23 EXPERT TESTIMONY ON CARING FOR THE MENTALLY ILL

24 DR. DUDLEY: Okay. We're ready to

25 start up again. Our last panel for this hearing is on

1 caring for the mentally ill. That will be the focus
2 of our three presenters.
3 Throughout the course of today and even
4 prior to today we've been hearing about the large
5 numbers of persons suffering from mental illness who
6 are in prisons across the United States. Estimates
7 vary from one jurisdiction to the other, but overall
8 it appears as if the -- nationwide there's about
9 16 percent of persons who are in prisons suffer from
10 mental illness. Clearly, that's really just the
11 identified population of persons who suffer from
12 mental illness.
13 Given the fact that statistics also
14 suggest that as much as 40 percent of inmates are at
15 some time, during the course of their incarceration,
16 treated for some type of mental illness, then there's,
17 obviously, a large unidentified population as well.
18 The Commission is interested in looking
19 at this issue in depth and trying to understand it as
20 completely as possible. We're concerned about why
21 there are so many inmates who are suffering from
22 mental illness in the prison system; should they be in
23 prison, should they be some place else? If they
24 should be some place else, why are they not there and
25 in prison instead?

1 For those who are incarcerated, what
2 are the impediments to their receiving appropriate and
3 adequate mental healthcare? What are the impediments
4 to identifying those who were not diagnosed before
5 they entered the prison system? What are the
6 impediments to identify with those individuals and
7 treating their mental illnesses?
8 What are the implications of all of
9 this for the safety of persons who suffer from mental
10 illness while incarcerated? What are the implications
11 for the safety of others as it relates to those who
12 are suffering from mental illness; others being other
13 inmates, corrections officers, et cetera?
14 How can -- particularly in light of
15 some of the things we heard this morning, we are not
16 only interested in adequate care, but concerned about
17 those who deteriorate even further while incarcerated
18 and resulting in either deterioration of their mental
19 illness, suicide attempts, other sorts of problems as
20 well.
21 And this also -- this issue of how our
22 persons upon release are best hooked up for continuing
23 treatment and aftercare services and is that something
24 that's doable and that we should be able to do much
25 better?

1 We have three very distinguished
2 persons with us today to speak to the Commission.
3 They include Jamie Fellner, who is an attorney in the
4 United States Program Director at Human Rights Watch,
5 she's the co-author of "Ill-Equipped, U.S. Prisons and
6 Offenders with Mental Illness," which is an exhaustive
7 look at the issues surrounding the incarceration and
8 treatment of persons with mental illness that was
9 published in 2003.
10 We have Dr. Gerald Groves. Dr. Groves
11 is a psychiatrist who attended mentally ill prisoners
12 in New Jersey prisons and jails up until a couple
13 years ago. He will describe a situation of care
14 impeded by institutional barriers and misdirected
15 priorities in which there appears little realization
16 of the negative consequences and lost opportunity of
17 inadequate treatment for those soon to be released
18 back to the community.
19 And then we have Dr. Reginald
20 Wilkinson, who has been the Director of the Ohio
21 Department of Rehabilitation and Correction for 14
22 years and has overseen an effort to greatly improve
23 the quality of care provided to the mentally ill in
24 Ohio's prison.
25 Each of our witnesses will have about

1 12 minutes to talk to us. We have a timekeeper
2 sitting right over here to my right who will let you
3 know when your time is up. Please try to cooperate
4 with her as much as possible so that we will have the
5 opportunity for discussion and questions after each of
6 you have completed your presentations.
7 Ms. Fellner.
8 MS. FELLNER: Thank you very much for
9 inviting me on behalf of Human Rights Watch to talk to
10 you. I think the work of the Commission is crucially
11 important and I'm glad you are going to be shedding
12 light on the well-being or lack thereof of those
13 members of our communities who are currently behind
14 bars.
15 I'm glad you have taken on the subject
16 of mental illness because I don't believe any
17 discussion of violence and abuse in prisons can ignore
18 the consequences of the high rates of incarcerations
19 of offenders with mental illness and the poor
20 treatment they receive behind bars.
21 Secretary Beard, in the last panel,
22 mentioned that there is a lot of anecdotes and not a
23 lot of data, and that certainly is true, but we spent
24 a long time, over a year, traveling from state to
25 state, reviewing thousands of pages of documents,

1 interviewing hundreds of people, mental health
2 practitioners, corrections officials, inmates,
3 lawyers, and we think the assessment which we have
4 here in "Ill-Equipped" is as solid as any that is out
5 there and I am pleased to be able to tell you that
6 although many people don't like our findings, nobody
7 has ever said that they're inaccurate, so I do hope
8 you will get a chance to read the report.
9 We chose the name "Ill-Equipped"
10 because we thought it was clever. We always try to
11 come up with clever names for our reports. It
12 reflects the fact that we believe mentally ill
13 prisoners are often too -- are ill-equipped to cope
14 with prisons and prisons are ill-equipped to cope with
15 them.
16 Prisons were never intended as
17 facilities for the mentally ill and, yet, that's one
18 of their primary roles today. There are three times
19 more mentally ill people in prisons than in mental
20 health hospitals, prisoners have rates of mental
21 illness that are two to four times greater than in the
22 general public. Somewhere between two and 300,000 men
23 and women in US prisons suffer from mental disorders,
24 including such serious conditions as schizophrenia,
25 bipolar, depression, posttraumatic stress disorder.

1 Research suggests that not only is the
2 absolute number of offenders with mental illness
3 increasing, but the proportion of the prison
4 population that is mentally ill is increasing.
5 So what do we mean when we say that
6 mentally ill prisoners are ill-equipped? Well, doing
7 time in prison is hard for everyone. Prisons are
8 tense, overcrowded facilities in which all prisoners
9 struggle to maintain their self-respect and their
10 emotional equillibrium. But we believe that doing
11 time in prison is particularly difficult for prisoners
12 with mental illness; illnesses that impair their
13 thinking, emotional responses and ability to cope. In
14 short, they are particularly ill-equipped to navigate
15 what is frequently a brutal and brutalizing
16 environment. They also have unique needs for special
17 programs, facilities and varied health services, which
18 as I'll discuss later, they don't get.
19 Moreover, our research suggested that
20 compared to other prisoners, prisoners with mental
21 illness are more likely to be exploited, victimized,
22 abused and raped by other inmates. They are also more
23 likely to be abused by correctional staff, who have
24 little training in recognizing the signs of mental
25 illness and little training in how to handle prisoners

1 who are psychotic or acting in bizarre, violent or
2 even disgusting ways.
3 Mental illness can impair prisoners'
4 ability to cope with the extraordinary stress of
5 prison and to follow the rules of a regimented life
6 predicated on obedience and on punishment for
7 infractions. These prisoners are less likely to be
8 able to follow the rules and then their misconduct is
9 punished, regardless of whether it results from or is
10 deeply influenced by their mental illness. Even their
11 acts of self-mutilation and suicide attempts may be
12 punished as rule violations.
13 As a result, mentally ill prisoners can
14 accumulate extensive disciplinary histories which will
15 end them up in administrative or disciplinary
16 segregation. And I don't know if earlier panelists
17 talked to you maybe yesterday about segregation and
18 it's something we can deal with in questions, if you
19 would like, but the bottom line is that putting the
20 mentally ill in segregation for extended periods of
21 time can simply aggravate their illnesses and act as
22 an incubator for worst illness and psychiatric
23 breakdowns.
24 So what do we mean when we say prisons
25 are ill-equipped? Well, certainly, they're better

1 equipped than they were 20 or 30 years ago, when there
2 were no mental health services to speak of. Thanks in
3 great part to prisoner litigation and concern and
4 courts, there are now many competent and committed
5 mental health professionals across the country who
6 struggle to provide good services to prisoners who
7 need them.
8 Yet, despite their good intentions and
9 despite some exceptions, prison mental health services
10 across the country are woefully deficient. They lack
11 adequate numbers of properly qualified staff and
12 adequate facilities in which to provide services.
13 They cannot provide adequate screening, evaluation and
14 monitoring. They do not provide prompt access to
15 mental health personnel and services for those who
16 need them.
17 It is rare to find prisons offering a
18 full range of appropriate therapeutic interventions.
19 Typically interventions are limited to medication, and
20 even that is often poorly administered and monitored.
21 Prisons do not develop -- prison
22 systems do not develop and implement individualized
23 treatment plans. They do not carefully identify and
24 properly treat suicidal prisoners. They lack
25 discharge planning that will ensure that prisoners who

1 are mentally ill will have access to mental health and
2 other support services when they leave prison.
3 And if some prisons and some prison
4 systems do some of these things, or even all of them,
5 they don't do it for everybody who needs it.
6 Even worse, in some prisons we have
7 found deep-rooted patterns of neglect, mistreatment
8 and even cavalier disregard for the well-being of
9 vulnerable and sick human beings. In the most extreme
10 cases conditions are truly horrific. Mentally ill
11 prisoners locked 24 hours a day in filthy and beastly
12 hot cells with not treatment at all, left covered in
13 feces for days; taunted, abused or ignored by prison
14 staff.
15 Suicidal prisoners are left naked and
16 unattended for days in bear and cold observation cells
17 with no mental health observations.
18 I hope I will have time and questions
19 to go into more detail on all of this but I would like
20 to focus in my remaining time on some of the
21 recommendations we have for the Commission.
22 First, I'm going to echo what I think
23 almost everybody up here has told you, which is none
24 of the problems you are confronting, problems of
25 abuse, problems of violence, problems of treatment of

