MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

4029

2003 SENATE HUMAN SERVICES

SCR 4029

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4029

Senate Human Services Committee

☐ Conference Committee

Hearing Date 02/11/03

Tape Number	Side A	Side B	Meter #
1	X		2243 - End
1		X	0 - 2028
2	X		0 - 170
Committee Clerk Signature	Donna Kremer		

Minutes: **Senator Judy Lee, Chairman,** called the meeting to order. Roll call was taken and all committee members present. Sen. Lee requested meeting starts with the committee clerk reading the first three sentences of bill and the testimony on the bill:

Testimony Support of SCR 4029

Senator Robinson - Introduced the bill (meter 2243) as a sponsor. We are all aware of the issues in our state with the growing population of the American Indian population. With that growth comes the problems associated poverty, diabetes, suicide, housing etc. Reviewed additional issues. Discussed his wife and his time on the reservation. We need to be positive but we have a lot of concerns.

Sen Polovitz asked if we have ever had a resolution like this before us? No, this is unique in its broadness

Sen Fischer discussed how we have studied smaller sections of this bill not all of them in its broad sense. Discussion of resolution being only to the legislative council wish it had more

meat. We need to incorporate the native American population in the whole working point of view of this bill. I will welcome anything you can do to enhance this resolution.

Tom Disselhorst, Attorney in behalf of Tex Hall. (meter 3300) Read Testimony-Attachment #1 and amendments-Attachment #2, Discussed creative ways to increase income in the tribes. Discussed 1/3 of or state pens population is American Indian. Think of the money we would save the state if we could reduce these portions to reflect the population numbers. Discussion of Federal Governments role. Respecting each others sovereign. Tribe representation in process. Discussed past resolutions.

"Renaissance Zone" discussed by Sen. Lee (meter 4355)

Discussion of tribal studies, funds, economic development i.e. gaming 1/10th of economic development and resources. Within the tribes there are differences There have been great strides by the reservations themselves for improvement

Carol Two Eagles - (meter 5845) showed support of bill. Discussed diabetes, livelihood changes, suicide rate, lack of religion/culture, inadequate sanitation. Economic Development. Discussed discrimination situations. (Tape 1, side 2, 94)

D.Joyce Kitson - "Pehinsawin" Northern Plain Indian Outreach, Bis. (meter 271) Showed support submitted report - attachment #3

Cheryl Kuloson - Executive Director of ND Indian Affairs Commission (meter 1085) - Testified her support. Discussed history and duties of Commission. The Governor's office hired her after she was in the department of Instruction of Indian Education for 12 years. We need to make sure we include the voice of the native American. Discussed processes of Native People. Discussed willingness of her office to support this legislation in anyway.

Bruce Murry - Employee of ND Protection and Advocacy Project (P&A) (meter 1900) Read Testimony Attachment #4. Sen. Lee discussed Health Component of Bill. Mr. Murry will be available to help with any part of this bill.

David Massey - Assistant Superintendent of Public Instruction - (meter 1900). Discussed Education concerns and available to help resolution in any way.

Testimony in opposition of SCR 4029

None

Testimony Neutral to SCR 4029

None

Senator Judy Lee, Chairman closed the hearing

Senator Judy Lee, Chairman reopened the hearing

Motion Made to DO PASS SB 2399 by Sen. Polovitz and seconded by Sen. Fischer

Roll Call Vote: 4 Yes 0 No 2 Absent

Floor Assignment: Sen. Polovitz

Senator Judy Lee, Chairman closed the hearing

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4029

Senate Human Services Committee

☐ Conference Committee

Hearing Date April 1, 2003

Tape Number	Side A	Side B	Meter #
1	X		2260 - 2322
Committee Clerk Signature	Donna Kramers Clerk		

Minutes:

SENATOR JUDY LEE opened the committee discussion regarding to moral or religious objections by a child placing agency and relating to licensure of child-placing agencies. She said the proposed amendments adds "cultural understanding". Senator Polovitz carried the bill. It seems like a good idea. Anybody object to that?

There were no objections. WILL CONCUR. (Meter # 2260 - 2322)

Date: 02-11-03
Roll Call Vote #: 4029

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

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Sen. ~~Polovitz~~ Seconded By Sen. Fischer

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman	✓				
Senator Richard Brown - V. Chair.	✓				
Senator Robert S. Erbele					
Senator Tom Fischer	✓				
Senator April Fairfield					
Senator Michael Polovitz	✓				

Total (Yes) 4 No _____

Absent 2

Floor Assignment Sen. Polovitz

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

REPORT OF STANDING COMMITTEE (410)
February 11, 2003 1:24 p.m.

