ORIGINAL

HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA
JUDICIARY COMMITTEE HEARING

SUBCOMMITTEE ON CRIME AND CORRECTIONS
HEARING ON DEPARTMENT OF CORRECTIONS PROGRAMS
(DRUG AND ALCOHOL, MENTAL HEALTH, AND MEDICAL CARE)

STATE CORRECTIONAL INSTITUTION AT CHESTER
500 EAST FOURTH STREET
CHESTER, PENNSYLVANIA

WEDNESDAY, APRIL 5, 2000, 1 P.M.

BEFORE:

HON. JERRY BIRMELIN, CHAIRMAN
HON. KATHY M. MANDERINO
HON. BABETTE JOSEPHS
HON. HAROLD JAMES
HON. DON WALKO

ALSO PRESENT:

BRIAN J. PRESKI, ESQUIRE
MIKE RISH

SHERRI A. REITANO
REPORTER-NOTARY PUBLIC

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1 CHAIRMAN BIRMELIN: Good afternoon,
2 ladies and gentlemen. I would like you to take
3 your seats so that we can begin our hearing. I
4 want to welcome you today to the Pennsylvania
5 House of Representatives Judiciary Committee,
6 Subcommittee on Crimes and Corrections Hearing.
7 I'm Representative Birmelin from
8 Wayne and Pike Counties and I'm the Chair of this
9 Subcommittee. I will be emceeing, if you will,
10 this hearing.
11 I'm going to ask the members of the
12 Committee and staff to introduce themselves.
13 REPRESENTATIVE MANDERINO: Good
14 afternoon. I'm Kathy Manderino, Philadelphia
15 County Representative.
16 REPRESENTATIVE JOSEPHS: Good
17 afternoon. Representative Babette Josephs. I'm
18 also from Philadelphia County.
19 CHAIRMAN BIRMELIN: And we also have
20 a staff member here from the democratic -- we are
21 having problems with the microphones.
22 For the benefit of the stenographer,
23 I'll reintroduce myself. I'm Representative
24 Birmelin from the District of 139th, Wayne and
25 Pike Counties.

1 And we have with us some other
2 Committee members. They did such a great job the
3 first time that I know you will the second time.
4 Would you reintroduce yourselves?
5 REPRESENTATIVE MANDERINO: Good
6 afternoon. Kathy Manderino, Philadelphia County.
7 REPRESENTATIVE JOSEPHS: Good
8 afternoon. Babette Josephs, Philadelphia County
9 as well.
10 MR. RISH: Mike Rish of the House
11 Democratic Judiciary Committee staff.
12 CHAIRMAN BIRMELIN: And one of the
13 gentlemen who will be wandering around during the
14 day and is wandering back is Chief Counsel Brian
15 Preski. He will be seated to my right, to your
16 left in your viewing.
17 There may be some other Committee
18 members that will be in attendance as the day goes
19 on. I will be sure to introduce them as they take
20 their place up here with the rest of the
21 Committee.
22 And I also want to remind those of
23 you who are here today that for those members of
24 the Committee who are not here, copies of your
25 testimony will be provided to them.

1 And also as a blanket statement --
2 and I may need to remind individuals as they give
3 testimony at a later time -- the Committee members
4 would prefer that if you have testimony, that you
5 don't necessarily read it word for word to us.
6 We would prefer that if you want to
7 use it as an outline or if you want to use it as a
8 reference point, that you may want to highlight
9 some of the statements prepared in writing; but
10 that we would like you to feel free to get to the
11 real core of the issue and tell us exactly what it
12 is that you would like us to concentrate on and to
13 be most focused on with your testimony today as
14 opposed to you reading, you know, 7, 8, 9, 10
15 pages of information to us that will be redundant
16 because we can read it ourselves.
17 We are interested in your testimony.
18 We do want copies of it. What we do when we are
19 given testimony is we get back to our hotel rooms
20 or wherever we go afterwards and we do read your
21 testimony and make notations on it based on what
22 you also said.
23 So don't feel as though you need to
24 sit and read, you know, a monologue to us.
25 Because if we do have it in writing then that will

1 suffice to have the written record. So feel free
2 to add to that and use it as a springboard for
3 your discussion.
4 Please don't feel that you are tied
5 down to reading every word that you've provided
6 for us in writing.
7 With all that having been said, I
8 also wanted to point out if you have a copy of the
9 agenda, you will see it is an action-packed,
10 full-of-information type of agenda that is
11 aggressively trying to be heard from a lot of
12 people probably in about a three-hour time span as
13 it is scheduled.
14 I will do my best to help us to stick
15 to the schedule all though that is not always
16 possible. So we're looking at a lot of people
17 giving a lot of testimony in a short period. It
18 would help to keep the hearing moving, but also to
19 have the hearing engage any one particular
20 testifier who thinks that he or she has to
21 continue well beyond necessary items that we've
22 asked for.
23 So we would encourage you to try and
24 keep your comments to the point and keep them on
25 target. And as we ask questions from the panel

1 here -- and we may or may not -- that you would
2 answer them as succinctly as possible.
3 Sometimes we find that people who
4 testify are asked a question and they sort of as
5 we in politics do go off on a tangent and talk a
6 lot more than what we asked for. We would
7 encourage you to keep your responses to questions
8 as succinct as possible.
9 With all of that having been said, we
10 would welcome you again and encourage you to take
11 notes on what we're talking about today.
12 Today's topic is on issues of drug
13 and alcohol, mental health, and medical care in
14 Pennsylvania's SCI. And we have those three
15 topics being presented today.
16 We are meeting tomorrow at Graterford
17 SCI where we will be talking about working
18 opportunities including correctional institutes in
19 the State prisons of Pennsylvania and later in May
20 we also have two hearings on other
21 treatment-related issues.
22 So we will in all at this point in
23 time have four committee meetings dedicated to
24 treatment issues with the potential of perhaps two
25 or three more over the rest of this year and

1 summer or fall, issues that we're not able to deal
2 with in the first four hearings.
3 So we encourage you to get copies of
4 the testimony of those who are giving it and also
5 to correspond with this Committee if you have any
6 comments that you would like to share with the
7 Committee.
8 Our first two testifiers today are
9 Mr. William Love who is the Secretary of the
10 Department of Corrections and Thom Rogosky -- I
11 hope I'm pronouncing it correctly -- who is the
12 Director of the Bureau of Community Corrections.
13 And, gentlemen, you have about 30 minutes to
14 present your testimony. Okay.
15 MR. LOVE: Good afternoon, Mr.
16 Chairman, members of the Subcommittee, and staff.
17 My name is Bill Love, Deputy Secretary for
18 Specialized Facilities and Programs for the
19 Pennsylvania Department of Corrections.
20 I'll be presenting an overview of the
21 drug and alcohol programs that we offer to the
22 men and women that are entrusted in our care at
23 the Pennsylvania Department of Corrections,
24 the 24 institutions and boot camp.
25 I appreciate this opportunity.

1 Following my presentation, Thom Rogosky, Director
2 of Community Corrections, will discuss several of
3 our drug and alcohol pre-release centers. Later
4 after Thom's testimony, you will hear testimony
5 from our vendors who work cooperatively with the
6 137 drug and alcohol specialists who provide
7 services for the men and women in our Department.
8 We have made a concerted effort to
9 promote sobriety and eliminate drugs within our
10 prisons. Our drug interdiction efforts have
11 resulted in a 99.8 drug-free system.
12 By eliminating a drug culture inside
13 our prisons, we have greatly enhanced the success
14 of our drug and alcohol treatment programs.
15 The brochures and information that
16 you will receive, you can see that there has been
17 a marked decline in recidivism which we believe is
18 directly related to our commitment to sobriety,
19 education, and work.
20 For the past four years, we have been
21 using a validated drug and alcohol screening tool
22 called the PACSI. Every inmate that enters our
23 system whether it is through a direct commitment
24 from the court or by the parole -- parole
25 violators are administered the PACSI.

1 From 1996 to 1999, 91 percent of the
2 men and women who are screened have indicated the
3 need for some drug and alcohol issues. As you can
4 see, we have a tremendous challenge responding to
5 the drug and alcohol needs of the men and women in
6 our Department.
7 As a result of our commitment to
8 increase drug and alcohol services to the inmates,
9 we have added six additional therapeutic
10 communities since 1995 bringing a total TCs,
11 therapeutic communities, to 11 in 8 of our
12 facilities.
13 Eight of our eleven are run for
14 general population inmates and the remaining three
15 are for RSAT programs. Participation in RSAT
16 programs consist of six months in a therapeutic
17 community while they are confined in a facility.
18 And then they serve six months in a community
19 correctional center and six months with intensive
20 parole supervision.
21 What that does is assure that there
22 is consistency and continuity in services that we
23 provide men and women in our centers, in our
24 communities.
25 These communities serve approximately

1 1,068 inmates per year. Overall we have increased
2 the number of inmates receiving treatment by 59
3 percent since 1995.
4 Over the past four years, we have
5 increased our budget for treatment of drug and
6 alcohol services by 300 percent, from $3.8 to
7 $11.4 million.
8 Let me take this opportunity to
9 briefly give you an idea of our treatment
10 initiatives and give you a little bit about what
11 we try to do.
12 We currently have more than 15,000
13 inmates in drug and alcohol programs. Our program
14 is minimum sentence driven. That means that every
15 inmate who has been identified as having a drug or
16 alcohol problem on their prescriptive program is
17 placed in the drug and alcohol program.
18 Because participation in the drug and
19 alcohol program is driven primarily by an inmate's
20 sentence, that often causes a waiting list for
21 services.
22 However, every inmate is given an
23 opportunity to participate and complete the
24 program prior to their release. We currently have
25 drug and alcohol treatment programs in all of our

1 facilities.

2 These include education, outpatient,

3 and self-help support groups such as relapse

4 prevention, criminogenic thinking, alcoholics

5 anonymous, narcotics anonymous. There are

6 therapeutic communities in eight institutions for

7 more intensive treatment.

8 Here at Chester the institution is

9 dedicated to a drug and alcohol treatment program

10 with the mandatory aftercare component.

11 The Chester program is unique unlike

12 any other program in the country. Chester has a

13 mandatory aftercare component and what else that

14 makes this program unique is because of its

15 holistic approach in treatment.

16 The Department recognizes that the

17 approach to female inmates with drug and alcohol

18 programs must be different than male inmates.

19 Literature and experience tell us

20 that women respond better to treatment programs

21 when they perceive their environment to be safe

22 and supportive.

23 Part of the treatment approach in

24 responding to our females is to take into

25 consideration a history of abuse and dependency.

1 We also have to take into consideration that many
2 of our women that come to our systems are mothers.
3 As of March of 1999, 82.1 percent of
4 the women entering our center were mothers. On
5 April the 1st, 2000, the Department opened an
6 entire housing unit at the State Correctional
7 Institution at Cambridge Springs to respond to the
8 needs of women with drug and alcohol problems.
9 This unit will provide housing and
10 programming to 177 women. This program is in
11 addition to the Wings of Life program that has
12 been operating at SCI Muncy, another facility that
13 houses females for a number of years.
14 We have utilized specialized training
15 and outside consultation to help us understand the
16 uniqueness of addressing this population's needs.
17 We believe that the key to any drug
18 and alcohol treatment is continued aftercare. No
19 matter how much treatment you provide inside, if
20 an inmate returns to the same community without
21 follow-up treatment, he or she are more likely to
22 relapse, violate parole, possibly commit another
23 crime.
24 We have made significant efforts to
25 strive and provide an aftercare program through

1 our community correction centers and also for our
2 private providers; Gateway, Civigenics,
3 Eagleville, and Gaudenzia. You will be hearing
4 part of their testimony later on.
5 We've established six therapeutic
6 communities for technical parole violators using
7 federal Residential Substance Abuse Treatment
8 (RSAT) funds. Three are currently operational and
9 another three will be on-line in June.
10 In order to make this program work
11 effectively, we have had to work cooperatively
12 with the Pennsylvania Board of Probation and
13 Parole.
14 The VERA Institute of Criminal
15 Justice through a federal grant is evaluating our
16 program. And we've also received high marks from
17 the Pennsylvania Commission on Crime and
18 Delinquency and the federal monitors to assure and
19 evaluate our success.
20 Additionally, we have partnered with
21 Temple University to conduct process and outcome
22 evaluations on our therapeutic community approach.
23 And preliminary reports also clearly indicate that
24 therapeutic communities will be a success in the
25 efforts that we are making.

1 We also have a very successful
2 halfway back program, Substance Abuse Violators
3 Effort (SAVE) which permit parole officers to send
4 inmates who have relapsed into an intensive
5 treatment program in the community rather than
6 sending them back to a State Correctional
7 Institution.
8 Again, our vendors will talk more
9 detailed about these programs. We are proud of
10 our partnership with drug and alcohol vendors.
11 And this relationship has enhanced the services
12 that we provide.
13 Our relationship with them has also
14 kept the Pennsylvania Department of Corrections on
15 the cutting edge of drug and alcohol treatment and
16 helps promote public safety for the citizens of
17 the Commonwealth of Pennsylvania which we see is
18 our ultimate goal.
19 Thank you very much for having an
20 opportunity to share this with you.
21 CHAIRMAN BIRMELIN: Thank you, Mr.
22 Love. Mr. Rogosky.
23 MR. ROGOSKY: Good afternoon,
24 Chairman Birmelin, members of the Committee, and
25 staff. My name is Thom Rogosky. I am privileged

1 to be the Director of the Department of
2 Corrections, Bureau of Community Corrections.
3 The Bureau of Community Corrections
4 is charged with the task of providing transitional
5 services to men and women who have exited or are
6 exiting from a State Correctional Institute.
7 The program was originally enacted by
8 Act 173 of 1968 and began in 1969. And in fact
9 the first community correction center opened in
10 Harrisburg on May 23rd, 1969.
11 We initially began with a small
12 number of inmates in a pre-release program. By
13 1995 we had 1,066 inmates in those programs.
14 Today, we have nearly double that number at 2,300.
15 We operate 14 community correction
16 centers. Community correction centers are State
17 operated facilities employing State employees in
18 leased buildings.
19 We supervise and award contracts to
20 private vendors. We operate 43 private facilities
21 throughout the Commonwealth which are monitored by
22 the Department of Corrections regional office
23 staff.
24 Six of our facilities are solely for
25 women. Two of those are on community corrections

1 centers, one in Pittsburgh and one here in
2 Philadelphia. The remainder are private
3 facilities.
4 And 13 additional facilities house
5 both men and women in separate areas of their
6 facilities. Each individual coming into the
7 community correction center has a prescriptive
8 program plan developed for them.
9 Counselors meet with the inmates at
10 least twice a week. Program plans are reviewed by
11 both staff and inmates. Those plans are modified
12 as necessary as a particular individual moves
13 through the program.
14 We have a responsibility for the
15 community. Inmates in those facilities are
16 monitored on a regular, irregular, and unannounced
17 basis to assure that we know of their whereabouts
18 at all times.
19 All inmates in our facilities are
20 physically able, are expected to work. We also
21 expect them to assume responsibility in our
22 facilities. Responsibilities for cleaning their
23 own areas. Responsibility for cleaning the
24 facility.
25 In our own facility we do not provide

1 full service. Residents are expected to budget
2 their money to purchase the food and to cook it
3 themselves.
4 Our vendors are required to provide
5 food services. All of this is done in the
6 guidance of center staff. Participation in our
7 program is a privilege.
8 We monitor individuals' behavior at
9 all times. Failure to abide by the rules and
10 regulations or to participate in programs, be
11 accountable, in other words being where you are
12 supposed to be when you are -- being where you are
13 supposed to be when you are supposed to be there.
14 Inmate participation in our community
15 corrections program is a privilege. An inmate's
16 failure to abide by the rules and regulations of
17 that program which can be where he or she says
18 they are going to be or required to be when they
19 are required to be there can result in an
20 immediate return to the State Correctional
21 Institution.
22 Let me talk a little bit about some
23 of the special programs that we have going on in
24 community corrections. As I'm sure all of you are
25 aware, we have a boot camp targeting the

1 nonviolent offenders.

2 We realize that the boot camp

3 provides treatment at that site. We also realize

4 that the inmates who participate in that inmate

5 program return to their communities.

6 We take them from a very intensive

7 drug and alcohol education and physical fitness

8 program back to the same communities they were

9 removed from without any assistance.

10 As a result of that, we developed

11 what we call the boot camp aftercare program. And

12 it is designed to do several things.

13 It is designed to provide a

14 transition in that highly intensive active program

15 back to the community.

16 It is designed to provide a

17 continuation of the physical fitness and wellness

18 that those inmates have developed at that camp.

19 It is designed to provide family

20 involvement in the program so they are part of the

21 transition back to the community.

