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LaCosta Rickgord — 10/3/03

Operator's Signature — Date

2003 HOUSE JUDICIARY

HB 1271

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1271

House Judiciary Committee

☐ Conference Committee

Hearing Date 1-29-03

Tape Number	Side A	Side B	Meter #
2		x	0-13

Committee Clerk Signature dPenrose

Minutes: 12 members present, 1 member absent (Rep. Onstad)

Chairman DeKrey: We will open the hearing on HB 1271.

Rep. Grande: Introduced the bill. (see attached Women's Prison Alternative)

Chairman DeKrey: I have a question. When we were undertaking this, where we these people.

Rep. Grande: I know that Cass County has on more than one occasion has made these offers and they have been ignored.

Chairman DeKrey: Thank you. Any testimony in favor of HB 1271.

Norbert Sickler, Administrator of SW Multi-County Corrections Center: (see attached testimony). There is an alternative.

Rep. Klemin: Can you briefly tell me about this facility is at New England.

Mr. Sickler: It was to be used for federal prisoners from out of state and we invested approx. a half million dollars into the renovations to provide for security, dormitory area, kitchen, etc. and has been kept up all the way through. It is meant as a minimum security facility.

Rep. Klemin: How many people could be housed there?

Mr. Sickler: Approx. 45, plus there are two other large buildings that could be utilized. We would be looking at a program that would be in conjunction with our facility in Dickinson, so we would have the inmates come to Dickinson, and then moved on to New England facility and could move them back and forth, depending on the type of security needed.

Rep. Klemin: So you have kept up the facility, is anyone using it at this time.

Mr. Sickler: The gym is used by the community as well as some of the other buildings.

Chairman DeKrey: Thank you. Any further testimony.

D. Joyce Kitson: (see attached handout) Opposed. A lot of our Native Americans are in the prison and are dying. One of the prison cells is unlivable, but prisoners are still living there. We have 200 deaths per year in ND. They call the doctor out there, the death doctor. We would like a facility for Native Americans.

Chairman DeKrey: Thank you. Anyone else to testify on HB 1271.

Beverly (did not sign the registration or give her name clearly) - opposed, they prisoners are not given proper diet, medication, etc.

Chairman DeKrey: Thank you. We will now close the hearing.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1271

House Judiciary Committee

☐ Conference Committee

Hearing Date 2-4-03

Tape Number	Side A	Side B	Meter #
2		x	38.4-45

Committee Clerk Signature JPenner

Minutes: 13 members present.

Chairman DeKrey: We will open the hearing on HB 1271.

Wade Williams, ND Association of Counties: Support. For the five or six counties that would have the possibility of providing correctional facilities for what the bill is trying to do. The legislative committee did have some stipulations, we would like to see the daily rate go from $35-45/day, and out of state inmates are getting $70/day. We would like to see that number go up to $70. We would also need to know what type of educational and programs that are outlined in the bill, what those would have to be, so we can better assess what the cost to us will be. Also in this situation, we have a number of counties that have facilities, have contacted the federal prisons. If this could be a more stable market for us, then the federal prisoners wouldn't be taken. We generally have federal inmates for one year or 18 months. Generally they are transferred to the county jails for the end of their term of sentence and are waiting to go home so they are pretty docile. We would like to see contract be established which would give us a little

easier time in preparing budgets, if we know we are going to have 5 state prisoners over a year or two or three year period.

Chairman DeKrey: Thank you. We will close the hearing temporarily for now.

(Reopened later on the same day in the same session)

Chairman DeKrey: We will reopen the hearing on HB 1271. Any testimony in support.

Glenn Giese: Support, feels the women's prison population would be a good fit with the New England facility. Southwest Multi-Correctional Center has done a good job with rehabilitating the facility.

Chairman DeKrey: Thank you.

Dick Johnson, Lake Region Law Enforcement Center, Devils Lake: Support, we currently have a real good relationship with the state pen. We do house probably 5 or 6 males and have referrals for another 5 or 6 this past week. We have had female inmates. We do have programs and staff available because of our federal juvenile program.

Rep. Bernstein: You have room for how many inmates?

Mr. Johnson: We could take 15 on a continual basis. We are doing some remodeling in an addition and that could change to a higher number.

Chairman DeKrey: I hear from Morton County that they can't arrest anyone on weekends because they are full with people serving sentences and come in and serve them on the weekends. Their jails are full on the weekends. Is that an issue for Lake Region.

Mr. Johnson: No, they are really good about that. The people have to serve when it is convenient for us.

Rep. Onstad: How many facilities are interested in taking inmates.

Mr. Johnson: I was told there was another facility, I know of 3.

Rep. Delmore: Do some prisoners present a problem for you.

Mr. Johnson: That is true. We have problem kids from time to time, we do sometimes exchange the juveniles with another facility to get them a different perspective.

Chairman DeKrey: Thank you.

Norbert Sickler, SW Multi-Correctional Facility: Support. We have a contract with the penitentiary. We work with both male and female prisoners, and this has worked out quite well. In regard to staffing the facility, we have a nucleus of workers, so I think workers wouldn't be a problem for us. The number we would be handle in Dickinson, a full security facility, is 10-12 female prisoners or male prisoners. In New England, a medium security area, all fenced in, and could take up to 38-40. We have a female dormitory that would handle a minimum of 35 with minimum staff security. In area of experience, we have had a contract with the penitentiary for several years, so we have experience working with them, and have handled some of the most aggressive federal juveniles from 14-21 years old. We do have trained counselors, etc. We could come up with a cost relatively close to $55 on up depending on the programs offered, and the number of inmates being taken care of, if smaller number of inmates, the cost will be a higher. With more inmates, the cost will go down a little.

Rep. Delmore: Would these women be from your area.

Mr. Sickler: No, but if have children, it is good to be located close to their families.

Rep. Delmore: If $55/day is the set amount, would there be other expenses that the state would need to pick up for you in order to make the program work for you.

Mr. Sickler: The contract we are familiar with, with the federal, they pay $45/day, and we provide for the $45/day all the in-house medical.

Chairman DeKrey: Thank you. Any further testimony in support? We will take the opposition now.

Elaine Little, Director of DOCR: (see attached testimony, 14.3-21)

Chairman DeKrey: Wasn't ND sued because the female prisoners weren't getting what the males were.

Ms. Little: Yes, two times, and they won both times.

Rep. Eckre: What is the average women prison stay.

Ms. Little: I'm not sure, if the sentence is 1 year or longer, is usually 31.5 months.

Rep. Onstad: The two previous groups stated the number they would be able handle, those weren't up to your expectations.

Ms. Little: If they provided the kinds of programs we provide, they would find the price is much higher per day, because they have so few inmates at their facilities. Most of those services don't now exist in the county jail that we provide, and in order for them to provide the same level of service, it would increase their prices per day.

Rep. Onstad: You're saying that it would be cheaper to build a new women's prison, vs. working with two smaller or three smaller women's prisons, for example, and bring them up to code? You think it is cheaper to do it with one new building vs. 3 existing facilities that have 80% of the services you require.

Mr. Little: Yes, we would renovate one building at the State Hospital in Jamestown, it would be cheaper, because we would be using federal funds, no general fund money in renovating the facility.

Rep. Grande: Could I have a request proposal for the services that would be necessary for the women's prison.

Ms. Little: That would take a while. We looked at doing that last summer, looked at privatizing the services and what that would cost, so we were looking at putting out a requests for proposals to see what that would cost, but the venders who were contacted told us that we shouldn't even think about having a request for proposal because it takes a long time to put together, and then want 60 days to respond, we could try to put something together for you, but it wouldn't be as comprehensive as what we'd need for a bill administrator make a decision on what cost they would have to charge us.

Rep. Grande: Could I have something on a smaller scale, the types of services that would need to be in place to do the programming you talked about. That would fit very well into what the county's talk about that they have available now. What types of things do you see in the facilities you are already utilizing, that they would have to upgrade to.

Ms. Little: As I mentioned, the way we use the jails now, is to send those who do not need treatment or programming or have refused treatment.

Rep. Grande: You talked about 50% of the inmates that have one year or less sentences. In that, I would think that those are your minimum security inmates. So dealing with that grouping, wouldn't that work.

Ms. Little: Our estimated population is estimated at 135, if half of those are sentenced to a year or less, we're still looking at 65 to 70 minimum custody. The only minimum custody I heard today, was the facility Mr. Stickler talked about, and it would house up to 35.

Rep. Grande: What do they need to do in the other facilities to be prepared to do so.

Ms. Little: Minimum custody has a lot to do with the environment. By definition a county jail is medium or maximum security. We need to provide a place where women are coming from - we need to provide housing for inmates that is close to their families. They wouldn't be able to visit their children if far away from their homes.

Rep. Grande: That being the case, what is being done on your behalf to deal with the number of women who are coming out of Cass County. If I looked at the numbers that were out on the net, the majority of these women that are being incarcerated are from Cass County. Have you looked at housing them in Cass County.

Ms. Little: As of today, out of 100 inmates, 21 are from Cass County. That is not the majority, they have chosen to stay in the Jamestown facility. However, Cass County has been overcrowded for a very long time, not just with the contract with the DOCR. I talked with Bonnie Johnson a week ago, and she mentioned that she had talked with a legislator, and at this time, they are not interested in contracting with us with the number of inmates who are currently being housed there. They are full. They would be interested if we would be looking at building additional pods. Any additional pod would be $1.5 million. That would be just for housing. Any additional programming of any kind would be additional cost to the $1.5 million. Their contract rate as of today is $60/day, but just for housing. Any kind of programming, medical would be on top of that.

Chairman DeKrey: Will future suits be filed if a prisoner is kept in a higher security prison if only supposed to be in a minimum security prison.

Ms. Little: Yes. That is our concern right now.

Chairman DeKrey: Thank you. We will close the hearing now.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1271

House Judiciary Committee

☐ Conference Committee

Hearing Date 2-5-03

Tape Number	Side A	Side B	Meter #
2		xx	30-37.5
Committee Clerk Signature	DPenrose		

Minutes: 13 members present.

Chairman DeKrey: What are the committee's wishes in regard to HB 1271.

Rep. Kretschmar: I move to amend HB 1271, line 7 change "shall" to "may".

Rep. Eckre: Seconded.

Voice vote: Carried.

Rep. Maragos: Move a Do Pass as amended and Rereferred to Appropriations.

Rep. Bernstein: Seconded.

13 YES 0 NO 0 ABSENT **CARRIER: Rep. Maragos**

DO PASS AS AMENDED & REREFERRED TO APPROPRIATIONS

FISCAL NOTE

Requested by Legislative Council
03/24/2003

Amendment to: HB 1271

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	($1,243,727)
Expenditures	$0	$0	$1,934,086	$0	$4,865,915	($1,243,727)
Appropriations	$0	$0	$1,934,086	$0	$4,865,915	($1,243,727)

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The figures in 1A. above represent the fiscal impact this bill has on the House version of the DOCR budget.

The fiscal impact of this bill is dependent on the existence of a qualified state facility for the housing of female inmates. The executive recommendation provides for a qualified state female facility. The House version of the DOCR budget does not provide for a female facility. Following is a description of the fiscal impact of this bill as it applies to 1) the House version of the DOCR budget and 2) the DOCR executive recommendation.

1) HOUSE VERSION - As the 2003-05 DOCR budget currently stands (House version), there is no funding provided for a state owned female facility. The House version provides funding to house all female inmates in county jails. However, it is the opinion of the DOCR, the funding provided in the House version is not adequate. The House version provides a total of $6,642,320 ($5,398,593 general funds; $1,243,727 federal funds). The DOCR estimates the cost of housing females in county jails to be $8,576,406 ($7,332,679 general funds; $1,243,727 federal funds). As a result the DOCR estimates that in order to implement this bill an additional $1,934,086 of general funds would need to be added to the House version of the DOCR budget.

2) EXECUTIVE RECOMMENDATION - As noted above the executive recommendation provides for a qualified state facility to house female inmates. As a result this bill would not have a fiscal impact on the DOCR executive recommendation.

NOTE: The DOCR currently has the authority to contract with counties to house female inmates.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

No fiscal effect

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

If no qualified state facility is available the DOCR estimates the cost to house female inmates in county jails to be $8,576,406 ($7,332,679 general funds; $1,243,727 federal funds) for the 2003-05 biennium and $10,264,508 ($10,264,508 general funds) for the 2005-07 biennium.

If a qualified state facility is available, such as provided for in the DOCR executive recommendation, it is estimated there would not be a need to house females in county jails. As a result there would be no expenditures required.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

As noted in 2. above, if no qualified state facility is available the DOCR would need a total appropriation of $8,576,406 ($7,332,679 general funds; $1,243,727 federal funds). The appropriation amount in the House version of the DOCR budget would need to be increased by $1,934,086 ($1,934,086 general funds).

If a qualified state facility is available, such as provided for in the executive recommendation, an appropriation to house females inmates in county jails would not be necessary.

Name:	Dave Krabbenhoft	**Agency:**	DOCR
Phone Number:	328-6135	**Date Prepared:**	03/24/2003

FISCAL NOTE

Requested by Legislative Council
02/07/2003

Amendment to: HB 1271

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

No fiscal effect. Due to the fact the 2003 - 2005 DOCR executive recommendation provides funding for the acquisition and operation of a womens unit, the DOCR does not anticipate the need to house females inmates outside of the DOCR system. Note: The DOCR currently has the authority to contract with counties to house female inmates.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

No fiscal effect

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

No fiscal effect

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

No fiscal effect

Name:	Dave Krabbenhoft	**Agency:**	DOCR
Phone Number:	328-6135	**Date Prepared:**	02/13/2003

FISCAL NOTE

Requested by Legislative Council
01/14/2003

Bill/Resolution No.: HB 1271

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2001-2003 Biennium		2003-2005 Biennium		2005-2007 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	($804,460)	$0	($804,460)
Expenditures	$0	$0	$266,948	($804,460)	$2,762,201	($804,460)
Appropriations	$0	$0	$266,948	($804,460)	$2,762,201	($804,460)

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2001-2003 Biennium			2003-2005 Biennium			2005-2007 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

The fiscal impact of this bill is very difficult to determine, the amounts reported above are estimated based on a number of unverified assumptions. The assumptions include but are not limited to; county correctional facilities will have adequate space to house female inmates, county correctional facilities will qualify to house female inmates, county correctional facilities will be able to provide necessary educational and vocational programs, chemical dependency treatment programs, mental health programs, medical services, and adequate recreational facilities and that the county correctional facilities would be willing to provide all the above mentioned at a daily rate of $70.15 per inmate. The fiscal impact to counties is not reflected above for the reason that the DOCR is unable to determine the actual cost to the county for housing female inmates as specified in HB1271.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The figures in 1A above reflect the estimated NET fiscal effect on the 2003-05 DOCR executive recommendation as a result of housing female inmates at the county level. As a result of housing all females at the county level the DOCR would lose its ability to contract with the Bureau of Prisons for 20 female inmates. The estimated federal revenue lost from not being able to house BOP inmates is estimated at $804,460.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The figures in 1A above reflect the estimated NET fiscal effect on the 2003-05 DOCR executive recommendation as a result of housing female inmates at the county level. As noted above it is estimated to require an additional $266,948 of general funds in the 2003-05 biennium and an additional $2,762,201 of general funds in the 2005-07 biennium to implement this bill. The estimated daily rate in this fiscal note is $70.15. The 2003-05 total estimated housing cost based on the $70.15 rate is $6,730,612. Please see below for the detail of the net fiscal effect.