Module No: SR-26-2291
Carrier: Polovitz
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SCR 4029: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (4 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). SCR 4029 was placed on the Eleventh order on the calendar.

(2) DESK, (3) COMM

2003 HOUSE HUMAN SERVICES

SCR 4029

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4029

House Human Services Committee

☐ Conference Committee

Hearing Date March 25, 2003

Tape Number	Side A	Side B	Meter #
1		x	7.4 - 35.3
2	x		15.0 - 17.9
Committee Clerk Signature	Sharon Engstrom		

Minutes:

Rep. Boucher for Sen. Robinson appeared as cosponsor in support stating this is a very straight forward resolution and feels the wording is very clear. We know that we have the 5 recognized tribes in one Indian community in the State of ND that is recognized as such a community and is a service area. We are finding we some very significant disparities in a number of the issues in regard to total and percentage of Native American populations as to some of the issues that we're dealing with. Lines 14 & 15 are very significant of great importance whereas the suicide rate for Indian youth between the ages of 15 and 24 is 382% higher than for non-Indian youth in the State. 16 & 17, Indians are 7 1/2 times likely live in households without adequate sanitation facilities in general in the ND population. 50% of the temporary assistance for need families and caseloads represent Indian families and the unemployment rate on our Reservations is 55% on an average. The one also that I think sticks out significantly, in 2001 of the 751 new admissions to

the Department of Corrections, Indians accounted for 18% of the male admissions and 27% of the female admissions.

Rep. Price: Do you feel we will get cooperation form the Tribes?

Answer: Can't speak for them but I can say this, people realize the importance of the relationships and between the Tribes and the Native American Communities across the state, there are the competitions that we have between the nonnative American Communities across the state. So consequently I think it becomes an issue we don't let those obstacles interfere with what we are trying to move forward with. Is this going to be a smooth road, no, but its a road that I think its necessary to go down and its a road that when we encounter some difficulties I don't think we stop, again take a look at the positives and move forward with that. Emphasizing the positives I think we can get a good handle on the negatives that exist.

Carol Two Eagles appeared in support stating there will be cooperation and that its not what you say but how you say it, we are a treaty people.

Jim Jacobson, Deputy Director of the ND Protection & Advocacy (P & A) appeared in support with written testimony.

No opposition. Closed hearing.

Rep. Niemeier noted that their were some amendments from the Three Affiliated Tribes and Rep. Devlin suggested that she talk to Rep. Boucher regarding the amendments.

Rep. Porter: If we're going to possibly look at putting those amendments on, I guess I would definitely look at the difference in language in the whereas portion of this where they are making innuendo's about what is causing the problems on an Indian Reservation, there is no facts or statistics to back it up and I don't think that is the appropriate case to make on the resolution. So

if its going to be seriously looked at, I would certainly hope that the language is also looked at to change.

Rep. Niemeier to Rep. Porter: Could you tell what you feel the presumption is?

Answer: In the Whereas part, poverty, diabetes, suicide, inadequate sanitation facilities, high instance of TANF participation, unemployment and a high number of people being incarcerated in the penitentiary are because of racial tensions and between Indians and non Indians, I just don't see it that way.

Rep. Porter: They are saying that is the contributing factor to all of those things and I don't know where you can show me in a medical journal that the prevalence of diabetes for a Native American is because of racial tensions between Indians and non Indians. I don't know where you can show me that a high number of TANF case loads is because of racial tensions between Indians and non Indians. I don't know where you can tell me that 751 new admissions to the Dept. of Corrections is because of racial tensions, that's making a huge presumptuous statement that I don't necessarily agree with.

Rep. Price: I understand these amendments are from Tex Hall but who presented them?

Answer; Don't know, they just appeared on the intern's desk.

Rep. Devlin: I don't think any of us had any problems with the amendment itself, it certainly is an area we agreed needed to be look at but the way the amendments are worded on here, it may very well create a fire storm.

Rep. Price: We will let Rep. Boucher take a look at it.

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SCR 4029

House Human Services Committee

☐ Conference Committee

Hearing Date March 26, 2003

Tape Number	Side A	Side B	Meter #
1	x		17.9 - 50.5
		x	56.0 - 60.1
Committee Clerk Signature	Sharon Langrow		

Minutes: Committee work.

Rep. Niemeier: Had a discussion with Rep. Boucher and he didn't except Mr. Hall's proposed amendments totally, he took a few things out of there and suggested some amendments and will distribute them.

Rep. Niemeier then explained the amendments and moved them, second by Rep. Potter.

Rep. Porter: Would like someone to explain what the negative conditions are.

