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
countertransactive 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 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 serious 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
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
hyperlsten 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: Schwarz.When 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: Just 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 practice 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.