22 Additionally, there are vocational

23 counseling services available through those

24 facilities. We have opened or will open up

25 facilities in Philadelphia, Harrisburg,

1 Pittsburgh, and Erie specifically designed for the
2 boot camp aftercare graduates.
3 The program consists of six months of
4 residency where an individual lives in the
5 facility and six months of aftercare in decreasing
6 intensity until the individual is finally placed
7 in an approved residence in the community.
8 Last year we opened the
9 first community correction center in Pennsylvania
10 for seriously mentally ill inmates.
11 The Department found that individuals
12 with those illnesses are exiting our State
13 Correctional Institutions with little family
14 support, eventually ending up back at our front
15 door.
16 Gaudenzia is our contractor for that
17 and Mike Harley will be speaking to you a little
18 bit later about this program. It is located here
19 in Philadelphia.
20 We believe it is the first of its
21 kind in the nation. We are filled. We have a
22 waiting list of individuals waiting to get in
23 there, and we're very pleased with the program.
24 We also provide services to the Board
25 of Probation and Parole in a program we call the

1 halfway back program, originally called the
2 prison diversionary program.
3 It is designed to provide services to
4 parolees who are encountering difficulties on the
5 street and who as an alternative to being returned
6 to the State Correctional Institution are placed
7 in a residential facility for a period of time
8 under intense supervision until the home
9 situation, the employment situation, or the
10 chemical dependency situation is dealt with.
11 We also have a rather unique program
12 with a vendor in York County, Crispus Attucks
13 Youth Build Program. This program provides
14 services to young men and women who lack
15 vocational training, skills, and education.
16 The program involves rehabilitation
17 of buildings in the York area. It involves
18 classroom education and GED for those individuals.
19 And, in fact, some of our boot camp graduates are
20 also participating in this.
21 There are two other programs -- there
22 are two other programs that I would like to speak
23 to you about.
24 Deputy Love mentioned one and that is
25 the SAVE program, Substance Abuse Violators

1 Efforts. This is a more intensive program than
2 the halfway back program. We have a contract with
3 Eagleville Hospital. It involves a period of
4 three months of intensive inpatient drug and
5 alcohol rehabilitation services at Eagleville
6 Hospital followed by nine months of lessening
7 degrees of outpatient treatment.
8 The other program Deputy Love also
9 alluded to was a Residential Substance Abuse
10 Treatment. You'll be hearing it referred to as
11 RSAT throughout the day.
12 This is again a more intensive
13 program than the SAVE Program. It provides a six
14 months therapeutic community experience in a State
15 Correctional Institution followed by six months of
16 residency in a community correction center or
17 contracted facility in the community that the
18 individual was returned from.
19 While they are in that residential
20 program, outpatient treatment services are
21 provided by the vendor who provided the TC
22 experience.
23 In addition to the drug and alcohol
24 treatment program, community corrections center
25 residents are monitored for drug uses. Secretary

1 Horn made a zero tolerance policy in effect for
2 our institutions. The same pertains to community
3 correction centers.
4 In fact, last year we conducted
5 33,991 urinalysis tests. Of those tested,
6 two-tenths of 1 percent were positive. You have
7 to keep in mind those individuals are in the
8 community going to jobs and returning on a daily
9 basis.
10 Any time a resident or an inmate of
11 our community correction center receives a
12 positive urinalysis, they can be returned to a
13 State Correctional Institution.
14 There is one fact that I'm really
15 proud of regarding our community corrections
16 program. Last fiscal year residents of the
17 community correction programs in Pennsylvania
18 earned $12,228,248 in wages. They paid $2,723,965
19 in taxes.
20 And as far as provisions of Act 84 of
21 1998 are concerned, they paid nearly a half a
22 million dollars in restitution, court costs, and
23 fines.
24 I hope I've given you a brief
25 description of the community -- of community

1 alcohol problem, that problem is identified and on
2 an annual basis is reviewed to see if they are
3 complying with what is expected. Drug and alcohol
4 is one of those issues that is monitored
5 throughout the program.
6 CHAIRMAN BIRMELIN: One of my
7 constituents came to see me a few days ago and had
8 been a prisoner in Muncy SCI. And she had been
9 referred there because the county in which she
10 lived did not provide drug and alcohol treatment
11 and they did in Muncy.
12 That is why she was sent there. She
13 said that she was very happy to have had the
14 opportunity to sit in on what she called AA
15 meetings, Alcoholics Anonymous. She said her only
16 real problem was that they only met once every two
17 weeks.
18 Is it a standard practice for people
19 who are in a prison or other drug and alcohol
20 programs to only meet with their groups once every
21 two weeks?
22 MR. LOVE: What the situation is it
23 depends on the intensity of the treatment needed.
24 If a person was only involved in drugs -- NA or AA
25 counseling once a week, then I think it would be

1 corrections and our drug and alcohol interdiction
2 measures. I'd be happy to answer any questions
3 that any of you have.
4 CHAIRMAN BIRMELIN: Thank you, Mr.
5 Rogosky. I guess my microphone is not working and
6 yours is. So I'll try to speak as loud as I can.
7 I have two questions for each of you.
8 Mr. Love, is every prisoner in the
9 drug and alcohol treatment program in the State
10 prison system?
11 MR. LOVE: Your question is does
12 every inmate get an opportunity to have drug and
13 alcohol treatment?
14 CHAIRMAN BIRMELIN: While they are in
15 prison if they came in with that problem.
16 MR. LOVE: Absolutely.
17 CHAIRMAN BIRMELIN: I'm assuming
18 that's a high percentage of your number of
19 prisoners.
20 MR. LOVE: What we believe is upwards
21 of 80 percent of the inmates that come into our
22 system have drug and alcohol problems. When they
23 initially come in, they meet with a counselor.
24 They develop an individual prescriptive program.
25 If they come in with a drug and

1 safe to conclude that the drug and alcohol problem
2 wasn't as severe as if they were in a program for
3 something a lot more severe with a TC or meeting
4 more often.
5 CHAIRMAN BIRMELIN: Thank you. Mr.
6 Rogosky, a couple of questions of you. How do you
7 measure the success of your programs of which you
8 just referred to?
9 MR. ROGOSKY: The Department has
10 conducted some recidivism studies recently. And a
11 study -- they conducted one study and the second
12 the following year and there seemed to be a
13 reduction in the recidivism.
14 And at the same time we looked at the
15 number of inmates in community corrections and
16 they have greatly increased. And we kind of have
17 been looking at that and that was one of the
18 factors that was considered. Additionally, there
19 are some national studies that show that
20 transitional services do work.
21 CHAIRMAN BIRMELIN: And I would agree
22 with you that is the experience that I had with
23 talking with a number people involved in this
24 field.
25 My second question to you is assuming

1 this is a successful program or successful
2 programs, plural, what is to prevent you from
3 doing more than you are currently doing if there
4 is a way great need for them?
5 MR. ROGOSKY: We currently have an
6 additional 14 facilities that are in some stage of
7 development. They are waiting for contracts to be
8 approved, waiting for individuals to identify a
9 facility. One of the most difficult processes in
10 community corrections is the opening of new
11 facilities.
12 Those of you who have seen where they
13 tried to open up a facility, there is a real fear
14 on the part of the general public of these
15 facilities.
16 While we try to alleviate that fear
17 with education, meetings with the advisory boards,
18 it is sometimes very, very difficult.
19 CHAIRMAN BIRMELIN: I probably misled
20 you as to two questions for you. I want to ask
21 you a third question.
22 MR. ROGOSKY: Sure.
23 CHAIRMAN BIRMELIN: Do these
24 facilities through the grants that they pay, what
25 portion of the cost of the program is reimbursed

1 through rent or whatever other means by which
2 these offenders contribute back to the halfway
3 houses and those similar programs?
4 Just a ballpark figure. You don't
5 have to give me what percentage you think it would
6 be.
7 MR. ROGOSKY: It is a very small
8 percent which I believe our budget from last year
9 there was $35 million and $1.5 million was
10 returned in terms of rent.
11 CHAIRMAN BIRMELIN: Would you say one
12 of the obstacles you have in establishing
13 community corrections is the cost?
14 MR. ROGOSKY: It is actually cheaper
15 to establish a community corrections center. Per
16 diem cost is lower than a correctional
17 institution. Our figures are $72 for an
18 institution, $54 for a community correction
19 center.
20 CHAIRMAN BIRMELIN: Thank you very
21 much. Any members of the Committee have any
22 questions? Representative Manderino.
23 REPRESENTATIVE MANDERINO: Thank you.
24 Working, not working? Okay. My first question I
25 guess goes to maybe something that I misunderstood

1 or misheard, Mr. Love, from your last comments.
2 I'm looking at enrollment statistics
3 in our drug and alcohol treatment programs which
4 have been on the increase in both funding and
5 enrollment.
6 But I was under the impression that
7 we still are not meeting the need that existed.
8 And I was going to ask you what percentage of the
9 need that we have are we meeting with the current
10 capacity.
11 But you said something to
12 Representative Birmelin that I maybe misunderstood
13 that you thought you were meeting a hundred
14 percent of the need. So can you both clarify that
15 and help me understand what the need is?
16 MR. LOVE: No, we are not meeting a
17 hundred percent of the need. I guess what I was
18 suggesting in responding to the question was when
19 I was asked about meeting one day a week.
20 I was thinking -- my response is if
21 they are only meeting one day a week, it is
22 because of the level of the need, the treatment
23 need.
24 And if they are just in AA, then that
25 would suggest that the treatment needs are

1 probably not as great as if they were placed in a
2 therapeutic community. But are we responding to a
3 hundred percent of the needs? No.
4 REPRESENTATIVE MANDERINO: Is the
5 Department collecting the statistics that you can
6 quantify how much of the need we are meeting with
7 our current budget allocations?
8 MR. LOVE: What I have is the
9 treatment needs in the TCs is 40 percent. But no,
10 I probably can't give you an accurate number at
11 this point.
12 But what I will do is research, look
13 into it, and make sure you get those numbers. I
14 wouldn't want to give you --
15 REPRESENTATIVE MANDERINO: The
16 other numbers that I'm looking for you will
17 probably also have to collect. But if you don't
18 have them, I would suggest from my point of view
19 these are numbers that I think are important to
20 collect.
21 It is not uncommon for me and I'm
22 sure my other colleagues to hear from constituents
23 or their families who were denied probation or
24 parole and sent back into the institutional
25 setting after going up for probation and parole

1 for lack of having received the proper treatment
2 while in the facility in order to be eligible for
3 parole.
4 What I am interested in is, are we
5 keeping data and statistics about the number of
6 instances in which this happens on an annualized
7 basis and what over an annualized budget it costs
8 us given how much longer they come back into the
9 institution and stay in the institutional setting
10 before they then go back to the Probation and
11 Parole Board and finally move on to a less
12 expensive setting?
13 I want to see the dollar numbers and
14 dollar figures of what it is costing us when those
15 things happen.
16 MR. LOVE: Sure. And I can
17 appreciate your concern about that. Let me say a
18 number of things.
19 Number one, a family member or inmate
20 may report that the reason why he or she did not
21 make parole is because of the lack of ability to
22 participate in the drug and alcohol program or a
23 program offered in the Department. I would
24 challenge that. The reason why I would challenge
25 that --

1 REPRESENTATIVE MANDERINO: I check
2 each time I get those inquiries with the
3 Department of Corrections and that is usually the
4 reason that I get from the Department of
5 Corrections. That my loved one's family member
6 was rejected or I get that reason from probation
7 and parole. Because sometimes I check both
8 places.
9 MR. LOVE: There may be a number of
10 reasons why they are not able to get in the
11 program. It may be because of -- they are not --
12 maybe they are in a restrictive housing unit
13 because of misconduct.
14 What I can tell you is that if an
15 inmate is scheduled to be released -- once they
16 come inside the institution, we know what their
17 sentence structure is.
18 We do identify what their programs
19 should be like consistent with their sentence
20 structure. So every inmate ought to be able to
21 have an opportunity to get involved in some kind
22 of program.
23 Again, there may be a waiting list.
24 We often hear there are waiting lists. A lot of
25 that has to do with inmates may have a 20-year

1 sentence. So we don't want to put them in a
2 program until they get close to their release
3 date.
4 There may be a number of reasons why
5 they are denied parole. But lack of participating
6 in a program, again, like I said, I would have to
7 know the individual cases.
8 One of the things that we have
9 done -- another thing that we have done is
10 standardized all of our drug and alcohol programs,
11 our sex offender programs so that when an inmate
12 goes from one institution to another institution,
13 the service and treatment is consistent.
14 What we have found in the past is
15 sometimes the Board will look at the level of
16 treatment that an inmate has received and may say
17 that it is not sufficient because of their history
18 of abuse or usage.
19 REPRESENTATIVE MANDERINO: You're
20 getting exactly to the point that I'm trying to
21 get to. It seems to me that if we are tracking
22 that information which is information that I think
23 would be important to track, that we would be able
24 to see a pattern develop which we could respond to
25 prior to the fact and again from a budgetary point

1 of view.

2 Again, both of you acknowledge that
3 the treatment is more effective both in a
4 community setting than it is in an institutional
5 setting and/or that it would be cheaper to give
6 them the treatment inside when we have a captive
7 audience to get them started on where they are
8 outside.

9 It seems to me if we were collecting
10 the data the way we wanted to, you could adjust so
11 that the result is not people going back in to
12 serve additional expensive time because of lack of
13 treatment.

14 MR. LOVE: That's why we appreciate
15 our relationship with Vera Institute and Temple
16 University because they are doing those kinds of
17 studies and evaluation.

18 REPRESENTATIVE MANDERINO: On the
19 community correction side, the same kind of
20 information that I'm interested in.

21 Again, I will often hear that
22 somebody has served their minimum and has been
23 approved for community placement but is still
24 serving inside an institution in our most
25 expensive setting. Again, because we are waiting

1 for an appropriate spot to open up for community
2 placement.
3 Are we keeping the numbers, the
4 dollar figures, the statistics on how many people
5 are in that status, for how long are they in that
6 status, and therefore what is their being in that
7 status costing us in one system versus another?
8 MR. ROGOSKY: I'm not sure we have
9 dollar figures to compare what that may be costing
10 us. But I believe it was three years ago
11 Secretary Horn agreed to utilize our inpatient
12 drug and alcohol facilities in the community and
13 to fund those for parolees or institutions that
14 the Board felt needed a period of time in a drug
15 and alcohol facilities.
16 We have those facilities in the
17 community and we utilize them. We have somewhat
18 of a waiting list. But with the new facilities,
19 we are bringing that waiting list down. So there
20 are facilities available. There are inpatient
21 licensed drug and alcohol treatment facilities
22 throughout the Commonwealth.
23 And the Board does have that option
24 if they feel someone needs an inpatient program in
25 order to parole them before they are sent into the

1 community. So oftentimes they do.

2 REPRESENTATIVE MANDERINO: Thank you.

3 I would think it would be very helpful to see that

4 kind of statistical data.

5 CHAIRMAN BIRMELIN: You can forward

6 that information to my office. I will see that

7 the other members of the Committee get it as well.

8 Representative Josephs.

9 REPRESENTATIVE JOSEPHS: I just want

10 to reaffirm what both Representatives have just

11 said. I, speaking for myself, am prepared to make

12 major statements in support of these programs for

13 which I'm often very critical of Secretary Horn

14 who I see in the back.

15 But I want to say that I absolutely

16 think that this is the best thing both from the

17 point of our fiscal integrity spending so much

18 money on corrections and for the safety of the

19 community.

20 I really do not want to send people

21 back into the community who are going to re-offend

22 and innocent people are going to suffer and

23 property is going to be destroyed.

24 Representative Manderino and I were

25 trying to remember. The community correctional

1 program, is that a second line item?

2 MR. ROGOSKY: It is part of our

3 institution budget.

4 REPRESENTATIVE JOSEPHS: So that if

5 you're just doing a --

6 MR. ROGOSKY: Within that budget. We

7 do have a budget, and I can give you those

8 figures.

9 REPRESENTATIVE JOSEPHS: If you

10 forward them to the Chairman, that works better

11 than if you say them out loud. And I'm also --

12 I'm concerned with the unmet need as well. I

13 think that all of us -- I speak for myself again.

14 But I think it is not uncommon -- it

15 is not uncommon for us to hear testimony like

16 yours and say, oh, there are good programs in the

17 community. There are good programs in the

18 institutions. Okay. That problem is solved.

