professional experience with DDS and I/DD services and my knowledge of Markelle and his record lead me to conclude that he is well-suited for community placement. As long as the expert guidelines are followed, Markelle can thrive in a communal setting without posing a threat to the community at large. DC and DDS are fully capable of serving him in this way and, in fact, they are charged with doing so. If DC does not take responsibility for Markelle, he will continue to experience significant harm during his incarceration and segregation at Butner.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 23 day of October, 2018

Marisa C. Brown

July 27, 2017

Sent via Email

Andrew Reese, Director
Thomas "Jared" Morris, Deputy Director
DC Department on Disability Services
250 E Street, SW
Washington, DC 20024

Dear Andy and Jared,

I am writing today to express in writing what I have said to you in numerous conversations: I wholeheartedly support and encourage the DC Developmental Disability Administration (DDA) to move forward in developing a set of services that will bring Markelle Seth back here from the federal prison in North Carolina as soon as possible and provide him with a highly structured, closely supervised, community-based program. I am familiar with Markelle's history. I have had lengthy and substantial in-person meetings with him and have read comprehensive evaluations including the most recent risk assessments. I also heard two entire days of courtroom testimony about him during his federal competency hearing and participated in earlier service planning discussions with DDA. I have no doubt that DDA is capable of serving Markelle safely in the community.

I first learned about Markelle's situation when I was contacted by his attorney, Lisa Greenman in 2015, at the suggestion of Elizabeth Jones. Colleagues within the DC legal community had warned Ms. Greenman that DDA resisted meeting the support needs of people with intellectual disabilities who had come into contact with the criminal justice system. During our first conversation I explained to Ms. Greenman the significant progress DDA has made over the past 15 years in establishing not only a wide array of services, but also the capacity to establish and maintain quality standards among their providers, develop support plans that utilize the principles of person-centered thinking and offer an array of clinical supports through DDA in-house staff and contractors. Among other things, Ms. Greenman sought help identifying potential sources of sexuality education and other supports for Markelle.

At Ms. Greenman's suggestion I visited Markelle at the DC Jail to meet Markelle to better understand if he would be able to benefit from sexuality education to learn and demonstrate the parameters of responsible adult behavior. I also met with him when he was having a dental problem but was fearful about allowing the dentist to treat him. It was easy to establish rapport with Markelle.. He is an extremely engaging young man who is engaging, receptive and eager for connection.

Unfortunately Markelle is an example of what happens to people with intellectual disability when they are not afforded supports either at home or through what should be their civilly protected right to a free and appropriate education. Markelle attended a charter school that was notorious for the way it disserved special education students and instead of receiving special education services he was entitled to until his 22nd birthday, was actually "graduated" early, before he was even 18 years old. He was not transitioned into services through RSA and/or DDA, was permitted to become his own representative payee for SSI in spite of being unprepared to make decisions for himself, and was given responsibilities for which he was not prepared. The District's safety net systems failed Markelle.

Having worked alongside staff from the DC Bureau of Community Services, the Mental Retardation and Developmental Disabilities Administration, and more recently the Developmental Disabilities Administration, I know the capabilities of the DDA to plan and monitor individualized services, and providers who are capable of executing the plans. Similarly, I am aware of the range of individual challenges that DDA providers are able to manage and I'm confident Markelle does not fall outside that range. A certain amount of risk is inherent in the nature of the work we do, and Markelle's disability related behavioral challenges present issues the developmental disability community is familiar with and well prepared to address. DDA already has a track record of serving individuals who present risks similar to and greater than Markelle.

The District asserted in filings on the Evans' case that it has the capability to provide comprehensive, community-based services to a wide range of people with intellectual disabilities, not only the Class members. Supporting Markelle in the community is part of the fulfillment of that assertion.

In addition, I would like to make sure you are aware of the ways the DDA Health initiative can assist in supporting Markelle. Markelle would be appropriate for a referral to the DDA Health Initiative health educator who can work with him to provide education about adult sexuality and the management of his healthcare. With the continuation of the Trauma Informed Initiative, Dr. Matt Mason can work with the assigned provider to support the delivery of services that address Markelle's trauma, including his extended incarceration without the benefit of appropriate supports. From a clinical perspective, I want to underscore that remaining in the criminal justice system is harmful to Markelle.

Our chosen life's work puts us in the position to help a lot of people and do a lot of good. It is rare, however to have the opportunity to impact social justice in the manner that could happen for Markelle Seth. The right thing to do is to effect his community placement as soon as possible. Thankfully, after years of extraordinary effort, the District can say that they do have the capacity to do it well.

Sincerely,

Marisa C. Brown

Marisa Brown MSN, RN

Director, DDA Health Initiative

cc: Lisa Greenman; Mark Back

Marisa C. Brown

Professional Experience:

2017 – Present ***Consultant on health-related issues concerning people with developmental disabilities. This includes standards-development, quality assurance and application of best-practices to community settings.***

1983 - 2017 ***Georgetown University Center for Child and Human Development***
University Center for Excellence in Developmental Disabilities Research, Education and Training (UCEDD), Washington, DC

2005- 2017 Project Director. Contract with the D.C. Developmental Disabilities Administration to develop accessible and high-quality healthcare for individuals with intellectual disabilities in community settings. Directs a partnership that includes the Georgetown University Department of Family Medicine. The project tasks include the identification of processes to systematically plan and evaluate the delivery of health care for people within the developmental disability services system, the development and provision of training and technical assistance to community service providers and health care personnel, identification of primary and specialty healthcare services for people with intellectual disabilities, and the identification of model service delivery options.

2006-2010 Project Director. Parent-Child Home Program. This home visiting program serves families with children 16 months to 2 years of age, offering bi-weekly home visits and working with parents to increase their capacity to stimulate their children's verbal development through the use of books and educational toys. Children at risk for developmental delay are targeted.

2001- 2008 Project Director. Home Instruction Program for Preschool Youngsters, funded by the D.C. Office of Early Childhood Development. This is a home visiting, developmental intervention program whose goal is to assist families to ensure that their young children are prepared to enter school. Families whose children are at high risk for developmental delay and disability are targeted. The project is implemented in collaboration with community-based and led organizations in two wards of the city that are significantly impacted by poverty, drug abuse and lack of family supports.

2001-2005 Coordinator for Information and Dissemination, UCEDD grant funded by the Administration on Developmental Disabilities. Responsible for dissemination of information using multifaceted approaches including: (1) conference/meeting presentations and poster displays/exhibits, (2) participation on committees, task forces and councils at the local, national and international levels, (3) printed materials available in alternative formats, and (4) Web-based and other electronic communication technologies. Also responsible for the provision of training and technical assistance on issues related to individuals with developmental disabilities and their families.

1998-2005 Project Director: National Center for Cultural Competence, Bureau of Primary Health Care Project. Responsible for the coordination of activities, provision of technical assistance and product development for this national training and technical assistance center which aims to increase the capacity of Title V, Sudden Infant Death and other Infant Death programs, and the Bureau of Primary Health Care programs to design and deliver services that are culturally and linguistically competent.

2003-2005 Senior Policy Associate for Family Engagement, National Center for Cultural Competence,

Cultural Competence Initiative for the Substance Abuse and Mental Health Services Administration (SAMSHA) Project. Collaborates with other team members to provide training and technical assistance to System of Care sites funded by SAMSHA, with a focus on the role of family members in the development of policies and services that are family-directed and culturally and linguistically competent.

1996-2002 Project Coordinator: DC Linkages, funded by the Office of Special Education Programs, U.S. Department of Education. Coordinates all activities of a project designed to build the capacity to identify refer and provide a continuum of services for young children with disabilities living in low-income communities in the District of Columbia.

1998-2002 Project Coordinator: Knock on Every Door, funded by the D.C. Early Intervention Program, Department of Social Services. Coordinates all activities of a project designed to enhance the accessibility of developmental screening for infants and toddlers residing in temporary shelter and facilitate their referral for eligibility determination for early intervention services.

1994-2001 Training Coordinator: Training Initiatives Project/Person Centered Planning, funded by the Administration on Developmental Disabilities. Responsible for coordinating training activities designed to assure that individuals with developmental disabilities and their families have increased opportunities for choice and control over their lives by building the capacity of the District's service delivery system to provide person-centered and culturally competent services and supports.

1989 - 1993 Georgetown University/University Affiliated Program, Washington, DC, funded through Administration on Developmental Disabilities, DHHS. Coordinator: "Making a Difference in the Lives of Individuals who are Developmentally Disabled" Training for Direct Service Personnel.

1993 -1996 Project Coordinator: Knock on Every Door, funded by the Hasbro Children's Foundation, this project developmentally screens and assesses children birth to 5 years of age who reside in emergency shelter. Coordinates all interdisciplinary team activities including coordination with appropriate city officials. Responsibilities include the planning and coordination of a day care training program for parents in emergency shelter.

1991- 1992 Georgetown University, University Affiliated Program, Washington, DC, funded by a contract the DC Commission on Mental Health. Clinical Nurse Specialist, Mental Health outreach clinic for people with mental retardation. Responsible for nursing assessment and case management within an interdisciplinary team.

2005-2010 Sexuality Educator (consultant) Paul VI Options Program. Classroom teaching of sexuality issues within the context of Catholic teaching to high school students with intellectual disabilities. Curriculum included events that were occurring in real-time for the students and their teachers and families. Eventually prepared classroom teachers to assume this role.

1985 - 1989 Alexandria (Virginia) Mental Health and Mental Retardation Services Board. Nursing consultant to an intermediate care facility for individuals with mental retardation

1983 - 1989 Georgetown University/ University Affiliated Program, Washington, DC.
* Coordinator for "Incorporation of Genetics into Clinical Practice".
* Nursing Consultant to the Bureau of Community Services Contract.
* Nurse Educator with the "Community Health Nurse Training Project".

1977 - 1980 National Children's Center, Inc., Washington, DC. Chief Nurse.

1976 - 1977	Central Wisconsin Center for Developmentally Disabled, Madison, Wisconsin. Staff Nurse.
1973 - 1976	Portsmouth Naval Hospital, Portsmouth, Virginia. Navy Nurse Corps Office, Staff and Charge Nurse.

Licensure: Licensed as a registered nurse in the District of Columbia and Virginia

Education:	Master of Science, Nursing	George Mason University, 1984
	Bachelor of Science, Nursing	Niagara University, 1973

Teaching Activities:

Guest panelist: Knowledge Sharing Workshop Afghan Disability Rights Conference: From Policy to Programming – public health models in developmental disability. Washington, DC, May 24, 2017

Faculty: *Providing High Quality Health Care Experiences for Individuals With Intellectual and Developmental Disabilities,* May 25, 2016 for Otpum Health Education.

Faculty: International Conference on Clinical Ethics Consultation. End of Life Decisions for People with Intellectual Disabilities, May 20, 2016.

Guest Faculty: Georgetown University Law Center. Understanding End of Life Decision-Making with and for People with Significant Intellectual Disabilities, Fall Semesters 2013, 2014, 2015.

Faculty: Ontario Partnership on Aging and Developmental Disabilities, Advanced Care Planning Workshop, Understanding End of Life Decision-Making with and for People with Significant Intellectual Disabilities, March 12, 2015.

Guest panelist: New Perspectives: Supporting Individuals with intellectual and Development Disabilities Through Life-Ending Illness, Grief and Loss, Hospice Foundation of America, 2013.

Faculty: Meeting the Health Care Needs of Individuals with Developmental Disabilities, Georgetown University Department of Family Medicine, Resident lecture, 2007-2011

Faculty: DC Health Resources Partnership, provided community education to registered and licensed practical nurses and other members of interdisciplinary teams with focus on the following topics: end-of-life planning, nursing assessment, positive behavioral supports, transition of care, patient safety, dementia and community health supports.

Faculty: Policy Academy: Transforming Mental Health Care for Children and Families through Planning, Policy and Practice, National Training and Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. August 2005.

Faculty: Training Symposium for Nurses Providing Services to Individuals Who Experience Mental Retardation and Other Developmental Disabilities in the District of Columbia. Quality Trust for Individuals with Disabilities, December 2004.

Guest Faculty: New Jersey Department of Developmental Disabilities Workshop Series: Achieving Organizational Cultural Competence: Implications for Programs that Support Individuals with Developmental Disabilities and their Families. November 2002

Guest Faculty: Training Institutes, National Technical Assistance Center for Children's Mental Health Center for Child Health and Mental Health Policy, Georgetown University, Developing Local Systems

of Care for children and Adolescents with Emotional Disturbances and their Families: Family Involvement and Cultural Competence. Presented two workshops dedicated to adolescents on transition issues from school to adult services.

Workshop Presenter: "Warning Signs that May Indicate Developmental Delay and Disabilities for Infants, Toddlers and Preschool Children." National Health Service Corps Annual Conference Series, 2000.

Guest Faculty: Training Institutes, National Technical Assistance Center for Children's Mental Health Center for Child Health and Mental Health Policy, Georgetown University, Developing Local Systems of Care in a Managed Care Environment, June 1998

Guest Faculty: Faculty Leadership Program, Summer Institute, University of Oklahoma Health Sciences Center.

Course Coordinator/Lecturer: "Making a Difference in the Lives of Individuals with Developmental Disabilities". Includes course development and implementation of a District-wide project to improve the education of personnel providing direct-care services to persons with developmental disabilities.

Lecturer: "Incorporation of Genetics into Clinical Practice". Professional Continuing Education for Nurses and Other Allied Health Professionals.

Course Coordinator/Lecturer: "Knock on Every Door" Child Care Aide Training Program. Includes course development and implementation of a 4-week training program for men and women who have been homeless. Coordination with DC Department of Employment Services to transition to employment or additional training.

Public Service:

Former Member: Human Rights Committees: Alexandria, VA and District of Columbia Disability Services Administration and National Children's Center, Washington, DC.

Former Member: Ready for Kindergarten Workgroup, DC Promise Neighborhood Initiative

Former Chair-elect: Healthy Families/Thriving Communities Collaborative Council, Washington, D.C.

Former Board Member: Midnortheast Family Collaborative, Washington, D.C.

Former Member: Midnortheast Family Strengthening Collaborative: Steering Committee Member. Represents Georgetown University Child Development Center in planning for community-based services that will ensure through a strength-based approach that children and families are assisted in accessing resources that will have a direct effect on the reduction of child abuse and child neglect.

Former Chair: Fairfax County Public Schools Advisory Committee for Students with Disabilities

Former Chair: Virginia State Special Education Advisory Committee

Former Chair: Parents and Children Coping Together (Statewide support network for families of children and adolescents with emotional and behavioral disorders)

Scholarship and Research:

Publications:

(Peer-Reviewed Journal Brown, M., Jacobstein, D., Seyoung Yoon, I, Anthony, B. and Bullock, K. (2016). Systemwide Initiative Documents Robust Health Screening for Adults with Intellectual Disability. Intellectual and Developmental Disabilities, 54 (5) 354-365.

(Chapter Contribution) Brown, M. (2014). The professional nursing role in support of people with intellectual and developmental disabilities. **Rubin and Crocker 3rd Edition: Health Care for people with Intellectual and Developmental Disabilities across the lifespan** edited by I Leslie Rubin, Joav Merrick, Donald E Greydanus and Dilip R Patel

(Peer-Reviewed Journal) Brown, M & Censullo, M. (2007). Supporting safe transitions from home to health care settings for individuals with intellectual disabilities. Topics in Geriatric Rehabilitation, 24 (20) 74-85.

(Issue Brief) Brown, M., Perry, D & Goode, T. (2003). *Effective Collaboration between Universities and Communities: Making a Difference for Young Children and their Families*. Washington, D.C.: Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities.