Rep. Niemeier: Poverty rate is 3 times, suicide rate, inappropriate housing, 57% of TANF recipients, high unemployment rate and the high percentage rate of Native Americans in the Dept. of Corrections. I think that makes a significant list of negative conditions.

Rep. Porter: I'm not sure what the ND Legislature can do to improve the negative conditions for the Indian population of the State. First we are stating we should study the issue and be it further resolved that we report our findings and recommendations. What is the State's responsibilities

are and the Federal Govt.'s responsibilities are when it comes to all these Whereas on the resolution.

Rep. Amerman: I'm not qualified either to answer this, but there could be Federal responsibilities and could be State responsibilities but its a humane responsibility and I think that encompasses whatever anybody can do to help out the situation and this is just a simple resolution to study it and maybe during the study they will come up with what federal and our responsibility is.

Rep. Pollert: I know the resolution is including sovereignty, which is a pretty wide broad and then its asking the State's ND Legislature to improve the negative conditions for the Indian population, yet they have their own sovereignty, shouldn't they be doing more of their responsibilities and make this forward. You can't have sovereignty and have the State of ND or someone help you out, you have to have one or the other. Would like to hear some comments about that.

Rep. Niemeier: Would also like to have Rep. Price tell how the Indian Tribes are involved in the TANF program.

Rep. Price: They are involved because they are state citizens, they have the opportunity to run their own program because Congress gives them special consideration, that's not allowed to any other group in the country and part of that is because of their sovereignty and their sovereign nation, so at times there is a sovereignty issue and times when they wish not to be or they aren't. That in itself is a whole issue for discussion, as when the Tribes choose to be a sovereign nation and when they choose not to be, and I don't think that's an issue that's ever going to be settled by an interim committee. My concern with the addition of the language on lines 21 is the

unemployment rate granted is higher on the Indian Reservation, but I think that its more an issue of rural ND, because most of our Reservations are all so rural. We have an issue with shortage of economic opportunities throughout ND and not just in that particular area. So in maybe in that we should consider something as far as the economic options in rural areas including reservations. I am a little concerned with the last insert determining what the Legislature can do. I think that's number 1 is automatically considered in be it further resolved. The concern I have there is that its assuming that we can fix it and its not something we can fix alone, its going to have to be a joint thing. The Federal, Tribes and whatever the State participation in that is because there are things that we as a State probably could do, but the Tribes won't let us do that. Goes back to cultural differences. Page 2, line 6, I'm opposed to inserting that language because number 1 I think its automatic in 7 through 9, but whatever is going to be moved forward has to be joint with the Fed's and with the Tribes because we can't do something to them to make it better. They are not going to let us do it, they don't want us to do it with the sovereign issue and if they are not in full agreement with it, it will never work anyway.

Rep. Porter: I've been involved with the A.G's Office on some hunting issues and the Attorney General's office never uses the word sovereignty because Reservations aren't sovereign nations in their minds with the on going negotiations with quasi sovereign, they have quasi sovereignty with certain issues that was granted from treaties all to the way back to the ____ Treaty. The on going issues of ownership of lake Sakakawea all the way to ownership of Oahe Reservoir to all other agreements between the States and the Tribes on the issues of what is or isn't their sovereignty based on those treaties is a huge deal. I think that using that word in a resolution

with those other on going negotiations is not proper from our stand point. I want to know or have clarity on what are the State of ND's responsibilities.

VOTE: 4 - 8 - 1 the whole amendment failed.

Rep. Niemeier moved section one amendment, second by Rep. Amerman. Vote: 4-8-1 Failed.

Rep. Price to Rep. Niemeier: Did they intend in this study to just determine that there is a lack of cultural understanding or is it going to try to educate us on the differences in culture?

Answer: I think that is part of the problem here or disagreements and I think there is racism on both sides, we need to get together and talking is a beginning in solving an issue that isn't good.

Rep. Niemeier moves page 2, line 4 amendment, second by Rep. Potter. Vote: 4-8-1 Failed

Rep. Niemeier moves page 2, line 6 amendment, second by Rep. Potter. Vote: 4-8-1 Failed

Rep. Porter moves page 1, line 2 after including, insert quasi and page 2, line 4 the same thing, second by Rep. Pollert.

Rep. Weisz: no problem with language, maybe we could use limited sovereignty instead of quasi.

Rep. Porter: We have no control over it, why study it.

Rep. Amerman: To study it, is to find out things and to better understand what we're dealing with.

Rep. Porter removes his motion and Rep. Pollert removes his second but also moves amendment to all Federally recognized sovereignty, second by Rep. Pollert. VOTE: 6-6-1 Failed

Rep. Wieland: I'm surprised they want this study because you open up the possibility that may be removed.