19 Let's move on. And it isn't.

20 Because I think that in spite of the

21 fact that you try, there is an enormous unmet

22 need. So I'm wondering through both of you if we

23 were in some kind of ideal situation, what would

24 you want them to think could really -- you know,

25 if I could say, okay, we'll fund community

1 services and we'll fund substance abuse treatment
2 aftercare transition as much as you need, what
3 would that look like?
4 MR. LOVE: What would a perfect world
5 look like in the world of corrections with all of
6 the money I want to spend on drug and alcohol
7 programs?
8 REPRESENTATIVE JOSEPHS: What would
9 the programs look like? How many people would be
10 in those?
11 MR. LOVE: Sure. First of all, I
12 appreciate your support of Secretary Horn's
13 commitment plus we have done tremendous things in
14 the last four or five years.
15 If I could create a perfect drug and
16 alcohol world, I think most -- most inmates who we
17 identify with drug and alcohol issues would
18 probably be in a therapeutic community.
19 Literature has suggested to us that
20 involvement in the therapeutic community with a
21 solid aftercare program and the type of
22 supervision that makes things consistent and work
23 within the problems is the most effective
24 treatment.
25 So what we would do is develop a lot

1 more. What I would do is develop a lot more
2 therapeutic communities. So that is how I would
3 get that world.
4 REPRESENTATIVE JOSEPHS: When you say
5 that if you will excuse me, is that in lieu of
6 incarceration or after or during incarceration?
7 MR. LOVE: The therapeutic community
8 is while they are inside. What we have done is
9 increased that. As I said earlier, we have
10 increased the number of therapeutic communities;
11 but we do recognize that that's the most effective
12 way of responding to this issue, with the
13 appropriate aftercare.
14 MR. ROGOSKY: I think that aftercare
15 is the key to success of those therapeutic
16 communities in our institution. I think we're
17 moving in a lot of tremendous directions in terms
18 of the community programs.
19 We have shortly coming a program
20 called CTEP, Comprehensive Training and Employment
21 Program. We have contracted with a vendor here in
22 Philadelphia to provide vocational opportunities
23 for inmates coming out of our boot camp.
24 They will provide jobs. They will
25 provide temporary financial resources. They will

1 provide vocational counseling and permanent
2 placement for those individuals.
3 We already have an RSP on the street
4 to deal with young adult offenders who will be
5 coming out of Pine Grove. And until that is
6 opened, Houtzdale to provide GED, to provide
7 vocational training for those individuals.
8 We will be opening up hopefully
9 within the next six months our second facility for
10 seriously mentally ill inmates. That is a great
11 need.
12 Our population in community
13 corrections has doubled in the past five years in
14 terms of drug and alcohol treatment.
15 The dollars spent on drug and alcohol
16 treatment in the community have risen by 400
17 percent since 1994.
18 REPRESENTATIVE JOSEPHS: Not to
19 mention people who have not had access to those.
20 MR. ROGOSKY: Yes, ma'am.
21 REPRESENTATIVE JOSEPHS: Thank you.
22 MR. RISH: Just quickly when you
23 refer to the recidivism rates, recidivism means
24 rearrest, reincarceration.
25 MR. ROGOSKY: The recidivism rates

1 means return to the Department's facilities.
2 MR. RISH: That wouldn't necessarily
3 mean in cases of drug and alcohol. Person was in
4 a local facility before that person had gone back
5 to using drug and alcohol but not necessarily a
6 residential community?
7 MR. ROGOSKY: If they return to one
8 of our institutions, it would be a technical
9 parole violator. That would be counted. But the
10 key in those studies is return to a State
11 Correctional Institution. Our systems can tell us
12 that.
13 MR. RISH: Thank you.
14 CHAIRMAN BIRMELIN: Chief Counsel
15 Preski.
16 MR. PRESKI: Deputy Love, I guess my
17 question is that oftentimes we hear how one
18 problem will mask another. That a drug and
19 alcohol problem masks an underlying mental health
20 problem. A sexual abuse problem masks an
21 underlying drug and alcohol problem which masks a
22 mental health problem.
23 What kind of coordination is there
24 between the various programs? I know you deal
25 with drug and alcohol. But is there an approach

1 where they get training and everybody talks to
2 each other or what happens?
3 MR. LOVE: Absolutely. In fact, we
4 do have staff that meets on a regular basis at
5 each institution to monitor and evaluate what the
6 needs are of that individual.
7 And it becomes obvious, it becomes
8 evident by doing this that if a person has a
9 mental health issue and is acting out, we need to
10 get together to work with the right people and to
11 help people understand this is a mental health
12 issue and not behavior.
13 Same way with drug and alcohol needs.
14 Once an inmate is in a drug and alcohol program,
15 therapeutic program, we ought to be able and we do
16 see what their other needs are.
17 Where a person is sexually assaulted,
18 for example, it is not uncommon for a person to be
19 experiencing some problems, experiencing some drug
20 and alcohol issues as a result of some other
21 personal issues, some other problems that they may
22 experience.
23 If we were to -- and we often do find
24 out that a person was victimized, sexually
25 victimized, at a young age and begin to act out

1 and have mental health issues, have drug and
2 alcohol issues. There is a team. A team of
3 psychologists, counselors, correctional officers
4 that meet on a regular basis to evaluate what
5 those issues are.
6 MR. PRESKI: My next question is
7 this, you said when the inmates come in, an
8 assessment is done to see what they need.
9 MR. LOVE: That's correct.
10 MR. PRESKI: What happens when an
11 inmate is going to be in one of the State
12 Correctional Institutions for a short time, you
13 find out that this guy is going to max out in 9
14 months and 12 months and you're going to be done
15 with him, is there an opportunity for someone who
16 is going to be here for a short time to have some
17 kind of treatment? What is the average length of
18 your treatment programs I guess?
19 MR. LOVE: Well, the average length
20 of drug and alcohol programs in a therapeutic
21 community is about one year.
22 With the standardization of our
23 program, we will make sure that everybody gets the
24 level of treatment that they need when it is
25 possible.

1 If an inmate has six months, eight
2 months, a year to max out, what we do is they
3 still go through that initial assessment we talked
4 about to identify what the issues are. If there
5 are mental health issues, what we did is we link
6 up with the community to identify resources, make
7 the appropriate contacts.
8 If housing is an issue, if mental
9 health services is an issue, then we link up with
10 the community to make sure there is continuity of
11 care. And you will hear that -- I think you will
12 hear that consistently with the testimony that you
13 will be hearing from our health care providers and
14 other care programming in the Department.
15 MR. PRESKI: And then, Director
16 Rogosky, just to ask you one question you answered
17 before in a different way.
18 We have always been told that to keep
19 one inmate in one State Correctional Institution
20 for one year costs about $25,500. You had
21 basically said $72 a day I think and then $54 in
22 the community centers.
23 Do you have that aggregate number of
24 what it costs to put one person for one year in
25 one of these places?

1 MR. ROGOSKY: $54 a day for the
2 community center is a rate times 365.
3 MR. PRESKI: You don't have to figure
4 it out now. If you can provide that, that would
5 be great.
6 MR. ROGOSKY: Sure.
7 MR. PRESKI: Thank you.
8 CHAIRMAN BIRMELIN: Thank you,
9 gentlemen, we appreciate your testimony. Our next
10 panel of presenters are Deb Beck, president of
11 Drug and Alcohol Service Providers of
12 Pennsylvania; Gary Tennis, Chief, Legislation
13 Unit, Philadelphia District Attorney's office and
14 also spends a great deal of time here roaming the
15 halls of the Capitol; and Larry Frankel, Executive
16 Director, American Civil Liberties Union of
17 Pennsylvania who also spends a great deal of his
18 time in Harrisburg as I might say Deb Beck does
19 too.
20 These three folks are common visitors
21 in many of the legislators' offices and committee
22 meetings. We welcome all three of them.
23 Before we hear testimony, I want to
24 introduce my democratic counterpart seated two
25 seats to my right, Representative Harold James

1 from Philadelphia County; and he is a Chairman of
2 this Subcommittee. We welcome him as well.
3 I'm not sure which one of you wants
4 to go first. So if you would, I will remind you
5 of what I reminded everybody else in the
6 beginning. Please don't feel obligated to read
7 your testimony. Highlight the golden nuggets and
8 we will read it on our own. And we will also give
9 you an opportunity to answer questions.
10 MR. TENNIS: I have to apologize in
11 the beginning. Actually, I have a flight. I have
12 to leave at 2:15 to catch a plane. So I have an
13 extra incentive to be brief.
14 CHAIRMAN BIRMELIN: As soon as you're
15 finished, you may leave.
16 MR. TENNIS: Thank you.
17 CHAIRMAN BIRMELIN: You don't have to
18 wait around here. You can scoot.
19 MR. TENNIS: There is a lot of
20 testimony I would like to hear. Unfortunately, I
21 must press on. This is an important issue. I'm
22 testifying here on behalf of the Pennsylvania
23 District Attorney's Association as well as my own
24 office, Philadelphia District Attorney's office.
25 In my opinion, I think that some of

1 the questions that you've asked about the
2 treatment and doing more treatment, still there is
3 more treatment. And I think there is probably a
4 universal agreement that is the case.
5 And at the same time I'd like to take
6 the opportunity on behalf of the DA's Association
7 to applaud Commissioner Horn for tripling and I
8 think I just heard now possibly quadrupling the
9 amount of resources going into drug and alcohol
10 treatment.
11 That is an extraordinary
12 accomplishment and I think it explains many of the
13 accomplishments that occurred in the prison system
14 such as the percentage of drug tests coming back
15 positive from 6 percent to 1 and a half percent.
16 That is remarkable.
17 Recidivism dropping from 50 to 39
18 percent. Prisoner assaults on staff dropping 32
19 percent. Prisoner assaults on other prisoners
20 dropping 26 percent. Even the number of cell
21 searches doubling, drug finds have been cut in
22 half.
23 So there is a combination of tough
24 enforcement and providing more resources for the
25 critical problem that drives crime throughout the

1 nation which is drug and alcohol addiction. And I
2 think we have to make -- the opinion of most
3 prosecutors in the State and my own opinion, we
4 have the best Prison Commissioner in the country.
5 And I think that he has done truly
6 remarkable accomplishments. There does need to be
7 continuity to that great work that has been done.
8 And then, of course, looking to where do we go
9 from here to continue on these improvements.
10 And I certainly support the
11 questioning of all of the Representatives to
12 continue to move in this direction and keep moving
13 forward.
14 At the same time, I understand that
15 it does have to be done in certain places in order
16 to safeguard the quality. But an explosion of
17 something or just done too quickly sometimes
18 quality control suffers. But it needs to occur as
19 quickly as possible.
20 You've heard me say this before.
21 I'll say it again. The Pennsylvania District
22 Attorney's Association strongly supports these
23 kinds of efforts and this particular model program
24 that we see here as well as drug and alcohol
25 treatment for all criminal justice offenders as

1 well as drug and alcohol treatment for all
2 individuals in the State outside of the criminal
3 justice system who need it.
4 And people say, why does a prosecutor
5 care about this? Because it brings down crime.
6 Two-thirds drop in recidivism compared to those
7 that don't get it, for those that get clinically
8 appropriate drug and alcohol treatment.
9 This also in terms of talking about
10 the budget. Aside from the costs you're talking
11 about, the data is consistently showing anywhere
12 from between $3 and $7 -- for every dollar spent
13 on drug and alcohol treatment, between $3 to $7 to
14 the State coffers primarily reduce criminal
15 justice costs but also health care, labor,
16 welfare, any number of other costs. It fiscally
17 makes no sense to skimp on treatment.
18 I want to particularly applaud this
19 institution we're sitting in today. This is an
20 example here of how this criminal justice system
21 should work as the RSAT system.
22 The Department of Corrections has
23 contracted one of the strongest drug and alcohol
24 treatment programs in the nation, Gaudenzia,
25 Incorporated.

1 And the Commissioner himself has been
2 personally involved in making sure that Gaudenzia
3 and the programs throughout the system have been
4 able to do the work and do the things that they
5 need to do.
6 He has -- our Commissioner
7 understands the relationship of drug and alcohol
8 addiction to crime and recidivism and is
9 personally committed to make sure that this works.
10 Another critical thing I applaud and
11 want to talk about is follow-up is critical to the
12 success of this, and the follow-up does occur
13 here.
14 General research from the
15 presentation here and what I found was that
16 offenders who complete the program here are
17 eligible for pre-release.
18 Pre-release includes clinically
19 appropriate treatment usually often in a halfway
20 house which we think would be ideal. They come up
21 for parole. Their treatment paperwork is
22 reviewed. They are paroled.
23 There is a collaboration there and
24 passing of information that occurs so that they
25 can get further clinically appropriate drug and

1 alcohol treatment.

2 You can go so far in a prison

3 setting. But to really complete drug and alcohol

4 treatment -- everything I heard over the past five

5 years -- you need follow-up and much more

6 treatment, follow-up treatment done outside of the

7 walls, outside of the prison setting.

8 The bottom line is in our opinion the

9 Department of Corrections is handling this program

10 the way it ought to be done. We think that

11 because of that the streets of our -- the streets

12 of our communities in this state are safer because

13 of what is being done.

14 And we want to congratulate the

15 Department of Corrections and the Prison

16 Commissioner. We were asked to make comments

17 about what things we would want done.

18 Not necessarily with the current

19 system but what I've seen from having the

20 opportunity to speak around the country and work

21 with other states, some of the flaws I've seen in

22 criminal justice programs, I would say that the

23 main one that I would be concerned about and I

24 would want to keep an eye on is staff to client

25 ratio.

1 Understandably as we attempt to try
2 to treat more people, try to bring as many people
3 for as little money as possible. Sometimes it
4 costs. Client to staff ratios get watered down
5 too much and you lose some effectiveness of
6 treatment. Recidivism rates could suffer, success
7 rates suffer.
8 If we go too far and are not careful
9 enough, they suffer to an extent that too many
10 people coming out of the programs will commit
11 crimes. And the public support of this kind of
12 program would dry up.
13 So I would urge just in general to
14 put that on the list of things to watch and I'm
15 not necessarily making any comments about the
16 current situation.
17 I think -- my final point I want to
18 make is that you shouldn't have to commit a crime
19 to get drug and alcohol treatment. At the same
20 time while we're -- we have a very good program in
21 the Department of Corrections.
22 The budget this year basically
23 proposed a $10 million reduction in drug and
24 alcohol treatment. $5 million cuts in
25 non-hospital residential rehab. There are

1 $5 million for BHSI from the way it was a year
2 ago. That is a $10 million cut.
3 So what we're having happen -- by the
4 way, I'm pleased that treatment is being done in
5 the criminal justice center.
6 What is happening is it is
7 increasingly difficult to get clinically
8 appropriate drug and alcohol treatment. This is
9 happening in other states as well. You have to go
10 out and commit a crime. It doesn't make sense.
11 If we can get the funding, if we can
12 keep the funding up at least if not increase it
13 for those people who need drug and alcohol
14 treatment before they get involved in the criminal
15 justice system, then we can save even more money
16 and make our streets safer.
17 I will urge again for you -- I think
18 it is appropriate this Subcommittee and Judiciary
19 Committee as almost to a person has shown strong
20 support for the kind of approach that our Prison
21 Commissioner and our Department of Corrections is
22 doing for expanding drug and alcohol treatment.
23 I think consistent with that support
24 I would urge this Committee to get involved in
25 taking another look at the Act 152 funding, take a

1 look at BHSI funding and try to make sure at a
2 minimum it doesn't get cut.
3 People need drug and alcohol
4 treatment and need this resource. And then for
5 one thing a lot of people in the criminal justice
6 offenders program in Philadelphia, they are
7 funding BHSI. They are getting treatment now.
8 BHSI's money has been cut.
9 In addition to treating people who
10 will commit crime -- many of them, maybe not all,
11 but many will commit crime if they don't get
12 treatment. So let's do that too.
13 If you're looking for ways for
14 expanding your funding, I would say that is a good
15 place to put a focus on right today.
16 Again, thank you. I want to applaud
17 the administration, applaud the Department of
18 Corrections for the great work they have done
19 here. We couldn't be happier with the tight
20 security to regain the control of the State
21 system.
22 The current Prison Commissioner has
23 made tremendous accomplishments. It shows a
24 commitment and we're very appreciative to that.
25 And I thank you for using this Subcommittee to

1 focus the spotlight on it.

2 CHAIRMAN BIRMELIN: Mr. Tennis, did

3 you say your plane leaves at 2:15?

4 MR. TENNIS: No. I have to leave at

5 2:15 in order to catch it.

6 CHAIRMAN BIRMELIN: I'm going to turn

7 to your right. Representative Josephs said she

8 had a question to ask you if you don't mind

9 answering the question from her before you leave.

10 MR. TENNIS: I'd be happy to.

11 REPRESENTATIVE JOSEPHS: Thank you,

12 Mr. Chairman. I'm glad that you asked us on the

13 Judiciary Committee to involve ourselves in making

14 sure that there is more funding for treatment for

15 people.

16 But I want to throw the ball back

17 into your court, Mr. Tennis. I do know that you

18 and I disagree on a lot of the issues that you

19 have brought before the Judiciary Committee.

20 But putting that aside, I have to

21 admit you bring them with great vigor, a lot of

22 preparation, a lot of your resources, grass roots

23 outreach, and all kinds of things you do know how

24 to do very well in order to get your goal

25 accomplished.

1 I exhort you. This is the challenge
2 I have to you to put that kind of energy,
3 expertise, and intense desire to make your point
4 into the effort to get us more treatment both for
5 people who have committed crimes and hopefully in
6 a way that will prevent people from committing
7 crimes.
8 So I really hope that you,
9 personally, and the DA's Association as a group
10 will up the ante on these issues which I believe
11 are going to make us much more crime free than the
12 kind of things that generally your association
13 would very effectively do.
14 MR. TENNIS: The only thing I can say
15 is just keep an eye on your mailbox. Keep an eye
16 on your mailbox.
17 REPRESENTATIVE JOSEPHS: I will.
18 Thank you.
19 CHAIRMAN BIRMELIN: After such high
20 praise from Representative Josephs, you're not so
21 euphoric that you miss your flight?
22 MR. TENNIS: I probably won't --
23 CHAIRMAN BIRMELIN: Thank you for
24 your time, Mr. Tennis. You are free to leave.
25 MR. TENNIS: Thank you.