1 the mentally ill can be dealt with if the U.S. prison
2 population is not reduced. Everything you deal with
3 or are going to be looking at is exacerbated by having
4 too many people behind bars.
5 Now, theoretically, you could have this
6 extraordinarily high incarcerated population and treat
7 them just fine if the resources were available, but we
8 all know that the states are not willing to provide
9 the resources to properly treat that many people and
10 we are seeing the consequences of that.
11 The starting point for prison reform
12 must be ensuring that prisons are reserved for
13 dangerous offenders who need to be incarcerated. Low
14 level, nonviolent, nondangerous offenders can be
15 punished through other means. If you reduce the
16 number of people coming into prison, you will free
17 state correctional resources to take care of those who
18 have to be in prison, including those who are mentally
19 ill.
20 Second, I won't have a chance to really
21 talk about this unless we get into it in the
22 questions, but Dr. Dudley raised the question of how
23 come we have so many mentally ill in prison and the
24 proportion is increasing and that's a function of two
25 things that have gone on in the community; one, with

1 the institutionalization, that was a good idea,
2 unfortunately, it wasn't followed by the development
3 of well-funded community mental health services which
4 the architects of the institutionalization had hoped
5 for, so you have people in the community basically
6 without access to care.
7 Second, we know that the criminal
8 justice system sweeps up, unnecessarily, many of those
9 mentally ill who can't get services. In fact,
10 sometimes jail is the first time they get any kind of
11 service. There are many reforms that could be made in
12 the criminal justice system that would reduce the
13 number of mentally ill people who are being brought
14 into it. And I urge you to take a look at the
15 consensus project which was shepherded by the Council
16 of State Governments which looked at the intersection
17 of the criminal justice system and the mentally ill
18 and made a number of very important suggestions for
19 reform.
20 But even if you greatly -- we could
21 greatly expand community mental health services and
22 undertake the necessary reforms within the criminal
23 justice system, we're still going to have mentally ill
24 in prison.
25 So the starting point, I believe, is

1 that the Commission should insist that correctional
2 systems provide quality mental health services,
3 regardless of the constitutional minimum. We can talk
4 later about legal standards, but the constitutional
5 minimum is simply not good enough and leading to
6 litigation to determine whether or not proper
7 healthcare services are being provided has proven to
8 be not as successful as we would like.
9 The problem with mental health services
10 is not the absence of knowledge. The components of
11 quality and comprehensive care in prison are well
12 known. What has been lacking is a commitment on the
13 part of the public, public officials and some
14 correctional professionals to ensure that standards
15 and policies are more than words on paper, and more
16 than just a protection against litigation. We hope
17 the Commission can help encourage that commitment.
18 High quality mental health services can
19 help some people recover from their illness and it
20 could help alleviate painful symptoms. It can enhance
21 independent functioning in the development of more
22 effective internal controls and coping skills. By
23 helping prisoners with this, treatment and services
24 enhance safety within the prison community, as well as
25 increases the prospect of successful re-entry when

1 offenders are ultimately released back home, as most
2 will be.
3 So providing appropriate mental health
4 services shouldn't be seen as just a legal obligation
5 or even a moral obligation, it is a public safety as
6 well as a human rights matter.
7 To provide decent mental health
8 services, as somebody mentioned earlier, it's about
9 money. There's just no way around it. Public
10 officials must have the resources that will enable
11 treatment and services for those prisoners who have
12 mental health or even other medical needs. We should
13 aspire to a zero tolerance policy for psychological
14 misery and pain that could be alleviated by
15 appropriate mental health treatment, but that standard
16 cannot be met without better funding.
17 I would also urge you to take a look at
18 and undertake efforts -- support efforts to minimize
19 the tension between corrections and mental health
20 cultures. Prisons and correctional systems have a
21 one-size-fits-all approach to conditions of
22 confinement, modified only according to security
23 needs. They're not designed to accommodate or benefit
24 prisoners with mental illness.
25 I would urge you to urge corrections

1 leaders and public officials to think outside the box,
2 to figure out other ways you can confine and inflict
3 the sentence of deprivation of liberty without
4 exacerbating mental illness or providing what is
5 ultimately a maligned or toxic environment for those
6 with mental illness.
7 I was going to talk about officer
8 training, but I have one minute.
9 Ask me, somebody, about review,
10 oversight and accountability mechanisms and I will
11 talk about that. So let me just give my concluding
12 comment.
13 Corrections officials recognize the
14 challenge posed to their work by the number of
15 prisoners with mental illness. They are caught
16 between a public that wants to incarcerate large
17 numbers of people but is not willing to provide the
18 resources that would enable corrections officials to
19 respect the rights of those prisoners to safe, humane
20 and rehabilitative treatment and conditions of
21 confinement.
22 We hope the Commission will help
23 marshal political sentiments and public opinion to
24 understand the need for enhanced mental health
25 resources for those inside as well as outside of

1 prisons.
2 DR. DUDLEY: Thank you, Miss Fellner.
3 MS. FELLNER: One sentence.
4 The problems we have documented can be
5 solved but to do so requires drastically more public
6 awareness, compassion and common sense than we have
7 seen to date. Thank you.
8 DR. DUDLEY: Thank you.
9 Dr. Groves.
10 DR. GROVES: Thank you. My
11 presentation will have a somewhat staccato quality
12 because I want to cover a number of points for sure
13 and if there is time remaining, we can fill in the
14 melody.
15 There has been a lot of excellent
16 testimony preceding mine and I reiterate some of it as
17 it relates to mental health. I agree with the
18 previous speaker that the welfare of prisoners is not
19 high on the agenda of the departments of correction
20 and, of course, this has implications to healthcare
21 and mental healthcare, which, if they were to be
22 properly implemented, would need a high degree of
23 commitment.
24 In my experience, departments of
25 correction have been motivated to provide minimum

1 levels of health and mental healthcare so as to avoid
2 suits.
3 Mr. Farrow, this morning, made very
4 eloquent testimony based on his experience as a
5 prisoner in the New Jersey system. He did say, as you
6 might recall, that he identified himself as having a
7 psychiatric problem at a certain point in time but
8 wondered if the onset might have been even earlier,
9 and that testimony describes a problem that we face
10 which I will just call the problem of caseness.
11 How does one tell when somebody is
12 psychiatrically ill or not? It's not that easy of a
13 matter even for experts. For experts we like to have
14 prolonged observations or repeated observations or
15 both because, typically, there are no laboratory or
16 pathological findings of a physical type that makes
17 psychiatric diagnoses.
18 In general, psychiatric disorders that
19 are characterized by reduced behavioral input, social
20 withdrawal, are better tolerated in departments of
21 correction than problems that involve increased
22 operative behavior, bizarre behavior or a high degree
23 of personal assertiveness. I don't know Mr. Farrow,
24 but one aspect of bipolar disorder is that people,
25 when they are hypermanic or manic, put out a lot of

1 behavior, are more assertive and sometimes highly
2 conflictual with authorities as part of their illness.
3 The concept of psychiatric illness is
4 evolving over time. So, for example, there's now
5 frequent diagnosis of ADHD, attention deficit
6 disorder. This is frequently associated with
7 impulsive behavior and oppositional defiant behavior.
8 My belief is that it is organically based, but it is
9 not well understood, but we're seeing many prisoners
10 now who exhibit these problems. It's very difficult
11 for the layperson to distinguish between psychiatric
12 disorder and willful defiance in these circumstances.
13 Because corrections officers or even
14 often nurses who work in correctional settings don't
15 have psychiatric training, as mentioned before, these
16 behaviors can be misinterpreted and lead to punitive
17 measures which aggravate the psychiatric problems.
18 There is a definite clash of cultures
19 between the health and mental health person on the one
20 hand and department of corrections. Departments of
21 corrections are modeled on a paramilitary model. As
22 some of the features of the paramilitary model they
23 involve hierarchy, rigidity, negligence of emotional
24 impact and emotional expression and lack of
25 flexibility.

1 On the other hand, the hippocratic oath
2 in the health professions, first, the first rule, of
3 course, is do no harm and the War on Drugs and the War
4 on Iraq, we understand there is a lot of collateral
5 damage and that's acceptable, but as medical people we
6 don't. So it's a real problem.
7 We are socialized to treat people as
8 individuals, understanding that there are many
9 differences between individuals who bear many
10 similarities. Within paramilitary systems these
11 people are treated alike, and this is a problem
12 because there is a lot of overlap within the average
13 person and the mentally ill person, and the proper
14 treatment of the mentally ill requires differentiated
15 approaches.
16 Part of the rigidity of departments of
17 correction is that their range -- first of all, that
18 they depend almost exclusively on punishment as a
19 means of behavioral control and, secondly, that even
20 within the category of punishment, the interventions
21 are very limited.
22 One of their favorite punishments is
23 isolation. Isolation involves not only physical
24 isolation, but denial of privileges, such as family
25 visits, which is very upsetting to many people, often

1 removal from work within the institution, if they had
2 a job, deprivation of exercise and outside time. Even
3 when mental health people understand and counsel,
4 these measures are likely to aggravate the situation.
5 They are, in many cases, disregarded. The best that
6 you will get is that you can get the person taken out
7 of isolation for a time, but it is clearly understood
8 that the clock on the punishment has merely been
9 suspended and when you have put the person back
10 together, they go back into the same condition to
11 finish with the time.
12 Another state prison where Mr. Farrow
13 was was renowned for having a big isolated section
14 where a lot of people were in that way.
15 Understanding the department of
16 corrections and mental health requires some
17 consideration of broader society of issues. In many
18 respects, departments of corrections are garbage
19 containers for human refuse. The idea is that we can
20 get rid of crime if we get rid of criminals and the
21 underlying belief is that there is a population of
22 criminals and a population of good people who retain
23 their identities through time.
24 The reality, however, is quite
25 different. People are criminals, very often, through