Rep. Niemeier motioned for DO PASS as Amended, second by Rep. Potter.

VOTE: 10 - 2 - 1 Rep. Niemeier to carry the bill.

Rep. Price: Judy spoke to her law professor that's in charge of the Indian Law Center and here is her response. I wouldn't have a problem with the bill to have the study but I do object to the language of sovereignty. Investigate the health issues but when you do an investigation of what the sovereign powers of a Tribe is, then you are getting involved in things that are Federal Tribal manner and it will be viewed that the State has no authority to make such an opinion.

Would anyone like to change their mind, based on that information?

33069.0101
Title.0200

Adopted by the Human Services Committee
March 26, 2003

House Amendments to SCR4029 - Human Services Committee 03/27/2003

Page 1, line 2, after the third comma insert "cultural understanding,"

House Amendments to SCR4029 - Human Services Committee 03/27/2003

Page 2, line 4, after the second comma insert "cultural understanding,"

Renumber accordingly

Date: March 26, 2003
Roll Call Vote #:

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SCR 4029

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass As Amended

Motion Made By Rep Niemeier Seconded By Rep Potter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair A			Rep. Bill Amerman	✓	
Rep. Robin Weisz		✓	Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter		✓			
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 10 No 2

Absent 1

Floor Assignment Rep Niemeier

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

REPORT OF STANDING COMMITTEE (410)
March 27, 2003 10:52 a.m.

Module No: HR-55-5863
Carrier: Niemeier
Insert LC: 33069.0101 Title: .0200

REPORT OF STANDING COMMITTEE

SCR 4029: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). SCR 4029 was placed on the Sixth order on the calendar.

Page 1, line 2, after the third comma insert "cultural understanding,"

Page 2, line 4, after the second comma insert "cultural understanding,"

Renumber accordingly

2003 TESTIMONY

SCR 4029

Att #1

MANDAN, HIDATSA, & ARIKARA NATION

Three Affiliated Tribes • Fort Berthold Indian Reservation

404 Frontage Road • New Town, North Dakota 58763-9402

TRIBAL BUSINESS COUNCIL
(701) 627-4781
Fax (701) 627-3805

Human Services Committee
North Dakota Senate
58th Legislative Assembly

Testimony of Three Affiliated Tribes
Mandan, Hidatsa and Arikara Nation

on SCR 4029
Study Resolution on Indian Issues
February 11, 2003

Mr. Chairman, members of the Committee, thank you for the opportunity to present testimony today in favor of SCR 4029, which asks the Legislative Council to conduct a study of factors affecting the Indian population of North Dakota and to determine what can be done by the North Dakota legislature regarding these issues. This testimony is being provided on behalf of Chairman Tex Hall of the Mandan, Hidatsa and Arikara Nation.

As Chairman of my Tribe, I am requested that amendments to this resolution be considered by the Committee. They are simple and hint at some of the causes of the dismal statistics cited in the Resolution, and I urge you to consider these amendments carefully.

Over a number of years, many have despaired at the statistics cited in this Resolution. Many have said that it is impossible for the state of North Dakota to do anything about these statistics; it is simply too big a task for the state and besides isn't it the Federal government's responsibility?

Impossible is simply not a word I accept. As I stated in my speech to the legislature, we are now in a position where we need to work together, the Tribe and the state, in an atmosphere of mutual respect for our sovereign rights, to improve the conditions for all people who live in our state, ~~and that~~ improving conditions for all the Native Americans who live on and off the reservations in our state. While Tribes believe their fundamental relationship is with the United States, and not the individual states, the Federal government does not do it all, and delegates many responsibilities regarding Tribes and our members to the states, and there is little Tribes can do about that. That is why it is so important that we work together on common problems.

Industry

What the statistics of this resolution also tell me very strongly is that denying that the state can do anything about these statistics costs the state of North Dakota literally millions of dollars per year. Look at the cost of housing inmates in the state penitentiary, one-third of

whom are Indians, or the cost of supplying Temporary Assistance to Needy Families to Indians, who are half the case load. Look at the cost of suicides and poor educational opportunities, or the cost of job insurance and so forth. If economic conditions are improved for Indians in our state, the state saves itself a lot of money. The deficit you are all talking about can virtually disappear; but we have to come up with some real solutions..

That is why I have so strongly stated in my speech to you and want included in this resolution the need to improve economic opportunities for our Native American populations in this state. There is a lot we can do, acting in cooperation with each other, to do that. Last week, I met with legislative leaders of both parties to discuss further what we can do, just in terms of looking at ways to increase the number of Federal contracts that can be obtained by our qualified Tribal and individually owned Indian businesses on the reservations.