Detail of Estimated Fiscal Impact of HB 1271

	2003-05		2005-07	
	General	Other	General	Other
Revenues				
BOP Inmates\1		(804,460)		(804,460)
Total Revenues		(804,460)		(804,460)
Expenditures				
Contract Housing\2	5,486,885	1,243,727	8,124,166	
Administration\3	340,000		340,000	
Women's Unit\4	(5,486,781)	(1,243,727)	(5,486,781)	
Medical\4	(492,495)		(567,385)	
Food\4	(334,245)	(50,876)	(401,383)	(50,876)
Positions\5	753,584	(753,584)	753,584	(753,584)
Total Expenditures	266,948	(804,460)	2,762,201	(804,460)

\1 - Revenues based on 20 BOP female boarder inmates charge a daily rate of $55.10

\2 - 2003-05 contract housing amount based on estimated average female population of 131 at a $70.15 estimated daily rate. The estimated daily rate consists of the following:

$53.75 - estimated average county housing daily rate

$ 9.92 - estimated daily medical cost

$ 6.48 - estimated daily programming cost

The estimated contract housing amount for the 2005-07 biennium is based on an estimated average female population of 158 at a $70.15 estimated daily rate.

\3 - Amount based on 4 FTE (2 transport officers, 1 program manager, 1 account technician), and mileage costs

$137,400 - Transport Officers

$100,000 - Program Manager

$ 60,415 - Account Technician

$ 42,185 - Fleet Services Charges (900 miles per week @ 41.5 cents per mile)

\4 - Expenditures budgeted for in the 2003-05 DOCR executive recommendation that would be affected if HB 1271 is passed into law

\5 - Positions funded with BOP inmate revenue in the 2003-05 DOCR executive recommendation, if HB 1271 is passed into law federal revenue would not longer be available

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

The estimated NET amounts reflected above document the estimated necessary adjustments required to be made to the DOCR 2003-05 executive recommendation if this bill is passed into law. Again it is very important to note that the figures represented above are rough estimates based on a number of unverified assumptions.

Name:	Dave Krabbenhoft	**Agency:**	DOCR
Phone Number:	328-6135	**Date Prepared:**	01/22/2003

30327.0101
Title.0200

Adopted by the Judiciary Committee
February 5, 2003

VR
2/5/03

HOUSE AMENDMENTS TO HOUSE BILL NO. 1271 JUD 2/6/03

Page 1, line 7, replace "shall" with "may"

Renumber accordingly

Date: 2/5/03
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1271

House Judiciary Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 30327.0101 .0200

Action Taken Do Pass As Amended

Motion Made By Rep. Maragos Seconded By Rep.

Representatives	Yes	No	Representatives	Yes	No
Chairman DeKrey	✓		Rep. Delmore	✓	
Vice Chairman Maragos	✓		Rep. Eckre	✓	
Rep. Bernstein	✓		Rep. Onstad	✓	
Rep. Boehning	✓				
Rep. Galvin	✓				
Rep. Grande	✓				
Rep. Kingsbury	✓				
Rep. Klemin	✓				
Rep. Kretschmar	✓				
Rep. Wrangham	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Rep. Maragos

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 14, 2003 10:56 a.m.

Module No: HR-29-2723
Carrier: Maragos
Insert LC: 30327.0101 Title: .0200

REPORT OF STANDING COMMITTEE

HB 1271: Judiciary Committee (Rep. DeKrey, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1271 was placed on the Sixth order on the calendar.

Page 1, line 7, replace "shall" with "may"

Renumber accordingly

2003 SENATE POLITICAL SUBDIVISIONS

HB 1271

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **HB 1271**

Senate Political Subdivisions Committee

☐ Conference Committee

Hearing Date **March 6, 2003**

Tape Number	Side A	Side B	Meter #
1		X	1623 - End
2	X		0 - 2361

Committee Clerk Signature Shirley Lorge

Minutes:

CHAIRMAN COOK opened the hearing on HB 1271. All members (6) in attendance.

CHAIRMAN COOK opened the hearing on HB 1271 relating to the housing of female inmates.

REPRESENTATIVE GRANDE, District 41, Fargo ND, introduced HB 1271. This bill does have one amendment that was made. It was a one word change but definitely changes the bill. We went from a shall to a may but even in doing so this bill still hold a lot on importance to the people in the state. This bill was drafted so they would have encouragement for the director of corrections to utilize the qualified county jails to house the female inmates. This came about because of the need for housing of fem le inmates in our state and the fact that there are excellent county facilities available that are not being utilized. Some of the people here will address you with their facilities and their willingness to participate in the housing of these inmates. The reason we need this bill is to push for use of these facilities because it is not being done to the extent possible. First this would give much needed dollars back to the counties because the

counties would be utilizing these facilities that aren't full right now. Secondly, there is a need for space for women inmates. These inmates could be housed in these facilities. Currently 50% of these inmates are considered minimum security inmates. Less than 50% of these inmates are serving less than one year and that would be another great qualification these facilities have. They have good programs in place. One of the things she requested of the committee is at the end of line 13, changing the period to a coma and then stating when requested by the department of corrections. In doing so, what it does is allows the county department of corrections to utilize some facilities for one or two inmates for a short period of time when needed or then at the time needed they would put together a full contract. This gives them contract ability for a larger amount of inmates for a longer period of time. We wanted to make sure that the counties were not being shut out because of what was written there and we don't want to limit the department of correction from having the ability to contract out when the need be.

SENATOR COOK said he notice that changing the word shall to may definitely changed the fiscal note.

REPRESENTATIVE GRANDE answered that it certainly did. Initially when the word shall was in there, the department of corrections felt that that was a mandate to them and that they must take all female inmates out of the facilities and utilize only county facilities and that was not the intention of the bill.

Norbert Sickler, Administrator of the Southwest Multi-County Correction Center, Dickinson, ND appeared to identify some of the services that they have available, so should the legislature and the department of corrections decide to utilize there services, they wanted to make sure that

the committee is acquainted with the services and that they can provide services that are required. (Se . attached handout)

Dick Johnson, Lake Region Law Enforcement Center, Devils Lake, ND, appeared in support of HB 1271. They feel it gives an option for the committee to consider . They are not opposed to DOCR. They feel there is an option that would be good for the county facilities and increase their revenue, cost effective for the state on a long term basis. In their facility they would be able to handle thirty females and they do have a complete program because they are required to do that under their federal program.

Glenn Giese, New England, appeared in support of HB 1271. There was a study done a few years ago and that showed that a job in a small town was probably equal to two hundred jobs in a larger city, so the impact would be great. (Passed out some pictures for the committee to look at) He feels they have a very good facility in excellent shape.

John Olson, appeared for ND State Attorneys, They feel this is a good bill and encourage a Do Pass.

Testimony Opposed to HB 1271

Elaine Little, Director of the Department of Corrections and Rehabilitation. She is not really opposing HB 1271 in its current form. With the amendment it took the bill from being a mandatory bill of housing all the women inmates in jail to permissive. They have been contracting with the county for ten years too house many of their inmates but until recently the facilities around the state didn't have female beds available. They do have some major concerns about utilizing a number of different facilities around the state on a contract basis as a women's prison. We can't handle the women inmates different than we do males. We aren't contracting

all the males out around the state, so legally we would be challenged if we try to contract the women around the state. She doesn't have a concern with the bill as it is stated.

Discussion regarding women inmates by committee; Tape 2 Side A Meter # 936 -2351.

No other testimony.

CHAIRMAN COOK closed the hearing on HB 1271.

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1271

Senate Political Subdivisions Committee

☐ Conference Committee

Hearing Date March 13, 2003 (Discussion and Action)

Tape Number	Side A	Side B	Meter #
2	X		452 - 2201

Committee Clerk Signature Shirley Lorg

Minutes:

SENATOR COOK told the committee HB 1271 relates to the hearing we had last week on housing female inmates. There are two suggested amendments. John Olson suggested an amendment that put language in that would give the prosecuting judge the opportunity to put female prisoners where they felt would be most appropriate.

SENATOR JUDY LEE said it is difficult to hear that there is a fine facility in Southwest North Dakota that no one is using right now, but realizes that the majority of the prisoners are not in Southwest North Dakota. How do we decide between the facilities and the services. The challenge is that the facilities are not where the services need to be.

SENATOR COOK said he seen in the testimony that one of the options was to sell this place to the Department of Corrections.

SENATOR SYVERSON asked if it would be appropriate to have an amendment written to include leaving the option up to the judge based on what this 58th session decides.

Continued discussion; Tape 2 , Side A Meter # 830 - 1648

SENATOR COOK said that he thinks the committee should amend the bill and get it to the floor.

SENATOR JUDY LEE moved an amendment on HB 1271.

SENATOR CHRISTENSON seconded the motion.

Roll call vote: Yes 6 No 0 Absent 0

SENATOR JUDY LEE moved a DO PASS as AMENDED.

SENATOR POLOVITZ seconded the motion

Roll call vote: Yes 6 No 0 Absent 0

Carrier: **SENATOR COOK**

30327.0201
Title.0300

Adopted by the Political Subdivisions Committee
March 13, 2003

3-14-03

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1271

Page 1, line 6, replace "The" with "If there is no qualified state facility available, the"

Page 1, line 7, replace "may" with "shall"

Renumber accordingly

Date: 3/13/03
Roll Call Vote #: 1

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1271

Senate Political Subdivisions Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 1271 30327.0201

Action Taken Adopt the amendments

Motion Made By Judy Lee Seconded By Sen. Christenson

Senators	Yes	No	Senators	Yes	No
Senator Dwight Cook, Chairman	V				
Senator John O. Syverson, V C	V				
Senator Gary A. Lee	V				
Senator Judy Lee	V				
Senator Linda Christenson	V				
Senator Michael Polovitz	V				

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3/13/03
Roll Call Vote #: 2

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1271

Senate Political Subdivisions Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number ~~1271~~ 30327.0201

Action Taken Do Pass as amended

Motion Made By Judy Lee Seconded By Sen Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Dwight Cook, Chairman	✓				
Senator John O. Syverson, V C	✓				
Senator Gary A. Lee	✓				
Senator Judy Lee	✓				
Senator Linda Christenson	✓				
Senator Michael Polovitz	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. Cook.

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 17, 2003 8:55 a.m.

Module No: SR-47-4864
Carrier: Cook
Insert LC: 30327.0201 Title: .0300

REPORT OF STANDING COMMITTEE

HB 1271, as engrossed: Political Subdivisions Committee (Sen. Cook, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1271 was placed on the Sixth order on the calendar.

Page 1, line 6, replace "The" with "If there is no qualified state facility available, the"

Page 1, line 7, replace "may" with "shall"

Renumber accordingly

2003 TESTIMONY

HB 1271

SOUTHWEST MULTI-COUNTY CORRECTION CENTER

66 Museum Drive, Dickinson, ND 58601
Phone: (701) 264-7790, Fax: 701-264-7687
Norbert V. Sickler, Administrator
Participating Counties: Billings, Bowman, Dunn, Hettinger, Slope, and Stark

December 13, 2002

Elaine Little, Director
Department of Corrections and Rehabilitation
PO Box 5521
Bismarck, ND 58506-5521

REF: Proposed Women's Lockup for State Inmates

Dear Ms. Little:

The Board of Directors and Administrator of the Southwest Multi-County Correction Center are prepared to propose to the State of North Dakota an option for dealing with the overflow of women prisoners. We have a facility at New England, ND, along with a facility in Dickinson that have the capacity to house and administer services to approximately 40-65 female inmates.

We are prepared to offer the state any of the following options in reference to the New England Facility:

Option #1

- To sell the facility to the State of North Dakota to be utilized within their expansion program for women prisoners. The facility has been renovated to provide security, treatment, education, and food services. To date, we have invested $400,000.00 in renovations to the facility, making it relatively ready for use.

Option #2

- To lease the facility to the State of North Dakota for a time period. This would be beneficial to both the State and the Southwest Multi-County Correction Center.

Option #3

- The Southwest Multi-County Correction Center would enter into an agreement with the North Dakota Department of Corrections and Rehabilitation to provide services for approximately 40-65 female prisoners with an agreement for a daily reimbursement rate to be determined through negotiations. The services would include:

Mental Health

- Assessment to determine mental health diagnosis.
- Therapeutic sessions to include individual, group, family, play therapy for visiting dependents, and victim awareness, etc.
- Psychotropic medication management provided by a psychiatrist, along with the services of a psychologist and registered psychiatric nurse.

Educational/Vocational

- Initial assessments to determine any learning disabilities and academic achievements.
- Educational classes enabling the inmate to obtain credits towards, and eventually earn, a diploma for GED, high school, college courses, along with courses enabling the individual to improve their academic skills.
- Vocational courses, including computer courses that will provide the individual with certification in programs such as Microsoft Word, Excel, Access and Power Point. Courses will also be available in food handling services.
- Life enrichment courses such as: living skills, parenting, legal aspects, sex education, gangs, anger, health, career development, and library usage.

Medical Services

- Initial physical examinations to include medical history, dental, vision, and follow-up treatment for any identified need areas.

Spiritual

- Initial assessments to determine spiritual therapeutic needs, along with followed up services in the areas of grief, forgiveness, encouragement of spiritual involvement, etc.

Substance Abuse

- An initial assessment to determine past history involvement, as well as treatment needs.
- Treatment would include an initial day-treatment program to be followed up by an intensive outpatient program, as well as a low-intensity, continuing care program.
- Treatment would also include a "Prime for Life" component, which is an educational-based chemical awareness program designed to provide individuals with the power of choice.

Leisure/Wellness

- An initial assessment to determine the level of prior education and knowledge, to be followed up by classes, in the areas of nutrition, personal hygiene, meditation and relaxation techniques. Methods of therapy would include music therapy, arts and crafts, equestrian therapy, horticulture, athletics and physical education, cultural awareness, drama, as well as high venture activities, which is a program currently utilized at the Dickinson facility.

All of the above treatment programs are administered to our present lockup population by state-licensed addiction counselors within a state-licensed addiction program. Special emphasis will be placed on working with and treating inmates who have developed a need for a methamphetamine treatment program.

We recognize that women have specialized substance abuse treatment needs. Methamphetamine addicts also require a specialized approach. Our program believes that traditional treatment does not necessarily address these specific needs. Therefore, we have developed an effective, holistic, therapeutic approach that includes alternative therapies. A more extensive and in-depth description of each program could be made available to you in the future.