(Planning Guide) "A Planner's Guide: Infusing Principles, Content and Themes Related to Cultural and Linguistic Competence into Meetings and Conferences" (2000). Georgetown University Child Development Center, Washington, D.C. **National Center for Cultural Competence.**

(Non-refereed Journals) "Advocates for Health" **Nursing Times**, 87(21), May 22, 1991, 62-64.
"Silent Pain" **Nursing Times**, 87(6), February 6, 1991, 62-65.

(Chapter Contributions) "Nursing Assessment" and "Supporting Positive Behavior" in Roth, S. and Morse, J. Eds. (1994). **A Lifespan Approach to Nursing Care for Individuals with Developmental Disabilities.** Baltimore, Md: Paul H. Brookes Publishing.

(Monograph) Taylor, T., & Brown, M. (1996). *Young children and their families who are homeless: A University Affiliated Program's Response*. Georgetown University/University Affiliated Program: Washington, D.C.

Exhibit 6

On Mar 12, 2015, at 5:11 PM, Nuss, Laura (DDS) <laura.nuss@dc.gov> wrote:

Dear Lisa:

Thank you for your email and zealous advocacy on behalf of MS. Nancy and I go way back. Given the long-standing Evans class action litigation and the D.C. Superior Court's involvement with the people we support through proceedings for civil and criminal commitment and annual re-commitment hearings, this agency is quite comfortable in its dealings with lawyers. Please be assured there will be no "counterproductive reactions" to your communication with me. As a matter of fact, I have been made aware of the situation with MS and know first-hand that the DDS/DDA Intake and Eligibility Unit and the DDS Office of the General Counsel and have been working together, and with you, on making an expeditious eligibility determination and in determining how best to proceed moving forward. We regularly work on forensic cases with the USAO and understand the process well. Based on your representations in another email string that included our General Counsel, no Jackson finding has been made for MS but I understand that a favorable eligibility determination is forthcoming. I encourage you to continue working with DDS and DDS/DDA staff identified in the emails below to develop a person-centered approach to supporting MS in the context of the court proceedings and the formal commitment process. I am copying our General Counsel to ensure that we move forward together on MS's behalf.

Best regards,

Laura

Laura L. Nuss, Director
Department on Disability Services
(202) 730-1607 office
(202) 257-6698 cell
For scheduling contact Tonya Poindexter, Executive Assistant, at (202) 730-1584, or
tonya.poindexter2@dc.gov

Exhibit 7

From: Lisa Greenman [mailto:greenmanlisa@gmail.com]
Sent: Thursday, March 12, 2015 6:38 PM
To: Nuss, Laura (DDS)
Cc: Back, Mark (DDS)
Subject: Re: introduction

Laura, this is the best possible news. I am pinching myself. Now that we know that a favorable eligibility determination is forthcoming, we can reach out with confidence to the USAO and all work together.

I know that typically it is the USAO that makes the request for commitment proceedings to be initiated, but I would like to avoid unnecessary months of MS suffering in inappropriate and dangerous settings by jumping ahead to the end game here, assuming all parties can get together on what a good outcome would look like, which I think we can.

We would like, ideally, to reach out to the USAO together with DDA and give them an understanding of what commitment would look like for MS — in particular, given their legitimate public safety interests, the degree of supervision and support that could be counted on. If the line prosecutors can be assured of this, then possibly we can avoid a long, drawn out process, *consent* to commitment under the criminal part of the statute, and move ahead so that MS can achieve the highest possible quality of life and the public can be assured that he will not present a danger. I know that DDA generally prefers to avoid commitment, but in this situation I believe it's the only way to satisfy public safety concerns and if we can't assure commitment then I don't think we can hope for the USAO to agree to anything other than a federal proceeding that will lead to institutionalization far from home, in the Bureau of Prisons' medical facility, which would be disastrous. I always would prefer to avoid commitment, but here it is unquestionably the path to greater liberty and dignity.

Exhibit 8

From: **Back, Mark (DDS)** mark.back@dc.gov
Subject: RE: introduction
Date: March 13, 2015 at 10:01 AM
To: Lisa Greenman greenmanlisa@gmail.com
Cc: Nuss, Laura (DDS) laura.nuss@dc.gov, Williams, Richard (DDS) richard.williams@dc.gov

MB

Nice to meet you as well, Lisa. I was speaking with Richard this morning and we will need to work together to get a suitable *Jackson* finding in order to move forward with commitment in the Habilitation Court. The competency evaluation from New York was acceptable for the eligibility determination, but it will be legally insufficient for the "criminal" commitment process before Magistrate Judge Melendez. When you get an opportunity, please reach back out to Richard to discuss. We would like to leave as small a footprint as possible with this matter.

Many thanks and best regards,

MDB

Mark D. Back
General Counsel
District of Columbia Department on Disability Services
1125 Fifteenth Street, N.W., 4th Floor
Washington, D.C. 20005
Telephone: (202) 730-1592
Facsimile: (202) 730-1514
mark.back@dc.gov

Exhibit 9

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services
Developmental Disabilities Administration

April 17, 2015

By Email Transmission to cdavisdc@aol.com

Mr. Markelle Seth, Inmate
D.C. Jail (Correctional Treatment Facility)
1901 E Street, SE
Washington, DC 20003

Dear Mr. Seth:

This letter is to apprise you of the status of planning efforts to provide supports and services to you as a person with an intellectual disability that has been determined eligible to receive services from the District of Columbia (District) Department on Disability Services (DDS), Developmental Disabilities Administration (DDA). As we understand your situation, you have been charged with a federal crime – using, persuading, inducing, and enticing a person under the age of eighteen to engage in sexually explicit conduct for the purpose of producing visual depictions of such conduct, specifically digital photographs and videos, and using materials transported by any means in interstate and foreign commerce in violation of 18 U.S.C. § 2251(a) – and therefore your criminal case is pending in the U.S. District Court for the District of Columbia. Your alleged crime is considered a "crime of violence" under D.C. Official Code § 23-133(4) (2008 Repl.).

As you know, DDS/DDA has been visiting with you at the D.C. Jail to conduct an assessment of your person-centered needs for purposes of developing an Individual Support Plan (ISP). In normal circumstances under the current ISP policy and procedures, DDS/DDA would work with your circle of support to approve and disseminate an ISP within one hundred twenty (120) days of your eligibility determination. DDS/DDA is unable to follow the timeline in its ISP policy and procedures for you because of your incarceration. DDS/DDA understands that you have been found incompetent to stand trial due to intellectual disability and some other mental health diagnoses, and that you will soon be sent to a federal correctional facility in North Carolina for further evaluation to determine if you can be restored to competency. The federal court has jurisdiction over you and will determine if you can be restored to competency or, in the alternative, that you are unlikely to regain competency in the foreseeable future. This determination is referred to as a *Jackson* finding. The *Jackson* finding would establish the specific bases for your incompetency and the likelihood of restoration to competency. Thus, the *Jackson* finding will guide how DDS/DDA will proceed with its further planning efforts.

In the event of a *Jackson* finding where you are determined by the federal judge to be unlikely to regain competency to stand trial and you are brought back to the District, DDS/DDA will resume its planning efforts, including the approval and dissemination of an ISP. As part of the process

once we have a *Jackson* finding from the federal court, DDS/DDA will work with your attorneys and the federal authorities in filing for civil commitment in the Mental Health and Habilitation Branch of the D.C. Superior Court's Family Division. The civil commitment process can take several months in usual circumstances. We are informed by our legal counsel that the federal authorities retain custody and jurisdiction over you even after the *Jackson* finding is made for a period of five years, the federal authorities may refuse to dismiss your criminal case, and dismissal of your criminal case by the federal authorities is subject to D.C. Official Code § 24-531.08 (2008 Repl.). Nevertheless, DDS/DDA intends to continue to move forward with planning efforts on your behalf as outlined above.

In conclusion, please be reminded that while DDS is collecting information and other necessary assessments that will facilitate the planning for person-centered supports and services for you, the ISP will not be developed until all of the above noted issues have been resolved and it is clear that you are free to avail yourself of DDS's supports and services following civil commitment. We look forward to working with you and your circle of support.

Sincerely,

M. Fofana

Musu M. Fofana
Program Manager
Service Planning and Coordination Division

cc: Christopher Davis, Esq. (cdavisdc@aol.com)
Lisa Greenman, Esq. (greenmanlisa@gmail.com)
Laura L. Nuss, DDS Director (laura.nuss@dc.gov)
Winslow Woodland, RN, MSN, DDS/DDA SPCD Director (winslow.woodland@dc.gov)
Robin Exton, DDS/DDA Program Manager (robin.exton@dc.gov)
Theresa D. Burrage, DDS/DDA SPCD Supervisory SC (theresa.burrage@dc.gov)
Chanel Marshall, DDS/DDA SPCD Service Coordinator (chanel.marshall@dc.gov)
Richard A. Williams, DDS OGC (richard.williams@dc.gov)
Jennifer C. Mullins, DDS OGC (jennifer.mullins@dc.gov)

Exhibit 10

From: "Morrison, Holly (DDS)" <holly.morrison@dc.gov>
Subject: RE: Update on Markelle Seth
Date: August 6, 2015 at 6:03:49 PM EDT
To: Lisa Greenman <greenmanlisa@gmail.com>, "Back, Mark (DDS)" <mark.back@dc.gov>
Cc: "Nuss, Laura (DDS)" <laura.nuss@dc.gov>, "Williams, Richard (DDS)" <richard.williams@dc.gov>

Dear Lisa,

We have identified a provider—Benchmark Human Services. They would like to meet with Markell, review records, interview staff, and conduct a formal assessment as soon as possible. When is a good time for us to call you to discuss?

Many thanks Lisa.

Best,

Holly

Holly Morrison, Deputy Director, Developmental Disabilities Administration
DC Department on Disability Services
1125 15th Street, NW 8th floor
Washington, DC 20005
202-730-1757

Exhibit 11

From: "Morrison, Holly (DDS)" <holly.morrison@dc.gov>
Subject: Introductions
Date: August 12, 2015 at 8:12:11 AM EDT
To: Lisa Greenman <greenmanlisa@gmail.com>, Doug Beebe <dbeebe@benchmarkhs.com>

Good Morning Doug and Lisa,
It is my pleasure to e-introduce you to each other. Lisa is the attorney for the gentleman we have been discussing and Doug is the President for Residential Services at Benchmark Human Services, a handpicked service provider interested in serving him. I have not shared his name with Doug yet. I want the two of you to have the opportunity to talk and see where we go from there. I know Lisa has lots of questions and wants to insure we are designing the best services and supports for MS.
Doug sent a proposal that I accepted to meet MS and conduct an assessment in North Carolina. We will need consents and Doug and the psychologist who will be conducting the assessment will need some background information. I don't need to be involved in the discussions—I don't want my schedule to hold this up. But I would like to be copied on email and get updates about where we are in the process, primarily so that I can insure we follow all of the required steps and so that I can authorize any payments. I am, of course, available if you would like me to join the conversation.
I am also copying Richard Williams, Assistant General Counsel here at DDS, who is familiar with MS's situation and has been working with us on this matter.
Please let me know if you need anything additional from me to get started. Many thanks!
Best,
Holly
Holly Morrison, Deputy Director, Developmental Disabilities Administration
DC Department on Disability Services
1125 15th Street, NW 8th floor
Washington, DC 20005
202-730-1757

Exhibit 12

610 East Landis Ave.
Vineland, NJ 08360
Phone: (856) 457-8001
Fax: (856) 457-7353
BenchmarkHS.com

Draft Description of Services for Mr. Markelle Seth

Purpose

Mr. Markelle Seth is a 22-year-old African American male diagnosed with Mild Intellectual Disability. He currently is being housed at the District of Columbia's Correctional Treatment Facility in Washington, DC. Mr. Seth has been charged with enticing person(s) under the age of eighteen to engage in sexually explicit conduct with the purpose of producing visual depictions. A report dated 12/22/2014 by forensic Psychologist Samantha Dimisa, PhD, from the Metropolitan Correctional Center in New York determined Mr. Seth to be not competent to stand trial. This finding is currently being challenged in federal court. In the event that the court upholds this finding, DC's Developmental Disability Administration is seeking to place Mr. Seth in a program that will both meet his needs and also account for concerns regarding the safety of others that are raised by the allegations referenced above.

This document provides a broad outline of services proposed to meet the habilitation and safety needs of Mr. Seth and the community by Benchmark Human Services. It is understood that DDA referred Mr. Seth to Benchmark because this agency has a proven track record of successfully serving individuals with intellectual and other developmental disabilities who have been involved in the criminal justice system, in particular individuals who have a history of dangerous sexual behaviors.

This plan has been developed based on: one in-person meeting with Mr. Seth; two meetings with DDA; review of records including psychological evaluations performed by DC Superior Court, the Federal Bureau of Prisons (2 evaluations) and a neuropsychologist retained by Mr. Seth's counsel, as well as D.C. Superior Court records relating to Mr. Seth's Neglect proceedings and Juvenile proceedings in Family Court.

Residential Services

A review of Mr. Seth's developmental, educational, legal, family and social history suggests that he would be responsive to and appropriate for placement in a highly structured and supervised community-based residential program, and that a more restrictive setting would not be necessary. Benchmark has safely and successfully served individuals similar to and more behaviorally challenging than Mr. Seth in community settings with appropriate structure, staffing and programming.

Clinical and other interviews indicate that Mr. Seth enjoys the company of others – particularly of other adults, whose approval he seeks. His history of multiple placements, including foster care and homelessness, and his interactions with others in these placements, however, suggests that a venue with no more than one to three housemates should be considered.

BENCHMARK
HUMAN SERVICES

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Given Mr. Seth's most recent history of alleged sexual misconduct, a highly structured (i.e., schedule driven) community-based residential program with significant staff supervision (i.e., at least 1:1 staffing on a 24-hour basis) is recommended.

In light of Mr. Seth's apparent willingness to live in the community, participate in his own rehabilitation and to acquire the life skills expected of an independent adult to the extent he is able, a mentoring/teaching style program is recommended where he will fully participate in daily living activities. Opportunities for advancing his independence skills on daily living tasks (i.e., hygiene, home maintenance, cooking, cleaning, laundry, shopping, budgeting, functional reading and writing) will be emphasized with a path to more independent living in the future to the extent that is indicated by the level of his functioning and appropriate consideration for the safety of others. These opportunities will be supplemented by intense behavioral management, ongoing supervision and counseling.

As with any individual who in enrolled in this program, the goal is to impart the necessary safety and self-management skills to Mr. Seth so that he may achieve increasing independence in his own community. There is no set time frame for Mr. Seth achieving access to increased independence, as it will be based on his progress.

Vocational Services

Services for Mr. Seth will include vocational supports during the working day. Staff working with Mr. Seth will function as job coaches – their main focus is to help prepare Mr. Seth for the work force. This preparation will begin with a thorough assessment of Mr. Seth's skills and interests, followed by resume building, completing job applications and teaching interview skills. The goal is to provide real work opportunities in the community within a year. Once employed, job coaches will participate in work activities with Mr. Seth – remaining present with him on site – to ensure his continued coaching and safety for himself and others.

Staffing and Supervision

Direct support staff will be carefully selected for their experience in working with individuals with intellectual disabilities who have a history of court involvement. In addition to required basic training related to supporting individuals like Mr. Seth (i.e., fundamental rights, person-centered planning, developmental disabilities, medication administration, first aid, aging across the lifespan, sexual development), staff will be provided with advanced training on topics such as positive behavior supports, legal involvement, and counseling and teaching strategies.

Initial staffing levels may be recommended or established by the court; however, given the history of Mr. Seth's involvement in the legal system, 2:1 staffing supports may be provided during the first six months if deemed necessary, and this level of supervision will be regularly reviewed. It is anticipated that Mr. Seth will be able to transition to 1:1 staff supervision within one year, with further changes in supervision dependent on his success in the program under the auspices of DDA and/or the court. Supervision should be provided to ensure that staff are

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close enough to protect Mr. Seth and others from possible harm. Typically, in a two to four-person home, at least two awake-overnight staff members are provided.