But there are many other ideas for improving economic opportunity that should be looked at, too; extending tax incentives to the reservations, providing more opportunity for Tribes and individual Indians to access capital through the state Department of Commerce and the Bank of North Dakota, improving communications between the various economic development centers of our state and the Tribes, meeting together to determine how we can improve the rural economy of our state and so forth.

Another area of great concern to me are continuing racial tensions that exist in places like within our higher education facilities and elsewhere in our state. It is not simply a set of isolated events, these incidents represent a pattern that is directed, for example, at those who might have a different cultural viewpoint about one or more issues. As leaders we must not let that continue, we must come up with ways to make our state a place where all races and all cultures feel welcome. That simply makes good economic sense, as we continue to want our economy to grow and provide a reason for our young people to stay in our state

As you can tell, this study resolution raises critical issues for the future of our state and the Indian people who live here. Because we are the fastest growing segment of the population, it would be very unwise not to ignore these issues and leave them for a future legislature. We cannot afford to wait. Too many Native American young people are expecting that our generation do something to improve the likelihood that they can be successful. That has been my mission and I believe that the state can have a very positive role in that effort.

I urge the Committee to give a DO PASS recommendation to SCR 4029, with the amendments I have suggested.

AH #2

Proposed Amendments to SCR 4029 (at the request of Chairman Tex G. Hall)

After line 24, on page 1, add the following WHEREAS clauses:

WHEREAS, factors, among others, that contribute to the statistics mentioned above include racial tensions between Indians and non-Indians and a lack of economic opportunity on or near Indian reservations;

In the first NOW, THEREFORE BE IT RESOLVED paragraph on the second page, add the following phrases as underlined.

That the Legislative Council study issues relating to the Indian population of the state, including sovereignty, racial discrimination, economic development opportunities, educational opportunities, population dispersement, unemployment, health concerns, suicide rates, living conditions, and impact on the caseloads of the Department of Human Services and the Department of Corrections and Rehabilitation to determine what the North Dakota legislature can do to improve the negative conditions for the Indian population in the state; and

Att #3

ADX Florence, Colorado
Supermax, Control Unit,
9-10-97 – 7-11-2001

State No. 22143

OCT 11 1999

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 involvement 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. Psychological Effects of Severe Isolation

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 declaration.) 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.

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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 those) 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, Sklar 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 realty-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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Att # 4

TESTIMONY
NORTH DAKOTA PROTECTION AND ADVOCACY PROJECT
SENATE CONCURRENT RESOLUTION 4029
FEBRUARY 11, 2003
SENATE HUMAN SERVICES
SENATOR JUDY LEE CHAIRMAN

Chairman Lee and members of the Senate Human Services Committee, my name is Bruce Murry and I am an employee of the North Dakota Protection and Advocacy Project (P&A). P&A supports SCR 4029.

P&A especially wishes to call the Legislature's attention to the prevalence of traumatic brain injury (TBI) among the state's Native American population. Nationally, TBI occurs at twice the average rate among Native Americans - 4% vs. 2% of the population. Anecdotally, P&A has observed in its outreach that this ratio seems valid or even conservative in North Dakota.

Because people with TBI can be difficult to categorize within existing disability definitions, they can fall between the cracks in current statistics and services. P&A requests that the portion of the study on Native American health pay special attention to TBI.

Thank you for this opportunity and I am available for any questions.

Help save a soul! Our Prisoners of War in North Dakota, South Dakota, Minnesota .....

February 11, 2003

Attention: State Legislatures

It has come to our attention as concerned citizens of North Dakota that there have been numerous arrests of Native Americans and the poor in both Morton, Burleigh, and Cass Counties. Who, are not allowed adequate not being represented by an attorney. Misdemeanors for the poor are as high as $3000 to $5000 cash bond for them. Many have lost time and jobs. In one instant a Sheriff from SD called the shots and jailed a Native American youth for 6 months in a hole before taking allowing him to appear before a judge, this youth attempted suicide here in the Mandan, after stopped and searched for not apparent reason he was admitted to Med Center One. In the Aberdeen area a Native American man was beaten by law officials and it is known that he was cremated. Two youth incarcerated in Minot Youth Correctional facility recently committed suicide. Two recently released ND State Prison inmates also committed suicide.

Enclosed please see the Fargo Forum's recent article of Officer Zieska shooting to death a former inmate from the ND State Prison who was vulnerable to begin. Mr. Ellingston like other inmates was forced to take psychotic drugs. This explains his attention deficit hyper-activity and rejection he received due to his behavior. These incarcerated individuals should be alive! We as citizens do feel safe at the hands of immature, incompassionate law enforcement officers due to the TERROR they cause and inflict upon our poor.