We are hopeful that the North Dakota Department of Corrections and Rehabilitation will give serious consideration to this option of dealing with the influx of women prisoners, especially those with a history of methamphetamine usage.

I would invite you and your staff to visit our facilities and our present programming, to self determine the quality of the facility and the programming we offer. I would also be willing to schedule a meeting for you and your staff to meet with our New England Liaison Committee in order to gain first-hand knowledge as to the acceptance by the local residents to the program outlined herein.

I thank you for any consideration you would give to this proposal.

Sincerely,

Norbert V. Sickler, Administrator

NVS/rb

Cc: Office of the State Governor
Office of the Attorney General

39508

Prepared by the North Dakota Legislative Council staff for Representative Grande
December 2002

WOMEN'S PRISON ALTERNATIVE

The following table compares the costs of the 2003-05 executive budget recommendation of purchasing the LaHaug Building from the State Hospital and renovating it into a women's prison and the alternative of contracting for prison space instead of building a women's prison. This alternative assumes that contract beds would be available, which is uncertain at this time. Any cost-savings is dependent upon the state being able to contract for any necessary beds.

	Executive Budget Recommendation - Women's Prison in LaHaug Building		Alternative - Contract for Extra Beds Required Rather Than Construct a Women's Prison
Costs	General Fund	Federal Funds	General Fund
Acquisition	$0	$400,000	$0
Renovation	0	843,727	0
Operating	5,341,590	0	0
Contracting	0	0	3,700,544
Total	$5,341,590 [1]	$1,243,727	$3,700,544 [2]

[1] A total of $5,466,781 is included in the 2003-05 executive budget for operating the women's facility. Also a 3 percent reduction was applied to the salaries and wages component ($4,839,705) to recognize savings from vacant positions and delays in filling positions in the amount of $145,191, resulting in the cost shown of $5,341,590.

[2] The population projections used for computing the cost of contracting prisoners assume the targets of aggressive parole and drug court expansion are met. The number of women to be contracted was computed at a rate of $56 per day at Cass County jail, the amount provided by the requester, and the beds needed ranged from 31 to 98 per month. The current rate charged by the Cass County jail to house prisoners is $50 per day for federal prisoners and $42 per day for county and city prisoners. Officials of the Cass County jail indicated they expect to be at capacity by April or May 2003, based on the current rate of growth. The number of men to be contracted was computed at a rate of $50 per day at the Appleton, Minnesota, private prison, which is the current rate North Dakota pays to house inmates at Appleton, and the beds needed ranged from 12 to 65 per month. Representatives of the Department of Corrections and Rehabilitation indicated the private prison in Appleton is currently at capacity.

If contract beds are available, which is uncertain, the alternative could result in approximately $1.64 million in a general fund savings for the 2003-05 biennium to contract out prisoners instead of locating a women's prison in the LaHaug Building.

DEPARTMENT OF CORRECTIONS AND REHABILITATION

3303 East Main, PO Box 1898 • Bismarck, ND 58502-1898
(701) 328-6390 • FAX (701) 328-6651 • TDD 1-800-366-6888
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Testimony on HB 1271
House Judiciary Committee
Representative Duane DeKrey, Chairman
January 29, 2003

The Department of Corrections and Rehabilitation (DOCR) is here today to testify against HB 1271. There a number of reasons that we do not believe that housing all female inmates in county jails would be a viable alternative. County jail cell availability for female inmates and legal issues of providing equal housing and program access to both male and female inmates are just two of the major issues that the State would face were this bill passed.

There are presently 100 female inmates in the DOCR's custody. We have contracted with a number of county jails to house both male and female inmates in the past 10 years. Our experience with the county jails is that there are few female beds available in the county jails. In June 2002 the female inmate population reached an all time high of 135. At that time, even though we were very overcrowded and searching for appropriate affordable county jail housing for the women, we were able to access only a few beds in county jails to ease the overcrowding in our prison for the female inmates. Many of the jails either have few or no female beds or female staff needed to house women inmates.

There are many other issues in contracting out the female inmates to the county jails in addition to the bed space issue. As noted in the bill, the county jail would have to be able to meet all of the security level, medical, treatment, education, vocational education, mental health and recreational needs that are provided by the Department. Presently county jails provide very limited medical and/or no treatment, education, industry programs or mental health services. Also, the majority of women inmates are minimum custody; the county jails have primarily maximum and medium custody cells. This is one of the major reasons the Department of Corrections is requesting to move the women who are housed in the JRCC into a separate women's prison that can separate the women by custody level and provide services appropriate for women inmates. A majority of the 100 women inmates are minimum custody but the DOCR has only 14 minimum custody beds. There is also no minimum-custody jail facility in the state that could house between 70-100 minimum custody women in the next biennium. Another issue relating to housing the women inmates in county jails is that the NDCC provides that inmates can be housed in a jail for a maximum of one year. During 2002 alone 51 women were admitted to prison with sentences longer than one year (average 31.7 months to

serve). Women inmates with more than one year to serve would need to be transported to a new jail each time they had served one year in a particular jail.

It's important that the women can be located in a women's unit or prison separate from male inmates. The Department of Corrections and Rehabilitation provides a system of services to the inmate population. This system includes case planning and management for the inmate from the time they enter the prison through the provision of aftercare services in the community if they are on parole or probation following their incarceration. In order that the female population has equal access to the same services as the male population it will be important that the female inmates continue to have access to this system of case management and treatment services. These services are important for access to the parole board and other community programs. All of these services could not be duplicated in every jail that might house female inmates on contract.

In addition to the facts that adequate and appropriate housing for the women inmates does not exist today in the county jails and that the county jails could not meet the system of services that are available to them in the DOCR, it would also become very costly to contract out all women inmates. By the 2005-2007 biennium we estimate that conservatively it would cost over $2 million more to contract the women to county jails than to house them in a separate building on the grounds of the JRCC as proposed in the Executive Recommendation.

Another issue that would be of concern for the DOCR and for the counties, I believe, is transportation of female inmates from the sentencing court to the contract jail. Presently all counties transport the inmate after sentencing to the JRCC, which is a centrally located facility for the counties from which the majority of women inmates are sentenced. It is important that the jail facility which houses the majority of the women inmates is centrally located, not only for purposes of transportation, but also to allow for family visitation, etc.

In summary, based upon current unavailability of jail cells for female inmates, the lack of program services in the jails, the legal issues of providing equal services to male and female inmates and the higher cost in future biennia to contract out all female inmates, the Department of Corrections and Rehabilitation does not believe that housing all women inmates in county jails is a feasible or appropriate alternative.

Submitted by Elaine Little
Director

Chris Dale Lyle # 05468-013
ADX Florence, Colorado
Supermax, Control Unit,
9-10-97 — 7-11-2001
State No. 22143
OCT 11 1999
D. Joyce Lipson

Stuart Grassian, M.D.
401 Beacon Street
Chestnut Hill, MA. 02467
Phone: 617-244-3315
Fax: 617-244-2792

PSYCHIATRIC EFFECTS OF SOLITARY CONFINEMENT

My name is Dr. Stuart Grassian. I am a Board Certified Psychiatrist and have been on the faculty of the Harvard Medical School since 1974. I have very substantial experience in evaluating the psychiatric effects of solitary confinement, and have been retained in class action suits concerning this issue in the states of Massachusetts, New York, Kentucky, and California, and have also evaluated and testified regarding the effects of such conditions in other lawsuits in Massachusetts, Texas, Georgia and Florida.

I have been on the teaching staff of Beth Israel Hospital continually since 1977, and have been from time to time on the faculty of major medical meetings, including the American Academy of Psychiatry and Law, and the American Psychiatric Association Institute on Hospital and Community Psychiatry. I have lectured on the subject of the psychiatric effects of solitary confinement in various settings, including Beth Israel Hospital/Harvard Medical School. I have published two articles on the subject of the psychological effects of solitary confinement, and am in the process of preparing a third article on this subject, based upon clinical data compiled as part of my involvemant as a psychiatric expert in Madrid v. Gomez, a class action suit concerning conditions at Pelican Bay State Prison, California's "supermax" prison facility.

In addition to my involvement in these cases concerning the effects of solitary confinement, I have also been retained as an expert in other areas of civil litigation, especially involving the psychological effects of trauma and childhood sexual abuse. In the past several years, I have been involved in continuing research regarding the effects of childhood sexual abuse and the manner in which memory of such abuse is maintained over the years; one paper stemming from this research has been submitted for publication, and a revised version will be incorporated as a chapter of a book, Trauma and Memory, to be published by Harvard University Press. I have also lectured on these subjects at various academic conferences. I am Board subspecialty certified by the ABPN in Forensic Psychiatry.

The information which follows is based upon my experience, research, and testimony. All of it has appeared either in previously published material and/or in court testimony and opinions of various State and Federal courts.

I. Summary of Opinions.

In my opinion, solitary confinement -- that is, confinement of a prisoner alone in a cell for all or nearly all of the day, with minimal environmental stimulation and minimal opportunity for social interaction -- can cause severe psychiatric harm. This harm includes a specific syndrome which has been reported by many clinicians in a variety of settings, all of which have in common features of inadequate, noxious and/or restricted environmental and social stimulation. In more severe cases, this syndrome is associated with agitation, self-destructive behavior, and overt psychotic disorganization.

In addition, solitary confinement often results in severe exacerbation of a previously existing mental condition, or in the appearance of a mental illness where none had been observed before. Even among inmates who do not develop overt psychiatric illness as a result of confinement in solitary, such confinement almost inevitably imposes significant psychological pain during the period of isolated confinement and often significantly impairs the inmate's capacity to adapt successfully to the broader prison environment.

Moreover, although many of the acute symptoms suffered by inmates are likely to subside upon termination of solitary confinement, many -- including some who did not become overtly psychiatrically ill during their confinement in solitary -- will likely suffer permanent harm as a result of such confinement. This harm is most commonly manifested by a continued intolerance of social interaction, a handicap which often prevents the inmate from successfully readjusting to the broader social environment of general population in prison and, perhaps more significantly, often severely impairs the inmate's capacity to reintegrate into the broader community upon release from imprisonment.

In my experience, many inmates housed in such stringent conditions are extremely fearful of acknowledging the psychological harm or stress they are experiencing as a result of such confinement. This reluctance of inmates in solitary confinement is in substantial measure a response to the perception that such confinement is an overt attempt by authorities to "break them down" psychologically, and in my experience, tends to be more severe when the inmate experiences the stringencies of his confinement as being the product of an arbitrary exercise of power, rather than the fair result of an inherently reasonable process. Furthermore, in solitary confinement settings, mental health screening interviews are often conducted at the cell front, rather than in a private setting, and inmates are generally quite reluctant to disclose psychological distress in the context of such an interview, since such conversation would inevitably be heard by other inmates in adjacent cells, exposing them to possible stigma and humiliation in front of their fellow inmates.

Lastly, the adverse impact of punitively imposed solitary confinement will generally be far more severe than the effect of such confinement when it is imposed for administrative purposes, since by intent, punitive solitary confinement imposes

stringencies and deprivations which are in excess of those which are minimally required to maintain an inmate in segregated confinement; such stringencies often include limitations on programming, occupational and educational opportunities, visitation, use of telephone, television and radio access, and access to reading materials, among others. Conversely, inmates housed in segregation for administrative reasons -- such as for the protection of the inmate himself from possible harm by other inmates -- will often retain access to these many of the same opportunities and privileges as provided to inmates housed in congregate housing.

Indeed, the insititutional policies which create different conditions in administrative segregation, as opposed to punitive segregation, reflect an important underlying reality -- that "institutional security" actually is employed to mean two very different things. The narrower usage of the term reflects concerns about the safety of the individual inmate being housed, as well as the safety of those with whom he has contact. The broader use of the term, however, is fundamentally unbounded -- or at least, has boundaries which are not really distinguishable from the the broad purposes of any system of criminal justice. The harsh stringencies which are employed in punitive segregation reflect institutional assumptions that the harshly painful deprivations assoicated with a sentence to punitive solitary confinement, will serve as a deterrence to <u>other</u> inmates who might be tempted to break institutional rules. This rationale for imposing pain on an offender -- the rationale that the punishment of <u>this</u> offender by his society might deter <u>other</u> possible offenders -- is simply a rationale for <u>any</u> system of criminal justice and punishment. A fifteen year sentence of punitive solitary confinement is an imposition of pain of staggering proportions. If, in response to one offense, both the prison institution <u>and</u> the broader society can <u>each</u> impose so heavy a burden of harm and pain upon the putative offender in order to deter other possible future offenders, then it seems to be an inescapable conclusion that this putative offender <u>is</u>, indeed being exposed to double jeopardy.

II. <u>SOLITARY CONFINEMENT CAN CAUSE SEVERE PSYCHIATRIC HARM</u>

A. <u>Solitary Confinement Can Cause a Specific Psychiatric Syndrome</u>.

During the course of my involvement as an expert, I have had the opportunity to evaluate the psychiatric effects of solitary confinement in well over 100 prisoners in various state and federal penitentiaries. I have observed that for many of the inmates so housed, incarceration in solitary caused either severe exacerbation or recurrence of preexisting illness, or caused the appearance of an acute mental illness in individuals who had previously been free of any such illness.

I became aware of the particular toxicity of solitary confinement when I first had the opportunity to evaluate prisoners in solitary confinement as a result of my involvement in a class action lawsuit in Massachusetts, <u>Libby v. Hogan</u>, which challenged conditions in solitary confinement at the maximum security State

challenged conditions in solitary confinement at the maximum security State Penitentiary in Walpole, Massachusetts. The clinical observations I made in the course of my involvement in that lawsuit, coupled with my research into the medical literature concerning this issue, have formed the basis of two articles I have since published on this topic in peer-reviewed journals. These are: 1. Grassian, S.(1983),"Psychopathological Effects of Solitary Confinement". American Journal of Psychiatry; 140, 1450-1454. 2. Grassian, S. and Friedman, N. (1986), "Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement". International Journal of Law and Psychiatry, 8, 49-65. These articles are included as Appendices E and F of this declaration. Moreover, my subsequent professional experience has included observations of similar phenomena in many other solitary confinement settings.

When I initially agreed to evaluate the Walpole prisoners, I had not yet reviewed the literature on the psychiatric effects of solitary confinement and, indeed, I was somewhat skeptical; I expected that inmates would feign illness and exaggerate whatever psychiatric symptomatology they suffered. I discovered, however, something very different. Contrary to my expectations, the prisoners appeared to be extremely defensive about the psychiatric problems they were suffering in SHU; they tended to rationalize away their symptoms, avoid talking about them, or deny or distort their existence, all in an apparent effort to minimize the significance of their reactions to isolation. Numerous interviews began with statements such as "solitary doesn't bother me" or "some of the guys can't take it -- not me", or even with the mention of a symptom and a simultaneous denial of its significance: "As soon as I got in I started cutting my wrists. I figured it was the only way to get out of here."