Behavioral Health & Related Services

Mr. Seth will have ongoing access to behavioral health services from Benchmark, which will include the development of a behavior support plan designed to prevent/manage undesired behaviors while describing methods to teach alternative behaviors. An interim behavior support plan will be developed during Mr. Seth's transition into community-based learning to be followed by the development of a comprehensive plan based on a functional assessment as soon as is feasible. Benchmark emphasizes positive behavior supports in the development and implementation of behavioral supports; while certain privileges may be made contingent on Mr. Seth meeting behavioral goals, no aversive interventions are utilized. Such an approach is consistent with evidence-based best practices in the field of developmental disabilities.

Consultations with professional services will be sought in the community, such as psychiatric care, psychosexual assessment and training, and counseling as needed. Georgetown University's Center for Child & Human Development has offered to provide consultation to Benchmark to explore Mr. Seth's needs, particularly in regards to assessment and education of sexual behavior.

Nursing Care

Mr. Seth's medical needs will be monitored on a weekly basis by a consulting registered nurse. All routine medical care will be provided in the community.

Safety

Benchmark recognizes that Mr. Seth's successful participation in a community-based program is dependent on keeping him safe and preventing harm to members of his community. In addition to a high level of supervision 24/7, staff will be trained in essential strategies for supporting individuals with developmental disabilities (i.e., overview of developmental disabilities, fundamental rights and preventing abuse and neglect, development across the lifespan, dual diagnoses, positive behavior supports, sexual development and behavior, health care management, essential lifestyle planning, etc.), and also in crisis management strategies using the Mandt System. Mandt is a comprehensive and integrated system of de-escalating undesired behavior (up to and including hands-on physical management if safety requires it) while supporting the emotional, psychological and physical safety of the individual and the people around the individual.

A variety of other safety support will be initiated, such as on-call services with managers and senior staff available around the clock to assist with potential crisis events, adjusting the physical layout of the home to reduce the potential risk of harm, and providing each client with their own bedroom to ensure privacy and a safe haven. Benchmark will also work with DDA to

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ensure clarity regarding the protocol that would be followed in the event of an elopement, including notification of law enforcement as well as DDA, so that an order for custody could be obtained. Benchmark has experience utilizing all of these measures.

From Benchmark's experience working with individuals with profiles similar to Mr. Seth, it is clear that while the above safety precautions are necessary and appropriate, the most essential keys to a successful and safe experience for Mr. Seth will be engagement in activities that are meaningful to him, ensuring staff assigned to supervise him are well-trained and supported, providing high levels of supervision, as well as continuous oversight and evaluation of program services. Building with Mr. Seth's active involvement a home and a way of life that he is invested in will be the surest way to achieve success and meet the needs of both Mr. Seth and his community.

Person Centered Planning

Mr. Seth's services will be driven by the philosophy of person centered planning, which is a set of approaches designed to assist individuals plan their life and desired supports to increase their personal self-determination and improve their own independence. As part of this philosophy, an "essential lifestyle plan" will be developed with Mr. Seth to help him discover and attain what matters most to him and identify what supports might be needed. Supportive team discussions related to health and safety (e.g., both the safety of Mr. Seth as well as community safety) with direct input from Mr. Seth are an integral part of essential lifestyle planning.

Exhibit 13

Matthew Mason, PhD, BCBA-D, LBA
Licensed Psychologist, Board Certified Behavior Analyst
12007 Yellow Bell Lane, Columbia, MD 21044
drmattmason@yahoo.com

RISK ASSESSMENT REPORT

I. IDENTIFYING INFORMATION

Client Name:	Markelle Seth
Date of Birth:	November 29, 1993
Referral Source:	Andrew Reese, Director, District of Columbia Dept. on Disability Services
Referral Date:	December 29, 2016
Name of Examiner:	Matthew Mason, PhD, BCBA-D, LBA
Report Date:	February 24, 2017

II. REASON FOR REFERRAL

Markelle Seth is a 23-year-old African American man who on 10-15-2014 was charged with violating Title 18, U.S.C., Section 2251(a), production of child pornography, involving the sexual abuse of two minors aged three and five. Following a competency hearing held in U. S. District Court in the District of Columbia on May 16 and May 17, 2016, Mr. Seth was found incompetent to stand trial and not restorable to competence due to his Intellectual Disability. Mr. Seth is now pending civil commitment proceedings. I was asked by Mr. Andrew Reese, Director, District of Columbia's Department on Disability Services, to conduct a risk assessment for the purposes of determining Mr. Seth's risk for reoffending and the recommended conditions that would be necessary to safeguard against his reoffending while being served in the community.

III. INFORMATION SOURCES

I interviewed Mr. Seth at the District of Columbia's Central Detention Facility on January 18, 2017. I conducted the interview using the following semi-structured interviews as a framework:

1. The **General Sexual Knowledge Questionnaire** (GSKQ) is designed to assess an individual's knowledge of sexual behavior across multiple key domains (physiology, sexual behavior, pregnancy, contraception, sexually transmitted diseases, sexual preference).
2. The **Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually** (ARMIDILO-S) is designed to assess dynamic

factors of engagement in sexually offensive behavior with individuals with a borderline to mild intellectual impairment, with or without learning disabilities, who have offended sexually or have displayed sexually offensive behavior.

Additional information was gathered from the following sources:

1. Competency Evaluation Report (09-11-2011) by Justine Bradshaw, MA, and Michael Barnes, PhD, Superior Court of the District of Columbia, Family Court – Social Services Division, Washington, DC.
2. Competency to Stand Trial Evaluation Report (12-22-2014) by Samantha DiMisa, PhD, Federal Bureau of Prisons, MCC New York, NY.
3. Forensic Evaluation Report (08-24-2015) by Kristina Lloyd, PsyD, Federal Bureau of Prisons, Federal Medical Center, Butner, NC.
4. Neuropsychological Assessment Report (10-19-2015) by Robert Denney, PsyD, ABPP, Springfield, MO.
5. Report and Recommendation (12-01-2016), United States District Court for the District of Columbia, Case No. 14-mj-608 (BAH/GMH).
6. Order, United States District Court for the District of Columbia, Case No. 14-mj-608 (BAH/GMH).
7. U.S. District Court for the District of Columbia Criminal Complaint, Statement of Facts and related Discovery evidence regarding the 2014 instant charges.
8. Telephone interview with Ms. Charlene Reid, Case Manager, District of Columbia Correctional Treatment Facility on 01-23-2017.
9. Telephone interview with Ms. Bridget Tyler, Case Manager, District of Columbia Central Detention Facility on 01-25-2017.
10. Telephone interview with Mr. Stephen Roszel, LCSW, District of Columbia Central Detention Facility (Acute Care Unit) on 01-27-2017.
11. Discussions with Marisa Brown, RN, Program Director, and Erica Thomas, Health Educator, Georgetown University's Center for Child and Human Development.
12. Disciplinary reports from the District of Columbia's Central Detention Facility.

The above information was used to complete the following assessments:

1. The **Sexual Violence Risk–20** (SVR-20) is a checklist of risk factors for sexual violence associated with sex offenders used to characterize an individual's potential risk of committing sexual violence and to inform plans to manage that risk.

2. The **Static-99–Revised** is an actuarial assessment for use with adult male offenders and is designed to predict the likelihood of future offending based on the history of the individual's offenses.

I interviewed Mr. Seth on one prior occasion (12-15-2015) while he was being held at the District of Columbia's Correctional Treatment Facility. At that time, I had been asked by Mr. Thomas Morris, Deputy Director, District of Columbia's Developmental Disabilities Administration (DC DDA), to provide recommendations to DC DDA for recommendations concerning program structure and services for Mr. Seth should he be served by DDA. Subsequently, I observed Mr. Seth's two-day competency hearing, which included testimony by two psychologists (one from the Bureau of Prisons and the other retained by Mr. Seth's counsel) and by two correctional staff (a case manager and an education director) who had worked closely with Mr. Seth. I have also interviewed Mr. Seth's counsel, Lisa Greenman, who has worked closely with Mr. Seth for over two years. I also contacted the U.S. Dept. of Justice prosecutors (Ms. Colleen Kennedy and Ms. Andrea Hertzfeld) and requested they provide information in their possession that should be considered in this risk assessment. As of the date of the filing of this report, the U.S. Attorney's Office had inquired regarding the purpose of this assessment but had not provided any additional information for consideration; any such information that is further provided by the USAO will be considered as a supplement to this report as necessary.

IV. BACKGROUND HISTORY

The following information was derived from available records, and summarizes Mr. Seth's complicated psycho-diagnostic, behavioral and legal history.

1. Psycho-Diagnostic

A review of available records indicates Mr. Seth has an early history of abuse/neglect (including failure to thrive) and infantile seizures. He has experienced multiple displacements (e.g., living with relatives, placed in foster care, living in a homeless shelter). Mr. Seth has sporadic contact with his father, mother, siblings and other family members. Mr. Seth attended a public charter high school in the District of Columbia and was identified during elementary grades with learning disabilities, and later identified with an Intellectual Disability (mild range). His Individual Education Plan (IEP) focused on supporting his learning activities across core academic areas (math, reading, writing), providing speech/language services and providing behavioral supports.

Since 2011, Mr. Seth has participated in several psychological assessments as part of court petitioned competency assessments. Following Mr. Seth's arrest for robbery and receipt of stolen property as a juvenile, a competency assessment was completed on September 28, 2011 by Ms. Bradshaw and Dr. Barnes from DC's Family Court Social Services Division. In addition to concluding that Mr. Seth was not competent, the report indicated that Mr. Seth was functioning in the mild range of Intellectual Disability (with no other mental health or developmental diagnoses identified). The report noted that Mr. Seth "… exhibits pervasive delays in many areas of cognitive functioning as well as challenges in both his adaptive functioning for communication and socialization." The report also noted that Mr. Seth's "...inability to retain information throughout the Competency Evaluation was due, in part, to his inability to sustain attention, tendency to dose off, and difficulty processing information."

Following Mr. Seth's arrest in the instant matter on October 2, 2014, a competency assessment was ordered by the court and completed on December 22, 2014 by Dr. DiMisa of the Federal Bureau of Prisons at MCC New York. Cognitive skills and adaptive functioning were assessed, and the report concluded that Mr. Seth was functioning in the mild range of Intellectual Disability. Dr. DiMisa also offered a provisional diagnosis of Autism Spectrum Disorder. In addition to broad deficits in cognitive skills, Mr. Seth's adaptive skills were rated extremely low in the areas of communication, functional academics, health and safety, self-care, self-direction and social skills. Relative strengths identified included the use of community resources and leisure behavior. The report also noted that Mr. Seth often did not exert adequate mental effort during parts of the assessment. During one portion of Mr. Seth's evaluation at MCC New York, Mr. Seth was held in a locked cell "… due to his inability to function in general population," particularly due to his lack of communication with others, withdrawal, intermittent compliance, low frustration tolerance, anger/agitation, and mild self-injurious behavior (e.g., head banging). Mr. Seth was also prescribed psychoactive medications to manage both anxiety (e.g., lorazepam) and aggressive behaviors (e.g., anti-psychotic haloperidol).

Mr. Seth was held at both the District of Columbia's Correctional Treatment Facility (DC CTF) and the District of Columbia's Central Detention Facility (DC CDF) prior to being sent to MCC New York for his competency assessment, and then following that assessment was returned to the DC CTF/CDF while awaiting transfer to the Bureau of Prisons Federal Medical Center located at Butner, NC. During his placement at these DC correctional facilities, Mr. Seth received mental health treatment for behavioral and mood instability, and was diagnosed with Mixed Depressive and Anxiety Disorder and Mood Disorder (Not Otherwise Specified). These conditions were principally treated with psychoactive medications (e.g., at various times mirtazapine, fluoxetine and buspirone for depression and anxiety).

Mr. Seth was transferred to the Federal Medical Center in Butner, NC, on May 7, 2015, to determine whether he could be restored to competency. According to records, Dr. Lloyd conducted daily observations of Mr. Seth, and completed a competency assessment on August 24, 2015. Dr. Lloyd concurred with Mr. Seth's previous diagnosis of Intellectual Disability, and did not find evidence to support a provisional diagnosis of Autism Spectrum Disorder. Dr. Lloyd did not find characteristics consistent with Anti-Social Personality Disorder and provided a "rule-out" diagnosis of Pedophilia (although also noted that Mr. Seth "...denied any thoughts, fantasies or behaviors consistent with that diagnosis."). No cognitive testing or assessment of adaptive functioning was performed in connection with this evaluation. Throughout Mr. Seth's six-week stay at the Federal Medical Center, it was reported that Mr. Seth displayed frequent behavioral problems, resulting in his repeated housing in an isolated cell. These problems included being oppositional or argumentative, not following established rules, engaging in property destruction, displaying low frustration tolerance, and difficulty sustaining attention. A behavioral support plan was developed but reportedly did not appear to impact these multiple behavioral concerns. It is notable that these behaviors, although frequent, appeared relatively mild and of brief duration. During his placement at the Federal Medical Center, Mr. Seth reported feeling anxious and depressed, and he was prescribed an anti-depressant medication (e.g., mirtazapine).

The most recent competency assessment was completed by Dr. Denney on October 19, 2015. Dr. Denney's assessment included comprehensive neuropsychological testing and assessment of Mr. Seth's adaptive functioning. This report indicated that Mr. Seth had significant impairments across all adaptive domains, as well as significant impairments in multiple cognitive areas including sustained attention, auditory processing, problem solving, abstract reasoning, mental flexibility, learning and retention, impulsivity, stress tolerance and emotional control. The report concluded that Mr. Seth was functioning in the mild range of Intellectual Disability, and, consistent with Dr. Lloyd's evaluation, did not endorse a diagnosis of Autism Spectrum Disorder. Dr. Denney agreed with Dr. Lloyd and Dr. DiMisa that there was no evidence of Antisocial Personality Disorder. The report also identified several relative strengths in Mr. Seth's cognitive profile, including verbal communication, focused attention and sociability. Dr. Denney noted that these strengths may give the false impression that Mr. Seth functions at a higher cognitive, emotional and adaptive level than is actual.

2. Behavioral

According to records, Mr. Seth had delays in developmental milestones such as walking and speaking, and suffered from infantile seizures for which he was medicated with phenobarbital

until he was about six years old. Between the ages of three and six, he received physical and speech/language therapy from the National Children's Center. He received special education services related to learning disabilities across core academic areas, speech/language deficits and behavioral support needs. As Mr. Seth progressed through school, he displayed increased challenging behaviors, including breaking school rules, stealing, poor attention and fighting with peers. He was also reported to have been bullied because of his disabilities. Some of Mr. Seth's behaviors resulted in suspensions from school. Mr. Seth's early records do not indicate any diagnosis or treatment related to mental health needs other than supports associated with his Individual Education Plan (IEP). There was a suggestion that his behavior deteriorated following the death of his grandmother in 2008 when he was 15 years old. Mr. Seth's father indicated that Markelle had difficulties following the rules at home and often displayed poor hygiene. Mr. Seth participated in the DC Summer Youth Employment Program for several years, but each time was ejected from the program for not being able to follow directions.

During his time in custody in connection with this case, Mr. Seth frequently displayed challenging or interfering behaviors. These included noncompliance with established rules, refusal to follow directions, minor property destruction, minor self-injury, refusal to respond, low frustration tolerance, impulsivity, poor hygiene, and verbal abuse. Because these behaviors occurred in an environment of incarceration where strict adherence to rule following is a requirement, Mr. Seth was often punished by being physically managed, having privileges restricted, and being removed from the general population and placed in isolation.