1 CHAIRMAN BIRMELIN: We will continue
2 with Ms. Beck's testimony.
3 MS. BECK: My goodness.
4 CHAIRMAN BIRMELIN: Are you in a
5 hurry to go somewhere?
6 MS. BECK: In fact, I'm staying. I
7 like being around places of healing, and I had a
8 quick tour of the therapeutic community. I want
9 to go a little longer.
10 Representative Josephs, I just feel
11 like I'd be remiss if I didn't tell you the
12 gentleman just leaving got into trouble recently.
13 The Executive Director of the present
14 institution's drug laws for pressing for
15 residential rehab for pregnant women.
16 In fact, he just got fired under two
17 different administrations and then reinstated by
18 the Congress after they realized that the right
19 thing to do was to include the treatment.
20 But good afternoon. I really
21 appreciate the opportunity. Chairman Birmelin,
22 Representative Josephs, Representatives Walko,
23 Representative Manderino, and Representative
24 James, Mike, Brian, good afternoon.
25 My name is Deb Beck. I'm president

1 of Drug and Alcohol Service Providers of
2 Pennsylvania. And you can see who it is we
3 represent. It is a state-wide coalition for drug
4 and alcohol treatment. Before launching into
5 this, I kind of wanted to respond to your question
6 earlier regarding the woman who was at Muncy and
7 was unable to get anything but one AA meeting.
8 Those of us in the treatment field do
9 not believe that AA is treatment. However, most
10 of the good treatment nationally and in this state
11 was founded by people in recovery who go to AA for
12 those who can't get well from AA alone.
13 So I would say to you that having a
14 treatment experience -- and I think Muncy now
15 since that time instituted a therapeutic community
16 which she would now get that. I used to run a
17 group out at Muncy and for a long time there
18 wasn't a program.
19 But I'm very pleased to be here. I
20 was commending the Governor and Secretary of
21 Corrections, Marty Horn. They deserve high praise
22 for trying to bring clinical realities to bear on
23 a criminal justice system addicted feminine
24 population.
25 I'm sorry to say that this is not the

1 case in most national policies. People have not
2 figured out that clinical realities of addiction
3 have not brought to bear on the policy and
4 planning. They are doomed to fail.
5 In fact, it is essential to find new
6 ways to lock up people with untreated addictions
7 and new things that we call it and I think society
8 has a right to calibrate punishment. But it is
9 not enough.
10 We must also do treatment or the
11 folks are going to go back and move into my
12 neighborhood and yours and probably repeat the
13 crime if they are involved in crime with their
14 addiction. Let me explain just very briefly.
15 People with addictions will sit
16 whatever time. Society pays more or less. Those
17 kinds of discussions are rather irrelevant to the
18 nature of addiction.
19 Society is relevant to society to
20 calibrate punishment but not addiction. And what
21 will happen if a guy with an untreated addiction
22 gets out of prison, he's going to come back and
23 commit a crime in your neighborhood or my
24 neighborhood.
25 It is not compassionate, in fact, to

1 release a person with the addiction, to let them
2 go without addressing the addiction much less for
3 my family, much less for my next victims of crime.
4 I also would be remiss if I did not
5 remind you that this is serious, serious business.
6 Alcohol and drug addictions are always fatal
7 illnesses if they go unchecked.
8 And some people would say who cares.
9 Who cares about that? Well, along the way in my
10 deterioration, I deteriorate dangerously and would
11 probably take my family and whole neighborhood
12 victims with me if that is the direction I'm
13 going.
14 I worked in the field now -- I can't
15 believe it -- for almost 30 years. And I know
16 many, many people in recovery. I don't know one
17 who didn't try to commit suicide sometime along
18 the way.
19 This is desperate stuff. And beneath
20 all that bravado you see, in fact, there is a
21 desperate person who without intervention is
22 likely to take everyone with them along the way.
23 I also know many recovery people who
24 think the criminal justice system saved their
25 lives by slowing them down long enough to take a

1 look at the problem and sadly, not enough,
2 sometimes referring them forcefully to treatment.
3 Unfortunately this connection is not
4 common between law enforcement and treatment. We
5 need to make it common.
6 Again, I commend the Secretary for
7 designing a program with the idea of the nature of
8 addiction in mind. It is likely to work. It is a
9 very interesting concept.
10 I also want to commend you here at
11 SCI Chester for hiring the old, most experienced
12 criminal justice drug and alcohol treatment
13 program in the State, Gaudenzia, Inc., to do the
14 job.
15 You are going to hear more from Mike
16 Harley who is both a state and national expert in
17 this area. I hope you will take this model and
18 study it, expand it, and research it, and get it
19 into women's prison also as soon as possible.
20 When I was working in Washington with
21 Gary Tennis, he was the Executive Director of the
22 President's Commission on Model State Drug Laws.
23 He commissioned a study and one of the areas he
24 commissioned a study on was all the cost benefit
25 analysis of criminal justice treatment.

1 And there are hundreds of studies.
2 And, in fact, if you want the volume, it is 44.3
3 where it makes a point. Everything that existed
4 before 1993 is in here. And I have annotated to
5 your material stuff since that time.
6 Hundreds of studies and there is no
7 disagreement in the literature. Untreated
8 addiction drives up crime. Treated addiction
9 drives it down. There is no disagreement in the
10 literature.
11 Over the last ten years -- I'm also
12 Chair of our national counterpart with the
13 President's Commission and I continue to do some
14 work. I got into the states and looked at the
15 criminal justice programs. I got a chance to look
16 at lessons learned.
17 And I wanted to share with you what I
18 have heard and also whnt to commend the
19 Commissioner for what -- I'm still calling
20 Secretary Horn the Commissioner -- Secretary Horn
21 for what he has done here so cautiously and
22 thoroughly and thoughtfully and also to give you
23 some warning lights.
24 First of all, go slowly as you
25 expand. Expand but go slowly. The experience in

1 Texas was there wasn't enough qualified treatment
2 to provide what was needed. They went too fast.
3 There was an error in drafting the
4 bill. They got the decimal point in the wrong
5 place. They went too fast. Gosh, it was a crazy
6 error.
7 Look for programs, number two, with
8 lengthy experience at working both with drug and
9 alcohol criminal justice populations, short-term
10 insurance industrial programs are not necessarily
11 as skilled in this area as you want.
12 In many other states I am aware that
13 correction heads are being courted adamantly by
14 people in programs with little experience but with
15 a lot of stockholders. So you want to be careful.
16 Insist upon provisions of the key
17 elements of a good program in your bid
18 specifications. Because if you don't do that in
19 your bid quotes, you're going to get a low bidder;
20 and I don't think you want a low bid drug and
21 alcohol treatment program involving people who
22 commit crimes.
23 You want to require that there is
24 lengthy experience of the staff in the program
25 providing this treatment, that they utilize a

1 therapeutic community model of care treatment;
2 that the treatment is long term both from the
3 inpatient and outpatient side.
4 Gary already mentioned the
5 staff-client ratios. Aftercare components around
6 the country -- rather around the country people
7 have sometimes discharged folks in the programs
8 that don't specialize in drug and alcohol. Or
9 where drug and alcohol patients are mixed with the
10 general population meaning the control of drug and
11 alcohol issues become a problem.
12 You want them to be released to the
13 halfway houses and outpatient programs with
14 specific drug and alcohol emphasis or you're going
15 to get into some trouble.
16 You want to look for the employment
17 of recovery people on staff. That is one of the
18 things that kind of is a mark of a good program.
19 Finally but not finally, if a program doesn't
20 incorporate AA and NA throughout it, I wouldn't go
21 anywhere near it.
22 Again, one additional comment, if you
23 want to establish a research component I would
24 suggest -- I know there is one with Temple but
25 also the nation's leading researcher in drug and

1 alcohol therapeutic community approached us in
2 Washington and said, How do I get to research in
3 Chester? I would love to have the opportunity to
4 do Chester SCI research.
5 We need to be careful again about the
6 nature of our competitive bidding. There is too
7 much at stake here to allow treatment like --
8 another common experience is programs that skimp
9 on staff or programs of insufficient experience.
10 I have been in this field long enough
11 to watch the philosophies of corrections move from
12 left to right along the pendulum.
13 And I got to tell you the majority of
14 folks who are in prison are here with untreated
15 drug and alcohol addictions. And there is not a
16 bit of evidence that the philosophy on either the
17 right or left extreme works at all in addressing
18 addiction.
19 Philosophies change, politics change.
20 The plight of addiction is unchanging. I would
21 plead with you to continue what has been started
22 with here to get us out of that pendulum.
23 Let's focus on the realities of
24 addiction, and then we won't have that shifting.
25 We anchor our policies in this area on the

1 realities of addiction.

2 Finally, be realistic. I want to

3 point out one other thing. We're in an ironic

4 spot. Criminal justice has become the safety net

5 system of law.

6 People can't get help until they

7 deteriorate through their insurance. Their

8 insurance coverage they already paid for but

9 through managed care they deteriorate down into

10 Medicaid and they are no longer eligible and

11 finally they end up getting help in the criminal

12 justice system.

13 I think despite a good law requiring

14 addiction treatment -- many of you voted for it,

15 Act 106 of 1989 -- people can't access what they

16 already paid for.

17 We have to make sure before the

18 person gets enmeshed in the prison system that

19 they get the help that they need while they are

20 still working and taxpayers.

21 Changes in the Medicaid eligibility,

22 the same problem. They have limited access to

23 treatment. And today people that need help can't

24 get it.

25 I'd like to close with these

1 recommendations. Careful expansion of this
2 treatment approach across the State with special
3 emphasis on including women.
4 Passage of Representative George
5 Kenney's bill, House Bill 2019, which would ensure
6 that people who have addiction coverage actually
7 can access what they already paid for while they
8 are still in the work force.
9 Restoration of funding to the
10 behavioral health initiative and Act 152.
11 Expansion of availability of residential rehab
12 centers for pregnant addicted women, an initiative
13 started by Senator Roxanne Jones to keep them out
14 of the criminal justice system.
15 Five, the development of a 5-year
16 plan to systematically assess some percentage of
17 offenders on a routine basis and where appropriate
18 require and fund treatment as part of sentencing.
19 Folks get into treatment as part of the
20 sentencing.
21 And in closing, I am heartened and
22 grateful for what I see as a gradually growing
23 consensus about the need for addiction treatment
24 both as a matter of compassion for the untreated
25 addict and his or her family and for the

1 protection of public safety, but also it is a
2 consensus I think reflected in the very panel
3 before you this afternoon. Thank you very much.
4 CHAIRMAN BIRMELIN: Thank you. Mr.
5 Frankel.
6 MR. FRANKEL: Good afternoon. First,
7 I want to congratulate all of you for surviving
8 yesterday's elections. I know some of you had
9 been opposed, some you had not. But it is nice to
10 know you are back. Second, I hope that you are
11 also successful in November.
12 I'm really here at this point to echo
13 what you already heard from my two colleagues.
14 While the ACLU does disagree with many of the
15 policies of the Department of Corrections, we have
16 no disagreement at all with the greater emphasis
17 on providing substance abuse treatment while in
18 prison. Why not use this time to do something
19 that may actually help reduce crime, recidivism.
20 And we applaud the efforts that have
21 been made to expand the quantity of the programs,
22 the variety of programs, and quality of programs.
23 And I echo the comments of Deb Beck and Gary
24 Tennis.
25 For all of you who keep track, this

1 is one of those days when the DA's Association and
2 ACLU agree. So there should be no problems. I
3 also like the comments regarding the need to have
4 more outside of prison before people get in
5 prison, before they commit the crimes. We are
6 only going to save money if we really implement
7 the laws and provide some of the funding that is
8 necessary.
9 We believe that far more can be done
10 to fight crime, more treatment programs, and
11 making sure that people access the treatment that
12 Title 18 and Title 42 go to pass. This should
13 make much more difference in the array of crime
14 happening in our communities.
15 This morning on my way to work, I ran
16 into a Judge at the Court of Common Pleas from
17 Philadelphia. She's been there a little over a
18 year, I believe; and she wanted to know what I was
19 working on, what I'm up to.
20 And I was telling her that I was
21 coming to this hearing here today. And she was
22 interested because she said in her year or so on
23 the bench that she had been doing criminal cases,
24 this is the problem she sees.
25 She knows what the underlying problem

1 with the Defendant in front of her is. She knows
2 what kind of sentencing would really help him.
3 There are not enough good programs. So people
4 will be back in front of her after they get out of
5 prison because they fail.
6 So I guess I lobby on behalf of Judge
7 Russo. She was interested in what is going on
8 here today.
9 She also asked me to convey the need
10 for more programs to deal with those dual
11 diagnoses where there may be mental health
12 problems and substance abuse problems. There are
13 not enough places in the system for those
14 offenders.
15 Having said all that, I do have one
16 concern that I do want to raise today and it is
17 anecdotal and similar somewhat to what
18 Representative Manderino raised when she asked
19 some questions.
20 But we hear about instances where
21 prisoners are really told if you go participate in
22 a program, you will be given favorable
23 consideration or your participation in the program
24 will be looked upon favorably by the Parole Board.
25 Only to find out when they apply for parole after

1 they have participated in the program that no or
2 little consideration is given whatsoever to the
3 fact that they participated in the program.
4 Now, I will state again this is an
5 anecdotal story. We get a tremendous quantity of
6 letters from prisoners. But the frequency with
7 which we hear that complaint causes me to want to
8 present to you here today, say that there may be a
9 problem with the connection between what is going
10 on in the institutions like this and the decisions
11 the Parole Board makes.
12 So similar to some of the statistics
13 that Representative Manderino asked for from the
14 Department of Corrections, I think there is some
15 questions that could be asked of the Parole Board.
16 What statistics do they have with people that have
17 been up for parole? What is the rate of actual
18 granting parole and denial?
19 Is this indeed a problem that
20 prisoners are really going to have less incentive
21 to participate in some of these programs if they
22 don't feel that they will be given adequate
23 consideration?
24 I don't know that you have any
25 witnesses here today, and I don't think that was

1 the intent of the hearing. But I do hope that as
2 a result of this hearing today, those questions
3 will be forwarded to the appropriate authorities
4 to see what kind of information they can provide.
5 With that, I'm getting you back on
6 schedule and I will answer questions. But I will
7 certainly understand if you don't want to ask any
8 questions.
9 CHAIRMAN BIRMELIN: You answered your
10 question. No, we're not prepared to ask people to
11 present that information.
12 I will make the offer to you that if
13 you have any questions that you would like the
14 Parole Board asked, that you may give them to me
15 and I will forward them to them in the auspices of
16 my position as Chairman of the Subcommittee.
17 MR. FRANKEL: Thank you very much.
18 CHAIRMAN BIRMELIN: And that offer is
19 available to anyone else who gives testimony
20 today.
21 If you have specific questions of the
22 Probation and Parole Board and you want some
23 questions answered, I will attempt to get the
24 answers for you.
25 That is probably the best that I can

1 do for you short of having a public hearing and
2 then discussion. And we have the potential of
3 doing that. Representative James.
4 REPRESENTATIVE JAMES: Thank you,
5 Mr. Chairman. I think at one of our previous
6 hearings upstate, Mr. Chairman, we did talk about
7 at some point maybe having hearings on parole.
8 So I think -- and that is good of the
9 Chairman to say that if there are questions, we
10 can ask them. And I think that is important.
11 Going back to -- thank you both for
12 testifying also. Going back to Deb when she was
13 talking about in the study. You said that you
14 would take the study -- hope that we would take
15 this model and study it. How long do you think
16 that study should take?
17 MS. BECK: I wouldn't suggest
18 holding up what is going on, this gradual
19 expansion. There is some research out there that
20 suggests how to set up good programs.
21 But I would suggest an ongoing study,
22 three years. Perhaps you should ask Mr. Harley
23 that. His facility is running the program here.
24 I would like to see how statistics
25 look three years out. Philadelphia University did

1 a similar study on Act 152. They looked at that
2 three years out. Now you're beginning to see some
3 results. Are they going back to work? Are they
4 taxpayers? How does the recidivism rate with
5 crime compare to other control populations?
6 REPRESENTATIVE JAMES: And you said
7 also we should go slow because we don't want to
8 overload the system. And you did use an example
9 of Texas saying that they went too fast, just that
10 they messed up with the budget.
11 Is that the reason we should go slow,
12 or we should really try to find appropriate
13 people?
14 Because, you know, it seems like we
15 went too slow already in terms of getting this
16 done. We started probably -- I've been here about
17 12 years and we've been talking about they needed
18 to do this a long time ago, you know. I don't
19 want to cause them to slow down.
20 MS. BECK: I agree. I hesitated to
21 say that. But I also need you to know that if
22 they do treatment cheap and they do it on sales,
23 then this program will be in danger. There is a
24 balancing act. But we also have some significant
25 regulatory problems we have to get by.