These prisons, jails, boot camps, foster homes would be empty if it was not for immature & ruthless officers, Security guards, probation officers, youth care workers, judges, prosecuting attorneys severely punishing our youth and adults. Taking the law into their own hands and calling the shots. Many of these individuals may never be released or allowed to communicate with their relatives. Of recent, I have been denied visitation to visit my 18 year old nephew, who, was abandoned by his parents and brother, has been sitting in Burleigh County jail since his grandmother died before Thanksgiving with a $5000 cash bond who defended himself from a terrorist. The perpetrator is free while the innocent sits and sits and sits.

I can only assume that someone is benefitting from the dollar or needs a raise or needs a new facility built for more jobs at the cost of lives. This must be stopped. We have PRISONERS OF WAR in our State. Please, read the enclosed 37 page report on what happens to our loved ones as they are traumatized over and over again. Some do not realize their condition. We, as citizens want these inhumane acts toward our loved ones stopped and those involved disciplined and a warning issued to them. ***Compensation*** is the word that should be used for their inhumane acts toward our loved ones. We, need a parental police force to guard our families now.

May God have mercy on us and our leaders in this tragic hour! ***Concerned Citizens***

Economy affects support for charity

By BLAKE NICHOLSON
Associated Press Writer

A sluggish economy affected public support for charities in North Dakota in 2002, although most American Red Cross chapters said the impact was not felt until the latter part of the year.

Donations to the Minot-based Mid-Dakota chapter in fiscal 2002, which ended June 30, were up 4.4 percent over the previous year, director Allan McGeough said. But he estimated that donations in the first half of fiscal 2003 were down 8.5 percent from the previous year.

The Fargo-based Minn-Kota chapter of the Red Cross saw public donations in fiscal 2002 increase 3.3 percent, director Kathy Schons said.

Public donations to the Red River Valley chapter in Grand Forks in the same time period were up about 15 percent, a spike that director Mason Hollifield attributed to the ongoing flooding problems in the region, including northwestern Minnesota.

"If people see the (Red Cross) service and appreciate the service, the funding is going to increase," Hollifield said.

However, he said donations in the last half of calendar 2002 dropped about 11 percent compared to the previous year. He blamed the sour economy.

The Red Cross' Bismarck-based Burleigh-Morton chapter, which covers 14 counties in south central and southwestern North Dakota, saw public donations last year drop about 50 percent, or about $100,000.

The region was ravaged by drought in 2002, but chapter director Keith Engbrecht said it was difficult to place all the blame for the drop in support on the weather.

"Clearly, the economy could be a factor," he said. "The response to Sept. 11, 2001, was major, not only from the Red Cross but from other charitable organizations. Lots of people would point to that and say people spent all their money."

Scott Crane, president of the Fargo-based United Way of Cass-Clay, said a swell in donations after the 2001 terrorist attacks did not carry over into 2002.

"In 2001, we saw an 11 percent increase in our giving, and we had hoped to continue that (in calendar 2002) with about a 5 percent increase," he said. "But there was some softness in the economy that impacted us a little bit."

Donations to the chapter last year were up only 2 percent over 2001, Crane said.

Contributions to the Bismarck-based Missouri Slope Areawide United Way in calendar 2002 were up 3.3 percent over 2001, administrative assistant Connie Berland said. She said chapter officials were not counting on a carry-over in the giving spirit generated by the terrorist strikes.

"We knew it was going to be a tough year economywise," Berland said. "A lot of corporate donations were down because of that."

Man shot by police led troubled life

FARGO (AP) — Friends and relatives say Jesse Ellingson led a troubled life that included health problems and prison, but they also saw kindness in the man who was killed in a confrontation with police.

Ellingson, 25, who grew up in Northwood, was shot to death early Sunday by Officer Brad Zieska after a domestic assault and car chase. Police said Ellingson charged officers with a machete and disregarded orders to put down the weapon.

Zieska, 29, is on administrative leave pending an investigation, standard procedure after a police shooting.

Police records show Zieska, a Fargo police officer since 1999, received high marks in dealing with drunk and disorderly people and enforcing a "zero tolerance" approach to alcohol and disorder complaints. Earlier, he worked for the Bismarck Police Department and as a security guard in Fargo.

"He has an excellent work ethic," Police Chief Chris Magnus said.

Ellingson had been convicted of various offenses since assault on a police officer and criminal trespass in Grand Forks, Jamestown, Minot and Fargo, court records show.

For a time in high school, he lived with his grandparents, Cheryl and Benny Ellingson, in a home on the Goose River west of Northwood.