As my interviews progressed, these facile accounts gave way to descriptions of experiences which were very worrisome. For example, one inmate was unable to describe the events of the several days surrounding his wrist-slashing, nor could he describe his thoughts or feelings at the time. Similarly, the prisoner who said he could "take it" eventually came to describe panic, fears of suffocation, and paranoid distortions which he suffered while in isolation. Moreover, the specific psychiatric symptoms reported were strikingly consistent among the inmates:

1. The Specific Psychiatric Syndrome Associated with Solitary Confinement.

a. Hyperresponsivity to External Stimuli

More than half the prisoners reported a progressive inability to tolerate ordinary stimuli. For example, "You get sensitive to noise -- the plumbing system. Someone in the tier above me pushes the button on the faucet ... its too loud, gets on your nerves. I can't stand it. I start to holler."

b. Perceptual Distortions, Illusions, and Hallucinations

Almost a third of the prisoners described hearing voices, often in whispers,

Almost a third of the prisoners described hearing voices, often in whispers, often saying frightening things to them. There were also reports of noises taking on increasing meaning and frightening significance. For example, "I hear noises, can't identify them -- starts to sound like sticks beating men, but I'm pretty sure no one is being beaten ... I'm not sure." These perceptual changes at times became more complex and personalized: "They come by with four trays; the first has big pancakes. I think I am going to get them. Then someone comes up and gives me tiny ones -- they get real small, like silver dollars. I seem to see movements -- real fast motions in front of me. Then seems like they are doing things behind your back -- can't quite see them. Did someone just hit me? I dwell on it for hours."

c. Panic Attacks

Well over half the inmates interviewed described severe panic attacks while in SHU.

d. Difficulties with Thinking, Concentration and Memory

Many reported symptoms of difficulty in concentration and memory; for example, "I can't concentrate, can't read ... Your mind's narcotized. Sometimes can't grasp words in my mind that I know. Get stuck, have to think of another word. Memory's going. You feel like you are losing something you might not get back." In some cases this problem was far more severe, leading to acute psychotic, confusional states. One prisoner had slashed his wrists during such a state and his confusion and disorientation had actually been noted in his medical record.

e. Intrusive Obsessional Thoughts: Emergence of Primitive Aggressive Ruminations

Almost half the prisoners reported the emergence of primitive aggressive fantasies of revenge, torture, and mutilation of the prison guards. In each case, the fantasies were described as entirely unwelcome, frightening and uncontrollable. For example, "I try to sleep 16 hours a day, block out my thoughts -- muscles tense -- think of torturing and killing the guards -- lasts a couple of hours. I can't stop it. Bothers me. Have to keep control. This makes me think I'm flipping my mind ... I get panicky -- thoughts come back -- pictured throwing a guard in lime -- eats away at his skin, his flesh -- torture him -- try to block it out, but I can't."

f. Overt Paranoia

Almost half the prisoners interviewed reported paranoid and persecutory fears. Some of these persecutory fears were short of overt psychotic disorganization. For example: "Sometimes get paranoid -- think they meant something else. Like a remark about Italians. Dwell on it for hours. Get frantic. Like when they push buttons on the sink. Think they did it just to annoy me." In other cases this paranoia deteriorated into overt psychosis: "Spaced out. Hear singing.

cases this paranoia deteriorated into overt psychosis: "Spaced out. Hear singing, people's voices, 'Cut your wrists and go to Bridgewater and the Celtics are playing tonight.' I doubt myself. Is it real? ... I suspect they are putting drugs in my food, they are putting drugs in my cell ... The Reverend, the priest -- even you -- you're all in cahoots in the Scared Straight Program."

g. Problems With Impulse Control

Slightly less than half of the prisoners reported episodes of loss of impulse control with random violence: "I snap off the handle over absolutely nothing. Have torn up mail and pictures, throw things around. Try to control it. Know it only hurts myself." Several of these prisoners reported impulsive self-mutilation; "I cut my wrists many times in isolation. Now it seems crazy. But every time I did it, I wasn't thinking -- lost control -- cut myself without knowing what I was doing."

2. This Syndrome has the Characteristics of an Acute Organic Brain Syndrome -- a Delirium.

Clearly, these symptoms were very dramatic, and they moreover appeared to form a discrete syndrome -- that is, a constellation of symptoms occurring together and with a characteristic course over time, thus suggestive of a discreet illness. Moreover, this syndrome was strikingly distinct from the more common array of functional psychiatric illnesses -- indeed, some of the symptoms described above are found in virtually none of these disorders: Acute dissociative, confusional psychoses are a rare phenomenon in psychiatry; random, impulsive violence in the context of such confusional state is even more unusual. Moreover, the type and extent of perceptual disturbances seen in this syndrome are exceedingly uncommon among the functional psychiatric illnesses. For example, loss of perceptual constancy (objects becoming larger and smaller, seeming to "melt" or change form, sounds becoming louder and softer, etc.) is very rare, and when found is far more commonly associated with neurologic illness (especially seizure disorders and brain tumors affecting sensory integration areas of the brain) then with primary psychiatric illness. (When seen in primary psychiatric illness, it is basically only seen in especially severe, insidious, early onset schizophrenia -- the kind of schizophrenic illness which has always been thought to clinically "feel" like a fundamentally biological/neurologic disease.)

In addition, functional psychiatric illness very rarely presents with such severe and florid perceptual distortions, illusions, and hallucinations simultaneously affecting multiple perceptual modalities -- auditory, visual, olfactory, tactile, kinesthetic. (In fact, in the more common psychotic illnesses such as schizophrenia and psychotic depression, auditory hallucinations are by far the most common type, visual hallucinations come a distant second, and hallucinations in all other modalities are actually very uncommon; moreover, combined modality hallucinations -- other than the combination of auditory with visual -- are exceedingly rare.)

Similarly, hyperresponsivity to external stimuli with a dysesthetic

Similarly, hyperresponsivity to external stimuli with a dysesthetic (subjectively painful) response to such stimuli, is likewise rare; in fact it is exceedingly rare, so rare that appearance of this symptom also would tend to suggest an organic -- brain dysfunction -- etiology. (This symptom is similar, for example, to the experience many people have during a febrile illness of finding any touching of their body exceedingly unpleasant or the inability of a patient with a headache to tolerate an even ordinary volume of sound, or the inability of some pregnant women to tolerate even ordinary smells without becoming nauseated.)

Thus, the fact that all of these quite unusual symptoms ran together in the same syndrome was itself a clear confirmation of the distinct nature of this syndrome. While this syndrome is strikingly atypical for the functional psychiatric illnesses, it is in fact quite characteristic of an acute organic brain syndrome -- that is, delirium, a syndrome characterized by a decreased level of alertness, EEG abnormalities, and by the same perceptual and cognitive disturbances, fearfulness, paranoia, and the same agitation and random, impulsive and self-destructive behavior which I observed in the Walpole population.

Moreover, delirium is a syndrome which is known to result from the type of conditions -- including restricted environmental stimulation -- which are characteristic of solitary confinement; even the EEG abnormalities characteristic of delirium have been observed in individuals exposed to conditions of sensory deprivation. By now, the potentially catastrophic effects of restricted environmental stimulation have been the subject of a voluminous medical literature; annual international symposia are being held on the subject, and the issue has even found its way into the popular media. (This literature is summarized in the appendices to this letter.)

B. Psychiatric Disturbances Occurring in Other Settings of Restricted Environmental Stimulation

My involvement in class-action lawsuits in New York State, California and Kentucky has yielded observations of the effects of solitary confinement which are quite parallel to my observations at Walpole. (The findings at Pelican Bay State Prison, California, are discussed at Paragraphs 73-77 of this affidavit, and those at the Federal Correctional Institute at Lexington, Kentucky are found in paragraph 78.)

In addition, earlier published reports on the effects of solitary confinement describe findings which are quite similar to my observations at Walpole. In addition, a pattern of psychiatric disturbances similar to those I found at Walpole have been seen in a variety of other -- non-prison -- settings, all of which, however, share in common features of restricted environmental stimulation:

These latter have included observations of prisoners of war, of hostages, of patients with impairment of their sensory apparatus (for example, hearing or visually impaired patients), of patients confined in the intensive care unit, of patients undergoing long term immobilization in hospital (e.g. spinal traction patients), of observations of psychiatric difficulties suffered by explorers (for example, Arctic and

observations of psychiatric difficulties suffered by explorers (for example, Arctic and Antarctic exploration by individuals and small groups) and of observations of difficulties encountered by pilots during solo jet flight.

In all of these situations, despite the multiple differences which exist between them, the very same syndrome emerges. The literature documenting this fact is well-known, rich and detailed. It is reviewed in the Appendices to this declaration.

C. The Historical Experience With Solitary Confinement: The Nineteenth Century Experience.

1. The Origin of the American Penitentiary and the Nineteenth Century German Experience.

Preindustrial societies often did not make any fundamental distinction between deviant behavior seen as the product of "criminal intent" as opposed to behavior seen as stemming from "mental illness." For such societies, deviant behavior -- whatever its origins -- was a social evil that was deeply feared and cruelly punished.

But in the early nineteenth century, a surge of great social optimism swept over America, and perhaps an overly optimistic faith in the possibility of rehabilitation of persons whose behavior was deviant. Not coincidentally, this spirit gave rise virtually simultaneously to two great social reform movements in the United States: the development of large mental hospitals and the construction of the first large penitentiaries.

Both of these institutions were founded upon the premise that psychological and social deviance was largely a result of the evils and stresses of "modern society", and both held a fundamental belief that healing would naturally occur if the deviant individual was removed from the evils of the larger society, and thus enabled to come to know his own true nature.

In the case of the mental hospital, this belief gave rise to the concept of a healing, pastoral, therapeutic community. But in the case of the penitentiary, an additional safeguard was obviously required; the inmates clearly had to be protected, not only from the evil influences of the broader society, but also from the evil influences of each other. The proper approach thus appeared to be to give each inmate the opportunity to live a life alone, like a penitent monk in his own monastic cell.

Thus, the earliest American penitentiaries were, generally, systems of rigid solitary confinement. Extravagant attention was paid to the design of these institutions, to ensure the absolute and total isolation of the offender from any "evil and corrupting influences." The Philadelphia Prison, completed in 1829, was particularly conscientious in this regard:

> The arrangements ... guaranteed that convicts would avoid all contamination and follow a path to reform. Inmates remained in

contamination and follow a path to reform. Inmates remained in solitary cells for eating, sleeping and working. ... No precaution against contamination was excessive. Officials placed a hood over the head of a new prisoner when marching him to his cell so he would not see or be seen by other inmates . ... Thrown upon his own innate sentiments, with no evil example to lead him astray, ... the criminal would start his rehabilitation. Then, after a period of total isolation, without companions, books, or tools, ... (he) would return to the community cured of vice and idleness, to take his place as a responsible citizen. (Rothman, pp 86-87)

The American penitentiary, and the Philadelphia System, became world-famous; no important visitor to the United States neglected to tour its penitentiaries and to bring back their principles for emulation in Europe. Some such as de Tocqueville of France and Nicholas Julius from Prussia came specifically for that purpose (Rothman p. 91). de Tocqueville wrote of the utter, "perfect" desolation of the American penitentiary, of the "profound silence" within its "vast walls," likening it to the silence of death. (Rothman, p. 97)

2. <u>Psychological Effects of Severe Isolation</u>

The openness with which these institutions were held up to public scrutiny led in time to open concern about the psychological effects of such confinement. During a tour of the United States in 1842, Charles Dickens wrote with pathos of the Philadelphia Prison:

> The system here is rigid, strict and hopeless solitary confinement . ... Over the head and face of every prisoner who comes into this melancholy house, a black hood is drawn, and in this dark shroud, ... he is led to the cell from which he never again comes forth, until his whole term of imprisonment had expired. He is a man buried alive ... dead to everything but torturing anxieties and horrible despair. ...
>
> The first man I saw ...answered ... always with a strange kind of pause ... he gazed about him and in the act of doing so fell into a strange stare as if he had forgotten something.
>
> In another cell was a German ... a more dejected, broken-hearted, wretched creature, it would be difficult to imagine.
>
> There was a sailor. ... Why does he stare at his hands and pick the flesh open, upon the fingers, and raise his eyes for an instant ... to those bare walls ... ? (quoted in Liederman, p. 66)

American concern about the effects of rigid solitary confinement began as early as the 1830's. Statistical comparisons began to be made between the Philadelphia system and its chief competitor -- the Auburn system prevailing in New

York State at Auburn and Sing-Sing penitentiaries. The latter system also utilized solitary confinement, but less rigidly; inmates left their cells to work together in workshops and exercise in a common courtyard, although here, too, absolute and strict silence was maintained at all times. Statistical comparisons began to generate evidence that "it was unnatural ... to leave men in solitary, day after day, year after year; indeed, it was so unnatural that it bred insanity." (Rothman, p. 87). The Philadelphia Prison appeared to have a higher incidence, not only of insanity, but also of physical disease and death than its New York State counterparts.

Meanwhile, the American system had been emulated in many major European prisons, such as at Halle, Germany. Although the Americans had been the world leaders in instituting rigid solitary confinement in their penitentiary system, German clinicians eventually assumed the task of documenting its effects, ultimately leading to its demise.

Between 1854 and 1909, 37 articles appeared in German scientific journals on the subject of psychotic disturbances among prisoners, summarizing years of work and hundreds of cases. A major review of this literature was published in 1913; (Nitsche, 1913). A summary and synthesis of this rather large body of work appears as an appendix to this declaration.

But it should be noted that interest in the problem was not purely academic; psychotic disturbances among prisoners were of such frequency in these prisons that they attracted administrative as well as clinical concern, and great effort was made to explain this disturbing incidence. Thus, the literature covered a variety of issues, speculating for example, on the "moral degeneracy" of the prison population, some authors by comparing the psychopathology of those who committed "crimes of passion" with those who committed "crimes against property," or by detailing the incidence of the major diagnostic categories of the time (e.g., "circular insanity," "alcoholic psychoses," epilepsy, general paresis, etc.) among the prison population.

However, multiple reports based on careful clinical observation suggested that a substantial majority of these prison psychoses were direct reactions to the conditions of imprisonment itself. Gradually a clinically distinguishable syndrome of acute reactive prison psychoses began to be defined. Different variables were considered in attempting to explain the etiology of these reactive prison psychoses, including, for example, long versus short duration of imprisonment, or imprisonment of those already convicted versus imprisonment while awaiting trial. However, the most consistent factor described, reported in over half the total literature, was solitary confinement.

D. The Twentieth Century Experience: Prisoners of War, "Brain Washing", and Experimental Research.

1. Prisoners of War and "Brainwashing".

Unfortunately, other than some anecdotal reports, there was little discussion of the psychological effects of solitary confinement in the medical literature during the first half of the twentieth century. Undoubtedly, this was in part a consequence of the disastrous earlier experience with such confinement. As statistical evidence accumulated during the nineteenth century that solitary confinement produced a very disturbing incidence of insanity, physical disease and death, the system had fallen into disrepute, and with this, it had changed from an open, optimistic experiment in social reform into a hidden, secretive means of punishment and control.