Although numerous and frequent, Mr. Seth's problematic behaviors appeared relatively low in intensity and of brief duration. Prison staff characterized Mr. Seth's behavioral outbursts as immature and impulsive. Frequently they related to conflicts over control of a communal television. Mr. Seth reportedly responded well to de-escalation strategies during these outbursts, and he typically de-escalated quickly and often expressed remorse after calming. Frequently, Mr. Seth would reach out to preferred jail staff or his counsel, Ms. Greenman, to assist with problem solving or calming, demonstrating an interest in establishing supportive alliances. Otherwise, Mr. Seth received little or no formal psychotherapy throughout his incarceration to address his mental or behavioral health needs.

It is crucial to appreciate that Mr. Seth's Intellectual Disability encompasses multiple permanent deficits in his cognition, adaptive skills, emotional dyscontrol, and executive functioning; these deficits are significant contributing factors to his behavioral profile, including his sexually inappropriate behavior. Also, Mr. Seth's cognitive, behavioral and emotional traits have repeatedly been characterized as those of an immature child as opposed to those of a "hardened" offender.

Mr. Seth seeks out positive attention and approval from others, is friendly and sociable. He is talkative, shows concern for others and has a sense of humor. Despite his circumstances, Mr. Seth presents as an upbeat and optimistic person, and does not give the impression of resisting supervision or supports. During several meetings with nursing and sexual health education staff from Georgetown University's Center for Child and Human Development, Mr. Seth was described as collaborative and outgoing. Prison staff also describe Mr. Seth as immature in a childlike way, and not like a hardened or deceitful criminal. These traits suggest that Mr. Seth can establish trusting relationships with caregivers, an important factor in creating effective community-based supports.

3. Legal

As a child, Mr. Seth had two documented contacts with the juvenile justice system. Mr. Seth was arrested on or around March 7, 2011, at age 17, for simple assault; however, no charges were filed. On August 29, 2011, Mr. Seth was arrested on charges of unarmed robbery and associated receipt of stolen property. A delinquency petition was filed but was later dismissed after a court-ordered competency assessment completed on September 28, 2011 by Ms. Bradshaw and Dr. Barnes from DC's Family Court Social Services Division determined that Mr. Seth was incompetent and not likely to attain competence. This report concluded that Mr. Seth lacked the ability to follow court proceedings and assist in his own defense, largely due to poor cognitive skills (limited attention, difficulty processing information, low frustration tolerance) and due to a marginal understanding of courtroom procedures and roles. On January 22, 2009, a custody order was filed alleging second degree child sex abuse on August 28, 2008, when Mr. Seth was 14 years old; the Attorney General moved to quash the custody order and dismiss the case, and from available records it does not appear Mr. Seth was ever arrested or charged.

As an adult, Mr. Seth was arrested and charged for several minor offenses prior to the current charge. On July 28, 2012, Mr. Seth was arrested for second degree theft in Maryland, and a warrant was issued on January 6, 2014 for failure to appear. On March 14, 2014, Mr. Seth was arrested in the District of Columbia for second degree theft and sentenced to unsupervised probation. On April 14, 2014, he was arrested for failure to pay a DC Metro fare, and on April 24 for unlawful entry; the disposition of these last two charges is unknown but presumed to have not been prosecuted based on Mr. Seth's available records.

On October 2, 2014, a month before his 21st birthday, Mr. Seth was arrested in DC on the instant charge of first degree child sex abuse for which he was subsequently charged with production of child pornography. The alleged victims were members of a household Mr. Seth

had been incorporated into by a man he called his "godfather," whom he'd met at a homeless shelter, and were ages three and five at the time. The discovery materials provided by the prosecution reference other children living in that household who may have been involved as well, though no charges pertaining to other victims were filed. The discovery materials also describe a May 2014 incident involving Mr. Seth and his younger sister, then age 10. In that instance, the child's adoptive mother reported overhearing sexually explicit telephone conversations between Mr. Seth and his sister in which they spoke of plans for having sexual contact and referred to having had such contact in the past. The report also refers to an allegation dating to 2009, in which the adoptive mother reported that Mr. Seth was observed masturbating next to his sister. It appears neither incident was charged.

The October 2014 federal charge led to a series of competency assessments. The competency assessment completed on December 22, 2014 by Dr. DiMisa of the Federal Bureau of Prisons at MCC New York concluded that Mr. Seth was not competent to stand trial and stated that Mr. Seth, "… does not possess a rational and factual understanding of the proceedings against him, does not have the capacity to assist legal counsel in his defense, and cannot adequately make decisions regarding his legal strategy." Based on this conclusion, which was based on findings consistent with those of Mr. Seth's juvenile competency assessment from 2011, Mr. Seth was found incompetent by the Court on March 27, 2015.

Mr. Seth was transferred to the Federal Medical Center in Butner, NC, on May 7, 2015, for treatment towards restoration of his competency. Following Mr. Seth's participation in restoration activities, an August 24, 2015 competency assessment by Federal Bureau of Prisons psychologist Dr. Lloyd concluded that Mr. Seth was competent to stand trial. A subsequent competency assessment completed on October 19, 2015 in the District of Columbia by Dr. Denney concluded that Mr. Seth was not competent to stand trial and unlikely to be restorable based on Mr. Seth's inability to participate and contribute to his own defense in the context of his intellectual disability.

Following a competency hearing on May 16-17, 2016, the U.S. District Court for the District of Columbia ruled on December 22, 2016 that Mr. Seth was not competent to stand trial and unlikely to be restorable. The ruling was based on the December 1, 2016 Report and Recommendations entered by the magistrate judge in the case. Mr. Seth has since been transferred from DC's Central Detention Facility back to the Federal Medical Center in Butner, NC, for a dangerousness assessment and consideration of federal civil commitment.

V. CLIENT INTERVIEW

Mr. Seth arrived at the interview room at the District of Columbia's Central Detention Facility dressed in an orange jumpsuit, white t-shirt and white running shoes. He arrived handcuffed with a belly chain. Ms. Lisa Greenman, Mr. Seth's legal counsel, was also present during the interview, and informed Mr. Seth and me that either of us could ask her to leave at any point during the interview. Ms. Greenman requested from the escorting jail officer that Mr. Seth be uncuffed for the duration of the interview but this request was refused.

I explained to Mr. Seth the purpose of the evaluation, which was to determine Mr. Seth's risk of reoffending and whether there were conditions that could permit him to reside safely in the community. I informed him that the results of this assessment were not confidential, and that the results and my opinion may be shared with his legal counsel, the Court, and the District of Columbia's Department on Disability Services. Mr. Seth indicated that he understood the limits on confidentiality and expressed his willingness to participate. I encouraged Mr. Seth to answer my questions thoroughly and honestly to the best of his abilities and he indicated his intent to do the best he was able.

Mr. Seth is of average build and height and was wearing an orange jumpsuit that was slightly wrinkled and an undershirt that was somewhat dirty. He appeared clean, reported recently having had a haircut and was clean-shaven. Mr. Seth uses glasses for reading but the frames were reportedly broken; he carried the lenses for his glasses in his waistband but did not use them during the interview. He displayed a broad range of normal affect and mood, with a normal rate of speech with no problems in articulation. No unusual mannerisms were observed during the interview. He denied suicidal ideation and did not report false sensory perceptions. Mr. Seth reported his overall mood to be positive, although he reported being prescribed an antidepressant (e.g., fluoxetine) due to periods of depression (although he also stated that he did not consistently take his medication).

Throughout the interview, which lasted between three and one-half to four hours, Mr. Seth was attentive and answered all questions posed to him. Several times he did call out to other inmates who walked past the interview room to express brief niceties, and each time he apologized for being distracted and continued with the interview. Mr. Seth was well-oriented during the interview, and appeared fully alert throughout.

The interview began with a review of Mr. Seth's general understanding of sexuality using the General Sexual Knowledge Questionnaire (GSKQ), which included questions related to physiology, sexual behavior, pregnancy, contraception, sexually transmitted diseases and sexual

preferences. Mr. Seth's answers on the GSKQ indicated a basic and inconsistent knowledge of sexuality. He attempted to answer every question, although early on he appeared hesitant and self-conscious. Mr. Seth appeared to struggle understanding some questions because of unfamiliar terminology, although he answered all probe questions accurately and responded to alternative phrasing of some questions. While Mr. Seth was able to accurately identify various body parts of depictions of male and female figures, he demonstrated only a basic knowledge of the biological functions related to sexual development and function. For example, he appeared familiar with the term "puberty" and described it in terms of transitioning from childhood to adulthood, but he was unable to accurately describe the physiological changes that accompany this transition. Mr. Seth demonstrated a general knowledge of male and female functions regarding sexual intercourse and masturbation, but lacked comprehensive knowledge. For example, Mr. Seth correctly defined what the term "virgin" meant (e.g., "Someone who never had sex.") but did not know what the term "incest" meant; he was not familiar with the terms "ejaculation" or "erection" but was familiar with colloquial equivalents (e.g., "coming" and "hard on"). Mr. Seth could describe how women become pregnant, but not the physiological indications of pregnancy or when a woman is more likely to become pregnant. Mr. Seth has a basic understanding of some forms of contraception (such as condoms and the pill) and where to obtain contraception. He has a poor understanding of sexually transmitted diseases, although he did identify that using a prophylactic can prevent STDs. Finally, Mr. Seth identified an interest in both men and woman, and understood the difference between heterosexual and homosexual behavior. Mr. Seth's total score on the GSKQ was 55 out of a maximum score of 110. This score is within the average range of scores for individuals who are diagnosed with an Intellectual Disability and who have not received formal treatment for sexual misconduct (typical scores for this population range between 37 to 57 with a mean of 47). In comparison, the typical range of scores for individuals without an Intellectual Disability is between 76 and 90 with a mean of 82.

Mr. Seth's responded openly to questions based on the Assessment of Risk and Manageability for Individuals with Developmental and Intellectual Limitations who Offend Sexually (ARMIDILO-S), which assesses the dynamic risk of engagement in sexually offensive behaviors. The ARMIDILO-S identifies characteristics that may either increase the likelihood of re-offending (risk factors) or decrease that likelihood (protective factors). The ARMIDILO-S was designed specifically for the assessment of individuals with Intellectual Disabilities. Information gathered from staff interviews and record reviews were also used to identify these factors. Mr. Seth's responses were made in the context of a more than two-year period of incarceration, most of which was spent at the District of Columbia's Central Detention Facility (CDF) or Correctional Treatment Facility (CTF). These environments are highly structured and secure; minor deviations from routine or rules are met with outcomes such as isolation, reduced

mingling with other inmates, and reduced access to preferred activities or areas. Mr. Seth's behavior was inherently restricted by the physical environment (containment) and by continuous supervision.

Mr. Seth acknowledged during the interview that he had had difficulty complying with established rules and the routine at the DC CDF/CTF and at the Federal Medical Center. While stating that he had positive relationships with many of the staff who work at the DC CDF/CTF, he expressed a dislike for what he referred to as strict rules and a lack of freedom, and said he often got into trouble breaking the smallest of rules such as not tucking in his shirt. Mr. Seth tended to respond to interview questions with concrete answers and limited insight into his plight. For example, he stated that he was looking forward to his transfer to the Federal Medical Center in Butner, NC, explaining that it was a "...better facility with a larger yard and more food." When I pointed out that he would be farther away from his family and friends, and that there is a possibility that he may be held at the Federal Medical Center for a long period of time, this did not seem to change his opinion.

As interviewed staff consistently noted, Mr. Seth required a high degree of monitoring while at the DC CDF/CTF – more so than other inmates – reportedly because he had such difficulty understanding and adhering to rules. Staff members concurred that Mr. Seth had difficulty following rules not because he was a hardened criminal or oppositional in nature, but rather because he was immature, impulsive and had a strong desire for immediate gratification. Staff members also described Mr. Seth as a likable person with a sense of humor and playfulness that was very childlike, with a typically positive attitude.

Mr. Seth described himself as easy to provoke and become angry, and this matches the description from staff. Staff also described him as emotionally volatile, highly impulsive, argumentative with a tendency to sulk and refuse to interact when he did not get his needs immediately met. Staff also described Mr. Seth as highly distractible, and said he had great difficulty learning even the smallest unfamiliar task or rule (he required almost continuous supervision and frequent reminders).

Although he is friendly, socially inclined, and clearly enjoys interacting with others, Mr. Seth has had difficulty developing relationships with other inmates as a result of his emotional immaturity and behavioral dysregulation. Mr. Seth's poor self-regulation and immature coping style was consistent while incarcerated; this is not surprising given his cognitive limitations and the limited supportive therapy that has been provided during this period.

Mr. Seth did not endorse being sexually deviant or otherwise preoccupied with sexual activities. Prison staff members agreed with this characterization, noting that although he was vulnerable to being taken advantage of by other inmates, he was not likely to try to take advantage of others, to attempt to develop relationships for the purposes of gaining sexual favor, or to otherwise act in a sexually predatory manner. Mr. Seth denied any interest in children. Mr. Seth was able to understand the requirement that he maintain distance from children should he be allowed to live in the community, although he did express concern about children who might be in distress. Prison staff members concurred that Mr. Seth has not expressed an interest in children.

Mr. Seth denied that using substances was a problem, stating that he did not like alcohol but he had smoked "weed" (e.g., marijuana) every few weeks when he lived in the community. He further stated that he had been smoking weed when he was arrested for charges of child sexual abuse (although there is no evidence in the record of this). Staff members noted that Mr. Seth did not acquire or use any illicit substances while incarcerated.

While discussing the possibility of community placement, Mr. Seth expressed his fear of being harmed while living in the community. He asked whether he could carry a pocket knife for self-defense. When it was explained to him that carrying any weapon would likely be forbidden if he were to participate in a community-based program, Mr. Seth asked if he could instead carry chemical mace. When provided with the same explanation that he would not be allowed to carry any weapon, he asked how he would be kept safe. When I explained to Mr. Seth that if he resided in the community, he would be fully staffed and it would be his community-based staff's responsibility to keep him safe, he appeared comforted. He did add, however, that he would wear a belt "just in case." Mr. Seth did not express resistance to being supervised, although he did express a preference for staff who listened to his needs. Mr. Seth appeared to understand that he would require 24-hour supervision in order to live in the community, and he stated that he would cooperate with staff and supervision requirements.

A small, core group of prison staff worked consistently with Mr. Seth at the DC CDC/CTF (e.g., two case managers, a social worker, and a supervising officer). This core support group described Mr. Seth as more vulnerable and immature compared to other inmates, and that he was singled out for additional attention by this core group to keep him safe at both facilities. Throughout his time at the CTF, he was housed in the Medical Unit not because he was ill, but because prison staff believed that separating Mr. Seth would protect him from harm by other inmates and the medical unit offered more frequent supervision and support with a lower staff-to-inmate ratio. At the CDF, Mr. Seth was housed on the Mental Health Unit.

Risk factors that may contribute to Mr. Seth's reoffending include noncompliance with supervision and rules, emotional dysregulation, impulsiveness and poor coping skills. Protective factors that may reduce Mr. Seth's risk of reoffending include a high level of supervision, consistent application of rules, positive relationships with supervising and therapeutic staff, lack of sexual misconduct and sexual preoccupation when in a supervised setting, and lack of substance use/abuse. Mr. Seth's willingness to engage with responsible and supervising adults, his admittance to his sexual misconduct, and his ability to develop therapeutic relationships are also important protective factors.

VI. RISK ASSESSMENT SCALES

The Sexual Violence-20 (SVR-20) is a checklist that was developed for use in criminal or forensic settings where an individual has committed or is alleged to have committed an act of sexual violence (defined as "actual, attempted or threatened sexual contact with a person who is non-consenting or unable to give consent"). While the SVR-20 is not an actuarial or predictive tool, it is designed to estimate the relative risk (e.g., Low, Medium or High) of sexual re-offending and identify risk factors associated with the likelihood of future sexual violence. The SVR-20 has been used with individuals with and without Intellectual Disabilities.