1 a part of their life and they are good through most of
2 their life and good people are sometimes criminal for
3 a while.
4 But using the garbage can analogy, once
5 people get put in there, there's no concern about them
6 getting out. You might deodorize the garbage can
7 every now and then so it doesn't smell too badly but
8 nobody is really that concerned about what you look
9 like when you get out.
10 This whole approach has vitiated what
11 would be a much more logical approach, which would be
12 to integrate mental health and healthcare within
13 correction systems and healthcare throughout the
14 community. After all, most of the healthcare that
15 most prisoners receive will occur outside of the wall
16 and it seems to me that some creative approaches could
17 integrate this treatment.
18 Why, for example, should a citizen who
19 is entitled to Medicaid or Medicare suddenly lose
20 health benefits when they enter the current department
21 of corrections to receive possibly much inferior care
22 within?
23 One might also consider that if the
24 collateral damage from the War on Drugs was colored
25 white, instead of brown or yellow or black, the

1 society at large would never have tolerated it for
2 this long.
3 So some people infer from the function
4 of the departments of correction and, in fact, from
5 the entire criminal justice system that it has some
6 rather dire purposes, not officially spoken out, but,
7 nonetheless, seemingly very active.
8 It's inconceivable that a society can
9 incarcerate this many of its people, especially young
10 people, when you consider all of the negative impacts
11 that that will have on families. Everyone of these
12 young black men or Latino men that is incarcerated,
13 many of these guys have families. So not only are the
14 innocent being punished, but the very purpose of
15 society are being undermined by this blanket approach
16 to the control of crime.
17 When one considers that the War on
18 Drugs is one of the main mechanisms by which prisons
19 have been filled up over the past couple of decades,
20 typically, without the provision of adequate
21 treatment, it just appears like an extremely cynical
22 and counterproductive exercise.
23 After all, if we're going to
24 incarcerate people for drug abuse, why not treat them
25 so that they can resume their lives and they get out

1 in some better form, but this often does not happen
2 much.
3 Also, contemporary at times is a high
4 degree of comorbidity between substance abuse and
5 mental illness. And the inadequacies of the mental
6 health treatment program, prejudice the outcome for
7 this duly-affected people.
8 Lastly, a couple words about race,
9 class and gender. Women are being incarcerated at a
10 much higher rates and they present special problems
11 for mental health professionals. The first is the
12 callousness of the separation of these women, who are
13 often arrested for nonviolent crimes, from their
14 children. A woman a hundred yards away from an
15 elementary school to pick up her children might be
16 arrested and given absolutely no opportunity to make
17 arrangements for the care of her children, who are
18 then often farmed out to some agency. This is deeply
19 troubling for many women.
20 The other problem with women has to do
21 with their secondary sexual characteristics and the
22 fact that they are usually add-ons to male jails. In
23 Mercer County, where I was working for a while, you
24 know, they don't even have brassieres to fit all the
25 sizes of breasts that the women have, so, you know,

1 women are walking around in various stages.

2 But, still, the officers are primarily

3 male so you have a situation where, for example, a

4 woman who is in isolation for suicidal prevention, who

5 might be dressed in a paper suit under those

6 circumstances, is being watched in repose through the

7 night by male correction officers. Often in a cold

8 room, one might add.

9 The other special problem for women is

10 the problem of menstruation which exerts special

11 demands for personal hygiene and are potentially very

12 disruptive within the population if certain woman have

13 not taken care of this problem adequately.

14 Thankfully, in some ways women are more

15 likely to express their emotional distress verbally

16 and directly than men and in my experience women have

17 been attended to more frequently for mental health

18 problems in the jail than the men, on a proportionate

19 basis.

20 I believe, also, that disruptive

21 behaviors on the part of women are better tolerated

22 than in a male-dominated institution, where such

23 behavior by men provokes a lot of retaliation and the

24 need for assertion of physical dominance.

25 Lastly I talk about a subject sex in

1 jails. This has mental health implications and health
2 implications. The general pretense is that sex is
3 forbidden in jail and it doesn't occur. Sexual
4 activity is widespread in jails between people of the
5 same sex, between corrections officers and people who
6 are held there and so on. The pretense that it
7 doesn't exist and the refusal to provide protection in
8 mitigating measures, such as condoms, is terrible. Is
9 exposes to people of risk of HIV and other diseases,
10 which then destroy the brain. I think I will stop for
11 the time.
12 DR. DUDLEY: Thank you, Dr. Groves.
13 MR. WILKINSON: I could spend my entire
14 time responding to the previous two speakers but I
15 think I won't, I'll go through my testimony, but,
16 believe me, I will respond to a couple of the
17 statements that were made.
18 It's a privilege to provide this
19 testimony to the Commission. This oral testimony,
20 however, is just an abbreviated version of my
21 previously submitted written testimony that maybe you
22 all have. I would be remiss, albeit, if I did not
23 convey my apprehension about the mission of this
24 initiative. When the abuse commission was announced,
25 many persons who serve as corrections administrators

1 across this nation were equally apprehensive. If it
2 were not for the intervention of respected members of
3 the Commission as Gary Maynard, you may very well have
4 experienced a major anti-abuse commission response.
5 The final product that this Commission
6 will publish will certainly evoke professional
7 responses from agencies and organizations that
8 represent prisons and jails.
9 My corrections career has spanned 32
10 years, just to add to a little more of my resume, and
11 I have served in numerous administrative capacities,
12 including warden, deputy director of prisons and now
13 director. I have served in numerous national and
14 international capacities as well, such as past
15 president of both the American Correctional
16 Association and the Association of State Correctional
17 Administrators. I am also the chairperson of the
18 National Institute of Corrections Advisory Board and
19 president and executive director for the International
20 Association of Re-entry.
21 I am pleased that I have been able to
22 specifically -- asked to specifically address issues
23 relating to offenders with a mental illness. For over
24 ten years I have made this subject one that deserves
25 the highest priority.

1 There was a statement recently made
2 that corrections administrators don't make this a high
3 priority; that is absolutely, unequivocally not true.
4 A number of venues that corrections administrators
5 participate in with the National Institute of
6 Corrections, with the Association of State Correction
7 Administrators, the Council of State Governments,
8 individual state jurisdictions have all had major
9 initiatives relating to the mentally ill offenders so
10 an awful lot is going on and I list a number of those
11 initiatives in my written testimony.
12 As Ms. Fellner mentioned earlier, jail
13 and prison is sometimes the first contact that
14 identifies a problem right there, that we are the
15 persons who are put in place to help save some of what
16 should be a social problem or community problem in the
17 first place. We shouldn't have to be dealing with
18 these issues if it was dealt with elsewhere.
19 Many persons with a mental illness have
20 co-occurring disorders. Mental illness can be
21 complicated with certain other offender groups, such
22 as sex offenders and persons who are aging in prisons
23 and female offenders, as you previously heard.
24 I am also concerned with the high
25 number of persons who have been assessed as having

1 retardation and developmental disabilities while
2 incarcerated. Moreover, there are, obviously, varying
3 degree, as you all are also aware, of mental illness.
4 According to the Bureau of Justice
5 Statistics, 16 percent of all persons incarcerated
6 have a diagnosed mental illness. About half of those
7 persons who have a mental illness in prison have a
8 serious or an Axis I level of mental illness
9 diagnoses.
10 I disagree with the notion that you
11 previously heard that, you know, prisons are garbage
12 containers of the human refuge. We consider ourselves
13 to be professional practitioners in the justice
14 business and I know of no one in our profession who
15 would remotely identify with that type of label of our
16 profession, neither of you would accept that as a
17 characterization of your professions as well.
18 We don't have favorite punishments in
19 our prisons. It's the court's responsibility to
20 punish offenders and not that of a state or local
21 correction system. It's our responsibility to carry
22 out the orders that the courts have imposed upon
23 persons who have been sentenced to our jurisdictions.
24 Given the fact there are nearly
25 2.2 million persons in prisons and jails, you may

1 understand how detention facilities have, in fact,
2 become the new asylums. Deinstitutionalization has
3 been a major movement for community mental health
4 providers for a number of years. I believe we are now
5 experiencing a transinstitutionalization of persons
6 with a mental illness; that is, many persons who may
7 have been civilly committed to a mental hospital 20
8 years ago have now found their way to prisons and
9 jails.
10 What this means for corrections
11 administrators is that we not only are responsible for
12 de facto mental health systems, but we have become de
13 facto mental health directors.
14 As you might imagine, the daily
15 challenges that confront a correctional agency are
16 wide-ranging and formidable. Our agency, which
17 operates 32 prisons, is the nation's sixth largest
18 state correction systems. Thus, one of the monumental
19 challenges facing us is providing healthcare for
20 44,000 prisoners.
21 Two major events took place which gave
22 rise to our agency's renaissance in prison mental
23 healthcare. First, in 1993 we experienced a prison
24 riot where nine inmates and one employee were killed.
25 This event put the department under the public

1 microscope. Second, in 1993 a federal lawsuit was
2 filed claiming that care for prisoners with a serious
3 mental illness was inadequate. This litigation was
4 settled and resulted in a five year consent decree.
5 There was never an admission of unconstitutionality or
6 deliberate indifference.
7 Beyond all the legal and practical
8 reasons one might express, above all, providing good
9 mental health services, and this is what we believe,
10 is the right thing to do. However, treatment for
11 inmates with mental illness is more than just doing
12 the right thing. It is a constitutional requirement,
13 we're well aware of that, and enforceable in the
14 federal courts.
15 Let me share with the Commission some
16 of the overarching reasons why operating a
17 comprehensive and sound mental health delivery system
18 is important to our operation.
19 Nearly seven percent of Ohio's inmates
20 are diagnosed with a series mental illness. A host of
21 other inmates with a less serious mental illness
22 co-exist as normally as possible in the prisoner
23 population. Therefore, good management and effective
24 clinical care are required to deal with this
25 prodigious problem.

