COMMISSION ON SAFETY AND ABUSE
IN AMERICA'S PRISON

PUBLIC HEARING 2 - DAY 1
JULY 19, 2005
NEWARK, NEW JERSEY

OVERCROWDED FACILITIES AND
THE USES AND EFFECTS OF ISOLATION

TRANSCRIPT of the stenographic notes of the proceedings in the above-entitled matter, as taken by and before MARGARET M. REIHL, RPR, CRR, CSR, Notary Public of the State of New Jersey, held at the Mary Burch Theater, Essex County College, 303 University Avenue, on Wednesday, July 19, 2005, commencing at 8:45 a.m.

APPEARANCES:

COMMISSIONERS:

THE HONORABLE JOHN J. GIBBONS (Co-Chair)
NICHOLAS de B. KATZENBACH (Co-Chair)

STEPHEN B. BRIGHT
RICHARD G. DUDLEY, JR., M.D.
CHARLES FRIED
JAMS GILLIGAN, M.D.
RAY KRONE
MARK H. LUTTRELL
SAUL A. GREEN
GARY D. MARYNARD
PAT NOLAN
STEPHEN T. RIPPE
LAURIE O. ROBINSON
SENATOR GLORIA ROMERO
TIMOTHY RYAN
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THE HONORABLE WILLIAM SESSIONS

COUNSEL:

JON WOOL, SENIOR COUNSEL
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EXECUTIVE DIRECTOR:

ALEXANDER BUSANSKY

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OPENING STATEMENTS

JUDGE GIBBONS: Good morning. We're going to start this morning introducing the people who are at the table and I think we'll first hear from Alex Busansky, our Executive Director.

MR. BUSANSKY: Good morning. I'm Alex Busansky, the Executive Director, and I just want to welcome everybody here to our second hearing in Newark, New Jersey.

JUDGE SESSIONS: It's hard to hear you.

MR. BUSANSKY: Sorry about that, Judge Sessions.

This morning will begin with introductory remarks by General Katzenbach, and then we'll proceed with witnesses.

Judge Gibbons and General Katzenbach, if I could just ask you to go around the room and introduce all the commissioners and get a brief sentence from all of them, that would be terrific.

JUDGE GIBBONS: Yes. The gentleman whose just been speaking is Alex Busansky, the Executive Director for the Commission.

And on his left is Jon Wool, Senior Counsel for the Commission.

On his right is Pat Nolan, President of

Prison Fellowship's Justice Fellowship and member of the National Prison Rape Elimination Commission, and just incidentally, a former prisoner.

On his right, Gary D. Maynard, Director of the Iowa Department of Corrections and President-Elect of the American Correctional Association.

On his right, Senator Gloria Romero, California State Majority Leader and Chair of the Senate Select Committee on the California Correctional System.

On her right, Saul A. Green, former United States Attorney for the Eastern District of Michigan from 1994 to 2001.

On his right, Stephen T. Rippe, Executive Vice President and Chief Operating Officer of the Protestant Episcopal Cathedral Foundation and a former Major General in the United States Army.

On his right, Frederick A.O. Schwarz, Jr., Senior Counsel at New York University Law School's Brennan Center for Justice, and Chairman of the Vera Institute Board of Trustees.

Nand on his right, Margo Schlanger, a leading authority on prison and inmate litigation and Professor of Law at Washington University.

MR. KATZENBACH: Good morning. I'm Nick Katzenbach and let me introduce the other members of the Commission.

On my right, starting at my far right, The Honorable William Sessions, former U.W. District Judge in the Western District of Texas, and former Director of the Federal Bureau of Investigation.

Next to him is James Gilligan, a nationally renowned expert on violence and violence prevention.

Next to him is Mark Luttrell, Sheriff of Shelby County, in Memphis, Tennessee, and a former warden at three federal prisons.

On his left is Ray Krone, who spent more than a decade in prison, some of it on death row, before DNA testing cleared his name.

On his left is Stephen B. Bright, one of the best known advocates for the rights of prisoners.

On his left is Laurie O. Robinson, former U.S. Assistant Attorney General in charge of the Office of Justice Programs.

Her left is Charles Fried, Professor of Consitutional Law at the Harvard and a former Solicitor General of the United States.

On his left is Timothy Ryan, Chief of Corrections for Orange County, Florida, one of the largest jail systems in the United States.

On his left and my immediate right is Richard G. Dudley, Jr., often called on for expert opinions about the lasting psychological damage of violence and abuse in prisons.

We're here today in Newark as part of a year-long process to examine the serious problems in our nation's prisons and jails; and how those problems affect the estimated 13.5 million people who are incarcerated over the course of a single year, the 750,000 men and women who staff all those facilities and, indeed, affect all of us, because what happens behind bars is not only our responsibility as citizens, but it is a part of our society and what happens there doesn't stay there.

What happens in prison and jail affects the very fabric of our society as millions of people return to the community, either at the end of their sentence or at the end of their shift. And there's much more at stake beyond the important issue of public safety. When we fail to make peoples' living and work environments safe places where they are respected, we not only fail those individuals, we

erode collective faith in the American justice system, in our core values, and in our own self-respect. We become more fractured as a society.

It's a complex web of policies, practices, institutional struggles that undermines whether those facilities are safe, humane and effective. When things go terribly wrong inside a jail or prison, there's usually an underlying institutional cause. It can't be blamed on just a few bad habits.

What we're focusing on today and tomorrow are widespread, seemingly intractable institutional problems: Overcrowding, the use and misuse of isolation, the medical healthcare neglect that endangers individual inmates and officers and, also, public health. These problems challenge and frustrate the many conscientious, hardworking correction officials around the country, partly because they can't prevent or fix them on their own but deal with them, they have to.

The phrase institutional policies and practices sounds abstract; it's not. It's life for Pearl Beale, after being her son Givon was murdered in an extremely crowded jail in Washington, DC. The jail that's still overcrowded and deemed too dangerous for

New York Times reporter Judith Miller, but not for the mainly poor and African-American people confined there.

But when you hear Sergeant Gary Harkins, a 25-year veteran of the Oregon Department of Corrections describe working in facilities so safe and humane that he can walk the halls with only a whistle or radio for protection, the term direct supervision no longer seems abstract.

I began my remarks by saying we're here to examine the problems, and that's true. We're also here to try to figure out how to deal with at least some of those problems and one of the best ways to do that is to ask the leaders in the profession, whose voices aren't always heard.

Among the people testifying later today and tomorrow are Richard Stalder, who heads the Department of Public Safety and Corrections in Louisiana and is also president of the Association of State Correctional Administrators.

Jeffrey Beard who runs the Pennsylvania Department of Corrections.

Reginald Wilkinson, Director of the Ohio Department of Rehabilitation and Correction.

And Arthur Wallenstein, who oversees

corrections in Montgomery County, Maryland.

The Commission looks forward to your testimony and we know that we have much to learn from you.

It's fitting to hold this hearing in New Jersey and not just because it's my home and that of Judge Gibbons, government officials in New Jersey grapple with all these problems we'll discuss over the next two days, and there may be real progress in some areas.

Not so long ago, for example, prisons in New Jersey were extremely overcrowded but smart policy decisions by corrections leaders and state lawmakers brought that situation under better control, at least in the state's prisons.

I want to thank all of you today, and people throughout the state and, particularly, in the City of Newark who have so warmly welcomed the Commission.

PRISON POPULATION, SIZE AND DEMOGRAPHICS, TRENDS AND CONTEXT

MS. ROBINSON: I would like for our first panel, to call witness Allen Beck to come forward. Our first panel will be addressing prison population, size and demographics, trends and context.

This first panel actually consists of one witness, but because of his very broad experience and knowledge, one person in this case can constitute a virtual panel.

I've had the privilege in the US Department of Justice for seven years of working with Dr. Allen Beck, who is Chief of the Bureau of Justice Statistics Correction Statistics Program. Dr. Beck has agreed to appear here today to provide what I think are very important background statistics for the Commission relating to incarceration rates and demographics concerning the nation's prisons and jails and I think this is, indeed, very important backdrop information for our work.

Dr. Beck earned his Ph.D. in sociology at the University of Michigan and has worked as a statistician at the Bureau of Justice Statistics for 20 years. His past work at BJS has included studies related to, just as examples, recidivism, estimates of lifetime chances of going to prison, trends in US probation and parole populations and rising incarceration rates.

He is currently responsible for an enormous initiative relating to prison rape in which commissioner Pat Nolan is involved as a member of the

national commission. And Allen Beck is also overseeing important special projects at BJS on subjects ranging from causes of death among prison and jail inmates, to prisoner re-entry and inmate medical problems.

As all of us know, in the field of corrections emotions run very high. Advocacy groups abound and facts, figures and statistics are frequently cited and thrown around to bolster various positions and, at times, it can be very confusing to sort those through. In that maze the clarity of BJS's statistics for many decades have stood as very clear, black and white kind of grounded basis on which we can all rely and much of that has come from Allen Beck, someone on who all of us in the field have come to rely.

In many ways, as many of us know, BJS is the justice equivalent of the Bureau of Labor Statistics in that field and, Allen, I was thinking of saying you were kind of our field's equivalent of Allen Greenspan, but then I thought, no, that's a bad analogy, I won't do that.

But we are delighted to have you here today and before turning to you to proceed, I wanted to turn to fellow commissioner Tim Ryan for some

additional introductory comments.

MR. RYAN: Thank you, Commissioner Robinson. I also wanted to commend Dr. Beck -- Chief Beck for being here. I've been involved with jails for now 35 years and many of those years I have certainly counted on the work that you have done, it's been much appreciated, and I think for this Commission's report, however, moving from anecdotal information to the quantifiable statistics, what's real, what's true and what's really going on in the field is critically important to how we move and what direction we take at the end of this report, and I know that the work you have done have made it very real.

I also want to commend you for an opportunity I had last December for attending the meeting in Washington with you on the Prison Rape Elimination Act, putting a group of folks together that made it very real for us to help and assist you in a direction to go relative to that report and I want to thank you for making that happen because I think it was a critical component in the success you have received and the quantifiable information that's going to be available in the future.

So I also commend you for being here

and look forward to your report. Thanks, Allen.

DR. BECK: Thank you very much. I am honored to be here and --

SENATOR ROMERO: Excuse me. I can't hear you, and I would ask for the commissioners too, if you could speak directly into the mike. It's hard to hear. And for the witnesses, if you could maybe just pull the mike on to your notebook and speak directly into it, I would appreciate it. Thank you.

MR. KATZENBACH: You can pretend you are a rock singer.

DR. BECK: Yes, I have fantasies of being a rock singer, tell my wife that.

JUDGE SESSIONS: It is not better. We can't hear. The reporter cannot hear.

DR. BECK: Try it again.

MS. ROBINSON: Pull it closer, Allen.

DR. BECK: I'm delighted to be here, and honored, I'm quite flattered by the introduction. I hope I can live up to those very kind words.

Let me say that I hope that the work that I do will inform the Commission and assist in the deliberation of the Commission and have an important impact on the discussion. I know the data we collected at the Bureau of Statistics --

MS. ROBINSON: We can't hear you. Allen, if you can actually just pull it really close.

JUDGE SESSIONS: I will tell you about the problem. There is a piece of equipment here that's on.

DR. BECK: Tremendous feedback.

JUDGE SESSIONS: So there's back sound here, and she cannot hear you.

DR. BECK: And so, what I would like to do this morning is go through some basic statistics that I've collected, assembled, for this Commission. I'm not going to march through all the slides, I'd just like to make some major points that I believe are contained in the slides that I have put together.

Let me say that this has been a phenomenal time in the history of the United States, we've seen dramatic growth in the correctional system throughout the country; not just prisons, not just jails, but all forms of corrections. We've gone from about 1 percent of the adult population under correctional supervision back in 1980 to over 3.2 percent of the adult population under correctional supervision, despite drops in crime in the most recent decade. And so we have seen a dramatic expansion of the correctional system in the United States. Prisons

and jails are a part of that system and it's important to understand their part, that if small changes in that system, one part of the system can have fairly dramatic impact on other parts of the system.

And so we've seen in the last 25 years a quadrupling of the incarceration rate in the United States, in prisons, and we've seen an increase from about 100 per 100,000 jail inmates in 1983, when we first started collecting data on jails, to over 283. So we've seen a very dramatic increase in the nation's prison and jail populations.

At this point we're looking at about 2.1 million adults under correctional supervision that is in prisons and jails and an additional nearly 5 million on probation and parole, so we've seen a very substantial impact.

But it's important to understand that prisons and jails are part of the larger system and as we've seen growth in prisons and jails, we've also seen growth in probation and parole. And, in fact, during the 1980s the probation population and the parole population grew faster, not slower, than the prison and jail population.

Let me say that our experience in the last two decades, since 1980, is that the growth in

the prison population is not about crime, it's about how we have chosen to respond to crime and, that is, we've introduced sanctioning policies that have had profound impacts on the size and composition of the nation's prison population. And so we have seen dramatic growth in the likelihood of going to prison, in the 1980s that was primarily a driver of growth of that population, in conjunction with increasing crime.

In the mid 1990s we saw an increased sentences, new sanctions imposed to increase the length of stay. There are only two ways to grow prison population; one is send more people there and the other way is to hold them there longer, and we did both in the 1990s. And so there wasn't real direct one-to-one relationship between shifts in crime and rising prison populations.

We also have seen in the 1990s growth leading to increasing numbers of offenders being returned to state prison after being released, after having been on parole or some other form of post-custody supervision. We saw a dramatic increase in the number of parole violators being returned to prison, that has abated. We have leveled off in that. Since 1998 we have seen a fairly flat number coming in each year. About 200,000 admissions to state prisons

each year being parole violators, that is people who failed while under post-custody supervision. That has not grown.

On the other hand, we see now an emerging trend of growth coming directly out of court, new court commitments rising faster in the last couple of years than parole violators.

The sentencing reforms of the 1990s had a profound impact and a lasting impact on this growth of the population. We had a drop in the numbers of people being released from prison and had we not seen a drop, we would probably see nearly 100,000 more people coming out each and every year than we did had those rates occurred in 1990.

We saw an average increased length of stay from about 22 months to 30 months and one of the remarkable things is really that was achieved not by very long draconian sentencing, long lengths of stay, but, really, if you will, to use a statistician's term, a clipping off of the bottom distribution, that is those serving less than six months was cut in half, going from a quarter volume of inmates serving less than six months to under 12 percent.

JUDGE SESSIONS: Will you say that again.

DR. BECK: Yes.

One of the things that are often missed in studying prisons is that people don't stay very long, that is there is a portion of the population that comes in, comes out, moves very quickly. And before the sentencing reforms, we had about a quarter of the inmates getting out who have served under six months. The nature of sentencing reforms was due to increases in mandatory minimums, to impose a certain mandatory minimum, and you see these in the statistics, that is the drop in the proportion of inmates who actually served six months or less and it went from about 26 percent serving six months or less in 1990 to the latest count of 14, 15 percent serving six months or less. So we have churning going on, as well as increasing lengths of stay in the general population.

Twenty-two months -- going from 22 months on an average time served to 30 months is a big change, that has a profound impact on the size of that population.

Growth is not about increasing the number of drug offenders. Contrary to the myth and a lot of popular belief, the growth in the prison population isn't about drugs, isn't about people being

held for drug law violations. It is about the sentencing reforms that increased sanctions on violent offending, increased the likelihood of going to prison for violent offenders increased substantially and increased the length of stay for violent offenders.

The consequence of that is that the growth, at least half of the growth in the nation's prison population, and particularly among men, almost two-thirds of the growth being linked to increasing numbers of people being held for violent offenses under the current offense. And so we've seen a substantial amount of stability in the population being held for drug offenses and that stability is the result of constant flow in to state prisons for drug law violations, and that's about 100,000 a year and it's been very stable for the last decade.

But, on the other hand, we've seen increases in the number of parole violators coming back to prison and a large share of those parole violators are drug offenders. And so what we're seeing is divergence at the front end, substantial divergence at the front end, given dramatic increases in arrests for drug law violations and then, if you will, at the back end we're seeing drug offenders getting out in higher proportions and failing and

coming back in, and that's the dynamic and that's the impact of drug law violating here that we see in state prisons.

The federal system is substantially different, almost all the offenders held for drug law violations in the federal system are there for drug trafficking, importation, smuggling and we've seen, as a result of those sentencing guidelines in the federal system, a real punch in terms of the likelihood of going to prison and the length of stay, the length of stay for drug law violating in federal prison nearly doubles as a result of the sentencing guidelines.

Let me also say that there are real indicators of stability and, in large part, as a result of no new sentencing reforms that have dramatic impacts on lengths of stay. There's not much discussion right now about increasing sanctions, increasing punishment. Absence of that discussion, absence of new laws to enhance punishment, we're not likely to see dramatic growth in the future.

That is, in fact, growth may well become very much more closely linked to crime and demographics, unlike the past two decades in which it's been strongly related to sentencing and sanctioning, in the future it appears to be every

indication that the growth is going to be more strongly related to patterns of crime and criminal involvement. Obviously, if we see an upturn in crime in rates, age specific crime rates, we're going to have a very dramatic impact on prisons and jails.

Let we also say that in much of this discussions have always been about prisons. We also have a large jail population, about 713,000 in our latest count, our one day count. There are about eight to 9 million people who are admitted and released from prison -- from jails each year. We have about 12 million admissions. Obviously, there's some who get admitted more than once during the year, and quite a number of them. So local jails are often ignored in the policy discussions and, yet, they serve a variety of functions and provide an array of programming and services related to successful re-entry.

Jails are profoundly impacted by the other parts of the correctional system. And so if you look at one day population, about half of the people in jail are there because of failed community supervision. They're there because the inmate -- the offender failed while on parole, failed while on probation or failed while under some kind of pretrial

release.

The growth in the nation's jail population is strongly linked to community corrections and the outcome of community corrections. Again, to the theme of an inter-related system of probation, parole, prisons and jails, we have seen no change in the outcomes of probation supervision, no change in the outcomes of postcustody supervision.

The rates of recidivism are stable and have been very stable for the last decade. And so we have a fixed rate of failure, about 16 percent of the 2 million people being discharged from probation each year are being returned to incarceration and somewhere around 42, 43 percent of those discharged from parole each year are being reincarcerated, and that has been stable for over a decade, despite all changes that we've gone through in corrections.

We have had a dramatic increase in capacity and contrary to a lot of belief, prisons and jails are less crowded today than they were in 1990. That's not to say they're not crowded, but they are less crowded. We've built more capacity in the last decade than we had of inmates.

One of the things about the 1990s was a very strong economy so not only did we have the will

to incapacitate more adults in the United States, we had the ability, we had the ability to fund that capacity.

And so at this point our best estimates are jails are operating at about 94 percent capacity, prisons, state prisons are operating at between 100 percent in capacity and 115 percent in capacity. Now, that's an improvement over the 1990s. The federal system is very crowded. They're operating at about 40 percent over capacity.

Now, there are various ways of dealing with crowding. You can, obviously, double bunk, you can change your bedding and use space that may have not been intended for housing, you can also enter into contracts with private facilities, you can also keep inmates longer in jails before they arrive at state prison or federal prison.

Systems do all of those things.

We've seen during this time no evidence of increasing disorder. We look at rates of assault relative to inmates, assaults relative to staff and we see declines in that. We also see dramatic drops in homicide rates. A 90 percent drop in homicide rates over this period of time. We see a dramatic drop in suicide rates in local jails. And so the evidence of

increasing disorder is not there.

We have other measures of disorder relative to assaults, self-reported victimization by inmates, work I've done suggests that if you project out what the likelihood of an inmate is to get assaulted, that is injured in a fight, that projection is about 7 percent; that is at intake, the probability of being assaulted is about seven in 100. It would be interesting to see what those numbers look like in our new inmate surveys when we get them in.

I want to say further the prisons and jails are a major provider of healthcare for a population that's been deprived of healthcare in many other circumstances. And so we see dramatic commitment from prison and jail authorities to provide that healthcare. The costs related to that healthcare are substantial. Our estimate is that 13 percent of the state operating expenditures per inmate per year are spent on healthcare. Obviously, you can test more and find more problems.

My work in looking at hepatitis, for instance is that when we test, we find that about one in three test positive for hepatitis C. Even though it's targeted, in some places it is not and when we do broad-based targeting, we still come up with very high

rates of hepatitis.

The good news on HIV is that we've seen real stability in the HIV population, HIV/AIDS populations. It's about 2 percent of the state population, federal population and inmates housed in locals jails are HIV positive. A very good note is that deaths due to AIDS-related causes in prisons and jails have plummeted as a result of anti-viral therapies.

So in closing let me say that we have a population that's grown dramatically and the statistics clearly show some of the nature of that, of that growth, but we have not, at the same time, seen any indicators of increasing disorder and we certainly have good news related to basic indicators of health and that is indicators of dropping rates of suicide, homicide and death rates, generally. So, with that, I'll open it up to questions.

MS. ROBINSON: Dr. Beck, thank you very much for your statement.

Let me open the questioning by zeroing in on the safety and abuse issues and picking up on your comments about homicide, suicide, et cetera and asking are there areas where BJS is not now collecting statistics, and putting budget issues aside, where you

would recommend that BJS should be collecting more information and statistics to have a clearer picture about this or related issues?

DR. BECK: Sure. Well, let me say that I've been committed, at least in the last ten years, in this area so you will get better statistics on healthcare.

JUDGE SESSIONS: You're down again.

DR. BECK: I've been committed in the last ten years, at least, my work, to get better statistics on healthcare. It's a real challenge to get those statistics and, in part, it's because the data don't exist.

We need, I think, in corrections to do more testing, to draw more blood, to do more screening and to do that in ways, from a statistician's point of view, to estimate incidence and prevalence. That's the first thing. And that's not just the Bureau of Justice Statistics, it's not something we can solve, it's really something the field needs to address and that is more wide-scale testing of and reporting of medical problems that inmates bring with them to the prisons and jails.

There are, obviously, things that we're working on related to mental health, for instance.

We've introduced screening devices to get a better measure of mental illness prevalence by seriousness, level of seriousness and to assess levels of treatment need. We, obviously, have improved our measures related to dependence and abuse in terms of substance abuse, alcohol and drugs. So those things are on the way, but I think fundamentally, we need better measurement of chronic diseases and various medical problems.

There are many things that we need in the field of criminal justice statistics. I think the twinkle in my eye is about trying to do statistics -- better data collection with respect to parole, postcustody supervision. We have a lot of discussion of re-entry in this country, some of that has come as a result of our work, though we really do need to do larger scale, national collections on parolees to look at the nature of the supervision, look at the basic needs, circumstances surrounding those parolees as they return to the community.

It's not about conducting a long survey and following them for many years, it's really doing snapshots, and trying to get better statistics. So I have many on my list, but those come high.

MR. RYAN: Dr. Beck, if the statistics

are down, murder rate is down, suicide rate is down, assaults are down, and that's come about over the last ten years, at least in your statistical report on it, what sort of things are going right in the business and what areas of focus should we be looking at?

DR. BECK: Well, let's take suicide, suicide in jails. One in three inmates who die from suicide -- that die in local jails die from suicide. We've seen a dramatic reduction in the rate of suicide in local jails as a result of training, of staff to be sensitive to detecting risks for suicide, we have policies training in place, we have suicide watch units, we have suicide cells, we have increasing surveillance and we've utilized real, real dramatic reductions as a result of that. Now, that occurred, you know, in the 1980s, when much of that was going on, up to about 1993.

Since then we haven't seen much change. We've reduced suicide rates. We're still seeing roughly 300 suicides in local jails each and every year out of about 900 deaths. But I think the story on suicide is dramatic reduction as a result of standards and policies and training and greater attention to that variation.

In terms of homicides we have seen real

reduction in homicide, particularly in state prisons, a 90 percent reduction since 1980. I think that's a good indicator of increasing control over facilities, whether that's through better staff training, better design, enhanced surveillance, I'm not sure what it is, but it clearly is the result of correctional practices because as the push on the other side, and that is we're increasingly putting violent people in state prisons and violent people commit violent acts whether they're inside or they're out, and so we've seen that crosspressure and the statistics show that unambiguously a real serious drop in homicide.

Obviously, small facilities, the smallest of jails have the largest problems, yet very few people are in those facilities. They have fewer resources, perhaps less training, perhaps less staff, less ability for surveillance, combined duties that put inmates somewhat at risk as a result of that. But relatively few inmates are actually housed in those small facilities that have higher rates of homicide and suicide.

MS. ROBINSON: Allen, let me ask you quickly, how reliable are the self-reports in the prisoner surveys you do? For example, our data on mental illness, I believe, is based on those

self-report surveys.

DR. BECK: Yeah, sure. Well, I did that, worked on that report, a staff member of mine did it, I don't know, half a dozen years ago, trying to measure prevalence of mental illness. It was the first time we attempted such an effort, such an undertaking. But when we put that number out, it was about 16 percent determined to be mentally ill or having had a history of mental illness in prison and jails.

I can say that mental health advocates thought that we were underreporting that. I can say the corrections folks thought we were overreporting it, and so we were somewhere in between there.

As a result of that experience, we've invested heavily in using DSM-IV measures and various screening devices to try to get at dimensions of mental illness, to get at the seriousness of mental illness. Not all that 16 percent is mental Axis I, not all of them are schizophrenic, not all of them are serious mentally ill, and so I think on some measures self-reported data are very, very good. Obviously, the more sensitive the issue, the more careful you have to be in framing those questions. And particularly in my work in sexual violence, that comes

through loud and clear.

Obviously, this is an environment which is very difficult to work in right now as a result of human subjects protections, increasing IRB reviews, increasing concerns for the risk that my work might impose on our respondents. So there's an increasing need to measure those very sensitive items, but increasing difficulty to do so.

MR. RYAN: Dr. Beck, do you have any information on inmate-staff ratios and how those play out in operation and safety?

DR. BECK: Well, not only did we fill to capacity, we added staff and we have -- there's a slide in the piece that shows that for local jails we have somewhat of a drop in the inmate-to-staff ratio, that is correctional officers, not total staff, not professional staff, not administrative staff, not clerical staff, but supervisory staff.

We have seen in prison an increase in the number of inmates to staff in that ratio and that's, in large measure, the result of facilities operating and becoming larger. And so with larger facilities you don't have the need for as many staff per inmate, if you will, economies of scale, unfortunately, but that's the reality. Larger

facilities -- we're seeing larger and larger facilities in state prisons, state confinement facilities.

MR. RYAN: But as a follow-up to that, just for a second, if the numbers of inmates are going up, staff is somewhat the same, I guess, is what I hear you saying?

DR. BECK: That's right.

MR. RYAN: But the number of assaults and other things relative to that seem to be the same or are going down. Is there no correlation then?

DR. BECK: Well, it's not just about staff but how you train them, how you utilize them, also about instruction and new design and particularly with direct supervision facilities we see real improvements in order, institutional order.

MR. RYAN: Thank you, Doctor.

MS. ROBINSON: We have time for one other question from the panel. Judge.

JUDGE SESSIONS: Thank you. This relates only to state prisons and data that we're actually gathering on state prisons, do you have any -- just a question, and then you can take me around the block on it.

DR. BECK: Sure, sure.

JUDGE SESSIONS: Is there any data that tells you from the state's prison systems that measures when they come in, through a physical or other means, those people who are contagious or have HIV, hepatitis C, hepatitis B, or tuberculosis, when they come in is there such a statistic on what state prisons give you and, also, on what it is when they go out? And the thrust of the question is the danger posed by people who are you say now serving -- 15 percent are serving less than six months in the prisons, that means there is a very fast turnover in people in and out of prisons, not just jails, but prisons, and I'm just interested in what data you have on coming in and going out, what's the rate of contagious disease?

DR. BECK: Sure. Yes. Let me also say that in jails the length of stay is much, much shorter. In the local jail, you know, you have about 60 percent of the population that's unconvicted and the flow through a local jail is predominantly people who are held postarraignment and then, subsequently, released. And so, you know, we're looking at maybe a two day average for the unconvicted population and somewhere around two and a half weeks for the convicted population. The convicted population is

moving and moving around, they're not all sentenced, they're being held for other authorities, and so a large share of those being convicted are being moved.

So the jail population provides some opportunity for community health, for public health to intervene, and particularly for screening among those who are actually sentenced and to be held in local jails.

There's much greater opportunity, however, in state prisons and, you know, there is substantial screening. There's an admission interview that's conducted and in that screening there's a mental health assessment, there's a risk assessment, there's a needs assessment that's often done, within the first few months there's a needs assessment.

In terms of measuring TB, HIV, hepatitis, STDs more generally, I think that's done more generally on a need-to-test basis, sometimes costly, blood driven. Often times what's done is you draw blood and there's an opportunity to also test for hepatitis C, so it's not a full range of tests that are conducted.

Now, our census of prisons, our census of jails, we're conducting both censuses this year, will ask about screening for mental health, for

instance, ask about other screening for TB and along those lines. We did one back in 2000 for prisons, for instance, at a facility level, 1,668 facilities that we were in, and we asked about screening.

Now, most facilities, most systems test at point of entry, not at time of release. The Federal Bureau of Prisons, for instance, tests at time of release for HIV, for instance, to protect itself against, you know --

JUDGE SESSIONS: It would seem logical, from the public health perspective, to actually test in the state prisons because there are many, many, many more people in the state prisons on exit or have some means of measuring the medical condition, the contagious condition of those people who are actually exiting the prisons, the state prisons, going back into the public.

DR. BECK: Right. Yeah. Let me say by point of closing, people who get out of state prison often return to chaotic lives and often return to conditions in which healthcare is not readily available and so you see mortality rates that are twice the rate outside than inside for all causes of death. Even if you compare by age group, and eliminate deaths through automobiles, those death

rates outside are substantially higher than inside.

JUDGE SESSIONS: Thank you.

MS. ROBINSON: Alex, I'm wondering if we can take leave for three other quick questions.

MR. BUSANSKY: If they're quick questions.

MS. ROBINSON: Okay. We're going to ask quick questions. The sheriff has the first.

SHERIFF LUTTRELL: Dr. Beck, I would like clarification on one comment that you made. I think I heard you correctly, but let me ask for clarification.

You mentioned that part of the problem with jail overcrowding is failed community programs; is that correct?

DR. BECK: That's right.

SHERIFF LUTTRELL: Okay. Many community programs at the local level rely on grant funding. Are you seeing any relationship between a decrease in grant funding at the federal level and failure of the programs at the local level?

DR. BECK: No, I really have no information on that. Any kind of correspondence there is well beyond me.

Jails perform a fair amount of

community supervision, about ten percent, about 70,000 inmates, offenders, are actually supervised in the community by jail staff, and that's increasing.

You know, in terms of any trend in failure while under postcustody supervision or on probation, there is no training. It's a remarkably stable line. Again, about 15 percent of probationers discharged each year from probation fail, they're incarcerated, and about 42 percent of parolees are incarcerated, another ten percent abscond, they're on the run, they're not being returned, so the failure rate is substantial.

You know, our recidivism statistics -- and this is another area where I would like to do more investment is in studying recidivism in a more regular basis and looking at the factors related to recidivism, but our recidivism statistics show almost no change. I did the first study nationally in 1983 and the more recent one done in 1994, it's almost identical. We almost didn't need to do the 1994 study.

MS. ROBINSON: Pat Nolan.

MR. NOLAN: Dr. Beck, in response to Mr. Sessions' question, you talked about intake. That, frankly, surprises me, both personally and in my

talking to inmates and people from other systems.

I'm not aware of an intake medical exam of most prisoners and, myself, it consisted of a questionnaire that I filled out and they counted my teeth and discarded they medical records that I brought in with me, literally, said we have no use.

DR. BECK: Yes, I think that's the nature of it. He said it's not drawing blood on the need to draw blood.

JUDGE SESSIONS: Can't hear you.

MR. NOLAN: He said it's not drawing blood.

So there is no testing, but even -- the only report there was of any conditions I had was what I volunteered in the self-report questionnaire and, again, the records that I brought with me were discarded in front me, they felt they had no use for them.

So I think Mr. Sessions was asking what we do we have to analyze, and I know Hugh(sic.) has brought this up, we need to look at what diseases people bring in with them but also at exit, it may be a new thing in the BOP, but I was not tested, that was '96, so maybe they've added it since then, but it was at the height of the AIDS thing, there was no testing

of tuberculosis, HIV, hep C, all the things that are pretty significant, and staph infections, which were significant among the population I was with. So I'm not sure --

DR. BECK: I'm not sure I characterized it correctly. Let me say that I don't think I'm in disagreement with you.

You know, most testing is done on a targeted basis, it's cost effective. You determine if there's an inmate at risk, there's an event, you test that person as a result of that event.

You know, in BOP there's been testing done on tuberculosis in San Diego, and if you talk to Dr. Kendig(ph.), the medical director in San Diego, he reports very high rates of TB in San Diego in the intake, federal intake.

And I think earlier I mentioned that I really do believe we need better data on the prevalence, and we need to draw more blood, we need to --

MR. NOLAN: Does that doctor in San Diego do that voluntarily, in other words, it's not a --

DR. BECK: You would need to talk to Dr. Kendig --

MS. ROBINSON: Can I suggest, we do need to keep these questions and answers very short because we're over time. We want to get to the other folks.

Senator Romero.

SENATOR ROMERO: Thank you, Dr. Beck.

It strikes me, though, that your data are overly optimistic. If we look at the rates of suicide and homicide, that's sort of the extreme. And my question would be more so day-to-day, ordinary assault, attempted assaults, theft, intimidation, et cetera, and I'm questioning again to what data you might have there.

The other issue that I would ask of you too is the sufficiency of the reporting mechanisms; there are not necessarily incentives to report and there's a bureaucracy in terms of reporting itself.

So I'm wondering if you could address the questions of not necessarily suicide and murder, which are the most extreme, even in terms of looking at your data you have included on prison disturbances, it still deals with more so perhaps a prison riot or resulting in death. Can you address the trends with respect to day-to-day, because, frankly, I would think -- I'm not as optimistic in terms of looking at

the interpretation of this data as this appears to give me.

DR. BECK: Right. And I would agree with that. I would agree with the need for more data on assaults and conditions of confinement. Those data are very hard to come by, let me say, because the absence of standardized reporting in the field, you know, the absence of standardized definitions, what is -- what constitutes a serious assault or a serious injury; it varies and it varies substantially.

It's very difficult to overcome those obstacles to data quality and data collection given, you know, the diversity of the systems there, whether they be state or local.

I said we do get some things on self-reports and there's a table in there based on my inmate survey in 1997 which looks at self-reported injury in a fight since admission, by length of stay. And, obviously, if you stay a very long time, the odds of you being injured in a fight are fairly substantially, one in five I believe is about the number. It's also linked to, you know, whether you are a violent offender or not. But, again the statistics there on assaults are very difficult to achieve, to collect.

I think the Association of State Correctional Administrators, on their work on performance measures are trying to, frankly, address some of that. It is, however, a life's work and I think, you know, we can improve those statistics, but we'll never have perfect comparability.

I think homicide and suicide are pretty good indicators of overall order. If you have lots of disorder. If you had a trend, not the level, if you had a trend in assaults, you might expect increasing numbers of homicide, particularly with the pressure related to violence and housing violent offenders. The level of assault is simply not known. I cannot measure well the level of assault in using administrative records as they exist today. I can get at self-reports, but those are very -- those are a little on the soft side, if you will, in addition to that, so I concede to all of that.

But I think -- I don't think one should dismiss the importance of this homicide and suicide trends.

MS. ROBINSON: Judge Gibbons.

JUDGE GIBBONS: Dr. Beck, are there available statistics with respect to the number of people in general facilities who are under 18 years of

age?

DR. BECK: Yes. We put out a report every six or 12 months and we've seen a dramatic drop in the number of kids held in state and federal prisons, dramatic drop, it's cut in half since 1995. About 5,300 prisoners were under the age of 18 in 1995, that's based on a prison census that we conducted then. Since 1998 or so I've been collecting it every six months and reporting on it. The latest count we have is right around 2,500 in state and federal prisons, complete enumeration, no estimation, complete counts.

Now, on the jail side, we're having somewhere around seven or 8,000 kids being held in local jails. Those are not held long, necessarily, but they are there on a one day count, and that's not been going up.

And so I think what we're seeing is real attention to this issue and we've seen greater and renewed efforts to move kids out and to divert kids from adult institutions. I think that's a success of work on the part of advocacy groups.

MS. ROBINSON: Dr. Beck, unfortunately, we're going to have to wrap up. I think we could sit here and question you all morning, there's a such a

breadth of material you are familiar with. Thank you so much for being here. We very much appreciate it.

We're now very privileged to have the State Commissioner of Corrections for New Jersey, Devon Brown, with us who has generously offered to make a few remarks. I think he is going to be joining us out here.

Before turning over the microphone to him, however, we want to note that he's worked in the field for more than three decades and is known both for his humanity and for his relentless pursuit of reform. His many achievements since he became Commissioner of Corrections in April of 2002 range from cutting staff overtime to increasing the number of inmates who have received GEDs, to transforming one of the most problematic state prisons into a place of relative calm.

Commissioner Brown, we're delighted to have you here and welcome. And can I suggest that you pull the microphone right up close.

MR. BROWN: To the Honorable John Gibbons, former U.S. Attorney General Nicholas Katzenbach, members of the Commission, colleagues and all participants, good morning, and welcome to the Garden State. On behalf of Governor Richard Coty and

all citizens of our proud state, we are truly honored by your presence.

Benjamin Franklin once described New Jersey as a valley of humility between two mountains of conceit. Of course, the mountains to which he referred are New York City and Philadelphia. But I, respectfully, take issue with Mr. Franklin and believe that he had an axe to grind as his son William, the royal governor of New Jersey, remained lawless throughout the war for independence, causing a rift between father and son which was never actually healed. Hence, his valley of humility description.

I would contend, ladies and gentlemen, that New Jersey, smaller than both our neighbors to the north and the south, holds national prominence in many arenas; stem cell research, scientific and pharmaceutical exploration, and if you will forgive my slight and benign conceit, progressive correctional policy and intervention.

Far from being the lesser sibling of the law enforcement community, the New Jersey Department of Corrections has been in the national forefront of providing definitive, research-driven innovations in the custody and care of the offender population, and our dedicated correctional employees

charged with their supervision are, indeed, second to none. With your kind indulgence, I shall outline a few of our contributions to the advancement of the correctional field.

As the nation's offender population has grown, there has been a concomitant, get-tough-on-crime trend permeating the courts and state houses throughout the land. Mandatory minimum sentencing, drug free school zones and three strikes laws, in conjunction with a marked reduction in the funding for inmate programming have been a harsh outgrowth of the lock em up and throw away the key mentality. More reminiscent of a French revolution than the 21st century.

And while the impetus for these stringent measures can be laid at the feet of elected officials, it is we, the members of the correction profession, who must deal with this sad aftermath; the result, more than 2 million American citizens are presently behind bars.

Moreover, unprecedented numbers of children are now orphaned as an unintended consequence of parental incarceration. Children who, in turn, seem destined to become offenders themselves and at increasingly younger ages. This is the hand we in the

corrections profession have been dealt and play it we must, no matter how difficult with fewer resources.

We are charged with the Herculean task of correcting the incorrigible, deterring the determined, punishing the wicked, rehabilitating the wretched and restraining the dangerous. In essence, we are asked to produce success where other institutions of society have tried and failed. We, the Jersey Department of Corrections, are making a concerted effort to address these enormously important responsibilities, for we fully recognize that inmate rehabilitation and public safety are unquestionably intertwined and not mutually exclusive variables.

Every parent, every educator and, yes, every correctional professional can attest to the veracity of our grandparents' observations and admonishment that idle minds are the devil's workshop. We know that few conditions compromise the safety and security of a correctional institution as does inmate inactivity, and since 95 percent of inmates rejoin society at some point, a dirth of offender programming and education translates into a breach of public safety.

In the interests of protecting society we understand that providing measures to reduce

recidivism, by doing so we are, in essence, reducing the rate of victimization. Unfortunately, there has been elementable ignorance in the country of the correlation between inmate programming, public safety and safer prisons.

Furthermore, all too often the recidivism phenomenon has been described but not fully examined and explained. In an effort to provide a more balanced perspective of the recidivism question and to remain consistent with its quest to improve the quality of life for the people of the great State of New Jersey, our Department of Corrections has made a major commitment to increasing the formal and informal education of its prisoners. For we understand, as did Socretes, Dacart and other leaders of our great civilization, that through education comes enlightenment and through enlightenment comes a more constructively-oriented society.

As prisoners are, quite literally, a captive audience, educationally enriching material and activities are very interwoven within all aspects of our daily routine. Even recreational activities in our correctional system have a predominant educational theme, including television viewing where once Jerry Springer and the Young And The Restless reigned

supreme, prison dayrooms are now focused upon the contributions of Abraham Lincoln, Nelson Mandela and Clara Barton. As videos from the Biography channel, A&E, and the Discovery channel are the only programming allowed in our prison common areas, with the exception, of course, of news and sporting events.

Purchased through the Inmate Welfare Fund, overburdened New Jersey taxpayers do not pay for this project, nor are they forced to absorb the cost of the board game, proverbial wisdom, educationally enriching decks of playing cards, the plastic chess boards or the tournaments they have engendered, one of which was covered by ESPN on January 29th, it was broadcast across the globe where two of our inmates trounced, absolutely trounced nationally ranked chess masters from Princeton University.

With the introduction of the nationally sponsored stock market game, 110 inmate teams compete against each other and outside teams, with one of them defeating -- and I have to pause to chuckle, defeating PaineWebber without the benefit of cable TVs, Lou Dobbs or the Blumberg network. They literally took their marbles home and refused to play us again.

The contemplation that there is a great deal of wealth to be made carrying a portfolio,

instead of a gun, had never occurred to most of these inmates before.

Just in passing, you are privileged to have one of the premier directors of local detention centers join this panel today, Art Wallenstein. Mr. Wallenstein followed me during my tenure of the directorship of the Montgomery County Department of Correction and Rehabilitation. Art may recall a Washington Post publication devoted to our use of that time of the stock market game. We won first place across the region. We did so because our jail inmates had the understanding of a newly-emerged product and its impact upon not just the United States but the world. They had the wherewithal to invest in that product, that product was Viagra.

As any liberal might take strongly in the focus and gravity of our approach, a pragmatist must ask, do these programs have an impact on inmates once they leave? Are there fewer inmates reoffending and, consequently, fewer victims of crime here in New Jersey?

In keeping with the national insistence on evidence-based governmental policy development, the New Jersey Department of Correction has subjected its programming efforts to rigorous research to determine

if education does, indeed, have an impact on rates of recidivism. In an effort to control many of the methodological difficulties that often plague such research, the New Jersey Department of Corrections adopted a rigorous, highly sophisticated, empirical design, producing perhaps the most stringently structured research on the subject to date.

300 inmates were studied at random and it was found that New Jersey inmates who participated and graduated from the GED program during the years 1991 and 2000 demonstrated at significantly lower levels of reoffending than the inmates who did not participate in the GED program during the same period. The decreased level of reoffending was consistent across rearrest, reconviction and reincarceration rates.

This study conducted by our policy and planning office, in conjunction with support from our Office of Educational services and the office of information technology found that 43 percent of the inmates who received a GED recidivate, while 55 percent of the max comparison group of inmates who did not receive a GED returned to prison during the period under review of four to five years.

I would like to point out that

traditional research follow-up is three years, but our examination was extended an additional two years, obviously, lending rate of credence to our study. Should there be any doubt in the merits of our approach, please know that our last GED testing produced an 81 percent success rate, far exceeding that of our public schools.

To those who would defame the virtues of inmate education, I would again invoke the words of Benjamin Franklin, "experience keeps a dear school but a fool will learn in no other."

History has taught us that ignorance breeds crime and if it is not addressed, society will pay the price again and again and again. In short, more education, less crime, less taxpayer dollars spent on the criminal justice system and the price of incarceration, less violence against prison staff and inmates, safer communities for us all. There's great proof in Victor Hugo's advise "open a school, teach the uneducated, close a prison."

Since 1996 the state, like many other prison systems, has been contracting to provide medical and mental health services to inmates. In the ensuing years the department has refined and strengthened its provider agreement for inmate medical

care, incorporating a higher accountability on the part of the provider and we are confident that the current arrangement provides adequate inmate care in the most efficient use of taxpayer dollars.

Additionally, we believe, as do many of our sister states, that establishing a relationship with the state university provides major benefits to both parties, financially and qualitatively. Accordingly, the state has recently entered into an agreement with the prestigious University of Medicine and Dentistry of New Jersey to provide mental health services to our inmates. We join for other states in recognizing the tremendous overall benefit of partnering with our medical schools.

And further evidence of our input in helping to improve the operations of our nation's delivery of correctional medical services, the New Jersey Department of Corrections produced and disseminated to 32 other states the only training video in the country on the nature and treatment of MRSA in a correctional environment. As you all know, this is a highly contagious disorder that plagues jails and prisons nationwide.

Such creativity stands in firm testimony of the New Jersey Department of Corrections'

national leadership and commitment to furthering the profession, not only within our own borders but throughout the land.

As you are all are aware, combatting addiction is a major correctional challenge. The link between this nemesis and criminal behavior is well established. It is, therefore, no surprise that drug-driven crime is the source of incarceration of a majority of our state inmate population. We clearly recognize that addressing addiction is central to fulfilling our public safety and offender rehabilitation mission.

As its primary strategy to address those seriously addicted offenders, the department has adopted, again, a research, evidence-based continuum of care approach.

I'm quite proud that the American Correctional Association has included our department in its formulation of standards for all the nation's prisons in the delivery of these services.

I hasten to say that the New Jersey Department of Corrections stands as a leader in this country in its forward-thinking approach to inmate safety, to staff safety and to the advancement of the profession.

In regard to staff safety, it is, unfortunately, a realism that between 24 and 40 percent of all law enforcement in this country have at one point during their tenure been involved with domestic violence. That's a sad reality. Here in New Jersey we take this very seriously and we developed the first and only comprehensive program on combatting this problem.

We embarked upon this three years ago. During the course of those three years we had four fatalities among our staff. I am quite pleased to report today that there has been a 33 percent reduction in the number of domestic violence incidences in our state. This has come about, I think, in large part between -- because of the concerted efforts that we have put in place in developing our program.

Let me conclude by saying this: Like our sister and brother states, our correctional employees walk the most challenging beats in the community. Please know we do so with pride, proficiency and professionalism. Thank you so much.

If you have any questions that you would like to pose to me, I would be quite delighted.

JUDGE SESSIONS: I do, if you have a

moment.

MR. BROWN: Yes, sir.

JUDGE SESSIONS: The last reference you made to a contagious circumstance was a staphylococcus disease or staph -- what is that called?

MR. BROWN: The initials it's called, MRSA.

JUDGE SESSIONS: Say it into the microphone.

MR. BROWN: M-R-S-A.

JUDGE SESSIONS: All right. Now, that went right along with HIV, stapho -- I mean, B and C on hepatitis?

MR. BROWN: Yes, sir.

JUDGE SESSIONS: Of those things that can be tested and found, I asked Mr. Beck earlier about this, and I'll ask you, because I'm really interested in what you do on entrance and exit because I see that you were the warden of the Maryland Reception Diagnostic and Classification Center.

Did you test coming in to the prisons, not the jails, but the prisons systems and were they tested on exit? Because I'm concerned about what impact that has upon release.

MR. BROWN: Depends on the type of

disorder that you are trying to assess and just I'll tell you that it's routine to test for pregnancy at the point of reception and I would share with you we test when they go out too, you can understand why.

JUDGE SESSIONS: But on contagious disease, what is the circumstance?

MR. BROWN: On contagious diseases it varies across the nation as to the approach that is taken, depending, again, on the nature of the disorder that you are assessing.

For example, with hepatitis C, the CDC and other bodies do not necessarily recommend that you do this, but you look for certain patterns of behavior, certain histories of the individuals that lend themselves most readily to hepatitis C and those are the ones that you target for testing.

JUDGE SESSIONS: So there is no data coming in or going out, necessarily, on the population as a whole?

MR. BROWN: For hepatitis C?

JUDGE SESSIONS: Any of those, HIV, hepatitis C, hepatitis B?

MR. BROWN: For any of them the testing for -- again, it varies across the nation, but the testing for HIV is mainly voluntary testing.

JUDGE SESSIONS: And it's not done routinely on exiting?

MR. BROWN: No, sir.

JUDGE SESSIONS: Nor tuberculosis?

MR. BROWN: Nor tuberculosis.

JUDGE SESSIONS: Thank you, sir.

MR. BUSANSKY: I'm sorry, I'm going to have to interject, just because of the schedule we have, we are already behind, and so I would ask if any commissioners have any other questions for Mr. Brown, perhaps during the next break we can talk to him or get him questions at another time.

And, again, Thank you very much Mr. Brown.

MR. BROWN: Welcome to New Jersey.

MR. KATZENBACH: Grateful for your coming, Commissioner. It's good to have a real commissioner among all these temporary ones.

PERSONAL ACCOUNTS

DR. GILLIGAN: On behalf of the Commission on Safety and Abuse in America's Prisons, I'm honored to welcome our first four witnesses who will testify as to personal accounts of experiences in American prisons and jails; Pearl Beale, Gary Harkins, Bonnie Kerness and Daud Tulam.

Ms. Beale is the mother of Givon Pendleton, who was stabbed by another inmate and bled to death while detained in the Washington, D.C. jail. Miss Beale will describe the overcrowded conditions that led to this tragedy and its impact on her and her family.

Mr. Harkins is a corrections officer with over 20 years of service in the state of Oregon. Mr. Harkins will describe how direct supervision and regular contact between officers and prisoners made it possible for him to work in the isolation wing of the state's maximum security death row prison with only a whistle for protection.

Bonnie Kerness, the Associate Director of the American Friends Service Committee's Prison Watch will read letters from New Jersey prisoners who are currently living in isolation and she will describe what she's learned about the use of prolonged isolation and its impact on prisoners from her many years of advocacy on their behalf.

I might mention it's relevant I think to note that the committees on torture of both the Council of Europe and the United Nations consider the kind of prolonged isolation that we use in this country as a form of torture.

Finally, Mr. Tulam, who was recently released from incarceration will describe how he spent 18 of his 25 years in New Jersey prison facilities in isolation and its effects on him and others.

Through their personal accounts this panel will help to illustrate the issues of overcrowding in prisons and jails and the use of isolation in those facilities and how these issues affect prisoners, staff and their families alike.

Before we begin, I sincerely want to thank each of you for your willingness to come before this commission to discuss your own personal experiences. Thank you.

MRS. BEALE: Good morning, commissioners. My name is Pearl Beale. I live in Forestville, Maryland, just across the District of Columbia line. For nine years I have worked as a elementary teacher for the Prince George's County Public School System. Prior to that I worked as a mental health counselor for the Department of Health for the federal government.

I would like to thank you for the opportunity of hearing my story today and for inviting me here.

On December 11, 2002 my 24-year old

son, Givon Pendleton, was fatally stabbed nine times by another inmate at the DC jail. As he lay there dying in the jail, no correctional officers were aware of what was happening, no correctional officers saw what was happening.

My son was being held on a pretrial status for nonviolent charges. But his attacker, another inmate, was awaiting trial on two first-degree murder charges. Not long before attacking my son, he and his gang had brutally beaten another inmate, yet he was allowed to move freely among the jail.

That horrible day I will never forget. Yet, when I remember my son I have fond memories. I remember he would always consider me, he would always call to check to make sure I was okay if he wasn't coming home overnight. He was very family-oriented. He enjoyed playing sports, basketball, football, with his cousins. He had a humble and quiet spirit. He was attending DeVry Institute of Computer Engineer. He was making good grades. He dreamed of becoming a computer engineer and he had the brains to do it.

My son was not perfect. As a mother I taught him the difference between right and wrong, but he chose to make some negative choices and, for that, he was in the penal institute. He was basically a

good child.