1 I'm very proud that I put one on the
2 table that is controversial, certainly not to me.
3 Right now because of a combination of odd
4 regulations, we're having difficulty being allowed
5 to hire recovering alcoholics and addicts who may
6 have a past criminal involvement and good recovery
7 and have lots of counseling skills.
8 There have been some regs. that made
9 it hard for us to be able to do that across the
10 state. And I would tell you I ran a skid-row
11 street program. You don't want to run a criminal
12 justice program without people that have been
13 there and we have got to unpack that.
14 And I would -- any help that you
15 could give us in unpacking that. We're losing a
16 resource. Now I'm not saying anybody in recovery
17 is a good counselor. That's not the case.
18 I've been told that's what I'm
19 saying. That isn't what I am saying. We have a
20 huge staffing problem. Our system also has been
21 buffeted by fluctuations of federal funding which
22 are changes in the Medicaid law and state and
23 federal law. Our system is closing down.
24 We're losing people who are going to
25 work in other areas. That is the reason for the

1 slow go. I don't want us to mess up and say our
2 treatment doesn't work when we didn't use what we
3 know we should be using.
4 REPRESENTATIVE JAMES: Those
5 regulations, are they state and federal or
6 regulatory ones?
7 MS. BECK: Health Department here in
8 the State.
9 REPRESENTATIVE JAMES: Maybe what you
10 can do if you haven't already, advise us of those
11 documentation that you have and let us know what
12 some of those regulations are, how they need to be
13 changed. So at the same time as we advocate for
14 more funding, more resources, we can also work on
15 these regulatory changes.
16 MS. BECK: We're in a very odd spot.
17 A lot of the folks who are now in recovery got
18 their addictions -- people with 20 years of
19 recovery who may or may not have degrees or have
20 the wrong degrees. Yet those are the folks now
21 having difficulty staying in the field. So I will
22 jump at that opportunity. Thank you.
23 REPRESENTATIVE JAMES: We may need
24 certain kinds of waivers or whatever. So we may
25 be able to do something like that. And I think

1 that if you would document that for the Committee,
2 we would be supportive of it.
3 MS. BECK: Thank you.
4 REPRESENTATIVE JAMES: Thank you,
5 Mr. Chairman.
6 CHAIRMAN BIRMELIN: Thank you, Ms.
7 Beck. Thank you, Mr. Frankel. Our next panel of
8 witnesses are Angus Love, Institutional Law
9 Project; Nan Feyler, Executive Director, Aids Law
10 Project of Pennsylvania; Nan McVaugh, Pennsylvania
11 Prison Society; and Jessica Raymond, also from the
12 Pennsylvania Prison Society.
13 I'm not sure which microphone works
14 or who wants to go first, whichever one. You
15 figure it out. I have figured out which one of
16 you is Mr. Love.
17 But if you ladies would introduce
18 yourself so that not only myself but the
19 stenographer will know who is speaking when you
20 begin to speak, first by introduction and then
21 whoever is designated as the first speaker we will
22 pick up.
23 MS. FEYLER: My name is Nan Feyler.
24 I'm an Executive Director of the AIDS Law Project
25 of Pennsylvania.

1 MR. LOVE: Angus Love, Executive
2 Director of the Pennsylvania Institutional Law
3 Project.
4 MS. MCVAUGH: Nan McVaugh. I'm a
5 retired educator from the Pennsylvania School
6 System, a Graterfriends Board member and Convener
7 and Official Visitor of the Pennsylvania Prison
8 Society.
9 MS. RAYMOND: Jessica Raymond,
10 Pennsylvania Prison Society, Official Visitor for
11 SCI Chester and Delaware County Prison.
12 CHAIRMAN BIRMELIN: Is there one that
13 decided that they should be the first one to
14 speak? Before you begin, let me again ask you
15 to -- same request that I made to previous
16 speakers, that you not necessarily read your
17 printed testimony.
18 And I know that we have printed
19 testimony for three out of four of you. But you
20 may want to summarize, capsulate, give us the
21 Reader's Digest condensed version, the high
22 points.
23 I don't know how else to say that.
24 Be as concise, precise as possible. So, Nan
25 Feyler, you are first.

1 MS. FEYLER: I appreciate this
2 opportunity. I will do my best. I have quite a
3 bit of passion around this subject. I will try to
4 be as concise and compassionate if I may.
5 I'd actually like you to pre-focus
6 briefly to think about HIV issues for those folks
7 incarcerated.
8 And by way of introduction, I run the
9 AIDS Law Project serving the needs of people with
10 AIDS and HIV throughout the state. And for the
11 last four or five years we've run a program
12 specifically to try to respond to the growing
13 number of incarcerated folks living with HIV in
14 State prison and county jails.
15 Many of the issues parallel the
16 issues or I should say that people who are living
17 with HIV, most of them struggle with drug or
18 alcohol addiction and may have mental health
19 issues. We are -- for many individuals there are
20 a layering of problems along with their drug
21 addiction.
22 There are four issues I would like to
23 briefly address that relate to the medical care of
24 folks within our State prisons.
25 By way of introduction -- you may

1 know this. But the epidemic of HIV is flourishing
2 in our state and county prisons throughout the
3 country.
4 As of 1998, there were 5.5 times more
5 folks incarcerated with HIV in prisons than on the
6 street. And in some prisons, for example in New
7 York State, as many as 20 percent of the female
8 inmates were HIV positive. They have more
9 aggressive testing than in Pennsylvania.
10 We would find our numbers paralleling
11 some of the highest states in the country. The
12 prevalence of HIV and AIDS is higher in Hispanic
13 and black inmates and disproportionately high
14 among women.
15 According to the Department of
16 Corrections, as of December 1997, almost 700
17 inmates with HIV and the numbers are growing.
18 This is about 2 percent of our prison population.
19 The other sort of piece of news along
20 with that, if you think about who is locked up and
21 who is at risk of HIV, it is very much the same
22 group.
23 The incarceration of folks with drug
24 and alcohol problems very much parallel with those
25 folks being confirmed with HIV. That is an

1 alarming rate.

2 In the last few years you also may

3 know the availability of promising medications and

4 medical protocols have made a difference in the

5 survival rates of the lifestyle with HIV. The

6 standard of care now requires a combination of

7 therapies, very aggressive and difficult complex

8 regimes.

9 The issues I want to talk about

10 relate really to how you deliver those medications

11 within our State prison system.

12 One of the first issues I want to

13 mention is that we see a pretty overwhelming

14 problem with interruptions of medications in our

15 prisons.

16 Unfortunately one of the limitations

17 of HIV medications is the risk of the patient to

18 develop a drug resisting strain of HIV. As we

19 say, HIV medications are very unforgiving. And in

20 short, this is a public health threat.

21 In fact, the trend around the country

22 is for the Department of Public Health and

23 Department of Corrections are trying to work

24 together, something I'm recommending here in

25 Pennsylvania.

1 What we find though is that if
2 someone is interrupted or misses a dose of HIV
3 medication only a few times, the strain of HIV
4 becomes resistant not only to that medication but
5 that class of medication.
6 So while it sounds overly
7 complicated, the bottom line to understand is that
8 when you deliver these medications, they have to
9 be delivered without interruption.
10 Unfortunately, interruptions is a
11 real problem in our State prison. While we've
12 made a lot of progress with people getting on
13 regimes, in a recent survey we have done with
14 folks on our mailing list, 76 percent indicated
15 they have experienced routine interruptions in
16 their meds.
17 Specifically, refills are late.
18 Inmate is too sick to wait in line, inmate newly
19 arrived to prison, and medications were given at
20 the wrong time, or the person was in the RHU.
21 So one of my first recommendations is
22 there needs to be much more aggressive quality
23 assurance to make sure that not only these
24 medications are prescribed, that there are no
25 interruptions on delivery.

1 Otherwise, we're going to continue a
2 public health threat that we see where there will
3 be resistant strains of HIV and people's health
4 will fail which I remind you is much more
5 expensive as well as a very difficult issue
6 obviously.
7 The second issue relates to delivery
8 of medication. And I wanted to point out to you
9 in the Committee that the trend in Pennsylvania
10 has been to take HIV infected inmates off directly
11 observed therapy.
12 This is something that I have at
13 least as an advocate not been able to sort of
14 persuade our medical directors is not in the
15 inmates best interest. And I would like to share
16 briefly our concerns.
17 What we see is that inmates used to
18 have keep on person. They used to have HIV
19 medications in bubble packs.
20 But the trend is to take them away
21 from -- medication from inmates and require them
22 to go directly to observed therapy. We find this
23 very troubling.
24 I'll give you an example. In Muncy
25 and Cambridge Springs in the women's prison where

1 if I were checked and my CB count was quite high
2 and acidity -- as a matter of fact, much of this
3 is vendor driven.
4 But in any case, the delivery of
5 medications was switched. What happened then is
6 that the women who were HIV and hadn't told their
7 kids and were still dealing with the myriad of
8 issues were required to go to the medical line.
9 And the last line of the day was only for people
10 with HIV.
11 So while this might sound like a
12 small issue, what we found it is representative
13 throughout prisons that inmates were deciding not
14 to be on the medication for fear of disclosure
15 back home.
16 Or we find that there are still many
17 prisoners who are required to walk outside in all
18 weather all year round to get their medications or
19 walk very long distances. And they are,
20 therefore, unable to do so because of fatigue and
21 illness and are unable to access these lifesaving
22 medications.
23 Finally, I believe that we're doing a
24 disservice for the community by not teaching HIV
25 inmates how to take these complicated medications.

1 There is a tremendous issue on the street about
2 how to deal with folks with HIV and yet we're
3 releasing folks without any experience of having
4 managed this very difficult disease.
5 So my second recommendation is that
6 we reinstitute keep on person for inmates who
7 demonstrate the ability to adhere to these
8 routines.
9 Thirdly, I'd like to talk a bit as I
10 did when I testified a few years ago about the
11 need for more continuity of care and transitional
12 discharge planning.
13 In other words, we need to do more to
14 help folks that are coming out of prison who are
15 HIV. The very good news -- and I applaud the
16 administration and Secretary Horn -- is that HIV
17 infected inmates receive a 30-day supply when they
18 leave. And that is terrific.
19 We are, in fact, just finishing some
20 litigation with the County of Philadelphia trying
21 to get a 5-day supply. This really is an
22 important safety net.
23 Remember, what we're worried about is
24 the kind of resistant strains of HIV. There was a
25 study where 28 percent of the people newly

1 infected with HIV were infected with a strain
2 which is already resistant to treatment. This is
3 a serious public health threat.
4 So what we need to do then is make
5 sure that our HIV infected inmates get the supply
6 of medication but are linked to physicians.
7 I'd like to share briefly a survey
8 that we have done of inmates who are leaving the
9 prison. Seventy-nine inmates requesting case
10 management assistance from BEBASHI to help them
11 when they get out. Over 50 percent learned they
12 were HIV for the first time while incarcerated.
13 I think that is a tremendous
14 opportunity to get people in care. But 87 percent
15 indicated they have no doctor when they get out.
16 Almost all of them haven't a clue where to get HIV
17 treatment or any medical treatment.
18 I should say as an aside, 60 percent
19 of them have no place to live. 37 percent have no
20 family support when they get out. 93 percent
21 don't have a job. And just as an aside, 79
22 inmates themselves report that 73 of them are
23 addicted to drug and alcohol in spite of all of
24 the work that has been done.
25 I'd like to integrate HIV care into

1 our continuity of care. Because we have a good
2 foundation with good medical care and a 30-day
3 supply of meds., we need to really start
4 coordinating with the case managers.
5 As an aside, those programs in other
6 states have seen marked reduction of recidivism
7 where these programs have been in place.
8 So my recommendation is that we
9 follow the lead in other parts of the country and
10 that we develop and coordinate and broaden
11 participation of all segments of public health,
12 criminal justice, and community based
13 organizations to really look at.
14 It is no longer when somebody walks
15 out the door that's the end of their care. We see
16 that with D&A. We see that they worked with
17 community corrections in Philadelphia to make sure
18 that they do know about HIV resources for their
19 folks.
20 But now we need to work together and
21 try to have the Department of Public Health and
22 the Department of Corrections really be much more
23 systemic in making these links, public health as
24 well as helping individuals.
25 My final recommendation is education

1 and prevention. I'm not a great expert on this
2 subject. I tend to help folks who are infected.
3 But I do know that everyone who is
4 incarcerated is by definition -- virtually almost
5 everybody has a drug and alcohol problem from my
6 experience.
7 I was yesterday speaking with an
8 ex-offender living with HIV. He started using
9 drugs when he was 8 years old and was in our
10 facility for 6 years. We know that from the
11 testimony and from your experience that this is
12 very prevalent.
13 But we're not doing, I think, an
14 adequate job of prevention within our prisons and
15 encouraging HIV testing for inmates. You look at
16 the 44 women in Muncy who are HIV. You know more
17 than that are HIV.
18 There is just -- you look at the
19 national statistics and look at that. And I think
20 we have to ask ourselves why. Some of it is
21 psychological. Certainly some of it is
22 programmatic.
23 So I suggest that we encourage
24 education. We expand that. We do more regular
25 peer education. We try to really target folks to

1 go get tested, get treatment, and then link them
2 to treatment when they get out.
3 And, finally, I am here to advocate
4 Pennsylvania joins the other two states and eleven
5 cities around the country and distribute condoms
6 to incarcerated individuals.
7 There are studies done to show that,
8 in fact, that this has been an effective HIV
9 prevention and STD prevention and does not
10 threaten prison security.
11 We know it is against the rules for
12 prisoners to have sex. But we should also
13 recognize as most correctional folks do, it
14 happens routinely.
15 A guy yesterday, my ex-offender
16 friend, said he just -- he actually didn't see
17 this as -- when I talked to them inside, they say
18 to me sex is relatively routine and it is not
19 generally coercive.
20 There may be power dynamics, but
21 there is plenty of it is what they said. And as
22 our county, Philadelphia, has recognized, it is
23 good public health sense to make condom
24 distribution available and reinforces healthier
25 activity when they get back out on the street.

1 So I appreciate your thoughts about
2 this. Obviously, I would love the chance to talk
3 to you more and follow-up on anything should that
4 be helpful. Thank you.
5 CHAIRMAN BIRMELIN: Thank you. Mr.
6 Love.
7 MR. LOVE: Thank you, Chairman
8 Birmelin and members of the Committee. I'm
9 Executive Director of Pennsylvania Institutional
10 Law Project which is the sole provider of civil
11 legal services to over 75,000 institutionalized
12 persons in Pennsylvania.
13 As such, we get about 10,000
14 complaints or requests for service per year
15 primarily through the mail from inmates but also
16 from family members, phone calls, and occasional
17 visits to the office.
18 I will say that pretty significantly
19 the most frequent complaint involves medical care.
20 And of the medical care complaints most recently
21 the most frequent complaint talks about Hepatitis
22 C. So I'm here today to talk a little bit about
23 Hepatitis C.
24 And what I would like to encourage in
25 summary is a rational approach to a very difficult

1 and new emergent problem, not just prison
2 correctional officials but for health care
3 officials throughout the country.
4 On one hand we could do nothing with
5 Hepatitis C as we've done until recently by the
6 Department of Corrections. Or we can do
7 everything that the vendors are urging us to do,
8 test everyone and treat everyone with very
9 expensive drugs.
10 I think we have to find a middle
11 ground between those two extremes to deal with
12 this very significant problem.
13 It is my understanding Hepatitis C
14 was really identified only in the early 1990s. We
15 had Hepatitis A and B and then a new strain was
16 developed and they didn't know what to call it.
17 So for lack of a better word, it was identified as
18 Hepatitis C.
19 I believe there has been some
20 additional strains that have come about since
21 then. It wasn't until October of 1998 the Centers
22 for Disease Control in Atlanta issued the first
23 protocol for treating Hepatitis C. And it was
24 titled "Recommendations for Prevention and Control
25 of Hepatitis C Virus, (HCV) Infection and

1 HCV-Related Chronic Disease."
2 Hepatitis C quickly became the most
3 common chronic blood-borne infection in the United
4 States. During the 1980s, there were 230,000
5 cases reported each year.
6 According to the Third National
7 Health & Nutrition Examination Survey as of 1994,
8 it is estimated 3.9 million Americans have been
9 infected by this disease.
10 This is the tenth leading cause of
11 death among adults in the United States, about
12 25,000 deaths annually. And that is Hepatitis C.
13 Of those deaths, 40 percent can be attributed to
14 the Hepatitis C strain.
15 As many of the folks who are infected
16 with Hepatitis C are middle aged and won't be
17 showing symptoms that lead to death for many
18 years, these numbers are probably lower than what
19 they are going to be.
20 It is estimated there are 1.4 million
21 infected individuals passing through correctional
22 facilities each year. As with many infectious
23 diseases, a prison population presents unique
24 challenges to the health care community.
25 Hepatitis C virus is spread similarly

1 to HIV. An exchange of bodily fluids must take
2 place in order to be transmitted. The most common
3 methods of transfer involve sexual relations, IV
4 drug use, and blood transfusions.
5 Theoretically none of these
6 activities would occur in a prison. But reality
7 is that, as Nan mentioned, we know that is not the
8 case.
9 California recently tested the entire
10 prison system and found 41 percent infected with
11 Hepatitis C. Pennsylvania officials predict our
12 system would be somewhere between 25 percent and
13 39 percent. That would translate to as many as
14 10- to 14,000 individuals having this disease.
15 Pennsylvania Department of
16 Corrections has responded to this crisis.
17 Commissioner Marty Horn has appointed a Task Force
18 to study the issue and to come up with a protocol
19 for the treatment of Hepatitis C.
20 It is my understanding that this
21 protocol has undergone several revisions and has
22 begun to be put into place.
23 According to some information that
24 was reported over the weekend, I understand there
25 are 3,100 individuals currently identified with

1 Hep. C in the system and 100 are receiving the
2 combination drug treatment of Interferon and
3 Ribavin.
4 The treatment of this drug -- the
5 drug treatment received is extremely expensive
6 according to an article in the New York Times in
7 June of last year. One year of drug treatment
8 costs between $15,600 to $17,300 per year or
9 $1,300 to $1,400 per month.
10 And I understand that there are three
11 doses per week of the treatment and the treatment
12 can go six months to a year depending on a variety
13 of circumstances.
14 The Department of Corrections as we
15 know contracts with for-profit private
16 corporations to provide the delivery of medical
17 care services.
18 This further complicates the issue of
19 treating these individuals as the contract
20 negotiations between these entities have to
21 include a significant new cost such as Hep. C.
22 I'm not sure that all of these things are factored
23 into the current contractual arrangements.
24 I share with Nan a concern about
25 interruptions in drug treatment. I just got a

1 report today that they ran out of Interferon at
2 Graterford recently.
3 And I'm very concerned about the
4 implications of individuals that start on the drug
5 treatment such as this and then get interrupted.
6 I'm obviously not a doctor but I believe that
7 Nan's concerns about the effects on HIV
8 individuals may be the same for Hep. C as far as
9 interruptions of drug treatment.
10 The Pennsylvania Department of
11 Corrections currently offers limited testing when
12 individuals are tested for Tuberculosis on an
13 annual basis. Blood tests look for elevated liver
14 functions. If these are indicated, medical
15 personnel recommend Hep. C tests be given.
16 Individuals also have the right to
17 request a test voluntarily. There is no mass
18 testing for Hepatitis C.
19 If individuals are found to be
20 positive, a host of possible potential exclusions
21 barring them from drug treatment. These include a
22 history of mental illness, a history of extensive
23 drug and alcohol abuse, and individuals who
24 received the drugs in the past and did not respond
25 to them.