1 For both security and health reasons we
2 need to know whether offenders are demonstrating
3 purposeful negative behavior, as opposed to those who
4 are acting out because of their mental illness.
5 Whether a prisoner has an acute
6 psychiatric illness or a personality disorder,
7 correctional staff should be concerned when preventing
8 further deterioration. Suicide and suicide attempts
9 are stark examples of the consequences of unknown and
10 unattended deterioration.
11 Prisoners with a weakness, either
12 physical or mental, are at a disadvantage and
13 sometimes preyed upon by stronger inmates. It is our
14 mission to protect the vulnerable prisoners.
15 Knowing inmates' physical and mental
16 limitations allow staff to appropriately house,
17 classify, assign jobs and treat prisoners. Good
18 mental health, then, includes good screening and
19 evaluation.
20 And because 97 percent of all prisoners
21 will return home, for community health and safety
22 reasons, operating a holistic mental health service
23 delivery -- mental health system is often a high -- is
24 the highest priority for persons in my capacity.
25 One of our prisons is a psychiatric

1 hospital. We actually have to operate a certified
2 psychiatric hospital that's a prison. In addition,
3 our 32 prisons are divided into nine separate clusters
4 or catchment areas. Each cluster has a designated
5 residential treatment unit assignment to one of the
6 nine RTUs is for appropriate care and never, never for
7 disciplinary action.
8 Thus the structure of the mental health
9 services in Ohio resembles a triangle with our Oakwood
10 Psychiatric Hospital at the top treating the most
11 seriously mentally ill persons in a hospital setting,
12 the RTU has an intermediate venue for chronic -- for
13 treating many in chronic care patients and we also
14 have a number of outpatient treatment services that
15 exist in every one of our prisons.
16 The recruitment and training and
17 deployment of staff is a major challenge, but,
18 nevertheless, one that is a high priority for us.
19 Overall, the mental health staff have increased
20 dramatically in our state; nevertheless, maintaining
21 adequate staffing requires due diligence in
22 recruitment.
23 Staff training is equally important.
24 Critical staff must adapt to the correctional
25 environment, regardless of staff members credentials.

1 Specialized mental health training is provided for all
2 correctional staff, including custody, medical,
3 clerical and mental health persons who are assigned to
4 work in segregation, medical and mental health areas.
5 This is a two-day program designed to increase
6 knowledge about mental health support, appropriate
7 attitudes and behaviors and better integrate security
8 and mental health concerns.
9 Coordination is required to ensure
10 successful re-integration of mentally ill persons who
11 return to the community. Most prisoners who are
12 released back into the community only receive about
13 two weeks of medication to sustain them; that's a
14 problem. Thus, in the spirit of re-entry, referrals
15 regarding the continuity of mental health services
16 must be a priority of discharge planning. Most
17 persons with a mental illness are able to work, but
18 when you combine the stigmas of being a formerly
19 incarcerated person and one having a mental illness as
20 well, work possibilities diminish significantly.
21 Nevertheless, this special needs group can achieve
22 successful community reintegration.
23 I want to briefly discuss the impact of
24 so-called supermax prisons on persons with a mental
25 illness. I agree that it's a good idea to avoid

1 placing persons with an active mental illness in a
2 supermax prison. I don't agree that inmates should
3 not be assigned to one because a mental illness might
4 develop or cause decompensation to occur with inmates
5 whose mental illness is in remission. Albeit,
6 continuous monitoring of unusual behavior by prisoners
7 assigned to a supermax institution should be an
8 ongoing security and clinical responsibility.
9 So, from my perspective, it is clear
10 that comprehensive mental healthcare for offenders
11 yield positive results.
12 In conclusion I am in no way suggesting
13 that Ohio's mental health system should be the
14 prototype for any other correctional jurisdiction.
15 What may work in Ohio may not work in other states.
16 Although any correctional administrator will admit
17 that continuous improvement is an ongoing part of our
18 mission, there is very little evidence of intentional
19 and widespread abuse inflicted upon persons with a
20 mental illness in prisons and jails this nation. Yes,
21 there are isolated and unacceptable incidents that
22 occur, but these incidents are no way reflective of
23 the normal correctional protocols of how persons with
24 a mental illness are managed. There is no such thing
25 as a one-size-fits-all process.

1 I am appreciative of being able to
2 provide this testimony to the Commission.
3 DR. DUDLEY: Thank you, Dr. Wilkinson.
4 We are now going to open up for any
5 questions that any of the commissioners might have.
6 I'm going to take my prerogative by asking the first
7 question.
8 I would like to hear all of you comment
9 on the issue of the other group, not the percentage of
10 people with the profoundly -- profound mental
11 illnesses like schizophrenia who are previously
12 diagnosed, but those with less severe illnesses. The
13 issues of really identifying this population, and you
14 seem to have some disagreements about even if this
15 population is identified, how would they best be
16 managed while incarcerated.
17 I believe I heard you say,
18 Dr. Wilkinson, you didn't feel there should be any
19 difference in the way that population would be managed
20 as it relates to isolation and those sorts of things.
21 I think, I believe, Ms. Fellner, you were saying
22 something quite different in that regard; that we
23 should be employing the knowledge we believe we have
24 about the risk of deterioration of this population,
25 for example, with putting them in certainly long term

1 isolation.
2 I just want to be clear about what you
3 all felt about the management of that population,
4 again, not the profoundly mentally ill, but this other
5 population.
6 MS. FELLNER: I think people with
7 personality disorders pose a really serious challenge
8 for corrections. On the other hand, I think it
9 behooves corrections to work with mental health staff
10 to figure out appropriate responses, given that a
11 large part of the population does have personality
12 disorders.
13 The other thing is, and it may get too
14 technical, I don't know, often you will have Axis I
15 and Axis II diagnoses, these are complex situations,
16 as Dr. Groves said, often, you know, accurate
17 diagnoses are hard to come by.
18 Certainly, we have found with women --
19 for example, women who are suffering from
20 posttraumatic stress disorder, and I think you all
21 know that a very high percentage of women that go into
22 prison have suffered sexual or physical abuse before
23 and are suffering PTSD. That has been traditionally
24 diagnosed as somehow that they were just acting out or
25 behaving badly. So the insights now from mental

1 health, I think, can help guide a lot of what is done.
2 With regard to long term isolation,
3 Human Rights Watch's position is that in most cases
4 long term isolation under the severely deprived
5 condition of many supermax is a human rights
6 violation. Nobody should spend years in a small cell,
7 let out two or three times a week, with minimal human
8 contact.
9 There may be times in which short term
10 use of that kind of control is necessary and if
11 somebody is dangerous enough that they require really
12 long term, maximum control, then the prison systems
13 have to find ways to alleviate the consequences of the
14 isolation, figure out ways to have more social
15 interaction and whatnot.
16 Certainly people who are mentally ill,
17 and I haven't given enough thought recently to
18 separate out Axis I and Axis II and which kind should
19 be, but there have been settlement decrees, and I
20 can't remember Ohio's, which have specified in the
21 settlement which kinds of -- which offenders with
22 which kinds of mental illness should not be put in a
23 supermax because of the likelihood of decompensation.
24 The other thing about -- and it may be
25 different in Ohio in many ways because of the

1 settlement in Ohio. They are way ahead of many prison
2 systems.
3 Mental health treatment is often
4 particularly lacking in supermax because there's
5 fewer -- less access by mental health service
6 providers into those units and they do cell-front
7 interviews; they will pass by and say, hi, how are you
8 doing and that counts as a mental health intervention.
9 So you have sick people in a countertherapeutic
10 environment getting less mental health services.
11 MR. WILKINSON: I will be happy to
12 chime in.
13 One of the biggest populations of
14 persons who have the non-Axis I or serious mental
15 illness diagnoses are the women. We have -- the
16 percentage of women who have a diagnosed mental
17 illness is almost double what the men have, but their
18 issues are different, in some cases; they have the
19 emotional disorders, the post-traumatic stress issues,
20 the, you know, postpartum syndrome issues, and it's
21 all very complicated in terms of how you deal with
22 that while operating a facility for females.
23 But the issue is we know that and so we
24 try to integrate these women and men with these
25 diagnoses as normally as possible, but the issue is we