On that December day, when my son's life was rudely ended, he was waiting for his chance to present his case in court, but he never got that chance. Instead of being given an opportunity to a trial, as we all are guaranteed by our constitution, he was handed a death sentence that was carried out prior to any trial or conviction. In fact, the day I buried him was the day he was scheduled for court.

Today, my tears still flow and my questions still go unanswered. Who could do something so -- how could something so devastating happen in a supposedly secure and monitored environment? Where were the correctional officers as my son lay bleeding to death? Where were they when he was struggling for his life? How did the knife get into the jail and why has the knife never been found? Why weren't there any cameras in the area where my son was killed?

Givon was in the custody of the Department of Corrections and they were supposed to protect him, but they did not.

Since Givon's death I have attended several DC County oversight hearings. The hearings have basically been on the overcrowding, understaffing and the inadequate conditions at the DC jail.

I have learned that the DC jail was subject to a court order that imposed a cap on the population up until June of 2002, when the court lifted the order and returned the control of the jail to the district. The district then increased the population by almost 50 percent, but didn't increase the staff. They didn't increase the staff used to supervise inmates in their cell blocks. My son died six months later.

The council introduced emergency legislation in an effort to make DC Department of Correction make changes, but those changes have yet to be enforced by the city officials. Unfortunately, the conditions that existed before my son's death still remain unchanged. The jail consistently is operating with hundreds of inmates above the maximum security capacity.

I'm sure these factors led to the opportunity for Judith Miller, a reporter, that she should not be housed in the DC jail but should instead be given the opportunity to be housed at a more safer, alternate location. While she had the visibility and political clout to negotiate a stay in a better run facility in Alexandria, Virginia, my son and countless others were not as fortunate.

The sad but true fact is that two days after my son's death, another inmate was stabbed. The day after that, still another inmate was fatally stabbed.

In December 2003 four inmates were shot with a hand gun that was smuggled into the supposedly weapon-free facility. No correction officer saw it happen. Authorities didn't witness the shooting and could not explain how the hand gun got into the jail.

These are just a few examples of the violence that results from the overcrowding, understaffing and generally inadequate conditions that exist in the jails like DC.

When these incidents occurred, no correctional officer saw or heard anything. In each case relief officers weren't sent to replace officers who had to eat lunch or take a break.

To this day, pretrial inmates are still being housed with violent offenders. The supervision and protection of men and women awaiting trial in the jail is frightful.

I'm still waiting for answers or accountability for my son's death. When one loses a spouse, they're called widowers. When a child loses his parents, they're called orphans. What do you call

a mother who loses a son or a child? I don't have a word to explain the pain.

I have been asked, what do you want out of this? I reply none of this would bring my son back. It won't dry my tears and it won't fill the emptiness that I have in my heart to hear his voice or to see his smile, but maybe, just maybe it may help another mother who won't feel the pain of losing a child.

I thank you all for caring enough to look into the conditions of the jails. I hope something concrete will come out of your work. I think it is important for us as a society to not forget those who are incarcerated. They might be out of site, but they're not out of our concern and not out of our minds, and that we must fight for basic rights and humane treatment for protection for those incarcerated from injury and death.

Once again, I thank you.

DR. GILLIGAN: Ms. Beale, let me begin by mentioning that there are no words that can serve as an adequate response to what you've just described. I want you to know that you do have our deepest condolences for what happened to your son and that we join you in your hope that this Commission can

accomplish concrete change. And it's because of people like you who are willing to share your most painful experiences that we have the chance to do just that.

You mentioned the New York Times reporter Judith Miller and we know the fact that she was able to avoid going to the DC jail. If Judith Miller had, in fact, gone to the DC jail, do you think it would have raised awareness regarding the conditions there and, if so, why, what's the difference?

MRS. BEALE: Of course it would have. I don't know Ms. Miller personally and I have mixed feelings about that, but I wouldn't want anyone to have to go to the DC jail. But I think if she had gone, that it would bring the awareness up, she would be able to report exactly what the conditions are there.

DR. GILLIGAN: Could we go on to Mr. Harkins' testimony.

MR. HARKINS: My name is Gary Harkins and I'm in my 25th year at the maximum security Oregon State Penitentiary located in Salem, Oregon and during my career I have worked every uniformed position at the penitentiary.

So what's happening in our prisons? Over 33,000 correctional staff are assaulted each year, an average of 90 staff assaulted each day. In the past five years, 47 correctional staff did not go home to their loved ones.

However, until privately operated prisons, which hold over 173,000 state and federal inmates as of 2004, June of 2004, are required by state or federal statutes to report their staff and inmate assault rates, we will not know the whole story.

Based on one study, the rate of assaults on private prison staff are 49 percent higher, and inmate-on-inmate assaults in private prisons are 66 percent higher than public facilities. Unless HR 1806, the Private Prison Information Act is enacted by Congress, I believe we will never know the full story on safety and abuse in America's prisons.

The Oregon State Penitentiary was built in 1866 on 26 acres. OSP houses four classifications of inmates, from minimum to maximum custody. While OSP was originally designated for 1,380 inmates, it now houses approximately 2,050, down from a high of over 2,200 a few years ago.

When I started with the department we

only carried a whistle for protection. Today, all uniformed staff are issued one pair of handcuffs, a radio and a whistle. Until 10 years ago, non-uniformed staff were not allowed to carry radios, but it changed after a food service person was assaulted in an isolated area.

Just recently, six uniformed staff on a shift were allowed by management to carry 1.5 ounces of Capstan and an extra pair of handcuffs.

The penitentiary and most of the department's other institutions operates on a direct supervision model where staff readily mixes with the inmates. At the penitentiary, 330 uniformed staff supervise 2,000 inmates, making our overall staff to inmate ratio 1 to 27. Compare those ratios to the department's management to line staff ratio of 1 to 7 during the weekdays. The line staff must be harder to manage than the inmates.

As of today, the penitentiary is over 60 uniformed staff short. The filling of these vacancies would greatly increase the safety of staff and inmates in these areas. One result of this staff shortage is the penitentiary's overtime budget is over $1 million a year. Another result of this staff shortage is the inability to have our 15-minute rest

breaks. As a result of this inability, some staff sneak out for them when they can, but it has had serious, unfortunate consequences, including a stabbing.

As a result of our direct supervision philosophy and architectural design, we do not have gun walks or observation platforms to watch inmates or other staff in the units. The only exception is the yard towers to back up the yard staff. The cell arrangements are such that the C/O must walk the tier on a regular basis in order to make wellness and sanitation checks.

At OSP it's not uncommon to have seven staff mingling among 1,500 inmates on the recreation yard. There is one isolated dorm housing 88 inmates, with only one uniformed staff working the floor. About 20 years ago we did have a uniformed staff member stabbed in the dorm.

During meals, five staff supervise a dining room that holds approximately 350 inmates at a time, 50 inmate food workers.

We strongly encourage staff to talk to inmates and vice versa. This close interpersonal contact humanizes the individuals, lowers tensions and makes for a safer institution for both inmates and

staff. We often learn information inside our institution that helps solve ongoing criminal investigations in the community. As a result of this interpersonal contact, the vast majority of problems and situations are handled at the lowest possible level.

When I started with the department in 1980 our training consisted of two weeks of new employee orientation before we ever set foot in the institution. After these two weeks, we were sent in to work, often with the inmates showing us what to do. In 1990 the state law changed, making it mandatory for C/Os to attend the same academy that the city and county staff had been attending for years.

Today the academy training lasts five weeks. This academy training is supplemented by one week of institution specific training. While this training is adequate, it could be better. A few years ago, at the urging of Corrections USA, the U.S. Department of Labor issued their recommendation of 520 hours of academy training for a C/O prior to working in an institution.

Unfortunately, in Oregon, there's not any consistent follow-up to the academy training in subsequent years. The State of Oregon does not

require staff to maintain any minimum physical fitness standards or remain proficient in firearms. In the Oregon DOC, the line staff are not given proper training to work effectively with the mentally ill inmates, violating the department's own policy requirements.

The non-uniformed staff who supervise inmates only receive two weeks of general new employee orientation. Even though they sustain 10 percent of the injuries caused by inmates, they do not receive any training in self-defense, working with the mentally ill, verbal judo, health and fitness, and other important training. The non-uniformed staff are only allowed to carry a radio and a whistle.

When I first started at the Oregon State Pen, inmates had a wide range of educational and vocational programs. Inmates had the ability to earn a GED and continue all the way up to obtaining a doctorate. Over the years we've involved to where we do not have any teachers on staff or even offer a GED program for the inmates at the pen.

Currently, in the entire 13 facility Oregon Department of Corrections system, we offer only five work-based education programs at five of the 13 institutions. At the penitentiary alone, along with

the educational programs, we used to offer nine vocational programs and three industrial programs and, also, inmates were given the opportunity to learn vocational skills in electrical, plumbing and general maintenance. Today at the pen, out of 24 programs, only three remain.

For the past decade in Oregon, we have seen the closing or downsizing of mental health institutions and facilities. Currently, there are discussions about closing down the Oregon State Hospital due to its dilapidated condition. For the general population, the penitentiary has four mental health counselors, one psychologist, one coordinator of behavioral services and one behavioral specialist.

In the psychiatric unit there are two mental health specialists, one mental health director and one psychiatrist. They are supplemented by six other part-time employees, however, all these staff work Monday through Friday, 8:00 to 4:00, there's no mental health treatment in the six minimum custody institutions often.

At least 40 percent of the inmates in general population are on some sort of a psychotropic medication. The psychiatric unit has 54 cells with five uniformed staff on day shift, along with the four

treatment staff. On nights and weekends it is staffed along with three uniformed staff. The unit's primary purpose is to stabilize the mentally ill inmate so they can be treated back to general population. We have converted one and a half of a tier in a cell block to house 40 mental health inmates attempting to transition from the psychiatric unit into the general population. At least one mental health counselor is supposed to visit this tier on a daily basis.

A few years ago the administrative rule on inmate discipline was changed to where mental health workers could declare an inmate mentally incompetent at the time of an assault on staff and, therefore, not responsible for his actions. Staff were beginning to question if there's something in our system that makes inmates become insane after they're committed to our care.

At OSP we have a 120 bed disciplinary segregation unit to handle those inmates who have committed a serious violation of the rules. The segregation unit held death row inmates until it was transferred to the intensive management unit three years ago.

Today it's not unusual to have up to one half of the segregation beds occupied by mentally

ill inmates. Due to overcrowding, in segregation we double bunk 30 cells, so we really have to make sure that the two cellmates are compatible with each other. Sometimes even after assurances from the inmates themselves, we end up with fights between cellmates. In the past we would place a potential suicide threat in with a cellmate to help alert us to an attempted suicide. This practice ended when an inmate successfully committed suicide and the cellmate did not intervene.

In segregation we have five isolation cells or black boxes that can be used for further segregating those who act out within segregation. These inmates are monitored by close circuit TV and regular rounds every 15 minutes.

When I started with the department a lot often the inmates would throw urine and feces on staff or flood the tiers with about a foot of water on the floor. There would be all sorts of debris from the inmates' cell, including the urine and feces in the water on the tier. Back then we would find the biggest staff members on duty, we'd take off our watches, remove our pens, glasses and ID tag, put on slick rubber boots, wrap a towel around our neck for protection and go in and wrestle the inmate and place

him in restraints. Imagine how crowded it got in a six by 10 foot cell with two inmates, six staff, a double bunk, table, sink and toilet and everyone covered in urine and feces. Injuries to staff and inmates were not uncommon in a cell extraction.

Unfortunately, today only eight of the 90 cells currently have Lexan sheeting on the front of the cells to prevent the throwing of bodily fluids. Nowadays we have all sorts of protective equipment and tools to use in cell extraction, reducing injuries to both staff and inmates to where they're only a slight fraction of what they were before.

The intensive management unit was built in the early 1990s and was designed for maximum custody inmates. This unit now houses 27 death row inmates. These cells have the fronts covered in one quarter inch holes to deter the throwing of bodily fluids. One negative aspect about the building is that it is very noisy. Experienced staff often wear ear plugs in the unit.

There is very little staff interaction with the inmates in this unit. This new pod-type of design makes for a more indirect approach and allows for fewer staff to work the area. The staff are only on the tier when they have to feed, issue supplies or

take an inmate to an appointment. This lack of interaction creates or maintains an us versus them mentality on both sides.

All in all, I believe the Oregon system where we use direct supervision is a good one. It allows us to run safe and secure institutions by using interpersonal interactions between staff and inmates. I believe this helps in the rehabilitation of the inmate and better prepares them to reenter society. Unfortunately, new prison designs are not being built on this model. With the drastic cutbacks in educational and vocational programs, rehabilitation opportunities are harder to obtain.

With the huge influx of the mentally ill into our institutions and staff are not being trained, the stated purpose of our institutions is being challenged. Are we a correctional institution or are we a mental health treatment facility? I'm not sure those two areas are truly compatible with each other.

I want to thank you for holding the hearings and for your time and allowing me to participate.

DR. GILLIGAN: Thank you very much.

Could we now hear from Ms. Bonnie

Kerness.

MS. KERNESS: Thank you. One small correction, I'll be sharing testimonies from prisoners throughout the country.

Since 1975 I have been a human rights advocate on behalf of prisoners throughout the United States. I coordinate the Prison Watch Project for the American Friends Service Committee, which is a Quaker-based organization. AFSC's Prison Watch is an advocacy project which monitors prisoners and their conditions of confinement. We receive testimonies through the mail and collect telephone calls from people in federal and state prisons and county jails. We also hear from family members, lawyers, advocates and correctional staff, with whom we often consult or provide technical assistance.

An important backdrop of our work are the United Nations convention and other international and regional treaties that the United States has signed, including the Convention Against Torture.

In 1984 we received a letter from a prisoner who was being held in the management control unit at Trenton State Prison. He said he had been placed in isolation and had no idea why. He asked us to monitor him, which we did through 2000, when, after

16 years, he was released from that unit. For many of those 16 years I visited him and noticed a distinct increase in irritability and repetitiveness. He reported feeling emotionally deadened. He would report on the changing emotional state of other prisoners there, noting which ones began to break down emotionally and physically. There were at least two men who refused ever to come out of their cells, another began to masturbate when officers or other line staff came on to the tier.

Since that time, AFSC's particular focus has been to monitor the escalating use of extended isolation in US prisons in the form of control units, supermax prisons, security threat group management units and administrative segregation units. We receive about 1,800 calls and letters each year.

One result of our monitoring is our awareness that the majority of reports on the use of devices of restraint are coming to us from men, women and children living in isolation cells. These last years have been full of thousands of calls and complaints of an increasingly disturbing nature. The proportion of those complaints coming in from women living in isolation has risen dramatically.

In January I was invited to speak

before the UN Committee On Women and I would like to share with you some of the testimonies that I carried there. One voice was that of Judith V., a 45 year old mother of three, New Jersey, serving a life sentence. Judith wrote of her depression and desperation, reporting that she had stopped bathing and stopped combing her hair.

She said, I was locked in isolation, sitting there day after day, week after week, month after month, year after year, not once was I ever taken out of my isolated cell. I was in a separate building and was not allowed to have recreation, library, television or church. I was prevented from making telephone calls or having visits. I was allowed a short shower, after which I was locked back in my cage. The cell had a window that was 4 inches wide and 3 feet long. The window was wide enough to fit one eye. I needed fresh air so badly that I started to rub my nails against the rubber seal around the window. It was a thick and hard rubber which I rubbed for eight months to get a tiny opening. I felt worse than a caged animal. I spent three years there and have phobias where I still need to be enclosed in my cell.

Judith's story doesn't end there. She

was abused sexually by two members of correctional staff and when she came forward to report the abuse, she wrote that they put her back in isolation.

A woman from Texas writes, the guard sprayed me with pepper spray because I wouldn't take my clothes off in front of five male guards. They carried me to my isolation cell, laid me down on my steel bed and took my clothes off. They left me with the pepper spray on my face and nothing to wash my face with. I didn't give them any reason to do that, I just didn't want to take my clothes off.

Another woman from Arizona wrote, saying that the only thing you get in isolation here is a peanut butter sandwich in the morning, a cheese sandwich in the afternoon and for supper another peanut butter sandwich. She reported drinking toilet water when she got thirsty.

Keisha, a New Jersey prisoner in the county isolation unit, who was in her late 50s, tells us a number of women are suffering from mental illness, including herself. She talks about her depression, her suicidal feelings, saying, we are forced to sleep on the floor in the middle of winter with bad backs and aching bodies, cold air still blowing in from the vents no matter what the

temperature is outside. At 2:00 in the morning they wake you and tell you to clear the cell. They go through your personal belongings and put them in the trash.

We recently received a letter from a man being held at the same county jail as Keisha, who talked about being forced to wear what he called a chicken suit in isolation. He said that the suit was made of transparent material. The man was a minister imprisoned for lack of child support and was mortified at the exposure of his body.

A man writes telling us of the suicide of another man at Ohio State Penitentiary. He says that no one told this man why he was in segregation, he had no violence on his record, he was transferred with no conduct report, no notice, no conference and did not know why he was there. In a letter to his family he spoke of having no hope.

Another wrote from the federal facility in Florence, Colorado talking about his disorientation. He described sleep deprivation because of the lights never being turned off, the constant banging of electronic doors, the echo of his own voice in the steel and concrete cell and thoughts that he was already in his grave. There are counts

every hour with people knocking on the door and putting a flashlight in my eyes all night. I'm unable to read and find myself drifting, not able to absorb a thing.

In a visit I had with one prisoner he said if I locked you in a small bathroom for 22 hours a day, you're not going to get into much trouble, but when they let you out, you are going to get into trouble like you would never have seen before. He said, I have never met anyone who has been exposed to isolation whose attitude didn't harden. We were sitting in a small, sealed cinderblock booth in the visitor's room, speaking through a telephone. The man could see me through the glass but hardly anything else. He said the control and humiliation presses into my face all the time.

This 56 year old man noted that one of the most difficult things is the noncontact visits themselves. I haven't touched my three daughters since 1989.

Another described a new supermax unit. I got a concrete bunk, felt steel mattress, a steel toilet and a telephone booth sized shower in the cell. Water comes out in 90 second sprays, making me feel like a house plant. The outer door is solid steel,

with a peep show panel of plexiglass. Meals are in the cell, all movement is in restraints. Outside rec is an area at the base of the cell block, high concrete walls, look straight up and it's crisscrossed with eye beams, covered with steel mesh; look through this and you can see a patch of blue.

The prisoners describe an environment so devoid of stimulation that it is toxic to mental functioning. I've spoken with people who begin to cut themselves, just so that they can feel something.

I once asked a man why he threw feces, what could possibly compel him to do that? He said it was the only power that he had left.

People tell me that they experience a progressive inability to tolerate ordinary stimulation. Many describe having panic attacks and problems with impulse control.

Some of the most poignant letters I receive are on behalf of the mentally ill being held in isolation, like the man in California who spread feces over his body; staff response to this was to put him in a bath so hot it boiled 30 percent of the skin off him.

Mentally ill prisoners are disproportionately combined in sensory deprivation

settings. The isolated mentally ill suffer cruelly with many decompensating. I have my Master's degree in social work and for 30 years have treated hundreds of ex-prisoners with the symptoms of posttraumatic stress. Once released, the prognosis for those who have lived in long term isolation is difficult.

I have had the good fortune over the years to form some remarkable relationships with front line officers, teachers, mental health workers, administrators and other members of departments of corrections. I've had the privilege of being able to voice my concerns.

In one very recent dialogue a New Jersey correctional officer talked to me at length about his experiences working in an isolation unit. He said that he felt personally safer when the movement of prisoners was controlled, saying there is very little you can give to isolation prisoners except to check on them regularly, to let them hear a voice and to know that I'm there and that I know they're there.

He talked about the stress of working in a control unit environment. He talked about friends going on stress leave, willfully taking smaller pensions. He said that the attitude of many

prisoners was that you can't do anything to me, you can't do anything else to me, and that people in isolation units with that attitude were often agitated and enraged.

When I see a human being who is reduced to throwing feces and urine, it wears me down, he said. I believe that there is a place for isolation, but I am breathing the same canned air, sitting under the same fluorescent lights, listening to the same noises. I don't believe this is good for officers or good for the prisoners. It's too much for both. You can't leave someone in a cage month after month for the duration of their sentence.

This particular 20 year officer served in Vietnam. He went on to talk about seeing symptoms of madness in people who were POWs there, saying -- going on to say that there's no difference in what was done there and what we are doing in long term isolation here.

Over the years the testimonies which come in my mail daily have rocked my soul, they haunt me. I have come to believe that Departments of Corrections are more than a set of institutions, they are also a state of mind.

In May of 2000 the United Nations

Committee On Torture cited excessively hash regime of supermax prisons as violations of that treaty, adding that such violations are widespread in the United States. The UN Human Rights Commission specified that prolonged solitary confinement is prohibited as a form of torture.

The testimonies I've heard for 30 years have implications for all of us. In a system where 95 percent of the prisoners return to our communities, the impact of these practice is felt beyond prisons. To take away someone's Civil Rights is something we can and should debate regularly as a society. To take away someone's human rights isn't negotiable.

You, as commissioners, are breaking down the wall of silence that has been built around prisoners. The AFSC is grateful for your willingness to listen.

DR. GILLIGAN: Thank you very, very much.

We will now hear from Daud Tulam.

MR. TULAM: Good morning and thank you for inviting me to share my experiences.

I was born in October 1954 and raised in Salem, New Jersey, not far from Wilmington, Delaware, which is also where I currently live. In

1980 I was arrested and convicted of armed robbery and assault and because it was my second offense, I was sentenced to an extended term of 20 to 40 years.

I first entered prison in 1974 and was paroled in '78. My second offense began in 1980 and it ended in July of 2004. Of that time I spent 18 years in the management control unit here in New Jersey State Prison, currently in Trenton. Initially I started in the general population, but after roughly five years I was placed in the control unit for the first time after a hearing determination. I was released a couple of years later for a period of three months, after which I was placed back in the control unit for the remainder of my sentence.

The MCU is an isolation facility whereby inmates are locked down in single cells roughly the size of nine by 13 feet for 23 hours out of every day, seven days a week. Inmates are let out of their cells for each meal to receive their trays and, also, for some exercise in a small fenced-in area every other day. Inmates are also permitted to have TVs and radios in their cells only at their expense, in other words, you have to buy them. But there was little or no library access.

My unit had 24 cells, which often

capacitated as many as 20 people at any given time. When you were in your cell, you could not see into anyone else's cell. Although spending this much time in lockdown isolation could be detrimental to one's psyche, I found that I was able to survive by -- my experiences by having the ability to adapt. Motivational factors played a large role in helping me to make it through prison. I was motivated to see my family again and I was also determined that I would not be broken by those who would want to see that.

I also made a commitment to myself that every day in prison I would -- it would be a day to educate myself and better myself. I used my ability to read and write and to keep my mind occupied, rather than idle. I developed a very regimental routine that I would follow each day to pass the time and to keep myself busy. I would wake up the same time every day, I would read and write for a period of time as well.

In addition, I was able to maintain strong family connections which helped me a great deal. Inmates who did not have that kind of support tended to have difficulty. It was very difficult for me, therefore, in the last year prior to my release when both my older brother and my father passed away. It would have been much more difficult to finish my

time if I had many more years to go without their support.

During the time I spent in the control unit I noticed that some other inmates struggled with the lockdown conditions. I observed that some individuals who were quite normal when they arrived on the unit started to change over time; some started talking to themselves, some developed poor hygiene habits, I even observed and heard a number of attempted suicides.

In order to place an inmate in the control unit he's supposed to be reviewed every 90 days, however, I found the reviews were just a sham with no real investigation as to whether to continue to be -- to confine a prisoner in MCU. In fact, I didn't have a disciplinary write up for a number of years prior to my release and, yet, I spent that entire time in the control unit.

Because of this, after a few years I even stopped participating in the administrative review process because I knew I was not going to be released from the MCU.

Based on my observations and experience, the MCU was used to isolate and remove from the general population any inmates who were

politically conscious and had influence with other inmates. I believe it was used simply to wear prisoners down, to break up any sort of community that developed within the general population.

At the time I was first placed in the MCU I was a member of the Inmate Legal Association. The ILA was successful at bringing a number of lawsuits concerning officers brutality in the early and mid-1980s and I believe that that's why I and several other members were originally placed in MCU. After words, the ILA pretty much became an impotent organization.

More recently, within the last four to five years the New Jersey Department of Corrections created a second control unit for alleged gang members. Inmates in this unit have a more tightly controlled environment than the MCU, but they have more clearly-defined methods for release into the general population. I have just completed my first year of reintegration into the general society. Although I made it out and have been able to adjust pretty well, there have been some nasty effects from the time I spent in the control unit and in prison in general.

I have noticed that my social skills

deteriorated and although I was on the quiet side to begin with, I am now much more reserved around others. I also have become desensitized to violence, having seen so much while incarcerated. To this day I maintain very disciplined -- I maintain a very disciplined structure to my life that I observe is uncommon among society in general out here.

Overall I spent more than half of my life in prison and of that time I spent most of it in isolation control unit. Because of all that time, I cannot be sure of all the ways that experience has affected me, but I'm sure that whatever those effects are, they'll remain with me for the rest of my life. Thank you.

DR. GILLIGAN: Thank you very much.

I want to thank each and every one of you for coming forward today. I -- unfortunately -- because we're running short on time, we're going to have to forego our usual practice of opening things up for questions now. We will have to take a break.

However, during the break I understand that you would be willing to have private discussions with whoever in the audience or among commissioners would like to ask you questions.

So let's take a break now and then we

convene here at 11:30. Thank you.

(Brief recess.)

EXPERT TESTIMONY ON OVERCROWDING

MR. KRONE: I believe now we're going to continue now with the introduction of the overcrowding panel.

On behalf of the Commission on Safety and Abuse in America's Prisons, I am honored to welcome our three witnesses; Vincent Nathan, Craig Haney and Richard Stalder. The Commission has invited this prominent group of experts to express the causes, implications and consequences of overcrowding in our prisons and jails.

Overcrowding directly impacts both inmates and correctional officers every hour, every day that people are inside of a facility.

This morning we are taking a serious look at how facilities operate above capacity or overcrowding, as we will call it. Many have safety failures, violence and abuse that directly impacts both inmates and correction officers. Through our witnesses today, we will consider the extent to which overcrowded prisons and jails are more difficult to operate and how overcrowding contributes to the breakdown of social order in a facility, harming both

prisoners and correctional staff.

This panel will address these issues from several complimentary perspectives. Our witnesses have dealt with the challenges posed by overcrowded facilities in different capacities. We will draw upon their experience to develop a balanced report on the state of our knowledge on the link between overcrowding and violence. We will hear about how overcrowding causes systematic breakdowns that results in dangerous conditions. In the academic literature removed from daily experience of the inmates and corrections officers, there is no established connection between overcrowding and violence.

We will hear from our witnesses today about how individual accounts, court cases and media reports, and even our witnesses' own experiences, are more able to make the obvious connection between overcrowding and violence.

Attorney Professor Vincent Nathan has served as a consultant for several state departments of corrections. He has also been retained as an expert in conditions, lawsuits and studied prison violence at University of Toledo Law School.

Dr. Craig Haney, professor of

Psychology at the University of California, Santa Cruz, will help us understand the consequences of deteriorating prison environments to inmates.

Richard Stalder, Secretary of Louisiana's Department of Public Safety and Corrections, has worked with the department for over 30 years in different capacities. He will describe the systematic conditions related to overcrowding problems and how correctional institutions respond.

Let me thank each of you for taking the time to appear at this hearing. Our goal is to learn from your many years of experience and many years of hard work. We are confident by helping us, you will contribute to helping making correctional institutions safer, less abusive and more humane for those incarcerated, and safe for the men and women who work inside. Thank you.

MR. NATHAN: My name is Vincent Nathan. Let me begin by --

JUDGE SESSIONS: Would you pull the microphone up closer. We can't hear you.

MR. NATHAN: Good start. Is that better?

JUDGE SESSIONS: Much better.

MR. NATHAN: Thank you. Let me begin

by thanking the Vera Foundation for inviting me and I would like to thank, as well, the members of the Commission for their expression of interest and concern about the problems we've been hearing about and we'll be hearing about today.

I'm going to focus on the impact of crowding on the operation of a prison or a prison system and attempt to formulate for you a description of the perspective of the conscientious Director, Secretary of Corrections, who is faced with the exceptional difficulty of maintaining a safe and secure and, hopeful, industrious prison system, despite that person's inability to control the size of the population and, in many senses, the resources available to deal with that population.

You notice I used the word responsible as an adjective. In 1965, when I began working in prison and jail litigation, typically as a representative of the federal court, I did not meet very many Directors of Corrections whom I would have described as responsible. Now, let me add a quick cliff note. Special Masters don't go into good prisons as often as they go into bad prisons so I'm not suggesting that everyone with that length of experience or experience at that time was part of the

problem.

But what I can say with confidence is that of all of the things we have accomplished through litigation, through the adoption of internal professional standards, through increased expectations, the impact of efforts on citizens groups and others, of all the things that we've accomplished I think the thing that may have been most valuable has been the enormous change in the prospective attitude and behavior of people at the administrative executive level of corrections in the United States.

We are talking about people, for example -- and I'm going to make a couple of references to my State of Ohio, we're talking about spending almost $2 billion a year and we have a person, Reggie Wilkinson in this case, who is responsible for the operation of almost 40 prisons and some 42, 43,000 inmates and he has qualities of administration and he has a sensibilities and concerns that simply -- that I simply did not see 25 or 30 years ago, and I think that's true of many, many corrections administrators.

Now, the concern that I tried to express in the brief statement that I gave you is that when state governments initially reacted to

correctional overcrowding by ignoring the problem, we've had a couple things going for us. At first we had the federal courts, who did step in and who did, not solve the problem, but accomplished a great deal and we've had a response to that in the form of building and expanding; not reducing population, but making more room. And, of course, that costs a lot of money and in the '90s money was cheap, it was easy to budget those kinds of expansions, it was politically easy and it was at least economically feasible.

As the population increase has stabilized for at least a little while, or nearly stabilized, what concerns me so much is that we are going to see an increase in population soon and that we are going to find ourselves without the benefit of the courts for a number of reasons that I outline in my statement, and we're going to find ourselves without the money that we had in the 1990s to address the problem.

The difficulties that administrators face in attempting to maintain safe institutions, to maintain staff moral, to prepare prisoners for re-entry, which is a fundamental responsibility in the state, to accomplish anything constructive is made so much more difficult by the inability to do anything

but respond to the daily crises in the form of violence, in the form of staff responses, in the form of deterioration of physical facilities and all of the problems that result from an overcrowded environment, it's a heartbreaking experience for people like Reggie Wilkinson and other directors.

And I remember he said to me -- a couple of years ago he said, you know, we're going to make it, our population is going down, we actually lost -- we pulled our population down by 6,000. Now, that wasn't just happenstance, that wasn't just -- it wasn't because Ohioans quit committing crime, they have a lot of crime in Ohio, they have a lot of crime in all of our big cities in the state, but our legislature began to catch on and we began to decriminalize, we began to take some steps that resulted in reduced incarceration. And then the money went away. And what have we done?

We've closed three or 4,000 beds to save money because we don't have any money for our colleges, we don't have any money for maintenance of Medicaid, we don't have money for secondary education. And even though the corrections department continues to be the only state agency with an increase in its budget, that increase is marginal compared to what it

was accostomed to.

And so, as I point out in my written remarks we continue to, as many states do, double cell inmates who have just walked in the front door of the prison, we know nothing about them, we have no idea how two men or two women will respond. In fact, turning to women, the intake facility for women in Ohio maintains 250 women in one dormitory before they are classified. Now, if classification means anything, that kind of crowding and the resultant response that is inevitable, simply turns the concept on its ear.

We have an opportunity now, it seems to me, while we enjoy the benefits of reduced pressure on intake, to begin to think seriously about the number of prisoners a particular jurisdiction is prepared and able to accommodate financially, physically and to develop policies that will bring our system into some form of balance. If we do not accomplish that, we are going to lose what I think is the most crucial -- the most crucial resource we have today to take the improvement of prison to the next stage, and that is the talent that we see in a large number of directors, a substantial number of wardens and deputy wardens and captains and majors and line correctional officers who

really feel differently about what they do for a living than they did 30 years ago, and who are prepared to make prisons work.

And if we say no, by our actions, we don't want to help you make it work, perhaps they will leave and when they do, they will replace -- they will be replaced by people who are willing to accept the status quo and work from there, and that's what we had for so long and that's what produced the problems of the '70s, the '80s and the '90s. Thank you very much.

MR. KRONE: Craig Haney now, please.

MR. HANEY: Thank you. Thank you for an opportunity to address such a distinguished group about such an important topic.

When people discuss and analyze prisons, and it's been evident in this morning's presentations, much depends on one's perspective. Depending upon that perspective, the glass is either half full or half empty. I want to acknowledge at the outset that I am a half empty guy.

I was a graduate student in 1971 and I was one of the principle researchers in what has become a notorious experiment in psychology, the Stanford Prison Study. And I sat as a graduate student and watched healthy, normal, young men turned

into either largely sadistic acting or behaving prison guards or victimized and, soon, emotionally dysfunctional prisoners in the period of six short days.

Since that time, almost 35 years I have spent a lot of my professional life going in and out of correctional institutions throughout the United States, touring, inspecting, interviewing prisoners and, to a certain extent, staff and administrators as well. I would estimate nearly 100 of these tours and inspections in different facilities around the United States.

Much of my involvement has been precipitated by litigation, so, like Vince Nathan, I am typically not called in to examine prisons at their best. I acknowledge to you at the outset, I have not seen American prisons at their best, but I have seen many of them at their worst and I have seen many of them with issues that this commission addresses, issues of safety and issues of abuse are at the forefront.

I can tell you that when I began this work, the concept of double celling was regarded not just by academics, but by prison administrators as well as an unmitigated evil. Nothing has changed

except for the numbers of people that we have in prison to shift that judgement. Nothing has changed in academia to suggest that crowding is not harmful, nothing has changed in prison administration to suggest that prisons cannot be run better when they are not overcrowded. What has changed are the norms; the perspective from which we view these issues.

Of all the things that have happened in American corrections over the last 35 or so years since I have been a witness to it, nothing is more important than overcrowding, in my opinion. There are many issues, but overcrowding, if one had to pick one, it would be the single one, and the related concept or trend of overincarceration.

Now, overcrowding in this context I think is a bit of a term of art; it does not just mean too many people for the space available. It also means housing more prisoners in environments that don't have the infrastructure to manage them properly. Housing more prisoners in environments that don't have adequate programming resources, housing more prisoners in environments that don't have medical and mental healthcare that is commensurate with the number of people who are confined. And, by that measure, American prisons are and have been for the last 35

years, in many jurisdictions, woefully overcrowded.

Overcrowding does mean to a certain extent, however, social density and that's something that ought not be lost sight of. The average American prisoner lives in an environment roughly the size of a king size bed. If you have a king size bed at home, that's about 60 square feet, the average American prisoner lives in an environment just a little bit bigger than that. You have a modest size walk-in closet or a very small bathroom, imagine living your life in an environment that size, imagine having all of your worldly possessions in there with you and then imagine also having a friend to share that space with you, or an enemy as the case may be, because, as you well know, virtually every prison in the United States in double celled, if they are lucky. Some of them are housed in the space that size with a third person in certain jurisdictions, with which I'm sure you are familiar. So overcrowding does mean an absence of appropriate space, a lack of sheer physical freedom.

But it also means a lack of adequate programming. By most estimates, half or so of the prisoners confined in American prisons lack meaningful work opportunity, half or so. About an equal number lack adequate educational opportunities. In my state,

California, the average reading level of prisoners confined in our prisons is seventh grade and many of them, many of those prisoners have been in those prisons several times. So whatever kind of educational resources we're devoting to the process of educating them, they are not learning and they are not improving.

There is a lack of adequate mental health program and medical resources in many facilities, in many facilities in the United States, in part because the sheer overwhelming numbers of people who are confined inside our prison system. Indeed, many prison systems lack the opportunity and the resources with which to do even adequate screening of people who are coming into the system. And, of course, if you can't identify a mental health or medical problem, you cannot treat it adequately. Most systems -- again, I will speak to my own state -- do no more than a superficial job of addressing these issues, in part because there are simply too many people coming into the system to devote the necessary amount of time to adequately assessing them and then, in part, frankly, because we don't have the resources with which to address their problems, even if we adequately identified them.

Now, you heard some testimony earlier today that despite the overwhelming oppressive numbers in the system, somehow we have managed to keep order, some semblance of order in most places. You are going to hear more about this this afternoon, I know, but let me share with you the mechanisms that I have seen used in order to keep some semblance of order inside these overcrowded and barely overrun and overwhelmed facilities.

In many prisons in the United States, maximum security prisons, there are metal detectors, x-ray machines, leg irons, waist chains, handcuffs, black boxes, holding cages, violent prisoner restraint chairs, psychiatric screening, chain link fences concertina wire, tasers, stun guns, pepper spray, tear gas canisters, gas grenades, and, in some jurisdictions, mini 14 and 9-millimeter rifles, 12-gauge shotguns and the like in place, inside housing units. That is, in some sense, the way we have managed to maintain control and stability in some of our worst and most overcrowded prisons.

You are going to hear later on this afternoon about another technique which has emerged in the course of this recent period of overincarceration and overcrowding, the use of the supermax prison,

where people are kept, at best, 23 hours a day lacking any human contact. I have regularly interviewed people who have been in these facilities for five or 10 or 15 years during which time, among other things, they have not touched another human being with affection.

In my written statement to you and in other materials that I know people have written about these issues, we have addressed at length the psychological and psychiatric consequences of confining people in overcrowded facilities and of confining people in facilities where they are subjected to these forms of social and institutional control. There is a significant psychological and psychiatric price which is exacting and I would suggest to this Commission that unless we can get a handle on the overcrowding and overincarceration which has plagued our country over the last 35 years, then we will not be able to solve the many problems that you have been addressing and thinking about and analyzing. Thank you.

MR. STALDER: Thank you. Richard Stalder, Secretary of Public Safety and Corrections in Louisiana. First, let me say that the fact as a witness I don't have on a shirt and tie is not a sign

of disrespect of this Commission, it's a sign and simply reflects the fact that at 6:00 this morning the button on my buttondown collar escaped from my shirt and remains at large and, therefore, I'm doing the best that I can.

I would like you to know -- I want to begin, I guess, with my conclusion. On behalf of the Association of State Correctional Administrators, on behalf of the American Correctional Association, of which I am a past president, the executive director, Jim Gallon(ph.) is in the audience, I think, Mr. Ryan, you would agree as the past president of the American Jail Association, we share with you a very common goal in your work and that is to advocate for safe and stable and productive and organized and disciplined correctional environments in America. That is what we want.

Senator, we, as an association, have been working four years with the Department of Justice through VJA to develop the very kinds of performance measurements that you called for this morning, consistent across the board ability throughout America to say how many assaults do we have, how many escapes, not just the deaths and the suicides, but at a level of performance measurement that gets down into our

operations that can provide meaningful information to people like you to explore these problems. We are four years into doing that and we have six pilot states. Mr. Maynard is one of the pilot states, I'm one of the pilot states. We'll add probably seven or eight states by August or September and, hopefully, be in full operation in another six months. That would be the kind of information that you need and I'm proud that our association is doing that.

I want to speak to you about overcrowding, not from the fire marshal's perspective. I think I'm going to echo a little bit about what Vince and Craig said. You know, overcrowding from the fire marshal's perspective is, you know, can you exit people quickly in an emergency? What are your exit aisle widths and how big are your doors and where are your keys?

From the health department's perspective, overcrowding is contingent upon how many sinks do you have and how many toilets do you have and how many showers do you have?

And I think from our perspective, particularly from my perspective as an administrator, overcrowding means do you have more inmates than your resources can support? You know, we can have a

thousand bed prison -- two identical thousand bed prisons, one which is significantly overcrowded and one which is very safely and productively run simply as a function of the resources that are put into it.

You know, I want to very specifically urge your advocacy for certain things. One is for pay and benefits for correctional officers, people who work in our prisons and our jails. You cannot run the kind of safe and stable facilities that you want and that we advocate for without a well trained, career staff.

In Louisiana I regret to tell you that we start our correctional officers at the state level at $18,000 a year, gross. Now, if they're fortunate enough to be able to participate in our group benefits insurance program, that takes $3,600 off the top. Most of our correctional officers are eligible, thank God, for their children to participate in the Children's Health Insurance Program, funded federally, so at least the kids can enjoy health benefits. Our turnover is 30 percent a year.

If this Commission can advocate for pay and benefits for correctional officers in our prisons and our jails, you will take a significant step forward in promoting safety in these environments.

You've heard earlier this morning about the medical and mental health interests. Dr. Karl Menninger wrote a wonderful book years and years ago in Topeka, Kansas called "The Crime of Punishment." We shouldn't lock up the mentally ill, he said, we don't need to punish the mentally ill. And, unfortunately, as a society we forgot to read the last chapter. We read all the first of the book and we should deinstitutionalize the mentally ill, we forgot the last chapter that said we need to provide community support for the mentally ill.

And so the mentally ill became the homeless and began to interface with the justice system and tomorrow you will hear from Director Wilkinson, who Vincent mentioned earlier, tomorrow you will hear about that very tragic reality that our correctional institutions are becoming de facto mental health clinics, but we have to have the resources to deal with it. Without the resources, without the staff, without the professionalism that's needed to cope with those kinds of problems, you will not have the kind of safe environment that you promote as a Commission.

The medical issues. You know, when we talk about safety, I like to say public safety

relative to corrections is not just about keeping dangerous people behind bars. Public safety is about making sure they don't exit our system with contagious diseases. So that if we know that someone has disease prevalence or that we have a higher disease prevalence in our institutions, we need the resources to deal with that, and I would urge this Commission to be sure that the scope of what you do and advocate for includes advocacy for the treatment of disease in our institutions.

Twenty-five percent of the inmates in the State of Louisiana -- we test for tuberculosis, we test once a year, everybody, staff and inmates -- we have 25 percent tuberculosis prevalence. That doesn't mean they're sick, it means they test positive and we have to treat them. You know, the great news about tuberculous is detection is cheap and treatment is cheap, so that's an easy one.

Unfortunately, hepatitis C, as you heard Dr. Beck talk about this morning, probably one out of three inmates in America, because it's a disease of intravenous drug abuse and it's a disease of lower socioeconomic status have hepatitis C and, regrettably, the treatment is 18 months long and it costs about $20,000 per inmate. You know, if I

treated everybody in the State of Louisiana in my correctional system who had hepatitis C, the cost would exceed the annual limit for bonded indebtedness for the entire state. We need help. We need attention to those kinds of resource issues.

Relative to overcrowding, I would like you to please consider supporting, for example, the Prison Rape Elimination Act Provisions For Safeguarding Communities.

It all has to do with we have a fixed resource base and we continue to pour more people into it, how do we make those resources stretch to accomplish our goals? And in my mind the best way is to quit putting so many people into the system, which means we need to pay attention to prevention, which in my mind means that we need to take -- we heard in Ohio people read at the seventh grade level, in Louisiana we had tested some 26,000 inmates four years ago and people come into our system at the fifth grade level, the fifth grade reading level.

You know, and that doesn't mean -- we can look at all the records and everybody claims I graduated from high school or I finished 11th grade, I finished 10th grade. They may have, you finish that all you want, you still can't read the fifth grade

level, that's, unfortunately, the reality we have.

We need to put resources into basic education in our prisons. We need to put resources into substance abuse treatment. 80 percent of the people that we deal with have substance abuse problems that were -- that in some way affected their criminal behavior. We need to teach job skills. I mean, three-fourths of the people who come to prison in America weren't working when they got arrested. Let's teach job skills.

Let's teach values. You know, our people come to us and they have a value set that's formed by the culture of gangs and the culture of drugs and not by preachers and teachers and parents. We do a lot with that in Louisiana. I think, Mr. Nolan, you are aware of that. We believe that our faith-based efforts, our faith-based communities can do a lot to help people restructure values.

You take those four pieces and then all of a sudden people leave prison and they don't come back at the rate of 43 percent after five years in Louisiana. They come back far less frequently, which means there's far less overcrowding, which means we don't need more resources, which means we can take our existing resource base and spread it to accomplish

these goals better. That, I think, is a voice that we need this Commission to adopt and to take.

We need to pay attention to our kids. My time is up. The one minute thing is about to wave. Our children -- prenatally and in early childhood there's so much that we can do to divert them from criminal activities, so much. I think Head Start is a wonderful program, we support it in our department, all over the state, three and four year old kids learning how to learn and then they go to school and they succeed in school and they don't come into our justice system.

You know, that's one of the most important things we can do relative to overcrowding, in my opinion, is to support programs for children and this Commission I think, and I hope, can take a step forward and say, you know, in all of this that we deal with and we talk about safety and abuse in America's prisons, let's deal with some of these issues that can help make sure that people don't get the opportunity to come into prison.

On a final note, I'm sure you are all aware of this horrible statistic. The children of the people in our prisons are seven times more likely to go to prison than other kids in similar socioeconomic

status, seven times more likely. You know, I hope that this Commission will look at that tragic statistic and say, you know, to deal with overcrowding, to promote safety, let's pay attention to kids, particularly the children of people who are in our prisons.

Those are the types of things that I hope that you will be able to do that will be a concrete and a significant level of support for making sure that America's prisons and jails are operated as safely as possible. Thank you for the opportunity to testify.

MR. KRONE: I would like to start off the first question to you, Mr. Stalder. I recognize that a lot of things involving prison reform and safety, you know, right away brings an outrage to the public, they already got it too easy in there, they got three hot meals a day and the politicians are really reluctant to back any type of studies, any type of legislation that makes them appear soft on crime and, you know, threatens their re-election.

My question to you is you working on the inside, you know how the prisons work, your ideals and opinions of what needs to be done in there, how readily is that accepted by your other co-workers,

your other peers, your other people in the profession in the other states? Do you recognize how much resistance is there or how much support is there for these type of changes that we're talking about here that need to be done to address this overcrowding issue?

MR. STALDER: Mr. Krone, there was more resistance a decade ago. Today there is very little resistance to the type of program that helps people leave prison and not come back for this very simple reason. If you were a legislative panel in Louisiana, I could sit before you like this and tell you that the reality is that every year 15,000 people leave Louisiana's prisons; within five years, 43 percent of them will return, that's 7,000 people coming back to prison at a cost of $25,000 per bed to build the bed they sleep in, and at a cost of $35 a day or almost 13 and a half thousand dollars a year to pay the operating expenses for them to stay in prison, and that what we do to teach job skills and basic education and what we do with substance abuse education and what we do on the values piece keeps them from coming back. So that means, Mr. Legislator, whether you are Republican or Democrat, whether you are republican or democrat, whether you are liberal or

conservative, what that means is you have money now that you can spend on higher education, that you can spend on road and bridges, that you can spend on services to the elderly, that you can spend on services to children, and that message comes through very clearly, even in places like Louisiana.

MR. KRONE: Keep that message covered.

MR. RYAN: Let me go back to basics for a second. One of the terms that we use is overcrowding. For me, that terms gets kind of confused in the fact that there is an assumption that we're crowded at the beginning.

What Mr. Beck said is that our jails are at 94 percent, our prisons at 100 percent and federal prisons at 140 percent I think is what he said.

Can you help me better understand the concept of the design to capacity facility its operational capacity, its consitutional capacity and what that all means relative to the consequences of each.

MR. HANEY: Well, let me just offer one insight about it. I mentioned to you when I first started doing this work 35 or so years ago the concept of double celling was anathema to most not only

scholars, but correctional administrators. Prisons were regarded as overcrowded when they approached 90 percent of capacity and that was because correctional administrators understood that you had very -- you had increasingly fewer degrees of freedom to manage prisons effectively when you had problems, when you had prisoners who needed to be separated, et cetera, as the prison got closer and closer to its design capacity.

But we've long since have given up on the notion of 90 percent as overcrowded. We don't even begin to think about overcrowding until we're at 100 percent of capacity.

It sure comes as no surprise to you if I say that prisons are not built to be particularly spacious or luxurious, so a facility that is 100 percent of capacity really is operating at a very tight literal physical capacity to hold people.

Now, in California, as Senator Romero knows, we're operating at 180 percent of capacity, which means we have almost twice as many people in the prisons in California as those prisons were built to hold, and it's a sizeable population, we've got about 150 to 160,000 people I would argue to you who are significantly, painfully overcrowded. And the

management problems which come about as a result, I think, multiply out well beyond the simple space capacity issue.

MS. SCHLANGER: I had a similar kind of question based on Dr. Beck's presentation and, that is, is it the feeling of people on the ground -- what he said was that we're currently less crowded than we were ten years ago. And I wondered, if it feels like that. And I'm always very distrustful of capacity figures because you can take the same thousand bed prison and call its capacity different things, depending on the mind-set of the designer and what that designer expects is going to happen with the housing in that prison.

So I guess -- not percentages of capacity or whatever, that seems to me like it's not that likely to be that illuminating, but just the feel of the prisons, does it seem like prisons are less overcrowd now than ten years ago or the same or more or am I wrong about those capacity figures?

MR. STALDER: Commissioner, I want to answer this very quickly and then let Vince and Craig, if he wants to say something, but there is a long tail of building beds in the prison business. It's about three and a half years to bring beds online.

In Louisiana we grew by 2,500 to 3,000 inmates a year in the mid '90s, which caused a significant construction boom and, as Dr. Beck said, growth is fairly static right now. I say static, we go 2 percent a year, I mean compared to what we were growing a decade ago -- growth is static, the long tail of that construction caused us now to have, in essence, surplus capacity and that surplus capacity means I think that Dr. Beck is right, that we're not significantly overcrowded in most jurisdictions.

Now, I don't know what the future will hold, but today there is capacity to handle the number of inmates that we have, particularly in Louisiana.

MR. NATHAN: I think I would disagree with that. I agree, sir, I would dispense with the word overcrowding, I don't think it adds light. Prisons should not be crowded and when you have a system with 45 and 55 and 60 square feet cells in which virtually every inmate is double celled and when you have the breakdown of infrastructure that Dr. Haney has described, you have a crowded prison and the crowding is interfering with operations.

My very point, Professor Schlanger, that in Ohio the response of the legislature to a lessening of the population was to close prisons.

We're no less crowded, we're no less crowded.

Now, to go directly to the question of what do these capacity figures mean; the architect is told design a prison for a thousand people, he or she designs the prison and says the design capacity is 1,000. Then the question of capacity becomes political and if we have to put two people in a cell, then we double that capacity and we call it operational capacity and we find someone who will say I can run that prison safely at 2,000. Well -- and people will disagree about that.

I have not, in my experience over the past several years, seen anything that causes me to feel optimistic, that we are less crowded today than we were and, yeah, we're managing the prisons. Part of that is skill on the part of prison administrators, part of it is what Dr. Haney described, we have tipped the scales of control in some ways that, to me, are some troubling, but I think we have a terribly crowded system in the United States and that we have made virtually no inroad.

Keep in mind that when we talk about a reduction in the rate of increase, we're not talking about pure prisoners, we're talking about not having quite as many more. That would be my response to the

two questions.

MR. GREEN: Mr. Nathan, you talked about, though, hitting a point in time with kind of the static growth where the policies and decisions that we make going forward are so important.

Can you just expound on that a little bit more in terms of the kind of things you think we need to grapple with and the kind of policy considerations we need to be making at this time?

MR. NATHAN: I believe that we are -- and I can't tell you really why, we are at a point at which we know crime, reported crime and even reported victimization has fallen dramatically. We don't know why, but we know it's happened.

We know that money is scarce and is likely to remain so for the foreseeable political future, at least. We know that we continue to have an enormous number of people in prison, but it seems to me that we have an opportunity now, when at least we don't have folks backed up 10 miles waiting to get into our prisons, we are not backing up hundreds and thousands of people in county jails -- although that is still a problem in some states -- awaiting entry into the prison system, that now is the time to take stock; what do we have?