1 Unlike HIV, Hep. C can take many
2 forms. Some individuals live their entire life
3 and don't have any problems. Other individuals
4 live 20 or 30 years before symptoms will appear.
5 Some develop chronic problems within 10 years,
6 some respond to the drug treatment and others do
7 not.
8 Current information available
9 suggests 30 to 50 percent of the individuals do
10 respond to the combination Interferon and Ribavin
11 drug treatment. Some have very severe side
12 effects and others do not.
13 This disease is very difficult to
14 predict and accordingly education to the public
15 about this is difficult.
16 We applaud the Department of
17 Corrections for coming up with the protocol for
18 Hepatitis C. We believe more can be done. The
19 biggest area for improvement is educating the
20 prison population regarding the disease.
21 Similar to HIV, we believe there is a
22 need for public education to the inmate
23 population. We recommend posting of information
24 about the dangers of Hepatitis C and encouraging
25 those individuals who have engaged in high risk

1 behavior to be tested.
2 There are many fine educational
3 materials available. Such materials should be
4 posted on each cell block and also be available in
5 Spanish.
6 Similar to HIV, there are videos for
7 many illiterate folks and also there could be peer
8 groups organized to assist folks in dealing with
9 this problem.
10 This would be consistent with the
11 Department's policy of early intervention in the
12 area of chronic diseases in order to reduce the
13 long-term problems related to liver damage in the
14 future.
15 We also urge the Department to
16 continue its testing program in hopes of expanding
17 the number of individuals that are identified
18 with Hep. C and the number of individuals who will
19 be receiving drug protocol.
20 As I mentioned, there are 100
21 individuals receiving drug treatment out of a
22 potential of 14,000 people that may have this
23 disease.
24 Another potential problem involves
25 availability of liver transplants. To the credit

1 of the Pennsylvania Department of Corrections,
2 they recently revised their policies and have made
3 the transplant option available.
4 While it is initially expensive, in
5 the long run it will save considerable amounts of
6 money and improve the quality of life for the
7 patient.
8 For these reasons, we encourage the
9 expansion of the transplant program. This should
10 especially be true when there are family donors
11 available.
12 While we can differ on many of the
13 policies of our criminal justice system, I think
14 we should unite when it comes to matters of public
15 health. The Department has correctly noted we can
16 pay now or we can pay later.
17 We agree with the Department that
18 preventive measures are the best course of action.
19 For these reasons, we encourage the Department to
20 expand its educational activities in hopes of
21 raising awareness of Hep. C and encouraging those
22 who need treatment to seek it.
23 Hopefully, they will respond to
24 treatment and minimize the difficulties for all
25 concerned down the road.

1 Treatment of those individuals to
2 reduce Hepatitis C morbidity and mortality will
3 have broad implications for our overall public
4 health. Thank you very much.
5 CHAIRMAN BIRMELIN: Ms. McVaugh.
6 MS. MCVAUGH: Yes. My name is Nan
7 McVaugh. As I stated, I'm a retired educator with
8 the Pennsylvania School System. I'm a
9 Graterfriends Board member and a Convener and
10 Official Visitor of the Pennsylvania Prison
11 Society to several State prisons.
12 I have been involved with prisoners
13 and prisons for 10 years and serve on a Citizens
14 Advisory Board for Parole and Probation. And this
15 fall I will participate in the offender advocacy.
16 I consider myself a very balanced individual.
17 And I have been involved, as I said,
18 approximately ten years. I also wanted to state
19 that I try to cooperate with many and have
20 interactions with Superintendents of prisons,
21 their assistants, all of the way down to
22 counselors, unit managers, and correction officers
23 with whom I have interacted throughout the
24 years.
25 The following cases that I'm going to

1 cite relate to medical mental health issues and
2 drug and alcohol. It is my hope that stating this
3 information that the system can be improved.
4 I fault no particular group or
5 individual. To save money at the present time
6 does not always make sense. To delay treatment
7 may drastically increase tomorrow's costs in both
8 treatment policy and in litigation.
9 I would like to begin with an
10 individual who first was referred to us from
11 parole. These cases that I'm citing are all
12 within the last year, year and a half.
13 When he arrived to meet us, he was in
14 pain. He had just reported from his kitchen job.
15 At first he thought we were doctors. He had
16 insisted on showing us an open wound of about 1
17 inch.
18 Due to the oozing, he had tucked
19 pieces of toilet tissue around it. He said he had
20 had a lymph node removed. This was done in a
21 facility without a complete infirmary.
22 When the stitches were removed, the
23 individual asked about perhaps being too early to
24 do this. The reply given to him was, "God will
25 heal it for you."

1 About a year later we saw him again.
2 This time he was so emaciated and ill, we barely
3 recognized him. We were sitting with him and he
4 was on the chair and I felt that within moments he
5 would just collapse. So I ran out into the
6 original visiting room and I said to the officer,
7 please, please get this man back to his cell as
8 soon as you possibly can.
9 Since it was a Sunday, we could not
10 talk with the staff of the prison with whom we
11 have a very positive relationship.
12 I informed him we would send a fax
13 immediately the next day or that day so the man
14 could be transferred to get his treatment. He
15 indeed was, but he is now in another institution
16 facing similar types of situations. He is also
17 very ill. He has been diagnosed as HIV positive.
18 Another individual, a paraplegic, was
19 forced to reuse catheters. The instructions on
20 the box stated do not do this. We checked with
21 outside sources. We checked with the company. I
22 believe it was in Georgia. We called them. We
23 checked with nurses from different departments.
24 And they all said if the individual
25 is in a home situation it could be done due to

1 cost but definitely not in an institution or
2 school atmosphere.
3 In addition, he was also forced to
4 use the same latex gloves, inexpensive, to remove
5 the feces physically himself from his person. He
6 was actually told just wash them off.
7 Another prisoner was given his
8 medication by way of a plastic medicine holder.
9 The pills were tightly sealed. He at the time was
10 taking medicine three times where he was still
11 suffering from an ulcerated colitis.
12 The medicine was to prevent him from
13 bleeding so much in his lower intestines. He had
14 all kinds of symptoms which I outline in my
15 testimony. He was very sluggish, felt very -- not
16 great. So he wrote an inmate's request to go to
17 medical and was seen there.
18 The nurse explained to him that the
19 medicine he was taking was not for colitis. It
20 was for another prisoner in the institution that
21 had a serious heart problem.
22 It should be noted at this point the
23 prisoner has been taking the medication for a
24 couple of weeks. We were told that the company --
25 which I won't mention here but it is in my

1 testimony -- is that it would package the
2 medication and therefore it wasn't the prison's
3 fault but the vendor company that was sending in
4 the medicine.
5 However, the staff of the institution
6 did nothing to ensure there were no further
7 effects which would harm the prisoner.
8 Finally, the wife -- the family
9 notified the prison. The prisoner made contact
10 with a captain. It was only after this that the
11 medical staff looked into the effects this
12 incorrect medication had had on the prisoner.
13 They tried to assure the milligrams
14 would not be enough to be sufficient to cause him
15 bodily harm. No tests were done. And had not the
16 family requested this and really called the
17 prison, it is possible the prisoner could have
18 suffered severe medical problems, perhaps even
19 death.
20 A similar event occurred with a
21 prisoner in another prison. This prisoner was
22 also referred to us for other reasons, not for
23 medical reasons. As a result -- he was given the
24 wrong medication. He is now deceased, and the
25 case is in litigation.

1 To comment briefly on medical
2 situations while held in the RHU, I have grave
3 concerns about John W. who has congenital cerebral
4 palsy with spastic paralysis and cannot urinate on
5 command.
6 Due to this medical disability, he
7 has spent seven plus months in the RHU with
8 multiple misconducts and is faced with another
9 year possibly.
10 Previously during nine years, he had
11 no misconducts. He has no drug or alcohol
12 background. Because he is forced to take extra
13 water so that he can provide additional tests
14 periodically, this is affecting his bladder.
15 He would willingly give blood as a
16 sample, but the answer is no. Therefore, he is a
17 59-year-old man who will have accumulated almost
18 two years time as I stated in the RHU.
19 And he endures severe coldness in his
20 cell, is given medication to try to help him to
21 give a sample. These are possibly destroying his
22 bladder.
23 He also -- we have in our possession
24 a document from the same prison doctor. 1994, it
25 states, "May not be able to give a spot urine on

1 demand. He may use a bag to carry books." We
2 have a copy.
3 In addition, he tries to drink large
4 amounts of water; but this can cause retinal
5 damage. He has glaucoma. He tries to explain
6 this to the hearing examiner. The comment is,
7 "Tell it to the Secretary." So today I'm doing
8 that.
9 Health matters have become very
10 serious in origins for various reasons. As I
11 stated, both individuals had mental health issues.
12 We have one case we know very well.
13 He was sent to a forensic unit. He had a history
14 of slashing his wrists. While he received
15 positive treatment at the unit for his depression,
16 he was moved back to his home institution to serve
17 multiple months.
18 When we brought the concerns to a
19 variety of people, the Superintendent and
20 Deputies, their response to us was, "He enjoys
21 slashing his wrists." I don't believe that any
22 man enjoys slashing one's wrist.
23 Ultimately, he was transferred to
24 another institution where once again he received
25 positive mental health treatment. But once again

1 because he required RHU time, he was tossed back
2 and forth.
3 Within a period of time, he too
4 became a statistic, deceased. The reason for
5 death was an alleged heart problem. Apparently he
6 complained of chest pains. But as a mental health
7 prisoner in the RHU, he was not believed.
8 The following conversation was
9 reported to me by prisoners who overheard this in
10 conjunction with officers who finally came to
11 quiet the prisoner who was making a commotion to
12 get help: "Nigger, you'll max out right hear in
13 the RHU. I don't care what I or my officers have
14 to do. We'll do whatever it takes, you piece of
15 shit." Then to the two officers present he asked,
16 "Isn't that right?" They both stated, "Yes, sir."
17 One went on to say, "I'll pass the word."
18 This situation could have and should
19 have been prevented. I guess the officer was
20 correct. The prisoner maxed out in the RHU. He
21 was a man we knew well with a great deal of talent
22 in many ways, educational and otherwise. He was
23 in his young 30s.
24 A case which had the same results
25 occurred in February 2000 with a death row inmate

1 at a western prison. I have attached details to
2 my testimony as reference.
3 As a newspaper reporter wrote, "A
4 simple virus succeeded where the State had
5 failed." Another inmate may also have died of
6 neglect after being ignored.
7 I could cite many cases involving
8 mental health and medical issues while in the RHU,
9 documentation to prove all of them. They range
10 from severe mental health diagnosis such as
11 paranoid schizophrenic to mild depression.
12 They include men with past addiction
13 problems who are presently in wheelchairs having
14 spent four years in the same RHU in isolation to
15 those men who are also in wheelchairs who are sent
16 to mental health units due to thoughts of suicide.
17 Once again they received positive
18 treatment from the mental health units at various
19 prisons, but then they are sent back.
20 And as several staff have confided,
21 blatant neglect has been bestowed upon them from
22 untrained officers.
23 It has been reported that in some
24 special needs units, prisoners receive little or
25 no recreation, zero programming, and they are

1 exposed to correctional officers with little
2 sensitivity training.
3 I do not fault those men sometimes.
4 Because how do you know how to deal with mental
5 health unless you have been given training? It is
6 not an easy job.
7 Even if the staff member has a
8 schedule to follow, they may not arrive and may
9 even falsify records. I might add that nurses and
10 other positions are understaffed. They are burned
11 out. I support them.
12 Perhaps more beds and staff are
13 needed for these units at the various
14 institutions.
15 Men in the RHU will find a lack of
16 medical care, particularly those with chronic
17 illnesses such as diabetes and high blood pressure
18 which are prevalent among half of the Americans.
19 They state they are only seen through
20 windows or doors, not examined properly, and their
21 records are inaccurate. Log books should be
22 checked.
23 It also has been stated that perhaps
24 physical medical doctors are afraid to interact.
25 I'm not sure of that.

1 After reading numerous cases, one
2 major problem seems to be that even when prisoners
3 are sent out to the very specialists and they
4 receive positive comments and treatment, questions
5 and opinions, when they return, the
6 recommendations are not followed due to the
7 outside vendor refusing the necessary treatment.
8 These could involve things like
9 hernias causing the men great pain. Surgery was
10 denied.
11 Dental problems where the men's teeth
12 are extracted, but they are not allowed a partial
13 plate until they have four teeth extracted. And
14 this can go on for four or five years. Meanwhile,
15 their jaw is adjusting.
16 One severe case deals with an injury
17 while working in the inmate dining room in 1995.
18 After 40 months of pain, it was determined several
19 disks were damaged.
20 He received surgery this past June.
21 Yet it took multiple efforts and countless visits
22 with medical to convince them. It has previously
23 been suggested that the injuries did not exist or
24 were psychosomatic.
25 He is now in the SNU with a strap-on

1 cast from his foot to his chest and walks with a
2 cane. He is permanently disabled.
3 This type of scenario appears to be
4 prevalent. The prisoner keeps complaining, blood
5 tests, etc. are done but follow-up work is
6 neglected.
7 Finally, the prisoner keeps
8 protesting some more and medical staff may make
9 every effort to intervene -- I know many of
10 them -- but the person in charge refuses.
11 This results in cases of prostate
12 cancer, dangerous cysts in a throat of a man that
13 can hardly swallow. Liver problems that were not
14 diagnosed as Hepatitis but finally after biopsies
15 they are still encountering problems. Vision
16 problems, even blindness where the person is
17 denied a cane and unable to walk without
18 assistance.
19 It is reported that if this is not a
20 life or death situation, then the surgery or
21 procedure is not needed. This is applied
22 constantly. I've seen it in the last year
23 particularly for men maxing out.
24 When I say men, I'm probably
25 including women also. But I do not go into

1 women's prisons. So that's why I keep saying men.
2 But I'm concerned for the community
3 particularly as Angus said with Hepatitis C and
4 HIV. I know many of them and they are being
5 denied because they are maxing out in another
6 month or five months or less than a year.
7 There are also veterans to consider.
8 They too are suffering from all types of mental
9 and physical problems.
10 Disabled veterans at 30 percent and
11 above when they are released are entitled to free
12 medical care. However, those incarcerated, 10
13 percent dating back to 1976. It was thought that
14 those in prison receive adequate treatment. As we
15 know, times have changed and job situations are
16 not good in most of our State prisons.
17 In ending, I could refer to hundreds
18 of cases all documented from across the state. I
19 have included several letters written by prisoners
20 or parents dealing with some of the issues. All
21 have given me permission to include these in my
22 testimony today.
23 I hope, I pray that you take the
24 time at your leisure but soon to go through the
25 letters that I have included. I know each and

1 every one of those inmates. I vouch for them.
2 This is over a year's period of time at length.
3 Again, I thank you for allowing me to
4 testify and will be happy to answer any questions
5 or provide further documentation.
6 I want to cooperate with everybody
7 including the correction officers and Mr. Horn.
8 Thank you.
9 CHAIRMAN BIRMELIN: Thank you, Ms.
10 McVaugh. Ms Raymond, did we receive your
11 testimony ahead of time? I understand you have
12 the folder right there. Are you going to present
13 that?
14 MS. RAYMOND: It is presented to you.
15 CHAIRMAN BIRMELIN: Okay. Are you
16 going to read that portion of that?
17 MS. RAYMOND: Yes. I will try to
18 paraphrase. You do have a copy there, don't you?
19 CHAIRMAN BIRMELIN: Yes, I do. I
20 just didn't know for sure if you wanted to speak
21 at all about it.
22 MS. RAYMOND: Oh, yes, I do.
23 CHAIRMAN BIRMELIN: Thank you.
24 MS. RAYMOND: My name is Jessica
25 Raymond. I'm a visitor with the Pennsylvania

1 Prison Society. I've been an official visitor
2 since 1976 at Delaware County Prison and here at
3 SCI Chester since August of 1998.
4 I consider myself at the bottom of
5 the food chain. I've been to many conferences and
6 I heard many people speak about programs and
7 philosophy of programs, perhaps the way the
8 programs are going to work.
9 But as an official prison visitor, I
10 pick up the crumbs as the sandwich filters down
11 through prison levels. I received letters, phone
12 calls from inmates, from families, from friends,
13 from other agencies.
14 I always communicate with every
15 person that contacts me. And if need be, I come
16 to the prison. I visit, I discuss, and try to
17 help solve the problem.
18 When I first came to SCI Chester, I
19 was given a liaison person to contact. I have
20 written numerous letters to my liaison person at
21 SCI Chester. I have received one response from
22 her, and that was a letter admonishing me.
23 My medical issues all go to
24 Superintendent Byrd. I am not permitted to speak
25 or contact the medical department at SCI Chester.