1 know who has been diagnosed with what. So if there is
2 decompensation or deterioration of their diagnoses,
3 then we'll try to intervene, we'll try crisis
4 intervention, whatever it is that's necessary in order
5 to make sure that person doesn't decompensate and
6 don't deteriorate to the point where it's going to
7 elevate to a more serious mental illness.
8 So we're well aware of it, we want
9 these people to work, we want them to be in school, we
10 want them to do things as normal as possible if, in
11 fact, there is such a thing in these environments.
12 DR. GROVES: Do you wish to hear from
13 me?
14 DR. DUDLEY: Well, actually, I
15 particularly wish to hear from you.
16 We heard testimony earlier about some
17 of the work that's been done and from which we've
18 learned, for example, how persons with certain
19 psychiatric disorders, again, putting aside major Axis
20 I disorders like schizophrenia or bipolar disorder,
21 are likely to have, you know, particular difficulties,
22 for example, like with isolation and in that category
23 included say, for example, people with attention
24 deficit disorder and, you know, likely a population
25 not to know when they come into prison that they have

1 this disorder. And you had mentioned that as part of
2 your testimony and how important it is to appreciate
3 things like that and be able to differentiate a person
4 with attention deficit disorder from somebody who is
5 just a management problem because they just want to
6 give us a hard time.
7 And so, yes, I did want you to comment.
8 DR. GROVES: Well, as far as Axis II
9 diagnosis are concerned, in general there's no
10 attention to these because it's even harder to make a
11 distinction between Axis II and the normal behavior.
12 The second thing is that in my opinion,
13 certainly, jails and many prisons really represent a
14 hyperstress environment so it's difficult to say
15 whether people's adaptation, as we see them, really
16 represent Axis II pathology or not.
17 To make a diagnosis of Axis II you need
18 to either have a history or a series of observations
19 which indicate that what you are seeing are stable
20 patterns of adjustment over extended periods of time.
21 JUDGE SESSIONS: Doctor, can you define
22 Axis II for me, because I'm ignorant.
23 DR. GROVES: Right. The Diagnostic and
24 Statistical Manual, current edition IV, has a five
25 axis diagnosis protocol. Axis I, at least is what

1 most lay people would consider to be psychiatric
2 illnesses or major psychiatric illnesses, things like
3 schizophrenia, what used to be called manic depressive
4 illness, it's now called bipolar disorder, problems
5 like anxiety disorder, depression, PTSD, posttraumatic
6 stress disorder. Those are sort of -- all disorders
7 which can be chronic but they may be episodic, but
8 they're generally recognizable.
9 Axis II are reserved for what is called
10 personality disorders. Personality disorders,
11 briefly, represent patterns of adjustment to personal
12 relationships and their environment in general which
13 are somewhat maladaptive. But those people don't have
14 psychoses, that's not listed there, and they're sort
15 of not abnormal in the sense that Axis I people are.
16 And then on Axis III are listed medical
17 conditions which may be contributing to the Axis I
18 pathology.
19 Axis IV is reserved for stressors which
20 may be related to it, and then Axis V is what they
21 call general adjustment function, GAF is just what I
22 remember, but that's scored from zero to 100 and gives
23 an idea of a person's level of general adjustment.
24 JUDGE SESSIONS: So Axis II and Axis IV
25 are two of the big pressures in prison?

1 DR. GROVES: I beg your pardon?
2 JUDGE SESSIONS: Axis II and Axis IV
3 are two of the big pressures in prison; personality
4 disorders and stressors?
5 DR. GROVES: No. Personality disorders
6 are not really -- I'm saying they're disregarded
7 because of the difficulty of diagnosis and also
8 because of the kinds of treatment we just specified.
9 JUDGE SESSIONS: Thank you.
10 DR. GROVES: Axis II --
11 DR. DUDLEY: We'll add that mental
12 retardation --
13 DR. GROVES: Sorry?
14 DR. DUDLEY: Mental retardation is also
15 Axis II.
16 DR. GROVES: Right. So, you know, in
17 Axis II there's no medication, treatment for that per
18 se. So the treatments for Axis II have to do with
19 psychotherapy and environmental manipulation and,
20 generally, as Ms. Fellner had indicated, these are not
21 available in prisons.
22 There is one exception in my experience
23 and that was a highly specialized prison called the
24 Adult Diagnostic and Treatment Center of New Jersey.
25 Very fancy name for the sex offender prison but it was

1 very unique, it was started in the '70s and it was
2 based on the therapeutic milieu which involved
3 intensive individual psychotherapy, group
4 psychotherapy and medication where indicated.
5 In my experience it has been quite
6 highly successful. It started out as a prison for
7 white guys. Very few nonwhite people there.
8 Beautifully appointed, computers, the works. It's not
9 as white as it was and it's not as therapeutic as it
10 was. I leave it to you to infer whether those things
11 might be related. But it does provide a model for an
12 approach to treating criminal offenders that might --
13 I mean, when you think of how people feel about sex
14 offenders and the fact that you can have a treatment
15 program actually helps these guys, and I followed a
16 few of them in my private practice afterwards -- up to
17 maybe four or five years, they haven't reoffended --
18 it suggests to me there are possibilities for helping
19 other types of criminal offenders that would make them
20 much better integrated into society and much more
21 valuable. These guys I am following, they are working
22 and why couldn't we do that for other people,
23 especially when we consider situation like say Trenton
24 State Prison Mercer County. A lot of the guys in
25 Trenton, even when they go to high school and have a

1 diploma, they're not competent at the high school
2 level that you would expect. So these are poor people
3 in whom there's been little social and other forms of
4 investment and prisons would afford us an opportunity
5 to invest in those people and allow them to play much
6 more constructive roles in society. I hope that
7 answers your question.
8 MS. FELLNER: Can I just add something
9 quickly which follows on what Dr. Groves is saying and
10 I think probably comports with what Reggie has seen.
11 A lot of people who end up in prison,
12 in addition to whatever addiction or whatever, have
13 poorly developed internal control mechanisms, poorly
14 developed coping skills because of their life history.
15 So prison could, in fact, if it were modeled
16 differently and this responds to something Margo was
17 asking earlier, could be an opportunity -- if somebody
18 has to be in prison, let's design a prison system
19 that's going to take full advantage of the opportunity
20 presented by having that person for one, two, three
21 years rather than, in fact, reinforcing a lot of
22 negative traits so that when they come out they not
23 only have all the collateral barriers to re-entry by
24 having been incarcerated, but certain patterns either
25 remain the same or have gotten worse because of the

1 prison environment.

2 MR. BRIGHT: Dr. Wilkinson, this
3 question, talking about your hospital and talking
4 about the increase in the number of people, do you
5 have some people in your system and of the seven
6 percent of your inmates who are severely mentally ill
7 who just simply shouldn't be there? You also said
8 earlier that they would have been civilly committed a
9 few years ago and now they're going into -- you're
10 getting them instead of them going to the mental
11 hospitals.

12 Are there people that just your
13 department is not equipped to deal with who ought to
14 be going into psychiatric hospitals, as opposed to
15 your department of corrections?

16 MR. WILKINSON: I think part of the
17 problem in Ohio is that we are equipped to do deal
18 with them, you know, and maybe if we weren't, then
19 maybe judges would be less reluctant to send those
20 persons to prison to get treatment.

21 You know, we have -- yes, absolutely.
22 We not only have persons with a mental illness who
23 probably shouldn't be in prison, but we have people in
24 the general population who probably shouldn't be in
25 prison for whatever reason. But the bottom line is

1 that we do have them.

2 If there were more interventions, for
3 example, with law enforcement, where many of the
4 persons who were arrested could go to a crisis
5 intervention center in the community instead of jail,
6 then we wouldn't have the kind of problems that we
7 have in jails and prisons in this country. You know,
8 if there were other kinds of treatment in lieu of
9 convictions sentences that courts could impose,
10 instead of the typical ones that we know have
11 exacerbated the numbers in our prison population, we
12 wouldn't have the problems that we're having now.

13 So I would unequivocally say yes, we
14 have people with a mental illness who should not be in
15 prison.

16 MR. BRIGHT: And following up on that,
17 your hospital, your prison hospital or mental health
18 prison hospital, is it at capacity? Do you have empty
19 beds? I mean, how does that relate to the people who
20 need hospitalization and do you ever have a waiting
21 list or whatever for that?

22 MR. WILKINSON: Well, actually, the
23 number -- we have double the capacity in our prison
24 hospital. The number of persons in our hospital is
25 steadily diminishing. I mentioned about the

1 residential treatment units and our catchment areas,
2 the number of those persons are going down because we
3 are providing interventions, we're doing preventive
4 mental healthcare and that is helping us to reduce
5 cost. We've actually closed several of our
6 residential treatment units.
7 So even though the number of persons
8 who are coming to prison with a mental illness is
9 either stable or increasing, the intervention that we
10 put in place and the money we're spending to provide
11 that intervention is reducing the number of persons
12 who actually need to take up mental health beds,
13 either in the hospital or in the residential treatment
14 unit.
15 MR. BRIGHT: Can I ask one more
16 question. Can I ask a supermax question.
17 In your supermax do you have when an
18 inmate is there there's complete deprivation,
19 newspapers, magazine, television, or not, and what do
20 you think of that?
21 MR. WILKINSON: No, it is not complete
22 deprivation and I don't think a federal court in this
23 country would allow that. Prisoners in our supermax
24 have access to visiting, they have access to --
25 MR. BRIGHT: By TV or in person,

1 visiting by TV?

2 MR. WILKINSON: No, in person, yes. We
3 have recreation where prisoners can recreate together.
4 We have areas where programming takes place now where
5 they can, you know, get a GED together. So they have
6 outside recreation as well.

7 They have access to all the appropriate
8 reading materials, as does anybody else in any part of
9 our 32 prisons do. So there is no such thing as
10 complete deprivation in our supermax prison.