He had been diagnosed with Tourette's syndrome, attention deficient disorder and attention deficient hyperactivity disorder, family members said.

"If he was on his medications, and supervised, he was fine," said his grandmother, Cheryl Ellingson.

Ellingson's father, Jeff, said his son was "very kind and could be very thoughtful."

"I understand he wasn't completely in the right, but I think they used too much force on this," Jeff Ellingson said.

Police said Zieska acted properly.

Washington Post

WASHINGTON — The Bush administration is developing a parallel legal system in which terrorism suspects — U.S. citizens and noncitizens alike — may be investigated, jailed, interrogated, tried and punished without legal protections guaranteed by the ordinary system, lawyers inside and outside the government say.

The elements of this new system are already familiar from President Bush's orders and his aides' policy statements and legal briefs: indefinite military detention for those designated "enemy combatants," liberal use of "material witness" warrants, counterintelligence-style wiretaps and searches led by law enforcement officials, and, for noncitizens, trial by military commissions or deportation after strictly closed hearings.

Only now, however, is it becoming clear how these elements could ultimately interact.

For example, under authority it already has or is asserting in court cases, the administration, with approval of the special Foreign Intelligence Surveillance Court, could order a clandestine search of a U.S. citizen's home and, based on the information gathered, secretly declare the citizen an enemy combatant, to be held indefinitely at a U.S. military base. Courts would have very limited authority to second-guess the detention, to the extent that they were aware of it.

Administration officials, noting they have chosen to prosecute American Taliban John Walker Lindh, "shoe bomber" Richard Reid and alleged Sept. 11 conspirator Zacharias Moussaoui in ordinary federal courts, say the parallel system is meant to be used selectively, as a complement to conventional processes, not as a substitute. But, they say, the parallel system is necessary because terrorism is a form of war as well as a form of crime, and it must not only be punished after incidents occur but also prevented and disrupted through the gathering of timely intelligence.

BISMARCK TRIBUNE

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Bismarcktribune.com

SUNDAY, JANUARY 12, 2003 — BISMARCK-MANDAN, N.D.

Illinois governor empties state's death row

By DON BABWIN
Associated Press Writer

CHICAGO — Calling the death penalty process "arbitrary and capricious, and therefore immoral," Gov. George Ryan commuted the sentences of 167 condemned inmates Saturday, clearing Illinois' death row in a move unprecedented in scale in U.S. history.

Ryan's action, just two days before he leaves office, drew immediate angry reaction from prosecutors, the incoming governor and relatives of some of the victims.

He said he sympathized with the families of the murdered women and children who had been murdered, but said he felt he had to act.

"I am not prepared to take the risk that we may execute an innocent person."

Illinois Gov. George Ryan, in a letter to victims' families

"I am not prepared to take the risk that we may execute an innocent person," he wrote in an overnight letter to the victims' families notifying them of his plans.

With death row inmates he had recently pardoned sitting in the audience as he spoke Saturday, Ryan framed the death penalty issue as "one of the great civil rights struggles of our time."

"Our capital system is haunted by the demon of error — error in determining guilt, and error in determining who among the guilty deserves to die," Ryan said. "What effect was race having? What effect was poverty having?

"Because of all these reasons, today I am commuting the sentences of all death row inmates."

Ryan had halted all executions in the state nearly three years earlier after courts found that 13 Illinois death row inmates had been wrongly convicted since capital punishment resumed in 1977 — a period when 12 other inmates were executed.

He said studies conducted since that m[illegible]um

SEE RYAN, 8A

TESTIMONY
NORTH DAKOTA PROTECTION AND ADVOCACY PROJECT
SENATE CONCURRENT RESOLUTION 4029
March 25, 2003
HOUSE HUMAN SERVICES
REPRESENTATIVE CLARA SUE PRICE, CHAIRMAN

Chairman Price and members of the House Human Services Committee, my name is Jim Jacobson and I am the Deputy Director of the North Dakota Protection and Advocacy Project (P&A). P&A supports SCR 4029.

P&A especially wishes to call the Legislature's attention to the prevalence of traumatic brain injury (TBI) among the state's Native American population. Nationally, TBI occurs at twice the average rate among Native Americans - 4% vs. 2% of the population. Anecdotally, P&A has observed in its outreach that this ratio seems valid or even conservative in North Dakota.

Because people with TBI can be difficult to categorize within existing disability definitions, they can fall between the cracks in current statistics and services. P&A requests that the portion of the study on Native American health pay special attention to TBI.

Thank you for this opportunity and I am available for any questions.