Okay, we know how many beds we have in Ohio, we know how much money we have and we simply need to define correctional policies from the point of view of how many people are we going to incarcerate, permit to be incarcerated and then what are we going to do with the rest of them, by way of diversion, by way of other kinds of programming. And then we need to accept the fact that, yeah, the criminals will always commit crimes for which we don't have an answer but -- and I want to answer your question on as practical a level as I can.

It's a time when the phenomena arises that elements come together that sort of give the system, the political system, a breathing spot or, a breathing space, then we could begin to think about what to do.

I think in Ohio, Director Wilkinson may disagree with me when he talks with you, but it seems to me that we didn't make a wide policy decision when we decided to take advantage of our decrease in population to maintain crowding and keep these beds empty. That's to me, was not a wise -- that was an opportunity we had. I want us to go back and seize it, I hope that we will.

I hope that at least begins to answer

your question, I'm not sure.

SHERIFF LUTTRELL: Let me address a question to the three of you and ask you for brief comments.

First of all, I think as a Commission we are very fortunate to have what I think is a good blend of the academic, the clinical and the practical and I think each of the three of you -- each one of you represent those three values very well.

Richard, I would like to add one point to what you were saying about investment in programs in our facilities and reflect on something that Dr. Beck mentioned this morning. I have had the good fortune to work in both prisons and jails so I can kind of look at both sides of the equation.

Dr. Beck mentioned this morning that part of the problems with our jail overcrowding has been a decrease in the quality and quantity of community programs and when we talk about prison overcrowding, we talk in large part about the recidivism rate. Until we have adequate support programs in our community to really compliment the programs that we are initiating in our prisons, it's going to be very difficult for us to sustain the good programs that we have in our prisons.

Some of the best drug programs I've seen have been in prisons, yet there doesn't seem to be a nexus to the community when many of these people are released. So there's got to be support in the community if we're going to impact the recidivism.

But I would like the three of you to really talk about, very briefly -- I think the common thread that runs through all of this is shrinking budgets effectiveness. State and counties over the last three or four years have had some significant problems when it comes to funding all types of programs, whether it's education, mental health or corrections. And, quite frankly, politically we'll never compete with education and with several other programs in the community.

The overcrowding problems impacts programs, quality of programs impacts staffing, impacts facilities.

Can you all just give an opinion or a recommendation on paradigmships; do we need to start refocusing another way in addressing these problems? We've talked about investing in staff training, we've talked about investing in programs, I just mentioned community programs; but do we need to start thinking in new terms about what can be done to address the

consequences of crowding? Do we need to start thinking of some new approaches to correctional management that maybe the textbooks haven't addressed yet? Let me just throw it out for a little brainstorming response.

MR. STALDER: I think, Sheriff, that, first of all, we are ready as a country, I know we're ready as a state in Louisiana to acknowledge that prison ought to be for people who are violent, who habitually break the law and who threaten our safety. And we haven't always felt that way in Louisiana, having the highest incarceration rate in the nation, which reflects a time in the '70s and the '80s when we decided to slow down an armed robbery amongst 20 and 21 years old was to say you are not going to be locked up for 50 years, now you are going to be locked up for 99 years, and those kids could have cared less about what the sentence for armed robbery was. But we built that long tail on, we're paying the price today.

But across America I think you're finding the paradigm shift is that low level drug and property offenders ought to be handled in our communities, that it's cheaper, that it's more effective and that it promotes safety and it promotes the kind of goals this Commission has and that, to me,

is the most fundamental paradigmship that we see going on.

And I go back to what I said earlier, it really is no longer a partisan issue, it's really no longer a liberal-conservative issue, it's really no longer those kinds of things that split us so much in the past. Everybody understands that true sentencing reform ought to mean that we keep dangerous people in prison and not dangerous people in our communities, and that our communities can effectively handle those issues and do it in a way that promotes exactly the kind of safety that we advocate.

MR. HANEY: Prisons and punishment have been play things of politics in this country for the last 30 or more years and I think many of the issues that you are addressing here have come about as a result of the wrongheadedness of many policies that were adopted for largely political reasons and, frankly, somewhat irresponsibly because they were not followed with -- as you heard just in this panel, they were not followed with the resources that needed to be invested in making the policies even workable, let alone humane.

A paradigmship, yes, at two levels. One is that we have to go back to viewing prisons, as

you have just heard, as the criminal justice system's response, absolute last resource, and not compete with one another over who could talk about putting the most people away for the longest period of time. That kind of thinking is what has gotten us here and what has gotten us many of the problems that you've heard so much about today and I'm sure in your other hearing.

The other thing, frankly, and I don't know whether it's been addressed with this Commission or not is you know that during this period we not only overincarcerated people, but we changed at the beginning of this era of overincarceration the philosophy which we use to justify incarceration.

People went to prisons beginning in the early 1970s for punishment, not rehabilitation. That, I think, was a psychologically naive shift. Human beings do not sit still well, the notion that we could put them in places and suspend them in animation somehow I think was just naive, and the notion that we could put people there and acknowledge the fact that they were there to be punished, by which we meant they were there to be hurt. Punishment means inflicting pain. That we could put people in places for long periods of time and inflict pain on them during the period of time that they were there and not have the

responsibility to do something positive or beneficial for them while they were there, I think, has now run its course and we need to go back to thinking about -- again, as you already heard in just this panel, go back to thinking about programming, what could be done to ensure that people come out of these institutions in better shape than they went in.

MR. NATHAN: Craig, I would argue -- I agree with you that that responsibility is not simply the responsibility of the prisoner, it's a responsibility of the society and we know that what we're doing now in the criminal justice system isn't working and we can talk, and I very much agree with Richard, that we have to think about people who simply can't come into the system. We simply don't have room or resources for them, it's a waste of resources.

And, by the way, a footnote, we're competing real well with education. Our education budget in Ohio is flat for the next two. Our correction budget is going up by two-point something percent, which is ridiculously low from the point of view of corrections, we're used to six and eight percent increases, but we're still way ahead of education.

We need to think about the length of

sentence. Somehow, and I notice this with my students, when I say someone goes to prison for five years, that's a slap on the wrist. Tell me whether any of you could give up the next five years.

I met an 86 year old man on death row in Mississippi, they are going to have to put him in a wheelchair to take him into the execution chamber. We are developing geriatric, skilled nursing home facilities in our prisons all over the country or we're letting that population rot, and that's some of us, that's me, where I go, I hope, it's what I need.

But we need to understand that piling time on top of time on top of time isn't accomplishing anything. It's defeating any effort to resocialize or promote re-entry. I think it dilutes punishment, I agree. You tell me 50 years, 90 years, I don't give a damn. What's the difference? My life expectancy is another 12, 13 years.

I mean, I wonder -- and I have no respect for what the man did, but I'm wondering what's this fellow's thinking about, you know, wouldn't a three or a five year sentence make our point? That's a long time. Some of us would be dead, for some of us that would be a life sentence, for all of us that would be a totally ruinous event, and that's what I

find surprising, that people think that -- I hear, I can do that time standing on my head. Well, try it. Try standing on your head 30 minutes or six months or a year.

Our sentences are simply too long and there is no justification. Nothing can be shown to have been accomplished by keeping a person in prison 15 years as opposed to three or four.

MR. BRIGHT: But what would you say about incapacitation, that's the argument, isn't it?

MR. NATHAN: Well, I understand that that's an argument in the first place from the perspective of an inmate who is killed by another prisoner or staff member who is assaulted by a prisoner or killed. Incapacitation is in the eye of the beholder.

But so we take -- let's don't talk about the worst, most vicious, violent crimes, because there are some that I would have difficulty responding to, but let's talk about serious economic crimes.

Do you think that Martha Stewart can serve, what, six months, is more likely to commit a crime than someone who spends five years or seven years and then gets out? I don't know. I think that year was probably a tough year. It would be a tough

year for me, and I just don't buy it.

MR. BRIGHT: I don't necessarily think that, but I think the question is for the person who has done three or four armed robberies by the time they're 19, is five years enough or is a longer sentence necessary to prevent that person from having anymore armed robberies, not worrying as much about the person but worrying about people in the society and whether or not they're robbed.

MR. NATHAN: Well, you know, the question of why we live, Steve, in such a violent society is one that we all have partial answers to. To tell prison administrators that they're supposed to resolve that problem is unrealistic. It seems to me that every time we put someone in prison for ten or 15 years, we've got someone lining up to take that person's place.

And I just simply don't buy the idea that by keeping a person in prison, let's say ten years, that we're going to have any impact on armed robbery.

And, you know, maybe another way to look at it is this; maybe it's our responsibility, if we're given the resources in corrections, we've only got three or four or five years with this guy, or two

years. You know, the Europeans are doing it. They're not slaughtering each other at the rate that we are, at least not in their criminal realm. And they get along with three and four year sentences for homicide.

MR. FRIED: You don't buy it, but do you have evidence and statistics to support your unwillingness to buy it? There's evidence and statistics that indicates you are wrong.

You don't like it, but you may be wrong, and what Steve says may be correct and supported by the facts. And I don't think you are not buying it is an answer.

If you have facts, please let us have them, but I don't think you have them.

MR. BRIGHT: Well, what would you say, Mr. Stalder, what would your answer to that be?

MR. STALDER: Mr. Bright, I would go back to the paradigm question. I would say I'm just a -- just from -- a little, old, simple guy from Louisiana.

The paradigm shift is not going to occur at the top end of the scale, first. I believe we ought to lock up people who are dangerous and violent for long and certain terms, and I think that that level of incapacitation is something that we owe

ourselves as a society.

But what we have done is locked up too many people who aren't dangerous to us for long and certain terms and that has had a very costly consequence for us as a society, for our states, for our country.

So in Louisiana we did a great thing five years ago, we changed the mandatory minimum sentence for possession with intent to distribute cocaine or distribution of cocaine from five years flat, no parole, no probation, no suspension offense to two years flat, and now we're starting to reap the savings from that, and I think that is consistent with what Vincent is saying.

But I personally believe that those who are violent and cause injury ought to be locked up for long and certain terms, without apology and we ought to pay the price, but we are paying the price for far too many who aren't dangerous.

MR. BRIGHT: Well, I guess the question is can you put sort of a percentage on that; how many of those people that you are getting in your system there are those that don't need those sentences like the drug people.

MR. STALDER: In Louisiana we are

attacking mandatory minimums. I think we probably intake as many as 35 to 40 percent people who are either technical violators or people who commit low level crimes and who face mandatory minimum terms because of that. We are gnawing at mandatory minimums.

We have now the political will to say that for nonviolent crimes, for property crimes and drug crimes, that we will reduce that and then let the individual show on their own merits whether or not they ought to be released. I don't believe in automatic release. I don't think lock somebody up for three or five years and let them out, but let them demonstrate that they participate in educational programming, let them demonstrate that they tried to better themselves, let them demonstrate that they are able to take care of their family, let them demonstrate that their values have shifted and then give them the opportunity to show us that as a society for people who don't pose that level of risk.

MR. KRONE: If I may interrupt here. This is about overcrowding and, as I understand to say, it's not the violent criminals that are overcrowding our prisons, is that correct, so we really are concerned about those sentences that are

putting nonviolent people in violent situations and overburdening our prison system, that's what we are addressing.

MR. NATHAN: Well, one question I would raise is how much of what we described as correctly violent crime is drug related, you know? If you don't have the money to buy drugs, you are kind of a weak guy like me, you would rather have a gun and you can make a robbery or a burglary to get the money for your drugs.

So I'm not sure that you can't go back to the drug question that's been raised and draw a pretty clear line of cause and effect, even when you discuss violent crime.

MR. KRONE: Violent issue as a result of a medical dependency that we are not treating or working on.

MR. HANEY: Let me -- Professor Fried brought up the issue of evidence and let me suggest to you that there is not one shred of evidence to suggest that the reductions in crime which we have enjoyed over the last decade or so are, first of all, remotely commensurate with the extraordinary increase in the rates of incarceration.

You heard this morning we were talking

about a quadrupling of the rate of incarceration in this country at many billions of dollars of investment and the decrease in crime rates have been significant, but they did not commence until a very significant change in the economic picture in the United States began in the 1990s.

So the extraordinary increase in incarceration took place in the late '70s and throughout the entire decade of the 1980s bore not direct fruit whatsoever in terms of reduced crime rates. There may have been a carryover effect into the '90s, no question about it, but statisticians suggest that only a small percentage of decrease in crime rates over the 1990s is attributable to the massive increase in the number of people in prison.

Now, add to that the question of opportunity costs. What could have been done with those billions of dollars instead to address crime, not after, but before it took place, and then address, or take into account, the issue of the consequence of these very selective policies of incarceration in certain communities in the United States, particularly African-American communities, particularly with respect to African-American men.

I'm sure you know the statistics that

there are communities, large urban communities in this country where a third to a half or more of the African-American men between the ages of 18 to 25 are incarcerated, and those kinds of incarceration rates have devastating effects, not just on those men directly, but on families from which they come, the neighborhoods in which they live and the communities to which they will return.

There is, again, no evidence to suggest that the reduction in crime rates is commensurate with the devastating human as well as economic costs of those policies for those communities.

MR. NATHAN: Let me drop one very quick footnote.

We're also pleased that the rate of crime is going down. The rate of increase among women going to prison today is as high or higher than it was in the '70s. Some day we will have half a million women in prison in addition to our million and a half men.

MR. KATZENBACH: You sound as though you didn't believe in equality.

MR. NATHAN: Well, if that's the definition of equality, you've pinned me to the wall.

SENATOR ROMERO: It seems to me that

when we talk about crowding and overcrowding, of course, it's subjective, it varies from state to state, from jurisdiction to jurisdiction. I think I would say it's about caseload inevitably, it's about space and it's about resources and, of course, all of this embedded in a political context.

But aside from the sentencing, which I absolutely think needs to be addressed, aside from looking at not only inmates, but the parole population. In California there's 165,000 inmates, 300,000 on parole, and most of them go back on some kind of technical violation, but I think another issue that I've seen, at least, sitting on the public safety committee in the State Senate in California is I don't want to say it's a new trend, but it has increased and that's the question of enhancements.

Use a gun, get this. Kill somebody under the age of whatever, get this additional. So it's not necessarily the sentencing, but it's adding on to the sentencing. Silence in those committees, absent in those committees, the witnesses, our corrections officials.

I guess, if anything, what I really do think that is needed is to have communication with respect to what is the effectiveness of the sentencing

and for how long and what is the worthiness of these enhancements because as long as we have a silence at the witness table when this legislation is going through, it's going to be law and order, business as usual, sounds good for the sound bite for the media, slap on the enhancements.

Any comments from you as to how we might engage corrections officials in our own states and others nationally to address this type of legislation that has come through California and hasn't stopped, and I would imagine if it's happening in California, it's happening throughout the nature.

MR. STALDER: Senator, in Louisiana we call it a fiscal note and when that type of legislation is proposed, I go to the table and I don't attempt, necessarily, to try to shake Louisiana's sentencing laws, which is really a legislative function, but I do go to the table and I say if you do this, this is how many millions and millions and millions of dollars it's going to cost, starting this fiscal year and how it will grow, and, you know we have -- do the charts and graphs and we believe -- I think that's an appropriate role for correctional administrators, is to explain what the consequence of the sentencing structure revision would be and, having

done that, then we find that many, many times people will say, well, I just really didn't realize that that was going to be that expensive and then it pretty well backs up and that takes care of it.

SENATOR ROMERO: Well, you do that in Louisiana, what about your cohorts? I haven't seen that in California.

MR. HANEY: I would call it a correctional environmental impact report that I think would be very helpful to have attached to any law that was under consideration that would increase the numbers of people who are going to prison or the lengths of time they would spend there and have the corrections department come in and say not only what's the direct economic impact of this, but how is this likely to effect the functioning of the prison system, and then until that's done, the law can't be passed.

MR. FRIED: Bringing us back to what is the subject of this Commission, do the three of you, and I guess Mr. Stalder is perhaps the best position to address this, think that it would be useful for this Commission to suggest minimum standards; square feet per inmate, double bunking or not bunking, correctional officer to prisoner ratio, things of that sort, so that you could have a kind of baseline which

said below this it is no longer acceptable and then, of course, your impact statement is a brilliant idea for dealing with the overcriminalization point, because I don't think that's our job.

Our job is to say what is the effect of those things on the conditions in the prison, but in order to be effective could we come out with something like minimum standards; would that be useful? Would anybody believe it? Is it feasible? Does it make sense?

MR. STALDER: Commissioner Fried, I am probably the strongest advocate for meeting minimum standards that you will find anywhere around the country.

MR. FRIED: I didn't know that.

MR. STALDER: I know that Commissioner Ryan is shaking his head. We in the 25 years of federal court supervision of the Louisiana correctional system by subscribing to the standards of the American Correctional Association and the Commission on Accreditation for Corrections, they have volumes of standards, we subscribe to 469 standards for the operation of our adult prisons and we entered into about a 24-month process, we accredited every prison and the federal judge said -- initially said

I'm releasing you from court supervision and releasing you from the monitoring of my special master, as long as you maintain American Correctional Association accreditation. It is a very remarkable tool to maintain minimum standards.

There are those who criticize those standards and I believe that the criticism --

MR. FRIED: What is your view of them?

MR. STALDER: My view of them is they provide a solid foundation upon which to build safe and nonabusive correctional environments, a solid foundation, and that foundation is what we've used in Louisiana. And Commission Nolan I know has been in our largest maximum custody prison and I hope believes that it's a safe and stable facility. It's the oldest and the largest facility in the United States that's accredited by the American Correctional Association.

MR. FRIED: So if you put that together -- you have those minimum standards and you put that together with your impact statement and every time somebody proposes some criminalization, you say fine, here are the standards, we've got to meet those; if you do that, then you can really put a dollar amount on whatever changes in the criminal justice system are being proposed; another five years, fine,

match that with the standards, in our state that means so and so.

MR. STALDER: Yes, sir. And I think as you look around this Commission, Commissioner Ryan, Commissioner Maynard, as you hear of Director Wilkinson that Vincent talked about earlier, strong -- not just proponents of, but participates in the accreditation process and the belief, the firm belief that those standards provide that level of foundation for our operations that result in the type of safety that this Commission advocates for.

MR. NATHAN: Professor, if I could take your question and relay it directly to the issue of crowding.

I think it's very difficult to argue that the ACA standards, which I do support, and the accreditation process, which I do support, that those have been effective in eliminating or substantially reducing crowding in the United States, the standards have simply changed.

I want to make a very quick point about the idea of impact statements and I will do this, you know, in just a minute. There is a problem with impact statements. If I have a system now, and I'll just take the crime armed robbery, and the average

time served is six years, average time served, not sentence. Now, in order to get some votes I want to double the sentence from let's say 10 years to 15. There will be no economic impact in year one or two or three or four or five. There will be no impact until we get to the point that someone who, on average, would have gotten out stays in, and I don't see legislators thinking in those terms.

I think that when you say to a legislature there's going to be this terrible financial impact in 2012, well, I'll be governor by then.

And so while I do agree that we should do them, there's no question, we should do it, educate the public, the press and the legislature, keep in mind that it's really kind of a free ride for the folks who are voting for these add-ons or for these increased sentences because those people are spending -- these criminals are spending some time now and until we get to the point they're spending more time, we're not spending anymore money. So it's not today's problem and, boy, politicians love that.

SENATOR ROMERO: But as one of those, I do think that you are right, a lot of people do look to say it's the next -- especially states that have

term limits, however, there is a free pass. If you are not there at the table facing those tough-on-crime legislators, then they get the free pass.

MR. NATHAN: That's right.

SENATOR ROMERO: And so I do think, and I really like the idea of the environmental impact report for the prisons, that silence is enabling to continue that trend to really not being responsible.

MR. NATHAN: And you are absolutely right and anyone in corrections who is not trying to educate the legislature on the realities, in my opinion, is failing corrections as an industry, as a profession.

MR. NOLAN: Two points. As a recovering politician, it's not just that they think they will be governor, they are scratching an itch that the public feels. The public thinks these sentences and doesn't think of the cost of them and we -- I think an important part of this Commission's work is trying to break that idea that longer sentences mean a safer community and that there's no cost.

But having been at Angola, which was the most dangerous prison in the United States and is now the safest in the United States, the length of

sentence doesn't really impact that because 95 percent of those inmates are going to die in that facility, it's an astounding situation, but they've made it a safe facility, even with the relative hopelessness of ever getting out.

And, Mr. Stalder, I would like to talk to you about the challenges that you faced in changing that because I would assert to this Commission, it's not just policies, which are very important, it's also leadership and commitment to change, having a vision that there can be a peaceful prison and then setting the standards to drive it. Secretary, if you could talk about the challenges you faced and the leadership.

MR. STALDER: Commissioner Nolan, as you know, it's a fundamental sense of on-site leadership through the warden and support of staff, both correctional officer staff, programming staff and our faith-based community. I mean that's really been -- Angola is the only prison or now that we've spread it a little bit to Mississippi and Florida -- we were the first prison to have an adjunct location of the New Orleans Baptist Theological Seminary on site with a four-year and a two-year graduate program that didn't cost the taxpayers of the State of

Louisiana a nickle and we graduate ministers, who then go out and work with our chaplaincy to promote the kind of change in values that's so important.

I guess, Commission Nolan, the only thing I would say it's necessary but not sufficient to teach how to people to read and write, it's necessary but not sufficient to teach people job skills, it's necessary but not sufficient to deal with substance abuse, it is absolutely imperative that we deal with the values issue and our faith-based communities across Louisiana have really stepped up to do that.

As you know, Angola has three churches that were built by the faith community in the State of Louisiana, three. We have built seven chapels at prisons in Louisiana interdenominational chapels; Christian, Muslim, Jewish, it doesn't matter, each at a cost of $450,000, not a nickle of taxpayer money, every dime contributed by the faith community and that level of commitment, Mr. Nolan, is what I think has says the most, coupled with the leadership on site, for how we reformed our operations, not only at Angola but throughout the Louisiana system.

MR. KRONE: Well said.

With that, unless there's any questions, I think we pretty much ran out of time and

we're going to have to thank you all for that insight that you have given us.

And we are going adjourn now for lunch. We will resume again at 2:00. I would like to ask all the witnesses; prior, present and upcoming to exit through the door here. I would like to remind the audience there is a cafeteria available within this building where you can get a lunch and, as I said, we're back here at 2:00. Thank you.

(Lunch recess.)

MS. SCHLANGER: We're going to hear next from Michael Jacobson, who is the Director of the Vera Institute of Justice, which is obviously the sponsoring organization for this Commission. Before he joined Vera as its fourth director in January 2005, he was a professor at the City University of New York Graduate Center and the John J. College of Criminal Justice. He's got a Ph.D. in sociology and, also, some very practical experience.

He was the New York City Correction Commissioner from '95 to '98 and he was the City's probation commissioner before that.

Prior to that, he worked in the New York City Office of Management and Budget from 1984 to '92.

He is the author of "Downsizing Prisons, How To Reduce Crime And End Mass Incarceration," which is a book that was published this year. He serves currently as the Chair of New York City's Criminal Justice Agency.

So thank you very much for joining us.

MR. JACOBSON: Thank you, Chairman Katzenbach and commissioners for inviting me testify.

I would like to do three things in the few minutes I have to testify. First, simply to welcome you to New Jersey, the New York/New Jersey metropolitan region. It's great to have you here.

The second, sort of briefly to talk from the outside -- a person sort of on the outside of what you are doing on the importance of your work and, third, to talk about the need to focus your attention on governors and state legislators whose policy decisions have created the size, scope and, to a large degree, the operations of our system of imprisonment, or mass imprisonment, which characterizes our current system of punishment.

So, first, as I said, welcome to New Jersey, it's great to have you here and look forward to the rest of today and tomorrow.

On the work you are doing, I would like

to emphasize how important it is to have a completely independent, diverse and thoughtful group of people, some of whom have a great deal of expertise on this issue and some who don't, focus attention on our jails and prisons, where now over 2.2 million people incarcerated in this country.

You are doing this work at a time when many states are beginning to re-examine many of the policies and laws that have been inimical to the growth in our prison systems. A great deal of policy attention is now being paid around the country to who we are sending to prison, for how long and at what costs and benefits. Specifically, as you heard this morning from several of the folks who testified, the issue of our huge national return to prison points. 52 percent within three years. And the process of discharge planning and prisoner re-entry, all of which are the subject of quite intensive interest at all levels of federal, state and city and county governments around the country.

The issue, however, of what happens to people in our jails and prisons receives far less attention. Understandable in some ways, there's a lack -- as Allen Beck mentioned this morning, a lack of uniform, standard data on prison conditions

generally, on violence and use of force specifically, and that, coupled with the fact that prisons are closed and what sociologists call total institutions allow uninformed perceptions of what happens in our prisons. Those who have preconceived notions of how our different systems operate can simplistically characterize them as anything from brutal, violent places where no one is safe to then being soft country clubs where prisoners lounge around, watch cable TV, eat well and have unlimited recreation and generally live fairly well.

Both these views are incredibly simplistic and neither acknowledges the enormous challenges faced by correction professionals who have to manage these institutions and these challenges, I would argue, are perhaps the most difficult of any job in our current criminal justice system.

Forcing policymakers and the public to think in a more informed, rational way about what does and should happen to people in our prison systems can only result in a better, fairer, more effective and just system. Any contribution you can make to this will have a lasting and important and significant impact.

Finally, I implore you to focus some of

your attention on our governors and state legislatures. Correction commissioners have not created the scope, complexity, crowding, health problems and the myriad other issues you've heard about in our nation's prisons. Legislatures and governors generally have. Correction commissioners do not decide how much money is required to run their systems, state legislatures and governors decide that.

And, frequently, these elected officials also decide how much and what kind of programs will exist in our prisons.

Over the last 30 years in this country correctional policymaking has largely been taken out of the hands of experts and into the hands of governors, state legislatures and other elected officials.

You cannot, I would argue, usefully examine the issue of safety and abuse in America's prisons without focusing an intensive and critical eye on the role played by these elected officials in creating the systems we now have.

The field of corrections policy has, by far, the biggest gap between what we know and what we do and for this you can see and you will hear testimony and do research on what we know, for

instance, about educational, vocational work and drug treatment programs and how little of that we actually do.

This gap between our knowledge base and our practice exists because correctional policymaking at all levels has occurred in an extremely hyperpoliticized environment where issues of punishment have had and continue to have tremendous political capitol.

As a result, even the best correction managers cannot compensate for a state system that is crowded, underfunded, understaffed, growing and, these days, under tremendous pressure to cut costs. Toward this end and future hearings, I would hope that you ask some of these elected officials and policymakers to testify as well.

My time is up. I will end by thanking you again for your work and the difficult challenge you've set out for yourselves and I wish you all good luck. Thank you.

MR. SCHWARZ: So, Mr. Jacobson, I think you were here before lunch when there was some discussion about the -- whether there was a correlation between incarceration or incapacitation and the decline in crime and what that correlation

was. Now, presumably, it can't be zero and it can't be 100 percent, but what does the data show and what are the reasons underlying the data?

MR. JACOBSON: Well, let me answer that question a few ways. First, just to give you a brief sense of what the sort of the most empirical research on this issue of the relationship between our build-up of the use of prisons and crime decline shows.

There's been a fair amount of empirical work on this, mostly by Al Blumstein and William Spellman, who have done different sorts of work around this. Both their work seems to indicate that if you look over the last decade or so, that our build-up of imprisonment is responsible for somewhere around 20 to 25 percent of the nation's crime decline. This is a matter of some debate, there's still a lot of work to do. This, obviously, varies also incredibly state by state.

So, for instance, if you live in a state like New York; New York, over that last 10 or 15 year period has had one of the slowest-growing prison systems in the country. In fact, in the last five or six years New York state has a shrinking prison system, larger, I believe, than any prison system in the country. And during that, during the last 10 or

15 years New York has, by far, the largest crime reduction of any state in the country.

On the other hand, you have a state like West Virginia, which has had a massive buildup in its prison system, one of the largest buildups in the last ten years, and has also seen an increase in the amount of violent crime.

So there are some very significant variations on a state by state level but when you look at the national data, the consensus seems to be somewhere around 20 to 25 percent of the crime reduction can be explained in statistical terms through a buildup of imprisonment. So you are right, it's not nothing, it's certainly not majority and the questions that both researchers and policy folks ask themselves when they look at that data is that 25 percent came at a significant cost, financial cost, social cost.

So one of the questions we like to struggle with is for the billions of dollars that we spent to get that 25 percent, could those dollars have also been spent in another way that perhaps would have given you even more crime reduction?

The second general response to that question, it sort of illuminates the first, is that

not only is the buildup of the prison system responsible for a portion, but going out in the future it's going to be responsible for a declining proportion and that's because in this country we've always locked up violent offenders for a very long time. We've never been soft on violent crime. People who commit and get convicted of violent crimes have always been spent long period of time in prison.

So two things have happened during the last really 35 years, but certainly over the last 10 or 15 years. First, we've taken folks who are convicted of violent offenders and kept them in prison even longer. Is there some benefit to that? Probably, but, also, what's happened is that -- you can see this the best when you look at the three strikes laws, what three strikes laws generally do is upon the third strike you may be in prison, and then California has the most inclusive three strikes law in the country, you can go to prison for 25 years to life, when you look at what happens in a place like California or other states is that even before the three strikes law existed in California, when you committed and got convicted of your third felony in California, you were already going to prison for a very long time. So if you committed a third strike in

California when you were 35 years old, before the three strikes law, you may have already gone to prison for 10 or 15 years and gotten out when you were 50. Now what the three strike law does it keeps you in prison for the years 50 until you die, when you are in your mid '70s, exactly at the point of time when you get no public safety benefit whatsoever of keeping people in prison.

So we've increased the length of stay for violent offenders and you get more and more marginal results of public safety from that because they're already in prison for so long.

And the other thing we've done is that we keep putting less and less risky people in prison and that makes sense because of the length of stays we already have for violent offenders and as we fill our prisons with folks, especially drug offenders who pose relatively little threat to public safety and that, coupled with the fact that a lot of research shows that when you put a drug offender in prison, your sort of atypical, nonviolent, low level street drug offender, we're not talking about kingpins here, there's close to a one for one replacement effect.

That is, when you put someone in prison for dealing drugs at a street level, you are

essentially opening up an economic opportunity. That's a job that's waiting to be filled by someone else who comes in and does that. Unlike, for instance, when you put a violent offender or a rapist in prison for a good number of years, you clearly get a deterrent effect and incapacitation effect. No one is waiting to take that rapist's job. That's not true in the whole area of drugs.

So as we expand our prison system geometrically and, again, although the rate of increase has slowed, the base is so large that even though we're only increasing by two or three percent a year, we're still putting huge numbers of people in prison, new numbers each year, you get to have less and less of a public safety effect.

So even if you think that 25 percent is a realistic number over the last decade, you are going to get less and less and less public safety benefits from continuing to grow our system.

MS. SCHLANGER: Thank you very much.

THE WITNESS: You're welcome.

EXPERT TESTIMONY ON ISOLATION

MR. MAYNARD: Good afternoon. I'm Gary Maynard, I will be chairing this afternoon session on isolation and I would like to introduce the members of

the Commission who will be helping me. It will be Laurie Robinson and Stephen Rippe and Gloria Romero.

On behalf of the Commission on Safety and Abuse in America's Prisons, I'm honored to welcome Fred Cohen, Stuart Grassian and James Bruton. This distinguished group is here to help us understand perhaps the many forms of isolation in prison and jails and their consequences for inmates, prison staff and society.

Today we'll hear about several forms, administrative segregation, punitive segregation or disciplinary segregation, and long term isolation in control units. Primarily aimed at reducing violence in prison, each of these generally involves the confinement of the inmate to a cell eight by 10, roughly for 23 hours a day, with little interaction with other inmates and, in some cases, little or no programming.

The research in this area on the effects of this is pretty limited and we hope that the panelists can broaden our knowledge on these issues.

We would like to understand, as a Commission, what circumstances inmates are held in segregation, what constitutes inappropriate isolation and, by the same token, what constitutes appropriate

isolation and what are the effects of that on inmates and prison staff.

In addition to answering these questions, we hope to discuss steps forward, that is for alternatives to or the safer use of isolation in our nation's prisons.

Fred Cohen is an attorney who has studied isolation in the mentally ill in prisons across the country. He has served as an expert witness or court appointed monitor on major cases in eight states.

Dr. Stuart Grassian, a psychiatrist, who, for 25 years, was on the teaching faculty at Harvard Medical School, is the nation's foremost expert on the psychological effects of solitary confinement.

James Bruton is the retired warden of Minnesota's maximum security prison at Oak Park, Oak Park Heights, and has 34 years of service in the field of corrections.

Together they provide us with a wealth and breadth of expertise. Let me thank each of you for taking the time to appear at this, our second hearing. We have a lot to learn from you and we will start the session with the panel member, Mr. Cohen.

MR. NATHAN: Let me thank you for inviting me and it's certainly a thrill to be able to spend mid-July in Newark.

JUDGE SESSIONS: Apparently, the mike is not on at all.

MR. COHEN: Not on at all? I don't know how to work it.

How is this one? Oh, okay.

I think I just lost that not so funny joke about being in Newark in the middle of July, but I will repeat the thanks for having me and since I do most of my work in correctional mental health law, it's understandable that I would be talking about isolation.

I'm not going to concentrate on isolation as it relates to vulnerable populations in particularly the seriously mentally ill or the at-risk persons who are maybe not SMI, but are at risk. I will say a word or two about it. I'm sure Dr. Grassian, who is certainly one of the experts in the country, will touch on that.

I want to make four points and I would like to spell those points out and then go back and develop them as time allows or as your interest seems to allow.

Number one, in discussing or debating the uses of isolation in penal settings, I think we need a lot more clarity and a lot more precision on the terms of the particular confinement that we're going to discuss and that you are going to make recommendations on.

I thought the same thing as I listened to the overcrowding discussion, there really wasn't any consensus or really a shared understanding, I thought, about what it meant to be overcrowded, except maybe in the sense that pure numbers and architectural and operational overcrowding, you know, weren't really fully descriptive of the feeling that any of us that go into the prisons get when we feel that these places are overcrowded. So I'll talk a little about the need for more precision.

I throw out this concept to you, or proposition. Since the kind of isolation that I would describe, ultimately, in its most extreme form, I would rather treat as a kind of human right issue rather than a condition of confinement issue and, along with that, as a sort of legal proposition, the greater the deprivation, I think the more suspect to practice and the greater the obligation on proponents to come forward with evidence to justify it, in policy

and in procedure.

I too make my obligatory references to Dickens and Tocqueville in the paper that you have in order to segue way into what I think is some very interesting 19th century material and we all know -- I think we all know the history of penitentiaries and the uses of extreme insanity-producing isolation in those days.

The main point I'd like to leave you with to think about, when Auburn, for example, in New York adopted isolation as a variant on the Philadelphia theme, there was at least some theory of human behavior that was behind the use of that practice, some idea that human redemption was possible and that penitence and penance was possible in a solitary, isolating environment.

At Almyra -- interestingly enough, two things that distinguish Almyra from today. At Almyra there was not only this theory of criminogenic, criminal behavior behind it, rightly or wrongly, there was the theory, there was an opportunity to work in one's cell. Inmates actually could, even though it was solitude, inmates then could work at weaving or shoe repairing.

Today's isolation is even more extreme

and it has not even a hint of criminological theory about it, it is purely a matter of an administrative response to what's perceived to be troublesome behavior.

In thinking -- fourth point. In thinking past isolation and the problems associated with the mentally ill, and I say thinking past it because if you, as a Commission, can't condemn isolation of the seriously mentally ill and those who are at risk, then you really can't do anything in this area, that's the easiest possible case to make.

The tougher case is to make a case for condemning or severely limiting isolation for let's for want of a better term say the regular prisoner.

It occurred to me, and I throw this really out just for some thought, and the paper you have will illustrate that I haven't thought it all the way through, that there may be some analytical kinship between isolation and however we define it, it certainly means being locked in a room under very strident circumstances, and the uses of mechanical restraints. That may seem an oddball kind of a paradigm or model to think through, but I think it is worth thinking about.

And let me work my way backwards with

the time I have and leave the others -- let me take what I think is the last point because I think it's something the Commission could do, something you could say.

When we talk about the uses of mechanical restraints and, in particular, I don't mean handcuffs as such, I mean four or five-point restraint, strapping somebody down, just as a model. Even ACA standards, which are not the model of making things really tough, trust me, despite what you heard this morning, it's not the toughest thing for prisoners and administrators to live with, even the ACA standards would say mechanical restraints are not be used for punishment, they are to be done with the permission of the warden or the warden's designee, it's to be for a limited amount of time, there has to be medical oversight, you have to have observation, constant or regular observation. Well, you think, my God, well, how does that apply to the uses of isolation?

We think of mechanical restraints, and we should, as being permissible legally and ethically only in terms of minutes, maybe hours. You do think of isolation in terms of, you know, maybe days, weeks, but what's so terribly wrong with isolation as it's

being used, it seems to me is, is it's become a regular part of the rhythm of prison life. It is not necessarily the first response to a troublesome inmate, but it is a regular, kind of a normal response. And I'm sure Dr. Grassian, better than I, could tell you about what some of those destructive results are.

I have been in a lot of these situations and I have talked to a lot of inmates, mentally ill or otherwise, and I have a lot of my own impressions about them.

When you think about juvenile law, as a footnote, the same chapter will be headed isolation and restraints. It's a curiosity, I think. When you think about adults being locked up for year after year after year, there's a division, conceptual division, a thinking division, a cultural division between strapping somebody down for a limited time until the danger has passed and the uses of isolation.

So I would think one of the things that the Commission might do -- and I'm not looking at those numbers, I should -- is to outlaw the most extreme forms of isolation; the dark cell, the noncommunication, which doesn't exist as such anymore.

But there's like a second degree of

isolation, more of the sort that you described, Mr. Maynard, in your introduction where the 23-hour-a-day lockup, seven days a week, the very limited, the no congregate activities, no eating alone, there's really no outdoor exercise.

I don't think that the courts are going to outlaw what I would call second degree isolation. The courts have outlawed that form of segregation in some notable cases in Wisconsin, for example, and California on behalf of the mentally ill, but they have not done that for the non-mentally ill, not-at-risk for becoming mentally ill population.

But what a wonderful thing it would be if the Commission, in its deliberations, thought through all of the stuff you heard this morning and will hear, the destructiveness that this too ready response, too often used response to inmate mismanagement causes.

I've seen -- you heard in the testimony of the individual witnesses, very moving testimony that we heard this morning about some of the destructiveness the woman from the Friends society reported on. I've seen it, I've written about it and I think -- let me just say, I will pause with those four points, having made those four points, tried to

make those four points and open myself up to your questions at the right moment.

MR. MAYNARD: Thank you, Mr. Cohen.

Dr. Grassian.

DR. GRASSIAN: Thank you. Thanks to the commissioners for allowing me to address you today.

I wanted to start by saying very clearly and very simply, the evidence is overwhelming and conclusive that solitary confinement, housing an inmate alone 22, 23 hours a day, in a small cell, with minimal environmental stimulation and opportunities for social interaction can cause and does cause severe psychiatric harm.

It's also been, I think at this point, pretty clearly established that part of that harm is a very specific syndrome associated with these kinds of conditions of confinement which in its most severe cases can result in an overpsychotic state, agitated delusional, hallucinatory psychosis with great deal of confusional elements. Actually, it's a form of delirium that can occur. We often think of delirium as being a product of an absence of adequate internal alerting systems, or particular activating systems parts of the brain not functioning properly, but for

individuals who are deprived of an adequate level of external stimulation, the same phenomenon can occur, and the prison system is a particularly toxic environment for producing it.

In one part, because prisoners who end up in solitary confinement are very commonly precisely the same group of people who are the most vulnerable to getting these kinds of very severe psychiatric affects. The prisoners who end up in solitary confinement tend to be affectively labile, labile, impulse ridden, people with poor internal controls. You very often see people with one or another sign of subtle central nervous system dysfunction, people who have had childhood histories of severe attention deficit hyperactivity disorder; these are the types of individuals who are not going to be able to tolerate prison conditions very well, they are going to have difficulty and if the prison's response is one of putting them in solitary confinement, you can predict, quite clearly, that they're going to get sicker, they're going to get more agitated and they're going to, very often, be stuck in this vicious cycle where the more agitated, the more out of control they become, the more the prison response is to put them in these very stringent conditions of isolation, for

extremely long periods of time.

Fred was talking about the comparison between psychiatric seclusion and solitary confinement. Well, psychiatric seclusion, in most jurisdictions, there are very stringent controls on how long a person can be kept there with monitoring every number of minutes, psychiatric review every hour. And now we're having a situation where people are being kept in solitary confinement and literally mentally rotting, becoming psychotic, paranoid delusional and they're being kept there for years.

This is not just a problem with people who have had serious mental illness prior to incarceration. There are many people, documented cases, many documented cases of people who develop this very characteristic, psychiatric syndrome, associated with solitary confinement during periods of incarceration in solitary, people who had no prior history of serious mental disorder but had vulnerabilities factors, such as attention deficit disorder, central nervous system dysfunction, things of that sort.

So this is not -- I want the commissioners to understand, I don't think this is a question that's open to debate. I have provided you

with a very large statement on this issue, citing about 100 references in medical literature. This is a problem which has become a very important problem in a great variety of settings, not just prison settings.

It's become a problem that we identify with polar exploration, with concerns of NASA with space travel, submariners. It's a problem that's existed in a great number of medical situations, people in prolonged traction, people who have impairments of their sensory apparatus causing some degree of sensory deprivation, the same syndrome is described in all of these phenomena, and, as I said there's a fairly extensive body of literature on it.

As Fred mentioned, solitary confinement was, in fact, almost the exclusive mode of incarceration was the penitentiary began in the United States. The penitentiary was a distinctly American invasion and it was initially begun in the early 19th century as an element of great social progress and reform, a repudiation of punishment, an optimistic belief in the ability for people to change. People freed from the constraints of the evils of modern society being sent to a monastic cell with a bible and with work that they would naturally heal. It was a very open system, open to review, and the review was

very clear and it was also catastrophic and the system eventually fell into disfavor. People like Tocqueville and Dickens and a whole variety of other people saw that system and spoke about it, wrote about it.

In 1890 the United States Supreme Court in a rather dramatic case commented specifically about the effects of solitary confinement in prisons. Mr. Medley, there was a case -- it was a case Mr. Medley had killed his wife in Colorado and he was duly tried, convicted and sentenced to death by hanging. In the interim between the commission of the crime and the trial and sentencing, the law in Colorado had changed. It used to be that prior to being executed, prior to being hung, you would be in the county jail for 30 days. The new law called for the person to be in the state prison in solitary confinement from anywhere from zero to 60 days prior to being hung.

Mr. Medley claimed that he couldn't possibly be prosecuted under the new law because the hardship of zero to 60 days of solitary confinement was so severe that as an additional punishment to the punishment of death, it was too great, it was ex post facto. He also claimed, correctly, that Colorado

legislature had made a mistake. When they passed the statute they didn't have a bridging statute, a bridging clause that would allow your old statute to remain in effect, so you couldn't be sentenced under the old statute that was no longer in effect, so he asked to be released.

The United States Supreme Court ordered Mr. Medley to be released. They ordered the warden of the prison to bring him to the gates of the prison and release him because the additional punishment of zero to 60 days of solitary consignment was such an arduous, additional burden that they couldn't possibly impose it.

They recognized in 1890 that solitary confinement had such a tendency to cause severe mental suffering and psychosis, it couldn't be added to the sentence of death. And I just assert to the commissioners that we've come a long way downhill since 1890. Thank you.

MR. MAYNARD: Thank you, Dr. Grassian.

Mr. Bruton.

MR. BRUTON: Again, I also thank you and I'm honored that you asked me to come and speak to you.

I am a former warden, retired. I spent

34 years in the corrections business, not just in prisons, I spent a lot of time in institutions, I ran two facilities, and I also worked on the streets for years as a probation officer and was in our central office as a deputy commissioner, a member of the state parole board, and so I've seen inmates and criminals at just about every level in the institutions, as well as in the field and as well as in the juvenile end.

And I also teach in five colleges and universities and many of the things I'm going to say today I try to teach people coming into the business about a philosophy that Minnesota has had that's worked, that's been effective and is, clearly, the foundation of managing prisons in a proper fashion.

Dignity and respect. I haven't heard those words in -- a whole lot today, I think I heard them a couple of times, but it's something that's almost forgot in institutions. The public certainly doesn't want to hear it. The public is more interested in us continuing to punish people as they go to prison, they go down every day and I will embellish it a little bit, and poke people with a hot stick and make their life miserable so they won't ever come back to prison, but they forget about what you've said many times today, that 95 percent of the people

who come to prison get out some day.

I had a book that was published last year and a chapter in the book is called "With Dignity And Respect," and it's about the importance and the fundamental process of running a prison, whether it be a high security prison or whether it be a minimum security prison, inmates need to be respected and they respect respect and it works. And it's not because we're trying to molly coddle inmates or we're trying to make everything wonderful for them or we feel bad for them; it's for two reasons.

Number one, it's the right thing to do -- actually, three reasons. Number one, it's the right thing to do, the way you treat people. Number two, as we mentioned, 95 percent of the people are going to get out some day, and, number three, we've got a lot of staff, a lot of good people that go inside those institutions every day and must be safe and you have to find a way to make them safe.

When I went to work every day managing Oak Park Heights as the warden, I walked around the halls and spent a lot of time inside that institution and one half of the people I walked by in the halls had killed somebody. 95 percent of the people had hurt somebody in their crime. And when you have a

very distilled population like that, where half of the people that you work with every day have killed somebody and 95 percent have hurt somebody, you better find a way every day for them to get up in the morning and look forward to something positive or you got big trouble.

Now, when Oak Park Heights opened in 1982 it was really the prototype of the supermax design. There really wasn't anything quite like it. There had been a lot of things -- institutions that have been formed off of it, but it's certainly not as big as some of the larger institutions, like Pelican Bay and others that I have been to and toured through the years, but it set the tone for security, high security.

But what made a difference and what made -- I think the count is something like over 50 foreign countries have now come to see, is not the security and not the control, because it's all of that, in fact, I truly believe, and I've seen many of the high security prisons and Oak Park Heights, I believe, is the most secure institution ever built anywhere in the world, I truly believe that, especially with a newly designed unit that came on within the last couple of years, but they came to see

how it's managed. How you can not have a population locked down 23 out of 24 hours a day, how you can manage that type of population with the majority of the inmates out of their cells, because that's the way it's managed. Most of those inmates, high security inmates with that type of a distilled population are out of their cells most of the day and in a couple minutes I'm going to tell you the effectiveness of it and how it's worked.

There's some basic fundamental philosophies that seem to be forgotten in a lot of states around this country and it appalls me to come back and go to states where I see it done properly and to go to other states where no one seems to care. Satisfy the politicians in some states by locking people up and throwing away the key. Let's build more prisons to incarcerate more people and find ways to keep them in their cells so they don't hurt anybody, it's just simply wrong and it doesn't work.

And in a second, as I mentioned, I'm going to tell you some things that prove that we have been effective.

Now, I have heard all the of the things about, well, California is bigger and we have prisons as big as your whole population, and that's very true

and there's some things that work in Minnesota that may not work in California and may not work other places, but the basic fundamental way of how you manage a prison and how you manage people does work and it is effective and it's been very effective for us.

We have a responsibility, whether it be a high security prison or a low security prison, and maybe even more so in a high security prison, to create an environment conducive to rehabilitation for people who want to make a change in their life. Why wouldn't we do that? Remember, 95 percent are getting out some day. If somebody wants to learn how to read, why wouldn't we teach them? If they have a chemical problem, why wouldn't we find a way to solve that chemical problem?

You know, in our society we don't go out and blame doctors who don't cure cancer patients, unless they don't give that cancer patient everything in the medical profession to try to ease their pain or solve their medical dilemma that they're facing. We don't do that. We shouldn't go out and blame wardens for not rehabilitating people, unless that warden or administrator or commissioner doesn't give that opportunity for a person to change, because I think we

have a responsibility to blame that in our system.

We have to create a safe and secure environment for people to live in every day, our staff and the inmates, and it's absolutely essential and we have to do it, and dignity and respect is where it starts.

We've got to find a way for these people -- and there are people who need to be locked up and should never get out, no question about that. There are people who need to be locked in segregation units, controlled and confined for long periods of time without human contact because they're so dangerous that they will kill, and I have known some of those who have killed inside institutions, but they still need to have incentive-based programs, and when I mean human contact, I'm talking about being out with the general inmate population because they kill people, they're just very dangerous and we haven't found a way to stop that from happening, but they need the human contact.

When I was warden we developed a program in our segregation unit of the most secure prison in the state, and I think the most secure prison ever built, where we had volunteers from a program called AMICAS that came in and walked the cell

blocks in segregation so that those inmates had an opportunity to communicate and talk with somebody that wasn't wearing a uniform or a suit and it was a very effective program. It gave them something to look forward to, somebody to talk to. The people were screened, they were obviously trained and it was very effective.

And the training of the staff is something that's extremely important as we get into these high security prisons.

When you look at an inmate -- I'm going fast because I have a lot of points that I want to make for you and I don't want to run out of time if I can help it.

But when you look at some of the sentences that these people have, and they have no hope, I mean they look ahead at 30 years -- I talked to a young man 17 years old, his first eligibility for parole he will be 47. That's a long time. You better find a way for these people -- and this was a very violent inmate -- to get up every day and look forward to something positive.

I remember walking into a cell one morning, Saturday morning -- and I spent a lot of time in institutions, a lot of time talking to inmates, a

lot of time showing that we will respect them and I expected the same back from them, and, in most cases, I got it.

But I walked into a cell one morning when we were housing a long term federal inmate that had come to us. Oak Park Heights had one of the biggest contracts in the country, taking high security, very dangerous and violent, high profile federal cases. And I walked into this cell on a Saturday morning because I hadn't had a chance to talk to this guy when he first came in and I asked the officer, pop the cell door when I get down to his cell, and the cell door made a loud click. It was like 8:30 on a Saturday morning and inmates didn't have to be at work and so forth. This guy had only been with us a couple days.

The cell door clicked and I walked in and this guy flew out of his cell with his fists clenched and he started to come at me and I backed up and I said, hey, hey, stop, what are you doing? And he said, well, who are you? And I said I'm the warden, I'm Jim Brutan, I just want to talk to you for a minute. And he backed off and I said what was that all about, after I calmed him down. And he said, Warden, I'm sorry, it will never happen again, but you

need to remember that in other institutions that I've been in when somebody opened my door in the morning and I didn't know who was coming, I was getting a beating or I was going to segregation or I was going in chains somewhere, and I have never forgotten that.

Another inmate said to me one time -- and I know inmates don't always tell the truth, but sometimes it's hard to make some of this stuff up, said to me thank you, Warden, for the way I was treated last night when I came in. I said, how were you treated? He said the staff put me in a cell and said good night, we'll see you in the morning. I said, what's so unusual about that? He said, the last place I was in the staff said where would you like your body sent if you are murdered here, and I have never forgotten that type of statement because that did set the tone for many of the involvement that inmates had in the programs that they were involved in, or lack of programs.

Incentive based program is important no matter what type of population you have. You may have inmates serving short term isolation in segregation for maybe 20 days, 30 days or whatever. You might have inmates in segregation serving a year or more for possibly a serious assault or you might have, as

you've talked about, high security control type institutions where there is simply lockdown and in some cases they haven't done anything wrong in institutions.

There are states in this country that lockup prisoners simply because they have a gang affiliation, whether they have done anything in the prison right or wrong, and I happen to think that's wrong. And so there's a lot of things that go on every single day in institutions around the country that are counterproductive.

Food, phones, medical and visiting. If you can solve your problems around food, phones, medical and visiting and you are on top of it every single day, you are probably going to have a fairly decently run prison without a lot of violence.