11 MR. BRIGHT: Okay. Thank you.

12 DR. DUDLEY: Commissioner Schwarz.

13 MR. SCHWARZ: SchwarzWhen Ms. Fellner
14 started her testimony you talked about anecdotes and
15 data and I've got a question trying to get at that a
16 little bit, which starts with a direct one for
17 Commissioner Wilkinson, and then maybe as to all three
18 of you.

19 Are consent decrees a good source, a
20 reliable source of data, what are the reasons you
21 entered into the consent decree that you did enter
22 into, because I know there are multiple reasons for
23 doing that? And then, more generally, about if there
24 is a lack of data, what are the causes for a lack of
25 data, who has responsibility for lack of data? And, I

1 suppose, most importantly, if there is a lack of data,
2 what could be done by way of providing for certain
3 information that regularly would be required to be
4 provided? The first one is a narrow question to you
5 and then broader one to all of you.
6 MR. WILKINSON: The question of why we
7 entered into a consent decree was pretty simple for us
8 and it was -- and Jamie mentioned it earlier -- it was
9 a pretty unique consent decree because it was not
10 contentious at all.
11 We knew that the system was broken.
12 We, to this day, still believe the mental health
13 system we had 12 years ago met the constitutional
14 minimum. But we knew it was broken enough that it
15 didn't -- wouldn't take much for that to go south on
16 us. So what we wanted was a state of the art mental
17 health delivery system.
18 By entering into the consent decree we
19 found out that there were some things that we could
20 reasonably improve that would allow us to have a state
21 of the art mental health system. Now, we could have
22 done the same without the lawsuit.
23 And so I'm not, you know, saying to you
24 let's sue everybody so that we can have, you know, a
25 good mental health system, because that's not what I

1 think the answer might be. But in our case, you know,
2 it certainly was a consideration, not to mention the
3 expense of going through the litigation and the time
4 and other complications associated with that type of
5 endeavor.
6 MR. SCHWARZ: SchwarzJust to make an
7 observation on that, my experience for five years as a
8 government lawyer was very often good commissioners
9 wanted help from the lawyers to lose a case so that
10 they could get, you know, money and help and
11 requirements and it's not a horrible thing, but it's
12 true.
13 MR. WILKINSON: You will never hear me
14 admit that.
15 MS. FELLNER: We certainly found that
16 in our interviews; quite a few correctional leaders
17 said, off the record, thank God they were sued,
18 because that's a way to pry money out of very
19 reluctant legislators.
20 I wanted to --
21 MR. WILKINSON: But I will say now that
22 it's different. You know, 12 years ago there was new
23 money that came to us for this. Today it's robbing
24 Peter to pay Paul. So if we got new -- so if we got
25 money today from a legislature, it's going to come

1 from somewhere else in our budget, it's not going to
2 be new money so the rules have changed.
3 MS. FELLNER: That's why I emphasized
4 the need to reduce the population. We can't do it all
5 and states want to do it all by keeping increasing the
6 numbers of people in prison, that's why you are
7 between a rock and a hard place.
8 I wanted to respond on the data
9 question. I think first you have to ask what kind of
10 data you were looking for and so that will depend what
11 the source is and where.
12 Consent decrees and monitoring can
13 provide a very valuable source of data because you
14 have somebody who is an independent expert brought in
15 with no agenda who is observing what's going on and
16 filing reports with the courts and with the
17 departments. Unfortunately, often those monitoring
18 reports are under seal because the parties have agreed
19 to put them under seal. I don't think that serves the
20 public interest. I think names should be removed, but
21 I think it would be in the public interest to have
22 those monitoring reports public and to have as much
23 transparency and data available to the public so that
24 you know what, in fact, is going on.
25 DR. GROVES: I wasn't sure if I

1 understood your question entirely. Were you also
2 interested in knowing the effectiveness of the consent
3 decrees on actual practiceSchwarzs within
4 institutions?
5 MR. SCHWARZ: Not so much. I mean,
6 that's important, but I was interested in what
7 conclusions we could draw from the fact of the consent
8 decree on certain subjects.
9 MS. SCHLANGER: On the topic of
10 lawsuits as sort of a regulatory device, I wonder -- I
11 hear different things when I talk to people and I
12 wonder what you all think has been the impact of the
13 prison litigation format on that method of oversight,
14 the PRLA was enacted nearly ten years ago now so
15 there's been time for it to settle out, and I wonder
16 how it's feeling.
17 MS. FELLNER: I think it's had a highly
18 pernicious impact. There was a lot of talk at the
19 time the PRLA was passed about peanut butter, creamy
20 versus crunchy peanut butter lawsuit and certainly
21 there have been some of those, but the PRL sweeps too
22 broadly so that if you want to complain about being
23 raped by a staff member, if you want to complain about
24 being beaten up by a staff member, you are subject
25 still, and those are very serious complaints,

1 obviously, you are subject to the same PRLA
2 restrictions, which make it you have to exhaust your
3 internal administrative remedies, which can be very
4 hard to do; I mean, you make one little error and
5 you're out, which cuts back way back on fees, which
6 makes it hard to find lawyers -- lawyer fees, which
7 makes it hard to find lawyers who will take your
8 cases, and legal aide cannot represent prisoners so
9 it's cutback on legal representation, and there are a
10 number of other problems with it.
11 If you think of the photos in Abu
12 Ghraib, the guy standing there with the dog, naked
13 with the chain, he could not bring a lawsuit today
14 because PRLA says you have to have physical injury.
15 So that incredible humiliation and abuse, he could not
16 bring a lawsuit. There clearly needs to be some
17 modification to PRLA to ensure that prisoners are not
18 deprived of access to the courts, while protecting the
19 courts and prison officials from obvious spurious,
20 frivolous claims.
21 One of the ways also I would urge you
22 to look at is at grievance systems. When prisoners
23 feel their concerns are heard, when they have good
24 grievance systems where they feel that, you know,
25 they're being listened to, they are less likely to

1 spend all their time filing lawsuits that aren't going
2 to go anywhere.
3 MR. WILKINSON: I appreciate what Jamie
4 has provided for you, and I don't disagree with that,
5 but I will tell you that if it weren't for the PLRA, I
6 would not have entered into this consent decree
7 because, typically, these cases such as Ruiz and
8 Perini, you know, these cases can go on for 20 years.
9 I was not about to be involved in a consent decree
10 that did not have an end to it.
11 This one was -- had a very definite end
12 to it, everybody agreed and I think the one thing that
13 the PLRA did for us was to provide some parameters
14 and, singularly, it went well for us.
15 DR. DUDLEY: Mr. Maynard.
16 MR. MAYNARD: I had a question for
17 Dr. Wilkinson. We've heard about, talked about a
18 little on the Commission the performance-based
19 measures system that ASCA has worked on for the last
20 couple years and when we talk about data, I'm just
21 curious what your thoughts are about the viability of
22 some of that data being available in the future to
23 this Commission for determining what really the facts
24 are in the conditions across the country in the
25 prisons.

1 MR. WILKINSON: Thanks, Director
2 Maynard.
3 One of the things that's been lacking
4 in our business is having good information; we know
5 that. So over the course of the last five years or so
6 the Association of State Correctional Administrators,
7 which is a group that represents all the directors,
8 commissioners and secretaries of commissions, not the
9 jails albeit, petition to the U.S. Department of
10 Justice to help fund a system whereby we can actually
11 start counting things differently and counting things
12 with the uniform measures in mind, using key
13 indicators, using data dictionaries, using language
14 that we can all understand instead of each
15 jurisdiction having their own rules.
16 So we now have county rules, we now
17 have key indicators that we're building upon that will
18 allow us to be able to compare information from
19 jurisdiction to jurisdiction. That's going on as we
20 speak. We're entering into the third phase of this
21 project now and, in fact, the jurisdiction of Iowa and
22 Ohio are one of the pilot states for this major, major
23 initiative that the Department of Justice saw fit to
24 invest in.
25 So when you talk about data, we know we

1 have a lack of data. We also know that good data,
2 evidence-based information will allow us to make
3 better decisions about managing this population and
4 any other group of people, whether it related to
5 security or programming, in order for us to save
6 money, in order for us to reduce recidivism, in order
7 for us to minimize victimization in our community, so
8 it's a big deal.
9 DR. DUDLEY: Each of you mentioned
10 substance abuse, drug treatment issues in different
11 sorts of ways and I think, Dr. Wilkinson, you
12 mentioned the issue of co-existing disorders, I think
13 you did too, Dr. Groves.
14 I'm wondering given what we know the
15 treatment of patients with dual diagnosis and
16 substance abuse diagnosis and other mental health
17 problem, what is your thinking about the better
18 integration of mental health services with drug
19 treatment services for the effective treatment of duly
20 diagnosed inmates?
21 MS. FELLNER: I think that's called a
22 softball question. I mean you've sort of -- I think
23 we all know what the right is answer is.
24 I would simply point out it is a
25 problem not only in prisons, but in the community as

1 well, and prisons just sort of carry that forward
2 where mental health systems sometimes don't want to
3 deal with drug addiction and vice versa and,
4 obviously, integrating it would make a great deal of
5 sense.
6 DR. GROVES: I agree. What's happened
7 in the field is that there has been some bifurcation
8 between substance abuse treatment and the treatment of
9 other mental illnesses and the personnel involved in
10 the two are somewhat different.
11 Substance abuse treatment is largely
12 driven by substance abuse counselors typically,
13 although there is a cadre of psychiatrists trained in
14 substance abuse treatment, and I happen to be one of
15 those, but the opportunity to implement that kind of
16 unified model is not that easy to come by, in New
17 Jersey anyway.
18 One of the things -- it's very hard to
19 have access, reliable access to patients in New Jersey
20 facilities. The so-called security arrangements of
21 the prisons predominate over everything and that
22 becomes a cloak that often hides agendas and
23 conveniences that are really not relevant to
24 prisoners' welfare. So it's hard to find, say, a four
25 hour stretch of time within the day where you can just

1 see patients. If you want to see them in the medical
2 department, then the people -- the officers have to
3 bring them to the medical department. They often say
4 that they don't have the personnel to do it. If you
5 don't want to see them there, then you have to go to
6 the different cells to see them.
7 So the place like Trenton State Prison,
8 the whole line of guys, in cells with bars, if you
9 want to speak to the guy, you speak to him through the
10 bar. The prisoners on either side have mirrors that
11 they are using to see what's happening and they're
12 also listening. So what kind of confidentiality do
13 you get and what kind of counseling can you do under
14 these circumstances? It's very --
15 I mean, unless the welfare of the
16 prisoners and their health and mental healthcare is
17 prioritized, it is very difficult to do that. We need
18 some mechanism that would say, look, treating these
19 guys for these problems is really important, these
20 guys or women, men or women, it's very important, and,
21 therefore, we'll make the kind of security
22 arrangements that will allow these things to take
23 place, but that's not what we get.
24 So those are some of the practical
25 problems that currently exist for integrated and

1 impactful treatment method.