TRIBAL BUSINESS COUNCIL
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Human Services Committee
North Dakota House of Representatives
58th Legislative Assembly

Testimony of Three Affiliated Tribes
Mandan, Hidatsa and Arikara Nation

on SCR 4029
Study Resolution on Indian Issues
March 25, 2003

Mr. Chairman, members of the Committee, thank you for the opportunity to present testimony today in favor of SCR 4029, which asks the Legislative Council to conduct a study of factors affecting the Indian population of North Dakota and to determine what can be done by the North Dakota legislature regarding these issues. This testimony is being provided on behalf of Chairman Tex Hall of the Mandan, Hidatsa and Arikara Nation.

As Chairman of my Tribe, I am requesting that certain amendments to this resolution be considered by the Committee. They are simple and hint at some of the causes of the dismal statistics cited in the Resolution, and I urge you to consider these amendments carefully.

Over a number of years, many have despaired at the statistics cited in this Resolution. Many have said that it is impossible for the state of North Dakota to do anything about these statistics; it is simply too big a task for the state and besides isn't it the Federal government's responsibility?

Impossible is simply not a word I accept. As I stated in my speech to the legislature, we are now in a position where we need to work together, the Tribe and the state, in an atmosphere of mutual respect for our sovereign rights, to improve the conditions for all people who live in our state, and to improve conditions for all the Native Americans who live on and off the reservations in our state. While Tribes believe their fundamental relationship is with the United States, and not the individual states, the Federal government does not do it all, and delegates many responsibilities regarding Tribes and our members to the states, and there is little Tribes can do about that. That is why it is so important that we work together on common problems.

What the statistics of this resolution also tell me very strongly is that denying that the state can do anything about these statistics costs the state of North Dakota literally millions of dollars per year. Look at the cost of housing inmates in the state penitentiary, one-third of

whom are Indians, or the cost of supplying Temporary Assistance to Needy Families to Indians, who are half the case load. Look at the cost of suicides and poor educational opportunities, or the cost of job insurance and so forth. If economic conditions are improved for Indians in our state, the state saves itself a lot of money. The deficit you are all talking about can virtually disappear; but we have to come up with some real solutions.

That is why I have so strongly stated in my speech to you and want included in this resolution the need to improve economic opportunities for our Native American populations in this state. There is a lot we can do, acting in cooperation with each other, to do that. I have met several times during this session with legislative leaders of both parties to discuss further what we can do. One result of this effort is another bill pending in the legislature, HB 1504, that provides funds for an economic development study to be performed that includes studying how we can make economic development happen for the Indian reservations in this state.

But this resolution should also be passed, because there are a number of additional issues facing Indian tribes besides economic development. We must get at some of the root causes of the statistics that are presented in this resolution. One issue which remains is that continuing racial tensions exist in our state and we need to be able to confront these issues by providing people who have been discriminated against with a real remedy. As leaders we must not let racial issues fester, we must come up with ways to make our state a place where all races and all cultures feel welcome. That simply makes good economic sense, as we continue to want our economy to grow and provide a reason for our young people to stay in our state, as the recent Save North Dakota panel of young people has pointed out.

As you can tell, this study resolution raises critical issues for the future of our state and the Indian people who live here. Because we are the fastest growing segment of the population, it would be very unwise not to ignore these issues and leave them for a future legislature. We cannot afford to wait. Too many Native American young people are expecting that our generation do something to improve the likelihood that they can be successful. That has been my mission and I believe that the state can have a very positive role in that effort.

I urge the Committee to give a DO PASS recommendation to SCR 4029, with the amendments I have suggested.

Proposed Amendments to SCR 4029

After line 24, on page 1, add the following WHEREAS clauses:

WHEREAS, factors, among others, that contribute to the statistics mentioned above include racial tensions between Indians and non-Indians and a lack of economic opportunity on or near Indian reservations;

In the first NOW, THEREFORE BE IT RESOLVED paragraph on the second page, add the following phrases as underlined.

That the Legislative Council study issues relating to the Indian population of the state, including sovereignty, racial discrimination, economic development opportunities, educational opportunities, population dispersement, unemployment, health concerns, suicide rates, living conditions, and impact on the caseloads of the Department of Human Services and the Department of Corrections and Rehabilitation to determine what the North Dakota legislature can do to improve the negative conditions for the Indian population in the state; and

PROPOSED AMENDMENTS TO SCR 4029

Page 1, line 21, after "percent" insert ",and there is a lack of economic opportunity on or near reservations"

Page 2, line 4, after "sovereignty," insert "cultural understanding, economic development opportunities,"

Page 2, line 6, after "Rehabilitation" insert ", to determine what the North Dakota Legislature can do to improve the negative conditions for the Indian population in the state"

By: Niemeier & Boucher