I'm within my last minute so I am going to really speed up here a little bit.

Institutions need to be managed properly and it starts at the top. It starts in the commissioner's office and it starts with wardens and if there's any erosion of any of four words and any of four actions that go around those four words, it's honesty, integrity, credibility and trust. You've got to have it, you've got to be in those institutions

every day, you've got to be talking to inmates and they've got to look forward to something.

I know inmates that will never get out of control-type environments for the rest of their life and I don't believe they ever should, but I also believe they've got to find a way that their good behavior is going to get them something positive; a visit, a magazine, a television set, or whatever it is, and it all goes along with the different type of confinement that they're in.

I'm a very big believer in control and security, you have to have it, but it also goes with dignity and respect.

And the last thing I want to say is I'm very pleased to be here and I hope sincerely, and I say this with all due respect, I hope this isn't just another Commission. I hope it's something that you really can do because this country is in sad shape when it comes to managing prisons. And I think we have to do it in and we have to do it right and we have to have influence upon your report. I think it has to have some monitoring, maybe some funds attached to it, there have to be fines, there have to be penalties and things have got to change in this country because we're in pretty sad shape when it

comes to how we manage high security prisons. Thank you very much.

MR. MAYNARD: Thank you. Panel members, we'll open it up for questions now.

MR. FRIED: I thought this is very impressive and very instructive, very.

But I saw a certain tension between Mr. Bruton and Mr. Cohen because Mr. Bruton was not nearly so absolute as the other two gentlemen.

You said that you think there are some inmates who need to be locked up in very, very secure conditions, maybe even for the rest of their lives, you just said it. I don't think your two colleagues agree with that and I wonder if the three of you could somehow have a bit of a dialogue on that because I'm confused.

MR. BRUTON: Let me give you an example, sir, of something of why I believe that, and it's a very small number of people. I'll give you an example of an inmate. He's killed six people, four of the -- five of the people resulted in his incarceration.

About five years ago in our system on Thanksgiving day in the lesser secure facility than Oak Park Heights he murdered another inmate. He

murdered the inmate over a cell change. He couldn't get a cell change so he figured if I murder an inmate I'll get the cell change myself.

And so he took a change of clothes to work, because he knew it was going to be a bloody mess that day, didn't know for sure who he was going to kill, waited for an inmate in his work area and beat him to death and was intending to kill a couple of officers at the same time, but, because of an intervention and so forth, he didn't.

He was convicted of first degree murder, life without parole, on top of four other life sentences, never going to get out. He has been somewhat trouble after he came into the institution. He came from the first institution where he committed the murder to Oak Park Heights. I've known him for 20 years, know of the violence and danger of the type person. I met him at the door when he came into our holding room and I said, you are going to go -- in a polite and respectful way, because I thought he needed to hear it from me -- you are going to go to the segregation unit, you are going to serve your time for this murder and when that time is up, you're going to be in a controlled environment for the rest of your life.

And with the incentives -- and I'm not going to go into all the things we did to try to make his life as pleasurable as we possibly could under those conditions, but the question I would have with it is how do you explain to an inmate's family or to an officer's family if he kills again; if he kills another staff or another inmate inside, how do you explain that? And it's not a cover your rear end kind of situation, it's just simply purely proper management, but in a dignified and respectful way.

So that's certainly the exception rather than the rule, but there are people like that and I firmly believe it.

MR. BRIGHT: But it's complete sensory deprivation?

MR. BRUTON: No, absolutely not.

MR. BRIGHT: There's stimulation, the person doesn't get to mix with other people, but there's still stimulation?

MR. BRUTON: Actually, in the new unit that just opened there is an opportunity for a guy like that to watch television. We made sure that looking out the window was into a grassy area, we made sure that there's opportunities for visit, gym time, a whole variety of things, just not in the same way as

everybody else because he's too dangerous. And I don't know how you explain his next murder.

And shortly after we put him under those conditions there was a plot to have myself and one of our program directors -- that we picked up that he was planning to try to get us in a position to kill us and it wasn't about me, it was about protecting our staff and protecting the inmates serving time that have a right to do it safely.

DR. GRASSIAN: I want to just add to that. I don't think there's really any disagreement about this. Certainly, there are going to be inmates, hopefully rarely, who are going to have a very difficult time being together with other inmates without a danger, without significant danger that can't be accepted. And when you have a situation like that, you have to do whatever you can to ameliorate those conditions and I think that Warden Bruton is a perfect example of a person who is dedicated, has been dedicated in his professional life to doing so, to try to increase the amount of social and perceptual stimulation that you can within the limits of this person's predilection towards violence.

MR. COHEN: Thank you. I thought that was an excellent question and there is a certain

amount of tension, partly because I didn't -- my answer -- my presentation was fragmented.

At the definitional level, I mean to say that the kind of isolation that's referred to sometimes in the literature as dark cells, inmates held in solitary confinement, almost complete sensory deprivation, lack of access to any light, sound, fresh air, et cetera, I think with perhaps a few more criteria that should be banned, totally.

But then when you move down to the, like I was calling it, the second degree of isolation, I ended the paper, which I do think you have, by saying if there are extraordinary individual situations where somewhat prolonged isolation, as a final alternative, must be used as a protective measure, especially at this formative stage as we try to think through isolation, legally and ethically, then I think the proponents should come forward, make their case, overcome the human rights issue and then demonstrate why it should be available. A case like this, yes, but it doesn't have to be that grade one isolation.

MR. FRIED: So if I understand, Warden Bruton, the way one would reconcile these statements is the isolation should not go beyond what the safety

requirements demand. And the safety requirements may demand almost total lack of face-to-face or unmediated human contact, but it's hard to believe that the safety requirements ever demand no view of the grass or the sky or no view -- or maybe no television or no books, that can't be safety anymore; is that somehow --

MR. BRUTON: You are absolutely right. And the sad part is there are a lot of prison administrators that believe that is what you have to have in order to keep your staff and keep other inmates safe. See, you don't even have to have -- with the general bulk of your high security population, and I'm a very strong believer in this, total confinement, the 23 hours a day.

Oak Park Heights is operated with these types of inmates out of their cells most of the day.

And I failed to mention, I just want to mention it quickly, why it's worked. Twenty-three years of operations, never been a homicide. Twenty-three years of operations, never been an escape, never been an attempted escape. Very little drugs inside the institution.

When I was warden, I don't take the credit for it, but it's the time period I know best

because I was warden there, we went two years without a dirty urinalysis test inside the prison, and that's the staff doing their job every day.

Very few weapons. Weapons and drugs are high in demand in high security prisons and they're prevalent, not at Oak Park Heights and that's a credit to the staff.

Gang members, we got them from Minneapolis, Chicago, all over the area. Is it a big problem every single day? Do we feel the need to lock up people every day because they're affiliated with a gang? No. And the most important ingredient and the most important report card and summary of whether a prison is operating safely, every single day is can you walk around it every single day and be safe? Absolutely. At Oak Park Heights never been an incident during a tour or anything like, so those are six things in the report card that proves you can do it in a high security prison. Unfortunately, it's just not followed very directly.

Discovery Channel did a program some years ago on Oak Park Heights and on the Oklahoma system, and I'm not faulting anything against the Oklahoma system, but it was their most watched program they ever had on their series called "On The Inside"

and it featured a half hour of Oak Park Heights where we managed the same type of inmates out of their cells most of the day and a half hour of direct total lockdown 23 hours a day. Talk about a difference of night and day, unbelievable.

MR. MAYNARD: We have a question from Laurie Robinson.

MS. ROBINSON: Mr. Bruton, I am really interested to hear your description of this, and I think Professor Fried has really put his finger on an important point here about the differences in the conditions under which people are held.

I think it also raises an important issue that we were discussing at lunch today, that the definition of isolation differs so considerably across all of the states and even within states, within different facilities.

And I'm wondering if you think it would be helpful for this Commission to be addressing the need for standards in this area, not necessarily to be spelling out those standards, but to be raising the need for those and to be addressing some kind of minimum standard as to conditions of confinement in isolation.

MR. BRUTON: Well, I thought it was

really interesting to look at some of the documents that the Commission put out, for example, the 95 percent that get out, but the one that struck me the most is that if you look at the number of required and mandatory standards in our prisons, the answer is zero. Not one mandatory -- certainly, constitutional issues are a different story, but we have accreditation that was talked about earlier, I was the first accreditation manager at Oak Park Heights when it opened in the early '80s, we were the first maximum security prison to be accredited, I'm a big believer in it but I don't think it has the teeth that it should have, but those are the type of things that wardens need to be sure are followed.

If you have accreditation, the only way it has teeth is if the warden of the institution is inside every day being sure those standards are being followed. I know wardens that never go inside their institution or they do with a security squad.

I had somebody ask me one time, well, are you going inside without a security squad? And I thought how could I go inside and walk around without walking around by myself and then let me staff go in there every day? If you've got an environment that's so unsafe that you have to have a security squad, then

what the hell kind of institution are you running? And, I'm sorry, but that's not necessarily something that isn't uncommon.

MR. MAYNARD: Senator Romero.

SENATOR ROMERO: Thank you. Just like the earlier panel on crowding and overcrowding, it seems that the use of the supermax is somewhat subjective and changes from state to state and, therefore, you have classification issues. In California at least -- the reason it's been primarily to control prison gangs, rape the prison gangs if we dare to be very creative, not street gangs but prison gangs.

What is this nationally, what's the pattern? There are many who will argue in California that the prison gang members are not the worst of the worst, which I often here is the justification for the increased use of supermax.

Can you give us a national profile of how states are moving and what worst of the worst means in terms of classifying inmates to go into these supermax facilities?

MR. BRUTON: Well, I can answer to some extent. Connecticut, I think, was the first state to start locking up gang members --

SENATOR ROMERO: Now, street gang members or prison gang, because in California we make a very distinct --

MR. BRUTON: As I recall, back some years ago they were one of the first states that identified people who came into the prison system by certain criteria. Often times, similar to what police gang strike forces use on the state, they had to meet certain criteria. And then they would lock them up, they would not release them from that confinement unless they indicated by signing documents and whatever that they would no longer be gang members. That was very unpopular in a lot of states. We fought it.

We've had different commissioners through the years that have looked at the idea of locking up gang members and most of the wardens have fought it, said it's bad.

I can't speak to California and some of the larger states because I'm, frankly, am not sure what your gang problems are. But I think, for the most part, it's pretty split as far as opinions on that. I think the Bureau of Prisons has gone to that some years ago and I'm not sure about it. But it's kind of a trend that has started to identify some of

those major problems.

SENATOR ROMERO: I would hope that as we approach as a Commission, we can look at this because it may vary dramatically from state to state.

MR. BRUTON: It does for sure, no question about that.

SENATOR ROMERO: And then I guess related to that and perhaps, again, if any of you could address this, it seems, at least in California to be relatively easy to be put into a supermax facility but getting out is a whole different process.

Any recommendations from you with respect to periodic reviews and what would be considered to be appropriate in terms of mental health or violence control or behavioral change, any evidence-based research that shows set periods of time that may be effective or after a while just simply a waste of our money?

In California it's $90,000 a year to incarcerate an inmate in a supermax facility. On average it's bout $34,000 for your typical inmate.

DR. GRASSIAN: I'm certainly not an expert on this issue, but I have heard of research and listened to research regarding the issue of prison gangs, which look at prison gangs and the depth, the

intensity of them as really being a product of a kind of default system in the correctional system itself. That when you really don't have opportunities for positive movement within a system, then there's more of a tendency for these gang phenomenon to harden and crystallize.

So what you may be seeing in California, to some extent, is a product of kind of giving up of rehabilitation in the prison system and you are left with very little else but to protect yourself, protect each other and this kind of insulation that occurs as people form or, you know, become more embedded in prison gangs.

It may be a product of the prison system as much as a cause of the prison system to respond.

MR. COHEN: If I may just say a couple general words about that. I think what's happening is that -- with supermaxes, there's an unspoken -- basically unspoken kind of an agreement among correctional pros that these are very expensive white elephants. We can't find enough of the worst of the worst to put in them, that's the beginning point, and so you begin to fudge on who is the worst of the worst and then you have gang break up and you have a lot of

different reasons for using supermaxes.

I would -- since construction is so shabby today, you know, we don't have to worry about the great construction of prisons from two years ago -- from 200 years ago. They're going to have to find alternative uses for supermaxes. I know that that's going on in some states right now. There are a couple of architectural problems with that because they're not built for programming so you don't find program space, you don't find office space, you don't find outdoor recreation space, and that costs some money, but it's probably a better thing to do if you are going to keep -- unless you are going to wait for the building to collapse of its own poor, shabby construction, it's probably a better thing to do.

I was in a supermax last week with 240 inmates built for 500. They're all built about the same, they look exactly the same. And there were inmates jogging on empty cell blocks, playing handball against walls, tables put in the middle of the floor, inmates eating outside.

What's quietly happening is because you can't say to the legislators, we never should have built that supermax, you use it for different purposes, even if you don't rename it. So at least in

Ohio, I think Ohio supermax has become the max and it will probably house death row.

And the final thought, if I may, the fact that you have a gang problem, and who am I to deny that, whether it's prison gangs or street gangs, it does not lead invariably or even logically to the use of extreme forms of isolation. It leads to separation, it leads to separation.

The European model is for your worst inmates, the worst of the worst, they're in small units of 10 with special programs. No one has mentioned that. And that is to put people away because they are management problems and not intervene behaviorally with why they are what they are and how they got there, that's almost impossible too. That is purely punitive.

SENATOR ROMERO: If I could make one last comment, and I think what you said is really key.

Are we using and going toward the secure housing units, supermaxes, whatever you want to call them, really as population management and using the guise of violence control out there to justify that it simply is more and more a management problem?

MR. COHEN: Well, that's my -- I mean just in general, I know there are exceptions as a

program here and there and we're hearing about it, but, basically, it's a management response to some real problems, some not so real. It has nothing to do with changing behavior, except inherent in the conditions is to make people generally worse. That's at least that's my experience.

DR. GRASSIAN: I was just going to say and never forget that if you go to a place like Pelican Bay shoe, you are going to find a lot of people who belong in a psychiatric hospital. They are management tools to control any kind of disruptive behavior and, unfortunately, mental health staffs in these types of facilities very often want to decrease their workload and it's very easy to do that because there's so little behavior that you can actually observe in Pelican Bay's shoe that it's very easy to think this guy is fine, he may be quietly psychotic but who cares is kind of the attitude. He may be thought disordered, he may be delusional, but he is quiet. As long as he isn't disrupting us, he's okay. And guess what, it's pretty hard to disrupt anybody when you are in one of those shoe cells at Pelican Bay.

You know, it's wonderful to hear Warden Bruton talking about the need for windows. I once

spoke to an inmate who was at Pelican Bay, which has no windows, and he had been at Tehachapi, another state prison in California, in the shoe. He spent the whole day looking out of a window watching people hang gliding and doing whatever they were doing. That kept him alive, kept him involved in the world. And Pelican Bay, by design, had none of that, nothing to see.

MR. BRIGHT: And what's the theory behind that? I mean what's the theory of completely -- you can't read the newspaper, magazine, you can't look out the window, I mean, what's the theory behind that?

DR. GRASSIAN: There was a theory in Pelican Bay, which they went on to deny was the theory, even though we had documents demonstrating there was, that by instituting sensory deprivation and punishing people, you can enduce behavior change. That was the theory. That's the only theory that I ever saw.

MR. BRIGHT: But the related question to that that I would ask both of you is people are also released from Pelican Bay, they are taken in handcuffs from Pelican Bay down to the bus station, un handcuffed and put on the bus for Los Angeles; is that

a good idea? From the standpoint of public safety is that a good idea?

DR. GRASSIAN: Over lunch I was talking to a person -- one of the inmates I interviewed at Pelican Bay who I went to the prison psychiatrist and said this man is so sick, you've got to put him in a hospital. They said no, he's too dangerous, we can't put him in a hospital. I said, well, you've got to medicate him, even against his will. Oh, we don't medicate people against their will at Pelican Bay. Well, guess what, his term of confinement ended and he was put on the bus to San Francisco.

DR. GILLIGAN: Did he make it?

DR. GRASSIAN: Thank God he didn't hurt anyone, he was back in prison within 24 hours. He was grossly psychotic, paranoid, violent individual.

MR. BRUTON: I thought it was interesting what we were talking about just before we came in; Pelican Bay when it first opened 60 Minutes did quite an expose on the institution, you might remember, and both of us had -- we never met, both of us remembered this statement that was made by one of the staff and that was probably 15 years ago it was made, whenever it opened, and Mike Wallace from 60 Minutes asked him a question, well, you lock these

people up and you do all this to them and you got all this confinement and no contact with the outside world and then you release them, and the response by the staff was that's not our problem. And I have never forgotten that.

MR. MAYNARD: We have a question from Steven Rippe and the next one from Ray Krone.

MR. RIPPE: Warden, I was really glad to hear you talk about dignity and respect. I mean, you can argue that fundamental in any organization it's effective is an organization where people treat each other on a day in and day out basis with dignity and respect and so when we put together our recommendations, what are some practical things that you can tell us? I mean where do you start without it sounding like a buzz word in the report?

MR. BRUTON: Start with the staff. When you hire staff and you train staff and you monitor staff and you do their evaluations, you have to make sure they believe in that and when they don't, they get disciplined, and sometimes you have to fight the unions with that and so forth, but it has to be a fundamental premise in the institution, every single day that you treat inmates the same way you would want your mother, father, sister, brother treated if they

were in, in fact, an inmate. And if you can do that and you can keep on the staff and that means wardens and associate wardens and captains have to be inside those walls, walking around, talking to staff, talking to inmates and making sure that they believe in it. And it does work.

I remember the first warden at Oak Park Heights, my mentor and great friends, one of the best wardens I ever knew, used to say I'll take the staff and we'll set this beautiful edifice, this wonderful maximum security prison aside and I'll take the staff and inmates and we'll operate in a bunch of tents over in the field before I would take a bad staff in this great institution. I thought that was such a great statement.

I said it at a legislative hearing one time and the legislator raised his hand and said what would the per diem be if you were in tent with a -- so I didn't raise it again -- but it's very, very important.

And the staff are sometimes, I think, something that is forgotten inside institutions and I'm not -- honestly, I'm not trying to pat myself on the back by saying this, but I made it a habit of all the years I ran institutions that on the holidays,

when those officers were in those cell blocks and down in the units every day, I went into every institution, on every shift, on every Thanksgiving and every Christmas and did nothing but walk around and say to every single staff, thanks for being here today, it means something to us, because we had the inmates locked in because we wanted to get as many staff off as we could, but at every institution these people have to be there. And it's one of the toughest jobs you could ever, ever fined and they do a great job.

But it's key with staff and it has to be something that is just driven every single day to the point where they actually think the warden is crazy because their safety -- we changed the word a pat search, when you pat down an inmate, to contact search changed the word because we wanted them to understand that their contact with that inmate and how they perform that duty might save their life. And it's amazing what I have seen come through various areas where you have had poor searches and so -- but the staff is the key and we were very fortunate.

We hired a lot of staff in the early '80s when the economy was bad, we had a lot of the mines close in Northern Minnesota, we hired -- about 50 percent of the staff we first hired at the maximum

security prison had college degrees, they wanted to work in prison, they wanted a job, they were trained properly. We brought in seasoned people who understood and believed in the philosophy, some are still there today, continuing on with that philosphy and it works because if you got a bad staff, it doesn't make any difference what the warden thinks.

MR. MAYNARD: Okay. We have a question from Mr. Krone.

MR. KRONE: I'm going to pass and thank you for the time. My question is kind of answered in the past three answers.

MR. MAYNARD: Next one would be Mr. Pat Nolan and you, Judge.

MR. NOLAN: I had the privilege in my younger life to meet Reverend Richard Bernbrant(ph.), who was for 15 years a prisoner in Chowchesky's(ph.) dungeon, and he described his life there and it's, sadly, very similar to the conditions you've described. I took David Aikman, formerly of Time Magazine, into Pelican Bay and he came out and said this is a sanitary dungeon. That's the description, it's clean but it's a dungeon nonetheless.

And I'm so glad, Mr. Bruton, you mentioned dignity and the words you described, the

four Fs, not Fs -- food, phone --

MR. BRUTON: Food, phone, medical and visiting.

MR. NOLAN: Pardon me?

MR. BRUTON: Food, phone, medical and visiting.

MR. NOLAN: I heard an echo of what Burrell Kane down at Angola said, which is good food, good fun, good medicine and good brain, and down there they don't have any -- (inaudible) -- good brain, but it's the same thing, it's human dignity.

But I was in the legislature when Pelican Bay was approved and came online and it was sold to us that this was for the worst of the worst. This was for people that were so dangerous even our high security prisons couldn't contain them.

My impression is though, that there are others there that are not that and so I would ask you from your experience how many are vexation litigants, a pain in the neck to prison officials, which I picked up in dribs and drabs a substantial number are this habitual litigants versus those that truly are physically a threat to the staff, as well as other inmates?

DR. GRASSIAN: There certainly are some

who are vexation litigants and that the staff see them as a pain and want to get rid of them. But I would emphasize how many of these people who are said to be the worst of the worst are simply the wretched of the earth, they're sick people.

And one of the phenomenon that one sees in Pelican Bay and in other prisons is what's called a revolving door, where people go between the worst conditions of solitary confinement, which are just psychologically toxic, get so sick, so disrupted, they end up being committed to a psychiatric hospital. They recompensate in the psychiatric hospital just enough to go right back to the shoe environment, and it goes back and forth and back and forth and back and forth. And I literally have seen cases where it was 20, 30 back and forth and back and forth.

And at some point can't you get it; they're doing well in the psychiatric hospital, they recompensate, they're not a danger and, you know, in fact -- I mean not at Pelican Bay, but there was a time when I was involved with a community mental health center inpatient service, I was taking care of some of the same guys who were in maximum security at other times in the prison system in Massachusetts, and all I had was myself and perhaps an elderly female

nurse to help me out, and it was dignity and respect. You have to respect people and you are going to be safe.

If you don't respect them and you want to control them, then use of black boxes and the chains and all this other kind of stuff and when those people get out they're going to be as sick and as violent and as much a danger to society as you could possibly make them.

MR. MAYNARD: We've got 15 minutes. Three more questions. Judge Sessions and Dr. Dudley, Sheriff Luttrell.

JUDGE SESSIONS: I found the testimony of the three of you very engaging. I found Mr. Bruton's testimony exhilarating.

My question is very simple, what replication of this pattern is followed in the State of Minnesota, are there other prisons in the State of Minnesota that follow your pattern, or in the United States that follow your pattern and training and the procedure by which you take the most difficult circumstances and make it liveable and well run?

MR. BRUTON: In the mid '70s Stillwater Prison in Minnesota was thought to be one of the worst institutions in the country.

JUDGE SESSIONS: Where was that?

MR. BRUTON: Sillwater, Minnesota, it's about a mile from the maximum security prison of Oak Park Heights, old institution, been around forever. A man by the name of Frank Wood took over the prison in the mid '70s, brought this fundamental philosophies to the man I mentioned earlier, the friend and long-term colleague -- brought the philosophy with him to Oak Park Heights, developed it as warden, later became deputy commissioner and commissioner, and it's at every one of the institutions. Every one of the wardens in Minnesota could sit here and say basically the same kinds of things that I say and believe it.

And you could go into most of our institutions at the associate warden level, at the captain levels, at the lieutenants levels and they would say the same thing. They believe it, it's part of our system and it's not just Minnesota nice. We have a lot of very bad people in prison, but our system has been effective and it works.

JUDGE SESSIONS: A follow-up question. Norm Carlson went to University of Minnesota.

MR. BRUTON: Know Norm very well.

JUDGE SESSIONS: You are, obviously, a friend. Does any of your teaching of the Minnesota

experience come from him or spread from him to the Bureau of Prisons?

MR. BRUTON: I used to tour Norm Carlson's classes at Oak Park Heights, so he learned from me -- no, I'm just kidding.

Norm is one of the finest administrators I have ever known. He taught at the University for a long time. I teach over there as well. He is now, I think, retired from teaching and -- but, no, he's been a strong believer in the Minnesota philosophy for a long time.

JUDGE SESSIONS: What did your peers in other states adopt or did they say about the Minnesota experience?

MR. BRUTON: Well, a lot of them think we're crazy. A lot of them think that you can't possibly take high security people that are management problems and not lock them up all day and have problems with them, but I have never had an institution warden or an administrator from another state come, tour the institution and come back and not say this is really something.

And we've given a lot of presentations to wardens and so forth around the country and been supported by ACA when we talk about no drugs in the

institution and they say -- and the American Correction Association or the National Institute of Corrections will say he's not lying, we've seen the documents, they don't have a drug problem.

And so it's a lot of very strong belief in a philosophy and a lot of good people through the years that believe it, but I truly believe it's in all of our institutions, it's been very effective. I just am very saddened that it isn't in a lot of the states.

I've been around prisons a long time. I've never been afraid, until I walked into some prisons in other states and then I couldn't wait to get out because I was terrified, and that's pretty sad.

JUDGE SESSIONS: Do you think those training manuals are available to the Commission?

MR. BRUTON: I've got two things I'd like you to look at. One is a manual of the American Corrections Association put out a couple of years ago, it's called "Supermax Prisons, Beyond The Rock," I don't know if you have seen that, there's about eight wardens, I was one of them that wrote a chapter in there. I don't agree with everything in there. I agree with my chapter, but most of it is really good. This is a very good document.

Another one came out last year by the American Correction Association called "Becoming A Model Warden, Striving For Excellence." A lot of this is about my friend Frank Wood, it was written by a professor from Northern Iowa University. I think you really need to see these documents, they're very, very outstanding. And then, of course, you've got to buy my book, that's called "The Big House."

JUDGE SESSIONS: What about teaching manuals, are those available?

MR. BRUTON: Well, of course, the policy manuals in the institutions have been copied and modeled in many states, I don't know how many have followed them through the years. They have been -- I think they're very, very well done and effective because of the accreditation process that has enforced that and so forth.

So I thank you for your comments.

MR. MAYNARD: Sheriff Luttrell.

SHERIFF LUTTRELL: This is probably a rhetorical question, but I'm going to ask it anyway because I think it really needs even more emphasis.

I think one of the greatest travesties that we see in the correction system is the mission that we've been asked to assume as it relates to the

mentally ill and more and more we're seeing more of that mission come to us in our prisons. Some of the better mental health programs that I have seen are in some of our prisons, but, yet, that's not the way it should be handled.

We do, typically, in submitting prisons, handle them just as we've talked about here, by isolating them. I'm into paradigmships. I've discussed paradigmships this morning. I'm looking, as a practitioner, for different approaches to the old problems.

When we can't get the cooperation of the mental health community to buy into this problem and help us with the solution, what alternatives do we have as practitioners to deal with this increasing problem of the mentally ill in our prisons? I will just ask that to whoever wants to answer it.

DR. GRASSIAN: It would be hard for me to start with the premise that you can't involve the mental health system. I have said, in fact, I said at lunch that I think often the mental health system in the states is reluctant to be involved.

But I think part of your mission is to get them involved and to require them to meet their own mission, which is to take care of the mentally

ill. They are a system with limited resources and it is all too easy for the departments of mental health to try to put off their people who should really be their responsibility primarily and just say that they're not. I have seen that over and over again. And then the Department of Corrections is left in an impossible situation, not really having the tools to deal with inmates or people who need to be protected, that society needs to be protected from them, but they also need to be rehabilitated psychiatrically.

So I think that Department of Corrections would be wise to put pressure on that system to change and to redefine its mission.

You know, for example, I've seen states where the Department of Mental Health will accept a mission of taking care of the chronic mentally ill in the prison, as long as they're passive, but they won't take care of the ones who can be dangerous, who can be volatile, explosive, why? They're also mentally ill. And a lot of those people, of course, have mood disturbances, lot of them have central nervous system dysfunction, they should be taken care of that group of people.

So you have to put pressure on the Department of Mental Health to say, yes, you've got

responsibility for this patient population and don't say they're -- don't try to cop out by saying they're malingering when it's clear they have a clear histories of mental illness even prior to incarceration.

MR. COHEN: I have thought about this and thought about it for a long time and if you divide this process that surrounds your question into going in and diversion, being in and, say, aftercare, going out, you know, the corrections is filled with all these ironies, where do we spend most of the money? On the inside, actually, you know, for this population, where it's probably least -- where you are going to get the least bang for your buck, so to speak.

So some form of -- at the moment we can't constitutionally or morally or ethically ignore the fact that 15 to maybe 21 percent of the prison population qualifies as seriously mentally ill and, therefore, are constitutionally required to receive some form of treatment.

Just as an aside, when we -- when I was a monitor in the Dunn case in Ohio, in 1995 there were six-point -- seven full-time psychiatrists, when the decree dissolved five years later there were 60.

Certain irony in that, but, you know, the system met its constitutional and treatment obligations and, conceptually, the truth is if you saw that film, the New Asylums, I mean the prisons -- the Frontline film, the prisons have, by default, certainly not by choice, become the new mental hospitals, just as prisons are the new -- the largest provider of medical care in most states now -- many states are prisons, as is true of mental health.

But if I may say, in ending, that, you know, while we try to attend to diversion, mental health courts and the like and doing what you constitutionally and ethically should do inside, aftercare is even more important. I mean, legally, the DeShaney principle, the obligation to treat ends as soon as the inmate's foot hits the pavement, that's the end of the legal obligation to provide medical or mental healthcare. There's some exceptions. There's a New York City case based on local law -- (inaudible) -- but that's basically it.

So you are going to have to not look to the courts, and it's the courts that have brought about all of this change, you are going to have to look to policymakers, legislators, advocates to come up with aftercare. It's got to be something more than

15 days of medication and there's the mental health center, hope you get there. There has to be. I mean it's just criminal, because they are going to come back.

MR. BRUTON: When Oak Park Heights opened in 1982 the administration of the department was wise enough to build right into the institution a mental health unit, so the mental health unit is at the maximum security prison. So every day the kinds of people we've been talking about are dealing with officers, psychiatrists, psychologists, behavioral therapists, psychiatric nurses and caseworkers, in the mental health unit, in maximum security prison.

Most of the inmates go in voluntarily, certainly staff are, you know, urging them to get in, some are committed through the courts, but a very effective way to manage a prison population at the highest security every day when you got your mental health unit a few feet away.

MR. MAYNARD: Dr. Dudley, you have a question?

DR. DUDLEY: Putting aside for the moment the inmates who are known to be mentally ill when they enter or should be known to be mentally ill because they have histories or whatever when they

enter, do you know of anyplace that does a good job of -- again, putting that population aside, differentiating between those who are, in fact, management problems and those who simply do not have previously identified mental health problems, but, in fact, do have mental health problems before making these decisions about putting them in isolation?

And if you know of such a program, who is making that determination, who is doing it well? I mean, how do they do it?

DR. GRASSIAN: I am not aware of any system that does that determination well. As Craig Haney said this morning, obviously, we tend not to get called in to systems that are going, that are functioning well, so there may well be such systems. But, in my experience, I have seen cases after case, situation after situation where there really is no adequate assessment.

And, I mean, there aren't the resources for the assessment. There aren't people who are adequately trained, who have enough time.

You know, when you have a system that's overburdened, overcrowded, understaffed, underfunded, underresourced, it's going to end up being a default system, and the default system in corrections, I

think, is a system of just brutal control. And, unfortunately, I think -- at least that's what I've been seeing in the prisons that I've been involved with. And I think that Minnesota, sadly, may be an exception to a general rule.

DR. DUDLEY: But, I mean, I'm asking in a sense because even if you could manage to say, okay, let's not put people who have already been identified as seriously mentally ill in isolation because we absolutely know that that's not going to be helpful, there's still this -- I mean, given the fact that we're dealing primarily with poor people and people that may not have had mental health services anyway before they become incarcerated, there's has to be this large -- we know there's this large population of not previously identified people who you are suggesting are vulnerable to deteriorating.

DR. GRASSIAN: I think that those cases -- actually, there are criteria that one should be looking at in identifying those people. You are going to find that that population that's vulnerable tended to have problems with impulsivity, emotional lability often starting in childhood, very often have central nervous system dysfunction, very often -- a number of them are either borderline mentally retarded

or mentally retarded. If you look at their committing offense, it tends to be an act that was impulsive, not well planned, not thought out. So there is a whole pattern.

DR. DUDLEY: That's what I'm saying, do you know of anyplace that actually has --

DR. GRASSIAN: No, no, and I certainly have cited those criteria and not seen places.

MR. COHEN: Can I refer you to something? Obviously, not at the moment, but in the paper that I put together for you, footnote 8 set out -- in footnote 8 of the paper that I prepared for the Commission I put out -- I set out the Ohio exclusionary criteria which begins with seriously mentally ill and then a whole series of other categories which is mentis to add up to vulnerable, so without repeating them, they are there and, for the most part, it does work, you have multiple diagnoses, you have triple screening and, of course, some people get through who may not, you know, meet all of the category criteria for a mentally ill.

But I think from what I've seen, it works, and this is to exclude from OSP, from the supermax, not necessarily from segregation.

MR. BRUTON: I think where the problem

comes in, though, to a great extent is the classification systems that most states use because they put a lot of emphasis, and they should, initially, on the crime and how much time somebody is going to serve. And the misconception, certainly from the public without question, is that if you committed a horrendous crime on the outside and you were convicted and you got a lot of time, you are going to spend all your sentence in a maximum security prison when, in fact, many of those people are the best prisoners. Now, they need to be in high security for a period of time to get some years under their belt because then they have more to lose than gain if they cause problems, but if somebody said to me you are going to open a brand new 500-bed facility and you can pick your inmates, I would say give me 500 first degree murderers because they are generally going to be the best inmates.

And so what we have -- and I think you are right when you talk about overcrowding and you have systems that just can't deal with the volumes of people is these people become misidentified after a number of years. They don't need that kind of custody level, but their crime and amount of time just keeps them there.

MR. MAYNARD: Any other questions?

I want to thank our panel, very very helpful, and I'll turn it back to you, Mr. Chairman.

MR. KATZENBACH: Thank you very much. We all learned and appreciate what you have to say. We have difficulty now trying to adjust and fit it in with everything else that we've heard. I know I speak for Judge Gibbons and for all of the Commission, being very grateful for what you've done. Thank you.

(Hearing adjourned at 3:31 p.m.)

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C E R T I F I C A T I O N

I, MARGARET M. REIHL, a Registered Professional Reporter, Certified Realtime Reporter, Certified Shorthand Reporter and Notary Public of the State of New Jersey, do hereby certify that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place, and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

Margaret M. Reihl, RPR, CRR
CSR #XI01497 Notary Public

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COMMISSION ON SAFETY AND ABUSE
IN AMERICA'S PRISON

PUBLIC HEARING 2 - DAY 2
JULY 20, 2005
NEWARK, NEW JERSEY

PHYSICAL AND MENTAL HEALTH CARE AND RELATED ISSUES

TRANSCRIPT of the stenographic notes of the proceedings in the above-entitled matter, as taken by and before MARGARET M. REIHL, RPR, CRR, CSR, Notary Public of the State of New Jersey, held at the Mary Burch Theater, Essex County College, 303 University Avenue, on Wednesday, July 20, 2005, commencing at 8:46 a.m.

APPEARANCES:

COMMISSIONERS:

THE HONORABLE JOHN J. GIBBONS (Co-Chair)
NICHOLAS de B. KATZENBACH (Co-Chair)

STEPHEN B. BRIGHT
RICHARD G. DUDLEY, JR., M.D.
SAUL A. GREEN
GARY D. MARYNARD
PAT NOLAN
STEPHEN T. RIPPE
SENATOR GLORIA ROMERO
TIMOTHY RYAN
MARGO SCHLANGER
FREDERICK A.O. SCHWARZ, JR.
THE HONORABLE WILLIAM SESSIONS

COUNSEL:

JON WOOL, SENIOR COUNSEL
MICHELA BOWMAN, COUNSEL

EXECUTIVE DIRECTOR:

ALEXANDER BUSANSKY

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OPENING STATEMENTS

JUDGE GIBBONS: Good morning and welcome to the second day of the second public hearing of the Commission on Safety and Abuse in America's Prisons. In his opening remarks yesterday, co-chair Nick Katzenbach explained that the focus of this two day hearing is on the institutional causes of violence and abuse. In other words, widespread, intractable problems that are bigger than any individual. Yet real people, those who are incarcerated and those who work in the prisons and jails, confront these problems and suffer from them ever day.

Yesterday we heard testimony about two such problems, overcrowding and the use or misuse of isolation. Today we explore the state of medical and mental healthcare in correctional facilities. The heart rendering failures, as well as the programs and people who are producing successes and there couldn't be a more appropriate time for this kind of an inquiry.

As you heard yesterday, our prisons are increasingly filled with people who are seriously mentally ill, partly as a result, I suppose, of fewer psychiatric hospitals and other community-based mental health services. And two weeks ago in California a

federal judge placed the state's prison medical care system into receivership after experts documented 64 preventable deaths and many, many, many serious injuries due to medical malpractice or malfeasance during the course of the past year. The enormity of the crisis and responses is unprecedented. And today's witnesses, including Dr. Joe Goldenson, an expert in the California case, will help put the California problem in context for us.

In just a few minutes, you will hear Sister Antonia Maguire recount from her own experiences case after case of medical failures and neglect, often with dire consequences for the women incarcerated in the New York State Prison System where she works. Her testimony forces us to confront the fact that the medical care of some people in some facilities is nothing less than abusive and inhumane.

But you'll also hear from Arthur Wallenstein, a 30 year corrections veteran who ran one of the first facilities to be accredited by the American Medical Association and who currently oversees corrections in Montgomery County, Maryland. He'll testify that the quality of correctional healthcare overall has improved dramatically over the course of his career, and to quote him, it is not

singularly a story of abuse but rather a much broader story of change, constitutional growth and development.

Just a state away, in Pennsylvania, Jeffrey Beard is evidence of the evolution that Arthur Wallenstein refers to. Jeffrey Beard oversees a system of state prisons that has one of the best protocols nationally for dealing with infectious diseases, an aggressive policy and practice that protects inmates, officers and, ultimately, the public health. He will tell us that decent, effective healthcare in prisons is both the right thing to do and the smart choice. As he puts it, if we don't pay today, we will really pay tomorrow.

The witnesses who will testify about mental healthcare in prisons are just as diverse in terms of their experience and perspectives. You'll hear Dr. Gerald Groves describe battling officers, administrators and an underlying culture of disrespect in the New Jersey facilities where he worked just to provide basic mental healthcare. And you'll hear Dr. David Kountz describe a fruitful partnership and treatment between Somerset, New Jersey county jail, where he works, and the Robert Wood Johnson Medical School, a division of the New Jersey School of

Medicine and Dentistry. Same state and quite different experiences.

The challenge before all of us is to resist the temptation to choose among these accounts, as if the failures negated the victories or vice versa and, instead, to accept this patchwork reality and learn from it. I very much look forward to what we're about to hear today and invite forward the members of our first panel.

PERSONAL ACCOUNTS

MR. GREEN: On behalf of the Commission on Safety and Abuse in America's Prisons, I would like to welcome everyone to the second day of our hearings in Newark, New Jersey. Before I introduce each of our witnesses, I would like to thank them for their willingness to discuss their very personal and moving experiences with us.

Joe Baumann is a state correctional officer in Southern California with 19 years of experience working in prisons. His work has included two years spent in a mental health unit for women where there was a single staff psychologist caring for 700 inmates. Mr. Baumann will testify to the wide-range of problems he has experienced firsthand as a correctional officer, problems ranging from extreme

overcrowding to virtually nonexistent mental healthcare.

Thomas Farrow is a former inmate who was incarcerated for over two decades in the New Jersey Department of Corrections. Diagnosed with bipolar disorder, Mr. Farrow will describe the poor mental healthcare which he received and the abuse of mentally ill prisoners that he witnessed while incarcerated during an era when the New Jersey prison system was engaged in efforts to improve its quality of care for the mentally ill.

Sister Antonia Maguire is a chaplain of Taconic Correctional Facility, a women's prison in West Chester County, New York. Sister Antonia has been working in prisons for over 30 years and is a member of the Franciscan Missonary Sisters of the Sacred Heart. She will testify about her experiences ministering to women prisoners and, particularly, the grave difficulties they face in obtaining adequate medical care.

Before we begin I would like to take the opportunity to thank each of you again for your willingness to come before this commission to discuss your experiences. We will begin with Joe Baumann.

MR. BAUMANN: Thank you. I would like

to thank the Commission for this opportunity. My name is Donald Joseph Baumann, I am a correctional officer with the State of California. I started with the state about 19 years ago. I realize the amount of time I have allotted is brief so I will keep my comments relatively short. I encourage any member of the Commission to ask any follow-up questions or stop me during the break, if they need to.

Since coming to the Department of Corrections I've been assigned to the California Institution For Men, California Institution for Women and I am currently assigned to the California Rehabilitation Center. While assigned to these three institutions I have had the opportunity to work medium security general population, administrative segregation, protective custody housing, reception centers and several mental health programs.

I'm also the current CRC Chapter President of the California Correctional Peace Officers Association, a position I've held since 1998. I point this out to you primarily because I've been threatened with discipline in the past for speaking out about conditions in the prison system. Particularly, if I identify myself as an employee of the department. The observations and opinions I

express here are mine, solely and not those of the department, nor the union.

In my capacity as a CCPOA activist, I've had the opportunity to travel to all 32 adult prisons and observe their operations and negotiate terms and conditions of employment for our members with various levels of departmental management. I have seen overcrowded prisons that lack sufficient space for proper medical and mental health facilities, prisons that cannot recruit or attain qualified medical healthcare professionals and a cadre of custody and medical staff that are stretched to the limits with the day-to-day grind to do a thankless job.

As a correctional officer, I've helped to disarm and restrain a suicidal inmate who was slashing his wrists with a box cutting razor blade, using nothing but a mattress because we lacked to put men in training to do it any other way. I have had to walk inmates who had a mouthful of their own fecal matter to a psychiatrist for an exam. I've seen inmates inappropriately housed for long periods of time because the lack of bed space, placing the other inmate staff and the general public at risk.

California is the largest correctional

system in the United States with over 160,000 inmates in its various institutions, camps and community correctional facilities and an additional 120,000 offenders on parole.

Most of its institutions currently house over 190 percent of their design capacity. Several exceed 220 percent, including my own.

Estimates vary on the number of inmates with mental health concerns in the CDC, ranging from 8 percent to as high as 30 percent.

During the 1980s and '90s the CDC and the state legislature commissioned several studies on conditions of the mental health delivery system within the department and consistently came to the conclusion that CDC was not meeting the constitutional level of mental healthcare for its inmates.

During the same time period, inmate advocacy groups embarked on litigation in an attempt to address the issues outlined in those reports. Primarily, Coleman versus Wilson. Coleman versus Wilson alleged that the department's mental healthcare was inadequate in several areas, including intake screening, access to care, treatment and records-keeping and constituted cruel and unusual punish. As a result, the Federal Court ordered the

department to develop a remedial plan to correct these deficiencies. The court also ordered a Special Master to oversee the implementation of the plan, which addresses several areas, including the processes for identifying and screening inmates in the intake reception process, access to mental healthcare for inmates in the general population, staffing standards for psychiatrists, psychologists and other mental healthcare professionals, monitoring and documenting the use of psychotrophic drugs and guidelines and drugs over the use of forced medication.

Unfortunately, CDC's remedial plan failed to formalize training for correctional officers and supervisors to help them differentiate between behavior that is attributed to mental health disorders and normal disciplinary issues. This is an extremely serious problem since unless a given correctional officer is familiar with the particular inmate involved, outbursts and unusual behavior are often misinterpreted and, therefore, reacted to in a way that may worsen a given situation. An officer generally assumes that an inmate doesn't make his bed or clean-up after himself because he is lazy, rather than realizing that the individual may be decompensating. Because we're not properly trained

and are often unfamiliar with the individual inmate, officers may also interpret outbursts of anger or other emotion as an inmate wanting attention when, in fact, an inmate is in serious distress and lacks the faculties to properly express that fact.

I have personally had cases where inmates have stopped taking their medication because they're feeling better at a given point in time and have decided they don't need it anymore. Several days later the inmate realizes they're decompensating decompensating and need to see the doctor. Other times I've seen radical changes in behavior and refer the inmate to the psychologist or psychiatrist.

But on more than one occasion I've had medical staff advise me to have the inmate sign for a sick call and they will be seen in two or three days. Left untreated for that length of time, the inmate becomes a ticking time bomb and a danger to themselves, staff and other inmates. Because of my working relationship with the doctors at my particular institution, I was usually able to get the inmates in to be seen as someone was available, but that's by no means the norm in these type of situations.

There are also occurrences when COs are reluctant to confront inmates who are act out in some

fashion for fear of being injured or maimed, or out of fear of being accused of overreacting. Staff are also often afraid that an escalation may be taken out of context by their superiors and will then lead to discipline within the department or criminal charges by either the state or federal government. This is always in the back of their minds. At the same time they also fear that if they don't intervene, they will be accused of underreacting. It's a catch-22 that no one has ever attempted to address, and the lack of training to interpret and address behavior, combined with chronic understaffing and the lack of effective supervision, only exacerbate the problem.

As I sit here and speak to you today, at least ten percent of all correctional sergeants' and lieutenants' positions in the State of California are being run unfilled so that the department can generate salary savings, right now as I speak.

Currently, correctional officers receive a 15 page training module entitled "Identification of Special Needs Inmates" and this is all the training we receive in the area. The training module is designed for the employee to read during the normal working hours, while conducting their normal duties. It contains information on the following

topics; diabetics, heat-related illness, epileptics, developmental disability training, ADA and suicide prevention.

Correctional officers are the employees with the highest level of interaction with the inmate population. They are the ones required to monitor the day-to-day behavior and activity of the inmates who are placed in the mental health delivery system, as well as those that haven't, yet we're not properly trained to do so.

When CDC implemented the first phase of the Coleman Remedial Plan at CRC back in July 1995, I requested that local management negotiate the impact of the implementation with the local chapter. I wanted an opportunity to formally review the department's operational procedures and policies and their training modules, in order to be able to address any potential impact the remedial plan would have on my membership, who worked in a prison that was already at that time 225 percent over capacity and it suffered several rounds of staffing reductions.

Local management refused, saying that the remedial plan would have no impact on the correctional officers and CRC. They said there was no additional training necessary in suicide

identification/prevention, forced medication procedures, et cetera, because there was no requirement to do so in the remedial plan.

In January 1996 an inmate utilized several combination locks in a mesh laundry bag, assaulted a correctional officer at my institution. After a violent struggle with several staff, the inmate was subdued and ultimately transferred to another institution. The victim of the assault medically retired because of the significance of the head injuries she received.

The follow-up investigation revealed that the inmate had a long history of schizophrenia and hadn't received his medication in the three weeks he had been housed in prison. No one at healthcare services had been monitoring the inmate's medication regimen. The confrontation between the officer and the inmate was triggered over the inmate's distress over his mother's failing to arrive for an expected visit. The woman had passed away five years previous.

When I approached management about my concerns related to staff and lack of training and a lack of written policies and procedures, the response I received was you're -- you've always had them here, treat them like you've always treated them. Since

that date, the number of inmates at CRC's mental health delivery system has climbed from less than 300 to more than 800. While we've received an increase in psychologists and psychiatrists, we've never received additional staff necessary to supervise and distribute medication within the allotted time frames, and the training received by C/Os is still lacking at best.

Again, I want to thank the Commission for the opportunity to participate in this forum. Many of the issues the plague the inmate population directly affect the working conditions and safety of the correctional officers of this country. I would hope through processes like this one that the stereotype of the violent, knuckle dragging prison guard can be put to rest once and for all. For too long it's been used to simply systemic problems that the vast majority of the public has no interest in, prisons. Thank you.

MR. GREEN: Mr. Farrow.

MR. FARROW: Good morning. I want to thank the commissioners for inviting me to speak and I especially want to thank them for holding these hearings because they opened the door for a lot of possibilities for qualitative change in New Jersey.

My name is Thomas Farrow and I would

like to share with you my experiences as someone who has struggled with mental illness while incarcerated in the New Jersey prison system. As we sit here I would like to remind the Commission that in this state alone there are perhaps thousands, several thousands of prisoners with serious mental health problems suffering from inadequate care and mistreatment in New Jersey's prisons today.

In some ways my story is one of relatively good fortune. I remained fairly stable throughout my incarceration, but faced some of my biggest personal challenges during my transition out of prison.

I am not here to tell you that there is no treatment on the inside and there's always greet treatment on the outside; rather, I would like to impress upon this Commission that much of the mistreatment and abusive of inmates with mental illness persists in our prisons despite improved conditions. And although it can be difficult to get treatment in the free world without any money or resources, the fact does not justify the serious abuse and degradation of mentally ill prisoners that I have witnessed during my time in prison.

A little bit about myself. I was first

incarcerated in 1970, when I was sentenced to death in New Jersey. In 1972 the United States Supreme Court declared the death penalty unconstitutional and my death sentence was commuted to life in prison. I remained in prison until 1984, when the governor commuted my life sentence and I was granted parole after I had demonstrated my rehabilitation through efforts I made to educate myself and gain a degree.

I may have had a longer history of mental illness that went undiagnosed, but it was in 1995 that I was hospitalized for the first time, after I had a serious reaction to a medication for depression. I was diagnosed as bipolar disorder at that time.

Then in 1996, while I was an outpatient at Saint Mary's Hospital, I was returned to prison for a technical parole violation and was confined for eight years and five months prior to my release this past May 2nd.

At the time that I re-entered the prison system, the conditions and treatment of the mentally ill in New Jersey was deplorable. There were only five full-time psychiatrists in the entire Department of Corrections, serving at least 2,000 identified mentally ill prisoners. And when I say

identified, the overwhelming majority of the people with mental illness in the prison system of this state are not diagnosed, which means that there was no meaningful treatment for those patients whatsoever. There was little or no sensitivity among staff to the special needs of the mentally ill and prisoners with serious mental health problems were being physically abused by staff and other inmates and often landed in segregation as a result of disciplinary action when they needed some form of treatment.

A class action suit was filed that same year, in 1996, on behalf of all mentally ill prisoners in the state and in 1999 that case was settled in the United States District Court for this district. The settlement was to begin a new era in the treatment of mentally ill prisoners in New Jersey, however that did not happen. It changed disciplinary regulations so that prisoners with pending disciplinary charges were to be screened for mental health needs and referred to mental health treatment, if it was deemed appropriate. If means that it still depended on the attitude of the prison guards, which had a great deal to do with interfering with the operation of the program.

Prisoners confined in the segregation who were suffering deterioration in their mental

health status were to be referred by the mental health staff for review of their segregation in order to decide whether it was appropriate to end that confinement in light of their mental health status. All new prisoners were to receive a mental health assessment within 72 hours of their arrival. Officers and other staff were all to be given more training about mental health illness and how to deal with the mentally ill in prison. More psychiatrists and psychologists were to be hired and special mental health units were to be created at three different facilities so that prisoners who were vulnerable to the general population and needed care would be able to get it.

Over the course of my remaining years in prison I witnessed firsthand the efforts by the Department of Corrections to adhere, to a certain degree, to the Settlement Agreement and while I saw some improvements, many of the worst problems still continue and they persist. Even with the addition of psychiatric staff, it is nearly impossible to receive meaningful mental health counseling in prison.

First, counseling requires trust and an ongoing relationship with a psychologist. As a prisoner you may be transferred at any time, abruptly

ending the relationship you have with your provider, and there is tremendous turnover in the psychiatric staff so that even if a prisoner stays in one facility for an extended time and is assigned to a psychologist that he trusts, it is unlikely that that psychologist will remain long enough to provide meaningful care. It takes time to build a relationship with a mental health provider and you must eventually be able to share very personal details about your life for counseling to be effective.

Prison is a hostile environment that uses your illness against you so, naturally, it's difficult to trust the prison psychologist, who is to you only a stranger who works for the prison system.