2 And one of the reasons that we're so

3 dependent on medication is that although ideally

4 psychiatrists should spend significant amounts of time

5 with patients in order to select the right medication,

6 if they're given medication at all, we're often

7 reduced, like Mr. Farrow said, to 15-minute

8 interviews, which are basically medication checks.

9 But for a population that is that vulnerable and

10 living under such difficult circumstances, I don't

11 consider that adequate.

12 It is a model that is used by managed

13 care in the community, but it's a model that's really

14 much more based on profit motives and the rationing of

15 care in the community that is an optimal health or

16 mental healthcare.

17 DR. DUDLEY: Do you feel that you have

18 a better -- have you been able to tackle this issue of

19 treatment of the duly diagnosed?

20 MR. WILKINSON: Well, not as well as I

21 know we should because there's still a problem in

22 terms of assessment, the time you might have to

23 deliver. You heard Dr. Beard earlier say that you

24 can't do good substance abuse treatment in a couple of

25 months and when that person has a mental illness then,

1 you know, that needs to be treated as well.
2 It used to be, of course, as all of you
3 know, we didn't say co-occurring disorders or
4 co-existing disorders, you know, five years ago; we
5 said duly diagnosed persons and somehow or another
6 we've gotten politically correct. I like the new
7 ones -- new title, but not for the same reasons I
8 think everybody else does. Co-occurring to me means
9 you can have more than just two and many of these
10 persons that we have to deal with have more problems,
11 believe me, than just mental health and substance
12 abuse.
13 You know, if you are a sex offender,
14 you need treatment; if you are an aging person, you
15 need different types of interventions.
16 So when you add those complications to
17 the fact that you are in prison and you are going to
18 get out one day and you got to look for a job, then
19 there are a number of problems that we have to take a
20 look at simultaneous to the ones that might fall under
21 the categories of a DSM-IV.
22 DR. GROVES: You know, I wanted to make
23 a comment. It's not directly related to what preceded
24 just now, but the issue of the scarcity of resources
25 for treating prisoners has been raised several times.

1 One of the consequences of the get
2 tough on crime and long mandatory sentences is that
3 prisons are now caring for an aging population. We
4 are talking now about sometimes people in their 80s.
5 So if you can consider the kind of expenses that you
6 generate for people who are, say, age 60 to 80 to 85,
7 they're tremendous. So -- and those people have the
8 kind of medical problems that you have to respond to;
9 talking about carcinomas, acute heart problems and the
10 like, strokes. So that that just eviscerates the
11 resources left for the younger guys; the guys who are
12 between 20 and 40 and relatively healthy, you know
13 what I mean, you just don't have the money for that
14 under those circumstances.
15 So a lot of politicians, I don't think,
16 understood the implications of long sentences, but we
17 are beginning to feel it now and have been feeling it
18 for some time.
19 MS. SCHLANGER: I wonder if you could
20 tell us a little bit about another issue, which is
21 mental retardation. We haven't heard very much about
22 it, about its prevalence or, I suppose, really the
23 challenges it poses for safety and abuse, which is
24 this Commission's project, and so I wonder -- it seems
25 like it's been lurking at the edges of some stuff that

1 you all have been saying and I would love to hear what
2 you have to say on that topic.
3 MR. WILKINSON: We have a unit
4 specifically for persons who have been diagnosed with
5 retardation, and I know retardation and developmental
6 disabilities are defined differently in different
7 states.
8 But in our jurisdiction you don't have
9 retardation if you were not diagnosed with it before
10 you were 18 years old. You don't get rid of a mental
11 retardation. You can get better with a mental
12 illness, but as it is defined in our jurisdiction, you
13 don't get better so we can't really treat it. We can
14 help provide training, we can help persons with
15 retardation to exist normally, we can teach them how
16 to comb their hair, we can teach them how to do family
17 style dining, we can teach them how to clean
18 themselves or work areas, but, nevertheless, many of
19 the persons who have retardation also have a mental
20 illness and it complicates matters when we're trying
21 to figure out, well, what do you treat? And how do
22 you make these persons -- and this is where it gets
23 back to the question of should these people be in
24 prison or not?
25 I tend to suggest many of the persons

1 that we have in our institutions who are currently
2 diagnosed as having retardation would not have been
3 there five or ten, 15 years ago, but yet we do. So
4 we're not only mental health directors, I'm a director
5 of a significantly-sized mental retardation operation
6 in our jurisdiction, and so is every other director of
7 corrections in this country.
8 MS. SCHLANGER: And are those inmates
9 at risk for being harmed or are they dangerous to
10 others or both?
11 MR. WILKINSON: Yes, both, all of the
12 above. That's why we have to properly classify these
13 persons, that's why assessment and diagnoses of these
14 persons, when we first get them, is important. It's
15 important before we get them, for the pre-sentence
16 investigation phase, when they are first arrested and
17 sent to court, that's when the paper trail should
18 begin and we should have access to all of that.
19 We should not have to wait until that
20 person gets to prison, especially if there is a
21 pre-existing disorder. We need to know that
22 information and there is a lack of that information
23 being transmitted to us so that we can make good
24 classification, good job assignments and use that
25 data, you know, in order for us to make good

1 correction decisions.
2 MS. FELLNER: The problem Reggie was
3 just saying about getting pre-prison data is not just
4 for mental retardation, but, also, mental illness.
5 You will often have a lot of information about a
6 person's prior diagnoses, treatment and whatnot as
7 part of the pre-sentencing or as part of, you know,
8 court mitigation argument, whatever, and that
9 information is typically not sent to the prison and it
10 is typically the case that people in -- mental health
11 people in the prisons won't ask for it, so a huge
12 wealth of data that could be helpful in treatment gets
13 lost.
14 DR. GROVES: And there's some sort of
15 technical difficulties with the mental retardation in
16 prison. In the first place, if the person is sort of
17 mildly mentally retarded or sort of borderline, they
18 may not experience that much difficulty in a prison.
19 If they're more severely effected, it's a problem.
20 But if you are getting the person,
21 first of all, and you don't have any history,
22 documented history, the appropriate diagnosis demands
23 expenditure of some resources. You really should do
24 an IQ test by somebody who is trained to do it,
25 usually the psychologist, at least a master's level

1 person. It's sometimes difficult to get that sort of
2 personnel, certainly in jails and sometimes in
3 prisons.
4 And mental retardation can mimic other
5 conditions because other conditions can affect the
6 intellectual function and make sure seem retarded when
7 they're not.
8 So it's not quite as easy an issue as
9 it might appear at first, in terms of whether a person
10 is mentally retarded or not.
11 DR. DUDLEY: Mr. Schwarz.
12 MR. SCHWARZ: SchwarzThis is a
13 question, Director Wilkinson, for you that's not
14 limited to mental health, but there's discussion about
15 whether there are people being sent to prisons who
16 don't need to be there and whether, also, the number
17 of people in prisons gets in the way of corrections
18 professionals doing the job that they would like to
19 do. And maybe you could answer this question either
20 from your own point of view or if you didn't want to
21 talk about your own point of view, say what you think
22 most of your colleagues believe.
23 Do most corrections professionals
24 believe that the number of people being sent to
25 prisons per order of the legislature is getting in the

1 way of their doing the kind of job they would like to
2 do as corrections professionals?
3 MR. WILKINSON: Interesting question.
4 I have never heard it couched quite that way. I do
5 believe that most correctional administrators will
6 suggest that there are persons in their population who
7 should not be there. Considering, you know, the
8 number of gray hairs I have today, I have no problems
9 in saying we have a lot more than we should have.
10 Other corrections administrators might be more
11 reluctant to say it in that way.
12 But we've done research and we know
13 that given the same histories that persons might have
14 in one county, given if that person was sentenced in a
15 different county would determine whether or not they
16 would go to prison.
17 We're concerned now about the female
18 population. Exponentially there are more females,
19 percentage-wise, that are being sent to prison than
20 males, and we have absolutely no idea why. I've
21 actually commissioned a study to find out why that's
22 actually going on. I had to open up a third or fourth
23 facility just for female offenders just in recent
24 months, so it's a problem.
25 I do believe that most corrections