According to the SVR-20, Mr. Seth's risk factors include sexual deviation (e.g., sexual abuse of minors), a history of having himself been a victim of child abuse, presence of major mental illness (which according to the SVR-20 includes both mood instability and intellectual disability), relationship problems (in particular with family members), employment problems (lack of sustained employment), past nonviolent offenses (regardless of arrest or conviction), high density sexual offenses (multiple victims and/or occurrences), and unrealistic plans following discharge from incarceration. As part of the SVR-20, the Psychopathy Check List–Revised (PCL-R) was also completed, and indicated that Mr. Seth does not present with psychopathic traits. The risk factors identified in the SVR-20 are consistent with information contained in available records, from information gathered from interviews with staff and others, and from discussions with Mr. Seth. According to the SVR-20, the overall rating of Mr. Seth's risk for future sexual violence is within the Low to Moderate range.

The Static-99 Revised is an actuarial assessment for use with adult male offenders and is designed to predict the likelihood of future offending based on the history of the individual's offenses. Relevant risk factors that were identified by the Static-99 included Mr. Seth's relative young age at the time of the alleged offense, his victims being unrelated to Mr. Seth, one of the victims being male, and Mr. Seth not having been in a long-term intimate relationship (e.g., at least two years). Although Mr. Seth has been involved with the legal system as a juvenile and a

young adult (his arrest in this case came about two months before his 21st birthday), this involvement did not result in related convictions (primarily due to lack of competency or charges not being filed). The Static-99 places Mr. Seth in the Above Average range of risk for re-offending. Individuals in this risk range are predicted to have a 5-year recidivism rate of 17.3% (with a 95% confidence interval of 14.5% to 20.5%). This prediction assesses historical and "static" factors only and does not incorporate contextual factors such as the effect of supervision or supports that would be provided to Mr. Seth should he be placed in the community subject to court ordered civil commitment.

VII. RISK SUMMARY

To provide for community safety while ensuring that Mr. Seth has every opportunity to succeed and to avoid re-offending, it is my recommendation that he be served in a highly structured, closely supervised community-based program. Mr. Seth's cognitive, behavioral and emotional characteristics are not uncommon among individuals diagnosed with an Intellectual Disability. Mr. Seth's prior and current behavior does not appear to be based in an underlying psychopathic condition, and his sexual misconduct appears to be a function of inappropriate supervision and deficits associated with Intellectual Disability. A carefully designed and appropriately staffed community-based program focused on Mr. Seth's learning, behavioral and emotional needs has, in my opinion, a high likelihood of success in preventing his re-offending.

Developmentally, Mr. Seth has a serious history of trauma and neurodevelopmental deficits. His early childhood experiences include serious abuse/neglect, and are coupled with delays in physical development, broad learning disability, and comprehensive deficits in cognitive and executive functioning. Mr. Seth's has serious and permanent limitations in learning, memory, making reasoned choices, and language processing. This means that he will need significant mentoring and supervision to function effectively in the community, especially with regards to following accepted norms of social behavior and engaging in safe sexual practices.

Behaviorally, Mr. Seth has serious and long-standing difficulties with impulsivity, sustained attention, and need for immediate gratification. His limited coping skills (coupled with serious cognitive deficits) often result in undesired behaviors including noncompliance with rules, withdrawal from others, verbal abuse/threats, minor physical aggression, and minor property misuse. Mr. Seth does not appear to be a flight risk, however, and his desire for social engagement, approval and need for supportive relationships are important compensatory strengths. His sexually inappropriate behavior appears more opportunistic than predatory in nature, and influenced by his limitations in cognition and self-management.

Emotionally, Mr. Seth demonstrates significant dysregulation, resulting in mood shifts that are often disproportionate to the circumstances. Mr. Seth appears to have an underlying mood disorder (anxiety and/or depression), although it is unclear whether this is primarily a result of an underlying neurological problem, a history of abuse/neglect, a history of displacement, or his incarceration (although quite probably it is the result of a combination of these factors). Mr. Seth will need significant therapeutic supports to manage his emotional needs, including counseling, psychiatric assessment, and mentoring. In addition, targeted counseling and education to address his sexual behavior and related self-management is necessary. Mr. Seth has demonstrated the capacity for establishing appropriate emotional ties, empathy and a desire to please others; these traits are indicators that he will be able to develop lasting, useful relationships with community-based staff and other supportive adults in his life.

Environmentally, Mr. Seth's child sexual abuse charges stem, in part, from a lack of supervision by responsible adults and from having been affirmatively placed in a position of caring for children. Continuous supervision at home, in the workplace and any other place he visits in the community is mandatory. This of course includes ensuring unsupervised access to children does not occur.

VIII. RECOMMENDATIONS

It is my opinion, based on the above information, that with appropriate services in place, Mr. Seth can be safely and successfully supported in the community. Based upon my extensive experience with many individuals with a variety of sexual behavioral problems, it is my opinion that Mr. Seth will respond well to supervision and supports. Mr. Seth's sociability, eagerness to please and willingness to create alliances with responsible adults are highly indicative that he will succeed if provided with appropriately designed supportive living and work environments that incorporate effective supervision.

In order for Mr. Seth to successfully integrate into a community placement, avoid sexual re-offending and minimize other problem behaviors, a number of support strategies should be incorporated.

1. **Community Supports.** Mr. Seth should participate in a highly structured (i.e., schedule driven) community-based residential program with at least 1:1 staffing on a 24-hour basis. Consistent and continuous supervision is the most effective predictor of preventing sexual re-offending. A comprehensive understanding of Mr. Seth's strengths and weaknesses by staff is essential to supporting Mr. Seth's self-management and safety skills required to maintain his placement in the community. Staff should be thoroughly trained on the nature

of Mr. Seth's offenses and on non-negotiable safety practices. Mr. Seth should not live or work in areas with unsupervised access to children, and his behavior in the community must be monitored to prevent any unsupervised contact with minors. Mr. Seth has a strong desire to connect with others and can be highly sociable; it would be of benefit to his continued social development to share his living space with no more than one other individual. Any other individual being considered for cohabitation should be carefully screened for mutual compatibility, and the addition of a housemate should in no way interfere with the safety goals of Mr. Seth's services or his supervision requirements.

The second most effective predictor of preventing re-offending is providing a full and consistent daily schedule of employment and other meaningful activities. It is essential that Mr. Seth acquire and maintain fulfilling employment. Mr. Seth has very limited work experience, and he has experienced job failure in the past. Employment support staff or job coaches must conduct a thorough job skill assessment and assist Mr. Seth in applying for and acquiring meaningful work. While working, Mr. Seth will require continuous supervision for the foreseeable future. His round-the-clock staffing will ensure that he has such support while at work (or job training) and throughout his daily activities. Mr. Seth's work supervision must be consistent and carefully coordinated with residential supervision.

2. **Safety Supports.** Mr. Seth's residential program should establish prudent environmental safeguards. These should include selecting a residence that limits access to children but allows access to other community resources. In practical terms, this means Mr. Seth should reside in a lower-rather than higher-density neighborhood if possible (e.g. a residence in a house or a smaller apartment building as opposed to a large apartment complex). A residence that promotes effective monitoring of exits is important, as is creating a safe and welcoming home environment. A residence that is equipped with window and door chimes is encouraged. Likewise, employment training or work activities should not include activities that allow unsupervised contact with minors, and work environments must allow continuous supervision.

3. **Counseling & Psychiatric Supports.** Mr. Seth's support services should include the development of a comprehensive behavioral management plan, a crisis management plan, supportive psychiatric care, intensive counseling services, and a thorough psychosexual assessment and related sexual education. Engagement in mental health counseling is strongly recommended for Mr. Seth to address issues of past abuse, displacement and sexually inappropriate behavior. Any counselor to whom Mr. Seth is referred should have experience in treating victims of abuse and/or Post-Traumatic Stress Disorder and experience working with individuals with intellectual disability. Issues that should be

addressed in this setting include past abuse, relationships, self-management, sexually appropriate behavior, and self-esteem. Mr. Seth would benefit from consultation with a health and sexuality educator who could further assess Mr. Seth's education needs and develop a sexual behavior safety protocol. Mr. Seth should also participate in a psychiatric evaluation to determine whether medication is appropriate to support his emotional and behavioral variability (although this will not teach adaptive behaviors).

4. **Crisis Management**. A carefully constructed, comprehensive crisis management plan should be developed for Mr. Seth. The overall goal of this plan should be to first avoid or prevent crises from occurring, and then to manage crisis behaviors that will ensure the safety of the community and Mr. Seth. Staff will be required to participate in DDS-approved behavior intervention procedures (e.g., Mandt, CPI, or Positive Behavior Strategies); however, additional training or supervision in crisis responding may be required. Antecedent conditions and precursor behaviors must be monitored, identified and prevented or mitigated, and step-wise procedures for a variety of possible scenarios must be created to ensure continued community safety is maintained. Additional crisis management supports should be available and protocols for accessing them should be described clearly in the plan and well understood by staff, such as temporarily increasing staffing or supervision, using a crisis response team, providing on-site de-escalation supports from a qualified mental health professional, and accessing emergency psychiatric care (which may also be defined in a behavior support plan).

5. **Self-Management.** Mr. Seth's community-based program must be capable of addressing Mr. Seth's developmental and behavioral needs and of ensuring the safety needs of his community. Initially, supports for Mr. Seth will be externally mediated (e.g., through staff supervision, scheduled activities and environmental design). The long-range goal for Mr. Seth will be to establish sufficient self-management over his own behavior so that he will be able to live and work in the least restrictive setting possible. Strategies to transfer external control to self-management (internal control) should be implemented over time. Increasing his range of coping strategies will help Mr. Seth deal more effectively with everyday challenges and is a necessary component of learning self-management skills.

6. **Non-Directive Strategies.** Often, behavior problems are a reflection of the conflict between an individual's needs for gratification and the environment in which the individual must live, go to work or otherwise follow rules and engage with the community. Non-directive strategies should be incorporated into Mr. Seth's day to address potential conflicts.

   For example, if a problem arises, staff should avoid phrasing expectations as unilateral

demands and elicit cooperation by offering reminders or asking him to choose an action from a list of options. When Mr. Seth is challenged or ordered by others, he is more likely to engage in an aggressive response (usually verbal threats, refusal or property misuse). Staff should be willing to rephrase requests, be nonconfrontational, find different ways of communicating a message, or allow Mr. Seth additional time to process information. Operationally, this means defusing the "staff-client" power struggle and adopting the role of a mentor or teacher rather than guard or enforcer. Mr. Seth has shown himself to respond positively to interventions from a trusted source (e.g., his case manager at the CTF) even when he is emotionally escalated, and he has a history of reaching out to trusted adults to assist him in de-escalating (e.g., his counsel Ms. Greenman). Mr. Seth should be permitted to engage with trusted individuals in order to problem solve provided this does not violate programmatic or safety rules, compromise supervision or interfere with therapeutic relationships.

Another example of a non-directive strategy is to "train loosely", where opportunities to instruct on skills are not restricted to training trials. Instead, instruction should be provided whenever and wherever the opportunity presents itself. The purpose of using this strategy is to expand the learning process during opportunistic times and locations where the skills are required.

To be sure, these non-directive strategies must be provided within a framework in which specific safety rules and limits are non-negotiable. Mr. Seth must be fully informed of requirements of supervision, of restrictions on contacts with minors, and on following established rules and routines. Mr. Seth must also be made aware of the consequences of violating such rules, which may include loss of community placement and liberty, and potential incarceration.

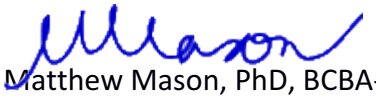
7. **Positive Programming Strategies.** Challenging behavior frequently occurs in settings that lack the opportunities for and instruction in adaptive, age-appropriate behavior. Creating an environment of positive programming will make it more feasible to effectively and directly address Mr. Seth's challenging behaviors. For example, a person who is taught the difference between demeaning criticism and well-intended feedback may act differently in response to the feedback received from others; this empowers the person to maintain socially effective control over their world. Mr. Seth's disruptive behavior may also be related to the misperception of social cues. In other words, due to limited comprehension of social cues, he may perceive certain events as being threatening and result in a forceful reaction. An effective intervention would include helping Mr. Seth discriminate between threatening and non-threatening events.

Some of Mr. Seth's challenging behaviors reflect his inability to cope with undesired events such as delay in gratification, denial of desired outcomes, or the requirement to perform a non-preferred activity. If Mr. Seth is to lead a full life, from time to time he will face the disappointments everyone must face, such as not getting something that he wants, when he wants it, being told by somebody that a relationship is not possible, being criticized or reprimanded, etc. In the face of these events and the emotions they understandably arouse, Mr. Seth's coping skills have not had the opportunity to develop much beyond juvenile responses; he is unlikely to develop much beyond this level through experiencing "natural consequences." Thus, direct teaching on discriminating social cues, learning to self-identify arousal levels, and engaging in coping and self-calming strategies are important positive programming goals.

Mr. Seth appears to negotiate his needs with staff in the face of desiring immediate outcomes. While some amount of negotiation is a necessary part of life, it must be made explicit to Mr. Seth that certain things are non-negotiable. These limits should be based on essential safety practices, such as avoiding substance use, following prescribed physician orders, following supervision requirements, prohibiting unapproved visitor access to his residence, remaining in the presence of designated staff and avoiding unsupervised contact with minors. It will be helpful to involve Mr. Seth in discussions of the contracts or rules that will govern his behavior as well as the consequences for rule violations. Such discussions should follow the principles of positive programming practices.

If you have additional questions regarding this report, please contact me at any time.

Respectfully Submitted,



Matthew Mason, PhD, BCBA-D, LBA
Licensed Psychologist

Exhibit 14

PROTECT INTERNATIONAL
RISK AND SAFETY SERVICES INC

June 18, 2017

Lisa Greenman
Attorney At Law
5636 Connecticut Avenue NW #42290
Washington, DC 20015

Re: ***U.S. v. Markelle Seth***

Dear Ms. Greenman,

As per your request, I have reviewed several forensic mental health reports completed over the years to provide an independent opinion of Mr. Seth's violence risk based on them.

In reaching findings and forming opinions, I reviewed the following forensic mental health evaluation reports, provided by you:

1. Competency evaluation report by Justine A. Bradshaw, MA, and Michael E. Barnes, PhD, dated 28 September 2011 ("Bradshaw & Barnes, 2011").

2. Competency evaluation report by Samantha E. DiMisa, PhD, and Elissa R. Miller, PsyD, dated 22 December 2014 ("DiMisa & Miller, 2014").

3. Forensic evaluation report by Kristina P. Lloyd, PsyD, dated 24 August 2015 ("Lloyd, 2015").

4. Neuropsychological examination report by Robert L. Denney, PsyD, dated 19 October 2015 ("Denney, 2015"), which incorporated information from the District of Columbia public school system from the 2010/2011 school year ("DC public schools, 2010/2011"), the District of Columbia Central Detention Facility from 2015 ("DC CDF, 2015"), and a psychological evaluation by Joette James, PhD, from 2015 ("James, 2015").

5. Risk assessment report by Matthew Mason, PhD, dated 24 February 2017.

6. Forensic evaluation report by Manuel E. Gutierrez, PsyD, dated 6 March 2017.

7. Forensic evaluation report by Kristina P. Lloyd, PsyD, dated 11 April 2017.

As my task was to review existing forensic mental health reports, I did not review primary information sources myself or interview Mr. Seth. The reports I received, and the information contained in them, were sufficient for me to reach findings and form opinions.