Between 1996 and 2005 I was incarcerated at four different prison facilities and saw many different psychologists and counselors. For most of those years I was in I was lucky to see any single psychiatrist or psychologist more than three times. It was not until I was transferred to the psychiatric unit at Northern State Prison here in Newark that I saw the same psychologist for a year and a half. The psychiatrist who ran the mental health unit at Northern State Prison was making an effort to maintain a more stable environment for the prisoners

and staff so that there was a better chance of receiving meaningful treatment there, but, in general, I did not trust any of my counselors, and most prisoners do not trust them either.

Most of my encounters with mental health providers, like those of most prisoners, were extremely brief and only for about 15 minutes. We knew we could not expect to see them for long and they worked for the prison and we knew that even if we felt comfortable, confiding intimate things with a counselor, we could not be sure that what we shared would not some day be used against us.

There are other problems that commonly interfere with the prisoner's ability to get quality mental healthcare. Many of the people on the mental health staff in all of these prisons are from other countries and so they have difficulty communicating with prisoners, not only because of language barriers but largely because of the enormous cultural differences between them and the prisoners.

It is less difficult to get medications in prison, but this is both good and bad. While medication is widely dispensed to prisoners, it is not always appropriate and its effects are not monitored closely. Prisoners often feel that the prison

administration would like to keep them sedated rather than help them to be helped.

We all heard the story about the prisoner who was strapped naked into a restraining chair and forced to take his medication and while this may not happen that often, it is a fear we all share and this fear motivated many prisoners to avoid any contact with mental health providers.

Perhaps the single biggest problem that prisoners with mental illness face in prison is the insensitivity of correctional staff. In my experience the majority of corrections officers respond to outbreaks by mentally ill prisoners as a disciplinary matter, a response to which usually ends with the prisoner being placed in lockup where he would go without any form of treatment and into a process of deterioration.

I witnessed a lot of resistance by correction officers to the administration's efforts to empower mental health providers to intervene on behalf of mentally ill prisoners. This resistance took many forms. For example, at times when I would meet with a psychiatrist to discuss my medication, the officer who escorted me there would purposely and unnecessarily stand in the door and listen to what we had to talk

about, which made it impossible for me to confide in the doctor and signalled to me, also, that there was no respect for the doctor-patient relationship. Often correction officers would refuse to bring us to our appointments with mental health providers and it seemed they simply had no respect for mental health treatment.

But these forms of resistance are minor compared with the brutality that persisted even after the Settlement Agreement from the District Court. During my time in prison and particularly in the mental health units I had many -- I heard many accounts of beatings of mentally ill inmates who were subsequently thrown into segregation.

While I was in the mental health unit at Northern State Prison, goon squads, which is a term we used to describe groups of officers who are known to ban together to beat inmates, would come into the unit at night and take inmates that they perceived to be a problem and put them in the barber shop, which was an isolated area, where they would beat them.

Officers knew that prisoners often shared their medications and rather than address this problem through administrative channels, they would raid the unit in the middle of the night, take away a

prisoner whom they believed to be causing problems and beat him in the barber shop where no one would be able to witness it. I saw these goon squads take prisoners away and we all understood what happened to them.

I personally witnessed two serious beatings of mental ill inmates. In one case an older man in his 60s was attacked by a correction officer while he was waiting in line to get his Insulin. He was also a diabetic, like myself, and he was in a mental health unit with me and although he had a gruff manner, he was quite harmless. This officer perhaps misperceived his manner as hostile or dangerous and attacked and beat him with no apparent provocation.

I wrote the incident up following the attack and the officer was eventually removed from the mental health unit, but that eventually caused me some problems with other officers.

In general, I think it is fair to say that correction officers in the mental health units do not evidence any special training or sensitivity toward the mentally ill. In fact, in these units it appears that most of the officers are placed there because they have administrative problems of their own in other parts of the system and so these units become a dumping ground for officers that are labeled as

problematic.

Our problems persist in the special mental health units because overcrowding in the system at large has pushed an overflow of the general population into these units. In other words, these units were originally established, by law, for people with mental illness, but because of the overcrowding in the prison system they put other people from the general population into these units and that brings with it a whole host of problems that are outside of the spectrum of mental health.

The result is that these units are not always the refuge they are meant to be for prisoners with problems and who are particularly vulnerable. Much of the violence and corruption that exists in the general prison population, including drug dealing and gambling, is also brought into these units when they absorb prisoners from the general prison population.

I also witnessed deplorable conditions in the administrative segregation unit, or isolation units and they're called. For a period of time, it was my job to feed the prisoners in these units. I saw many prisoners with extremely serious mental illness who seemed to be deteriorating in their cells. I witnessed some of these men sitting or lying on the

floor in their own urine and feces. I got the sense that they were receiving little or no positive attention and many of them seemed to be in distress.

Finally, I would like to say a little bit about what I experienced prior to and in the months immediately following my release. I've had a very difficult time putting services in place to be able to continue medication and care after my release. When I became eligible for a halfway house, I slowly began to withdraw from my medication because I was both afraid that I would be denied entry into a halfway house if I was known to be on medication and because I did not know what services would be available when I got out and I did not want to have problems if I had to go off my medication abruptly.

Once I was placed in the halfway house I went back on my medication. But when I was released on May 2nd of this year I had absolutely no way of getting any medication, any prescriptions, any follow-up care, any treatment, any counseling service and I was -- I only had $15.58. My parole officer did not have any resources, even though he made tremendous efforts to help me. He made phone calls on my behalf and although I followed up on those phone calls with pleas for assistance from numerous sources, I had no

luck for quite some time.

I was hospitalized recently and developed pneumonia and while at the hospital I learned that my Lithium levels had dropped dangerously low. It is only recently that I was finally given charity care at St. Mary's Hospital in Passaic and through that charity was able to get outpatient assistance at the Seton Center and a prescription for my medications. I am now at the YMCA.

As difficult as this transition has been for me, I still consider myself lucky because I see numerous men that was in prison with me who have mental illness, they're homeless, they're not getting any medication, they're not getting any counseling and the parole authorities are not being bothered with them because they don't want the burden and they're just out there, floating. You know, some of them don't even know what day it is. I see many men on the street homeless in dire straits, having come out of prison and had no luck of finding any kind of services.

My own illness has not been so debilitating that I am unable to work and I have an education and ability to advocate on my own behalf. So many of the men I met in prison have illnesses that

make it impossible for them to be their own advocates or to maneuver through a system that requires extreme sophistication and persistence. They suffer in prison and they suffer when they get out.

Although this Commission is focused on the abuse of prisoners and not on the resources available to them when they get out, you should understand that the lack of care and truly effective therapy on the inside means that those people will be sure to be released in no shape to fight for the health they need on the outside. Abuse and degradation of the mentally ill in the New Jersey prison systems persist despite efforts to reform the system and it is my hope that this Commission will do something to address the attitudes towards prisoners that make it so difficult to change the way they are treated. Thank you.

MR. GREEN: Thank you, Mr. Farrow. Sister Antonia.

SISTER MAGUIRE: When I was asked to speak today to this commission, my immediate response was no. I felt it would be just one more attempt to bring the plight of the prisoners to the public's attention that would be just another exercise in futility.

However, that afternoon I witnessed a young woman being subdued by 11 officers. I attempted to go to her aide and was ordered back into my office and I watched until the end. After a sleepless night my no turned to yes and I'm here today.

I speak not as a representative for the Department of Corrections, but I speak through my own experience. I have been a chaplain in correctional facilities for almost 32 years. I've worked in both male and female maximum and medium security prisons.

I was able to watch Taconic change from a medium male facility to a female facility. That was quite a change. Two days before the women arrived the superintendent gathered all the staff in the visiting room and tried to brief us on how women should be treated. Amazingly, most of the staff who were there saw there would be no difference at all in treating women any differently than men were treated. The one question that was posed to the superintendent was, well, when they get here are you going to test them to see if they're pregnant? And the superintendent said, why would I do that? And their immediate response was, well, when you find that they are pregnant, we'll know whether it was them or us responsible.

Prisons were never made for women.

When Taconic changed over and the women came in, bathrooms had urinals. The programs were all male oriented. The women were expected to do the same hard labor that the men did, including working on the detail in a cemetary and lowering the bodies into a grave. I saw so many times women being put into a position where the labor was so extreme and so hard that I worried about what it would do to their physical bodies and began to ask that, you know, they be relieved from those kind of duties. And I was told over and over again they commit the crime, they're going to do the time and nothing is going to be changed.

I just for a moment would like to talk a little about how we raise children. We in the United States, if we have a little girl, three years old girl who runs and falls and scrapes her knee and she comes crying to you, usually we hold them and kiss them and comfort them. When her three year old brother falls and scrapes his knee and comes running to us we say stop crying, be a man, and from that moment we set the norms of behavior almost that males and females respond to.

The little girl who was cuddled and held and comforted becomes a prisoner one day and is

supposed to respond as a prisoner responds, whatever that is. If they show any emotion or if they expect to experience any touch, they're penalized.

Men, when they're little boys growing up, are used to group sports, showering together, being exposed to each other. Women, for the most part, have had a more modest bringing up. Very, very painful for women to endure that first initial shower where they're being viewed by several officers while they're being showered. Very painful for them to go to the visiting room and be strip searched prior and after the visit. I know many women who refuse visits all together because they can't go through that.

Perhaps 90 percent of the women in our prison are the victims of incest or terrible brutality in their childhood and to be exposed to the view of other people at this time in their lives is very painful to them.

In New York state, as far as I know, the past 20 years the number of men in prison has doubled, while the number of women in prison has quintupled. I would think that that is a case before us that we need to examine very closely and see what can be done.

I would like to tell you just a few

stories, stories that I have seen with my own eyes, that have occurred in one small prison in New York, but stories which I'm sure can be multiplied throughout the state many, many times.

I would like to introduce you first of all to Kathy. Kathy was a young woman serving time for drug use. Small amount of time. She was a very hard-working woman. She became sick one day, she had a cold, she felt, and she went to clinic. And when she went in, because it was wintertime they gave her a cold pack; standard procedure for all women who had colds in the prison, without thinking of what the effects of that medication would have on anyone.

Kathy took her medication dutifully and no change came by. She went every day for over a week to the clinic, reporting how sick she felt and that there was no change at all. The civilian staff with whom she worked saw how sick she was and they let her sit in the back and gave her tea and helped her rest. The officer on the floor would not let her stay on the floor, even in rainy weather, because she wanted her to be out and in the population.

Kathy became so sick that she had to turn away her visit when they came and the next day she called her mother and begged her mother to call

the superintendent. She said I haven't seen a doctor, please, I'm so sick, I need help, please call the superintendent tomorrow. And tomorrow never came for Kathy. At 2:00 that morning she was so violently ill that she banged on the door and, fortunately, a caring officer was there. Very frequently the officers do not respond to an inmate banging on the door in the night. He went immediately to her room, saw how sick she was and helped her to get dressed. He then called the sergeant to come and see.

We do not have medical services or anyone on duty in our facility from 11:00 at night until 6:00 the following morning. This in a facility where we have newborn babies, pregnant mothers, women with heart problems, many women with AIDS, no medical care at all.

The sergeant saw Kathy, saw she was very sick so he called his superior, the watch commander, to come in, walked up three flights of stairs to her room, saw how terrible she was and he said we've got to get her out of here. They brought her down three flights of stairs, shackled her, put her in a van and drove her across the street to the facility that had a clinic open at night. When she got to the clinic her heart had already stopped but

they resuscitated her because you are not allowed to die in prison, put her in an ambulance and brought her out to the hospital where she was pronounced dead. Upon the autopsy findings she had congestive heart failure and died from congestive heart failure. During the entire time she sought help not once did she saw a doctor, not once did anyone put a stethoscope to her chest, not once was her blood pressure taken. Kathy was 32 years old.

We have a newborn nursery. Babies are allowed to stay with their mothers for a year for bonding. Just a year ago we had a young mother whose four month old baby looked very lethargic to her. She brought him down to the clinic and the nurse said there's nothing wrong with him, he's doing fine. This went on for days. She kept bringing him to the clinic, she kept being told he was fine.

Finally, the counselor intervened and said this baby looked sick. The counselor said to me I think the baby is dying. They brought the baby down this last day and the nurse finally called and had the baby brought out to a clinic, but not to a pediatrician. Since the baby didn't have a temperature, he was sent back to the facility. The following day he was so very lethargic that they

brought him out to the hospital, brought the mother with him and she stood in shackles while the doctor pronounced him dead. Xavier was four months old.

A young woman was sent to my office because the teacher thought she was sick and could I help her. She was shaking, her eyes weren't focusing, she kept saying how very sick she felt, her stomach was very distended. I asked her if she saw the doctor and she said she had seen the doctor that day. And I said what did the doctor say? And she said, well, she took blood because she thinks maybe I'm pregnant. I said could you be? And she said no, I'm not, Sister. It was almost count time and I was afraid to send her back to her room because she looked so sick to me.

I called the clinic and I was screamed at, there's nothing wrong with her, she's been here she knows she's all right and I said she's not all right and I won't have it on my conscious by sending her back. So I said I'm writing it up in my report that I think she's sick. So eventually they sent her down to the clinic. She was Hispanic and I thought maybe because she didn't understand what they were saying -- we do not have interpreters -- and they said no, she understands.

They pulled her chart and they found

out that two weeks before she had had bloodwork done and her blood sugar level was 500. When she got down there they gave her ten units of Insulin and took her blood level sugar again, it was 595 and they gave her 10 more units of Insulin. And she didn't respond so they sent her out to the hospital, where she spent five days in intensive care and the doctor said to her I hope you are going to sue. She said I don't want to sue, I just want to live.

She came back to the facility, the following week. I had spent some time with her to tell her how to take care of her diabetes. I am a diabetic. I am in a wheelchair today partly because of the response of the diabetes to me, the destruction of the nerve cells. I don't want to see any woman have to go through what I've gone through. She came into my office looking sicker and when I said, you know, what's your blood sugar, she said it was 122 today. I said, that's perfect. I said, do you have any Insulin, she said yes, 30 units of Insulin, enough to have killed her.

I went to the deputy and I said If wonder if we have a protocol about diabetes because it doesn't seem that they know what they're doing down there. Women who have 180 to 200 blood level get two

and four units of Insulin, women with 130, 120 are getting 20 units of Insulin and just this past month a new diabetes protocol arrived at the prison beautifully bound, beautifully written, it's an excellent protocol, as are so many of the directives in corrections, excellent directives, they just are not followed.

Last person I would like to talk about is Esse. Esse had multiple problems. She had brain aneurysm, she has high blood pressure, she has AIDS, she had a bypass surgery just last year and she now this year was beginning to have -- experiencing the same problems she had prior to the bypass surgery. She went to the doctor and told him and he said everything that was wrong with your heart is fine now, they took care of it with the surgery, there's nothing wrong with you.

She used to tell me that she would wake up at night and she felt that her heart had stopped and she would sit up in bed and punch herself in the chest to jump start her heart again. She asked the doctor to check her heart because she was so frightened that she was going to die in prison and before she walked up the stairs her heart rate was 54. She climbed one short flight of stairs and her heart

rate was 120 and she used to say to me, I just pray to God I get out before I die and, fortunately, she did get out before she died.

Many people have said to me throughout the years why do you think the treatment of prisoners is so bad. Is it because of the lack of personnel? And, in part, yes, but, also, if you have ever talked to officers who have come through the training academy, they're taught that all inmates are con artists, don't trust them, they're out to get over on you.

And just as years and years ago slave traders were able to convince plantation owners that the black man was an animal with no soul and could be treated and worked as an animal, good people became slave owners. In our day the inmate is portrayed as an animal. I've heard it said over and over again, they're just animals, without souls, who deserve whatever they get, and sometimes good people buy into that.

And I sit before you today and I ask you to please, please, think very, very closely of what you have heard here and I just believe in my heart that if right-minded people can get together and make a decision to solve some of the problems and come

to the aides of our brothers and sisters who are incarcerated, then something could be done because each one of us, one day, will have to stand alone before our God and answer to the way -- for the way we treated his children and I know I, for one, cannot have that on my conscious.

MR. GREEN: Pat, did you want to start questioning, please.

MR. NOLAN: Thank you, each of you, for your compelling testimony. It's been said that the opposite of compassion is not hatred, it's indifference and thank you for not being indifferent and for trying to awaken compassion for people in some cases that have done bad things but are still worthy of dignity, in other cases are just sick, not bad, and each of your stories helps us understand the difficulties as staff member trying to obtain care for inmates and other staff to try to ensure the proper level of care.

Sister Antonia, you mentioned Kathy and in her death and you made a statement that prisoners are not allowed to die in prison. Can you explain that to us?

SISTER MAGUIRE: I wish I could. The only thing is there's a tremendous amount of paperwork

that happens when a person dies in prison and a lot of investigation when a person dies in prison. However, if they die in the hospital, that's taken out of the hands of the prison, so that they are brought out to the hospital to die.

MR. NOLAN: So they're officially declared dead on arrival?

SISTER MAGUIRE: Right.

MR. NOLAN: As opposed to --

SISTER MAGUIRE: Dying in the facility.

MR. NOLAN: Mr. Baumann, is that your experience and can you explain?

MR. BAUMANN: No, sir, we've had inmates pass away at the institution itself. Normally after about 3:00 in the afternoon till about 6:00 or 7:00 the next morning we have no one there who could legally pronounce the inmate dead so they will run them to the hospital and have the hospital actually do the pronouncement.

JUDGE SESSIONS: Mr. Baumann --

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: -- you referred to the fact that there was fear of charges being filed in connection with your service as an officer or other services of other officers. Tell us a little bit

about that.

MR. BAUMANN: You have a lot of times where you have incidents that are taken out of context or you are put in a catch-22 and you're constantly afraid of Internal Affairs coming in and trying to use an incident because of outside political pressures, internal political pressures within the department and that that incident will be taken out of context and then having Internal Affairs or Department of Management going out and shopping district attorneys if they take any sort of outside political heat for it.

And there are times where we've had physical altercations where we've had -- most recently, a shooting incident at Wasco State Prison. Long and short of it, the officer who had fired a nonlethal baton round from a 40-millimeter weapon had gotten familiarity training per departmental policy, but none of us had ever shot the weapon before. We were never properly trained to use it. It arrived, he was handed the weapon. An individual ended up dying as a result of the use of the weapon. You have got the family beating on the media, beating on everyone, wanting the officer prosecuted for it, yet he was caught in the middle of the situation.

Since that incident, the department has come back and now it's mandatory any institution that uses that weapon, annually, everyone has to fire three rounds, but that doesn't take and solve the issue at Wasco and the death of that inmate.

JUDGE SESSIONS: So it's your fear for both administrative charges and criminal charges?

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: Second thing in connection with the intake procedures, as you observed --

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: -- tell us about testing or things like HIV, hepatitis, tuberculosis, do you know whether in the intake --

MR. BAUMANN: The department has a standard mandatory test for tuberculosis on entry, not on exit. There's no medical testing on exit. They do voluntary testing for HIV.

JUDGE SESSIONS: Voluntary, by the party, if they are willing to be interested?

MR. BAUMANN: Correct, yes, sir. And we ran a blind study with UCC San Francisco, I want to say six or seven years ago, they just took a cross-section of the inmate population on hepatitis C.

We lobbied, the association lobbied for that. The department lobbied against it because the department's concern at the time was once they identify, they have an obligation to treat and they didn't want to have ten or 15,000 inmates running around with hepatitis C that they had an obligation to treat.

JUDGE SESSIONS: So what is the service as it stands now, is hepatitis C routinely tested or not?

MR. BAUMANN: No, it is not.

JUDGE SESSIONS: Is TB?

MR. BAUMANN: Not that I'm aware, it is not.

JUDGE SESSIONS: HIV is or not?

MR. BAUMANN: It's a voluntary test.

JUDGE SESSIONS: It's voluntary?

MR. BAUMANN: Yes, sir.

JUDGE SESSIONS: Are there any other testing on communicable diseases that you know of?

MR. BAUMANN: Not that I'm aware of, no, sir.

JUDGE SESSIONS: Thank you, sir.

MR. BAUMANN: Thank you, sir.

MR. NOLAN: Can I ask a follow-up?

MR. BAUMANN: Yes, sir.

MR. NOLAN: What about a mental evaluation on intake?

MR. BAUMANN: They have a set protocol on -- I believe there are four levels of screening on intake. The unfortunate part is that part of Coleman was it was supposed to be a confidential screening and then all follow-up care was supposed to be done one-on-one and individually.

One of the things that they cited in the suit was that you have 200 inmates in a holding tank, they push 199 of them into a corner and call an individual over into the opposite corner to screen, well, nobody is going to admit that there's a mental health issue there in front 199 other people. That still goes on less often than it did at the time of Coleman, but it still happens sporadically.

I'm not as well prepared for this as I would like to have been because last week I was at one of our institutions helping a local union negotiate the implementation of an enhanced mental health program where, because the lack of program space, management is putting cubicles on the day room floors for the psychiatrists and psychologists to work in and try to do mental health screening in an open cubicle.

They have the money from the

legislature to retrofit some existing space, two offices, but when the institution did that on another yard two years ago, they don't allow inmates into the program space; it's everybody's private offices and they still have the cubicles on the floors and they're still doing business as usual.

So I mean, you know, the legislature has been wonderful with most of that stuff, it's the department misusing the resources and no one outside stepping in and saying, you know, that's not right.

MR. NOLAN: That's great to see you speak out.

MR. BAUMANN: I appreciate your time.

MR. GREEN: Senator Romero.

SENATOR ROMERO: Thank you. Let me ask especially Mr. Baumann -- and I appreciate you being here and I know that I have certainly relied on you and some of the other correctional officers to assist me in moving forward on some of the reforms that I'm interested in, but how do we address this situation; for example, what is the role of the correctional officer in particular in bringing to our attention many of these and sometimes they're atrocities?

You may recall in California the case of an inmate who starved to death.

MR. BAUMANN: Yes, ma'am.

SENATOR ROMERO: I don't understand how an inmate starves to death in a state prison when there are medical practitioners, when there are wardens, administrators and correctional officers.

There was another case not too long afterwards, it became known as the Super Bowl Sunday, when an inmate bled to death and, again, there are still investigations on this, I don't know all the details, but how does an inmate bleed to death without the care being provided?

Now, certainly, in the aftermath of that there were, of course -- and I understand it -- the concerns from correctional officers to not be implicated in this, but, by the same token, what do we do to encourage officers, practitioners, administrators to speak up and to say this is how we will have an institution in which an inmate starves or bleeds to death, that silence is not tolerated?

Recently, a warden in California was fired from her position because of threatening others, essentially, to not speak out on abuses in the healthcare delivery system.

So what do we do at all levels to say when somebody dies -- and people die in our prisons

every day -- but how do we -- what do you, as a correctional officer, advise with respect to how do we get people to simply sometimes do the right thing and speak up?

MR. BAUMANN: I think a lot of the problem on the removal of the warden in San Quentin was kind of a mixed signal to -- at least to myself, I can't speak for all officers -- but there have been case after case after case of administrative misconduct where the warden hasn't been held accountable or the middle management hasn't been accountable.

We've had people step forward to report things and had the legislature or had the office of the inspector general or the governor's office turn their back on the employee and leave the employee hanging in the breeze. And it's a tough world to work in whenever you know that if you step forward and no one cares, that you are going to be left out there hanging on your own, and that means a lot.

There was an article, I believe it was in yesterday's paper, about the Kikendell(ph.) sexual harassment cases at VSPW. That had gone on for years and employees had come forward and come forward and nothing happened. And how do you instill a sense of

morality to a group of people of middle management and upper management?

You know, we've advocated for fair and impartial investigations for years and that's all we've asked, is if the allegations there, no matter what level of government, that the same protocols and procedures be put in place. And whenever someone steps up and says, you know what, this is going on, that somebody doesn't run to the papers, get their 15 minutes of fame and then turn around and go back and lock their office door. There's nothing more shameful.

And I have had officer after officer retaliated against for coming forward and they come back and sit down and say, why would I step forward? I'm going to ruin my life, I'm going to ruin my livelihood.

I've been threatened to be terminated over speaking out about it and the department's attitude is come back in eight months, we know you'll go to state personnel for it and win, but we'll put you through the bankruptcy and we'll put you through the changes.

MR. GREEN: Mr. Maynard, I know you have a question. Can I ask one first, though, please.

Mr. Farrow, what do you believe to be the most significant barriers to implementing the class -- the mandated class action settlement that you alluded to in your statement?

MR. FARROW: Well, first is the politics of the union for the correction officers. They wield a lot of power and they really don't want any kind of a program dealing with nonuniformed personnel implemented without their input.

Secondly, you have a hierarchy that has a wonderful philosophy in terms of the direction that they want to take the system and the kind of programs that they want to implement, but they're not in touch with the people on the ground.

Thirdly, you have elements in New Jersey that have been entrenched in the correctional system for the past 50 years. You have second and third, fourth generations working in the system, holding key positions in terms of operations and policy.

I think a case that you should try to get your hand on is Edward O. Lone versus the Department of Corrections, it's about a former warden. That case illustrates that New Jersey is perhaps one of the most racist, sexist departments in the state

and that has a lot to do with how programs are implemented and how resources are spent.

For example, you take a prison like Northern State, a prison like East Jersey in Rahway. These institutions are predominantly black and Hispanic and other than money spent for security reasons, there's very few programs in these prisons. But then you go to South Jersey to South Woods, which is a relatively new 278 million-dollar prison, if you are fortunate to get transferred there, all kinds of programs and opportunities are available to you, but it's predominantly a white prison, both in terms of staff and the inmate population.

There is really a north and south struggle going on in the Department of Corrections. The northern prisons versus the southern prisons in terms of resources, personnel. So there are a lot of problems.

I mean, the present commissioner, Mr. Brown, has a lot of good intentions, but what he fails to understand is that everything that has taken place in New Jersey has been the result of either court action or crisis. Very few changes have come about voluntarily in New Jersey.

MR. GREEN: Gary Maynard. And Gary is

going to be the last question because we have to move on to our next panel, so, Gary.

MR. MAYNARD: I just have a question for Mr. Baumann and I heard from Sister Antonia's testimony and Mr. Farrow's a description of correctional staff that were basically uncaring and treated offenders as animals.

Is that your experience with the correctional staff?

MR. BAUMANN: To some degree, yes, sir.

MR. MAYNARD: What percentage do you think of the total line staff would have compassion for the offenders?

MR. BAUMANN: I honestly couldn't tell you. I have worked three different institutions and it varies. A lot of it depends on the custody level of the institution and the programs going on at the institution; the lower custody, higher programming ones, it tends to be a lot higher than it is at the reception centers where you've just got bodies en masse going through.

And most of the time -- I know when I worked the reception center at CIM, you just had such massive quantities of inmates, I mean you are talking about 3,000 inmates a month rolling through the place

and everybody is just a number. You just try to -- it's a production line, you just try to keep the bodies, try to keep everything going because if you don't, you end up in the situation where you're having to lay bunks out in the dining halls and everything else so your only goal is to get them in, get whatever protocol you need done and get them back out the other end.

MR. GREEN: Again, on behalf of the Commission we want to express our appreciation for your coming in and sharing your personal experiences and the important information you shared with us today. Thank you so much.

We're going to break now until 10:15.

(Brief recess.)

EXPERT TESTIMONY ON THE QUALITY OF MEDICAL CARE

SENATOR ROMERO: On this next panel, this particular panel is going to examine the quality of medical care in our state institutions.

On behalf of the Commission on Safety and Abuse in America's Prisons, I am honored to welcome our next trio of panelists; Dr. Joe Goldenson, Dr. Robert Cohen and Director Arthur Wallenstein. Thank you so very much for joining with us.

This distinguished panel, the first of

three today to address medical and mental healthcare issues, will explore the quality of correctional healthcare. As a state senator from California, I will say that I know firsthand how important the following panels will be. In California, as many of you may know, our correctional healthcare system has been placed under a federal receivership. It's been estimated that one inmate is dying a preventable death every week in California. Federal Judge Thelton Henderson called what we have in California a trained incapacity. We simply cannot improve our own system and is it of our own design? I would hope that the panelists would address this when they speak.

However, California is not alone and that is why the following panels are essential, not only to our understanding of inmates' constitutional right to healthcare, but of the responsibilities of prison administrators, but also of the threat to the public health, which is another form of public safety.

Our first panel this afternoon to address medical and, later, taking a look at mental health needs, will raise concerns raised by the inadequacies of inmate healthcare and they will address mental health issues and treatment. Together we will explore the prevalence and causes of serious

medical care failures and their consequences and our obligation, not only constitutional, but moral obligations to address these problems as a manifestation of abuse.

In conclusion, taking into account known best practices, we hope the panelists will take the time to address viable models for improved quality of care.

We are joined today by three notable experts in the field. The first, Dr. Robert Cohen was the vice president of the Health and Hospitals Corporation, where he oversaw the healthcare services of New York City's prison units and public hospitals. He has directed the medical services on Riker's Island and acted as an expert consultant and monitor in several prison systems around the country. Dr. Cohen will testify to dramatic failures in providing adequate care to prisoners and the tragic consequences that can result.

Additionally, Dr. Joe Goldenson is an expert in infectious disease and public health, serving as an expert monitor in the California state prisons and that is how I have come to know him and greatly respect the work that he has done.

In partnership with the San Francisco

Department of Public Health, Dr. Goldenson currently directs medical services for the San Francisco County Jail. Dr. Goldenson will speak to significant barriers to quality prison medical care and to the current crisis that California state institutions are facing in providing quality care.

I do want to note at this point that Dr. Goldenson was one of the medical experts on the panel that evaluated inmate healthcare in California and his findings, his insight and recommendations were instrumental to the appointment -- to the decision to appoint a federal receiver in California.

Our final panelist is Mr. Art Wallenstein, who is currently the director of Maryland's Montgomery County Department of Correction and Rehabilitation. Director Wallenstein brings with him his vast knowledge of corrections techniques and rehabilitation initiatives, honed from his previous experiences as director of Washington's King County Department of Adult Detention and is both a warden and director of the Bucks County Pennsylvania Correctional System. He will speak to the specific challenges jails pose and the strategies he has employed to provide quality care in a jail setting.

I want to thank you for joining with us

today. I want to remind each of you that we have allocated 15 minutes each for you to present. We will begin with Dr. Goldenson, followed by Dr. Cohen and finally by Director Wallenstein. Upon conclusion of their testimony -- and our timekeeper will be flashing cards, please take note, zero means zero and it's a zero tolerance policy at this point on.

Following your testimony, we will engage in Q and A and dialogue from the panelists. I would like to begin with some questions and then turn it over to Steven Bright and Gary Maynard. We will ask initial questions on healthcare and then we will open it up for all commissioners to participate. We have an hour and a half to review this very serious matter. Let's not squander anymore time. Let's go ahead and begin with Dr. Goldenson.

Thank you for traveling to New Jersey.

MR. WOOL: Excuse me, Senator. I think it's ten to 12 minutes we're going to go with and consult with your timekeeper next to you, but let's go with 12.

SENATOR ROMERO: Okay. You've lost three minutes, 12 minutes.

DR. GOLDENSON: Gained two, actually.

SENATOR ROMERO: If you can speak

directly into the mike, please.

DR. GOLDENSON: Can you hear me? Good morning, Commissioners, and thank you for inviting me to this testimony.

When discussing safety and abuse in prisons healthcare is not the first and probably not the second or even the third thing that immediately comes to mind. When we're speaking about deaths and injuries in correctional facilities, violence -- either prisoner against prisoner or staff against prisoner -- is the usual suspect. The reality, however, is that much of the morbidity and mortality that we see in our nations' prisons is the result of inadequate and poor medical care, and that's some of the issues I want the talk about today.

As Senator Romero mentioned, I am one of the medical experts appointed by the Federal Court to look into the California system so a lot of what I'll be talking about comes from our recent reports on California, although I have also been a medical expert in Ohio and involved in a number of other states in terms of medical care, but, primarily, what I'll be focusing on is what we found in California.

Just for some background, in 1976 the United States Supreme Court in a case called Estelle

v. Gamble ruled that it was the government's obligation to provide medical care for those whom it's punishing by incarceration. In reaching this decision the court referred back to the Eight Amendment's prohibition against cruel and unusual punishment and stated, basically, that if the state takes away someone's freedom, then they're responsible for providing for their healthcare and safety.

The court set a high standard, though, in terms of how they would evaluate healthcare programs within correctional facilities and, basically, the standard is deliberate indifference to a serious medical need. A serious medical need is one which if not appropriately treated in a timely manner, can lead to either death, measurable deterioration in function, unnecessary pain or a risk to public health.

Deliberate indifference means that you have to prove that either the medical staff or the custody staff was aware of this risk to the individual and didn't do anything so that just showing that someone suffered harm because of poor medical care doesn't rise to the standard that the Supreme Court set. You have to show that someone in a position of authority knew about this and still let it happen.

Unfortunately, 30 years after Estelle,

many correctional systems in this country still have poor and inadequate medical care that does not meet the constitutional standards set by the Supreme Court over 30 years ago. And, in addition to that, many of the systems in this country where there is good medical care, the reason for that is that they have had to deal with the courts and either the court has set up court orders or there have been settlement agreements whereby healthcare is prioritized and the system is fixed.

In many of these cases either medical experts or special masters are appointed to oversee the medical programs while the state or the county is fixing them and to ensure that the court's decrees are being followed.

Recently in California, U.S. District Judge Thelton Henderson came to the decision that the California system was basically so broken and there was so much suffering due to the poor medical care that he came to, basically, the unprecedented decision to appoint a receiver to be responsible for the entire healthcare system in the California state prison system, despite -- California has 160,000 prisoners in 33 prisons so that, by far, it's the largest system and to go to the step of appointing a receiver was a

very difficult decision for the judge, but he felt that it was something that was necessary, given the gravity of the situation.

James Sterngold, who is a journalist who writes for the San Francisco Chronicle who was covering the hearings said that the decision by Judge Henderson followed weeks of testimony from medical experts that Henderson described as horrifying in its depiction of barbaric medical conditions in some prisons, resulting in as many as 64 preventable deaths of inmates a year and injury to countless others.

Judge Henderson said he was most moved by the, quote, uncontested statistic that a prisoner needlessly dies an average of roughly once a week through medical neglect or cruelty. He went on to say that the prison system offered and I'll call it again, at times, outright depravity. So it's very clear from California's example and other examples that the failure to provide adequate medical care can and does rise to the level of abuse in our prisons.

As a result of the testimony and the findings, the judge decided that California was not capable of managing its own healthcare system and appointed a receiver.

In my written report I go through a

number of reasons why I felt that providing medical care is so problematic in our correctional institutions and I would like to go over a few of those during my time here.

First of all, I think the major issue is that healthcare is just not a priority. Most correctional institutions, custody staff runs the institutions as they should, security is their main concern, again, as it should. The problem is that that -- the medical staff often is three or four rungs down on the supervisory chain so that a lot of the decisions about medical care from decisions concerning staffing, budgetary decisions, to the level of whether a prisoner should have a crutch or not, whether a prisoner can be transferred out of the facility for necessary specialty or emergency care are all controlled by the custody staff who really don't have the training or the education or the skills to make those decisions, but these are the people in many of our institutions who are making those kind of medical decisions or at least have control over the final outcome of those decisions.

Again, referring back to Judge Henderson, in his decision to appoint a receiver he stated that we have seen too often in the records

before me, medical decisions give way and suffer because of ill-advised security decisions so that prisoners don't even get to their medical care because of security decisions that hamper effective medical care.

Kevin Carruth, who at the time was the second highest ranking official in the Department of Corrections in California, at an evidentiary hearing stated that it is not the business of the California Department of Corrections to provide medical care and it never will be. He went to say that medical care is not one of the department's core competencies.

So this breakdown in terms of who really is managing the program and who is making the decisions has a number of effects, one of which is that many of the facilities lack appropriate funding and resources.

Again, lots of times the budget will come out, each facility will be responsible for its own budget and the warden or the sheriff controls those budgetary decisions and decides how much will go to medical, how much will go to custody and how much will go to other areas. Here again, custody concerns take precedence over medical needs.

I have two minutes. One thing I wanted

to say is that when prisoners enter facilities, they lose eligibility for Medicare and Medicaid, which means that the total cost then falls either on the county in the case of jails or the state in terms of state prisons and, you know, except for a cost-saving factor on the part of the federal government, there really is no reason that should happen and it places structural institutions at a real disadvantage in terms of having access to funding that's available to everyone else for healthcare.

In my report I document a number of cases where the care was either incompetent to cruel and we saw cases where it was just shocking to us that medical professionals were involved in the cases. We saw cases where on review it was clear the custody staff had a better idea of what was going on than the medical staff and the custody staff wanted people sent to the emergency room outside of the jail facility or the prison facility and the doctors were saying no, this guy doesn't need to go and he would die within two or three hours.

SENATOR ROMERO: Dr. Goldenson, your time has expired. We'll come back to you in Q and A. Thank you.

Dr. Cohen.

DR. COHEN: Good morning, Commissioner. Thanks for the opportunity to be here. In my written testimony, my discussion was fairly theoretical. I'm going to be more concrete in my examples to you today and just to say that the basis of my testimony, like others here, is that for the past 25 years I have worked in prisons, directing medical care in prisons, monitoring medical care. I am currently appointed by federal courts in Ohio, Michigan, Connecticut and New York to monitor medical care based upon class action suits which found that the medical -- which were settled because everyone agreed that the medical care failed to meet the constitutional standard that Dr. Goldenson just mentioned.

And although I'm going to give examples and anecdotes, I ask you to understand that these are easy to find. These are not rare events. Some of the things I will describe will be slightly horrific, but they are not unusual and it's why you are here today and I appreciate the work you are doing because there is a serious problem of violence and abuse in the prisons and, hopefully, your work will begin to reverse it.

When we are ill, we hope that our doctors will be there for us. They know, we know that

the experience of illness is frightening and difficult, the outcomes can be adverse and privileged citizens in this country expect their doctor to be an advocate for them to make sure we get our medicines, that we get the tests we need, that we will see the specialist that we have to see if the situation is complex and requires it, and we expect our doctors to be responsive to our pain, to our suffering and to listen to us, although many people feel their doctors don't spend enough time with them, and to be on their side.

And prisoners, of course, expect the same thing. They expect that their complaints of pain and suffering will be listened to sympathetically and they expect they need medication, diagnostic testing, access to specialists, they will get it too, but they don't expect to get it. Their experience is the experience that you have heard about and will continue to describe today, that they fear if the care they require is complex, expensive, requires trips outside the prison, that they may not get what they need, and they certainly won't get what they expect.

Now, there are doctors and other health professionals in jails and prisons who do provide good quality medical care, but there are others who don't

try. There are doctors working in prisons who do not want to be working in prisons, who have a fundamentally antagonistic relationship to their patients and who do not advocate on their patients behalf. These doctors approach their patients' complaints by dismissing significant symptoms, offering palliative treatment to them instead of careful evaluation and they're also incompetent doctors who don't know how to treat their patients.

And Dr. Goldenson has talked about the California experience; there 25 percent of the doctors are felt to be incompetent beyond remediation at the present time, and I can't speak to the similar data in other states, but that's unchallenged by the California Department of Corrections, as well as by the union of physicians in California.

Physicians may perceive their -- prisoners may perceive their physicians as remote and hostile and doctors often view their patients as manipulative and demanding. Prison administrators view a prisoner's request for sick call with a jaundice eye and support co-payments to discourage frivolous use of care. Patients who complain are viewed with skepticism and anger and their request for pain medication may result in anger responses from

providers.

Physicians who treat pain are viewed as prisoner friendly, which is not a -- which is not a position that many doctors want to be in a institution.

And when the patient's welfare no longer becomes the primary goal of the physician's activity, then we are faced with a discussion of how do we achieve quality of care in prisons. I will return to that point at the end.

I'm going to give a few examples right now. Dr. Goldenson and I are co-appointed in Ohio to monitor the medical care at the Ohio State Prison, a supermax facility outside of Youngstown, Ohio. And, of interest, I was the plaintiff's expert in this case, Dr. Goldenson was defendant's expert in this case.

And we each toured the facility, we each wrote a report, we did not speak to each other about the reports, although we did communicate that we were doing this because we know each other, and we wrote the same report. We described the same thing and, understandably, the settlement agreement was to implement our reports. And the implementation, I think this is important, actually, in terms of some

point of the questions asked before, was that if the two of us agreed, then the state had to do it. It was not required to go back to a court to prove contempt of the agreement that the parties had agreed to carry out, but if the two of us agreed, then the state had an obligation.

And when we got there, patients were not being treated for pain, pain medicines were not being prescribed. Patients were not allowed to be diagnosed with hepatitis C. Insulin for patients with diabetes -- it was the discussion earlier this morning about diabetic treatment -- were receiving their Insulin through the food slots in their steel doors, which had a glass -- you know, a glass view place and a food slot and the patients would put their belly up to the food slot and receive their Insulin.

I found this out when I was reviewing the medical record and the nurses are supposed to chart where in the body the Insulin is being given so there is a normal rotation so that areas of skin don't become unable to absorb the Insulin, and I saw that everyone was getting it in the same place over and over and over again. And I asked the nurses and they explained to me that's what they were doing.

I can't understand that, although I

can, it's very important for us to understand how can that happen? You know, what nurse goes through their training in order to do that? And I will answer that in questions, I think but I'll -- patients who were examined in Ohio state prison were rare and when they were examined, they were brought by a guard -- a guard -- by three guards. First they were chained, their hands were chained behind their back, their legs chained, their legs chained to their hands and shuffled down a hallway to a medical examining area where they were then chained to the wall and led -- and sitting on a table with their -- and we asked the doctor, how did you examine -- individually we asked the doctor, how did you examine the patients if they had abdominal pain, because they were like this (indicating), and he said it was difficult.

That's changed, although it was very difficult to change it. And the doctor who came in and started insisting that the patients have their chains removed when he examined them was subsequently fired and then rehired.

In Michigan, where I monitor medical care at the Southern Michigan Facility, which is the old Jackson Penitentiary, which was at that time the largest single prison in the United States, housing

5,000 men in a five story cagneist(ph.) facility. Today -- or hopefully not today -- but, certainly, recently, you know, patients with life-threatening medical illnesses who were known to have cancer would have their treatment delayed for three, six, nine months and every month a doctor would review the chart and be asked is it okay for them to wait another month, and every month the doctor would say yes. Why? I don't know.

I've talked to them and I thought and I believe, as did the judge in this case, that this is a serious, serious problem, although it's of note that the attorney general's representatives in one of the hearings in which I brought this to the judge's attention said what are your standards, Dr. Cohen, you know, are you using malpractice standards, is it a deliberate indifference standard, because we win these cases in court. They're losing right now, but that was the attorney general's, you know, position and one could understand how that could get transmitted back through to the medical staff.

I have some pictures here which I would like to have the Commission to see, you don't have to look at them right now, although you can. There are five copies of four pictures. And they are pictures

of a young man named Gregory Lee who was arrested a year -- little over -- about two years ago in Louisiana and he was convicted of a crime. He had been -- he had HIV infection, he had two T-cells when he came into prison and he was initially worked up at the New Orleans Parish Prison and then he was transmitted -- he was transferred to another prison and then, finally, to a private prison called Southwest Louisiana Correctional Center, where he never received any medical evaluation, where he was never seen by a doctor, where he was never seen by a nurse and where he one day was accused of escaping by walking from one place to another. There was no possibility of escape, but he was accused of escaping.

He was beaten for 12 hours and then he was -- and there are pictures which show him as he was transferred from Southwest Louisiana Correctional to Elaine Hunt Correctional Facility, which is a Louisiana state prison. And there is a picture of him with a rag in his mouth, with his arms bound behind his back, his legs bound together and his arms and legs chained together in a hog-tied position and that's how he was brought to Elaine Hunt, where they took this picture, for whatever reason.

And he was then placed in suicide -- he

was accused of escaping and said to be a suicide risk. He was placed in four-point restrain at Elaine Hunt for three days and then on the fourth day he was released from his restraints and a few hours later died. And there is a picture of him naked in his cell, dead, in Louisiana.

He never received any medical care, except for a lot of tranquilizers when he got to Elaine Hunt, and although medical tests were taken on admission there, they were never looked at.

These look like Abu Ghraib pictures when you see them, and I don't have a lot of pictures like that, but I have these pictures and they are -- they're the worst thing I have ever seen, but this happens in Louisiana regularly and this private prison company has been indicted for torturing prisoners on a number of occasions.

Few other points I would make, if I had more time, would be that there should not be unlicensed doctors in positions in prisons. In Mississippi, where I review the medical care for HIV prisoners five years ago, while under the direct control of the University of Mississippi Medical School, all of the doctors that -- whose credentials I could review, and I think it was all of them, had lost

their license to practice medicine in Mississippi, but were allowed to practice in Parchman Farms and in a women's facility and they were providing medical care to people with HIV infection completely in contradiction to the required standards, which are national in this.

Patients who had been on three drugs were taken off of their three drugs, placed on two medications, required to take the two medicines for six months and then a third drug was added. I guess my time is up, but I will --

SENATOR ROMERO: We'll return to you on Q and A. Thank you.

Director Wallenstein.

MR. WALLENSTEIN: Thank you. I would like to agree initially with Judge Gibbons who noted that this is a patchwork issue. It isn't all negative, it is certainly not all positive and, hopefully, the members of the Commission are able to engage this question of healthcare and mental healthcare as you look for solutions, advocacy, prescriptive packages and things that you can urge the profession, not simply of corrections, but of public policy to take. So I think I appreciate the patchwork notation.

There is no question, there is no doubt that correctional healthcare is a core competency in this profession. The statement of a colleague I'm sure was properly quoted, and I need to ensure that this Commission is aware, that to the great majority of correctional administrators, this is mainstream practice, as we move to becoming a de facto mental health system in the United States, that may be another issue, but medical care represents as core a practice within correctional operations certainly as security and it has been accepted and largely been in that domain since Justice Byron White, I believe, spoke in 1974 in the case of Wolff versus McDonnell. And while he was talking about disciplinary issues at the time, he noted as persuasively certainly as any decision that prisoners were not beyond the scope of the Constitution of the United States. And while the exigencies of an institutional environment may cause some issues to be considered, the Constitution was not thrown away. And he noted very directly that there was no iron curtain separating the prisons of this country from the Constitution of the United States.

Now, one value of being 60 is that I was here pre-Wolff versus McDonnell and pre-Estelle and I was there when these practices were, let's say,

wholly inappropriate, even in well-intentioned environments, because we lacked guidance, direction and standards. That's a big difference from deliberate indifference or uncaring, but simply the tools had not yet been developed and I feel that was certainly one of the things that I bring to this testimony is that I don't come from simply a rarefied environment in a wealthy Maryland County. I served as the assistant warden at the Illinois State Penitentiary at Joliet in Stateville -- I doubt that there are anymore difficult correctional environments in this country -- and had a chance to see the pre-Estelle practices and know the value of judicial involvement and know what has happened as a result of that judicial involvement.

I will return to that, but I want to make a few comments very briefly on jails. The title of this Commission is The Commission on Safety and Abuse in America's Prisons. When I was reading through the website just ten days ago I said, woops, the jail issue has been missed again, like it always is, and that's no criticism, and that led me to call the Commission and ask if I might testify because I saw your list of witnesses and they were highly competent and certainly could say all the things that

I might have said.

Allen Beck is one of the most credible people in this country in criminal justice and he did a brilliant job yesterday of talking about basic data. In the most recent report that his office publishes, prisoners at mid year, there is a discussion of 713,000 people in our jails on a given day and 1.3 million people in our prisons.

That says nothing about the number of people who filter through the jail system. The number is 10 million. It's only 650,000 to 700,000 who enter the American prison system each year and we know from the President's State of the Union address, about 650,000 depart. Folks, please consider the 10 million who go through the jail system in this country. You talk about infectious disease at the prison level, imagine the impact for the large number of these folks are quickly back on the streets of local communities and bring enormous difficulties and enormous consequences to local communities.

I need to reiterate this point because we find ourselves having to advocate for the jails. And my guess is it's because of the larger size of daily prison populations and the fact that part one crime is largely involved. But many of us, of course,

have read the broken windows approach and know that lesser crimes may have the dominant impact on public safety perceptions in the United States and jails are in a unique position to engage these issues because of their proximity to local communities.

When Judge White, from my perspective, exploded the issue of prison and jail conditions as a valid constitutional issue, he opened the door for the period 1974 through 1991 when virtually every aspect of corrections became open to constitutional practice. And you heard from Vince Nathan and Fred Cohen, veterans of the shop floor of those incredible years, where hundreds of Federal Court decisions were rendered, establishing core, basic floor practices and whether one colleague disagrees or not, healthcare is smack in the middle of those core practices.

In '76, as my colleague, Mr. Goldenson, so ably noted, Mr. Justice Marshall wrote for an undivided court in Estelle versus Gamble that there was no doubt that healthcare was mandated and while the deliberate indifference standard may have required a high degree of proof that there was significant violation to the folks on the shop floor myself, there was never a question that constitutional practices had to be carried out. Done, agreed to and buyer beware

if quality healthcare wasn't going to be provided.

The American Medical Association engaged this issue and established the first core standards program and that's something I really wanted to note to the members of the Commission. They prescribed and developed prescriptive packages, everything from what you do at the front door and to what you are supposed to do to refer clients to community-based programs upon their release. Those standards exist today and, if universally implemented, while there will still be some abuse, of course, day-to-day lack of concern will diminish.

The National Commission on Correctional Healthcare took over for the AMA, they exist today and their work is certainly instrumental in establishing core quality healthcare practices around this country. They don't obviate the need for, certainly, intensive attention and accountability, but no one in this profession could possibly say that healthcare is not a core element of correctional operations and correctional practices.

The American Correctional Association has adopted strict healthcare standards. Perhaps in part gleaned from NCCHC, but now independently as part of their standards program.

As of yesterday, in the jail side of the house there were only 124 jails in America that had received ACA accreditation. There were 242 jails in this country that had been accredited by the National Commission on Correctional Healthcare. Why do I note this? Kudos to those who do, but this Commission needs to reinforce that every correctional institution in this country needs to follow those standards. The public health service had a chance to buy into this many years ago, sort of chose not to and, hopefully, we can get the public health service back into this business.

That doesn't mean that everything is perfect, but it does mean that the standards exist to monitor core basic practices in this country regarding healthcare and they offer a template and they offer standards and they offer a road map and it means that community standards of care are brought into the institutions and there can be no debate any further about what quality practices are and they do establish constitutional minimum.

And while federal courts have been reluctant to say that accreditation is a core practice, those who are accredited and have followed the standards of NCCHC and the American Correctional

Association generally are not before federal district courts, don't have consent decrees entered against them and are generally working with individual cases where better care might have been provided, which is, hopefully, where correctional services as a whole should be on an ongoing and regular basis.

You learn from the exceptional case, you don't deal with death on a daily basis because you have standards and practices and protocols that are carried out, that are implemented and that are the subject of high accountability.

Let me begin where I ended and thank Dr. Goldenson for just mentioning that one comment; healthcare is a core, a nondebateable core practice in the area of corrections in this country. Accept nothing else and render your judgements in your report that mandate and allow no other tolerance of anything but quality healthcare.

SENATOR ROMERO: Thank you, Director.

Commissioner Bright, do you want to begin the dialogue?

MR. BRIGHT: Sure. I will be glad to.

I want to ask with regard to Dr. Goldenson, you are in San Francisco and, I assume, work for the jail authority there; is that right?

DR. GOLDENSON: No. Actually, in San Francisco the healthcare services are provided through the public health department.

MR. BRIGHT: The public health department.

DR. GOLDENSON: So I work for the public health department.

MR. BRIGHT: And Dr. Cohen was at Riker's and, I assume, worked for the New York Department of Corrections?

DR. COHEN: New York City Department of Health, right, but for the city, yes.