1 administrators will suggest that it's a concern, but
2 I'm not -- the number would have to be reduced in so
3 significant of a way that it would reduce the average
4 cost of incarceration of a person and not the marginal
5 cost. I could take out -- 20 people out of a prison
6 with 300 people and it's still going to cost me the
7 same to run that institution. If I could close the
8 prison with 300 people in it, then I would save that
9 average cost. So it's not just the question of how
10 many we have, at what threshold level does it exist
11 that it would really make a difference?
12 DR. GROVES: I think it's ambivalent
13 for an individual administrator at an individual
14 facility, they certainly often recognize that their
15 facility is overcrowded.
16 For example, Mercer County used to have
17 a detention center in Trenton and a correction center
18 a few miles away. The building in Trenton was a sick
19 building; plumbing was always breaking down in the
20 summer, people can't take a bath, can't flush a toilet
21 for days at a time and the same thing happened at the
22 new prison.
23 So you have all of these psychiatric
24 patients coming in, overloaded, people sleeping in the
25 gym, sleeping on the floor, cells that used to have

1 two people now have three people stacked on top of
2 each other. They're tearing their hair out.
3 And the psychiatric patients, because
4 of the rigidity of the system, one of the easiest ways
5 to get any attention or acknowledgment that you are
6 suffering is to say that you are going to commit
7 suicide or to make a gesture; like, you know, you tie
8 your handkerchief around your neck or you cut yourself
9 or something like that, then that's a problem for
10 them; you have to get isolated or they're worried
11 about you because of your history, then you have to
12 get taken out to the local hospital and, you know,
13 that's a big expense.
14 However, at the systems level there may
15 be different feelings because, you know, corrections
16 are a growth industry; it provides a lot of jobs in
17 segments of the community.
18 Mr. Farrow this morning talked about
19 the north-south axis in New Jersey. In New Jersey
20 south there are many farms that are going bust and the
21 guys who lived on that farm are the children of those
22 farmers of the previous generation. They are now
23 being -- many of them are being provided employment
24 through new prisons that are being put up and expanded
25 in the southern part of the state.

1 So if the corrections people are high
2 enough place, the volume of prisoners could involve
3 some growth of that empire and more security for
4 corrections on a whole as against an individual
5 institution.
6 MR. GREEN: I just wanted to ask
7 actually two questions, they're unrelated. One is to
8 Ms. Fellner, you mentioned about oversight and
9 accountability during your opening statement, you
10 didn't get a chance the fully address that, but, also
11 I wanted to ask then Dr. Wilkinson on a different
12 issue; you expressed in your opening statement about
13 some trepidation going into this and when the
14 Commission was announced and that that was something
15 that was somewhat part of correction officials around
16 the country.
17 In terms of our addressing this issue,
18 assuming that there are some important issues that
19 need to be addressed and that need to have impact, I
20 would like you to then maybe comment on is, it what we
21 say and how we say it? How do we, in fact, do
22 something that ends up being effective from the
23 perspective of correction officials, but first
24 accountability and oversight, Ms. Fellner.
25 MS. FELLNER: Yeah, I think probably

1 everybody remembers the sort of open -- what were they
2 called -- sunrise laws.
3 UNIDENTIFIED SPEAKER: Sunshine laws.
4 MS. FELLNER: Sunshine laws. Those
5 seem to bypass prison systems. Prison systems are
6 remarkably closed, not just that they keep prisoners
7 in, but it is very hard for the public or even
8 appropriate sectors of the public to find out what's
9 going on inside. And given all the problems which you
10 are looking at that prisons, by their very nature, can
11 have, oversight, outside oversight, I think, is
12 crucial.
13 Whether it be done through an
14 independent inspector general, whether it be done
15 through a commission, there need to be more mechanisms
16 so that there is an outside accountability for what's
17 going on inside, which in most jurisdictions or states
18 does not exist.
19 This is also particularly true for
20 mental health and medical care. I believe that there
21 should be -- call them boards, commissions or
22 whatever, independent experts in medical or mental
23 health fields who are charged with monitoring what's
24 going on, who can ask questions, who can get the data.
25 Often times, this data and this information only comes

1 out in litigation.
2 California shouldn't have required
3 those experts to go in, who you heard from earlier, to
4 uncover what should have been out for a long time.
5 Prison systems are reluctant to have
6 oversight, they are certainly wary of the press, for
7 good reason, but there needs to be more mechanisms of
8 transparency in general.
9 MR. GREEN: Dr. Wilkinson, could you --
10 MR. WILKINSON: When the Commission was
11 first announced, the way it got to us as correction
12 administrators is that it was a follow-up to the
13 scandal in Abu Ghraib in Iraq, and as it was
14 determined with that event, persons who were
15 professional corrections administrators had nothing to
16 do with Abu Ghraib. It was strictly a military event
17 and those persons were all cleared by the Department
18 of Defense Inspector General when that was
19 investigated.
20 But, nevertheless, it was extrapolated
21 as a result of that and characterized that Abu Ghraib
22 is no different than prisons that are operated in the
23 United States. The same way it's being said about
24 Guantanamo Bay and them being the new goologs(ph.) of
25 the 21st century.

1 So, as a result, we were preparing to
2 go to war, more or less, with this Commission and what
3 we thought may have been the intention, which was to
4 eventually come out with a report that would be
5 nothing but condemnation of how correctional
6 facilities in this country were ran.
7 If it were not for Gary Maynard, one of
8 your commissioners, who called and said, hey, you
9 know, I will be the conscious of the Commission, you
10 know, I will help provide any information necessary to
11 all of you, as well as the Commission members, so that
12 this can be a reasonable exercise, you wouldn't have
13 seen me here, you wouldn't have seen Richard Stalder
14 here, you wouldn't have seen Jeff Beard here, you
15 wouldn't have seen a number of things. You would have
16 heard from us, but you wouldn't have had us here in
17 the capacities that we were in.
18 Alex held a session in Washington, DC a
19 couple weeks ago, it was a wonderful round table
20 discussion, we heard from Judge Sessions and others of
21 you that more or less said what are saying; how can we
22 help? We would love to help, you know, we'll do
23 whatever it is, we'll provide data, we'll provide
24 documents, we'll sit in meetings with you, we'll
25 respond, we'll proofread, we'll do whatever you want,

1 you know, we will write the report for you if you
2 want. So, you know, I won't say we're necessarily
3 here to help but, you know, it would be a travesty in
4 our estimation if we didn't have at least the ability
5 to provide some feedback to you.
6 MR. BRIGHT: Well, the question too,
7 though, was what would you want it to say?
8 MR. WILKINSON: Well, the truth.
9 MR. BRIGHT: I mean, as somebody who is
10 running a very large -- sixth largest prison system,
11 what do you see as the major problems and what way do
12 you see in which policymakers, legislators or whatever
13 can help you do your job better?
14 MR. WILKINSON: Well, I think it needs
15 to, first of all, say the truth.
16 MR. BRIGHT: Of course.
17 MR. WILKINSON: And I have this
18 20 percent/60 percent/20 percent theory. I think
19 there are 20 percent of some really good best
20 practices out there that somehow or another you need
21 to identify, and there are 20 percent where there are
22 lots of problems, where things need to change, where
23 probably, you know, everybody would have meant that
24 this is an area for some sort of reformation.
25 But there is 60 percent of all of that

1 that's kind of on the bubble, it's not
2 unconstitutional, you know, we need to probably do a
3 better job, but we need help. We need technical
4 assistance. I'm not one to ask for money because, you
5 know, that's not something I think you can do, so I
6 think you need to stay away from the money question as
7 much as possible because this isn't -- you know, you
8 need to give us the tools to go to our legislatures
9 for it, but you are not going to get it from the
10 federal government, so we're relegated to knowing that
11 right now.
12 So we want to be able to say that there
13 are some tools available, technical assistance,
14 training, that can possibly be recommended. We want
15 to be able to identify how jurisdictions can identify
16 what's going on in other jurisdictions that they can
17 benchmark with, for example, and we need to, you know,
18 show that there are some bad practices out there, not
19 necessarily by identifying jurisdictions, but having
20 case examples of stuff that work.
21 We are now talking about the science of
22 what works and we think we are getting pretty close to
23 understanding what evidence-based practices -- you
24 know, the science of what works and those kinds of
25 things ought to be so whatever you come up with almost

1 need to be kind of an outcome based, you know,
2 recommendations instead of something that is just
3 going to sit on the shelf, like so many other
4 exercises have been that we won't look at any more.
5 MR. BRIGHT: I mean, some problems are
6 not necessary -- there are some bad practices, you
7 said the 20 percent, but then there are also some
8 things where you've just been handed -- a better
9 analogy than the one maybe used before -- but you've
10 just been handed more than you've been given the
11 resources, the personnel or whatever to deal with, I
12 mean -- or not you, but you and your colleagues across
13 the country, some more than others; that's a fair
14 statement; isn't it?
15 MR. WILKINSON: Yes, that's absolutely
16 true and that's why I think this work cannot be
17 relegated only to the corrections profession.
18 You know, I don't even use the word
19 criminal justice. I talk about something called
20 social justice because if there's going to be a
21 resolution, you know, to the problem that we have,
22 it's going to start way before it gets to us. It
23 needs to start in the community, it needs to start
24 with sentencing courts across the state, it needs to
25 start and linger in the hallowed halls of our

1 legislatures across the country.

2 So the issue is a lot bigger and much

3 more holistic than what we originally perceived as the

4 mission of this Commission.