With respect to my qualifications, I have provided a complete *curriculum vitae* to you under separate cover. Briefly, I obtained BA, MA, and PhD degrees in psychology at the University of British Columbia. I have been on faculty in the Department of Psychology at Simon Fraser University since 1990, and have held the rank of Professor since 2001. I have also been a Visiting Professor in the Faculty of Psychology at the University of Bergen in Norway since 2000. My expertise is in the field of clinical-forensic psychology, with a special focus on the assessment of violence risk and psychopathic personality disorder. I have co-authored more than 215 books, chapters, and articles. I have served as editor of two scientific journals; a member of the editorial board of seven journals; and *ad hoc* reviewer for more than 30 journals, as well as numerous granting agencies. I have been an executive committee member of several professional organizations, including President of the American Psychology-Law Society (Division 41 of the American Psychological Association), President of the International Association of Forensic Mental Health Services, and a Director of the Canadian Association of Threat Assessment Professionals. I have received various distinctions for this professional work, including the Career Achievement Award from the Society of Clinical Psychology (Division 12 of the American Psychological Association), the Saleem Shah Award for Early Career Research Excellence in Psychology and Law from the American Psychology-Law Society (Division 41 of the American Psychological Association) and the American Academy of Forensic Psychology, and the Distinguished Achievement Award from the Association of Threat Assessment Professionals. I have been qualified to give expert testimony in the Federal Court of Canada and the superior courts of the provinces of Alberta, British Columbia, Manitoba, and Ontario; and in the states of Arizona, California, Florida, Illinois, Iowa, Kansas, Missouri, Texas, Washington, and Wisconsin. I have also been qualified to give expert testimony before various parliamentary committees, inquests and inquiries, tribunals, and review boards in Canada and the United Kingdom. I have consulted to corrections, law enforcement, national security, health care, and other government agencies around the world, including in the United States.

Method

Violence is defined herein as actual, attempted, or threatened psychological or physical harm of another person, including intimidation or fear-inducing behaviour. This definition encompasses acts that would constitute criminal offenses against persons, as well as other offenses that are committed to further violence. Violence risk assessment is the process of evaluating people to characterize the risks that they will commit violence in the future (e.g., the nature, severity, imminence, frequency, and likelihood of future violence), as well as the steps that could be taken to minimize these risks.

To prepare this report, my work involved two phases. In the first, I summarized the previous forensic mental health reports; the results of this phase are presented below as my Findings. In the second, I interpreted the findings to reach my own conclusions about the violence risks posed by Mr. Seth and the management of those risks; the results of this phase are presented below as my Opinions.

Findings

For the purpose of forming opinions, I assumed the following to be true, based on the information I reviewed:

1. Mr. Seth has problems related to major mental disorder.

    a. He suffered from a seizure disorder from infancy until he was about 6 years old. He was treated with medications, and also received physical therapy and speech therapy for associated developmental disabilities.

    b. He has generalized deficits in basic cognitive functions, including attention and concentration, as well as significant learning problems. He attended school but was placed in special education classes. Despite attending school until he was about 17 years old, according to standardized testing his overall academic achievement is between the 1st and 4th grade levels (DC public schools, 2010/2011; Bradshaw & Barnes, 2011; James, 2015; Denney, 2015).

    c. He has generalized deficits in problem-solving, planning, and reasoning. According to standardized testing, his overall intellectual abilities are "extremely low," falling in the bottom 1% of the general population (Bradshaw & Barnes, 2011; DiMisa & Miller, 2014; James, 2015; Denney, 2015).

    d. He has generalized deficits in adaptive functions, including in the areas of self-care, finances, social skills, and interpersonal relations. His hygiene, oral comprehension, and reading ability are poor. He has problems with insight and empathy; although he has the capacity to appreciate mental states, he also has difficulties at times understanding the reasons for his own behavior and its impact on others. He is susceptible to manipulation by others. His ability to regulate his own emotions and behavior is poor, and he easily becomes agitated, frustrated, distressed, and angry. On occasion, when under stress, he may have experienced suicidal thoughts, as well as transitory perceptual and thought disturbance. He is unable to live on his own; since moving out of his family home when he was about aged 18, he has lived with various family members, in homeless shelters, or with acquaintances. According to standardized testing, his overall level of adaptive functions is "extremely low," falling in the bottom 1% of the general population (Bradshaw & Barnes, 2011; DiMisa & Miller, 2014;

Denney, 2015).

e. He has generalized deficits with respect to competency to stand trial, including a limited understanding of the legal system generally and the trial process specifically, as well as limited capacity to communicate with counsel and assist in his own defense. He has been considered incompetent to stand trial by evaluators on multiple occasions (Bradshaw & Barnes, 2011; DiMisa & Miller, 2014; James, 2015; Denney, 2015) and, on another occasion, as impaired but competent with accommodations (Lloyd, 2015).

Based on the overall pattern of symptoms outlined above, Mr. Seth was consistently diagnosed as suffering from intellectual disability (ID), also known as intellectual developmental disorder or mental retardation, of at least mild severity (Bradshaw & Barnes, 2011; DC CDF, 2015; DiMisa & Miller, 2014; Lloyd, 2015; Denney, 2015; Gutierrez, 2017; Lloyd, 2017).

Based on symptoms outlined above related to social skills and mood, Mr. Seth was diagnosed by some evaluators with comorbid mental disorders, including provisional (i.e., possible) autism spectrum disorder (DiMisa & Miller, 2014), mixed depressive and anxiety disorder (DC CDF, 2015), and unspecified mood disorder (Lloyd, 2015).

2. Mr. Seth has some problems related to personality. On one hand, he is often warm, pleasant, and cooperative and does not express generalized procriminal or antiauthority attitudes. On the other hand, starting in adolescence and persisting into adulthood, he is at times angry, uncooperative, rude, disruptive, or aggressive, and had contact with the criminal justice system on several occasions. Evaluators consistently concluded, however, that despite these problems Mr. Seth does not meet diagnostic criteria for conduct disorder or personality disorder (Bradshaw & Barnes, 2011; DiMisa & Miller, 2014; Lloyd, 2015; Denney, 2015; Gutierrez, 2017; Lloyd, 2017).

3. Mr. Seth has possible problems with substance use. On one hand, his substance use is limited to marijuana, there is limited evidence that marijuana use has impaired his functioning, past evaluators did not diagnose him with substance use disorder (Bradshaw & Barnes, 2011; DiMisa & Miller, 2014; Lloyd, 2015; Denney, 2015), and he has not been referred for substance use treatment. On the other hand, more recently he was diagnosed with mild cannabis abuse based on reports indicating he may have used marijuana on a frequent basis (Gutierrez, 2017; Lloyd, 2017).

4. Mr. Seth has possible problems with paraphilic disorder. Specifically, there was disagreement among recent evaluators concerning whether he should be diagnosed with pedophilic disorder (Gutierrez, 2017, and Lloyd, 2017; but cf. Mason, 2017). On one hand, he does not acknowledge deviant sexual

preferences, thoughts, fantasies, or urges involving children. On the other hand, he has a history of sexual contact with children.

5. Mr. Seth poses a risk for violence and sexual violence in the community that is clinically significant (i.e., requires management), if he were to be released into the community without appropriate management plans:

    a. According to a standardized psychological test widely used as an adjunct in risk assessment, the Hare Psychopathy Checklist-Revised (PCL-R; Hare, 2003), Mr. Seth was given scores that are clearly below the diagnostic cutoff for psychopathic personality disorder (Mason, 2017; Lloyd, 2017). Notwithstanding this, there is disagreement concerning whether the scores he was given reflect some elevated risk for general violence (Mason, 2017; Lloyd, 2017).

    b. According to an actuarial test of risk for general violence, the Violence Risk Appraisal Guide-Revised (VRAG-R; Rice, Harris, & Lang, 2013), Mr. Seth has a score that indicates about a 37% likelihood of general violence in the community over 5 years (Lloyd, 2017).

    c. According to a set of structured professional guidelines for assessing risk of general violence, Version 3 of the Historical-Clinical-Risk Management-20 (HCR-20 V3; Douglas, Hart, Webster, & Belfrage, 2013), Mr. Seth has a number of risk factors that indicate an overall risk for general violence that is high (Lloyd, 2017).

    d. According to an actuarial test of risk for sexual violence, the Static-99 Revised (Static-99R; Phenix et al., 2016), Mr. Seth has a score that indicates about a 15% to 21% likelihood of sexual violence in the community over 5 years (Gutierrez, 2017; Mason, 2017).

    e. According to two sets of structured professional guidelines for assessing risk of sexual violence, the Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Webster, 1997) and the Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend Sexually (ARMIDILO-S; Boer et al., 2013), Mr. Seth has a number of risk factors that indicate an overall risk for sexual violence that is low to moderate (Mason, 2017).

6. Mr. Seth does not have self-generated plans for the future that would effectively mitigate the risks he poses, and indeed lacks the capacity to develop such plans (Mason, 2017; Gutierrez, 2017; Lloyd, 2017). But detailed and feasible management plans have been developed specifically for and in collaboration with Mr. Seth that involve placement in a highly structured, closely supervised, community-based program (Mason, 2017). These plans take into account the risks he poses, as well as his treatment and supervision needs.

Opinions

Mental Disorder

(a) Intellectual Disability

There was unanimous agreement in the forensic mental health reports I reviewed that Mr. Seth meets diagnostic criteria for mild intellectual disability. I accept the accuracy of this diagnosis; the evidence supporting it is abundant, coming from diverse sources, including appropriate standardized testing, over a period of many years.

(b) Other Major Mental Disorder

Three evaluators concluded that Mr. Seth meets diagnostic criteria for comorbid major mental disorders, based on his problems related to social skills and mood regulation. I do not accept the accuracy of these diagnoses, for several reasons. First, two of the diagnoses were for "unspecified" (i.e., unclear or inchoate) mental disorders. Second, one of the diagnoses was "provisional" (i.e., uncertain or unconfirmed). Third, and most importantly, it is simply unnecessary to posit the existence of comorbid major mental disorders, as the social skills and mood regulation problems on which those diagnoses are based are entirely consistent with and better accounted for by intellectual disability. Authoritative treatises—such as the *Diagnostic Manual-Intellectual Disability* (DM-ID; Fletcher, Loschen, Stavrakaki, & First, 2007) and its recent revision (DM-ID-2; Fletcher, Barnhill, & Cooper, 2017)—provide guidelines for diagnosis of comorbid major mental disorder in people with intellectual disability; however, there was no indication that the evaluators who diagnosed Mr. Seth with comorbid major mental disorder were familiar with or relied on such guidelines.

(c) Substance Use Disorder

Two evaluators concluded that Mr. Seth meets diagnostic criteria for mild cannabis abuse. I do not accept the accuracy of this diagnosis. Although these evaluators provided evidence that Mr. Seth used cannabis, they did not provide evidence that it caused functional impairment beyond that which is clearly attributable to his intellectual disability.

(d) Paraphilic Disorder

Two evaluators concluded that Mr. Seth meets diagnostic criteria for paraphilic disorder, specifically, pedophilic disorder. I do not accept the accuracy of this diagnosis. Although these evaluators provided evidence that Mr. Seth has a history of sexual contact with children, they did not provide additional evidence of pedophilic interest or preference (e.g., persistent sexual thoughts, images, fantasies, urges, or physiological arousal involving sex with children) and indeed both acknowledged he denied such interest or preference. In the absence of such evidence, and based on the nature of the sexual contact that has been alleged, it is more likely that Mr. Seth's sexual contact with children was due to restricted opportunity for sexual contact with age appropriate peers,

along with deficiencies in judgment and impulse control, all of which in turn are a consequence of his intellectual disability; furthermore, these problems were exacerbated by a lack of appropriate intervention and supervision. This pattern of sexual contact among people with intellectual disability with children, sometimes referred to as pseudo-paraphilia or "counterfeit deviance," has been recognized in the literature on sexual offenders for decades. Authoritative treatises present guidelines for the diagnosis of paraphilic disorder in people with intellectual disability (e.g., DM-ID, DM-ID-2), but there was no indication that the evaluators who diagnosed Mr. Seth with paraphilic disorder were familiar with or relied on such guidelines.

Risk Assessment

(a) PCL-R

I have special expertise with respect to the PCL-R. I assisted in its development; in addition, I have conducted research evaluating its reliability and validity, conducted many professional training workshops on its use, and given expert testimony about it or based on it.

Dr. Mason scored the PCL-R to assess traits of psychopathic personality disorder as part of his administration of the SVR-20. He gave a total score he interpreted as indicating a "low" risk for violence—which, in the context of the SVR-20, is a total score ≤ 20. In her most recent evaluation, Dr. Lloyd (2017) administered the PCL-R as a violence risk assessment tool and gave a total score of 25.3; she interpreted this as indicating "high" risk for violence. Although I believe the PCL-R ratings given by Dr. Lloyd are too high and interpreted incorrectly, it is important to emphasize that Dr. Mason and Dr. Lloyd agree that Mr. Seth is *not* psychopathic according to the PCL-R (i.e., his total score is clearly below the diagnostic cutoff of ≥ 30), and indeed agree that he does *not* meet diagnostic criteria for any personality disorder.

I do not accept the accuracy of the PCL-R total score given by Dr. Lloyd, for several reasons. First, it appears that she omitted one PCL-R item, apparently Item 17, and subsequently adjusted or prorated her raw total score up from 24 to 25.3. I found sufficient evidence in the information provided in the forensic mental health evaluations, including those of Dr. Lloyd, to rate all 20 PCL-R items. If I am correct that Dr. Lloyd omitted Item 17, the net effect in this particular case was to artificially inflate the obtained total score by 1.3 points and change her interpretation of the score from "average" to "high" risk. Second, Dr. Lloyd gave Mr. Seth ratings that were too high on several PCL-R items. It has been recognized for some years in the literature that there are potential difficulties scoring the PCL-R in people with intellectual disability (e.g., Morrissey et al., 2010), and guidelines have been developed to assist evaluators (e.g., Morrissey, 2006), but there was no indication that Dr. Lloyd was familiar with or relied on such guidelines. When I rated the PCL-R based on the information summarized in the various forensic mental health evaluations, I found evidence for a high score for 6 items, a moderate score for 7 items, and a low score for 7 items. Overall, the total score I gave was 19 points out of a possible 40—considerably lower than that given by Dr.

Lloyd but consistent with the "low" score given by Dr. Mason.

I also do not accept Dr. Lloyd's interpretation of the PCL-R total scores she obtained. First, the PCL-R is not intended to assess risk in isolation, but rather to assess psychopathic personality disorder as part of a comprehensive and contextualized evaluation (e.g., Hart & Storey, 2013). Second, the literature on psychopathic personality disorder exercises caution when using the PCL-R to assess people with intellectual disability due to limited research supporting its meaningfulness in that population (e.g., Morrissey & Hollin, 2011), but there was no indication that Dr. Lloyd was familiar with or relied on this literature. Third, Dr. Lloyd incorrectly interpreted the PCL-R total score she gave Mr. Seth as indicating a high risk for violence. But even if one accepts the accuracy of the original score she reported (i.e., 25.3), it indicates average risk, not high risk; furthermore, if one accepts the accuracy of the PCL-R score given by Dr. Mason and me (i.e., ≤ 20), then it indicates low risk.

(b) VRAG-R

As the VRAG-R was administered only by Dr. Lloyd, there was no disagreement among evaluators concerning it. I was not able to evaluate the accuracy of the VRAG-R score reported by Dr. Lloyd, as she did not provide details of same. That said, I do not accept the usefulness of the VRAG-R in this case. First, the VRAG-R is a statistical profile that provides general expectations regarding recidivism risk based on limited historical information. It does not constitute a comprehensive or contextualized assessment. Second, there is no body of research that supports the accuracy of the VRAG-R (i.e., cross-validation or calibration research by independent researchers) either for offenders generally or for people with intellectual disability more specifically. Dr. Lloyd seems to imply in her report that research on the original VRAG can be used to support the validity of the VRAG-R, but this is not the case.