Its devastating psychological impact, however, did not change, a fact which became suddenly and very painfully evident in the 1950's as the American public began hearing the frightening and dramatic reports of "brainwashing" of American prisoners of war in Korea -- reports that alterations in the sensory environment were being intentionally imposed upon these prisoners in a seemingly Orwellian attempt to profoundly disrupt their psychological equilibrium. (Biderman and Zimmer, 1961).

By the 1950's, reports had already appeared of major psychiatric disturbances among survivors of prolonged solitary confinement in war (e.g. Burney, 1952), but during the decade of the Korean War, major attention was riveted on the occurrence of these disturbances, not only in war, but in a variety of other settings as well.

In 1956, the Group for the Advancement of Psychiatry (GAP) held a symposium -- "Factors Used to Increase the Susceptibility of Individuals to Forceful Indoctrination" -- to study methods used by the Chinese and Russian Communists to "indoctrinate" and "break the will" of political prisoners and prisoners of war.

Dr. M. Meltzer, former Chief Medical Officer at Alcatraz Federal Penitentiary, contributed his observations of psychiatric disturbances among prisoners exposed to punitive solitary confinement at Alcatraz. These prisoners were rarely confined for periods beyond one week. (Meltzer, 1956) Despite this, Dr. Meltzer described acute psychotic breakdowns among prisoners so confined; his descriptions closely paralleled the observations at Walpole: "The motor effects ranged from occasional tense pacing, restlessness and sense of inner tension with noise making, yelling, banging and assaultiveness at one extreme, to a kind of regressed, dissociated, withdrawn hypnoid and reverie-like state at the other ... (The) sense of self, the ego and the ego boundary phenomena are profoundly affected by the isolation." (Meltzer, p. 98)

In the same symposium, Dr. John Lilly of the National Institute of Mental Health noted that despite the importance of other factors which tended to "weaken personalities and make them more susceptible to [forced indoctrination]" -- such as semi-starvation, physical pain and injury, and sleep deprivation -- social and sensory isolation was still the central pathogenic factor in such confinement. (Meltzer, p. 89)

2. Experimental Research on Sensory Deprivation.

An experimental model was therefore designed to study the effect of restricted environmental stimulation (RES); this research, conducted during the 1950's and early 1960's, primarily at Harvard and McGill University Medical Centers, was in fact funded in large part by the United States Government -- and especially by the Department of Defense and U.S. Central Intelligence Agency. This research is described in an appendix to this declaration. Its relevant conclusions can, however, be described relatively briefly:

In these studies (Brownfield, 1965; Solomon, et al., 1961), subjects were placed in a situation designed to maximally reduce perceptually informative external stimuli (e.g., light-proof, sound-proof rooms, cardboard tubes surrounding the arms and hands to reduce proprioceptive and tactile sensation, and so on). The research revealed that characteristic symptoms generally developed in such settings. These symptoms included perceptual distortions and illusions in multiple spheres, vivid fantasies, often accompanied by strikingly vivid hallucinations in multiple spheres, derealization experiences, and hyperresponsivity to external stimuli. What was also clear, however, was that while some subjects tolerated such experiences well, many did not, and a characteristic syndrome was observed, including not only the above symptoms, but also included cognitive impairment, massive free-floating anxiety, extreme motor restlessness, emergence of primitive aggressive fantasies which were often accompanied by fearful hallucinations, and with decreasing capacity to maintain an observing, reality-testing ego function. In some cases, an overt psychosis supervened with persecutory delusions and, in some cases, a marked dissociative, catatonic-like stupor (delirium) with mutism developed. EEG recordings confirmed the presence of abnormalities typical of stupor and delirium.

These findings clearly demonstrated that this experimental model did reproduce the findings in the non-experimental situations, including the findings among prisoners of War held in solitary confinement.

E. Factors Affecting Response to Sensory Restriction and Solitary Confinement.

Much of the subsequent research in this area attempted to delineate variables which might explain these differing outcomes. These variables can be divided into two categories: 1) differences among various conditions of perceptual deprivation, and 2) differences in preexisting psychological functioning among individuals experiencing such conditions:

1. Differing Conditions of Isolation.

One of the factors commonly cited in the literature as related to outcome is differences in the intensity and duration of the sensory deprivation experience; more severe sensory restriction, the presence of noxious stimulation, and longer duration of the sensory deprivation experience, have all been associated with an increased

risk of adverse psychiatric consequences.

In my experience, while conditions experienced by inmates in various prison solitary confinement settings generally bear some similarities (e.g. a cell of roughly 50-80 square feet, approximately 22 1/2 hours/day locked in the cell, with about one hour/day 5-7 days/week of exercise yard), in other respects, the conditions are fairly variable. For example, some cells have barred doors, which allow better ventilation, sound transmission and visual connection with the outside environment than do mesh steel doors; solid steel doors are the most restrictive -- especially when they are either hinged or slide shut with almost no air gap from the wall. Moreover, administrative conditions regarding the amount and circumstances of visitation, the availability of reading material, radio, and television, and so forth, are all factors which vary from institution to institution, and even from time to time within a given institution.

2. The Perceived Intent of the Isolation Experience

In addition to the factors described above, another critical factor in determining the effect of isolation, appears to be the perceived intent of the isolation. Experimental research has demonstrated that an individual who receives clues which cause him to experience the isolation situation as potentially threatening, is far more likely to develop adverse psychiatric reactions to the isolation experience; conversely, if the subject has reason to believe the situation is likely to be benign, he will be far more likely to tolerate or even enjoy it. Among the latter group of subjects who tolerated isolation well, many reported pleasant or, at least, nonthreatening, visual imagery, fantasy and hallucinatory experiences, often associated with a state of hypnotic reverie: "His mind may begin to wander, engage in daydreams, slip off into hypnogogic reveries with their attendant vivid pictorial images ... he may be quietly having sexual or other pleasurable thoughts." (Wright & Abbey, 1965, pg. 6.)

This finding is perhaps not surprising. It appears that sensory restriction produces perceptual disturbances and illusions, which are analogous to those produced by hallucinogenic drugs -- and clearly, while there are some individuals who could be said to have volunteered to undergo such hallucinatory, psychotic-like experiences, it must be almost uniformly terrifying to be forced involuntarily to undergo an experience similar to that induced by hallucinogenic drugs.

3. Individual Differences in Response.

Many studies have demonstrated that there is great variability among individuals in regard to their capacity to tolerate a given condition of sensory restriction. This variability helps to provide further insight into the nature of the toxic effect of such isolation conditions, and provides striking corroboration of the fact that such environmental stimulation, especially when of prolonged duration, is toxic to brain functioning, and causes symptoms characteristic of stupor and delirium.

Generally, individuals with mature, healthy personality functioning and with intact central nervous system functioning -- and of at least average intelligence -- have been found to have greater ability to tolerate such isolation situations, while individuals with primitive or psychopathic functioning, individuals with borderline cognitive capacities, impulse-ridden individuals and individuals whose internal cognitive/emotional life is chaotic or fearful, are especially at risk for severe psychopathologic reactions to such isolation. (Appendix C describes these studies in more detail.)

Moreover, there is clear evidence that in a situation of restricted environmental stimulation, preexisting central nervous system dysfunction is a major predisposing factor to the development of adverse psychiatric reactions and of overt delirium. For example, in one study of patients suffering visual deprivation following eye surgery (eye-patched patients), those patients with pre-existing central nervous system dysfunction were found to be at especially high risk to develop symptoms of delirium. (Ziskind et.al 1960). Moreover, the presence of a preexisting personality disorder or impairment of psychosocial functioning was associated with increased risk of incapacitating fearfulness, paranoia, agitation and irrational aggression towards staff (Klein & Moses 1974). (A more extensive review of this literature is contained in Appendix A to this letter.)

In addition, individuals may at times be exposed to situations which cause impairment of central nervous system functioning. Such situations -- especially if they impair the individual's state of alertness, for example, sleep deprivation, abnormal sleep-wake cycles, or the use of sedating medication -- will substantially increase the individual's vulnerability to the development of delirium. Delirium among post-surgical patients, and the so-called "ICU Psychoses" are examples of this phenomenon. (Appendix A discusses this issue in more detail.)
And one of the characteristic difficulties experienced by inmates in solitary confinement is, in fact, abnormal sleep-wake cycles and impaired sleep.

a. Findings at Pelican Bay State Prison.

These findings received further corroboration in my observations of inmates at Pelican Bay State Prison, California. In 1991-92, as part of my participation in Madrid v. Gomez -- a class-action lawsuit challenging conditions at Pelican Bay State Prison, a new "supermax" facility in California -- I evaluated 50 inmates housed in the Special Housing Unit (SHU) at the institution, and prepared a lengthy report to the Federal Court of my findings. (Much of the literature review and historical material in the present declaration is taken from my Madrid declar. .on.) Many of the inmates I evaluated there suffered severe psychiatric disturbances while housed in Pelican Bay SHU -- either springing up *de novo* while so incarcerated, or representing a recurrence or severe exacerbation of preexisting illness. Of the 50 inmates I evaluated, at least 17 were actively psychotic and/or acutely suicidal and urgently in need of acute hospital treatment, and 23 others suffered serious psychopathological reactions to solitary confinement, including in several cases, periods of psychotic disorganization.

The clinical data at Pelican Bay also added striking corroboration that the severe and prolonged restriction of environmental stimulation in solitary confinement is toxic to brain functioning, by demonstrating that the most severe, florid psychiatric illnesses resulting from solitary confinement tend to be suffered by those individuals with preexisting brain dysfunction. As noted before, I have observed a high incidence of preexisting central nervous system dysfunction among inmates I have evaluated in solitary confinement settings. This was also the case at Pelican Bay, and statistical analysis of the Pelican Bay data quite dramatically demonstrated that inmates with such preexisting vulnerability were the most likely to develop overt confusional, agitated, hallucinatory psychoses as a result of SHU confinement.

b. Attention Deficit and Antisocial Personality Disorders

In addition, research regarding Attention Deficit Disorder and Antisocial Personality Disorder demonstrate that these conditions are similarly associated with a particular inability to tolerate restricted environmental stimulation. There is in fact increasing evidence that childhood impulsivity and Attention Deficit Hyperactivity Disorder bear some relationship to Antisocial Personality Disorder, that both are characterized by impulsivity and stimulation-seeking behavior, and that both involve biologically based abnormalities in central nervous system functioning. Moreover, the clinical literature demonstrates that individuals with Antisocial Personality Disorder are especially intolerant of restricted environmental stimulation. For example, Quay (1965) characterized the psychopathic individual as pathologically "stimulation seeking ... impulsive ... (and) unable to tolerate routine and boredom." (Appendix B contains a more detailed discussion.)

Given the exigencies of conducting clinical observations of inmates in solitary confinement, it is not surprising that little systematic attempt has been made to elucidate the underlying psychological characteristics of those most at risk for developing severe psychopathological reactions to such isolation. However, among the clinical reports on Ganser's Syndrome (a related condition) in nonprison populations are several studies of patients in psychiatric hospitals. These patients were, of course, available for extensive psychological assessment and observation, and these reports described the majority of these patients as suffering long-standing hysterical character disorders, having problems with severe impulsivity, childhood truancy, and antisocial behavior patterns. (Appendix B contains a more detailed discussion.)

Thus, the medical literature demonstrates that individuals whose internal emotional life is chaotic and impulse-ridden, and individuals with central nervous system dysfunction, may be especially prone to psychopathological reactions to restricted environmental stimulation. Yet among the prison population, it is quite likely that these are the very individuals who are especially prone to committing infractions that result in stricter incarceration, including severe isolation and solitary confinement.

c. Effects on Psychologically More Resilient Inmates:Baraldini v. Meese and Hameed v. Coughlin

In 1988, in the course of my involvement in Baraldini v. Meese, a class action challenging the confinement of a small group of women in a subterranean security housing unit at the Federal Penitentiary in Lexington, Kentucky, I had the opportunity to interview several women who were in confinement in this facility. These women had been convicted of having committed politically motivated crimes, were all highly educated, and had a history of relatively strong psychological functioning prior to their confinement. None of these women developed the florid confusional psychosis described earlier in this affidavit, yet each of them demonstrated significant psychopathological reactions to their prolonged confinement in a setting of severe environmental and social isolation. These included perceptual disturbances, free-floating anxiety and panic attacks. These inmates also uniformly described severe difficulties in thinking, concentration and memory; for example, one inmate reported that she was able to perform tasks requiring some mental effort -- such as reading or writing -- only for about the first three hours of the morning after she awoke; by then, her mind had become so slowed down, so much "in a fog", that she was entirely unable to maintain any meaningful attention or expend any meaningful mental effort.

In addition, in 1993, I evaluated Bashir Hameed, an inmate who had also been incarcerated in the SHU at Shawangunk C.F. and who had brought suit -- Hameed v. Coughlin, 89 CV 578 (NDNY) -- concerning his incarceration there. As I described in my testimony in that case, Mr. Hameed is an individual who evidenced strong prior psychological adjustment, and no prior psychiatric history, yet became significantly ill as a result of his SHU confinement.

F. Long Term Effects of Solitary and Small Group Confinement.

Long-term studies of veterans of P.O.W. camps and of kidnapping and hostage situations have demonstrated that while many of the acute symptoms I outlined above tend to subside after release from confinement, there are also long-term effects which may persist for decades. These not only include persistent symptoms of posttraumatic stress (such as flashbacks, chronic hypervigilance, and a pervasive sense of hopelessness), but also lasting personality changes -- especially including a continuing pattern of intolerance of social interaction, leaving the individual socially impoverished and withdrawn, subtly angry and fearful when forced into social interaction. (This literature is reviewed in Appendix D to this declaration.)

In addition, from time to time I have had the opportunity to evaluate individuals who had been incarcerated in solitary confinement several years previously; I have found the same pattern of personality change described above -- these individuals had become strikingly socially impoverished and experienced

intense irritation with social interaction, patterns dramatically different from their functioning prior to solitary confinement.

III Conclusions

The restriction of environmental stimulation and social isolation associated with confinement in solitary are strikingly toxic to mental functioning, producing a stuporous condition associated with perceptual and cognitive impairment and affective disturbances. In more severe cases, inmates so confined have developed florid delirium -- a confusional psychoses with intense agitation, fearfulness, and disorganization. But even those inmates who are more psychologically resilient inevitably suffer severe psychological pain as a result of such confinement, especially when the confinement is prolonged, and especially when the individual experiences this confinement as being the product of an arbitrary exercise of power and intimidation. Moreover, the harm caused by such confinement may result in prolonged or permanent psychiatric disability, including impairments which may seriously reduce the inmate's capacity to reintegrate into the broader community upon release from prison.

Many of the prisoners who are housed in long-term solitary confinement are undoubtedly a danger to the community and to the Corrections Offices charged with their custody. But for many, they are a danger, not because they are coldly ruthless, but because they are volatile, impulse-ridden, and internally disorganized.