MR. BRIGHT: And my question is this, and it's two sort of related questions, which is we see in this area of private healthcare providers, the largest being I think Prison Health Services, which we've had some experience with, and I just wanted to get what your comments were, all of you, with regard to private healthcare providers, both in jails and in prisons, and sort of related to that that in the very remote areas, where a lot of prisons are, particularly the supermax prisons and so forth, often way down in places where nobody much goes, the difficulty of finding doctors and nurses and the utilization of people, healthcare professionals, who are not able to

practice in the public at large, who have prior convictions or have been defrocked or someone spoke at the earlier panel about language and cultural differences of people --

DR. COHEN: On the for-profit area. When I worked on Riker's Island I actually was a contract, but a not-for-profit contract. I worked for Montefiore Medical Center in New York City, which had a contract with the City and we did not have a profit built into our thing.

I think that the recent New York Times story by Paul Vonzielbauer on PHS in New York City, I'm sure the Commission has access to that, you know, showed some serious problems with PHS care using unlicensed psychiatrists in a very intensive mental health program.

In general, whenever there is a contract which -- in which there is a risk contract -- "risk contract" in medicine means that every dollar you pay you don't keep yourself, then there is a incentive to provide less care.

Sometimes the for-profit contracts are written to avoid that by only paying for -- by encouraging the utilization of services and limiting the profits that can be made by not providing care, in

fact, sometimes even debiting dollars for unfilled positions. But, in general, my experience has been quite negative in this.

In Philadelphia, where I monitor the GL medical care for a number of years, PHS had the contract, and they refused to ever put in the bid that they needed to meet the care levels that were required because they knew they would be underbid by next year's bidder and that was a very serious problem.

And in Michigan, where I currently monitor, where Correctional Medical Services provides the medical components, that's the physicians, the hospital care and the specialty care, although they have an incentive to supposedly a cost-plus contract, they still have a relationship with the State of Michigan, which is not interested in paying cost plus for everything. And my experience is access to that specialty care is extremely limited in this group, less than half our patients get their care in the time it's allocated.

There are other questions but I will let my other panelist answer.

DR. GOLDENSON: I agree with Dr. Cohen in terms of the private medical services. I think one of the major problems with them is that when there is

a profit motivation, there is less likelihood that patients are going to be sent off-site for specialty services that are often only available in the community or for emergency services so that a number of cases I have reviewed where people have died, it's because they haven't been sent out in a timely manner to an emergency room and I think there's -- from talking to staff who work in these institutions, there's not a rule, but, basically, an understanding that you should try to avoid, as much as possible, sending people out.

You know, by contrast, in San Francisco, as I said, we're part of the public health department, the hospital that we send people to is part of the health department so it's all one system and, you know, what I tell my staff is if there's any question, you send someone to the emergency room, just to make sure that we're not missing something.

So it really is a difference in philosophy and what your motivation is, whether it's to provide the best possible care or to try to make a profit on it.

MR. BRIGHT: Is that fairly rare, to have the whole system together; the public health system, the public hospital and the jail all in one

unified system of healthcare delivery or do you know.

DR. GOLDENSON: It's not the usual model, but I know in California, at least, there are a number of counties where that is the model. I'm not aware of any state prison system where that's the model, but at least in California a number of the jail systems -- I mean the predominant number are still health services are run through the sheriff's department, but there are a significant number where it's provided through the health department.

In terms of your second question, I think that's a major concern in terms of having -- finding qualified physicians who are willing to work in what is often not very good working conditions and very isolated areas and at the same time not being paid what they could make in other places. And it's one of the questions that we're looking at in California because of the large number of institutions, many of which are in remote areas and not only for physicians but for nursing, there's huge numbers of vacancies in some of these facilities. Facilities with maybe four, 5,000 people where they only have two or three doctors currently.

You know, unfortunately, I think the answer is that you have to pay people more to attract

them to work in those situations. The other things we're looking at is a lot of these rural areas do have medical schools or residency programs in family practice, trying to connect the family practice programs with the prison systems to use some of these resources and make it part of the training program so that the residents and the faculty from these different residencies, part of the time, while they're in training, will be spent in the correctional facility.

MR. BRIGHT: What about using doctors who aren't licensed, generally?

DR. GOLDENSON: Well, I mean, I think that should not be allowed. The physicians working in correctional institutions need to have the same qualifications, the same licensure as someone working anywhere else.

One other point I wanted to make is that a lot of systems are starting to make more use of mid-level practitioners, such as nurse practitioners and physician's assistants, and in some of the more rural areas in San Francisco even we utilize nurse practitioners to a very large extent in providing the care. My experience has been that they're younger, they're more motivated, they're excited about working

and taking care of patients so that we've had a very good experience using nurse practitioners. And in California they're starting to make an effort to do that also because, unfortunately, a lot of the physicians that we're finding in the California prison system are retired physicians who may have been anesthesiologists, radiologists, pathologists, positions where they really didn't have primary care responsibility and so cardiothoracic surgeons dealing with some very complex medical problems.

So it's not only a question of what their licensure is or -- it's also are the people who are seeing -- are they trained in the skills that they need to -- are they credentialed and do they have the current privileges to really provide the care that's necessary and, unfortunately, as Bobby said, our findings were upwards of 25 percent of the doctors working in the California system were either incompetent or inappropriately credentialed doing the kind of care they're doing.

SENATOR ROMERO: Commissioner Maynard.

MR. MAYNARD: Thank you. I have a question for Dr. Goldstein and Dr. Cohen both, and following up on Mr. Wallenstein's testimony about accreditation of ACA or NCCHC accreditation in support

of that, I would like to know what your position would be about that type of accreditation and if not that type, what type of standards do you think that the healthcare should have? And you can be very brief in your answer.

DR. COHEN: I'm a member -- I'm on the board of the National Commission For Correctional Healthcare, I represent the American Public Health Association, and the American Public Health Association also issues standards from medical care. It just issued its third edition. The standards are a positive thing. The national commission standards are too easy sometimes, the American Correctional Association standards, historically, have been not adequate, although they're making an effort to improve that right now. It's not sufficient, though. I mean, it definitely improves it.

I do think that it's important to recognize that even if medical care is a core competency of correctional administration, there is a fundamental conflict between medical care and the other competencies, which are control and punishment. And these are -- medical care is not about punishment, it's about palliation and support, and these are in conflict. And when the medical staff don't realize

that they have to be in conflict, then in order to achieve their goals they have to -- this doesn't have to be ungentlemanly or ungentlewomanly, it can be respectful, but it can't be simple, it can't be that everything is okay.

When you send someone out of the facility, it means you are disrupting the facility. When you are ordering pain medication, you are potentially allowing pain medication to be in the institutions. When you are declaring an emergency, you are moving people around who perhaps should not be routinely moved around. So there is fundamental conflict.

MR. MAYNARD: What would be your solution to those problems?

DR. COHEN: Well, just -- my solution is to make sure the medical staff value their competency and the importance of maintaining this conflictual yet workable relationship. That they understand that if they need to do something and correction says no, if they really need to do it, they have to fight for it.

SENATOR ROMERO: Director.

MR. WALLENSTEIN: I agree with my colleague, but the remediation is enhanced management.

I mean, it is a top-down issue.

The Supreme Court told us you do it or you pay and you pay and you pay. So if administrators are selected who don't understand that it's a core competency or don't work with the staff so that conflict can be mitigated, as you so appropriately stated, you are not doing your job as an administrator.

Sure, we have staff, does John have to go out for the eighth time? NCCHC took care of that, they said nonmedical personnel shall not intrude in providing medical services. So a warden doesn't determine who needs to go out. Yes, you might wait for four police cars if the person is an escape risk, but the issue of the going is a healthcare decision and you either do it or you pay the penalty for failing to do it. That's why I make the point of core competency.

The modern manager today, given the Supreme Court engagement and involvement, knows you must blend the two, it's part of doing business.

SENATOR ROMERO: Commissioner Rippe, followed by Commissioner Schwarz.

MR. RIPPE: Yeah. One of the issues that the United States military faces is otherwise

healthy young men and women coming in really need dental care and it's mandatory after that to have a dental checkup.

Can you all address how we do dental care for inmates, especially long term ones?

DR. COHEN: It's -- there are -- most places, most states do a dental evaluation on intake for all prisoners. There are too many teeth pulled versus restorative work. I think it -- in some of the systems I have seen when under court order it's been okay, but I think -- it has not been litigated a lot, in my experience. I think it's probably nowhere near what it should be. There are a lot of extractions.

SENATOR ROMERO: Commissioner Schwarz.SchwarzI have one question for Dr. Goldenson and one question for Dr. Cohen.

Dr. Goldenson, for you -- maybe I'll do both questions and then turn it over to you.

For you it's -- you mentioned that the federal government will not supply Medicaid or Medicare payments to people who are incarcerated. Is that also the case for other people who are in institutional settings or are custodial settings singled out?

And the question to you, Dr. Cohen, is

about abuse and whether doctors see abuse and report it and, more generally, if you could comment based on your experience on whether there are difficulties or barriers to a group like us assessing the evidence on the extent to which there is or is not abuse in facilities.

DR. GOLDENSON: As far as I know, the loss of the health benefits is only for people who are incarcerated. People who are in mental hospitals, for example, maintain their benefits and that's how a lot of the care gets paid for, for people who don't have money. So that, again, I could be wrong on this, but my understanding is that it's the fact that someone is arrested and put into a correctional facility, they automatically lose their benefits.

DR. COHEN: I am sure that there is a substantial underreporting of violence in America's prisons right now. Traditionally, when there is an injury, there is a requirement for a report and medical staff have a component to that report. These reports actually usually end up being 20 to 50 pages of multiple observers.

What's important in terms of the data that's being collected is that the prisoners are not asked what happened, as part of the -- by the

physician or by the nurse examining them. There is some analysis, perhaps, by corrections, but the medical staff don't ask what happened.

And, for example, when I worked on Riker's Island, there was an epidemic of people falling out of their bunks and there was also an epidemic of people who were slipping in showers. This happens in prisons throughout the country. So there is lots of violence which is described as nonintentional violence, which is actually intentional violence, and I think it's very important that prisons begin specifically understanding it's a public health issue, which actually our country is engaged in for CDC in terms of they have a whole section on violence, but intentional versus unintentional violence, to identify that within prisons.

Also, there is -- medical staff do not, in this country, on a routine basis report violence that they observe. This was clearly a problem in Iraq, Afghanistan and Guantanamo and is also a problem in our country. I think one of the solutions to that is to bring into the United States international conventions against torture which specifically are designed to talk about conditions in prison, and make a requirement that medical staff report any

observations of violence to appropriate authorities within the institution. And the corollary of that would be that failure to make those reports should bring sanctions on to physicians.

SENATOR ROMERO: Commissioner Schlanger.

MS. SCHLANGER: My question is about private providers of healthcare services. And what Dr. Goldenson and Dr. Cohen said before is pretty uniformly negative about for-profit providers.

I wonder -- it seems like that's not going away so that uniform negativity is not -- hopefully, there's some opportunity there as well and I wonder where that might be and one idea that I have is about jails. I wonder if the private providers of healthcare, in small facilities especially, have the potential to bring in some kind of larger scale expertise that small jails just don't develop because they don't have sufficient people. And if that's something that there's any policy or recommendation or something that could move further in that direction, if there's anything constructive that could come out of this increasing privatization of healthcare in jails or prisons.

So I don't exactly know who is best to

answer that so I wonder what all three of you think.

MR. WALLENSTEIN: I've chosen not to utilize private providers. That doesn't mean there are not some that are not quite competent and, frankly, most of it relates to the development of the RFP and the degree of accountability. You get what you ask for and if you haven't built in core competencies and very detailed protocols, then you shouldn't expect to receive them.

Many jurisdictions are not very good at writing RFPs or requests for proposals and then in having highly competent contracted administrators review the nature of the work.

So I think there needs to be -- before a local jurisdiction embarks upon this there needs to be a real recognition that this request must be highly professional and must include, in total, the standards of the National Commission on Correctional Healthcare, the American Correctional Association or, frankly, it isn't worth engaging in that course at all.

I happen to believe public employees can do it better, and that's just a personal prejudice of mine, it does not mean there are not some very well-intentioned private providers but you need to monitor these issues until they drop.

DR. COHEN: I agree that the contract is -- I mean the important thing is the contract and the RFP. I mean if there is an ability to make money by not providing services, then that's going to happen. Small jails can -- could utilize the -- you know, potentially I mean, PHS or CMS or all these places will, in an hour, give you a proposal which will be very, very impressive, and Power Point, but whether that actually means anything within a facility, I'm not sure.

And, again, in the New York Times articles where the deaths were reported in small jails in New York state, these were almost all for-profit providers that were running the services at those times.

SENATOR ROMERO: Commissioner Sessions.

JUDGE SESSIONS: We've heard testimony over the last two days about the involvement of federal courts in mandating certain things.

Are there also mandates from state courts that relate to medical care that you have discussed?

DR. COHEN: In Pennsylvania, the Philadelphia -- there are two consent agreements in Philadelphia simultaneously, one federal and one

state, and I monitor the state, and it was very helpful, I think, to the system.

I think -- I'm not a lawyer, but I -- but my sense is that depending upon where the courts are, what the district is like, that state courts can be used as a forum for improving healthcare.

JUDGE SESSIONS: Is that true in California?

DR. GOLDENSON: I don't know if they can be used. I'm not aware of it ever happening and I know the state -- all of the -- there have been a number of lawsuits around healthcare, mental healthcare in the state prison system, dental care is one, Americans with Disabilities, and they have all gone through the federal courts and then most of the individual counties where -- that I am aware of with that consent decree, it has also been through the federal court.

JUDGE SESSIONS: Director.

MR. WALLENSTEIN: Over half of the states have state standards for jails.

JUDGE SESSIONS: Yes.

MR. WALLENSTEIN: Those standards can be enforced generally through the administrative process and then through state courts, but I will tell

you, the standards that are mandated in those documents inevitably came down through federal court intervention at one time or another. So the federal court is still a very friendly forum, not only for prisoners and their advocates, frankly, but for institutional administrators like myself, who want to be ordered to do things in an appropriate way.

It's almost striking to me because I thought this issue of healthcare, absent individual cases of problems, had been put to bed 25 years ago about the importance of healthcare in correctional institutions.

JUDGE SESSIONS: Dr. Goldenson, we have talked about the receiver appointed by Judge Henderson. Who was that appointed, do you know?

DR. GOLDENSON: The decision hasn't been made yet as to exactly who it is. The judge is considering a number of possibilities right now.

JUDGE SESSIONS: Talking about Medicare and Medicaid being taken away at the time they become incarcerated, is it restored when they are back out, even on parole, or is it still unavailable?

DR. GOLDENSON: Well, once someone is released from custody, then it is restored, so it's really suspended while they're in custody. Once

they're out of custody they can -- in most situations it's been suspended so that it's not difficult to get it started up again.

A lot of places I've been to are not aware that you can suspend it so it does get terminated, which means then the person has to reapply and that can take months to happen. So that it depends what jurisdiction is and what they're doing, but it really is for the period of time that the person is incarcerated that they lose it.

JUDGE SESSIONS: So this is nationally and not just California?

DR. GOLDENSON: Right, it's a federal law. From what I understand, it's the federal law that distributes the funding, mandating that the states cannot use it for anyone who is in a correctional facility.

JUDGE SESSIONS: Yes?

MR. WALLENSTEIN: I would like to respond on the county level. This is an unbelievable issue and I hope the Commission understands it. To take away benefits at the jail level from a person who has not been found guilty, to me has always raised an equal protection argument. Two people who are mentally ill, both arrested on the same day of the

same crime, one makes bail, one goes home, one goes to his provider and the other is removed from benefits. It makes no sense for the 10 million who are engaged at the local level.

Plus, remember, taking mentally ill people -- and that's a topic for this afternoon, which is a far more serious issue in my estimation, it isn't like us getting in our car and going to a location. Simply getting from point A to point B for most offenders, as you heard this morning for the gentleman from New Jersey, may arrive at a level of sophistication that simply isn't done.

Frankly, these benefits should be restored before the persons leave and it should be required that every institution in the country bring in social service, Social Security Administration, whatever is required so the benefit card is present the day they walk out.

MR. SCHWARZ: Did you actually say that someone losses their Medicaid and Medicare when they're put in a jail before they have been convicted?

MR. WALLENSTEIN: Yes, they are, suspended the day they walk in and, in many cases, it is revoked, not suspended. Many of us believe it should be suspended, fine, but, certainly, go into

practice the day they set foot back in the community.

JUDGE SESSIONS: Dr. Goldenson or Dr. Cohen or Director, what is the percentage, generally, of inmates who actually would otherwise be in mental institutions or have mental problems?

DR. GOLDENSON: National statistics are that anywhere from 12 to 20 percent of people in correctional institutions have serious mental health problems, which is like severe depression or psychosis or something like that. So not all those people would be in another institution, they might be in community care, but they would be on medications, they would be in residential programs, maybe mental hospitals, but they certainly do not belong in jail or prison.

And one of the things I was going to say, if I had more time, is the big issue is really, to me, the overcrowding of our jails and prisons and that there are so many people now incarcerated. Some of the prisons in California have five, 6,000 individuals in one facility that was supposed to hold two or 3,000. There's just no way you can develop a medical system that's going to be able to adequately function in that kind of setting. And so many of the individuals who are currently incarcerated either have mental health problems or substance abuse problems

that can and should be treated in the community or, at a minimum, have treatment -- they'll talk about this this afternoon I'm sure -- treatment in the facilities so that these folks don't get released and come back. I mean, within those two groups the rates of recidivism are extremely high.

JUDGE SESSIONS: Dr. Cohen.

DR. COHEN: I know the Commission understands, but I just want to stress that this discussion is taking place in aberration. That there are 2.2 million people in prison and jail in the United States today, with a rate of approximately 750 per hundred thousand and in France the rate is 75 per hundred thousand, in England the rate is 120 per hundred thousand, as it was in this country a number of years ago, and their rates of increase have been dramatically less than ours. The murder rates in Europe are one-fifth of what they are in our country and it becomes difficult or impossible, I think, to ratchet up, to scale up, to use sort of these industrial metaphors from Dell, you know, about their servers, when we're talking about humans in prison.

These institutions change qualitatively when they have so many of our people in it and, again, you know, this issue, I'm sure, the Commission is

addressing, you know, it's not just random people. You know, the chance of a black man being in prison is six times greater than a white man being in prison, but these numbers create the problems that you are describing today and there is no reason why there needs to be 2.2 million people in prison.

When all of us began our work, some of us felt that if we could take Belvy(ph.) -- (inaudible) -- and Estelle and say we had some equivalence principle of care, that the cost was going to be the same for prisoners or more because of the turnover than it would be for people outside of prison and by getting prisons to provide adequate care, forcing them to spend the amount of money that was required to do it right, that we would stop the growth of prison because it would be too expensive. Wrong.

JUDGE SESSIONS: Thank you. Let me give you another question --

SENATOR ROMERO: Commissioner Sessions --

JUDGE SESSIONS: I just got to ask. This may be incidental, but when an inmate goes into a clinic, does he become the patient of a doctor or does he become patient of the clinic?

DR. COHEN: It depends on the place.

Some places have a model where people are regularly seen by the same doctor, some places they're not.

JUDGE SESSIONS: You said that they could not be treated for hepatitis C. Can they be tested for hepatitis C and are they?

DR. COHEN: In OSP, when we started there --

JUDGE SESSIONS: OSP?

DR. COHEN: Ohio State Prison, they were not being tested or treated. They are now being treated, but that was because of the court intervention. The rest of Ohio would not be treated.

SENATOR ROMERO: Commissioner Nolan.

MR. NOLAN: Two issues, one is about dental care. My understanding from a lot of discussions on this, one of the reasons there are so few lawsuits about dental care is it's not life-threatening so it doesn't raise to the level of scrutiny. My experience is teeth are pulled -- either let them rot or they're pulled. In fact, when I was in prison I never saw so much flossing in my life because they're very protective of their teeth, they know they only have one set issued and they'll lose it. But that is a substantial problem of discomfort, pain.

Now, the second prison I was at they did send out for dental care, they put dentures. It was a much healthier system for the esteem of the inmates for their visits.

But the second issue, I would really compliment Director Wallenstein on the superior institution that he runs and at the risk of overstepping my bound, I visited his facilities right near Washington, D.C. and I know many of the commissioners come into Washington and walking through it, talking to the inmates, talking to staff, which I was totally free to do, it's astounding a jail, the lack of noise, compared to the noise level in most jails, it's just astounding, but the respect with which the inmates treat each other and the staff is remarkable and it's because of Director Wallenstein's leadership.

So I would hope that at some point when your travels take you near DC, it's not very far outside of it, and he was most hospitable and it was very instructive.

SENATOR ROMERO: Commissioner Green.

MR. GREEN: This is a question that's directed to Dr. Cohen and Dr. Goldenson, or maybe both will comment on it.

It's hard for me, and I guess as many of us on this Commission, to understand how healthcare is administered in a prison. I mean, we know what happens when we go to the doctor or when we end up in a hospital and I think about this in light of I think it was Dr. Cohen talked about how diabetes was handled in terms of the administration of Insulin and the person who was shackled to be examined.

How close to what we consider typical is medicine administered and at what impact does that have on the quality of the doctors or nurses who come in and our ability to recruit doctors and nurses into the setting; are there danger issues? What is the relationship like to administer medicine?

DR. COHEN: Well, the routine is that if the prisoner wants to get medical care, they request it through some process, which is called a kite or a sick call slip or they sign a piece of paper, and in most -- I don't know in most -- in increasing numbers of prisons and jails in the United States today once they do that, they're committing to pay for their care. There is a co-payment which is required in Ohio, in Michigan, not in New York state, but in many, many, many, many facilities right now. So they are now committed to pay three to $5 for the

care, which is a barrier, which is a barrier that we face also and I -- but so they put in the slip and then they -- usually a nurse, in some systems, in California, I believe, a nonmedical -- a non-nurse, a medical technician would review that and decide whether they can treat it or they need to refer to -- a nurse had to see the patient or a doctor had to see the patient and there would be time delays, depending upon the situation, how long someone would be seen.

I don't think that the medical staff feel that they're endangered in prison, although they fully accede to policies which make it appear as if they are in danger. So, for example, in segregation units doctors and nurses will allow for the kind of shackling that I described on a routine basis, even though they know the prisoners are not dangerous to them. Maybe I'm just -- you want to add to it?

DR. GOLDENSON: I will just say in terms of some of the more chronic diseases, like diabetes, that in the better systems there will be chronic care programs set up so that people will be seen on a regular basis, that they will get their medications, that it's not dependent on the patient him or herself putting in a slip for those kinds of problems, but once they get enrolled in the program,

then they're seen on a regular basis, the same as if you or I went to see our doctor and they said come back in three months.

Unfortunately, that's not true in a lot of systems. It's true in some and not true in others. It's what the direction things are moving, but I think a big problem still exists in facilities that I've seen with people getting their medications so that people who need Insulin or blood pressure medications are not routinely getting them all the time, that people who need to be seen and treated for their blood pressure aren't getting seen.

So that one of the things we found in California was not only were people dying -- you know, the acute, medical emergency type problems, but that people with diabetes, hypertension were dying from strokes and other things that were complications of their chronic illnesses that if those illnesses had been appropriately treated, they wouldn't have ended up dying. So that the deaths we were seeing were both preventable, some of them, if they just got appropriate emergency care; others, if they got appropriate care for their chronic illnesses.

SENATOR ROMERO: Commissioner Dudley; and then we are running out of time. We've got two

more commissioners wishing to speak and then we'll probably conclude the panel.

DR. DUDLEY: Putting aside the population of unlicensed or grossly incompetent doctors, I get the impression you are saying there are still going to be some good doctors in the system and some who have a variety of other issues that they bridge and I'm wondering what is your thinking about whether that group, you know, whether training or education or something can be done to better develop that group or should we get rid of them too, number one.

And, number two, what is your thinking about the responsibility of the profession to do more with regard to the training and development of a core physicians who -- should this be a specialty, for example, I mean, should there be something that's going on to develop a real interest in a pool of physicians who might be able to work in this setting?

DR. GOLDENSON: In response to your first part of your question, the competency of the physicians, one of the things that I think I found most shocking in terms of my involvement in the correctional medicine is the number of physicians and nurses that I have come across who, you know, clearly

are competent, they're educated, they know what to do, but they really dislike the patients, they feel the patients don't deserve medical care, they think they're all manipulating, trying to get drugs or trying to not work, and they just have a total disregard for the patients they're taking care of. And, you know, on one level, I will accept that there are people who are not going to like prisoners.

What's shocking to me is why someone like that, who has a medical education, who spent all that time learning a profession where they can help people would choose to work in a correctional facility. And if they have that attitude, I don't agree with it, I think it's wrong, but they can have the attitude, but then they shouldn't be working in corrections.

And I think a lot of it gets back to what you were saying earlier about the -- what's the messages coming from management and all too often that kind of an attitude is accepted by the officials higher up because it means it's less work for them, it means that you are not going to be sending people out, you are going to have cheaper medication costs.

I mean, one of the things that we saw in Ohio, when they brought in -- urging a physician

who really wanted to take care of the patients started ordering more medications is the nurses got very upset because, partly, it meant more work for them; they had to start going out, giving out more medications, they had to respond to what the patients were complaining about.

So I think there is, in addition to all the other problems we've discussed, there is a real problem in terms of attitudes and I think there needs to be a very strong message from administration that that's not going to be accepted and that when you are hiring people, that that needs to be part of what you are looking at, is what are peoples' attitudes about the population they are going to be working with.

DR. COHEN: I think that it's important to recognize that these are closed to forming institutions and that there are rare individuals who can professionally -- who can spend a career in them and not be hurt by the daily violence that takes place in prisons and I don't encourage -- the fact that someone has a lot of correctional experience does not look good to me on a resume. It might be fine, it might be terrific, but it might be a problem, and that's not to say there aren't spectacular nurses and doctors who have spent their lives trying to help

people, but it's everybody and it's a lot of people who can't.

And I think one of the things that needs to be done is to figure out how to identify failures. And I think one of the problems with the national commission and other standards is that they look at the institutional function and don't use, as the unit of quality, the individual patient. And that's not easy to do, it takes a lot more work, but if you don't do that, then people will suffer and the institution can look okay because so much of the volume of material is routine and will come out okay anyway.

If 90 percent of the people get their specialty consults, that looks okay if you say 90 percent is okay, but those ten percent who didn't were people who really had the complex problems that required urgent care, then you get the kind of things we all find.

SENATOR ROMERO: Director.

MR. WALLENSTEIN: I am very much opposed to a specialty in correctional medicine. NCCHC has argued we must meet community standards of care and the way you maintain that is by filling your institution with people with community experience.

DR. COHEN: I agree with that.

SENATOR ROMERO: Commissioner Gibbons.

JUDGE GIBBONS: Two quick questions.

First of all, we have a lot of private prison contractors in this country today. Do those contracts typically specify in any detail the obligation of the private contractor to provide healthcare?

The second question I have is are there any studies that we can be referred to with respect to the economics of private healthcare provider contracts as distinguished from the public health department model?

DR. COHEN: I don't think there are too many -- there are barely studies which compare state by state -- you know, adequately in terms of looking at the actual dollars, so I don't think that that is available for you. And I think we -- you know, we -- my experience, and Dr. Wallenstein's also, is that the contract can describe in great detail the amount of care and I think it's important that those contracts and settlement agreements micromanage the kind and quality of medical care that's being sought.

SENATOR ROMERO: And then I have one last question, we'll conclude the panel, although I

know that many others have other questions and we can follow-up during the lunch, I would hope.

Precedent was set in California with the appointment of the receiver. What message does this send to the rest of the state, both state prisons and jails; is that good news or is it bad news?

MR. WALLENSTEIN: I have no problem telling you that in large measure it's a return to practice of the late '70s and the early '80s when major class action suits were filed in this country.

Hopefully, my generation of administrators and my colleagues on this panel don't need that because we know what it is we have to do and we can manage to the exception not to having to see the entire house tumble down. So it's most likely an excellent wake up call, if, indeed, the practices were so negative.

DR. COHEN: I think there is another message. Although it wasn't a unanimous decision, Justice Stevens wrote a separate opinion in Estelle v. Gamble and he criticized the majority for requiring deliberate indifference rather than just doing the right thing. And, additionally, he quoted from a report from a legislative commission in California in 1972 which described exactly what Judge Henderson

described in his report today with actually malicious behavior on the part of doctors towards patients and unqualified medical technicians delivering a large amount of medical care.

So I think we have to say not that there's management failure, although there are management failures, but 30 years later what have we accomplished and what's happened in California during that time? The population is 165,000 people. You may not be able to do it and maybe you shouldn't and maybe there are other ways to organize society without having so many people in prison. I think that's the lesson that the constitutional solution has not succeeded to this point.

MR. WALLENSTEIN: Robert has raised a really good issue and a tough one for the Commission. Are you going to recommend that we meet standards for this incredibly inflated prison condition or is the Commission also going to engage in the issue of why we have so many people in custody? That's your issue to deal with.

No doubt, when Justice Marshall wrote his opinion in 1976 he never anticipated the size of the American correctional system that we have today and that's a very difficult issue.

SENATOR ROMERO: Dr. Goldenson, you have the last word.

DR. GOLDENSON: I think it's a very strong and a very good message to both the California system because I think it's a very hopeful message to me. I mean, we're going around telling people that, look, this is an opportunity to take a system that's totally broken and turn it into a quality system and we're going to work with you to do that.

And I think one of the things that's important to recognize is that the state did not oppose the appointment of the receivership at all and almost welcomed the assistance from the court in dealing with something which they acknowledge was something that they were not doing very well. And I think it's a message to other states that, one, they need to make sure that they're providing appropriate care; otherwise, the courts will also get involved in those situations.

So I see it as a very strong move forward by the judge and my concern is the same concern that's been raised here, that given the magnitude of the problem in terms of the numbers of people who are incarcerated in California, estimates are from the state itself that immediately they need

to hire 150 qualified physicians. You know, I question whether with a receiver or with whatever you're going to be able to find, today, 150 physicians who want to work in the situation that California is currently in. And my feeling is, and I've said this to the judge and at the status conferences, that healthcare is a constitutional issue and if you can't provide the level of healthcare that's necessary, then you have to reduce the population. I mean, it's either one or the other and you just can't keep building these facilities, knowing that you are not providing the necessary care.

SENATOR ROMERO: Dr. Goldenson, Dr. Cohen, Director Wallenstein, we want to thank you very much for your very informative and expert testimony. I think you saw all commissioners were engaged in questioning. We appreciate the insight you've given to us. We look forward to hearing additional recommendations from you as we go forward.

And I think is it? All right. It's lunch. Thank you.

(Luncheon recess.)

EXPERT TESTIMONY ON THE PUBLIC HEALTH IMPLICATIONS OF HEALTHCARE IN FACILITIES

MS. SCHLANGER: So I think we'll get

started. On behalf of the Commission on Safety and Abuse in America's Prisons, I'd like to welcome Dr. Robert Greifinger, Dr. David Kountz and Secretary Jeffrey Beard.

This distinguished group has agreed to appear before us today to address the public health concerns that arise in prisons and jails and, in particular, the health risks and financial costs created by failure when it occurs to adequately detect and treat infectious diseases in prisons and jail populations.

Our last panel discussed the most serious failures to provide adequate medical care in jails and prisons and some of the consequences of those failures, but I think we even began to hear last time, and we certainly heard some yesterday, that the consequences of inadequate medical care in prison extend far beyond the prison walls.

Most of our inmate population and all of our nation's correctional officers return to their communities. According to research conducted by Dr. Greifinger and others for the National Commission on Correctional Healthcare, in 1996 alone, somewhere between 1.3 and 1.4 million people infected with hepatitis C were released into the general population

from prisons and jails and an estimated 560 some odd thousand inmates with TB infection returned to their communities after some form of incarceration.

These numbers only scratch the surface of the health problems prisons and jails address daily and we hope that this panel which help us to identify risks and think creatively about solutions to the public health challenges our prisons and jails pose.

I guess in particular there's this question of whether prisons and jails are posing a challenge or presenting an opportunity for public health and medical professionals and from looking at the written versions of your testimony, I think that you would have a lot to offer on which of those or whether both of those are the right way to think about this question, so I hope you will do that.

The three members of our panel have extensive experience in managing prison and jail healthcare services and so let me start by introducing them.

Dr. Robert Greifinger has worked in correctional healthcare for 18 years managing health services at both Riker's Island in New York City and for the New York State Department of Corrections. He now works as a consultant examining the conditions of

confinement and health services in over 100 correctional facilities in 33 states. I assume not all at once. Dr. Greifinger will help us to understand the scope of the problem and the opportunities we have to address the risks through improved correctional healthcare.

Our next witness, Dr. David Kountz, is a specialist in internal medicine, the chief of primary care services at Robert Wood Johnson University Hospital and the management director of the Somerset County Jail here in New Jersey. Dr. Kountz will speak to the unique challenges that short term jail confinement poses in screening and treating infectious and chronic diseases and will address the value of the partnership between his medical school and the county jail.

Jeffrey Beard is the secretary of the Pennsylvania Department of Corrections and he spent a long and successful career in corrections management. He brings knowledge and expertise about the connections and about the various issues we're grappling with today and he can help us explore models for success. He will speak directly to the strategies that Pennsylvania has employed to address the public health challenges posed by an incarcerated population

and to protect the health of both inmates and correction staff.

So once again, let me thank you for coming and testifying today and I'm confident that your testimony will be really invaluable to us and so I'm looking forward to it.

Our business, I've been instructed to give you each -- to tell you each that you have 12 minutes. I'm not keeping time, however, that's over there, she's keeping time. At the end of the 12 minutes I may start off with a question or two and Judge Sessions will also help us get things started and, at that point, we'll open it up to the rest of the commissioners for other questions and to the panel for answers.

So I think we'll start with Dr. Greifinger. Thank you very much.

DR. GREIFINGER: Thank you, Margo. After the news announcement last night at 9:00 I want to say, may it please the Commission.

I am very pleased to be here myself and I want to talk with you a little bit about a journey that I've been on for the last 18 years. I began a journey 18 years ago to try to learn a little bit about the health status of the inmates, to learn about

access to medical care and quality of medical care for prisoners, to learn about the burden of illness. And after that I wanted to learn, well, how can we measure performance the way we do outside in the free world? How can we identify barriers to reasonable quality of medical care and to reasonable access to medical care?

And then I asked myself the question what can I do to help formulate solutions, to formulate remedies so that we can address some of the challenges that we've identified?

What I found early on was this was not just about humane or legal treatment of inmates. This was all about our health. It was about my health and yours and the health of our families because, among other things, the burden of illness among inmates is really very, very extraordinary. As you know, inmates as a group in the United States have extraordinary prevalence of communicable diseases such as sexually transmitted diseases, tuberculosis, viral hepatitis, HIV and the recent scourge that we've had throughout prisons and jails across the country is drug resistant skin infections.

I also learned on my journey that the quality of medical care varies really tremendously across the country. Some healthcare programs such as

the one Dr. Beard is going to discuss with you are really excellent. And others in this country, too many of them are shameful with the kind of -- and I've seen the kinds of things that Drs. Goldenson and Cohen described with shameful, not only in terms of what we do to the individuals, but shameful in terms of the risks we put our staff to and the risks of the public health.

Just recently, in the last couple of years -- again, I'll give you a few examples -- I was at the Julia Tutwiler Correctional Facility for Women in Alabama and there was a woman with active contagious tuberculosis. And was she in a respiratory isolation room? No. She was walking around the infirmary and walking through the segregated unit for HIV infected women, the most vulnerable to tuberculosis of anybody in this state. But that was not alone.

I went to Parchman Prison in Mississippi to another unit that segregates HIV-infected inmates and I found an outbreak of boils that went throughout that unit, with dozens of people having boils that were weeping puss, but no one was looking at it and trying to address it from a public health point of view. So not only were the

HIV-infected inmates at risk, but so were staff that worked there, the medical staff, the correctional officers and so were their families to whom they each returned at the end of the day, each day.

A few years ago at the Fulton County Jail in Atlanta, Georgia the care of HIV-infected inmates was essentially denied; it wasn't being given, and so people were dying. There had been something like -- I don't remember the exact numbers -- 29 deaths in 24 months, which when that system was fixed -- because of a consent decree and great work by the Southern Center for Human Rights, when that system was fixed it went down to two deaths in the next 24 months, so you can really make a big difference and protect the public's health.

I've learned on my journey that there's widespread ignorance about the value of inmate medical care, not just to the inmates themselves, but to all of us and to our families and to our communities. But I don't understand why we don't seize these opportunities that are there. Isn't it only rational to put our money in places where it makes the most sense for public safety, where it makes the most sense for public health?

The only thing I've learned is that

good policy often doesn't make good politics and that leads me to the conclusion that we need better leadership. We need leadership from each and every person on this Commission and from anyone who is going to take the time to read your recommendations. We need leadership that says this is in our interests, because the public forgets that every inmate who returns to the community with an untreated sexually treated disease or with HIV or with hepatitis C or tuberculosis puts our children at risk. Every inmate who returns to the community with untreated mental illness or with treatment that is interrupted, it's aborted on re-entry into the community puts our public safety at risk. Every inmate who returns to the community with untreated drug addiction puts our property at risk and puts our safety at risk.

We need to think about this window of opportunity that we have to really make a difference. So our challenge is to try to make good politics out of what is clear, I think, to everyone about what would be good public policy and I would like to give you seven steps. This may sound like a one-minute manager type of a talk, but I think there are only and simply seven things we could do that could really make a difference beyond the larger issue that was

discussed earlier, and that's to put fewer people behind bars, finding call it diversion programs or whatever through drug treatment and treatment of mental illness and perhaps being less harsh with some of our crimes.

But for the people who we are going to put behind bars, we need to do seven things. Primary and secondary prevention, that's number one. By primary prevention I mean preventing things from ever happening in the first place. Good examples of that are vaccines. If you get vaccinated against hepatitis B, you are not going to get hepatitis B. If you get vaccinated against influenza or pneumococcus, you are not going to get those diseases.

Secondary prevention means the early detection of something that's there in a medical intervention that's going to lead to cure. So if we screen for sexually transmitted diseases, we can cure those before they infect other people in the community. If we screen for HIV and hepatitis C and tuberculosis, we have short run gains, we're protecting against transmission in the community and there are good data -- if you look at the report to Congress on the health status of soon-to-be-released inmates, you will see good data that it's cost

effective for our society to do these -- this primary prevention and this screening and intervention. There are cost savings which will accrue directly to our society. But we can't be fooled by that, they're not cost savings that accrue directly to the Departments of Corrections which will have to bear the cost.

So when we allocate monies for correction, we have to remember that there will be cost savings for us socially and it may be worth a penny investment to get a dollar return by adding a public health agenda to our correctional budgets.

Second, alcohol treatment and drug treatment is mandatory. We don't do enough of it, everybody knows that. Drug treatment is effective, alcohol treatment is effective, not in everybody who goes through and not always the first time, but if you look at the data, there's cost effectiveness and we can't control this vicious cycle of people going -- reentering the community and getting back on their substances to which they're addicted, we're going to have this vicious cycle of recidivism, increased cost and danger to public safety.

As Dr. Cohen and Dr. Goldenson emphasized, we need to have a quality of medical care behind bars, it's the same as the quality in the free

world. There's no reason that it should be different. There's no reason that we should be treating hepatitis C differently behind bars than we do outside in the community. There was no reason for three or four or five years during the late 1980s when we were denying treatment to HIV-infected people after there was treatment available and there's certainly no excuse today. And there's no excuse to do that for hepatitis C and there's no excuse not to look for and treat sexually transmitted diseases and other curable diseases.

If the problem is we have treatment that will last longer than the term of incarceration, then our challenge is to find a way to have continuity and coordination of care on release so if a person is partially treated while they're inside, the minute they step out the door they've got insurance coverage and a place to go where the medical records can be transferred and they can continue their treatment.

We need to recognize the huge value of preparation for re-entry. We heard good testimony this morning about some of the problems. We know there are terrible consequences to inmates, especially those who are -- are coming off long-term incarcerations. We need to learn more about what

works. We need to learn more about how to build linkages with public health departments, with community mental health centers, with community health centers and other private resources in the community.

We need to acknowledge and reduce five barriers to change that I see. We've got the leadership problem that I've mentioned earlier, and I think that's the most critical. We've got a problem with cynicism. There is a cynicism that's pervasive, that keeps us from being able to do our jobs as professionals. We need to do research and evaluation and we need to learn more about the consequences of incarceration.

So I'm asking you to help find a way to view inmates as public health sentinels. We all have contact with returning inmates, we all have responsibilities, we all stand to gain economically, as well as gain in terms of our health. We need to learn how to promote the notion that public health is public safety. Thank you.

MS. SCHLANGER: Thank you, Dr. Greifinger.

We'll move to Dr. Kountz.

DR. KOUNTZ: Thank you. As the only resident living and practicing in New Jersey on this

panel, let me welcome all of you to New Jersey and thank you for this opportunity to share my perspectives with you.

I'm going to touch on two themes that I think I'm best qualified to comment on. One is the public health issues in jail settings and then to share some observations on a relationship that we have had at our medical school with a county jail and speculate on how this type of relationship might be in the public's best interest to expand into different communities to do some of what we have been able to do in the last seven years.

The care of inmates in jails should be of central concern to all citizens. Well-designed protocols and opportunities for follow-up are available in many prisons, but less so in jails, with more rapid turnover of inmates and greater challenges to make accurate diagnosis and initiate appropriate treatment.

One of our greatest challenges is the identification of infectious disease in our jail setting. There is a rich literature on the prevalence of infectious diseases in prisons, but not nearly as much as jails. It has been suggested that infectious diseases are even more prevalent in jails than in

prisons, as the rapid turnover makes diagnosis challenging. Further, there is a natural tendency to deal with acute crisis type medical problems, such as drug withdrawal, uncontrolled diabetes and accelerated hypertension.

This winter and spring, as I believe you heard yesterday, many jails and prisons focused their attention on an outbreak of a new community acquired -- community-acquired resistant staff aureus or MRSA. A relatively new infectious disease that was at risk of rising to epidemic proportions in institutionalized settings. It was through the superb oversight in communication between our staff and the state and county Department of Health that this potential epidemic was halted.

Here are some examples of the steps that were taken to control this infection in our facility. Because of our close working relationship with our state DOC, as well as our county Department of Health and dissemination of new information at the medical school, we become aware of the increasing number of cases of MRSA. Memos were crafted to our staff (medical, nursing and correctional staff), as well as inmates regarding surveillance and prevention.

We obtained resource material from the

Bureau of Prisons and worked with the administrative leadership in the jail regarding putting in place enhanced infection control strategies. A specific skin infection log was initiated using New Jersey Department of Health and Senior Services Data Collection Forms, which allowed pooling of data from many sites and early recognition of infection trends.

Procedures were implanted for identification of suspected skin infections, wound culturing, isolation and treatment recommendations were also put into place. Infection information sheets were posted in housing units for inmates to read and, of course, this information was available in multiple languages at low literacy levels. Custodial, administrative and visitor bathrooms had proper handwashing technique posters placed in them. Nurses and physicians spoke to inmates during intake examinations and during all sick calls visits, answering questions and reviewing good hygiene practices.

We also found that education was crucial for officers who assist in first recognition of hygiene issues and referral of inmates to the medical unit. Certainly, this was a challenging process but, ultimately, it was successful. I can say

with confidence that the number of confirmed cases were few, and that officers, inmates, visitors and staff were comforted by the degree of education and attention that this problem received.

Frankly, no stone was left unturned. The health of the public was secured through this close oversight of this potentially serious infectious process. It was encouraging for me to realize that the education of inmates was a strategy that could change behavior regarding hygiene and risk, and this bodes well when they are released.

At our institution the average duration of incarceration is eight days, but this is misleading. About ten percent of inmates are state inmates with prolonged stays. The remainder turn over much more quickly, thus, the inmate that one is most likely to randomly encounter is gone in three or four days. These statistics speak to the challenge of routine identification of high risk inmates, initiation of screening, treatment if necessary and follow-up.

Strategies to increase diagnosis of STDs is one example, or other infectious diseases, could be put into place but at what cost? Routine testing of all inmates with the use of rapid screening

tests would place a significant burden on laboratory and pharmacy costs. As suggested, this increase in diagnosis would not necessarily be translated into increased rates of treatment due to the turnover issues.

A practical consideration that we face with this population beyond cost, and perhaps this is a sad reality of our times, is managing expectations in a litigious environment. Making a diagnosis when an inmate is walking out the door places a burden on the facility to track that inmate down, certified and registered letters and other outreach. This places an additional burden on facilities that are often understaffed from the start.

Several correction centers, such as Hampden County in Massachusetts, have been effective in putting public health services in place in jail settings. Their model is not only of early detection and comprehensive assessment of health problems, treatment, disease prevents programs and health education, but also continuity of care in the community, with collaboration between the county health services department, community health centers and other local healthcare providers.

Could we develop such a model in

Somerset County or in other counties in our state where jails are present? If so, who would staff such health centers? Are local providers really out there who are willing to accept inmates as patients? These are all practical problems and ones that I have faced in the last seven years.

The value of hearings such as this is to give us an opportunity to speculate on best practice models, with a clear eye towards cost and practical processes. Most jail populations are extremely transient. The expectation that inmates will follow up in a local, that is to the jail community, is, I believe, somewhat unrealistic.

When we release records -- request release of medical records from our inmates to verify prior treatment and current medications, they are addressed across the state and beyond. Local physicians are often anxious about having inmates as patients, not just from the standpoint of image to their other patients, but also related to reimbursement.

As I conclude, let me speculate on the future and the role of medical schools to potentially advance the cause of approving care in jails. There are an increasing number of medical schools partnering

with state departments of corrections to provide or oversee all or part of correctional healthcare. In 2004 our university partnered with our state DOC to provide mental health services, and we are planning a national conference to address such partnerships next year.

As schools develop correctional health institutes or departments of correctional health, there will be a framework for expanding this mission to local jails. Medical schools, or, for that matter, schools of public health are not always the perfect partner. We tend to be inefficient and less costly, have missions that are competing, are overly bureaucratic compared with a private practice or in-house providers.

However, we have a steady stream of enthusiastic, idealistic future healthcare professionals eager to work in a variety of healthcare settings. As a medical student at Buffalo New York in the early 1980s I remember working on the ward where inmates from Attica Prison were transferred. With appropriate supervision, this was a superb opportunity to provide direct patient care and learn about infectious diseases. At that time it was beginning of the AIDS epidemic.

Medical, nursing and public health students take on community-based projects all the time. In our city of New Brunswick our students have begun a clinic providing care free of charge to citizens who have nowhere else to receive their care. Social services are also available. These examples exist in every school in this country. Why couldn't this model be expanded to counties for inmates or at centers near sites where inmates receive parole and social services?

Let me again thank the Commission for this opportunity to express my views on this important subject. To summarize, protocol driven care, attention to regional state and national trends for existing and emerging infectious diseases, chart audits and other monitoring to ensure the policies are being followed, education of staff and inmates and close linkage with county health departments are all tenets to control emerging infectious diseases. Further, I believe that there are new models that can and should be studied to provide best care for inmates. Thank you.

MS. SCHLANGER: Thank you, Dr. Kountz.

Secretary Beard.

MR. BEARD: Good afternoon. I want to

that you for inviting me here today to discuss this important topic and this is a topic that's important to us in corrections and it's important to the public as a whole.

I want to begin by saying that I believe that our prisons and jails generally do a good job providing healthcare to the inmate populations. There are a few systems where we're having problems -- California everybody has read about that in the newspaper -- and we do see problems in some of our jails and I think when we see those problems, they're largely related to funding issues and probably overcrowding.

But I believe the system works. And when the system doesn't work, the courts do intervene, just like they have in California. I would hope that we don't let a few facilities that are having problems, a few systems that are having problems or emotionally-charged anecdotal reports define what is happening in our corrections' healthcare today. If we do, we could do the same in any profession.

Just think about some of the problems that you've read about in the newspapers recently with police departments or police officers or hospitals, the high infection rates. I believe these reports do

not give us a true picture of what's going on in those areas. They don't give us a true picture of the fine job that's being done by thousands and thousands of hardworking men and women in our police departments and in our hospitals that are providing for the public's health and for the public's safety, and I believe the same is true in corrections.

And in corrections we have an even greater problem, and, that is, the public's perception of what occurs in our prisons and jails. It's a perception that is largely driven by the media who, unfortunately, in our case, reality does not sell, but sex, violence and corruption does.

If you want to know what is really happening in our prisons and jails, I ask that you take the time to visit and see what's really happening and in that regard I would invite you, and you have a standing invitation, to come and visit any prison that we have in Pennsylvania any time. Or if you would like to hold one of your commission meetings near one and come visit, please feel free to do and we'll work with you in setting it up.

Beyond visits to our facilities, if we are to conduct a review with meaningful outcomes, we need to move away from anecdotes and questionable

statistics and we need to focus on facts. To do so we must define what it is we want to know and then we have to establish objective measures to answer our questions.

While we are required in corrections to meet certain constitutional standards for healthcare and to do so we must focus on our inmates as being patients, I believe that we have a further obligation to our staff and our communities to do more. Our staff go home each day and they interact with their families and others in the community, and over 90 percent of our inmates will themselves go home some day. The inmates' risky behavior before they came to prison, their exposure to infectious diseases in the community, their substance toxicity and their socioeconomic instability all create a substantial public health risk.

We, therefore, also need to treat our inmates as vectors, as sources of infection and disease. While they bring their disease from the community to us, we must be careful to not to let these diseases multiply, which can easily occur in the close confines of our prisons. And we need to be concerned about their impact on our communities upon discharge.

We in corrections do have a unique window of opportunity. It's really an ideal situation for treatment because we don't usually lose our patients and when we do, we get into other problems. And we can provide a consistency of treatment that can't be provided in the community.

We also need to look at our inmates as being surrogates for our poor and minority communities. If we study our inmates in greater detail, we can better understand the healthcare in the communities from which they came. In Pennsylvania I think we are not only dealing with the basic required healthcare for inmates, we are also focusing on public health issues. I provided a written statement relative to how we are handling hepatitis C. I think what we do with HIV/AIDS, which can be a very complicated disease to treat, is state of the art as well. And we also focus very closely on TB and hepatitis B because of their ease of transmission.

Beyond assessment, prevention and treatment for these and other diseases, we also expend considerable effort on education and training for both our staff and inmates and we do comprehensive discharge planning which is critical for them to receive the continuity of care that they're going to

need.

But we have two major problems in corrections healthcare which prevents us from doing a better job in dealing with these and other public health concerns. First, there is a lack of data, a lack of general information about what's going on in our healthcare within our system. We have poor estimates of chronic diseases, for instance, like asthma, diabetes and hypertension. We lack other morbidity data, causes of hospitalization, causes of death, causes of medical expenditure. This is information that, if it was available, would be able to help drive the research agenda and this prevents us from better understanding the healthcare problem in corrections.

Second problem we have is funding. Corrections healthcare is not only a complicated and difficult business, it's one that could be very expensive. So that brings me to what I think this commission can do.

First, I think that you can help decide what it is we want to know about corrections healthcare, you can help us define the problem.

Second, you can help us establish standards and measures so that we have more data and a

better understanding of the problem and this will also help inform and drive a research agenda.

Third, you can help educate others in the public, and many in corrections as well, as to the public healthcare implications of correctional healthcare.

Fourth, and maybe most importantly, you can help educate those who fund corrections healthcare as to its importance to the public.

Fifth, just as we have with re-entry, you can help focus the need on a collaborative approach with other agencies and with public healthcare hospitals and the like.

Sixth, you can let people know that if they can't do it all today, there are things that they can do that's not that costly. They can focus on education, they can focus on training for better health habits, maybe they can focus on immunization for some of their staff first and then for some of the higher-risk inmates later.

