

COMMISSION ON SAFETY AND ABUSE In America's Prisons

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COMMISSION HEARING PROBES CROWDING IN PRISON, USE OF ISOLATION, & MEDICAL AND MENTAL HEALTH CARE

On July 19th and 20th, the Commission on Safety and Abuse in America's Prisons convened in Newark, New Jersey, to hear testimony about widespread institutional problems that can lead to violence and abuse if not properly managed. A transcript of the proceedings, in whole and by witness panel, is available on the Commission's web site (www.prisoncommission.org).

Highlights of the Hearing Include:

- Debate about the prevalence of overcrowding
- Data illuminating long-term trends in violence behind bars
- Testimony about the over-use of isolation, and signs of a shift
- Consensus about the need to provide quality medical care; but divergent views of current practice
- Concern about "the new asylums"

Debate about the prevalence of overcrowding. Allen Beck, Chief of the Corrections Statistics Program at the federal Bureau of Justice Statistics (BJS), testified that facilities are less crowded today than they were in the 90's – a view that sparked debate about how to define capacity and overcrowding.

Richard Stalder, head of the Department of Public Safety and Corrections in Louisiana and President of the Association of State Correctional Administrators said that from an administrator's perspective overcrowding means having more prisoners than your resources can support. "We can have 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." National expert Vincent Nathan helped to demystify the numbers: "The architect is told to design a prison for a thousand people," he said. "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."

Data illuminating long-term trends in violence behind bars. Allen Beck previewed data from an August report by BJS on deaths in custody that shows a decline in homicides and suicides beginning in 1980 and continuing through the early 90s. "I think that's a good indicator of increasing control over facilities," he testified. He also lamented the lack of reliable data on assaults and other problematic conditions of confinement. "Those data are very hard to come by, let me say, because the absence of

standardized reporting in the field.”

Professor Craig Haney responded to Beck’s testimony arguing that the increased control of prison populations and decline in deaths has in part been won through the excessive use of isolation and the proliferation of both lethal and non-lethal weaponry in living units and questioned the use of these tactics as a long-term solution to prison violence.

Testimony about the over-use of isolation, and signs of a shift. James Bruton, former warden of the supermax prison in Oak Park, Minnesota, discussed how he restricted the use of isolation, even for prisoners convicted of violent crimes and also known gang members. He recommended mandatory national standards to regulate the use of isolation and banning so-called “dark cells,” which inflict almost total sensory deprivation. And while national expert Fred Cohen testified that “isolation has become a regular part of the rhythm of prison life,” he too sees signs of a shift: “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.”

Consensus about the need to provide quality medical care; but divergent views of current practice. “The reality,” Dr. Joe Goldenson told the Commissioners, “is that much of the morbidity and mortality that we see in our nations’ prisons is the result of inadequate and poor medical care.” Dr. Goldenson directs medical services for the San Francisco County Jail and was involved in assessing health care crisis in California’s prisons. He and another witnesses, pointed to security decisions that hamper effective medical care; incompetent medical personnel; and an underlying lack of funding and resources for corrections administrators to improve care – problems that have consequences for the health of prisoners, staff, and the public.

Arthur Wallenstein, head of corrections in Montgomery County, Maryland, and a 30-year veteran of the profession took the long-view, emphasizing the vast improvement in correctional health care since the mid-seventies. “No one in this profession could possibly say that healthcare is not [today] a core element of correctional operations and correctional practices,” he testified.

Jeffrey Beard, Secretary of Corrections for the State of Pennsylvania concurred, “This is a topic that’s important to us in corrections.” And he argued against letting the “few systems that are having problems, and emotionally-charged anecdotal reports define what is happening in our correctional healthcare today.” Secretary Beard testified that “our prisons and jails generally do a good job providing healthcare to the inmate populations,” while Mr. Wallenstein lamented the fact that the day before the hearing just 242 of our nation’s jails were accredited by the National Commission on Correctional Healthcare, standards which, he argued, every correctional facility should follow.

Concern about “the new asylums.” Jamie Fellner, an attorney and director of U.S programs at Human Rights Watch told the Commission, “There are three times more mentally ill people in prisons than in mental health hospitals.” For Reginald Wilkinson, director of the Ohio Department of Correction and Rehabilitation, that means he and

other corrections administrators have become “de facto mental health directors.” It’s not a job he chose, but one he has embraced. Mr. Wilkinson is considered by many to operate a state-of-the-art prison mental health system.

Testimony by other witnesses suggests that prison mental health services elsewhere in the country could be, in the words of Jamie Fellner, “woefully deficient.” “What has been lacking,” she said, “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.” Testimony from Joe Bauman supported this assessment. A state correctional officer in California for 19 years, Mr. Bauman testified about grossly insufficient mental health training for officers: currently just a 15-page booklet entitled “Identification of Special Needs Inmates,” which is designed to be read during normal working hours. Another witness, Dr. Gerald Groves, asked the Commissioners, “Why should a citizen who is entitled to Medicaid or Medicare suddenly lose health benefits when they enter the department of correction?” Quality of care nationally, which has effects far beyond the mental health of individual prisoners, will not improve, Ms. Fellner said, unless the U.S. prison population is reduced.

Twenty-four witnesses testified in New Jersey, several offering accounts of the personal impact of crowding, isolation, and medical neglect and abuse. Their stories and more from these experts and others can be found in the hearing transcript and in written statements posted at www.prisoncommission.org.

The hearing in Newark was the second of four scheduled hearings. The next hearing will be in St. Louis, Missouri, on November 1-2 and will focus on corrections officers and the challenges of the job. A final hearing in Los Angeles, California, is scheduled for February 2006. The hearings are the most visible aspect of the Commission’s effort to explore the nature and extent of safety and abuse in America’s prisons and jails. The Commission expects to issue a final report and recommendations in April 2006.