As noted earlier in this statement, modern societies made a fundamental moral division between socially deviant behavior which was seen as a product of evil intent, and that behavior seen as a product of illness. Yet this bifurcation has never been as simple as might at first glance appear. Socially deviant behavior can in fact be described along a spectrum of intent. At one end are those whose behavior is quite "instrumental" - ruthless, carefully planned and rational; at the other, are individuals whose socially deviant behavior is the product of unchecked emotional impulse, internal chaos, and often of psychiatric or neurologic illness.

It is a great irony that as one passes through the levels of incarceration -- from the minimum to the maximum security institutions, and then to the solitary confinement sections of those institutions -- one does not pass deeper and deeper into a subpopulation of the most ruthlessly calculating criminals. Instead, ironically and tragically, one comes full circle back to those who are emotionally fragile and, often, severely mentally ill. The laws and practices which have established and perpetuated this tragedy deeply offend any sense of common human decency.

Stuart Grassian, M.D.

APPENDICES

A. Reports of Psychiatric Disturbances in Conditions of Restricted Environmental Stimulation.
B. The Nineteenth Century German Experience with Solitary Confinement: Ganser's Syndrome.
C. Experimental Research on the Psychiatric Consequences of Profound Sensory Deprivation: Factors Influencing Vulnerability to Harm.
D. Reports of the Long-Term Effects of Solitary Confinement in Former Hostages and in Prisoners of War.

APPENDIX A

REPORTS OF PSYCHIATRIC DISTURBANCES IN OTHER CONDITIONS OF RESTRICTED ENVIRONMENTAL STIMULATION

The psychopathologic syndrome which I have described in the body of this declaration is found in other settings besides isolation in civil prisons. Some of these settings involve small group, rather than solitary isolation, and the studies have demonstrated that isolated groups comprising two individuals may be the most pathogenic of all. These studies also suggest that those individuals with below average intelligence and poor psychosocial adjustment prior to isolation developed more severe psychiatric difficulties during isolation in some studies, such disturbances persisted in one year follow-up after reentry.

Aviation

Bennett (1961) described psychiatric disturbances among pilots of the British Royal Air Force who had been exposed in-flight to periods of restricted auditory and visual stimulation. All of the groups he described became significantly anxious--many suffering full-blown panic attacks--and many experienced unusual sensations which they were very reluctant to describe. The most severely disturbed groups refused to expose themselves further to the isolation conditions of these flights; at all levels of impairment, however, anxiety was common (both panic and free-floating anxiety). Pilots reported anxiety symptoms such as feeling "hot and tense and powerless" (Bennett, p. 162) and "nervous and afraid" (ibid, p. 164). Feelings of derealization, feelings of detachment from reality, and perceptual distortions were described. Some of these perceptual distortions were dangerous (e.g., having the impression that the aircraft was turning when it was not) and resulted in serious errors in judgment (e.g., making the aircraft spiral dangerously downward after attempting to "correct" for what was incorrectly perceived as a turning aircraft). Clark & Graybiel (1957) described strikingly similar symptoms among United States Navy pilots exposed to periods of in-flight isolation. Among pilots who flew alone, at high altitude, (i.e., in a situation of monotonous visual and

sensory stimulation) and flying with a minimum of pilot activity, over one third experienced frightening feelings of unreality and became severely anxious.

Small Group Confinement

Many studies--both anecdotal and experimental--have been made of individuals confined together in small groups; groups thus described have ranged in size from two to approximately sixty individuals, the larger groups include reports of men isolated on a Pacific island, submarine inhabitants, Antarctic explorers, etc. (see Zubek, 1969). The most consistent finding was of dramatically increased levels of hostility, interpersonal conflict and paranoia (Zubek, p. 377). Individuals exposed to such conditions also tend to become irrationally territorial, staking out "areas of exclusive or special use, [and] acting with hostility to trespasses by others." (Zubek, p. 380)

Confined groups comprising just two individuals may be the most pathogenic of all, associated with especially high rates of mutual paranoia and violent hostility. Admiral Byrd believed it to be extremely unsafe to staff an Antarctic base unit with just two men:

> It doesn't take two men long to find each other out . . . the time comes . . . when even his [campmate's] unformed thoughts can be anticipated, his pet ideas become a meaningless drool, and the way he blows out a pressure lamp or drops his boots on the floor or eats his food becomes a rasping annoyance. . . . Men who have lived in the Canadian bush know well what happens to trappers paired off this way . . . During my first winter at Little America I walked for hours with a man who was on the verge of murder or suicide over imaginary persecutions by another man who had been his devoted friend. (Quoted in Zubek, 1969, p.381).

Many men confined in Antarctic stations have experienced near psychotic states, creating a danger to all inhabitants of the work station (Zubek, 1969). The pathogenicity of such dyadic groups was confirmed in an experimental study involving volunteer sailors living and working together in dyadic pairs, socially isolated from the world for a period of ten days. Under such conditions, the sailors developed evidence of subjective distress, inability to concentrate, a breakdown of inner controls on behavior, hostility, and increasing schizoid withdrawal from social contact (Cole, J.D., 1967).

Polar Habitation

Psychiatric disturbances have been described in Arctic and Antarctic inhabitants (explorers, researchers and their support staff), spending varying periods in winter isolation. In these regions, winters last for up to nine months with weather conditions so cold (-100F) that leaving the confines of the indoors is dangerous. Typically, teams of work groups have fewer than 50 members who spend up to two years working in small quarters. Small group isolation conditions at

these stations have been compared to life in prisons by at least one researcher: " . . . the isolation imposed by the harsh environment [of the Antarctic] is rarely experienced outside penal conditions" (Biersner & Hogan, 1984, p. 491).

In a review of the literature on the psychological adjustment to Antarctic living, Rothblum (1990) described a staff wintering over at a British Antarctic station; those of the staff who adjusted best tended to be socially mature, intelligent, reserved and trusting individuals. Similarly, French, United States and Australian studies revealed that intelligence and previous social adjustment predicted a decreased risk for psychiatric disturbance among workers at Antarctic stations. On the other hand, lack of respect for authority and aggression were important markers for poor isolation adjustment (Mullin & Connery, 1959).

Similarly, Wright, Chylinski, Sisler and Quarrington (1967) correlated outcome measures with psychological testing obtained prior to work station assignment. They found specifically that persons with antisocial and psychotic tendencies were poor risks for efficient functioning in conditions of isolation.

As a result of these disturbing findings among Antarctic workers, systematic efforts have been made to provide psychological screening of potential station employees and to ameliorate the isolation conditions prevailing in such stations (Cochrane & Freeman, 1989). Despite these efforts, significant psychiatric disturbances have continued to be observed (Natini & Shurley, 1974). The fact that these individuals were confined in small groups rather than alone was not found to prevent these disturbances; indeed, one of the central pathogenic factors cited in this literature has been the interpersonal tension and hostility generated by small group confinement (Biersner & Hogan, 1984).

Strange & Klein (1974) and Rothblum (1990) described a "winter-over syndrome" including progressively worsening depression, hostility, sleep disturbance, impaired cognitive functioning and paranoia during small group winter confinement in the Antarctic. Strikingly similar findings were reported by the United States Navy Medical Neuropsychiatric Research Unit, which found high incidence of sleep disturbance, depression, anxiety, aggression, somatic complaints, and a progressive impoverishment of social relationships as the winter progressed (Gunderson, 1963; Gunderson & Nelson, 1963). Psychiatric problems worsened as the length of time in this confinement increased; in one study of a group of Japanese winter-stationed in the Antarctic periodic psychological testing revealed increasing levels of anxiety and depression as the winter progressed (Rothblum, 1990). Similar findings have been described among a group of Americans stationed in the Antarctic (Gunderson & Nelson, 1963).

In a review of the literature on the psychological adjustment to Arctic life, Cochrane and Freeman (1989) describe a syndrome which parallels the Antarctic literature: sleep disturbances, apathy, irritability, cognitive, dysfunction, hallucinations, depression and anxiety were widely reported as a result of the small group isolation endured by inhabitants. They also reported "depression, irritability, easily provoked anger which may escalate into dramatic and florid acting out and,

not surprisingly, a breakdown in relationships with other members of the group . . . insomnia, pallor, loss of interest, psychomotor retardation, paranoidal ideation, non-specific hallucinations of light flashes and sudden movements" (p. 887) Many individuals became intolerant of social contact, and fearful of reentering society. Even when Arctic workers were adequately preselected by psychological screening, trained and supported, sleep difficulties, apathy and irritability persisted.

Studies on reintegration into the home environment after Antarctic living even one year after reintegration, found persisting problems and symptoms, including sleep disturbances, cognitive slowing, emotional withdrawal, resentment of authority, indecisiveness and poor communication (Rothblum, 1990).

Biersner & Hogan (1984) summarized the findings related to personality variables in the Arctic and Antarctic workers:

> Individuals with high needs for novelty and new sensations . . . who are emotionally unstable, or who are unconcerned with social approval seem unsuited for . . . such environments. The opposite [traits are found in] those who adjust well (p.495)

Explorers: Solo Voyages

Anecdotal reports of shipwrecked sailors and individuals accomplishing long solo sea voyages have generally described "disturbances in attention and in organization of thought, labile and extreme affect, hallucinations and delusions" (Zubek, 1969, p. 7). Dramatic anecdotal reports have appeared from time to time. Some of these were summarized in a review article by Dr. Philip Solomon, one of the lead scientists in the Harvard Medical School/Boston City Hospital group:

> "Christine Ritter in her very sensitive document `A Woman in the Polar Night,' reported that at times she saw a monster . . . [and] experienced depersonalization to the extent that she thought she and her companions were dissolving in moonlight `as though it were eating us up' . . . The Spitzbergen hunters use the term ran (strangeness) to describe these experiences . . . ."

Tales of the sea have provided many accounts of hallucinatory phenomena. John Slocum sailed alone around the world . . . [in the South Atlantic] he suddenly saw a man, who at first he thought to be a pirate, take over the tiller . . . .

Walter Gibson, a soldier in the British Indian Army, was on a ship torpedoed in the Indian Ocean by the Japanese in World War II . . . . [The shipwrecked survivors] reported that "all of us at various stages in that first week became a prey to hallucinations" . . . [As the weeks passed] the feeling of comradeship disappeared and the men began to find themselves "watching our fellows covertly and suspiciously." Murder, suicide and cannibalism followed as social controls dissolved.

Medical Conditions

1. Eye Patched Patients

Restricted environmental stimulation conditions also occur post-operatively and in certain medical conditions: in a study of 100 American patients with macular degeneration of the retina (Holroyd, Rabins, Finkelstein, Nicholson, Chase & Wisniewski, 1992), a high percentage of such patients experienced disturbing visual hallucinations. Those patients who were relatively cognitively limited, those who were socially isolated and those with simultaneous sensory impairment in another modality (e.g., hearing-impaired patients) fared worst. But other factors, including the presence of concomitant medical illness, did not appear to affect the incidence of hallucinations.

In an especially relevant study of eye patched patients, Klein & Moses (1974) determined that psychologically well-adjusted patients (as assessed prior to surgery) tended not to develop visual hallucinations during the period when their eyes were patched, whereas those suffering preexisting personality disturbances did tend to develop such hallucinations. Among those patients who did develop hallucinations, almost half developed complex hallucinations involving human figures and with a content suggesting serious preoccupations with themes of depression and anxiety. Moreover, among those patients who had both preexisting personality disturbances and difficulty with their premorbid psychosocial adjustment, eye patching produced severe psychiatric symptomatology, including: paranoid thoughts about being poisoned, physically harmed or attacked; psychomotor agitation; interpersonal aggressiveness; inability to comply with staff directives; fearful visual hallucinations, and incapacitating anxiety. In this most disturbed group, symptoms had not remitted when observed one week after their eye patches were removed.

Other studies have also found patients to suffer from perceptual distortions, thinking disturbances and mood changes following the visual deprivation that is part of post-operative recovery in eye surgery (Ziskind, 1958; Ziskind, Jones, Filante & Goldberg, 1960). Furthermore, Ziskind et. al., (1960) noted that: "In patients with . . . brain damage, there were also delirioid symptoms, e.g., confusion, disorientation, memory impairment, vivid hallucinations [and disorganized] hyperkinetic activity" (p. 894). Finally, in Jackson's (1969) extensive literature review of hospitalized eye patched patients, psychiatric disturbance was commonly found. These patients suffered from unusual emotional, cognitive and sensory-perceptual disturbances, similar to those previously described.

2. Poliomyelitis

Polio patients confined to tank-type respirators have become psychotic as a direct result of such confinement; moreover, they became more ill, with more florid hallucinations and delusions, at night when sensory input was diminished. The same florid hallucinatory, delusional psychosis has been found in other patients similarly confined in tank respirators (Liederman, et. al., 1958).

3. Cardiac Patients

Patients with decompensated heart disease are at times placed on very strict bed rest; some of these patients have developed acute confusional, paranoid, hallucinatory psychoses, especially at night during periods of decreased sensory input (Liederman, et. al., 1958).

Studies of post-operative open heart surgery patients who were bed confined--their visual stimulation restricted to looking up at a white-tiled hospital room ceiling--revealed a high rate of disordered thinking, visual and auditory hallucinations and disorientation (Egerton & Kay, 1964; Kornfeld, Zimberg & Malm, 1965; Lazarus & Hagens, 1968; Wilson, 1972). There is an extremely disturbing incidence of psychosis following open heart surgery, ranging in various studies from 14 to 30 percent (Lee & Ball, 1975). Upon recovery these patients described their post-operative environment as a major pathogenic factor in producing their psychiatric illness (Kornfeld et. al., 1965). Perceptual disturbances and emotional liability, as well as paranoia, depression and obsessive-compulsive reactions to the restrictive post-operative environment have been documented in other studies as well (Ellis, 1972; Goldstein, 1976; Lee & Ball, 1975; Thomson, 1973).

4. Hearing Impaired Individuals

Another condition of restricted environmental stimulation leading to psychiatric disturbance involves the hearing impaired. Studies of the deaf (Altshuler, 1971; Houston & Royse, 1954) consistently find significantly higher rates of paranoia in these individuals. High rates of paranoia have been reported in both the developmentally hearing impaired as well as those who became deaf in later life (Zimbardo, Andersen & Kabat, 1981). Experimentally induced deafness in psychiatrically unimpaired adults also produced paranoia (Zimbardo, et. al., 1981).

5. Other Medical Patients

Disorientation and delusional psychoses have also been reported among immobilized orthopedic patients and in patients postsurgically bed-confined (Liederman, et. al., 1958). Nursing researchers (Downs, 1974) have studied this phenomenon and have concluded that frightening hallucinatory experiences "are probably far more widespread than has been reported" (Downs p. 434).

6. Occupational Situations

McFarland and Moore (1957) reported in the New England Journal of Medicine on a study of fifty long-distance truck drivers; of these, thirty experienced vivid visual hallucinations; some became disoriented, "as in a dream."