Finally, you can help educate the public on the broader systemic issues; how are we dealing with substance abuse within the community? In Pennsylvania one out of ten people who need treatment can get it. How about the mentally ill? Why are we

seeing more and more mentally ill in our prisons? What are we doing in our community with the mentally ill? And how about the public health system's interface with the poor and minority communities?

And we can look at who comes to our prisons and jails. We know that many of them come from a few, poor, inner city neighborhoods. We know that they have had a poor education. We know that there is a lack of employment opportunities. We know that many of them were at-risk children themselves, where their parents were in jail, where their parents had drug or alcohol problems. We could have intervened with them earlier on.

These things directly address who we can find in our prisons. It directly addresses our growing inmate population which further tends to squeeze our limited resources. These are things that can make a real difference.

Again, I invite this Commission to visit any of our prisons in Pennsylvania to look at healthcare or any other area of concern. I thank you for your time and I look forward to further dialogue.

MS. SCHLANGER: Thank you very much.

I have kind of an initial question that comes out of something that we heard -- that we on the

Commission heard yesterday so for those of you who weren't here, I hope I get this right to get your responses to it.

We were told yesterday that the mortality within prison, I think it was, I don't think it was jail and prison, the mortality within prison for various diseases is half what it is outside, once you control for age and socioeconomic status. That's not a figure I had ever heard before and I wonder do I have this right and what does that mean and what does that tell us about the existence or nonexistence of the problem?

DR. GREIFINGER: Well, that's kind of a red herring argument. Think about who is behind bars; it's mostly young men, 92 percent are young men, almost all of those are between the ages of 20 and 45. And what do men between the ages of 20 and 45 die from? They die from motor vehicle accidents, they die from gunshot wounds, they die from suicide, they die from -- if you think about all those things, those -- there's a protective effect of prison against those things because they're not driving cars, they're not getting drunk very much and they're not using drugs that much. So I think that's a little deceptive.

If you look at inmates' morbidity for

chronic diseases, we see -- we all -- no one has ever measured this scientifically, but all of us who work in correctional healthcare believe that inmates are ten years older, their bodies are ten years older than their chronologic age and it just seems to happen, their heart disease comes earlier, their diabetes comes earlier, their chronic pulmonary disease comes earlier and I think that speaks to several things; one is the lifestyle they live prior to being incarcerated and, secondly, the stresses and other adverse health consequences of prolonged incarceration.

MR. BEARD: Yeah, I'd just like to say I agree with a lot of what Dr. Greifinger said there, but I would also want to say that many of the inmates who come to us didn't know they had diseases when they got to us. We, for instance, in Pennsylvania test everybody for hepatitis C. Many of the inmates did not know they had hepatitis C when they came. Many of the inmates did not know that they had AIDS when they came and if they had stayed out in the community where they really don't have good access to healthcare, where they don't have the monies to pay for that healthcare, where many of them don't care to go for that healthcare, you know, I think they would have progressed much more rapidly in those diseases, where

we catch it, we're able to treat them and maybe slow down some of the deaths that would have otherwise occurred.

MS. SCHLANGER: I have one last -- I have one other question -- oh, please. I'm sorry.

DR. KOUNTZ: Yeah, I just was going to reserve that in our facility a young inmate came in with diabetes, as an example, which is an increasingly important problem, particularly among minority populations, they would be placed on a American Diabetes Association recommended treatment which includes several medications, careful attention to their glycemic and blood pressure control, and they would very likely do better than an age-advanced individual not incarcerated.

So the problem may be a later diagnosis, but with the protocol of care in place, if we had someone for a prolonged stay, we would be able to effect probably a reduction in their expected mortality or morbidity.

MS. SCHLANGER: So that gets me to second question and then I'll got to Judge Sessions, which is something that I think you said, Dr. Kountz, which is that there's this opportunity raised by the incarceration -- this opportunity raised by the

incarceration of these folks who are medically very needy, and what I'm curious about is it sounds like in your facility you try to take advantage of that opportunity.

I'm a little curious, what are the obstacles to other facilities taking advantage of that opportunity? Why don't -- why aren't public health departments around the country pounding on the doors of jails saying, let us in so we can treat people, they're all coming out, and we could get this chance to really get a lot of bang for the buck here. But you don't hear that. You hear people calling for it but you don't hear it happening, and I'm wondering what are the obstacles to that happening?

MR. BEARD: You know, I think that the obstacles there are on the same obstacles we see with re-entry in general. You know, one of the most important things for inmates to go out there and for them to succeed, they need to get a place to live, they need to get a meaningful job; if they've got healthcare issues or mental health issues it's got to be taken care of, and it's very difficult when we interface with the public because, largely, the public doesn't care about those things. The public doesn't want them to come out. The public wants to keep them

locked up and put away in prison and I think it's that lack of the public's willingness to reach out is what's causing the problems in the healthcare area as well.

DR. KOUNTZ: In response to your question, in our setting I think it has less to do with our county department of health, although they have been a superb partner, but it gets to a word that Dr. Greifinger used, which is leadership, leadership within our facility.

We've had a longstanding nurse administrator who has taken as her passion to put into place protocol driven care that -- and she's very willing to do to administration within the facility and others to fight for it. And I think we've just developed a good partnership, but I think many times the answer to why these things don't happen is we don't have a leadership within the facility who are willing to fight for it.

DR. GREIFINGER: I agree with David. It's a leadership issue and it's a leadership issue at the top of each level of government and public policy makers. Public health departments are funded usually by disease. They get a lot of their funding from the federal government, they get funding from one

department for tuberculosis and another for hepatitis and another for sexually transmitted diseases, and they really have never thought about and don't think about coming into prisons and jails to work in those areas, with the exception of TB, when we were having outbreaks of drug-resistant tuberculosis especially. Certainly, with tuberculosis it's a little different, but, for the other conditions they just -- they don't have the mandate to do it. No one is paying them to do it and so they say not my job. It's a very simple silo situation where they say not my job.

And corrections departments even, where there is enlightened leadership, have difficulty getting the resources to do what they want to do in order to do it right.

JUDGE SESSIONS: Dr. Greifinger, your mention of alcohol and drug treatment drove me to ask the question that I've always been curious about, long before I ever came on this commission, and that is about the timing of alcohol addiction and drug addiction in the prisons and when it should be and how it should be done.

DR. GREIFINGER: That's a good question. I'm not sure I have a good answer.

Jeff, do you know more about that than

I do?

JUDGE SESSIONS: Dr. Beard?

MR. BEARD: You mean once they come to us?

JUDGE SESSIONS: Once they come to you, what about the timing of the actual treatment? If you know that a person is a drug addict or you know that they're an alcohol addict and so many times they say, well, the last three months of a prison sentence --

MR. BEARD: First of all, if you try to do the last three months, you are not going to get too much.

JUDGE SESSIONS: I would think so.

MR. BEARD: Because three months is not sufficient amount of time to put somebody in the program, particularly if they have a serious drug and alcohol program. You probably need more like six, nine, maybe even 12 months in an intensive therapeutic community.

Ideally what you would like to do is try to engage that person in the treatment early in their admission into the institution and then put them into some kind of a relapse group once they finish that up. But the reality is because of the lack of resources within the prison setting, we're normally

only getting to those people before they get out, because we want to get the people before they leave so you tend to focus on them and you have to put off the people that are coming in because you are getting the ones going out.

JUDGE SESSIONS: What part of the prison system actually drives that particular training, that particular treatment; is it the medical, is it the psychological? Who is it that does it?

MR. BEARD: It depends in different areas. In our system it's, you know, a separate area, the drug and alcohol treatment program is really separate, it's really more with the counselors. It's not really tied with the psychologist or the medical department.

JUDGE SESSIONS: Dr. Greifinger, talking about screening --

MS. SCHLANGER: I think Dr. Greifinger had an answer to your first question.

JUDGE SESSIONS: Oh. I thought he said he did not.

DR. GREIFINGER: I did, but then I had something to supplement.

JUDGE SESSIONS: Pardon me.

DR. GREIFINGER: The last part of your question about who does the treatment is a real barrier in a lot of correctional systems. Typically, the mental health folks are completely separate from the drug treatment folks and in the systems -- there are some models of drug treatment that say you may not be taking any drugs, meaning you may not be taking any medication.

So if you have bipolar disorder and need to be on Lithium or you have schizophrenia and need to be on anti-psychotic drug, you don't get into the drug treatment program. Now, that's a shame because these are co-existing disorders, but they're different disorders, and we are punishing people who have these duel diagnoses by setting up that kind of an artificial barrier.

JUDGE SESSIONS: You talked about screening earlier on, Dr. Greifinger. What kind of system do you recommend for intake screening in prisons for those diseases that you've discussed and exit screening for those particular diseases that you've talked about?

DR. GREIFINGER: It's very important for the public health to screen for tuberculosis immediately on intake.

JUDGE SESSIONS: Routinely?

DR. GREIFINGER: Routinely, because -- except in areas where there's no background level of TB. There may be a few states in the country that done have much TB and I would say it would be less important, but, typically, I would say to screen for that. All correctional systems should be screening on intake for syphilis, they should be screening for, I believe, for HIV on a more routine basis than we do, I'm not advocating mandatory testing, but we should just offer the way we say we're going to draw your blood and test you for syphilis, we're going to draw your blood and test you for HIV.

I believe we should do risk assessment for screening for hepatitis C, that is we should say does the person have any risk factors; are they injection drug users, are they men sex who have sex with men and all the other risks and if they do, then they should be offered the opportunity for testing for hepatitis C.

JUDGE SESSIONS: Speak a moment about costs associated with that testing.

DR. GREIFINGER: The cost -- the testing for tuberculosis and syphilis is minimal, it's pennies and it's insignificant. Testing for hepatitis

C is much more substantial and has more consequences.

Remember that 80 percent of injection drug users, roughly, across the country are infected with hepatitis C, so that's probably somewhere between 20 and 40 percent of inmates are infected with hepatitis C.

So once we do the test itself, the test itself cost money and for those who test positive, we're going to have the reflex second level of testing to see if they're candidates for treatment. So that's money that's typically not in correctional healthcare budgets, with the exception of Pennsylvania.

The programs you are hearing about today are special, they're best practices, but they are not typical across the country. I don't know of any correctional healthcare program other than Pennsylvania that has as extensive screening and testing for hepatitis C.

JUDGE SESSIONS: What about HIV and tuberculosis?

DR. GREIFINGER: A few states still have mandatory testing for HIV, back from the days when folks thought staff would be at risk, but mostly it's voluntary, it varies in the assertiveness. Some places don't really want to find it, others are pretty

assertive.

For tuberculosis, fairly universal to have TB screening which is screened by a questionnaire; are you coughing, do you have night sweats, et cetera, put on a TB skin test, although too often it's not done until the 14th day, when I believe it should be done sooner, and then chest x-rays for those who have positive findings.

JUDGE SESSIONS: Do you have any suggestions of what can be done to ensure continuity of care of that prisoner or that inmate leaving prison and going back in the community?

DR. GREIFINGER: Yes. I think we need to build linkages and we can't depend on friendly collaboration between agency heads and community providers. We have to find a way to hold someone accountable for re-entry.

JUDGE SESSIONS: Dr. Kountz, your testimony gave me questions that -- oh, I'm sorry.

MS. SCHLANGER: Wait. I'm actually very -- the question you just asked, I wonder if Secretary Beard could speak to that at all.

How has Pennsylvania addressed the continuity of care on re-entry, and we've just heard that your program is a model program. Is it a model

in that way as well?

MR. BEARD: I don't know if we're a model in that way as well, but what we've been doing is working very closely with the Department of Public Welfare when we have people who are seriously mentally ill, people who have a need for further treatment, HIV, hepatitis C, whatever, and we're actually getting the medical assistance established before they leave and then we do the actual comprehensive discharge planning, like I said, by going out and trying to link them up with somebody out in the community where they can continue whatever treatment they need, be it mental health or be it medical.

MS. SCHLANGER: So you actually have somebody who tries to find an actual provider and make an appointment?

MR. BEARD: Yes -- well, I don't know if we got as far as make an appointment -- till they get out to our community correction centers. Our people -- most of our people leave our prisons and go to community corrections; when they get there, they would take that next step. Before they even leave the prison, though, we're setting up the medical assistance funding, which sometimes can take an awfully long time and then you have these people that

need the medical and mental health treatment and just go on and on and don't get it, and so in that way I think we are sort of ahead of the curve in getting things set up.

MS. SCHLANGER: And the medical assistance funding, is that the thing that we were hearing about before lunch with the Medicaid, Medicare suspension or withdrawal of folks who are --

MR. BEARD: Yes, because when people come to prison, they're not eligible for Medicaid anymore, and so that stops. And, you know, the difficulty is a lot of times -- some state departments of welfare don't want to really start them until they're back out into the community again. You know, we've established a good collaborative relationship with our department of health and welfare and they work with us and we get it set up and they can actually fill the applications out online -- or they don't fill it out our staff fills it out online, we don't let them use the internet, and then the assistance is ready when they get out there.

MS. SCHLANGER: Dr. Greifinger had another thing to say.

JUDGE SESSIONS: Dr. Kountz, you had taken and discussed continuity of care.

Do you have some observations about that in the jail setting?

DR. KOUNTZ: It's very difficult, sir, in the jail setting. It is --

JUDGE SESSIONS: Virtually impossible?

DR. KOUNTZ: It's almost impossible. I think to tackle that is a primary goal and would not necessarily be the best direction.

JUDGE SESSIONS: Let's talk about intake because I was amazed, again, at what you do on intake in jails.

DR. KOUNTZ: Yeah.

JUDGE SESSIONS: Tell us about the infectious diseases and the feasibility of actually testing on intake.

DR. KOUNTZ: Well, as Dr. Greifinger said, we universally screen and place a PPD within 24 hours, so we are universal with regard to testing for tuberculosis and we'll certainly initiate treatment or follow-up with a chest x-ray, regardless of the duration of incarceration.

With regard to the other infectious diseases, we are less consistent. When an inmate requests, who is in a high risk group -- based on our nursing and our physician screening, meet criteria for

a high risk group, if they request testing, we will provide it, but we are not routinely testing for hepatitis C, for example, at this point.

JUDGE SESSIONS: Do you have any mechanism that you use in your jail systems to provide information, for instance, to a prison if that particular individual ends up going to a prison?

DR. KOUNTZ: Yeah, that's very important, the communication between the facilities -- and thank you for mentioning that -- is exceedingly important and we probably invest more staff time in ensuring that we have as up-to-date record transfer as we can.

Records go with inmates, phone calls are made to convey information between facilities. That is a very routine part of our business.

JUDGE SESSIONS: So the prisoner is part of the mechanism to actually convey the information?

DR. KOUNTZ: Well, we wouldn't rely on the prisoner. We rely on documents from a facility that may travel with the prisoner but we don't rely on the prisoner --

JUDGE SESSIONS: How do you assure some degree of quality control across the mechanisms that

you have?

DR. KOUNTZ: One of the things that we do is -- I do random chart audits as medical director so --

JUDGE SESSIONS: What are random chart audits?

DR. KOUNTZ: Random chart audits might be picking 30 to 50 charts over a month and reviewing every aspect of the care of that inmate, including ensuring that there are signatures and clear completion of intake records; that if laboratory tests were ordered, received, they were documented and acted upon, that progress notes, et cetera, so that's one thing I do.

Once a year I have an outside physician, not part of our facility, do the same thing. It certainly could be more complete, but that's what we've done to this point.

JUDGE SESSIONS: Is it an audit upon which that physician makes an active continuing report for you?

Dr. Beard -- pardon me.

MS. SCHLANGER: Senator Romero had a question.

SENATOR ROMERO: Attitudes certainly

have changed in society, but there still are some very strong taboos, specifically when it comes to testing for HIV and full blown AIDS, and these, of course, can put the inmate at risk or perhaps find them segregated within an institution.

How have you handled these in your institutions; if you test, do you then treat and if you test and treat, how do -- what precautions, what education takes place, what choices are left to that inmate so that he or she does not become further victimized and/or isolated or discriminated against for working in, for example, the cafeterias of facilities?

MR. BEARD: Well, in Pennsylvania we don't universally test everybody for HIV because it's against state law, there's confidentiality things there, but what we do do is we try to encourage the inmates to take testing, particularly if there's symptomology there we do do the testing.

If we find that somebody is HIV positive, we work very closely with them to educate them about what it means and about what their treatment options are. I think the education part is probably almost as important as the treatment part.

SENATOR ROMERO: Well, what about

education of other inmates, because sooner or later, at least in my experience, is that other inmates will know of the HIV status of a particular inmate?

MR. BEARD: We have groups within the institution where people who are HIV positive and people who aren't HIV positive can go to the groups and learn more about HIV, if they want.

We have noticed a big problem with that, we did back when it first came out in the late '80s and everything, there was a lot of hysteria among the staff and among the other inmates and, you know, there was this segregation and everything, but at this particular point we don't segregate HIV inmates. They're out there, it's mainstream. And people -- we don't find that they're being discriminated against and I think part of is because we talk about it, it's open, people know how it gets transmitted and while we don't talk about who has the HIV, you know, you are right, people do find out that, you know, this person has it or that person has it, but we're not seeing a major problem with it.

SENATOR ROMERO: And let me just ask one other question; what about other populations, let's say immigrants, particularly undocumented immigrants, I'm curious as to what outreach or

protections you may employ to test and try to provide treatment for immigrants, particularly those who are undocumented, and then also women, any particular public health needs and concerns for women inmates?

DR. GREIFINGER: Well, the immigrant question, you need to think about two things; one is are they at risk for different conditions and, certainly, for tuberculosis they are much more -- have much higher risk than anyone else and you certainly look for that.

Secondly, in making a treatment decision with the patient, certainly you have to think about how long they are going to be around; if they're going to be deported soon and will be unable to continue treatment then it might not make sense to start, but I think I would make that on a case by case basis.

DR. KOUNTZ: With regard to women, at least at our jail, and, again, I think we are fortunate because we have a very proactive setting. We have a separate women's clinic where women inmates can go for pelvic exams, which is a little bit more convenient to do in a particular separate setting, and some of the presentation of these diseases, particularly infectious disease, can be different in

women. And by setting up a separate women's clinic, we feel we're able to address those needs.

DR. GREIFINGER: Jails have a very special issue with women. About four percent of women coming into jails in the United States are pregnant, so they certainly have a different health condition that needs to be attended to.

SENATOR ROMERO: If I could just thought finally say in California, of course Los Angeles, there are significant numbers of immigrants who are incarcerated. I would express concern that the decisions might be made in terms of treatment for immigrants because of the question of deportation. I think that does raise a question -- to me at least it raises concerns about the fair treatment within the setting and my urge would be that immigration status should not be a condition upon which treatment is then decided, even if they're going to be deported.

The reality is the TB will spread anyway so how do we check it?

DR. GREIFINGER: Well, I agree with you in principal and, certainly, I wouldn't hesitate to treat tuberculosis as something transmissible that way, but I would be careful about starting treatment for something like HIV because, you know, treatment

interruptions cause drug resistance and make it harder for that patient to find the right drug combination when they do get back on it. So it really has to be a very -- an individual decision and a careful decision.

MR. BEARD: In Pennsylvania we wouldn't treat immigrants any differently, and we do have a number of cases that are there for the INS. They would be treated just as anybody else, but we would pay attention to the time they're going to be there. If they're not going to be there long enough to complete whatever treatment it is, hepatitis C or whatever, then we wouldn't begin that treatment.

MS. SCHLANGER: We're developing a fairly long list so know that you are on your list if you have raised your hand.

MR. MAYNARD: I have a quick comment. Dr. Greifinger implied that Pennsylvania would be the only state that screened for hepatitis C and that's not true, Iowa does, and I imagine there are many others.

DR. GREIFINGER: I apologize.

MS. SCHLANGER: Mr. Nolan.

MR. NOLAN: I have a question for Dr. Kountz and Dr. Beard, and then for all three of --

JUDGE SESSIONS: Can't hear you.

MR. NOLAN: I have a question for Dr. Kountz and Dr. Beard about their systems, all three of you for system-wide.

When an inmate is being treated for a condition and received medication and they're released, are they given any supply of medication, number one?

Number two, is an appointment made for them on the outside so they can continue the treatment and is any provision made for coverage, if they had prior coverage or some sort of transmittal of them to a public health facility?

And, also, are there records copied and sent with them or transmitted in some way to the facility?

I would like to know within your own facilities what the practice is and, also, then nationwide what the standard of practice is in other systems throughout the country.

MR. BEARD: I can just say in Pennsylvania that we do give them -- as I said earlier, we start out, we get their medical assistance. If they have some serious medical or mental health problem, they're given a supply of medication when they leave, I believe it's a 60-day

supply at this particular point that they take with them.

Those people would normally go out to one of our community correction centers and at that point they would make specific appointments for them to get what they needed, and we wouldn't give the records normally to inmate to take, but the records would be forwarded to wherever, by fax or by mail or whatever would be most convenient.

MR. NOLAN: And why wouldn't the inmates be given their records?

MR. BEARD: We just normally wouldn't give the inmates their records because we wouldn't be assured that the inmates would get the records where they should get them.

DR. KOUNTZ: With regard to our jail setting, because of the short length of stay, it's usually not a case where we're able to easily and consistently provide follow-up. We do provide inmates with public health departments. We ask what county they plan to go to and we have a list of facilities where we think it's likely they can receive or apply for care.

If they have come from a private practitioner, we will offer to summarize information

and provide that information to that other provider.

MR. NOLAN: And how about medications?

DR. KOUNTZ: We tend not, with the exception of, perhaps, treatment for tuberculosis, we don't provide them medication when they leave.

DR. GREIFINGER: I would say we do a very bad job at this. Even -- some systems do fine, prisons tend to do a little better than jails, but we just do a very bad job. So when we're doing what we should be doing and getting people diagnosed and treated and getting them on meds and then we just drop them off and let them out, it's a terrible shame. It's a tragedy. It's an area that we need to all do better on and that's going to include better communication between the corrections folks and correctional healthcare people, and the courts have to be involved as well.

Some jurisdictions -- in jails people go to court, they're released from court and there may be some medication waiting for them in jail but you know the guy is not going to go back to pick it up.

MR. NOLAN: Just one comment. As inmates come out, they face a myriad of decisions and they're coming from a condition -- a circumstance where they have had no control over virtually any

decision in their life and that night they have to decide where they're going to sleep, what they do when they get up the next morning, how they look for a job, who they turn to for help, do they slide into their old habits and old patterns?

The difficulty of or the priority of continuing medication and medical treatment, from my experience, is not very high on their list and when they slip off their medications, they're a danger to the rest of us.

So, again, providing care while they're inside is very, very important and I commend you for that, but, also, helping them think through ahead of time and, if possible, making provision for them, saves them the burden of doing that while they're facing, literally, where they sleep that night and how they eat the next day.

MR. GREEN: Secretary Beard, in your opening statement I believe you indicated that the majority of corrections department are doing a good job in providing healthcare. One of the challenges facing this commission is documenting and gathering the data to support the kind of report we're going to have to make.

In making that statement, what kind of

data are you relying upon and what kind of data is available to us in reviewing and making judgement about the quality of healthcare being provided?

MR. BEARD: Okay. I think what -- two things I would like to say. I think, first of all, what I am relying largely on is the fact that I am part of an association of state correctional administrators and I meet with these administrators on a regular basis. I talk to them about a lot of things that go on in their system, they talk to me about things that go on in my system. We talk about healthcare issues as well.

And, you know, I think from the feedback I'm getting from them is that while, yes, there's a challenge there, that these people are concerned and they care. Maybe 20 years ago people didn't care, but today people do care. Healthcare is important to us in corrections today. It's important to these other directors that I talk to. And so I think that's where I make my statement that I feel that most are doing good.

But the second thing I would like to say is you bring up a good point. I can sit here and say something that, gee, I think they're doing good and somebody else can sit up here and say, gee, I

think they're doing bad and they can show you this horrific thing that has occurred somewhere. So what is the truth?

And that's why I also said what I think this commission needs to do is to define the problem and set measures that you can go out there and find out what really is happening. Well, I say that I go out and provide this aftercare, medical aftercare for my inmates and everything, and I think a lot of other places do too, even though it is a challenge and it is difficult, I couldn't sit here and tell you how many do it. Well, maybe that's one of the things this commission has got to go and say, well, let's go and see, how many are providing that? And that's a good question. Those are the kinds of data that we really need. And so just like I can make a statement that I don't have the foundation, so can other people.

MS. SCHLANGER: Dr. Dudley.

DR. DUDLEY: Dr. Kountz, I was struck by your example of employing inmate health education and about the implications -- the larger public health implications, as well as the goal of addressing the particular situation that you found yourself in. And I'm curious, I guess, from all of you about what your thoughts are about inmate health education as a public

health vehicle and do you see that as only something related to particular crisis that come up in a particular setting or do you see a larger role for inmate education, number one?

Number two, you and everybody else has spoken about the importance of the public coming to understand the public health implications of what happens with regard to health services within jails and prisons and I was wondering if you had any thoughts about how that could be facilitated as well.

DR. KOUNTZ: I can start with your question about inmate education and I think it's so easy to become cynical, but that was a very rewarding aspect of a difficult situation was -- which was seeing the look of interest on the part of inmates when we talked about, in this case it was the MRSA outbreak.

Now, granted, this is something that would effect them when they went right back to their pod and how do I keep from getting a boil like the guy next door, but it was a wonderful dialogue and I have great confidence that those individuals, when they leave the facility, will have a new awareness of hygiene.

Beyond that, educating inmates about

diabetes, about high blood pressure; often this is the very first time any healthcare person has taken the time to sit down with them and explain a condition that they were aware of, and their parents and grandparents. And it makes relationships within the facility much better, it creates a better sense of trust and so it's hard for me to quantitate the impact, but the goodwill and the ability to dialogue around care issues is -- (inaudible).

MR. BEARD: You know, I think that and -- I think I said that earlier, that education can be one of the most important components that we can do with the inmates and I know that during one of the things that we do on intake is we talk about the various infectious diseases and go over the things and how they can take care of themselves, how they can prevent from picking these diseases up, and we talk to our inmates about that.

And then we give further training to those if we find somebody who is positive -- say, hep C positive, they can get further education about the nature of their disease and everything like that. So that's something that is extremely critical, it's something that doesn't cost a lot of money and particularly in the jails, it's probably one of the

most important things that they can do because they don't have a lot of time to do anything else.

MS. SCHLANGER: Secretary Beard, I wonder if you could talk to us a little bit about private healthcare contracts and, in particular, I gather from some of the materials that I received that Pennsylvania has some contracts with Prison Health Services, which we've all been reading about as a -- not an always very effective provider.

So I wondered what you do to try to make sure that they are an effective provider in your facilities and if there are principles if there can be gleaned from that.

MR. BEARD: Well, I think the bottom line with privatized healthcare, and I sort of have mixed feelings about this because I've dealt with it over the years, and back and forth, and I don't know what the best answer is.

And, in fact, right now we in Pennsylvania are doing a study and we have a company that's in there taking a look at all the different ways that we can provide healthcare and see if we can do it better than what we're doing.

But the basic thing with corrections healthcare is you get what you pay for. And a lot of

these things that I read about PHS and, you know, they're all the same; CMS, PHS, Wexford, they all have their horror stories out there, and the ones -- the most recent ones I just read they were from, you know, a bunch of county jails, and I think in the New York area and, you know, when you really read through there -- I mean the RFPs that they did, you know, what they asked for probably wasn't done very well. You really have to know what you are looking for here. They probably don't have any kind of centralized ability to oversight these things.

In Pennsylvania what we do is we have very good RFPs that we've developed over the last 15 or 16 years and so we know exactly what we want and we ask for exactly what we want and we expect to get that. And we have people who work in our central office. We have about 20-some people, we have contract compliance monitors, we have quality assurance people that go out into the field on a regular basis, we have our own physician, our own doctor, our own dentist who goes out and checks on these people so then, you know, if I say something isn't right, they can he say, well, you are not a doctor, well, I have my own doctor that can go do that.

And also in Pennsylvania we haven't fully privatized; all we privatized is the doctors and the hospital care. They do that. The nurses work for us and we have a corrections healthcare administrator, so we have a little bit of balance there within the institutions.

So do I think it can be done right? Yes. Is it easy to do? No. Is it cheap? No. But if you really stay on top of it, if you've got good people to monitor it, if you put together good RFPs, you can do it, but I'm still looking for a better way.

MS. SCHLANGER: Dr. Greifinger.

DR. GREIFINGER: I agree with Dr. Beard. The matter of risk has to be taken into account. I think it is dangerous for government entities to think that if they lay off risk, it's going to be less expensive, so that risk is the issue. The specificity of the contract and the oversight is critically important.

I don't think it makes a difference if it's public or private, as long as you attend to those things. Some jurisdictions have reasons that they need to privatize. If, for example, the civil service pay rate for a physician is X and you can't get a competent physician for X, you know you've got to pay

Y, you've got to contract it out.

If you have a civil service system that has nurses that have been going from job to job, hanging out, you know, they work for the public health department, then they work for the -- in the mental hospital and then they finally got thrown out of the mental hospital but they're still on the civil service list and the only place they have to go is the prison, I'm not sure you want that nurse, but if you have to take that nurse, you're stuck. So the only way around it is to say, well, we have to contract out for nurses.

So unless governments can become more flexible with their pay and their personnel practices, sometimes it's better to go with a private contract, but it's got to be overseen, just like public employees have to be overseen, and we've seen some very bad care given by public employees as well.

MS. SCHLANGER: Let me follow up what Secretary Beard said with just one question. Why is it that we keep hearing about these bad RFPs? I mean, we also keep hearing about the terrific correctional professional organizations that help jurisdictions share information. Is this one of the gaps in that and so people don't share their RFPs, or -- I mean, is

there an obstacle there that's a barrier?

MR. BEARD: I don't know. I think one of the reasons is -- again, most of what you saw here were in jails and I don't know that the RFPs that we write would be all that applicable to the jails and to the jail settings because it's a whole different thing there. We certainly don't hide ours. Our stuff is put up online. It's available for people.

So, you know, I think what it is is you've got, you know, the smaller jails, they're not funded the way they should, they're looking for low bid and if you ask for low bid, that's what you get.

MS. SCHLANGER: Judge Sessions.

JUDGE SESSIONS: Yes. We haven't talked about correctional staff, infectious diseases. How do you go about protecting the staffs in jails and prisons?

MR. BEARD: Well, there's a couple things that we do. One of the things that we do, it's part of the education program, we have an actual -- part of our basic training and then we have actually it's a two year renewal that staff have to go through where we talk about all of these infectious diseases and we really preach universal precautions here.

And the other thing that we do is we

offer -- where it's appropriate we offer immunization to our staff. So, for instance, we're immunizing for hepatitis B. I know that's something that the CDCC would like to see everybody in prisons and jails do but, it's a funding issue. Fortunately, I had the money that I could spend on it, but not everybody has the money to spend on it. I know they were looking for some federal funds maybe and I guess that just never happened, but those are just a couple ways that we --

JUDGE SESSIONS: Does it include giving specific information about specific inmates, for instance, or questions about care?

MR. BEARD: We would prefer to leave it as a universal precaution because once you start telling them who has it -- first of all, I told you we don't test everybody for HIV so we probably have some there that have it that nobody knows it. So as soon as you start telling staff that these are the people that have it and they start focusing on that, rather than the universal precautions, that's an extremely dangerous situation.

JUDGE SESSIONS: So you do not, as a practice?

MR. BEARD: As a practice, no, but we

do have a union contract that requires us to keep a list and we don't identify what the infectious disease is, but we do have a list that people can go look at the list. I personally wouldn't do it, but, unfortunately, contractually we're obligated to do that.

JUDGE SESSIONS: But you feel a very definite responsibility to protect your staff?

MR. BEARD: Absolutely, absolutely responsibility.

JUDGE SESSIONS: Dr. Greifinger.

DR. GREIFINGER: It's very, very important, and I think most prison systems and most large jails do a fairly decent job of educating staff about how to protect themselves from blood borne diseases like HIV and hepatitis B and have them tested for tuberculosis. Not enough systems provide hepatitis B vaccination, I think that's a shame. That's an area where public health departments could take a very, very strong role in trying to get staff protected against hepatitis B.

JUDGE SESSIONS: Dr. Kountz.

DR. KOUNTZ: Much of the staff at our jail is not under my direct control so I can't comment. It's education. There's a great sense of

awareness and concern among the staff of, particularly infectious issues, so it's something I think the staff is very, very much aware of.

We, of course, keep inmates the first 24 hours in a holding area to reduce the potential risk of exposure to someone with active tuberculosis, and I think that's one of the most day-to-day, obvious way we protect staff and officers from that potentially infectious problem.

JUDGE SESSIONS: And what about other dangers to staff such as mental capabilities, violence, et cetera, how do you deal with that in informing the staff and protecting the staffs?

DR. KOUNTZ: Well, I think close presence of officers. We have a separate mental health provider will come in and be actively engaged in the care of an inmate if there was issues seem to be brought to bear. I'm not sure we do anything else that's specific. I'm not sure what you are looking for.

MR. BEARD: We tend to -- we put the mentally ill inmates in special needs units, so they're segregated in those units for their own protection a lot of times rather than for other peoples' protections so the staff are aware who have

those.

We also have units where we can actually commit -- short term inpatient units within our prisons that we can commit people to and we run a forensic hospital as well. We have a pretty good system in dealing with the mentally ill, I think, in Pennsylvania.

And, you know, it's something I looked at recently and, you know, I shouldn't say, we haven't had a homicide in our state for a long time, a staff homicide, and -- but when you go back and look at those staff homicides back in the 1970s, invariably it was mentally ill inmates who were involved in those homicides. And so I think that that's just one measure. I think we are doing a better job catching them when they come into the system.

We, for instance, have a special observation unit at our reception center. When we have a mentally ill inmate, they're pulled right out, they're put into that observation unit, they're set up on the treatment that they need, the regimen that they need and it seems to be working very effectively to deal with that issue.

JUDGE SESSIONS: Dr. Greifinger.

DR. GREIFINGER: I agree many systems

do a good job, but our officers also tend to be undertrained in a lot of places. We've had a lot of abuse, abuses of force on people who are mentally ill, people who are agitated for mental -- because of mental illness or agitated, because of their physical illness, often get punished, they get restrained, they get confined, they get segregated and it happens too often. I see it way too much.

So we shouldn't become complacent because we have standards that say we're supposed to have training and even when we do have training it's something that needs constant vigilance.

MR. BRIGHT: Could I just follow-up with that, Secretary Beard. How many of those units do you have -- mental health, how much has that increased let's say in the last five years, how many psychiatrists do you have? And are the numbers of that being a problem, because we were talking about how there are more mentally ill people coming into the system.

MR. BEARD: Well, there is definitely more mentally ill coming in, it is a problem. Four years ago about 14 percent of our population was mentally ill. Today 19 percent of our population is mentally ill. Now, seriously mentally ill is

something less than that, it's more like three or four percent that are really seriously mentally ill, but we do see a growing number of cases.

We have special needs units in all of our institutions to handle that, but we have the inpatient units in five facilities, we only run at about 80 percent capacity of those units. So we're not filling the units up. I think part of the reason is because we're dealing with these people quicker and getting them earlier on before we have to actually commit them. We're not letting them, you know, deteriorate and getting so bad that we have to put them into these units because at one time years ago we were talking about building these mental health units within all of our institutions, we actually built a bunch but we never had them open because we never go much beyond about 80 percent of our capacity.

So even though we are getting more mentally inmates, I think our system is dealing better with the mentally ill so they don't get to that point where they become acute or chronic and need to be put into these inpatient units.

As far as psychiatrists, I can't give you a number, I could go find it out, but we have psychiatrists, again, in all of our institutions. We

have, actually, a separate mental health contract that we get our psychiatrists from.

MR. BRIGHT: Do you find that these prisons in remote places, that that's a problem at all in finding doctor, nurses?

MR. BEARD: There's no question it's more difficult to recruit in some of the remote areas of the state and, of course, that's where we build most of our prisons, away from the -- you know, the urban areas and these places for economic development reasons and it is difficult in some prisons to get some of the professional people. It goes beyond doctors and it goes to teachers and psychologists and people like that are much more difficult to recruit.

But -- and, occasionally, in a prison we are short and if it's a doctor, our vendor has to cover, they have to get somebody in there to provide that coverage and that's one of the reasons why we went to a vendor, because they can more easily recruit people, they can pay more money than we can under the civil service that was mentioned and everything else.

MS. SCHLANGER: We have two people who want to ask questions and I think Dr. Greifinger had something he wanted to add and we'll break for a few minutes.

DR. GREIFINGER: I just want to say we're not doing well enough. I found a guy in a county jail last year who was in on a misdemeanor charge, he was lost there for two years, he was psychotic and he only spoke Vietnamese so everybody just stayed away from him because they didn't understand him. That's an abuse.

I saw a guy a couple weeks ago in a jail that is under court supervision and under the supervision -- under court supervision who was psychotic, agitated, angry, violent, he had been there for four months, had refused care once and so the psychiatrist said, well, he refuses, I'm not going to do anything. So they also made the assumption that they couldn't get him into a state hospital where he needed to be, so what did they do? They went to the judge and they said, Judge, we can't handle this guy in the jail, he's too violent and he's mentally ill. The judge said, fine, and then released him to the street.

That's a danger to public health. That's an abrogation of responsibility by the mental hospital that doesn't have a bed, by the jail that didn't try to make sure he got care and by the judge who let him go out onto the street, and we still have

that and we see that all over the country.

MS. SCHLANGER: Judge Gibbons.

JUDGE GIBBONS: Dr. Kountz, your arrangement on behalf of Robert Wood Johnson to provide medical services at the Somerset County Jail is very interesting.

Do you know whether any other New Jersey county jails have contracts with either a medical school or a New Jersey teaching hospital?

DR. KOUNTZ: I don't -- I don't know the exact answer. I would doubt it, but I think it's a model that -- for our jail and for our county and for us has worked very well.

JUDGE GIBBONS: And do you know whether or not any of the New Jersey penitentiaries have such an arrangement?

DR. KOUNTZ: I think as I mentioned in my testimony, in 2004 mental health services in the state are now provided by our University Behavioral Healthcare, which is one of the units of the University of Medicine and Dentistry of New Jersey.

JUDGE GIBBONS: But only mental health?

DR. KOUNTZ: At this point only mental health.

MS. SCHLANGER: Dr. Dudley.

DR. DUDLEY: I just wanted to go back a second to the mental health question. I was wondering, do you have any sense of distinguishing between those who come into the facility with a known history of mental illness compared to those who come to the institution without having had, obviously, adequate health and mental healthcare and had not been previously diagnosed or were not known to have mental illness and, therefore, the capacity of your health system to identify those people and get them to a mental health services, as opposed to people who were previously diagnosed, known to be -- inaudible.

MR. BEARD: I think in Pennsylvania most of them have been previously diagnosed. There are some cases where, I think we can find them but I think most of them have been diagnosed in the community, just haven't been handled very well in the community. We've closed our mental hospitals out there and while we're dealing fine with the people that were in the mental hospitals, I think they have resources for that, they're eating up all the resources so the new people that have mental health problems don't end up getting taken care of and then they, of course, end up, some of them, coming into our prison systems.

DR. GREIFINGER: Jails are a larger problem, there's a lot of undiagnosed illness, a lot of first episode manias, a lot of new schizophrenics, a lot of -- PTSD is terribly underdiagnosed, especially you know how prevalent it is among female inmates, so there is a lot of opportunity for diagnosis.

Some well in some places and it's missed in others. Other places at best you get a suicide screen. If you are not suicidal, nobody pays any attention to you in terms of a behavioral evaluation. Other places really do look, take a look-see but, unfortunately, most jails are way too passive about it.

MS. SCHLANGER: Dr. Griefinger, Dr. Kountz, Secretary Beard, thank you very much for coming before us. This has been very informative.

For you, if you are going to stay, for the commissioners and for people in the audience, we are going to break until 3:15 and then we'll conclude the day's hearing. Thanks.

(Brief recess.)

EXPERT TESTIMONY ON CARING FOR THE MENTALLY ILL

DR. DUDLEY: Okay. We're ready to start up again. Our last panel for this hearing is on

caring for the mentally ill. That will be the focus of our three presenters.

Throughout the course of today and even prior to today we've been hearing about the large numbers of persons suffering from mental illness who are in prisons across the United States. Estimates vary from one jurisdiction to the other, but overall it appears as if the -- nationwide there's about 16 percent of persons who are in prisons suffer from mental illness. Clearly, that's really just the identified population of persons who suffer from mental illness.

Given the fact that statistics also suggest that as much as 40 percent of inmates are at some time, during the course of their incarceration, treated for some type of mental illness, then there's, obviously, a large unidentified population as well.

The Commission is interested in looking at this issue in depth and trying to understand it as completely as possible. We're concerned about why there are so many inmates who are suffering from mental illness in the prison system; should they be in prison, should they be some place else? If they should be some place else, why are they not there and in prison instead?

For those who are incarcerated, what are the impediments to their receiving appropriate and adequate mental healthcare? What are the impediments to identifying those who were not diagnosed before they entered the prison system? What are the impediments to identify with those individuals and treating their mental illnesses?

What are the implications of all of this for the safety of persons who suffer from mental illness while incarcerated? What are the implications for the safety of others as it relates to those who are suffering from mental illness; others being other inmates, corrections officers, et cetera?

How can -- particularly in light of some of the things we heard this morning, we are not only interested in adequate care, but concerned about those who deteriorate even further while incarcerated and resulting in either deterioration of their mental illness, suicide attempts, other sorts of problems as well.

And this also -- this issue of how our persons upon release are best hooked up for continuing treatment and aftercare services and is that something that's doable and that we should be able to do much better?

We have three very distinguished persons with us today to speak to the Commission. They include Jamie Fellner, who is an attorney in the United States Program Director at Human Rights Watch, she's the co-author of "Ill-Equipped, U.S. Prisons and Offenders with Mental Illness," which is an exhaustive look at the issues surrounding the incarceration and treatment of persons with mental illness that was published in 2003.

We have Dr. Gerald Groves. Dr. Groves is a psychiatrist who attended mentally ill prisoners in New Jersey prisons and jails up until a couple years ago. He will describe a situation of care impeded by institutional barriers and misdirected priorities in which there appears little realization of the negative consequences and lost opportunity of inadequate treatment for those soon to be released back to the community.

And then we have Dr. Reginald Wilkinson, who has been the Director of the Ohio Department of Rehabilitation and Correction for 14 years and has overseen an effort to greatly improve the quality of care provided to the mentally ill in Ohio's prison.

Each of our witnesses will have about

12 minutes to talk to us. We have a timekeeper sitting right over here to my right who will let you know when your time is up. Please try to cooperate with her as much as possible so that we will have the opportunity for discussion and questions after each of you have completed your presentations.

Ms. Fellner.

MS. FELLNER: Thank you very much for inviting me on behalf of Human Rights Watch to talk to you. I think the work of the Commission is crucially important and I'm glad you are going to be shedding light on the well-being or lack thereof of those members of our communities who are currently behind bars.

I'm glad you have taken on the subject of mental illness because I don't believe any discussion of violence and abuse in prisons can ignore the consequences of the high rates of incarcerations of offenders with mental illness and the poor treatment they receive behind bars.

Secretary Beard, in the last panel, mentioned that there is a lot of anecdotes and not a lot of data, and that certainly is true, but we spent a long time, over a year, traveling from state to state, reviewing thousands of pages of documents,

interviewing hundreds of people, mental health practitioners, corrections officials, inmates, lawyers, and we think the assessment which we have here in "Ill-Equipped" is as solid as any that is out there and I am pleased to be able to tell you that although many people don't like our findings, nobody has ever said that they're inaccurate, so I do hope you will get a chance to read the report.

We chose the name "Ill-Equipped" because we thought it was clever. We always try to come up with clever names for our reports. It reflects the fact that we believe mentally ill prisoners are often too -- are ill-equipped to cope with prisons and prisons are ill-equipped to cope with them.

Prisons were never intended as facilities for the mentally ill and, yet, that's one of their primary roles today. There are three times more mentally ill people in prisons than in mental health hospitals, prisoners have rates of mental illness that are two to four times greater than in the general public. Somewhere between two and 300,000 men and women in US prisons suffer from mental disorders, including such serious conditions as schizophrenia, bipolar, depression, posttraumatic stress disorder.

Research suggests that not only is the absolute number of offenders with mental illness increasing, but the proportion of the prison population that is mentally ill is increasing.

So what do we mean when we say that mentally ill prisoners are ill-equipped? Well, doing time in prison is hard for everyone. Prisons are tense, overcrowded facilities in which all prisoners struggle to maintain their self-respect and their emotional equillibrium. But we believe that doing time in prison is particularly difficult for prisoners with mental illness; illnesses that impair their thinking, emotional responses and ability to cope. In short, they are particularly ill-equipped to navigate what is frequently a brutal and brutalizing environment. They also have unique needs for special programs, facilities and varied health services, which as I'll discuss later, they don't get.

Moreover, our research suggested that compared to other prisoners, prisoners with mental illness are more likely to be exploited, victimized, abused and raped by other inmates. They are also more likely to be abused by correctional staff, who have little training in recognizing the signs of mental illness and little training in how to handle prisoners

who are psychotic or acting in bizarre, violent or even disgusting ways.

Mental illness can impair prisoners' ability to cope with the extraordinary stress of prison and to follow the rules of a regimented life predicated on obedience and on punishment for infractions. These prisoners are less likely to be able to follow the rules and then their misconduct is punished, regardless of whether it results from or is deeply influenced by their mental illness. Even their acts of self-mutilation and suicide attempts may be punished as rule violations.

As a result, mentally ill prisoners can accumulate extensive disciplinary histories which will end them up in administrative or disciplinary segregation. And I don't know if earlier panelists talked to you maybe yesterday about segregation and it's something we can deal with in questions, if you would like, but the bottom line is that putting the mentally ill in segregation for extended periods of time can simply aggravate their illnesses and act as an incubator for worst illness and psychiatric breakdowns.

So what do we mean when we say prisons are ill-equipped? Well, certainly, they're better

equipped than they were 20 or 30 years ago, when there were no mental health services to speak of. Thanks in great part to prisoner litigation and concern and courts, there are now many competent and committed mental health professionals across the country who struggle to provide good services to prisoners who need them.

Yet, despite their good intentions and despite some exceptions, prison mental health services across the country are woefully deficient. They lack adequate numbers of properly qualified staff and adequate facilities in which to provide services. They cannot provide adequate screening, evaluation and monitoring. They do not provide prompt access to mental health personnel and services for those who need them.

It is rare to find prisons offering a full range of appropriate therapeutic interventions. Typically interventions are limited to medication, and even that is often poorly administered and monitored.

Prisons do not develop -- prison systems do not develop and implement individualized treatment plans. They do not carefully identify and properly treat suicidal prisoners. They lack discharge planning that will ensure that prisoners who

are mentally ill will have access to mental health and other support services when they leave prison.

And if some prisons and some prison systems do some of these things, or even all of them, they don't do it for everybody who needs it.

Even worse, in some prisons we have found deep-rooted patterns of neglect, mistreatment and even cavalier disregard for the well-being of vulnerable and sick human beings. In the most extreme cases conditions are truly horrific. Mentally ill prisoners locked 24 hours a day in filthy and beastly hot cells with not treatment at all, left covered in feces for days; taunted, abused or ignored by prison staff.

Suicidal prisoners are left naked and unattended for days in bear and cold observation cells with no mental health observations.

I hope I will have time and questions to go into more detail on all of this but I would like to focus in my remaining time on some of the recommendations we have for the Commission.

First, I'm going to echo what I think almost everybody up here has told you, which is none of the problems you are confronting, problems of abuse, problems of violence, problems of treatment of

the mentally ill can be dealt with if the U.S. prison population is not reduced. Everything you deal with or are going to be looking at is exacerbated by having too many people behind bars.

Now, theoretically, you could have this extraordinarily high incarcerated population and treat them just fine if the resources were available, but we all know that the states are not willing to provide the resources to properly treat that many people and we are seeing the consequences of that.

The starting point for prison reform must be ensuring that prisons are reserved for dangerous offenders who need to be incarcerated. Low level, nonviolent, nondangerous offenders can be punished through other means. If you reduce the number of people coming into prison, you will free state correctional resources to take care of those who have to be in prison, including those who are mentally ill.

Second, I won't have a chance to really talk about this unless we get into it in the questions, but Dr. Dudley raised the question of how come we have so many mentally ill in prison and the proportion is increasing and that's a function of two things that have gone on in the community; one, with

the institutionalization, that was a good idea, unfortunately, it wasn't followed by the development of well-funded community mental health services which the architects of the institutionalization had hoped for, so you have people in the community basically without access to care.

Second, we know that the criminal justice system sweeps up, unnecessarily, many of those mentally ill who can't get services. In fact, sometimes jail is the first time they get any kind of service. There are many reforms that could be made in the criminal justice system that would reduce the number of mentally ill people who are being brought into it. And I urge you to take a look at the consensus project which was shepherded by the Council of State Governments which looked at the intersection of the criminal justice system and the mentally ill and made a number of very important suggestions for reform.

But even if you greatly -- we could greatly expand community mental health services and undertake the necessary reforms within the criminal justice system, we're still going to have mentally ill in prison.

So the starting point, I believe, is

that the Commission should insist that correctional systems provide quality mental health services, regardless of the constitutional minimum. We can talk later about legal standards, but the constitutional minimum is simply not good enough and leading to litigation to determine whether or not proper healthcare services are being provided has proven to be not as successful as we would like.

The problem with mental health services is not the absence of knowledge. The components of quality and comprehensive care in prison are well known. What has been lacking is a commitment on the part of the public, public officials and some correctional professionals to ensure that standards and policies are more than words on paper, and more than just a protection against litigation. We hope the Commission can help encourage that commitment.

High quality mental health services can help some people recover from their illness and it could help alleviate painful symptoms. It can enhance independent functioning in the development of more effective internal controls and coping skills. By helping prisoners with this, treatment and services enhance safety within the prison community, as well as increases the prospect of successful re-entry when

offenders are ultimately released back home, as most will be.

So providing appropriate mental health services shouldn't be seen as just a legal obligation or even a moral obligation, it is a public safety as well as a human rights matter.

To provide decent mental health services, as somebody mentioned earlier, it's about money. There's just no way around it. Public officials must have the resources that will enable treatment and services for those prisoners who have mental health or even other medical needs. We should aspire to a zero tolerance policy for psychological misery and pain that could be alleviated by appropriate mental health treatment, but that standard cannot be met without better funding.

I would also urge you to take a look at and undertake efforts -- support efforts to minimize the tension between corrections and mental health cultures. Prisons and correctional systems have a one-size-fits-all approach to conditions of confinement, modified only according to security needs. They're not designed to accommodate or benefit prisoners with mental illness.

I would urge you to urge corrections

leaders and public officials to think outside the box, to figure out other ways you can confine and inflict the sentence of deprivation of liberty without exacerbating mental illness or providing what is ultimately a maligned or toxic environment for those with mental illness.

I was going to talk about officer training, but I have one minute.

Ask me, somebody, about review, oversight and accountability mechanisms and I will talk about that. So let me just give my concluding comment.

Corrections officials recognize the challenge posed to their work by the number of prisoners with mental illness. They are caught between a public that wants to incarcerate large numbers of people but is not willing to provide the resources that would enable corrections officials to respect the rights of those prisoners to safe, humane and rehabilitative treatment and conditions of confinement.

We hope the Commission will help marshal political sentiments and public opinion to understand the need for enhanced mental health resources for those inside as well as outside of

prisons.

DR. DUDLEY: Thank you, Miss Fellner.

MS. FELLNER: One sentence.

The problems we have documented can be solved but to do so requires drastically more public awareness, compassion and common sense than we have seen to date. Thank you.

DR. DUDLEY: Thank you.

Dr. Groves.