(c) HCR-20 V3

I have special expertise with respect to the HCR-20. I assisted in the development of it; in addition, I have conducted research evaluating its reliability and validity, conducted many professional training workshops on its use, and given expert testimony about it or based on it.

As the HCR-20 was administered only by Dr. Lloyd, there was no disagreement among the other evaluators concerning it. That said, I do not accept her HCR-20 findings or her interpretation of those findings. First, the literature on the HCR-20 recognizes that special consideration may be required when assessing people with intellectual disability (Johnston, 2002), and clinical guidelines have been published focusing specifically on the use of the HCR-20 with intellectually disabled sex offenders (Boer, Frize, Pappas, Morrissey, & Lindsay, 2010), but there was no indication that Dr. Lloyd was familiar with or relied on this literature. Second, it appears that Dr. Lloyd completed only Steps 1 and 2 of the HCR-20 administration procedure, omitting Steps 3 through 7. Completion of these latter steps is essential for rating the presence of the Risk Management factors,

as well as for rating the relevance of all the risk factors, developing an individualized formulation of violence risk, and identifying plausible scenarios of future violence. Third, Dr. Lloyd gave Mr. Seth ratings on the Risk Management factors that were too high. This was because she based her ratings solely on Mr. Seth's self-generated plans, rather than on the release plans detailed by Dr. Mason and accepted by Mr. Seth.

(d) Static-99R

There was no disagreement among the three most recent forensic mental health evaluations concerning Mr. Seth's score on the Static-99R. I reviewed the Static-99R scores reported by the most recent evaluators and accept their accuracy. That said, I do not accept the usefulness of the Static-99R in this case. The Static-99R is a statistical profile that provides general expectations regarding recidivism risk based on limited historical information. It is not intended to be used in isolation to assess risk, but rather intended to be administered and interpreted as part of a comprehensive or contextualized assessment.

(e) SVR-20 and ARMIDILO-S

I have special expertise with respect to the SVR-20. I assisted in the development of it; in addition, I have conducted research evaluating its reliability and validity, conducted many professional training workshops on its use, and given expert testimony about it or based on it. I am also familiar with the ARMIDILO-S, which was developed by one of the co-authors of the SVR-20. As the SVR-20 was administered only by Dr. Mason, there was no disagreement among evaluators concerning it. I accept Dr. Mason's SVR-20 and ARMIDILO-S findings, as well as his interpretation of those findings.

Risk Management

As Dr. Mason was the only person to identify a set of management plans that would be, in his opinion, necessary and reasonably sufficient to effectively mitigate the risks posed by Mr. Seth, there was no disagreement among evaluators concerning it. The recommendations with respect to supervision included 24-hour 1:1 staffing, specially trained staff, no more than one housemate, a busy schedule of daily activities, and no unsupervised access to children. The recommendations with respect to intervention included safety supports for the home setting, counseling and psychiatric supports, sexuality education, and a clear crisis management protocol.

I accept the validity of the management plans outlined by Dr. Mason, for two reasons. First, consistent with best practice, the plans were based on a comprehensive assessment of risk factors; an individualized, integrative case formulation; identification of plausible scenarios; and attention to strategic, tactical, and logistical considerations. The plans also reflect a deep understanding of intellectual disability in general and the needs of Mr. Seth more specifically. Second, the management plans are remarkable or noteworthy for being feasible (i.e., available, accessible, and affordable), attentive to Mr. Seth's unique risk, need, and responsivity factors (i.e., appropriate), and consented to

by Mr. Seth (i.e., acceptable).

Summary

In my opinion, there are four factors that account for the disagreements between evaluators—and, in particular, between Dr. Mason and Dr. Lloyd—with respect to the nature and management of risks posed by Mr. Seth. First, Dr. Lloyd did not sufficiently take into account Mr. Seth's intellectual disability when evaluating his mental health problems. As a consequence, she may have inaccurately diagnosed him with substance use disorder and paraphilic disorder. Second, Dr. Lloyd placed too much weight on Mr. Seth's recent history of behavior problems in custody. That history includes incidents that were primarily reactive in nature and minor in seriousness. Examples include minor rule violations (e.g., wearing the wrong clothes, not sharing a communal television with others) and problems dealing with interpersonal stress or conflict (e.g., rude or disruptive behavior when interacting with staff or fellow residents). Such incidents are expected when dealing with people with intellectual disability, especially when they are placed in closed living environments that lack the programs and trained staff to deal with their special needs (e.g., through contingency management, verbal de-escalation, and so forth). Third, Dr. Lloyd did not develop an adequate integrative formulation of Mr. Seth's violence risk. As a consequence, she failed to recognize that most of his risk factors (e.g., interpersonal problems, employment problems, problems with insight) are not independent but rather reflect a single underlying risk factor—namely, intellectual disability. Fourth, Dr. Lloyd did not adequately consider options for risk management of Mr. Seth. As a consequence, her report focuses on the risks he poses assuming he does not receive special supervision and intervention. For these reasons, I prefer and agree with the opinions about risk and risk management proffered by Dr. Mason as opposed to those proffered by Dr. Lloyd.

In my opinion, then, this appears to be a rather typical case of a young man with intellectual disability who has had some problems with delinquent or antisocial conduct. The primary risk factors are intellectual disability and attitudes that support or condone criminality and violence; all the other risk factors appear to play a less important role and some (e.g., problems with relationships, employment, insight, instability) are simply the natural consequences of intellectual disability. The primary scenarios of future violence in the community involved a repeat or continuation of past problems including: (a) sexual contact with children with whom he is acquainted, and (b) intimidating or assaultive behavior that is reactive in nature and of mild to moderate seriousness. Effective management of these risks appears to require a structured, closely supervised community based program staffed by people with special skills and experience managing those with intellectual disability. The overall risk of violence and sexual violence in the community appears to be low, assuming implementation of management plans as outlined by Dr. Mason. To be clear, Mr. Seth will almost certainly have adjustment problems, including occasional conduct problems, of the sort one expects when dealing with people with intellectual disability; however, the management plan should be sufficient to effectively mitigate his risks related to the two scenarios identified (i.e., sexual contact with children and intimidating or assaultive behavior).

Finally, following on the above, it is my opinion that placement in a correctional institution will do nothing to mitigate the risks for violence in the community posed by Mr. Seth. First, he requires specialized services delivered by trained staff. These are not readily available in correctional institutions. Second, he requires long-term services in the community. Time-limited services delivered in an institutional setting are neither necessary nor sufficient to ensure stable adjustment in the community. I am concerned that (continued) placement in a correctional institution may actually lead to iatrogenic risk. That is, if Mr. Seth is denied access to appropriate services, he is likely to have continuing problems with behavior in the institution that may result in increased levels of frustration or anger, an ever-growing record of institutional infractions, and worsened relations with staff. Put differently, placement in a correctional institution may *increase* his risk—actual or perceived—rather than decrease it, making it less likely that he will be perceived as suitable for release.

Declaration

All opinions expressed in this report are mine, and I hold them with a reasonable degree of professional certainty.

I do not have any relationships with the authors of the forensic mental health evaluations or commercial interests in the outcome of this case that would constitute a conflict of interest (actual, potential, or perceived) or that would otherwise prevent me from rendering objective and fair opinions in this matter.

Sincerely,

Stephen D. Hart, PhD

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Exhibit 15

Wholistic Services, Inc.

Proposal for Transition, Safety and Support Services for Markelle Seth

Company Name:	Wholistic Home and Community Based Services, Inc.
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I. About Wholistic Services

Wholistic Services was started over twenty-five years ago by a management team who already had many years of experience supporting people with multiple disabilities and with the community integration process. Since its inception, Wholistic has been providing a range of services in the District of Columbia to persons diagnosed with Developmental and Intellectual disabilities. We specialize in providing quality, person-centered services and supports to adults with all levels of intellectual impairment who also experience significant sensory, physical, behavioral and/or medical challenges. Of particular relevance to serving Mr. Seth, we also have substantial and successful experience serving individuals diagnosed with mild intellectual disability who require a high degree of supervision because dangerous behavior led them to be involved in the criminal justice system. Wholistic's name embodies our service philosophy. This philosophy, the total approach, is how our agency supports those with Developmental and Intellectual Disabilities in the most integrated and inclusive settings, consistent with safety of the individual and the community and with evidence based best practices.

Currently, Wholistic provides Intermediate Care Facilities for the Intellectually Disabled in eight homes, all of whom experience moderate to profound levels of intellectual impairment. Two of the homes have 24-hour nursing and serve medically fragile people. In addition, Wholistic operates Supported Living sites, a Residential Habilitation site, Individualized Day Services and a Day Habilitation service for the afore-mentioned population.

Key features of Wholistic's organizational experience and history include the following:

- A Knowledgeable, Stable, and Hands-On Management Team: The management staff of Wholistic consists of a dedicated group of professionals with many years of direct, hands-on experience in providing clinical and life skill supports. Upper management can be

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found regularly in the programs ensuring a strong system of internal oversight is in place and evident. House managers, nurses and QIDP staff are held accountable for their performance and leadership in providing safe and effective community services.

- Staff Experience and Stability: Our programs experience low staff turnover. At the direct support level the average staff has been with Wholistic for over two years. The QIDP/House managers average five years at Wholistic, and senior management averages ten years. New staff members are almost exclusively recruited through word of mouth based on known reputation. This organizational experience and stability extends to our clinical teams as well and ensures that the high quality of services and supports provided is consistent and reliable.

- History of Responsible Expansion: Wholistic has expanded gradually over the past 25 years, ensuring that senior level Wholistic staff has always been available to support the development of new services and settings. We have considerable experience in transitioning people who require intensive or pervasive supports and who may be very sensitive and vulnerable to change. Wholistic has always followed a model of gradual and responsible expansion, both to maintain our quality of services and to maintain fiscal integrity for the organization. Although we have experienced a number of payment problems in the District over the past years, they have never posed a threat to the fiscal soundness of the organization, the welfare of the people we serve, or the staff who serve them. Wholistic has never missed or delayed a payroll, nor have we ever failed to satisfy our facility leases or our obligations to other vendors such as day placements.

- Reputation for Quality Services and Supports: Wholistic has a long record in the District of providing reliable, competent and caring service to the people we serve. We provide effective transitioning, service planning, and coordination of care, community integration and program implementation for many people who face complex challenges. Wholistic has a history of maintaining high levels of compliance with federal and local regulations and policies, as well as a reputation of responsiveness to oversight agencies when concerns are identified.

- Experience with Vulnerable People: Since the organization began, Wholistic has served people with intense medical, behavioral and physical needs. Two of the eight homes currently run by Wholistic (Lawrence and Perry Street) serve medically fragile people and provide skilled levels of nursing on a 24 hour basis. The oversight history for those Wholistic programs confirms that the high quality services and supports provided are reliable and consistent.

- Protection of Safety, Health and Management Rights: Over the last 25 years of providing services to the District's most vulnerable adult citizens, our strong management oversight and dedicated, seasoned staff ensure that Wholistic reports and

thoroughly investigates all incidents and alerts and that problem situations are remedied in a timely manner.

Wholistic has been approved by the Department of Health to provide Medicaid Waiver Services for several years now. The Wholistic team was active in the roundtable process when Waiver service rules were developed at DDA, and is excited to be part of the self-directed, flexible service model that is available through waiver.

II. Examples of Successful Services to Court-Involved Individuals

Currently, Wholistic provides support to two persons whom have had substantial engagement with the criminal justice system.

AF is a 36 year old male who, in 2001, at age 19, was found incompetent to stand trial on charges involving inappropriate and dangerous sexual relations with young children and was ordered into the DDA system. He is mildly intellectually disabled and also has an Axis I diagnosis of bipolar disorder. AF was mandated to have 24 hours 7 day per week supervision and to be supported at a 1:1 staffing ratio at all times. Since being admitted to Wholistic, AF has blossomed. He resides in a two-bedroom apartment in a low density and communal neighborhood. His home is decorated to his liking and reflects his personal taste and style. AF is an avid gamer and has a complete gaming system set up in his room and living room. His staff are trained at least quarterly on key areas of support for AF to include behavior supports, Crisis Management and nutrition needs. AF is working on improving his food preparation skills and healthier eating. He cleans and maintains his home with little assistance from staff. He is fully responsible for his laundry and often coaches his roommate on how to complete laundry and other activities of daily living. AF lives a meaningful life and is engaged in activities of his interest. This year alone, he participated in track and field, volleyball and bocce ball in the Special Olympics, winning the silver medal in volleyball. He is an avid bowler and belongs to a bowling league made up of persons without disabilities. AF participates in an employment readiness program and volunteers at a local food bank once a week. He vacations yearly with friends and regularly makes CD compilations of varying types that he sells to friends and neighbors. Since his admission to Wholistic, he has had no interaction with the criminal justice system. He is thriving and hopes to obtain a job working at a grocery store. AF has been committed to District of Columbia since December of 2002. He has received sexuality education that has helped him to understand that the actions that led to his commitment were wrong. He likes his staff and his full and busy schedule, which is based on his interests, preferences, strengths, likes and dislikes. This individualized, person centered plan, combined with consistent and well trained staff, has created an environment that has allowed AF to thrive and not to resist the limits on his personal freedom. While there are inevitably issues and problems that arise, timely and appropriate interventions consistent with his crisis plan and behavior support plan are implemented by AF's well trained staff. This clear and consistent approach to behavior management has also contributed to AF's success.

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Another example of a successful transition from the criminal justice system into community based supports facilitated by Wholistic is BB. BB is a 54 year old male who was found incompetent in connection with a murder charge many years ago. BE has a diagnosis of psychotic disorder in addition to intellectual disability. Prior to his release into our services, BB spent a substantial period of time in St. Elizabeth's Hospital and the DC Jail. BB is six feet four inches tall and a man of stature. BB resides in a vibrant and culturally diverse part of the city. He lives in a spacious one bedroom apartment. His home is tastefully decorated and reflects his style. BB loves music and always has something playing in the background when he is home. His days consist of participating in Individualized Day Services four days a week and working as a janitor in a shopping mall for three hours, one day a week. Individualized day services are community based services that are specifically tailored to the needs of the person utilizing a choice driven process. We believe that when people have a meaningful say in how they spend their days, they are more inclined to engage and thrive and the problems that arise are less frequent and of lower magnitude. BB receives 24 hours daily 1:1 staffing services. Staff are trained at least quarterly on his needs to specifically include his behavior support plan and crisis prevention plan. Since BB's release into community based supports, he has spent time teaching himself the piano (he prefers to be self-taught and is quite accomplished), being an active member of his church, learning to prepare exquisite meals for himself and family, spending time with his sister and volunteering at a local recycling plant. BB hopes to obtain a more full time job as a janitor. BB began receiving services from Wholistic May 2nd of 2017 after a transition process initiated in October 2016. Over the course of eight months, Wholistic, with the support of DDA and BB's legal team, assembled a team of exceptional professionals and clinicians. The team met regularly with BB, though he was incarcerated, to develop and implement a detailed plan to ensure a smooth transition into the community. Most of these steps are mentioned below and would be utilized to ensure an effective transition for Mr. Seth. One of the key components of the transition was a meticulous analysis of the person-centered thinking process and identification of what was important to and important for BB. This process also engendered understanding of how to best manage conditions that may create adversity and/or stress and how to empower BE to make good decisions and live a meaningful life in his community.