7. Animals

As noted in the body of this declaration, many prisoners confined in solitary report become intolerant of normal levels of environmental--especially social--

stimulation. These reports receive experimental confirmation in laboratory research on animals. Such research demonstrates that sensory deprivation produces an intolerance to normal levels of environmental stimulation; animals exposed to sensory deprivation conditions became overly aroused--"hyperexcitable"--when exposed to normal levels of environmental stimulation, often resulting in severe behavioral disturbances (Riestin, 1961). Other studies have demonstrated that such animals often display diffuse, frenzied, random activity, and social withdrawal, and are prone to psychophysiologic illnesses (e.g., peptic ulcers) when exposed to environmental stress (Zubek, 1969).

Barnes (1959) produced agitation in mice and rats after a few days of isolation, a report which corroborated previous studies with rats. Others (Matsumoto, Cai, Satoh, Ohta & Watanabe, 1991) have also found that isolation induced aggressive behavior in mice (e.g., biting attacks). Further, social isolation has been demonstrated to produce profound and lasting psychological effects in primates. Washburn and Rumbaugh (1991) note that over 400 published investigations of the effects of social isolation on primates show such deleterious effects as self-mutilation and disturbances in perception and learning. They found than in adult rhesus monkeys even brief periods of social isolation produce compromised cognitive processing. McKinney, Suomi and Harlow (1971) produced symptoms of depression in rhesus monkeys by confining them for 30 days. They concluded that solitary "confinement produced greater destructive behavioral effects in less time and with fewer individual differences among subjects than did total social isolation, previously [demonstrated to be] the most powerful technique for producing psychopathological behavior among monkey subjects" (p. 1317). Induced depression through confinement has been reported in both young and mature monkeys (Harlow & Suomi, 1974). Finally, isolation-produced fear in dogs has been clearly demonstrated (Thompson & Melzack, 1956).

APPENDIX B

THE NINETEENTH CENTURY GERMAN EXPERIENCE WITH SOLITARY CONFINEMENT . . .

Between 1854 and 1909, thirty-seven articles appeared in the German medical literature on the subject of psychotic disturbances among prisoners, summarizing years of work and many hundreds of cases. A major review of this literature was published in 1912 (Nitsche, 1912) Solitary confinement was the single most important factor identified in the etiology of these psychotic illnesses.

Indeed, the first report on the subject of prison psychoses was that of Delbruck (1854), Chief Physician at the Prison at Halle, in which "the frequency of mental disturbances was at last so great that it attracted the attention of the

authorities." (Nitsche, p.1). Delbruck's report concluded that:

> Prolonged absolute isolation has a very injurious effect on the body and mind and that it seems to predispose to hallucinations . . . . He advised the immediate termination of solitary confinement. (Nitsche, p. 2).

In 1863, Gutsch reported on 84 cases of "The Psychosis of Solitary Confinement" and described vivid hallucinations and persecutory delusions, apprehensiveness, psychomotor excitation, sudden onset of the syndrome, and rapid recovery upon termination of solitary confinement. Many of these individuals developed "suicidal and maniacal outbursts." (Nitsche, p. 8)

In 1871, in a report on 15 cases of acute reactive psychoses, some of which apparently occurred within hours of incarceration in solitary, Reich described, in addition to hallucinosis and persecutory delusions, severe anxiety leading to "motor excitement . . .. The patient becomes noisy, screams, runs aimlessly about, destroys and ruins everything that comes in his way." He also described an acute confusional state accompanying these symptoms, sudden cessation of symptoms, recovery, and subsequent amnesia for the events of the psychosis:

> "The gaze is staring, vacant, indefinite. . . consciousness becomes more and more clouded . . . and later there is amnesia for all events during this time . . . He frequently awakens as from a dream . . . ." (Nitsche, pp. 32-33)

In a statistical summary, Knecht reported in 1881 on the diagnostic assessment of 186 inmates at the "insane department" of the prison at Waldheim, and concluded that over half the total were reactive manifestations to solitary confinement. The majority of these inmates fell insane within two years of confinement in solitary. (Nitsche, p. 17)

In 1884, Sommer reported on 111 cases describing an acute, reactive, hallucinatory, anxious, confusional state associated with solitary confinement, emphasizing the "excited outbursts" and "vicious assaults" of these patients. His patients' illness began with difficulty in concentration, and hyperresponsivity to minor "inexplicable" external stimuli. These "elementary disturbances of the sensorium (i.e., the five senses)" were seen as leading to "elementary hallucinations" which became more numerous, eventually including auditory, visual and olfactory hallucinations, and eventually becoming incorporated with fearful persecutory delusions. (Nitsche, pp. 12-16)

In 1889, Kirn described 129 cases of psychosis among the inmates at the county jail at Freiburg, concluding that in 50 of those cases, "solitary confinement can be definitely considered as the etiological factor, (and these) show a certain characteristic stamp" (Nitsche, p. 21) including persecutory delusions and hallucinations in multiple spheres (auditory, visual olfactory, tactile). He also noted that these symptoms often precipitated at night:

> The patient is suddenly surprised at night by hallucinatory experiences which bring on an anxious excitement. These manifestations become constant from now on, in many cases

> occurring only at night, in others also in the daytime. Attentive patients not infrequently hear at first a humming and buzzing in their ears, unpleasant noises and inarticulate sounds which they cannot understand until finally they hear well differentiated sounds and distinct words and sentences . . . . The visual hallucinations are very vivid. (Nitsche, p. 24)

In 1888, Moeli contributed a description of Vorbereiden -- "the symptom of approximate answers"[1]. Ten years later Ganser contributed to the literature the elucidation of a syndrome which included Moeli's symptom. (Ganser, 1898) As Arieti points out, Ganser's Syndrome became well-known -- indeed, almost a codification of the whole body of literature on the prison psychoses. Ganser provided a comprehensive and well-elucidated synthesis of symptoms, most of which had been previously described elsewhere. The syndrome he described included, (in addition to Vorbereiden), vivid visual and auditory hallucinations, a distinct clouding of consciousness, sudden cessation of symptoms, "as from a dream" and "a more or less complete amnesia for the events during the period of clouded consciousness." Ganser's most original description was of "hysterical stigmata" within the syndrome, including conversion symptoms -- especially, total analgesia. (Arieti, 1974, Vol. II, pp. 710-712)

Some of the German authors failed to note whether the inmates they were describing were housed in solitary confinement and, unfortunately, Ganser was one of these, stating only that his were "prisoners awaiting trial." However, Langard, in 1901, also reporting on observations of accused prisoners awaiting trial, described an acute violent hallucinatory confusion with persecutory delusions, and specifically stated that this syndrome occurred exclusively among those who awaited trial in solitary confinement. (Nitsche, p. 32)

Also in 1901, Raecke similarly reported on prisoners awaiting trial and described the full syndrome of Ganser, including Vorbereiden; he specifically condemned solitary confinement as responsible for the syndrome (Nitsche, p. 34). He described his cases as beginning with apathy, progressing to "inability to concentrate, a feeling of incapacity to think," and even catatonic features, including negativism, stupor, and mutism. (Nitsche, pp. 33-35)

In another report written the same year, Skliar reported on 60 case histories of which he identified 21 as acute prison psychoses caused by solitary confinement. While Vorbereiden was not noted, most of the other symptoms described by Ganser and Raecke were noted, including: massive anxiety, fearful auditory and visual hallucinations -- in severe cases, hallucinations of smell, taste, and "general sensation" as well -- persecutory delusions, senseless agitation and violence, confusion and disorientation. The psychosis developed rapidly -- at times within

[1] Vorbereiden is a rather remarkable symptom of deranged and confused thought processes in which the individual's response to a question suggests that he grasped the gist of the question, and his answer is clearly relevant to the question, and is related to the obvious correct answer , yet still oddly manages to be incorrect. An example would be: Q: "How many colors are there in the flag of the United States?" A: "Four." Q: "What are they?" A: "Yellow."

hours of incarceration in solitary confinement. Catatonic symptomatology was also noted (Nitsche, pp. 35-36).

The German literature reported only on prisoners who suffered gross psychotic symptomatology, some of whom were observed in hospitals or "insane departments" of prisons; thus, these reports generally described only syndromal expressions that rose to the level of overt psychosis. The German reports do, however, powerfully demonstrate the existence of a particular, clinically distinguishable psychiatric syndrome associated with solitary confinement.These multiple reports described a syndrome which included:

1. Massive free-floating anxiety
2. "Disturbances of the Sensorium", including --
   a. Hyperresponsivity to external stimuli
   b. Vivid hallucinations in multiple spheres (including auditory, visual, olfactory, gustatory and tactile modalities); in some reports, these began as simple "elementary" hallucinations and progressed to complex, formed hallucinations.
3. Persecutory delusions, often incorporating coexistent complex hallucinations.
4. Acute confusional states. In some reports, these were seen as beginning with simple inattention and difficulty in concentration. In others, the onset was described as sudden. The confusional state and disorientation was in several reports described as resembling a dissociative, dream-like state, at times involving features of a catatonic stupor, including negativism and mutism, and upon recovery leaving a residual amnesia for the events of the confusional state. Ganser and others observed hysterical conversion symptoms during this confusional state.
5. Vorbereiden: An infrequent finding, mostly described in conjunction with a confusional, hallucinatory state.
6. Motor excitement, often associated with sudden, violent destructive outbursts.
7. Characteristic course of the illness:
   a. Onset was described by some authors as sudden, by others as heralded by a progression beginning with sensory disturbances and/or inattention and difficulty in concentration.
   b. In many cases, rapid subsidence of acute symptoms upon termination of solitary confinement.

The German reports were generally based upon prisoners who had been hospitalized because of their psychotic illness; in contrast, the population reported upon in the Walpole study was not preselected by overt psychiatric status; despite this, all of the major symptoms reported by the German clinicians were observed in the Walpole population, except for Vorbereiden and hysterical conversion

symptoms. In addition, less severe forms of the isolation syndrome were observed in the Walpole population, including:

- Perceptual distortions and loss of perceptual constancy, in some cases without hallucinations.
- Ideas of reference and paranoid ideation short of overt delusions.
- Emergence of primitive aggressive fantasies which remained ego-dystonic and with reality-testing preserved.
- Disturbances of memory and attention short of overt dis-orientation and confusional state.
- Derealization experiences without massive dissociative regression.

Since Ganser's report has become the twentieth century's clearest memory of a much vaster body of literature, it is also of interest to review the literature describing observations of Ganser's Syndrome in non-prison populations. Several of these reports have been studies of patients in psychiatric hospitals suffering from this syndrome. Since these patients were hospitalized, it was possible to obtain more extensive evaluation and testing of their status. Several reports (Ingraham & Moriarity, 1967; May, Voegele & Padino, 1960; Tyndel, 1956; Weiner & Braiman, 1955) described a majority of the patients studied as suffering long standing hysterical conversion symptoms. Impulsivity, childhood truancy, and antisocial behavior were also commonly described. These findings suggest also that antisocial behavior patterns and psychopathic personality disorder may bear a close relationship to primitive hysterical personality disorder, a relationship which has been described by other authors as well (e.g., Woodruff, Goodwin & Gaze 1974).

APPENDIX C

EXPERIMENTAL RESEARCH ON THE PSYCHIATRIC CONSEQUENCE OF PROFOUND SENSORY DEPRIVATION: FACTORS INFLUENCING VULNERABILITY TO PSYCHIATRIC HARM

As noted in the body of this declaration, laboratory research has demonstrated that experimentally-induced sensory deprivation has major psychological effects, and can precipitate severe psychiatric illness (see e.g. Brownfield, 1965; Solomon 1961). This research generally involves short periods of relatively marked perceptual deprivation generally of a few hours in duration. Much of the research in this area attempted to delineate factors, in addition to the duration and intensity of sensory restriction, which might account for these differing outcomes; the factors which have been elucidated include two which are especially relevant to this discussion, and may help to explain the particular malignancy of sensory deprivation in solitary confinement:

The Influence of Expectation

Orne and Scheibe (1964) suggested that a subject's reaction to participation in a sensory deprivation experiment could be profoundly manipulated by external

cues imposed by the experimenter:

> [These] dramatic effects could be a function of the demand characteristics of the experimental situation . . . . There is evidence that preparing a subject for probable hallucinations significantly affects the frequency of hallucinations. Such devices as "panic buttons" in experiments . . . are in a sense eloquent instructions. The use of such a device increases the subject's expectation that something intolerable may occur, and with it, the likelihood of a bad experience. (p. 4)

In their own experiment, Orne and Scheibe exposed two groups of subjects to identical conditions of sensory deprivation. The experimental group's introduction to the experiment included the presence of a medical "Emergency Tray," and instructions about a "Panic Button." As predicted, the experimental group became significantly more symptomatic in measures of cognitive impairment and restlessness, and also more symptomatic in every other measure -- including perceptual aberrations, anxiety, and spatial disorientation.

In a related manner, prisoners in solitary confinement generally view such confinement as threatening and punitive, and often as a deliberate attempt to make them "crack up" or "break my spirit." In light of this , it is not surprising that the only recent report suggesting no major ill effect of solitary confinement (Walters, 1963) utilized prisoners who volunteered to spend 4 days in solitary confinement.

Individual Differences in Response

Several authors have directed attention to the fact that within a given experimental format, massive differences in response can be observed among individual subjects. Often subjects who tolerated the experimental situation well reported pleasant, or at least non-threatening, visual imagery, fantasy, and hallucinatory experiences:

> His mind may begin to wander, engage in daydreams, slip off into hypnagogic reveries with their attendant vivid pictorial images . . . he may be quietly having sexual and other pleasurable thoughts. (Wright & Abbey, 1965, p. 6)

On the other hand:

> Another subject in the same situation may deal with it in quite another manner. He may soon complain of all manner of things; . . . the bed is causing him a backache, his mind is a blank, . . . intense boredom, tenseness, depressive feelings or of having unpleasant thoughts or picture-like images that disturb him. (Goldberger, 1966, p. 777)

In response to these concerns about the incidence of psychopathological reactions to sensory deprivation, an important thrust of the experimentation in this area has been, by prescreening, to select as subjects only those persons demonstrating, by some measure, psychological strength and capacity to tolerate regression. The theoretical premise of such work has been, as Goldberger (1966)

states:

> In the sensory deprivation experiments, it is the ego's autonomy from the drives that is predominately involved . . . Differences in drive-discharge thresholds, phantasy, and daydream capacity, capacity for what Kris has termed "regression in the service of the ego" are other theoretically relevant structural dimensions accounting for differences in isolation behavior. (p. 778)

These ideas have been subjected to experimental verification, which has corroborated that same individuals tolerate such isolation better than others. For example, Wright and Abbey (1965) using the Rohrshach Test for prescreening, concluded that:

> [The Rohrshach] manifestations of an individual's defense and control mechanisms . . . appears to be a reliable measure for predicting whether or not an individual will be effective in controlling the drive-dominated responses that might emerge during his period of reduced sensory stimulation. (Wright & Abbey, 1965, p. 37)

Anecdotal reports in a similar vein appear from time to time in the literature. Freedman and Greenblatt (1960) mention one subject who became panicky during sensory deprivation and stated he had been diagnosed "borderline psychotic" (p. 1489). Curtis reports on a psychotic paranoid reaction in one subject who suffered delusions for several days afterwards, and severe anxiety and depression lasting several weeks; personality test prescreening had suggested "poor adjustment, hostility, lack of insight, and insecurity in interpersonal relationships" (Curtis & Zuckerman, 1968, p. 256).