DR. GROVES: Thank you. My presentation will have a somewhat staccato quality because I want to cover a number of points for sure and if there is time remaining, we can fill in the melody.

There has been a lot of excellent testimony preceding mine and I reiterate some of it as it relates to mental health. I agree with the previous speaker that the welfare of prisoners is not high on the agenda of the departments of correction and, of course, this has implications to healthcare and mental healthcare, which, if they were to be properly implemented, would need a high degree of commitment.

In my experience, departments of correction have been motivated to provide minimum

levels of health and mental healthcare so as to avoid suits.

Mr. Farrow, this morning, made very eloquent testimony based on his experience as a prisoner in the New Jersey system. He did say, as you might recall, that he identified himself as having a psychiatric problem at a certain point in time but wondered if the onset might have been even earlier, and that testimony describes a problem that we face which I will just call the problem of caseness.

How does one tell when somebody is psychiatrically ill or not? It's not that easy of a matter even for experts. For experts we like to have prolonged observations or repeated observations or both because, typically, there are no laboratory or pathological findings of a physical type that makes psychiatric diagnoses.

In general, psychiatric disorders that are characterized by reduced behavioral input, social withdrawal, are better tolerated in departments of correction than problems that involve increased operative behavior, bizarre behavior or a high degree of personal assertiveness. I don't know Mr. Farrow, but one aspect of bipolar disorder is that people, when they are hypermanic or manic, put out a lot of

behavior, are more assertive and sometimes highly conflictual with authorities as part of their illness.

The concept of psychiatric illness is evolving over time. So, for example, there's now frequent diagnosis of ADHD, attention deficit disorder. This is frequently associated with impulsive behavior and oppositional defiant behavior. My belief is that it is organically based, but it is not well understood, but we're seeing many prisoners now who exhibit these problems. It's very difficult for the layperson to distinguish between psychiatric disorder and willful defiance in these circumstances.

Because corrections officers or even often nurses who work in correctional settings don't have psychiatric training, as mentioned before, these behaviors can be misinterpreted and lead to punitive measures which aggravate the psychiatric problems.

There is a definite clash of cultures between the health and mental health person on the one hand and department of corrections. Departments of corrections are modeled on a paramilitary model. As some of the features of the paramilitary model they involve hierarchy, rigidity, negligence of emotional impact and emotional expression and lack of flexibility.

On the other hand, the hippocratic oath in the health professions, first, the first rule, of course, is do no harm and the War on Drugs and the War on Iraq, we understand there is a lot of collateral damage and that's acceptable, but as medical people we don't. So it's a real problem.

We are socialized to treat people as individuals, understanding that there are many differences between individuals who bear many similarities. Within paramilitary systems these people are treated alike, and this is a problem because there is a lot of overlap within the average person and the mentally ill person, and the proper treatment of the mentally ill requires differentiated approaches.

Part of the rigidity of departments of correction is that their range -- first of all, that they depend almost exclusively on punishment as a means of behavioral control and, secondly, that even within the category of punishment, the interventions are very limited.

One of their favorite punishments is isolation. Isolation involves not only physical isolation, but denial of privileges, such as family visits, which is very upsetting to many people, often

removal from work within the institution, if they had a job, deprivation of exercise and outside time. Even when mental health people understand and counsel, these measures are likely to aggravate the situation. They are, in many cases, disregarded. The best that you will get is that you can get the person taken out of isolation for a time, but it is clearly understood that the clock on the punishment has merely been suspended and when you have put the person back together, they go back into the same condition to finish with the time.

Another state prison where Mr. Farrow was was renowned for having a big isolated section where a lot of people were in that way.

Understanding the department of corrections and mental health requires some consideration of broader society of issues. In many respects, departments of corrections are garbage containers for human refuse. The idea is that we can get rid of crime if we get rid of criminals and the underlying belief is that there is a population of criminals and a population of good people who retain their identities through time.

The reality, however, is quite different. People are criminals, very often, through

a part of their life and they are good through most of their life and good people are sometimes criminal for a while.

But using the garbage can analogy, once people get put in there, there's no concern about them getting out. You might deodorize the garbage can every now and then so it doesn't smell too badly but nobody is really that concerned about what you look like when you get out.

This whole approach has vitiated what would be a much more logical approach, which would be to integrate mental health and healthcare within correction systems and healthcare throughout the community. After all, most of the healthcare that most prisoners receive will occur outside of the wall and it seems to me that some creative approaches could integrate this treatment.

Why, for example, should a citizen who is entitled to Medicaid or Medicare suddenly lose health benefits when they enter the current department of corrections to receive possibly much inferior care within?

One might also consider that if the collateral damage from the War on Drugs was colored white, instead of brown or yellow or black, the

society at large would never have tolerated it for this long.

So some people infer from the function of the departments of correction and, in fact, from the entire criminal justice system that it has some rather dire purposes, not officially spoken out, but, nonetheless, seemingly very active.

It's inconceivable that a society can incarcerate this many of its people, especially young people, when you consider all of the negative impacts that that will have on families. Everyone of these young black men or Latino men that is incarcerated, many of these guys have families. So not only are the innocent being punished, but the very purpose of society are being undermined by this blanket approach to the control of crime.

When one considers that the War on Drugs is one of the main mechanisms by which prisons have been filled up over the past couple of decades, typically, without the provision of adequate treatment, it just appears like an extremely cynical and counterproductive exercise.

After all, if we're going to incarcerate people for drug abuse, why not treat them so that they can resume their lives and they get out

in some better form, but this often does not happen much.

Also, contemporary at times is a high degree of comorbidity between substance abuse and mental illness. And the inadequacies of the mental health treatment program, prejudice the outcome for this duly-affected people.

Lastly, a couple words about race, class and gender. Women are being incarcerated at a much higher rates and they present special problems for mental health professionals. The first is the callousness of the separation of these women, who are often arrested for nonviolent crimes, from their children. A woman a hundred yards away from an elementary school to pick up her children might be arrested and given absolutely no opportunity to make arrangements for the care of her children, who are then often farmed out to some agency. This is deeply troubling for many women.

The other problem with women has to do with their secondary sexual characteristics and the fact that they are usually add-ons to male jails. In Mercer County, where I was working for a while, you know, they don't even have brassieres to fit all the sizes of breasts that the women have, so, you know,

women are walking around in various stages.

But, still, the officers are primarily male so you have a situation where, for example, a woman who is in isolation for suicidal prevention, who might be dressed in a paper suit under those circumstances, is being watched in repose through the night by male correction officers. Often in a cold room, one might add.

The other special problem for women is the problem of menstruation which exerts special demands for personal hygiene and are potentially very disruptive within the population if certain woman have not taken care of this problem adequately.

Thankfully, in some ways women are more likely to express their emotional distress verbally and directly than men and in my experience women have been attended to more frequently for mental health problems in the jail than the men, on a proportionate basis.

I believe, also, that disruptive behaviors on the part of women are better tolerated than in a male-dominated institution, where such behavior by men provokes a lot of retaliation and the need for assertion of physical dominance.

Lastly I talk about a subject sex in

jails. This has mental health implications and health implications. The general pretense is that sex is forbidden in jail and it doesn't occur. Sexual activity is widespread in jails between people of the same sex, between corrections officers and people who are held there and so on. The pretense that it doesn't exist and the refusal to provide protection in mitigating measures, such as condoms, is terrible. Is exposes to people of risk of HIV and other diseases, which then destroy the brain. I think I will stop for the time.

DR. DUDLEY: Thank you, Dr. Groves.

MR. WILKINSON: I could spend my entire time responding to the previous two speakers but I think I won't, I'll go through my testimony, but, believe me, I will respond to a couple of the statements that were made.

It's a privilege to provide this testimony to the Commission. This oral testimony, however, is just an abbreviated version of my previously submitted written testimony that maybe you all have. I would be remiss, albeit, if I did not convey my apprehension about the mission of this initiative. When the abuse commission was announced, many persons who serve as corrections administrators

across this nation were equally apprehensive. If it were not for the intervention of respected members of the Commission as Gary Maynard, you may very well have experienced a major anti-abuse commission response.

The final product that this Commission will publish will certainly evoke professional responses from agencies and organizations that represent prisons and jails.

My corrections career has spanned 32 years, just to add to a little more of my resume, and I have served in numerous administrative capacities, including warden, deputy director of prisons and now director. I have served in numerous national and international capacities as well, such as past president of both the American Correctional Association and the Association of State Correctional Administrators. I am also the chairperson of the National Institute of Corrections Advisory Board and president and executive director for the International Association of Re-entry.

I am pleased that I have been able to specifically -- asked to specifically address issues relating to offenders with a mental illness. For over ten years I have made this subject one that deserves the highest priority.

There was a statement recently made that corrections administrators don't make this a high priority; that is absolutely, unequivocally not true. A number of venues that corrections administrators participate in with the National Institute of Corrections, with the Association of State Correction Administrators, the Council of State Governments, individual state jurisdictions have all had major initiatives relating to the mentally ill offenders so an awful lot is going on and I list a number of those initiatives in my written testimony.

As Ms. Fellner mentioned earlier, jail and prison is sometimes the first contact that identifies a problem right there, that we are the persons who are put in place to help save some of what should be a social problem or community problem in the first place. We shouldn't have to be dealing with these issues if it was dealt with elsewhere.

Many persons with a mental illness have co-occurring disorders. Mental illness can be complicated with certain other offender groups, such as sex offenders and persons who are aging in prisons and female offenders, as you previously heard.

I am also concerned with the high number of persons who have been assessed as having

retardation and developmental disabilities while incarcerated. Moreover, there are, obviously, varying degree, as you all are also aware, of mental illness.

According to the Bureau of Justice Statistics, 16 percent of all persons incarcerated have a diagnosed mental illness. About half of those persons who have a mental illness in prison have a serious or an Axis I level of mental illness diagnoses.

I disagree with the notion that you previously heard that, you know, prisons are garbage containers of the human refuge. We consider ourselves to be professional practitioners in the justice business and I know of no one in our profession who would remotely identify with that type of label of our profession, neither of you would accept that as a characterization of your professions as well.

We don't have favorite punishments in our prisons. It's the court's responsibility to punish offenders and not that of a state or local correction system. It's our responsibility to carry out the orders that the courts have imposed upon persons who have been sentenced to our jurisdictions.

Given the fact there are nearly 2.2 million persons in prisons and jails, you may

understand how detention facilities have, in fact, become the new asylums. Deinstitutionalization has been a major movement for community mental health providers for a number of years. I believe we are now experiencing a transinstitutionalization of persons with a mental illness; that is, many persons who may have been civilly committed to a mental hospital 20 years ago have now found their way to prisons and jails.

What this means for corrections administrators is that we not only are responsible for de facto mental health systems, but we have become de facto mental health directors.

As you might imagine, the daily challenges that confront a correctional agency are wide-ranging and formidable. Our agency, which operates 32 prisons, is the nation's sixth largest state correction systems. Thus, one of the monumental challenges facing us is providing healthcare for 44,000 prisoners.

Two major events took place which gave rise to our agency's renaissance in prison mental healthcare. First, in 1993 we experienced a prison riot where nine inmates and one employee were killed. This event put the department under the public

microscope. Second, in 1993 a federal lawsuit was filed claiming that care for prisoners with a serious mental illness was inadequate. This litigation was settled and resulted in a five year consent decree. There was never an admission of unconstitutionality or deliberate indifference.

Beyond all the legal and practical reasons one might express, above all, providing good mental health services, and this is what we believe, is the right thing to do. However, treatment for inmates with mental illness is more than just doing the right thing. It is a constitutional requirement, we're well aware of that, and enforceable in the federal courts.

Let me share with the Commission some of the overarching reasons why operating a comprehensive and sound mental health delivery system is important to our operation.

Nearly seven percent of Ohio's inmates are diagnosed with a series mental illness. A host of other inmates with a less serious mental illness co-exist as normally as possible in the prisoner population. Therefore, good management and effective clinical care are required to deal with this prodigious problem.

For both security and health reasons we need to know whether offenders are demonstrating purposeful negative behavior, as opposed to those who are acting out because of their mental illness.

Whether a prisoner has an acute psychiatric illness or a personality disorder, correctional staff should be concerned when preventing further deterioration. Suicide and suicide attempts are stark examples of the consequences of unknown and unattended deterioration.

Prisoners with a weakness, either physical or mental, are at a disadvantage and sometimes preyed upon by stronger inmates. It is our mission to protect the vulnerable prisoners.

Knowing inmates' physical and mental limitations allow staff to appropriately house, classify, assign jobs and treat prisoners. Good mental health, then, includes good screening and evaluation.

And because 97 percent of all prisoners will return home, for community health and safety reasons, operating a holistic mental health service delivery -- mental health system is often a high -- is the highest priority for persons in my capacity.

One of our prisons is a psychiatric

hospital. We actually have to operate a certified psychiatric hospital that's a prison. In addition, our 32 prisons are divided into nine separate clusters or catchment areas. Each cluster has a designated residential treatment unit assignment to one of the nine RTUs is for appropriate care and never, never for disciplinary action.

Thus the structure of the mental health services in Ohio resembles a triangle with our Oakwood Psychiatric Hospital at the top treating the most seriously mentally ill persons in a hospital setting, the RTU has an intermediate venue for chronic -- for treating many in chronic care patients and we also have a number of outpatient treatment services that exist in every one of our prisons.

The recruitment and training and deployment of staff is a major challenge, but, nevertheless, one that is a high priority for us. Overall, the mental health staff have increased dramatically in our state; nevertheless, maintaining adequate staffing requires due diligence in recruitment.

Staff training is equally important. Critical staff must adapt to the correctional environment, regardless of staff members credentials.

Specialized mental health training is provided for all correctional staff, including custody, medical, clerical and mental health persons who are assigned to work in segregation, medical and mental health areas. This is a two-day program designed to increase knowledge about mental health support, appropriate attitudes and behaviors and better integrate security and mental health concerns.

Coordination is required to ensure successful re-integration of mentally ill persons who return to the community. Most prisoners who are released back into the community only receive about two weeks of medication to sustain them; that's a problem. Thus, in the spirit of re-entry, referrals regarding the continuity of mental health services must be a priority of discharge planning. Most persons with a mental illness are able to work, but when you combine the stigmas of being a formerly incarcerated person and one having a mental illness as well, work possibilities diminish significantly. Nevertheless, this special needs group can achieve successful community reintegration.

I want to briefly discuss the impact of so-called supermax prisons on persons with a mental illness. I agree that it's a good idea to avoid

placing persons with an active mental illness in a supermax prison. I don't agree that inmates should not be assigned to one because a mental illness might develop or cause decompensation to occur with inmates whose mental illness is in remission. Albeit, continuous monitoring of unusual behavior by prisoners assigned to a supermax institution should be an ongoing security and clinical responsibility.

So, from my perspective, it is clear that comprehensive mental healthcare for offenders yield positive results.

In conclusion I am in no way suggesting that Ohio's mental health system should be the prototype for any other correctional jurisdiction. What may work in Ohio may not work in other states. Although any correctional administrator will admit that continuous improvement is an ongoing part of our mission, there is very little evidence of intentional and widespread abuse inflicted upon persons with a mental illness in prisons and jails this nation. Yes, there are isolated and unacceptable incidents that occur, but these incidents are no way reflective of the normal correctional protocols of how persons with a mental illness are managed. There is no such thing as a one-size-fits-all process.

I am appreciative of being able to provide this testimony to the Commission.

DR. DUDLEY: Thank you, Dr. Wilkinson.

We are now going to open up for any questions that any of the commissioners might have. I'm going to take my prerogative by asking the first question.

I would like to hear all of you comment on the issue of the other group, not the percentage of people with the profoundly -- profound mental illnesses like schizophrenia who are previously diagnosed, but those with less severe illnesses. The issues of really identifying this population, and you seem to have some disagreements about even if this population is identified, how would they best be managed while incarcerated.

I believe I heard you say, Dr. Wilkinson, you didn't feel there should be any difference in the way that population would be managed as it relates to isolation and those sorts of things. I think, I believe, Ms. Fellner, you were saying something quite different in that regard; that we should be employing the knowledge we believe we have about the risk of deterioration of this population, for example, with putting them in certainly long term

isolation.

I just want to be clear about what you all felt about the management of that population, again, not the profoundly mentally ill, but this other population.

MS. FELLNER: I think people with personality disorders pose a really serious challenge for corrections. On the other hand, I think it behooves corrections to work with mental health staff to figure out appropriate responses, given that a large part of the population does have personality disorders.

The other thing is, and it may get too technical, I don't know, often you will have Axis I and Axis II diagnoses, these are complex situations, as Dr. Groves said, often, you know, accurate diagnoses are hard to come by.

Certainly, we have found with women -- for example, women who are suffering from posttraumatic stress disorder, and I think you all know that a very high percentage of women that go into prison have suffered sexual or physical abuse before and are suffering PTSD. That has been traditionally diagnosed as somehow that they were just acting out or behaving badly. So the insights now from mental

health, I think, can help guide a lot of what is done.

With regard to long term isolation, Human Rights Watch's position is that in most cases long term isolation under the severely deprived condition of many supermax is a human rights violation. Nobody should spend years in a small cell, let out two or three times a week, with minimal human contact.

There may be times in which short term use of that kind of control is necessary and if somebody is dangerous enough that they require really long term, maximum control, then the prison systems have to find ways to alleviate the consequences of the isolation, figure out ways to have more social interaction and whatnot.

Certainly people who are mentally ill, and I haven't given enough thought recently to separate out Axis I and Axis II and which kind should be, but there have been settlement decrees, and I can't remember Ohio's, which have specified in the settlement which kinds of -- which offenders with which kinds of mental illness should not be put in a supermax because of the likelihood of decompensation.

The other thing about -- and it may be different in Ohio in many ways because of the

settlement in Ohio. They are way ahead of many prison systems.

Mental health treatment is often particularly lacking in supermax because there's fewer -- less access by mental health service providers into those units and they do cell-front interviews; they will pass by and say, hi, how are you doing and that counts as a mental health intervention. So you have sick people in a countertherapeutic environment getting less mental health services.

MR. WILKINSON: I will be happy to chime in.

One of the biggest populations of persons who have the non-Axis I or serious mental illness diagnoses are the women. We have -- the percentage of women who have a diagnosed mental illness is almost double what the men have, but their issues are different, in some cases; they have the emotional disorders, the post-traumatic stress issues, the, you know, postpartum syndrome issues, and it's all very complicated in terms of how you deal with that while operating a facility for females.

But the issue is we know that and so we try to integrate these women and men with these diagnoses as normally as possible, but the issue is we

know who has been diagnosed with what. So if there is decompensation or deterioration of their diagnoses, then we'll try to intervene, we'll try crisis intervention, whatever it is that's necessary in order to make sure that person doesn't decompensate and don't deteriorate to the point where it's going to elevate to a more serious mental illness.

So we're well aware of it, we want these people to work, we want them to be in school, we want them to do things as normal as possible if, in fact, there is such a thing in these environments.

DR. GROVES: Do you wish to hear from me?

DR. DUDLEY: Well, actually, I particularly wish to hear from you.

We heard testimony earlier about some of the work that's been done and from which we've learned, for example, how persons with certain psychiatric disorders, again, putting aside major Axis I disorders like schizophrenia or bipolar disorder, are likely to have, you know, particular difficulties, for example, like with isolation and in that category included say, for example, people with attention deficit disorder and, you know, likely a population not to know when they come into prison that they have

this disorder. And you had mentioned that as part of your testimony and how important it is to appreciate things like that and be able to differentiate a person with attention deficit disorder from somebody who is just a management problem because they just want to give us a hard time.

And so, yes, I did want you to comment.

DR. GROVES: Well, as far as Axis II diagnosis are concerned, in general there's no attention to these because it's even harder to make a distinction between Axis II and the normal behavior.

The second thing is that in my opinion, certainly, jails and many prisons really represent a hyperstress environment so it's difficult to say whether people's adaptation, as we see them, really represent Axis II pathology or not.

To make a diagnosis of Axis II you need to either have a history or a series of observations which indicate that what you are seeing are stable patterns of adjustment over extended periods of time.

JUDGE SESSIONS: Doctor, can you define Axis II for me, because I'm ignorant.

DR. GROVES: Right. The Diagnostic and Statistical Manual, current edition IV, has a five axis diagnosis protocol. Axis I, at least is what

most lay people would consider to be psychiatric illnesses or major psychiatric illnesses, things like schizophrenia, what used to be called manic depressive illness, it's now called bipolar disorder, problems like anxiety disorder, depression, PTSD, posttraumatic stress disorder. Those are sort of -- all disorders which can be chronic but they may be episodic, but they're generally recognizable.

Axis II are reserved for what is called personality disorders. Personality disorders, briefly, represent patterns of adjustment to personal relationships and their environment in general which are somewhat maladaptive. But those people don't have psychoses, that's not listed there, and they're sort of not abnormal in the sense that Axis I people are.

And then on Axis III are listed medical conditions which may be contributing to the Axis I pathology.

Axis IV is reserved for stressors which may be related to it, and then Axis V is what they call general adjustment function, GAF is just what I remember, but that's scored from zero to 100 and gives an idea of a person's level of general adjustment.

JUDGE SESSIONS: So Axis II and Axis IV are two of the big pressures in prison?

DR. GROVES: I beg your pardon?
JUDGE SESSIONS: Axis II and Axis IV are two of the big pressures in prison; personality disorders and stressors?
DR. GROVES: No. Personality disorders are not really -- I'm saying they're disregarded because of the difficulty of diagnosis and also because of the kinds of treatment we just specified.
JUDGE SESSIONS: Thank you.
DR. GROVES: Axis II --
DR. DUDLEY: We'll add that mental retardation --
DR. GROVES: Sorry?
DR. DUDLEY: Mental retardation is also Axis II.
DR. GROVES: Right. So, you know, in Axis II there's no medication, treatment for that per se. So the treatments for Axis II have to do with psychotherapy and environmental manipulation and, generally, as Ms. Fellner had indicated, these are not available in prisons.
There is one exception in my experience and that was a highly specialized prison called the Adult Diagnostic and Treatment Center of New Jersey. Very fancy name for the sex offender prison but it was

very unique, it was started in the '70s and it was based on the therapeutic milieu which involved intensive individual psychotherapy, group psychotherapy and medication where indicated.

In my experience it has been quite highly successful. It started out as a prison for white guys. Very few nonwhite people there. Beautifully appointed, computers, the works. It's not as white as it was and it's not as therapeutic as it was. I leave it to you to infer whether those things might be related. But it does provide a model for an approach to treating criminal offenders that might -- I mean, when you think of how people feel about sex offenders and the fact that you can have a treatment program actually helps these guys, and I followed a few of them in my private practice afterwards -- up to maybe four or five years, they haven't reoffended -- it suggests to me there are possibilities for helping other types of criminal offenders that would make them much better integrated into society and much more valuable. These guys I am following, they are working and why couldn't we do that for other people, especially when we consider situation like say Trenton State Prison Mercer County. A lot of the guys in Trenton, even when they go to high school and have a

diploma, they're not competent at the high school level that you would expect. So these are poor people in whom there's been little social and other forms of investment and prisons would afford us an opportunity to invest in those people and allow them to play much more constructive roles in society. I hope that answers your question.

MS. FELLNER: Can I just add something quickly which follows on what Dr. Groves is saying and I think probably comports with what Reggie has seen.

A lot of people who end up in prison, in addition to whatever addiction or whatever, have poorly developed internal control mechanisms, poorly developed coping skills because of their life history. So prison could, in fact, if it were modeled differently and this responds to something Margo was asking earlier, could be an opportunity -- if somebody has to be in prison, let's design a prison system that's going to take full advantage of the opportunity presented by having that person for one, two, three years rather than, in fact, reinforcing a lot of negative traits so that when they come out they not only have all the collateral barriers to re-entry by having been incarcerated, but certain patterns either remain the same or have gotten worse because of the

prison environment.

MR. BRIGHT: Dr. Wilkinson, this question, talking about your hospital and talking about the increase in the number of people, do you have some people in your system and of the seven percent of your inmates who are severely mentally ill who just simply shouldn't be there? You also said earlier that they would have been civilly committed a few years ago and now they're going into -- you're getting them instead of them going to the mental hospitals.

Are there people that just your department is not equipped to deal with who ought to be going into psychiatric hospitals, as opposed to your department of corrections?

MR. WILKINSON: I think part of the problem in Ohio is that we are equipped to do deal with them, you know, and maybe if we weren't, then maybe judges would be less reluctant to send those persons to prison to get treatment.

You know, we have -- yes, absolutely. We not only have persons with a mental illness who probably shouldn't be in prison, but we have people in the general population who probably shouldn't be in prison for whatever reason. But the bottom line is

that we do have them.

If there were more interventions, for example, with law enforcement, where many of the persons who were arrested could go to a crisis intervention center in the community instead of jail, then we wouldn't have the kind of problems that we have in jails and prisons in this country. You know, if there were other kinds of treatment in lieu of convictions sentences that courts could impose, instead of the typical ones that we know have exacerbated the numbers in our prison population, we wouldn't have the problems that we're having now.

So I would unequivocally say yes, we have people with a mental illness who should not be in prison.

MR. BRIGHT: And following up on that, your hospital, your prison hospital or mental health prison hospital, is it at capacity? Do you have empty beds? I mean, how does that relate to the people who need hospitalization and do you ever have a waiting list or whatever for that?

MR. WILKINSON: Well, actually, the number -- we have double the capacity in our prison hospital. The number of persons in our hospital is steadily diminishing. I mentioned about the

residential treatment units and our catchment areas, the number of those persons are going down because we are providing interventions, we're doing preventive mental healthcare and that is helping us to reduce cost. We've actually closed several of our residential treatment units.

So even though the number of persons who are coming to prison with a mental illness is either stable or increasing, the intervention that we put in place and the money we're spending to provide that intervention is reducing the number of persons who actually need to take up mental health beds, either in the hospital or in the residential treatment unit.

MR. BRIGHT: Can I ask one more question. Can I ask a supermax question.

In your supermax do you have when an inmate is there there's complete deprivation, newspapers, magazine, television, or not, and what do you think of that?

MR. WILKINSON: No, it is not complete deprivation and I don't think a federal court in this country would allow that. Prisoners in our supermax have access to visiting, they have access to --

MR. BRIGHT: By TV or in person,

visiting by TV?

MR. WILKINSON: No, in person, yes. We have recreation where prisoners can recreate together. We have areas where programming takes place now where they can, you know, get a GED together. So they have outside recreation as well.

They have access to all the appropriate reading materials, as does anybody else in any part of our 32 prisons do. So there is no such thing as complete deprivation in our supermax prison.

MR. BRIGHT: Okay. Thank you.

DR. DUDLEY: Commissioner Schwarz.

MR. SCHWARZ: SchwarzWhen Ms. Fellner started her testimony you talked about anecdotes and data and I've got a question trying to get at that a little bit, which starts with a direct one for Commissioner Wilkinson, and then maybe as to all three of you.

Are consent decrees a good source, a reliable source of data, what are the reasons you entered into the consent decree that you did enter into, because I know there are multiple reasons for doing that? And then, more generally, about if there is a lack of data, what are the causes for a lack of data, who has responsibility for lack of data? And, I

suppose, most importantly, if there is a lack of data, what could be done by way of providing for certain information that regularly would be required to be provided? The first one is a narrow question to you and then broader one to all of you.

MR. WILKINSON: The question of why we entered into a consent decree was pretty simple for us and it was -- and Jamie mentioned it earlier -- it was a pretty unique consent decree because it was not contentious at all.

We knew that the system was broken. We, to this day, still believe the mental health system we had 12 years ago met the constitutional minimum. But we knew it was broken enough that it didn't -- wouldn't take much for that to go south on us. So what we wanted was a state of the art mental health delivery system.

By entering into the consent decree we found out that there were some things that we could reasonably improve that would allow us to have a state of the art mental health system. Now, we could have done the same without the lawsuit.

And so I'm not, you know, saying to you let's sue everybody so that we can have, you know, a good mental health system, because that's not what I

think the answer might be. But in our case, you know, it certainly was a consideration, not to mention the expense of going through the litigation and the time and other complications associated with that type of endeavor.

MR. SCHWARZ: SchwarzJust to make an observation on that, my experience for five years as a government lawyer was very often good commissioners wanted help from the lawyers to lose a case so that they could get, you know, money and help and requirements and it's not a horrible thing, but it's true.

MR. WILKINSON: You will never hear me admit that.

MS. FELLNER: We certainly found that in our interviews; quite a few correctional leaders said, off the record, thank God they were sued, because that's a way to pry money out of very reluctant legislators.

I wanted to --

MR. WILKINSON: But I will say now that it's different. You know, 12 years ago there was new money that came to us for this. Today it's robbing Peter to pay Paul. So if we got new -- so if we got money today from a legislature, it's going to come

from somewhere else in our budget, it's not going to be new money so the rules have changed.

MS. FELLNER: That's why I emphasized the need to reduce the population. We can't do it all and states want to do it all by keeping increasing the numbers of people in prison, that's why you are between a rock and a hard place.

I wanted to respond on the data question. I think first you have to ask what kind of data you were looking for and so that will depend what the source is and where.

Consent decrees and monitoring can provide a very valuable source of data because you have somebody who is an independent expert brought in with no agenda who is observing what's going on and filing reports with the courts and with the departments. Unfortunately, often those monitoring reports are under seal because the parties have agreed to put them under seal. I don't think that serves the public interest. I think names should be removed, but I think it would be in the public interest to have those monitoring reports public and to have as much transparency and data available to the public so that you know what, in fact, is going on.

DR. GROVES: I wasn't sure if I

understood your question entirely. Were you also interested in knowing the effectiveness of the consent decrees on actual practiceSchwarzs within institutions?

MR. SCHWARZ: Not so much. I mean, that's important, but I was interested in what conclusions we could draw from the fact of the consent decree on certain subjects.

MS. SCHLANGER: On the topic of lawsuits as sort of a regulatory device, I wonder -- I hear different things when I talk to people and I wonder what you all think has been the impact of the prison litigation format on that method of oversight, the PRLA was enacted nearly ten years ago now so there's been time for it to settle out, and I wonder how it's feeling.

MS. FELLNER: I think it's had a highly pernicious impact. There was a lot of talk at the time the PRLA was passed about peanut butter, creamy versus crunchy peanut butter lawsuit and certainly there have been some of those, but the PRL sweeps too broadly so that if you want to complain about being raped by a staff member, if you want to complain about being beaten up by a staff member, you are subject still, and those are very serious complaints,

obviously, you are subject to the same PRLA restrictions, which make it you have to exhaust your internal administrative remedies, which can be very hard to do; I mean, you make one little error and you're out, which cuts back way back on fees, which makes it hard to find lawyers -- lawyer fees, which makes it hard to find lawyers who will take your cases, and legal aide cannot represent prisoners so it's cutback on legal representation, and there are a number of other problems with it.

If you think of the photos in Abu Ghraib, the guy standing there with the dog, naked with the chain, he could not bring a lawsuit today because PRLA says you have to have physical injury. So that incredible humiliation and abuse, he could not bring a lawsuit. There clearly needs to be some modification to PRLA to ensure that prisoners are not deprived of access to the courts, while protecting the courts and prison officials from obvious spurious, frivolous claims.

One of the ways also I would urge you to look at is at grievance systems. When prisoners feel their concerns are heard, when they have good grievance systems where they feel that, you know, they're being listened to, they are less likely to

spend all their time filing lawsuits that aren't going to go anywhere.

MR. WILKINSON: I appreciate what Jamie has provided for you, and I don't disagree with that, but I will tell you that if it weren't for the PLRA, I would not have entered into this consent decree because, typically, these cases such as Ruiz and Perini, you know, these cases can go on for 20 years. I was not about to be involved in a consent decree that did not have an end to it.

This one was -- had a very definite end to it, everybody agreed and I think the one thing that the PLRA did for us was to provide some parameters and, singularly, it went well for us.

DR. DUDLEY: Mr. Maynard.

MR. MAYNARD: I had a question for Dr. Wilkinson. We've heard about, talked about a little on the Commission the performance-based measures system that ASCA has worked on for the last couple years and when we talk about data, I'm just curious what your thoughts are about the viability of some of that data being available in the future to this Commission for determining what really the facts are in the conditions across the country in the prisons.

MR. WILKINSON: Thanks, Director Maynard.

One of the things that's been lacking in our business is having good information; we know that. So over the course of the last five years or so the Association of State Correctional Administrators, which is a group that represents all the directors, commissioners and secretaries of commissions, not the jails albeit, petition to the U.S. Department of Justice to help fund a system whereby we can actually start counting things differently and counting things with the uniform measures in mind, using key indicators, using data dictionaries, using language that we can all understand instead of each jurisdiction having their own rules.

So we now have county rules, we now have key indicators that we're building upon that will allow us to be able to compare information from jurisdiction to jurisdiction. That's going on as we speak. We're entering into the third phase of this project now and, in fact, the jurisdiction of Iowa and Ohio are one of the pilot states for this major, major initiative that the Department of Justice saw fit to invest in.

So when you talk about data, we know we

have a lack of data. We also know that good data, evidence-based information will allow us to make better decisions about managing this population and any other group of people, whether it related to security or programming, in order for us to save money, in order for us to reduce recidivism, in order for us to minimize victimization in our community, so it's a big deal.

DR. DUDLEY: Each of you mentioned substance abuse, drug treatment issues in different sorts of ways and I think, Dr. Wilkinson, you mentioned the issue of co-existing disorders, I think you did too, Dr. Groves.

I'm wondering given what we know the treatment of patients with dual diagnosis and substance abuse diagnosis and other mental health problem, what is your thinking about the better integration of mental health services with drug treatment services for the effective treatment of duly diagnosed inmates?

MS. FELLNER: I think that's called a softball question. I mean you've sort of -- I think we all know what the right is answer is.

I would simply point out it is a problem not only in prisons, but in the community as

well, and prisons just sort of carry that forward where mental health systems sometimes don't want to deal with drug addiction and vice versa and, obviously, integrating it would make a great deal of sense.

DR. GROVES: I agree. What's happened in the field is that there has been some bifurcation between substance abuse treatment and the treatment of other mental illnesses and the personnel involved in the two are somewhat different.

Substance abuse treatment is largely driven by substance abuse counselors typically, although there is a cadre of psychiatrists trained in substance abuse treatment, and I happen to be one of those, but the opportunity to implement that kind of unified model is not that easy to come by, in New Jersey anyway.

One of the things -- it's very hard to have access, reliable access to patients in New Jersey facilities. The so-called security arrangements of the prisons predominate over everything and that becomes a cloak that often hides agendas and conveniences that are really not relevant to prisoners' welfare. So it's hard to find, say, a four hour stretch of time within the day where you can just

see patients. If you want to see them in the medical department, then the people -- the officers have to bring them to the medical department. They often say that they don't have the personnel to do it. If you don't want to see them there, then you have to go to the different cells to see them.

So the place like Trenton State Prison, the whole line of guys, in cells with bars, if you want to speak to the guy, you speak to him through the bar. The prisoners on either side have mirrors that they are using to see what's happening and they're also listening. So what kind of confidentiality do you get and what kind of counseling can you do under these circumstances? It's very --

I mean, unless the welfare of the prisoners and their health and mental healthcare is prioritized, it is very difficult to do that. We need some mechanism that would say, look, treating these guys for these problems is really important, these guys or women, men or women, it's very important, and, therefore, we'll make the kind of security arrangements that will allow these things to take place, but that's not what we get.

So those are some of the practical problems that currently exist for integrated and

impactful treatment method.

And one of the reasons that we're so dependent on medication is that although ideally psychiatrists should spend significant amounts of time with patients in order to select the right medication, if they're given medication at all, we're often reduced, like Mr. Farrow said, to 15-minute interviews, which are basically medication checks. But for a population that is that vulnerable and living under such difficult circumstances, I don't consider that adequate.

It is a model that is used by managed care in the community, but it's a model that's really much more based on profit motives and the rationing of care in the community that is an optimal health or mental healthcare.

DR. DUDLEY: Do you feel that you have a better -- have you been able to tackle this issue of treatment of the duly diagnosed?

MR. WILKINSON: Well, not as well as I know we should because there's still a problem in terms of assessment, the time you might have to deliver. You heard Dr. Beard earlier say that you can't do good substance abuse treatment in a couple of months and when that person has a mental illness then,

you know, that needs to be treated as well.

It used to be, of course, as all of you know, we didn't say co-occurring disorders or co-existing disorders, you know, five years ago; we said duly diagnosed persons and somehow or another we've gotten politically correct. I like the new ones -- new title, but not for the same reasons I think everybody else does. Co-occurring to me means you can have more than just two and many of these persons that we have to deal with have more problems, believe me, than just mental health and substance abuse.

You know, if you are a sex offender, you need treatment; if you are an aging person, you need different types of interventions.

So when you add those complications to the fact that you are in prison and you are going to get out one day and you got to look for a job, then there are a number of problems that we have to take a look at simultaneous to the ones that might fall under the categories of a DSM-IV.

DR. GROVES: You know, I wanted to make a comment. It's not directly related to what preceded just now, but the issue of the scarcity of resources for treating prisoners has been raised several times.

One of the consequences of the get tough on crime and long mandatory sentences is that prisons are now caring for an aging population. We are talking now about sometimes people in their 80s. So if you can consider the kind of expenses that you generate for people who are, say, age 60 to 80 to 85, they're tremendous. So -- and those people have the kind of medical problems that you have to respond to; talking about carcinomas, acute heart problems and the like, strokes. So that that just eviscerates the resources left for the younger guys; the guys who are between 20 and 40 and relatively healthy, you know what I mean, you just don't have the money for that under those circumstances.

So a lot of politicians, I don't think, understood the implications of long sentences, but we are beginning to feel it now and have been feeling it for some time.

MS. SCHLANGER: I wonder if you could tell us a little bit about another issue, which is mental retardation. We haven't heard very much about it, about its prevalence or, I suppose, really the challenges it poses for safety and abuse, which is this Commission's project, and so I wonder -- it seems like it's been lurking at the edges of some stuff that

you all have been saying and I would love to hear what you have to say on that topic.

MR. WILKINSON: We have a unit specifically for persons who have been diagnosed with retardation, and I know retardation and developmental disabilities are defined differently in different states.

But in our jurisdiction you don't have retardation if you were not diagnosed with it before you were 18 years old. You don't get rid of a mental retardation. You can get better with a mental illness, but as it is defined in our jurisdiction, you don't get better so we can't really treat it. We can help provide training, we can help persons with retardation to exist normally, we can teach them how to comb their hair, we can teach them how to do family style dining, we can teach them how to clean themselves or work areas, but, nevertheless, many of the persons who have retardation also have a mental illness and it complicates matters when we're trying to figure out, well, what do you treat? And how do you make these persons -- and this is where it gets back to the question of should these people be in prison or not?

I tend to suggest many of the persons

that we have in our institutions who are currently diagnosed as having retardation would not have been there five or ten, 15 years ago, but yet we do. So we're not only mental health directors, I'm a director of a significantly-sized mental retardation operation in our jurisdiction, and so is every other director of corrections in this country.

MS. SCHLANGER: And are those inmates at risk for being harmed or are they dangerous to others or both?

MR. WILKINSON: Yes, both, all of the above. That's why we have to properly classify these persons, that's why assessment and diagnoses of these persons, when we first get them, is important. It's important before we get them, for the pre-sentence investigation phase, when they are first arrested and sent to court, that's when the paper trail should begin and we should have access to all of that.

We should not have to wait until that person gets to prison, especially if there is a pre-existing disorder. We need to know that information and there is a lack of that information being transmitted to us so that we can make good classification, good job assignments and use that data, you know, in order for us to make good

correction decisions.

MS. FELLNER: The problem Reggie was just saying about getting pre-prison data is not just for mental retardation, but, also, mental illness. You will often have a lot of information about a person's prior diagnoses, treatment and whatnot as part of the pre-sentencing or as part of, you know, court mitigation argument, whatever, and that information is typically not sent to the prison and it is typically the case that people in -- mental health people in the prisons won't ask for it, so a huge wealth of data that could be helpful in treatment gets lost.

DR. GROVES: And there's some sort of technical difficulties with the mental retardation in prison. In the first place, if the person is sort of mildly mentally retarded or sort of borderline, they may not experience that much difficulty in a prison. If they're more severely effected, it's a problem.

But if you are getting the person, first of all, and you don't have any history, documented history, the appropriate diagnosis demands expenditure of some resources. You really should do an IQ test by somebody who is trained to do it, usually the psychologist, at least a master's level

person. It's sometimes difficult to get that sort of personnel, certainly in jails and sometimes in prisons.

And mental retardation can mimic other conditions because other conditions can affect the intellectual function and make sure seem retarded when they're not.

So it's not quite as easy an issue as it might appear at first, in terms of whether a person is mentally retarded or not.

DR. DUDLEY: Mr. Schwarz.

MR. SCHWARZ: SchwarzThis is a question, Director Wilkinson, for you that's not limited to mental health, but there's discussion about whether there are people being sent to prisons who don't need to be there and whether, also, the number of people in prisons gets in the way of corrections professionals doing the job that they would like to do. And maybe you could answer this question either from your own point of view or if you didn't want to talk about your own point of view, say what you think most of your colleagues believe.

Do most corrections professionals believe that the number of people being sent to prisons per order of the legislature is getting in the

way of their doing the kind of job they would like to do as corrections professionals?

MR. WILKINSON: Interesting question. I have never heard it couched quite that way. I do believe that most correctional administrators will suggest that there are persons in their population who should not be there. Considering, you know, the number of gray hairs I have today, I have no problems in saying we have a lot more than we should have. Other corrections administrators might be more reluctant to say it in that way.

But we've done research and we know that given the same histories that persons might have in one county, given if that person was sentenced in a different county would determine whether or not they would go to prison.

We're concerned now about the female population. Exponentially there are more females, percentage-wise, that are being sent to prison than males, and we have absolutely no idea why. I've actually commissioned a study to find out why that's actually going on. I had to open up a third or fourth facility just for female offenders just in recent months, so it's a problem.

I do believe that most corrections

administrators will suggest that it's a concern, but I'm not -- the number would have to be reduced in so significant of a way that it would reduce the average cost of incarceration of a person and not the marginal cost. I could take out -- 20 people out of a prison with 300 people and it's still going to cost me the same to run that institution. If I could close the prison with 300 people in it, then I would save that average cost. So it's not just the question of how many we have, at what threshold level does it exist that it would really make a difference?

DR. GROVES: I think it's ambivalent for an individual administrator at an individual facility, they certainly often recognize that their facility is overcrowded.

For example, Mercer County used to have a detention center in Trenton and a correction center a few miles away. The building in Trenton was a sick building; plumbing was always breaking down in the summer, people can't take a bath, can't flush a toilet for days at a time and the same thing happened at the new prison.

So you have all of these psychiatric patients coming in, overloaded, people sleeping in the gym, sleeping on the floor, cells that used to have

two people now have three people stacked on top of each other. They're tearing their hair out.

And the psychiatric patients, because of the rigidity of the system, one of the easiest ways to get any attention or acknowledgment that you are suffering is to say that you are going to commit suicide or to make a gesture; like, you know, you tie your handkerchief around your neck or you cut yourself or something like that, then that's a problem for them; you have to get isolated or they're worried about you because of your history, then you have to get taken out to the local hospital and, you know, that's a big expense.

However, at the systems level there may be different feelings because, you know, corrections are a growth industry; it provides a lot of jobs in segments of the community.

Mr. Farrow this morning talked about the north-south axis in New Jersey. In New Jersey south there are many farms that are going bust and the guys who lived on that farm are the children of those farmers of the previous generation. They are now being -- many of them are being provided employment through new prisons that are being put up and expanded in the southern part of the state.

So if the corrections people are high enough place, the volume of prisoners could involve some growth of that empire and more security for corrections on a whole as against an individual institution.

MR. GREEN: I just wanted to ask actually two questions, they're unrelated. One is to Ms. Fellner, you mentioned about oversight and accountability during your opening statement, you didn't get a chance the fully address that, but, also I wanted to ask then Dr. Wilkinson on a different issue; you expressed in your opening statement about some trepidation going into this and when the Commission was announced and that that was something that was somewhat part of correction officials around the country.

In terms of our addressing this issue, assuming that there are some important issues that need to be addressed and that need to have impact, I would like you to then maybe comment on is, it what we say and how we say it? How do we, in fact, do something that ends up being effective from the perspective of correction officials, but first accountability and oversight, Ms. Fellner.

MS. FELLNER: Yeah, I think probably

everybody remembers the sort of open -- what were they called -- sunrise laws.

UNIDENTIFIED SPEAKER: Sunshine laws.

MS. FELLNER: Sunshine laws. Those seem to bypass prison systems. Prison systems are remarkably closed, not just that they keep prisoners in, but it is very hard for the public or even appropriate sectors of the public to find out what's going on inside. And given all the problems which you are looking at that prisons, by their very nature, can have, oversight, outside oversight, I think, is crucial.

Whether it be done through an independent inspector general, whether it be done through a commission, there need to be more mechanisms so that there is an outside accountability for what's going on inside, which in most jurisdictions or states does not exist.

This is also particularly true for mental health and medical care. I believe that there should be -- call them boards, commissions or whatever, independent experts in medical or mental health fields who are charged with monitoring what's going on, who can ask questions, who can get the data. Often times, this data and this information only comes

out in litigation.

California shouldn't have required those experts to go in, who you heard from earlier, to uncover what should have been out for a long time.

Prison systems are reluctant to have oversight, they are certainly wary of the press, for good reason, but there needs to be more mechanisms of transparency in general.

MR. GREEN: Dr. Wilkinson, could you --

MR. WILKINSON: When the Commission was first announced, the way it got to us as correction administrators is that it was a follow-up to the scandal in Abu Ghraib in Iraq, and as it was determined with that event, persons who were professional corrections administrators had nothing to do with Abu Ghraib. It was strictly a military event and those persons were all cleared by the Department of Defense Inspector General when that was investigated.

But, nevertheless, it was extrapolated as a result of that and characterized that Abu Ghraib is no different than prisons that are operated in the United States. The same way it's being said about Guantanamo Bay and them being the new goologs(ph.) of the 21st century.

So, as a result, we were preparing to go to war, more or less, with this Commission and what we thought may have been the intention, which was to eventually come out with a report that would be nothing but condemnation of how correctional facilities in this country were ran.

If it were not for Gary Maynard, one of your commissioners, who called and said, hey, you know, I will be the conscious of the Commission, you know, I will help provide any information necessary to all of you, as well as the Commission members, so that this can be a reasonable exercise, you wouldn't have seen me here, you wouldn't have seen Richard Stalder here, you wouldn't have seen Jeff Beard here, you wouldn't have seen a number of things. You would have heard from us, but you wouldn't have had us here in the capacities that we were in.

Alex held a session in Washington, DC a couple weeks ago, it was a wonderful round table discussion, we heard from Judge Sessions and others of you that more or less said what are saying; how can we help? We would love to help, you know, we'll do whatever it is, we'll provide data, we'll provide documents, we'll sit in meetings with you, we'll respond, we'll proofread, we'll do whatever you want,

you know, we will write the report for you if you want. So, you know, I won't say we're necessarily here to help but, you know, it would be a travesty in our estimation if we didn't have at least the ability to provide some feedback to you.

MR. BRIGHT: Well, the question too, though, was what would you want it to say?

MR. WILKINSON: Well, the truth.

MR. BRIGHT: I mean, as somebody who is running a very large -- sixth largest prison system, what do you see as the major problems and what way do you see in which policymakers, legislators or whatever can help you do your job better?

MR. WILKINSON: Well, I think it needs to, first of all, say the truth.

MR. BRIGHT: Of course.

MR. WILKINSON: And I have this 20 percent/60 percent/20 percent theory. I think there are 20 percent of some really good best practices out there that somehow or another you need to identify, and there are 20 percent where there are lots of problems, where things need to change, where probably, you know, everybody would have meant that this is an area for some sort of reformation.

But there is 60 percent of all of that

that's kind of on the bubble, it's not unconstitutional, you know, we need to probably do a better job, but we need help. We need technical assistance. I'm not one to ask for money because, you know, that's not something I think you can do, so I think you need to stay away from the money question as much as possible because this isn't -- you know, you need to give us the tools to go to our legislatures for it, but you are not going to get it from the federal government, so we're relegated to knowing that right now.

So we want to be able to say that there are some tools available, technical assistance, training, that can possibly be recommended. We want to be able to identify how jurisdictions can identify what's going on in other jurisdictions that they can benchmark with, for example, and we need to, you know, show that there are some bad practices out there, not necessarily by identifying jurisdictions, but having case examples of stuff that work.

We are now talking about the science of what works and we think we are getting pretty close to understanding what evidence-based practices -- you know, the science of what works and those kinds of things ought to be so whatever you come up with almost

need to be kind of an outcome based, you know, recommendations instead of something that is just going to sit on the shelf, like so many other exercises have been that we won't look at any more.

MR. BRIGHT: I mean, some problems are not necessary -- there are some bad practices, you said the 20 percent, but then there are also some things where you've just been handed -- a better analogy than the one maybe used before -- but you've just been handed more than you've been given the resources, the personnel or whatever to deal with, I mean -- or not you, but you and your colleagues across the country, some more than others; that's a fair statement; isn't it?

MR. WILKINSON: Yes, that's absolutely true and that's why I think this work cannot be relegated only to the corrections profession.

You know, I don't even use the word criminal justice. I talk about something called social justice because if there's going to be a resolution, you know, to the problem that we have, it's going to start way before it gets to us. It needs to start in the community, it needs to start with sentencing courts across the state, it needs to start and linger in the hallowed halls of our

legislatures across the country.

So the issue is a lot bigger and much more holistic than what we originally perceived as the mission of this Commission.

DR. DUDLEY: We have to stop.

MR. WILKINSON: Sorry.

DR. DUDLEY: No. I eman that's an okay place to stop.

I just want to thank each of you for taking the time to come and meet with us. It's been enormously helpful and, hopefully, we'll be able to integrate what you've been able to tell us with the rest of the information we've gathered, so we thank you so much again.

CLOSING STATEMENTS

MR. BUSANSKY: You can remain seated. I just have a few closing remarks.

My name is Alex Busansky, I'm the Executive Director of the Commission on Safety and Abuse in America's Prisons and on behalf of the Commissioners and the staff, I'd just like to offer a few closing remarks.

First of all, I want to sincerely thank all of those individuals who have testified before the Commission here in Newark, New Jersey. Thank you for

candidly describing difficult personal experiences, thank you for sharing your knowledge and insight acquired over years of work in the challenging field of corrections, and thank you really for helping us in our inquiry here at the Commission.

I also want to thank those of you who took the time to listen to the testimony provided over the past two days. Being here makes you a witness to this inquiry. But, more importantly, being here gives you a chance to learn, along with us, about the most serious problems of abuse and safety in America's prisons and jails and how we might begin to solve those problems.

You've heard more than a few witnesses say that the public doesn't care about what happens to the men and women who work in, who serve time in our jails and prisons. Your presence shows that people in our communities; mothers, fathers, neighbors, brothers and sisters care about these issues. Issues that -- as commissioner co-chair Nicholas Katzenback said yesterday morning when the hearing began, issues that affect the very fiber of our justice system and of our society.

This is the Commission's second hearing and we will hold two more hearings before releasing a

final report and recommendation. You may not be able to come to those hearings; the next one is in St. Louis in November and the final hearing will be in California in January, but I encourage you to stay involved with us. Go to our website, the address is right up there on the screen, www.prisoncommission.org, register to receive updates about future hearings and other work. And e-mail or write to us if you have information or insights that you believe would advance our inquiry.

Again, on behalf of the Commission, thank you all again and this concludes our proceedings.

(Hearing concluded at 4:48 p.m.)

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C E R T I F I C A T I O N

I, MARGARET M. REIHL, a Registered Professional Reporter, Certified Realtime Reporter, Certified Shorthand Reporter and Notary Public of the State of New Jersey, do hereby certify that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place, and on the date hereinbefore set forth.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

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