III. Key Elements of Support Plan for Markelle Seth

Mr. Seth is a 23-year-old man who will be transitioning from the Federal Medical Center in Butner, NC. Mr. Seth has been continuously incarcerated at the DC Jail, the DC Correctional Treatment Facility or at FMC Butner since his arrest on October 2, 2014 in DC on the instant charge of first degree child sex abuse for which he was subsequently charged with production of child pornography. He has been found incompetent to stand trial. Mr. Seth has been extensively evaluated to include assessments of competence, a comprehensive neuropsychological evaluation and risk assessments. Those prior evaluations have been considered and integrated into the development of this plan. Mr. Seth is diagnosed with Mild Intellectual Disability and demonstrates significant weaknesses in language comprehension

and executive functioning including impulse control, problem solving and frustration tolerance. While during his incarceration Mr. Seth has been prescribed anti-depressant medication on occasion for anxiety and depression, he does not present with chronic and persistent mental illness. He is currently not receiving psychoactive medications and has never received formal mental health services or sexuality education in the community. The rate of behavioral concerns, such as verbal outbursts, aggression and oppositional behavior is not clear but is estimated to be low to moderate. If not appropriately supervised, Mr. Seth presents a risk of engaging in sexually inappropriate behavior with children. This is obviously a matter of significant concern and has been accounted for in this plan.

In order to ensure a smooth and appropriate transition for Markelle Seth, Wholistic proposes:

1. Pre-Transition Review (some of this has already been completed)

a) Conduct record reviews for Mr. Seth, and review all recent reports and recommendations for services.
b) Meet with Mr. Seth, family members, advocates, lawyers, providers, service coordinator and other available support team members (i.e., Georgetown University Center for Child and Human Development) to clarify the immediate and long-term needs and preferences of Mr. Seth.
c) Begin selection of staff, management and clinicians who will provide direct support and services.

2. Transition Planning

a) Identify staff development and preliminary training needs, medical assessment or consultation needs, ongoing support needs, and services or supports that may yet need to be developed or scheduled.
b) Create initial safety related protocols including crisis management plan, behavior support plan, health care plan, supervision protocols (e.g., one-to-one and/or two-to-one supervision), and environmental safety plan.
c) Identify suitable residential location based on risk assessment recommendations.
d) Provide initial training to identified staff and management regarding community transition, safety and habilitation needs for Mr. Seth.
e) Schedule intake assessments with psychological and psychiatric consultants, mental health counselor and sexual health educator.
f) Cross-train crisis support team members.

3. Transition

a) Complete orientation meeting with support team within 24-hours of transition to community residence.
b) Identify non-negotiable rules with Mr. Seth and create behavioral contract.

c) Conduct structured behavioral assessments and observations to establish baseline behavior rates, identify functions of targeted behaviors and develop a behavioral support plan within two weeks of transition period.
d) Conduct vocational assessment and develop plan for employment within one month of transition period.
e) Complete nursing assessment and nursing plan of care within one week of transition period.
f) Complete diagnostic, psychiatric and mental health assessments within two weeks of transition period.
g) Complete required modifications to the living environment to enhance safety within two weeks of transition period.
h) Schedule and conduct initial person-centered Individual Support Plan within 30 days of transition period.
i) Create daily schedule of activities with input from Mr. Seth within 30 days of transition period.
j) Identify appropriate and safe leisure activities and locations.
k) Conduct at least weekly quality reviews of services.

4. Staff Support, Development and Oversight Stabilization

a) Ensure that staff are trained to the point of competence on ISP's, BSP's and HMCP's and can demonstrate implementation of all health and safety related care plans and protocols.
b) Provide additional ongoing training to staff on key informational and support strategies, such as sexual development, risk monitoring, highly effective supervision, de-escalation strategies, mentoring, identifying at-risk behaviors, facilitating self-management skills, training "loosely."
c) Conduct staff meetings at least monthly or as needed and include supports from partnering agencies and consulting professionals.
d) Develop a staffing schedule that ensures high quality supervision and rotates relief and crisis staff on a regular basis.
e) Ensure continued oversight and contact with managing staff (house manager, QIDP, professional staff, senior management).
f) Review critical behavioral and mental health data on a bi-weekly basis or as needed (utilize standardized measurement tools).
g) Identify opportunities to increase Mr. Seth's self-management and safety skills on a continuous basis.

IV. Description of Safety and Community-Based Supports

It is understood that DDA referred Mr. Seth to Wholistic because this agency has a proven track record of successfully serving people with intellectual and other developmental disabilities who have been involved in the criminal justice system, in particular people who have a history of dangerous sexual behaviors.

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1. Residential Services

A review of Mr. Seth's developmental, educational, legal, family and social history suggests that he would be responsive to and appropriate for placement in a highly structured and supervised community-based residential program and that a more restrictive setting would not be necessary. Wholistic has safely and successfully served people similar to and more behaviorally challenging than Mr. Seth in community settings with appropriate structure, staffing and programming. Given Mr. Seth's most recent history of alleged sexual misconduct, a highly structured (i.e., schedule driven) community-based residential program with significant staff supervision (i.e., at least 1:1 staffing on a 24-hour basis) is recommended.

Clinical and other interviews indicate that Mr. Seth enjoys the company of others – particularly of other adults, whose approval he seeks. His history of multiple placements, including foster care and homelessness, and his interactions with others in these placements however, suggests that a venue with no more than one housemate should be considered at present. Any other individual being considered for cohabitation should be carefully screened for mutual compatibility, and the addition of a housemate should in no way interfere with the safety goals of Mr. Seth's services or his supervision requirements.

In light of Mr. Seth's apparent willingness to live in the community, participate in his own rehabilitation and to acquire the life skills expected of an independent adult to the extent he is able, a mentoring/teaching style program is recommended where he will fully participate in daily living activities. Opportunities for advancing his independence with skills of daily living (i.e., hygiene, home maintenance, cooking, cleaning, laundry, shopping, budgeting, functional reading and writing) will be emphasized with a path to more independence in the future to the extent that is indicated by the level of his functioning and appropriate consideration for the safety of others. These opportunities will be supplemented by intense behavioral management, ongoing supervision and counseling. A comprehensive weekly schedule of activities will be created and revised as necessary to promote consistency of staffing, supervision and support planning (see attached sample weekly schedule).

As with any person who is participating in this program, the goal is to impart the necessary safety and self-management skills to Mr. Seth so that he may achieve increasing independence. There is no set time frame for Mr. Seth achieving access to increased independence, as it will be based on his progress. As described below, Mr. Seth will be supervised by staff at all times, including when he is in his residence.

2. Vocational Services

Services for Mr. Seth will include vocational supports during the working day. Staff working with Mr. Seth will function as job coaches – their main focus is to help prepare Mr. Seth for the work force. This preparation will begin with a thorough assessment of Mr.

Seth's skills and interests followed by resume building, completing job applications and teaching interview skills. The goal is to provide real work opportunities in the community within a year. Once employed, job coaches will participate in work activities with Mr. Seth – remaining present with him on site and providing continuous 1:1 supervision – to ensure his continued coaching and safety for himself and others. Employment support staff or job coaches must be trained, consistent and carefully coordinated with residential supervision.

3. Staffing and Supervision

Direct support staff will be carefully selected for their experience in working with people with intellectual disabilities who have a history of court involvement. In addition to required basic training related to providing support (i.e., fundamental rights, person-centered planning, developmental disabilities, medication administration, first aid, aging across the lifespan, sexual development), staff will be provided with advanced training on topics such as positive behavior supports, legal involvement, and counseling and teaching strategies.

Staffing ratios may be as high as 2:1 during the first several months if deemed necessary, and this level of supervision will be closely reviewed. It is anticipated that Mr. Seth will be able to transition to 1:1 staff supervision within one year or less, dependent on his success in the program. Supervision will be provided in such a way as to ensure that staff are always close enough to protect Mr. Seth and others from possible harm. Typically, in a two- to four-person home, at least two awake-overnight staff members are provided.

Staff will utilize a mentoring model, which incorporates demonstrating desired behaviors, using nondirective coaching strategies to avoid power struggles, and using incidental teaching strategies; these strategies must be provided within a framework in which specific safety rules and limits are non-negotiable. Mr. Seth will be fully informed of requirements of supervision, restrictions on contacts with minors and unapproved visitors, adhering to established rules, avoiding use of illicit substances, and following scheduled routines. Mr. Seth will also be made aware of the consequences of violating such rules, which may include loss of community placement and liberty, and potential incarceration.

An on-call crisis team will be created and trained to respond to any crises that occur in order to support Mr. Seth's safety and his identified team. Crisis team members will be included in all required and routine staff trainings related to Mr. Seth's support needs. Crises team members will also be rotated through routine service schedules to ensure ongoing familiarity with Mr. Seth and his progress.

4. Behavioral Health and Related Services

Mr. Seth will have ongoing access to behavioral health services from Wholistic, which will include the development of a behavior support plan designed to prevent/manage undesired behaviors while describing methods to teach alternative behaviors. An interim behavior

support plan will be developed during Mr. Seth's transition into community-based learning to be followed by the development of a comprehensive plan based on a functional assessment as soon as is feasible. Wholistic emphasizes positive behavior supports in the development and implementation of behavioral supports; while certain privileges may be made contingent on Mr. Seth meeting behavioral goals, no aversive interventions are utilized. Such an approach is consistent with evidence-based best practices in the field of developmental disabilities.

Consultations with professional services will be sought in the community, such as psychiatric care, psychosexual assessment and training, and counseling as needed. Georgetown University's Center for Child & Management Development has offered to provide consultation to Wholistic to explore Mr. Seth's needs, particularly in regards to assessment and education of sexual behavior. Psychiatric consultation will be provided by Ron Koshes, MD, via a private contract for services with Wholistic. Behavioral and associated therapeutic services will be provided by Rebecca Yount, PsyD to address issues such as history of abuse, development of appropriate relationships, improving self-management skills, sexually appropriate behavior, and building self-esteem.

5. Nursing Care

Mr. Seth's medical needs will be monitored on a weekly basis by a registered nurse under the supervision of Wholistic. All routine medical care will be provided in the community.

6. Safety and Crisis Management

Wholistic recognizes that Mr. Seth's successful participation in a community-based program is dependent on keeping him safe and preventing harm to members of his community. In addition to a high level of supervision 24/7, staff will be trained in essential strategies for supporting people with developmental disabilities (i.e., overview of developmental disabilities, fundamental rights and preventing abuse and neglect, development across the lifespan, dual diagnoses, positive behavior supports, sexual development and behavior, health care management, essential lifestyle planning, etc.).

Antecedent conditions and precursor behaviors to critical behaviors will be identified, monitored, and prevented or mitigated, and step-wise procedures for a variety of possible scenarios must be created to ensure continued community safety is maintained. Additional crisis management supports will be available to staff, such as temporarily increasing staffing or supervision, using a crisis response team, providing on-site de-escalation supports from a qualified mental health professional, and accessing emergency psychiatric care (which may also be defined in a behavior support plan). Staff will receive training in crisis management strategies using the CPI System. CPI is a comprehensive and integrated system of de-escalating undesired behavior (up to and including hands-on physical management if safety requires it) while supporting the emotional, psychological and physical safety of the person and the people around the person

A variety of other safety support will be initiated, such as on-call services with managers and senior staff available around the clock to assist with potential crisis events, adjusting the physical layout of the home to reduce the potential risk of harm, and providing Mr. Seth with his own bedroom to ensure privacy and a safe haven. Wholistic will also work with DDA to ensure clarity regarding the protocol that would be followed in the event of an elopement, including notification of law enforcement as well as DDA. Wholistic has experience utilizing all of these measures.

From Wholistic's experience working with people with profiles similar to Mr. Seth, it is clear that while the above safety precautions are necessary and appropriate, the most essential keys to a successful and safe experience for Mr. Seth will be engagement in activities that are meaningful to him, ensuring staff assigned to supervise him are well-trained and supported, providing high levels of supervision, as well as continuous oversight and evaluation of program services. Building, with Mr. Seth's active involvement, a home and a way of life that he is invested in will be the surest way to achieve success and meet the needs of both Mr. Seth and his community.

Additionally, non-negotiable safety limits on Mr. Seth's behavior and activities will be established, monitored and enforced. As an example, Mr. Seth should not have access to areas where unsupervised contact with minors is likely and his behavior in the community must be monitored to prevent any such contact. Mr. Seth's residence should be located in a neighborhood that limits access to children but allows access to other community resources. In practical terms, this means Mr. Seth should reside in a lower-rather than higher-density neighborhood if possible (e.g. a residence in a house or a smaller apartment building as opposed to a large apartment complex). A residence that promotes effective monitoring of exits is important, as is creating a safe and welcoming home environment. A residence that is equipped with window and door chimes is encouraged.

7. Person Centered Planning

Mr. Seth's services will be driven by the philosophy of person centered planning, which is a set of approaches designed to assist people in planning their life and desired supports to increase their self-determination and improve their independence. As part of this philosophy, an "essential lifestyle plan" will be developed with Mr. Seth to help him discover and attain what matters most to him and identify what supports might be needed. Supportive team discussions related to health and safety (e.g., both the safety of Mr. Seth as well as community safety) with direct input from Mr. Seth are an integral part of essential lifestyle planning.

The long-range goal for Mr. Seth will be to improve self-management of his behavior so that he will be able to live and work in the least restrictive setting possible. Increasing his range of coping strategies will help Mr. Seth deal more effectively with everyday challenges and is a

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necessary component of learning self-management skills. Strategies to improve his self-management will be identified and incorporated into his person-centered plan.

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V. Sample Weekly Activity Schedule

Time	Tuesday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 am to 7:30 am	Wake Up, Medications, Breakfast	Wake Up, Medications, Breakfast	Wake Up, Medications, Breakfast	Wake Up, Medications, Breakfast	Wake Up, Medications, Breakfast	Sleep Late	Sleep Late
7:30 am to 8:30 am	Hygiene Prepare for Day	Hygiene Prepare for Day	Hygiene Prepare for Day	Hygiene Prepare for Day	Hygiene Prepare for Day	Wake Up, Medications, Breakfast	Wake Up, Medications, Breakfast
8:30 am to 9:00 am	Depart Home 816 Easley Street	Depart Home 816 Easley Street	Depart Home 816 Easley Street	Depart Home 816 Easley Street	Depart Home 816 Easley Street	Hygiene Prepare for Day	Hygiene Prepare for Day
9:00 am to 10:00 am	Psychiatrist 35 K. St NW	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Depart Home 816 Easley Street	Depart Home 816 Easley Street
10:00 am to 11:00 am	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Ave	Mall 8661 Colesville Road	Church 8900 Georgia Avenue
11:00 am to Noon	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Job Prep 900 Wayne Avenue	Mall 8661 Colesville Road	Church 8900 Georgia Avenue
Noon to 1:00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
1:00 pm to 2:00 pm	Bowling 11207 New Hampshire Ave	Basket Ball 200 Denver Court	Counseling 680 Rhode Island Ave	Basket Ball 200 Denver Court	Sex Education Georgetown University	Gym 8616 Cameron Street	Groceries 12011 Georgia Avenue
2:00 pm to 3:00 pm	Bowling 11207 New Hampshire Ave	Basket Ball 200 Denver Court	Counseling 680 Rhode Island Ave	Basket Ball 200 Denver Court	Sex Education Georgetown University	Gym 8616 Cameron Street	Groceries 12011 Georgia Avenue
3:00 pm to 3:30 pm	Return Home 816 Easley Street	Return Home 816 Easley Street	Return Home 816 Easley Street	Return Home 816 Easley Street	Return Home 816 Easley	Return Home 816 Easley	Return Home 816 Easley Street
3:30 pm to 4:30 pm	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home
4:30 pm to 5:00 pm	Dinner Preparation	Dinner Preparation	Dinner Preparation	Dinner Preparation	Dinner Preparation	Dinner Preparation	Dinner Preparation
5:00 pm to 6:00 pm	Dinner	Dinner	Dinner	Dinner	Pizza Party	Dinner	Dinner
6:00 pm to 7:00 pm	Clean Up Medication	Clean Up Medication	Clean Up Medication	Clean Up Medication	Clean Up Medication	Clean Up Medication	Clean Up Medication
7:00 pm to 9:00 pm	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home	Leisure In Home
9:00 pm to 10:00 pm	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed	Hygiene, Prepare for Bed