Grunebaum, Freeman, and Greenblatt (1960), prescreened 43 subjects and identified 7 as suffering "personality deviations." Two of these subjects, who were diagnosed as borderline, developed frightening, aggressive fantasies, paranoia, and difficulty in reality testing; one of them prematurely terminated the experiment. Two others were diagnosed as psychopathic; both forced the premature termination of the experiment by disruptive behavior.

Azima and Kramer (1956), using interview techniques and formal psychological test data, studied the effects of 2 to 6 days of sensory deprivation on hospitalized psychiatric patients. Among the previously non-psychotic patients they studied, two developed overt paranoid psychoses during the experiment, ultimately necessitating electroshock treatment. These particular individuals appeared to have been unable to tolerate the emergence of aggressive fantasies and images during the sensory deprivation experience.

Effects of Sensory Deprivation on Antisocial Personality Disorder:

Individuals with psychopathic personality disorder are probably among the least tolerant of sensory deprivation. Quay (1965) actually described the essential core of psychopathic

pathology as a pathological inability to tolerate restricted environmental stimulation:

> The psychopath is almost universally characterized as pathologically stimulus seeking and highly impulsive . . . . He is unable to tolerate routine and boredom . . . . (His) outbursts frequently appear to be motivated by little more than a need for thrill and excitement . . . . It is the impulsivity and lack of even minimal tolerance for sameness which appear to be the primary and distinctive features of the disorder. (p. 180)

He goes on to argue that psychopathic individuals may chronically exist in a state of relative stimulus deprivation:

> Highly impulsive psychopathic behavior [may be seen] in terms of stimulation seeking pathology. Decreased reactivity and/or rapid adaptation [to environmental stimuli] . . . produce in these persons an affective state . . . close to that produced by sensory deprivation in the normal individual.

He argues that behavioral impulsivity in such individuals may be an effort at coping with this condition of relative sensory deprivation which they experience:

> It may be possible to view much of the impulsivity of the psychopath, his need to create excitement and adventure, his thrill seeking behavior, and his inability to tolerate routine and boredom as a manifestation of an inordinate need for an increased or changing pattern of stimulation." (p. 181)

In a later study, directly comparing psychopathic inmates with non-psychopathic controls, Emmons & Webb (1974) corroborated these findings; the psychopathic inmates scored significantly higher on measures of boredom susceptibility and of impulsivity. The authors concluded that psychopaths are pathologically stimulation seeking and incapable of tolerating isolation conditions.

In a large scale study of criminal offenders suffering from mental illness, Cota & Hodgins (1990) noted that the prevalence rate of severe mental illness is higher among incarcerated offenders than among the general population; and that, compared with non-mentally ill inmates, the mentally ill inmates were more likely to be housed in solitary. (p. 271) Moreover many of these mentally ill inmates suffered from a combination of psychiatric disorders predisposing them to both psychotic breakdown and to extreme impulsivity (often including substance abuse). (p. 272). Such individuals tended to be highly impulsive, lacking in internal controls, and tended to engage in self-abusive and self-destructive behavior in the prison setting, and especially so when housed in solitary.

Many of the inmates placed in solitary confinement are thus likely to be among the least capable of tolerating the experience, and among the most likely to suffer behavioral deterioration as a consequence of such confinement.

APPENDIX D

REPORTS OF THE LONG-TERM EFFECTS OF SOLITARY CONFINEMENT IN FORMER POLITICAL PRISONERS AND IN PRISONERS OF WAR: SOLITARY CONFINEMENT AS A MEANS OF "BRAIN WASHING" AND "INDOCTRINATING"

Although concerns about the psychiatric effects of solitary confinement among prisoners of war were raised in the medical literature at least as early as post World War II, this issue reached massive public exposure only after the fearful news of "brainwashing" among American prisoners of war in Korea. As is well known, the 1950's were an era of tremendous fear of Communism and of the attempts by Communist States to "indoctrinate" people into their ideology. As noted in the body of this declaration, in the 1950's the U.S. Department of Defense and Central Intelligence Agency sponsored a great deal of research on these issues; Hinkle and Wolff (1956) published results of extensive research done by them for the Department of Defense. The paper documented interrogation techniques of the Soviet KGB in regard to the incarceration of political prisoners, and the Chinese communists' imprisonment of American prisoners of war in Korea.

The report indicated that the KGB operated detention prisons, many of which were "modern . . . well built and spotlessly clean . . . (with) attached medical facilities and rooms for the care of sick detainees. An exercise yard is a standard facility. Incarceration in these prisons is almost universally in solitary confinement in a cell approximately 10' x 6' in size. An almost invariable feature of the management of any important suspect under detention is a period of total isolation in a detention cell." (p. 126)

This isolation was seen as a central feature of the imprisonment. "The effects upon prisoners of the regimen in the isolation cell are striking . . . A major aspect of this prison experience is isolation . . . (In the cells) his internal as well as external life is disrupted (and) . . . he develops a predictable group of symptoms, which might almost be called 'disease syndrome.'" This syndrome develops over time.

> He becomes increasingly anxious and restless and his sleep is disturbed . . . The period of anxiety, hyperactivity, and apparent adjustment to the isolation routine usually continues from 1 to 3 weeks . . . The prisoner becomes increasingly dejected and dependent. He gradually gives up all spontaneous activity within his cell and ceases to care about personal appearance and actions. Finally, he sits and stares with a vacant expression, perhaps endlessly twisting a button on his coat. He allows himself to become dirty and disheveled . . . He goes through the motions of his prison routine automatically, as if he were in a daze . . . Ultimately, he seems to lose many of the restraints of ordinary behavior. He may soil himself; he weeps; he mutters . . . It usually takes from 4 to 6 weeks to produce this phenomenon in a newly

> Imprisoned man . . . His sleep is disturbed by nightmares. Ultimately he may reach a state of depression in which he ceases to care about his personal appearance and behavior and pays very little attention to his surroundings. In this state the prisoner may have illusory experiences. A distant sound in the corridor sounds like someone calling his name. The rattle of a footstep may be interpreted as a key in the lock opening the cell. Some prisoners may become delirious and have visual hallucinations.
>
> Not all men who first experience total isolation react in precisely this manner. In some, the symptoms are less conspicuous. In others, dejection and other despondence earlier, or later. Still others, and especially those with preexisting personality disturbances, may become frankly psychotic. (p. 129)

The authors note that the procedures in the Chinese detention camps are somewhat more complex. Prisoners there underwent an initial period of isolation similar to that found in the Soviet prisons. (p. 153) In the second phase, however they were housed in extremely tight quarters within "group cells" comprising approximately eight prisoners. Under the tensions and hostilities created in this environment, brutality of prisoners against other prisoners was almost inevitable and was, according to the authors, apparently an intended result of this "group cell" confinement. (p. 159)

There are many long-term studies of American prisoners of war; unfortunately, the factor of solitary confinement has not generally been separated out in these studies. However, one relatively recent study of Korean POWs describe long-term effects including interpersonal withdrawal and suspiciousness, confusion, chronic depression and apathy towards environmental stimuli. Irritability, restlessness, cognitive impairment and psychosomatic ailments were extremely common in the group, most of whom had suffered periods of incarceration in solitary confinement at the hands of the Chinese. This report also included a case report of one individual exposed to harsh conditions of solitary confinement for more than 16 months; 30 years after release, he continued suffering sleep disturbances, nightmares, fearfulness, interpersonal suspicion and withdrawal, severe anxiety and severe depression. These former prisoners also had psychosomatic ailments including gastrointestinal disturbances, chronic headaches and obsessive ruminations. They tended to become confused and thus cognitively impaired and were emotionally volatile and explosive.

In a more recent study, Sutker et al. (1991) studied former prisoners of war in the Korean conflict, approximately 40 years after their release from confinement. Solitary confinement was cited as one of the severe stressors in this group. These former prisoners demonstrated persistent anxiety, psychosomatic ailments, suspiciousness, confusion, and depression. They tended to be estranged and detached from social interaction, suffered from obsessional ruminations, and tended to become confused and cognitively impaired, suffering memory and concentration difficulties which affected their cognitive performance on formal testing.

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SOUTHWEST MULTI-COUNTY CORRECTION CENTER
66 Museum Drive, Dickinson, ND 58601
Phone: (701) 456-7790, Fax: 701-456-7687
Norbert V. Sickler, Administrator
Participating Counties: Billings, Bowman, Dunn, Hettinger, Slope, and Stark

TO: Representative Grande, House Judiciary

FROM: Norbert V. Sickler, Admin. of Southwest Multi-Co Correction Center
Dick Johnson, Admin. of Lake Regional Correctional Center
Tracey Trapp, Admin. of Stutsman County Correctional Center

DATE: March 5, 2003

REF: HB 1271 – County Facilities Ability to Provide Female Inmate Services

This memo is in response to your request as to whether or not county facilities would be able to provide the services requested by DOCR.

I: The following are a list of program needs, as identified by DOCR, which county facilities would need to provide:

- Alcohol and drug addiction treatment services including intensive outpatient treatment, day treatment services, AA
- Anger management
- Psychiatric services/medications
- Medical services including dental, optical and outside hospital and clinic services
- GED
- Religious services including a Sweat Lodge for Native Americans
- Work , vocational, industry programs
- Cognitive restructuring/self-change programming
- Case management services
- Contact visitation
- Transportation for inmates to all court and parole hearings
- Mother/infant housing/programming (as proposed for women's prison)

SWMCCC has a parenting program which would be modified for this requirement and also has the required housing available.

All of the above programming, as identified by DOCR, are presently being utilized in our facilities and with additional staff we would be able to provide all of these needs for the women inmates.

II: SWMCCC and other county facilities presently provide these following identified orientational testing and assessments and with additional staff would be able to provide these services.

- Full medical evaluation, including HIV test
- Alcohol and drug evaluation (ASI)
- LSI-R risk/needs scoring
- Psychiatric evaluations
- Sentencing reports
- Educational testing
- Provide orientation on all prison rules, performance based good time statute, etc.
- All above would need to be completed within four weeks

III: County facilities would be able to provide case managers who would supervise the case plan established for the inmates and manage such plan with an inmate on the time table established in order that the inmate could be treatment-complete at the time of their parole board healing.

IV: SWMCCC and other participating county correctional facilities would be able to accept and house female inmates referred to us, regardless of medical, behavioral or mental health reasons, if so required. Those cases involving medical or mental health special needs, which are beyond reach of correctional facilities would then be placed in medical and mental health facilities in the same manner that would be provided by DOCR.

SWMCCC has also been in contact with AN Enterprises, Inc. who has agreed to provide vocational training in the area of data processing, which would also provide minimum wage jobs for the female inmates to assist them in developing a saving account. (see enclosed letter from AN Enterprises, Inc.).

As of this date, counties who have expressed an interest, and have the capacity and ability to provide the required services, include Devils Lake Regional – 25-30 beds available; Stutsman County Correctional Facility – 30 beds available; and Southwest Multi-County Correction Center with 75 minimum/medium bed available at the New England Facility and 12 beds at the Dickinson Facility.

Sincerely,

Norbert V. Sickler, Administrator
Southwest Multi-Co Correction Center

Dick Johnson, Administrator
Lake Regional Correction Center

Tracey Trapp, Administrator
Stutsman County Correctional Center

AN ENTERPRISES, INC.

235 Sims
Dickinson, ND 58601
Phone: 701-225-4811
Fax: 701-225-1186
Website: www.AN-Enterprises.com

February 28, 2003

Mr. Norbert Sickler, Administrator
Southwest Multi County Correction Center
12th Street West & Sims
Dickinson, ND 58601

Dear Mr. Sickler:

My letter is in support of your efforts to have the North Dakota Women's Correctional Facility located in Southwest ND. AN Enterprises, Inc., is a data processing company located in Dickinson, ND. We currently process over 125,000 medical claims per week. AN Enterprises, Inc., would be interested in developing a relationship with your organization, if you are awarded the contract to provide a correctional facility for women. AN Enterprises, Inc., would not only be able to provide real life skills training in data processing for inmates, but we would be willing to hire the incarcerated inmates once they become proficient at data entry work. After their release, we would be interested in continuing employment for proficient individuals. Please keep in mind that the inmate who becomes proficient as a medical claims data entry operator is now very employable anywhere in the United States.

Thank you for taking time out of your busy schedule to discuss training and employment opportunities for inmates.

Sincerely,

Ken Nelson

Ken Nelson, President

DEPARTMENT OF CORRECTIONS AND REHABILITATION

3303 East Main, PO Box 1898 • Bismarck, ND 58502-1898
(701) 328-6390 • FAX (701) 328-6651 • TDD 1-800-366-6888
Website: www.discovernd.com/docr

TO: Representative Grande, House Judiciary
FROM: Elaine Little
DATE: February 5, 2003
RE: Request for information – relating to HB 1271

You requested a list of types of services that we would include in an RFP if we would contract out the housing of all women inmates to county jails. Following are some examples of types of services that are provided by the DOCR. This is not intended to be an all-inclusive list.

I. If a jail planned to house female inmates who had program needs, the jail would need to provide:
- Alcohol and drug addiction treatment services including intensive outpatient treatment, day treatment services, AA
- Anger management
- Psychiatric services/medications
- Medical services including dental, optical and outside hospital and clinic services
- GED
- Religious services including a Sweat Lodge for Native Americans
- Work, vocational, industry programs
- Cognitive restructuring/self-change programming
- Case management services
- Contact visitation
- Transportation for inmates to all court and parole hearings
- Mother/infant housing/programming (as proposed for women's prison)

The above programming would need to be available for women in both minimum security housing and medium/maximum security housing.

II. One of the jails would need to serve as the Orientation Unit for all female inmates sentenced to the DOCR. That facility would need to accept all females and would need to provide the following:
- Full medical evaluation, including HIV test
- Alcohol and drug evaluation (ASI)
- LSI-R risk/needs scoring
- Psychiatric evaluations
- Sentencing reports
- Educational testing

- Provide orientation on all prison rules, performance based good time statute, etc.
- All above would need to be completed within four weeks

IV. Based upon the case plan established for the inmate, the jail would need to manage the plan with the inmate on the timetable established in order that the inmate could be treatment-complete at the time of their parole board hearing.

III. The jails could not refuse to house inmates referred to them (i.e. because of medical, behavioral or mental health reasons) if they were in the appropriate security classification

These are some of the provisions that we would include in a RFP for the housing of women inmates in county jails. As I mentioned it would be a time consuming task to prepare a complete RFP. I hope the above information is helpful.