1 I do receive some responses from medical but not
2 very many.
3 I have all of my copies here of every
4 medical complaint, every letter I have written,
5 and the few responses that I have received.
6 Medical treatment both mental and physical is one
7 of the major complaints if not the major
8 complaint.
9 I cannot say my correspondence is
10 never looked into. I do receive words sometimes
11 from inmates and their families that situations
12 have been looked into and corrected. But that is
13 not common.
14 With medical, the best results I get
15 are when after a long period of frustration -- and
16 I mean months of working on one case -- I send my
17 documentation to Bill DiMascio, Executive Director
18 of the Pennsylvania Prison Society, and he
19 forwards that information to Catherine McVey at
20 DOC.
21 And in the two instances that I have
22 done this, action actually has been taken. But
23 only because I had to go through this route.
24 There are so many medical complaints and I have
25 them listed here.

1 I'm just going to give you a few of
2 the kinds of things that I hear about: Epilepsy;
3 sexual harassment, male correctional officers
4 harassing male inmates; personal cleanliness
5 denied, eight days with no shower, shave, change
6 of clothes, or linen; lack of physical therapy;
7 dental problems; confidential medical information
8 somehow known to correctional officers on the
9 block and then used to "abuse" that inmate;
10 therapeutic drug and alcohol program run by
11 Gaudenzia House -- I've been told by a number of
12 inmates that some of the staff do not want that
13 program to work -- hot urines in a drug-free
14 prison; mental abuse, especially RHU; toenail
15 fungus, request for some anti-fungal, "wait until
16 you're on the streets"; testicular cysts with
17 pain; refusal of Tylenol for pain or ice for pain;
18 et cetera, et cetera, et cetera.
19 All my documentation, letters are
20 here for review. I have actually detailed very
21 heavily two cases with which I've been working
22 here at SCI Chester.
23 And I know that I cannot give you
24 every single detail because of lack of time, but I
25 do want to take one of the two cases and give you

1 as much as possible.
2 I've been working with an inmate by
3 the name of Ezekiel Simmons since January of 1999.
4 In July of 1998, Ezekiel Simmons was playing
5 basketball in the gym and came down from a jump
6 and landed on another inmate's foot and he injured
7 his knee.
8 He was immediately taken to SCI
9 medical where they iced it, wrapped it, and gave
10 him crutches. He had continual pain. And then
11 two months later, his knee gave out completely.
12 Ezekiel Simmons has never seen the accident report
13 which is supposed to be filed after every prison
14 accident.
15 I first visited Ezekiel on 1/21/99,
16 seven months after his accident. He told me that
17 an MRI had finally been taken four months after
18 the accident. It showed a torn ACL and at least
19 one torn interior ligament. And I have
20 documentation from the group that took the MRI.
21 I visited with Mary Ann Williams,
22 Assistant to Superintendent Byrd, shortly after I
23 visited Ezekiel. And I did mention this problem
24 to her.
25 I wrote to Superintendent Byrd a few

1 days later about the knee problem. I have copies
2 of all my notes. I told her that Ezekiel Simmons
3 is a certified licensed heavy machine operator,
4 and that he will need two good legs in order to be
5 employed when he is released.
6 I received an answer shortly
7 afterward. This letter will be appropriately
8 reviewed. On 8/4/99 -- this was January. In
9 August I received correspondence from Ezekiel.
10 There has been no progress toward the
11 knee operation. His knee was cracking. He
12 continued to have sharp pain. He was still on
13 crutches one year after the accident. His back
14 was beginning to show the strain of crutch use.
15 Someone told him that SCI Chester was
16 not going to provide an operation. Copies of
17 letters to Superintendent Byrd regarding this
18 case.
19 Incidentally, in my second letter to
20 her, I did mention that recidivism is a real
21 problem. That we need to treat the medical
22 problems of inmates while incarcerated so that
23 when they are released, they can go back to work.
24 It is very important. And this man,
25 as I said, had great work opportunities. A month

1 later Ezekiel Simmons wrote to me and he had to go
2 to medical about his knee. And he said that Dr.
3 Khin was hysterical because one of my letters had
4 gotten into his file.
5 He told Ezekiel, I'm not responsible
6 for any of these decisions. And he would have
7 Ezekiel see an outside doctor.
8 The next day he was told by a unit
9 manager the institution was going to transfer him
10 out of here to get him as far away from his family
11 as possible. The reason given by the unit manager
12 was "behavior problems."
13 I would love to have you meet this
14 man. He is a sweet and gentle and kind and
15 thoughtful individual. His crime was nonviolent.
16 He is not a drug or alcohol abuser.
17 Three staff members informed Ezekiel
18 they would not vote for his transfer. And one of
19 them out and out said to him, Zeek, you're not a
20 behavior problem. So he wasn't transferred.
21 But interestingly enough, two weeks
22 later the unit manager who would not vote for his
23 transfer was himself transferred. Ezekiel Simmons
24 filed an injunction and a restraining order with
25 federal court so that SCI Chester could not

1 transfer him.

2 Meanwhile, he had filed a civil

3 action against SCI Chester, its medical department

4 in the US District Court for the Eastern District

5 of Pennsylvania.

6 Incidentally, this man has done all

7 of his legal work; and I'm impressed by his

8 ability and perseverance.

9 I received correspondence again in

10 November. Dr. Khin has yet to schedule him to see

11 another doctor about his knee as he had promised

12 in September.

13 Finally, I wrote a cover letter to

14 Bill DiMascio with documentation. He sent it

15 along to Kay McVey of DOC.

16 On 11/14/99 shortly after that

17 transaction, Ezekiel Simmons wrote to tell me that

18 Dr. Charles Hummer, III at Chester Crozer Medical

19 Center had examined his knee and that he was now

20 scheduled for surgery, seventeen months after the

21 accident.

22 He also informed me that his legal

23 mail was being opened without the inmate present.

24 By the way, this is a common occurrence as in all

25 prisons even though it is illegal to do so.

1 On 12/9, Ezekiel Simmons received
2 documents from the federal court that a motion to
3 dismiss his case filed by DOC Martin Horn, Mary
4 Byrd, Roxina Rumley had been received. Their plea
5 for dismissal of Ezekiel's case was denied.
6 Ezekiel Simmon's received his surgery
7 on 12/8/99, approximately one and one-half years
8 after he hurt his knee.
9 On 12/14, Ezekiel Simmons received
10 from the court Judge Marvin Katz had granted him a
11 court appointed attorney.
12 I was in to see Ezekiel Simmons in
13 January of 2000. And on that day SCI Chester had
14 sent him for a medical checkup with Charles
15 Hummer. Interestingly at that same time, two
16 court appointed attorneys came to see him and were
17 told that he wasn't available.
18 I only found that out because the
19 staff member here at SCI Chester told me. And I
20 consider that serendipity. Because when I wrote
21 to Ezekiel, he told me he had never been informed
22 that lawyers had come to visit him.
23 On 2/8, 2000, I wrote to
24 Superintendent Byrd to tell her that Dr. Hummer
25 had prescribed a knee brace for Ezekiel and it had

1 not been given to him.

2 He had the operation in December.

3 This is February. Dr. Hummer told Ezekiel Simmons

4 he should not be wearing the brace given to him by

5 SCI medical. He must get rid of it.

6 The surgeon had ordered a different

7 brace, but Dr. Khin did not get it for him. And

8 Roxina Rumley, health care administrator, said Dr.

9 Khin has the last word.

10 I asked Superintendent Byrd to look

11 into this. No response from medical. I'm

12 enclosing a copy of a letter from Bill DiMascio of

13 the Pennsylvania Prison Society to Catherine McVey

14 of DOC about the brace and the prescribed three

15 times a week physical therapy -- here it is --

16 that he is not getting.

17 Ezekiel Simmons gave a deposition to

18 Pennsylvania Deputy Attorney General Owen J. Kelly

19 and to Attorney Allen Gold, attorney for CMS, the

20 for-profit medical group that runs medical here at

21 Chester. He had no representation at the time,

22 legal or otherwise.

23 I know that this is legal for

24 attorneys to depose without the other person

25 having legal representation. I do see a problem

1 with that however. Two well-educated, highly paid
2 lawyers knowing how to ask the "right" questions
3 to elicit the "right" answers from a man that has
4 not had that education.
5 Ezekiel Simmons told me that he felt
6 a bit badgered by Attorney Gold. Ezekiel is not a
7 highly educated man, but I find him to be
8 intelligent and perceptive. He also told me that
9 during the attorney's deposition, one of them
10 stated that the time taken to surgery was
11 medically appropriate.
12 Now if my knee went out, I'd be at
13 the doctor the next day. I would have an MRI as
14 soon as I could schedule it, and the operation
15 immediately so I would not have further injury to
16 my knee. And I'm not even a heavy machine
17 operator.
18 I am sure everyone in this room would
19 do the same thing for themselves or for a family
20 member.
21 On 3/16, that's just a month ago, I
22 visited Ezekiel. He still had not received the
23 knee brace prescribed by Dr. Hummer.
24 I called Dr. Hummer and asked him
25 several questions. He requested that I write to

1 him and include the questions. I did so on 3/20.
2 I have not received a response to them. He is not
3 in his office this week.
4 However, his office did give me the
5 copy of the letter that Dr. Hummer recently wrote
6 to Dr. Khin here at SCI Chester wondering why he
7 has not seen Ezekiel Simmons for further
8 reevaluation of his knee.
9 I also included a copy of the
10 questions that I sent to Dr. Hummer which I fully
11 expect he will answer when he is back from
12 vacation.
13 Ezekiel Simmons' minimum release date
14 to enter a halfway house was to be 4/8, 2000. He
15 has been staffed for pre-release. All necessary
16 signatures were positive except for SCI Chester's
17 Superintendent.
18 Ezekiel Simmons did not originally
19 know the reason for his refusal. But when I
20 visited him on 3/30, 2000, he told me he had just
21 received a 2-year hit from the Parole Board. The
22 reason given was unfavorable recommendation from
23 SCI Chester.
24 He was told by someone here that the
25 Superintendent considers him a troublemaker. I'm

1 really saddened and dismayed by what has happened
2 to this man. I worked with him for a long time.
3 I think I know him. He is a really decent person.
4 He may never be able to get back into
5 heavy machinery. His knee may be damaged
6 permanently. It is very unjust. It is not
7 correctional. It is punitive.
8 And we need to make that
9 distinguishing area there. What is correctional
10 and what is punitive? This man is here to be
11 corrected for his punishment for his crime, which
12 is nonviolent by the way.
13 My question is, is money going to be
14 the bottom line now that we have vendors that are
15 for-profit operating our medical departments? I
16 also have a letter I enclosed that I sent to Judge
17 Katz who is Ezekiel's judge in the Eastern
18 District federal court.
19 I have all of my documentation from
20 Ezekiel. I have all of my documents from SCI
21 medical. And here I have copies of medical
22 complaints from other State institutions. These
23 are institutions I have not been visiting or
24 involved, but I have been sent these complaints.
25 I will not go into the detail on my

1 second case, but it is in the folder of testimony.
2 My last question is when I was here a week or so
3 ago, I requested that inmate Eric Ponder be able
4 to come to the hearing to do a short testimony.
5 And I do not see him in this room,
6 and I'm wondering if at this time the Committee
7 might request to have Eric come for a few minutes,
8 also another very fine young man.
9 CHAIRMAN BIRMELIN: I'm sorry for the
10 interruption. I'm told by Chief Counsel Preski
11 that he is scheduled to testify. He just didn't
12 show up on the schedule at this hearing today.
13 And he's later in the schedule.
14 I think he is scheduled -- well, he
15 was scheduled for 3:30. But what is 3:30 now? He
16 will be somewhere around 3:30. At this point in
17 time more like 4:30 or quarter of five.
18 MS. RAYMOND: Thank you. I'm very
19 willing to answer any questions. I know that I do
20 not have copies of my testimony for everyone, but
21 I know there is one or two up there. And I have
22 all of my documentation as well if anybody needs
23 to see any of it.
24 CHAIRMAN BIRMELIN: Representative
25 James.

1 REPRESENTATIVE JAMES: Thank you,
2 Mr. Chairman. Thank you all for testifying.
3 Mr. Love, how are you doing?
4 MR. LOVE: Good. Yourself?
5 REPRESENTATIVE JAMES: Tired. In
6 your testimony, you talked about 41 percent of the
7 inmates in California were tested for Hepatitis C.
8 Why was that? Was that something the legislature
9 did or something that the correctional department
10 decided to do?
11 MR. LOVE: They decided on mass
12 testing. My guess would be the Department of
13 Corrections. So they tested everybody in the
14 system but I'm not sure.
15 REPRESENTATIVE JAMES: And I see the
16 assessment in Pennsylvania would come out to
17 almost the same numbers possibly. Why hasn't
18 Pennsylvania done that?
19 MR. LOVE: We had a meeting with
20 Commissioner Horn's staff last summer. At that
21 time in California it was 39 percent and they have
22 since gone up.
23 And it was their opinion just to
24 guesstimate it would be between 25 percent and the
25 California high watermark of 39 percent. But the

1 decision has been made not to do mass testing in
2 Pennsylvania. So we won't really know.
3 REPRESENTATIVE JAMES: What can -- I
4 mean can they do it on their own initiative or do
5 we have to do something?
6 MR. LOVE: I think they can do it on
7 their own initiative. I think the CDC if I recall
8 the conversations has recommended mass testing but
9 have not felt the need to go in that direction.
10 REPRESENTATIVE JAMES: Based on what
11 is going on, do you think that it is something
12 that should be done?
13 MR. LOVE: I personally feel it
14 should be done. I think public health issues are
15 of paramount importance not just in correctional
16 personnel, inmates but to the general public. And
17 we know most of these folks are coming out.
18 And I think that there is a need to
19 educate folks about their situation and find out
20 as much as we can about their health situation in
21 order to protect them and others.
22 REPRESENTATIVE JAMES: Thank you.
23 Ms. Feyler.
24 MS. FEYLER: Feyler.
25 REPRESENTATIVE JAMES: Yes. In your

1 testimony you talked about inmates coming out and
2 87 percent of them reported that they did not have
3 a doctor to go to. Can't they go to the health
4 center?
5 MS. FEYLER: Sure. There is actually
6 a network of free physicians and a lot of us
7 working in Medicaid and insurance. So we feel the
8 problem to be solved is the linking.
9 There are -- especially in the
10 Philadelphia area. There are physicians
11 available. But what happens is that an inmate
12 comes out and has no idea where to go.
13 And even showing up to a neighborhood
14 health center you will not have HIV experience to
15 succeed on the medications. What we're suggesting
16 is that we work with the Department of Public
17 Health and the counties and state works together
18 to provide the linkage up front.
19 There are doctors available. There
20 are inmates that just need to make sure that the
21 education is given up front.
22 The community corrections facility,
23 as an example, we just did training. They had no
24 idea where there are doctors experienced to treat
25 people with HIV. Which really, it is a

1 communication linkage.

2 And finally what I would say also is
3 the money required to staff to help the folks make
4 the transition. Most folks coming into a home may
5 not be enough. We want them to succeed in their
6 HIV care.

7 REPRESENTATIVE JAMES: So in terms of
8 communication, is that something we as
9 policymakers have to do to enhance that
10 communication?

11 MS. FEYLER: Yes. I actually think
12 last year we worked on putting together a
13 statewide coalition on corrections; State parole,
14 State Department of Health, and others to get a
15 federal million-dollar-year grant that I don't
16 know if you are aware of.

17 But eleven states applied for seven
18 grants. Pennsylvania was approved and not funded.
19 That modeling is what the legislature should try
20 to somehow -- I'm not sure of the role, but to try
21 to get some sort of task force created to work on
22 this program where public corrections works
23 together with the Department of Health.

24 And yes, I think there should be some
25 initiatives to get the Department embarking on all

1 these so links could be made.
2 REPRESENTATIVE JAMES: I'm also
3 concerned about the high incidence or discussion
4 talking about TB.
5 MS. FEYLER: That's right. TB --
6 actually, Hep. C., TB, HIV, sexually transmitted
7 diseases. They are really, frankly, a larger
8 public health issue. HIV is obviously the most
9 expensive and life threatening to the individual.
10 But, yes, I think -- and frankly
11 mental health and D&A are issues that are sort of
12 overwhelming in nature. But studies do show just
13 as we talked about earlier with D&A, those
14 programs are in place.
15 There is less recidivism. And I
16 think that is a vehicle for people to move
17 forward. And I would include those other
18 infectious diseases.
19 REPRESENTATIVE JAMES: Thank you.
20 CHAIRMAN BIRMELIN: Representative
21 Manderino.
22 REPRESENTATIVE MANDERINO: Thank you
23 all for testifying. My question is to the
24 two women from the Prison Society. I did not have
25 a copy, Jessica, of your testimony. But now I did

1 look through the attachments that you put to your
2 testimony, Nan.
3 And I notice that many of the people
4 whose letters you have included had at one time or
5 another in the course of trying to get treatment
6 contacted public officials.
7 And I noted at least on one occasion
8 if not on more than one -- I'm not sure this is
9 what they were saying -- but they thought there
10 was direct retaliation for their actions having
11 contacted a public official.
12 If you have any experience, either of
13 you, that you can share with me about how often
14 you hear that. Is that something that is on
15 occasion or something that you hear fairly
16 frequently? I'm interested in your insight on
17 that issue.
18 MS. MCVAUGH: Hello. Is this on?
19 Yes, I can address that in general going back on
20 hundreds of cases in the last four years. It is a
21 problem. And recently and I did address this with
22 the institution.
23 Men come to see the Prison Society
24 about all issues, and many times it is not even a
25 complaint. It is just for the future for a home

1 plan or, you know, men that don't have families.
2 So it is not always to complain.
3 But they are told we want to go see
4 the Prison Society. Why? That's an elusive
5 thing. Besides that, they only help niggers. I'm
6 offended by that. I am deeply offended by that.
7 But I also want to strongly urge I do
8 relate this to the cooperative officials at the
9 institution. And I'm aware of the fact how hard
10 it is myself as a past educator. Unless it is
11 documented, documented, documented, even with poor
12 teachers, you can't just dismiss a complaint.
13 But it is prevalent when it is in
14 writing to any of the Senators or Representatives.
15 Yes, there is retaliation. I don't know how we
16 can solve it.
17 MS. RAYMOND: I will give you my
18 position as a prison visitor because I do not have
19 any factual information about this, but I do have
20 the information that inmates have given me.
21 When I do intercede in their behalf,
22 it is not looked upon kindly at all. And it is
23 almost a catch 22 for me. And I think that you
24 can understand that.
25 But another complaint I get that is

1 related to this is that many, many inmates are
2 afraid to speak out to me or to the grievance
3 committee or whatever it is that your SCI Chester
4 has. Because they say when you speak out, there
5 is retaliation. I can't document that. I can
6 only tell you I hear it over and over again.
7 MS. MCVAUGH: I want to add also one
8 point. I have referred this to a Senator whom I
9 know. My husband and my life have been directly
10 threatened indirectly. Do I have proof? How can
11 one have proof of that?
12 Except when we were told -- we happen
13 to live on Main Street and only somebody familiar
14 with the history would know that it has local
15 names. So I take my job also very serious. But
16 as I told the prison officials, no one intimidates
17 me.
18 I was a German teacher. I traveled
19 on my own in East Germany. Again because I'm
20 fluent, so I'm used to Gestapo tactics.
21 I support the staff officers and I
22 know many of them. But I will say that our lives
23 have been threatened. And we tell five people
24 every week where we are going and into what
25 prison. This is not a local incident. Thank you.

1 CHAIRMAN BIRMELIN: Chief Counsel
2 Preski.
3 MR. PRESKI: Just one question I
4 guess for Mr. Love and Ms. Feyler. Given the
5 nature of your testimony, basically you've
6 established with your testimony when you brought
7 something to the Department of Corrections, when
8 you brought something to Commissioner Horn whether
9 it be Hepatitis C or the HIV problems, they have
10 been very responsive to everything that you've
11 asked.
12 Maybe there is some things that you
13 would like them to do a little bit different,
14 things that you would like them to do a little bit
15 more.
16 But generally, is it not true that --
17 I mean your reactions or your relationships
18 between DOC and your own organizations when you
19 try to intervene on behalf of a prisoner or inmate
20 or anyone else, they have been pretty good.
21 Of course, in individual cases things
22 could have been better. But I guess I want a
23 brief comment. Is it not true that, you know,
24 they have been very responsive to everything in
25 advance?

1 MR. LOVE: I would say they have been
2 very responsive. Hep. C people have been
3 complaining since the early '90s. It is only
4 lately that a task force has been established. So
5 they have been responsive.
6 I guess I would prefer an earlier
7 response and more thorough response. But I would
8 say they have been.
9 MS. FEYLER: I think I make a
10 distinction between the policies and the systemic
11 issues where I think that in fact Secretary Horn
12 and his staff have been on board in trying to be
13 more proactive as opposed to the individuals.
14 I haven't shared individual
15 complaints. And institutional complaints -- we
16 intervene a lot where folks have been denied
17 medication or individual problems accessing health
18 care. I've tried with some success and sometimes
19 some hostility.
20 It is a large institution. It is a
21 large area. I don't want to get bogged down in
22 individuals at this point. All though I support
23 there are problems. I guess what I'm asking is
24 for more leadership including corrections to build
25 on what we have.

1 We certainly have the combination
2 therapy is relatively routine and people are much
3 more healthier than they were as a systemic issue.
4 I think that the Secretary is open to even moving
5 further ahead with the public health officials.
6 I think what I've raised are
7 important issues as well that I hope will be
8 reviewed. On the individual level there are still
9 problems, inconveniences. But on the systemic
10 level we could go forward.
11 MR. PRESKI: But the base is the
12 same?
13 MS. FEYLER: Pardon me.
14 MR. PRESKI: The base is good or the
15 base is same?
16 MS. FEYLER: I think things or HIV --
17 now I relate -- I get my information from letters
18 working with a lot of folks who have been
19 released. And I would say that overall the
20 standard of care is in place, that people are
21 relatively healthy.
22 I think that I haven't addressed as
23 much the issues are access, what happens if the
24 meds. don't work. But, yes, I think the base is
25 solid, much more solid than it was. I guess I

1 feel I don't want to minimize the concerns that
2 I've raised. But you could certainly say that.
3 Absolutely I am appreciative of where
4 we are as opposed to where we've been. But, you
5 know, I'm a lawyer and an advocate. I have to
6 push for more.
7 CHAIRMAN BIRMELIN: Thank you. I
8 want to thank all you folks for your testimony. I
9 appreciate you having given up your time to be
10 here. You have a closing statement for the group?
11 MS. RAYMOND: It is very short. It
12 is actually in my testimony but it's at the end.
13 It is a quote from -- recent quote from an inmate
14 that I'd like you to hear.
15 "The greatest mistake and injustice
16 done to prisoners is to treat them as if they are
17 a lower form of life, to segregate them from basic
18 human feelings -- care, compassion, understanding.
19 Abuse them, look to them as inferior, then release
20 them and demand that they make it."
21 MS. MCVAUGH: And I want to add one
22 last thing quickly. I think in my experience that
23 it varies greatly from institution to institution.
24 So you can get two institutions that are -- like
25 they're saying they are satisfactory. But that

1 third institution may be the direct opposite and
2 that makes all of the difference in the world.
3 CHAIRMAN BIRMELIN: And our next
4 panel to come forward -- and we're going to take a
5 short break.
6 (Break.)
7 CHAIRMAN BIRMELIN: We are going to
8 begin with the panel that is currently before us.
9 And for the benefit of the stenographer and those
10 of us here, if you folks could introduce yourself,
11 I would appreciate it.
12 MR. MAUE: Good afternoon, Chairman
13 Birmelin, Subcommittee members, and staff. My
14 name is Fred Maue. I'm Chief of Clinical Services
15 within the Department of Corrections.
16 To my far left is Ray Colleran. Ray
17 is the Superintendent of SCI Waymart Forensic
18 Treatment Center.
19 To my left is Catherine McVey.
20 Catherine is the Director of the Bureau of Health
21 Care Services.
22 And to my right is Lance Couturier.
23 Lance is the Chief Psychologist with the
24 Department of Corrections.
25 We have all devoted our careers to

1 trying to ensure quality health care in our
2 system. I'm going to read a brief statement. You
3 have a copy of my statement.
4 I'm just going to highlight some of
5 the things in the statement. I'm the only one
6 reading a statement in our group. Then we will be
7 more than happy to answer any questions that you
8 and the Committee have.
9 As you know, many of our inmates come
10 from difficult socioeconomic backgrounds. Access
11 to preventive health care was limited. Many can't
12 afford health care and many have issues of IV drug
13 use and as a result infectious disease such as
14 Hepatitis C, HIV, and TB are not uncommon in the
15 system.
16 Our inmates all have multiple mental
17 health and medical problems. Mental illness is
18 identified in 13.7 percent of our population and
19 3.1 percent have serious mental illness, and
20 mental retardation is prevalent in 1.25 percent.
21 Inmates suffer the stigma of being
22 both mentally ill and an inmate and have the
23 medical problems as well in addition to the drug
24 abuse.
25 This necessitates not only

1 specialized care and multi-disciplinary care in
2 our system but also makes release planning very
3 difficult and complex.
4 Inmates over the age of 65 in our
5 system comprise .8 percent of our population in
6 1995 and in 1999 comprise 1.2 percent of our total
7 population. So this population is growing.
8 Elderly medical needs for skilled and
9 personal care as well as treatment for chronic
10 diseases continues to grow. Our prison at Laurel
11 Highlands is a geriatric prison specializing in
12 the care of elderly and seriously ill inmates.
13 Our constitutional duty under the
14 Eighth Amendment of the Constitution, it
15 challenges us that if we know of an inmate's
16 problems yet make no effort to treat or fail to
17 provide an inmate with an access to proper
18 evaluation for a problem, we risk violation of
19 that Eighth Amendment.
20 We have a physician-driven system.
21 Physicians make treatment decisions in our system.
22 They follow community standards.
23 The challenge for us is how to
24 prioritize care, how to devote the most resources
25 to inmates that need them the most.

1 We're committed to quality health
2 care that enhances the safety in our institutions
3 and improving the health care of our inmate
4 population and public health of citizens of
5 Pennsylvania. And we wish to prevent the spread
6 of further diseases.
7 Finally, inmates fear that health
8 care will not be provided to them when they are in
9 need. We, as medical professionals, strive to
10 build trust by using sound medical judgment and
11 dignified, ethical relationships with inmates as
12 mandated by our DMC ethical policies and our
13 professional lives.
14 By doing this, we enhance compliance;
15 and, therefore, this helps to prevent the spread
16 of disease. We seek to treat all medical needs of
17 inmates. And in most cases I believe we are
18 successful. Thank you. That concludes my
19 remarks.
20 CHAIRMAN BIRMELIN: Thank you,
21 Dr. Maue. Dr. Couturier, is that the correct
22 pronunciation?
23 MR. COUTURIER: Yes, sir.
24 CHAIRMAN BIRMELIN: I've been
25 practicing that since I came in this afternoon.

1 You're the head of psychological services?

2 MR. MAUE: Yes, I am, sir.

3 CHAIRMAN BIRMELIN: Is that for the

4 entire State system?

5 MR. COUTURIER: Yes, it is.

6 CHAIRMAN BIRMELIN: And I noticed in

7 the remarks of Dr. Maue, he stated that mental

8 illness is identified in 13.7 percent of the

9 population. Are they throughout the State prison

10 population in all of the prisons or are they more

11 or less under certain institutions?

12 MR. COUTURIER: We have on the mental

13 health roster inmates in all of the prisons.

14 However, some our facilities, for example

15 Graterford, Frackville, Cresson, Muncy in

16 Pittsburgh have on-site psychiatric units.

17 They have special needs units in

18 addition to inpatient and outpatient care. Some

19 folks with more serious mental health problems

20 might go to those facilities.

21 CHAIRMAN BIRMELIN: You didn't

22 mention Waymart.

23 MR. COUTURIER: Waymart and also

24 Cresson.

25 CHAIRMAN BIRMELIN: Does that -- is

1 that included in that list?

2 MR. COUTURIER: Yes, it is.

3 CHAIRMAN BIRMELIN: And why is it

4 that you don't with mental illness patients put

5 them in a -- or concentrate them?

6 Since it is only 13.7 percent, put

7 them all in one facility or two facilities? Is

8 there a problem with doing that?

9 It seems to me you're spreading

10 mental health services over a larger number of

11 institutions when you have that small a segment of

12 the prison population. It might be more

13 specialized and efficient to deal with them if

14 they are only in two or three facilities.

15 MR. COUTURIER: Well, actually the

16 large bulk of the individuals on the mental health

17 roster are fellows and women who basically get

18 along okay and they function in the prison.

19 They hold down jobs in the prison,

20 may go to school, get along on the block. They

21 are on medication. And it is much like it is in

22 the community where you would run into a lot of

23 folks who may be involved in treatment and do

24 fine.

25 CHAIRMAN BIRMELIN: Well, the reason

1 I'm following this line of questioning is I know
2 for instance the Highland SCI deals with the
3 geriatric population for those facing more of the
4 diseases or problems of, you know, onset with age.
5 And Waymart, you know, more difficult
6 criminally insane which used to be a facility for
7 that purpose.
8 I'm just wondering if there is some
9 benefit to more selective prison populations being
10 targeted at certain prisons throughout the whole
11 State system.
12 MR. COUTURIER: That could certainly
13 be considered. But I should also point out that
14 20 of the prisons have special need units, and
15 these are specialized blocks where individuals
16 with mental illness and handicaps can actually
17 live on that specialized block or receive more
18 protection.
19 They receive more treatment, and they
20 can go back into generally the area of the prison
21 for their work or education or other things.
22 CHAIRMAN BIRMELIN: Thank you. Mr.
23 Colleran, I don't want you to have come all of the
24 way down here and not get asked a question. I
25 know you'd be gravely disappointed if that was to

1 happen. And I don't know that other members of
2 this panel have any for you but I do.
3 I know that you're basically in my
4 backyard. Those present here know Waymart SCI is
5 if I had a good arm I could throw a rock.
6 But you deal specifically in Waymart
7 SCI with sex offenders and drug offenders, lower
8 classification --
9 MR. COLLERAN: Yes, it is.
10 CHAIRMAN BIRMELIN: -- among all
11 those specialties and mentally ill. One of the
12 problems we have not talked about today is the
13 sex offender program. And I'm not sure if we are
14 going to do that later in any of those as well.
15 Can you briefly share with us how the
16 sex offender program fits in with behavior in the
17 prison? Are these people who continue to have
18 sexual problems? Are they transmitted or have a
19 sexual predator status out in public or prison?
20 We've heard several comments from
21 people today that apparently sexual activity in
22 the prisons is not uncommon.
23 MR. COLLERAN: At Waymart, we have a
24 large portion of sex offenders. Roughly 500 of
25 the inmates incarcerated are charged with sexual

1 offenses. Waymart is considered a specialized
2 facility which was rightly named.
3 We have in addition to mental health
4 cases we also treat drug and alcohol offenders and
5 as you said a large number of sex offenders.
6 Sex offenders at Waymart -- and
7 keep in mind Waymart is a Custody Level 2
8 institution -- are involved in treatment programs,
9 involved in the daily operation in the prison.
10 They work, participate in programs, activities
11 like all of the other inmates.
12 They also -- something that a lot of
13 people wouldn't realize is that they are confined
14 in dormitories. We have a good deal of control in
15 a dormitory setting because of the presence of the
16 correction officer unit, monitor unit.
17 We do not have -- I would be foolish
18 to say there is no elicit sexual activity in the
19 Waymart area or institution. However, I think in
20 our institution we have good control over that if
21 only by the physical layout of the institution or
22 surveillance of our staff.
23 We also because of our management
24 philosophy have unit teams on every unit including
25 the specialized sex offender unit. We have unit

1 teams present on the unit. We again have an awful
2 lot of inmate-staff contact.
3 So I would say at Waymart we have
4 very little sexual activity and would be
5 considered -- or activity brought from the street
6 into the institution.
7 CHAIRMAN BIRMELIN: Dr. Maue, let's
8 make an assumption that what was said earlier by
9 some of the other previous panels that sexual
10 activity does occur in this population and to some
11 extent is common knowledge or common practice.
12 You can attribute the word common to
13 whatever fashion you wish to attribute it. Does
14 the DOC -- and I'm not sure to what extent you
15 screen people when they enter.
16 Does the DOC have a system in place
17 to determine whether or not or what prisoners have
18 sexually transmitted diseases when they enter your
19 ranks as opposed to when they are on their way out
20 the door so that you can track how much of an
21 approximate problem sexually transmitted diseases
22 are in the prisons themselves?
23 MR. MAUE: We just began a tracking
24 process within the last few months entering
25 inmates with sexually transmitted diseases and

1 then how many new inmates develop those while they
2 are in prison. I don't have that statistic here
3 with me right now, but I can certainly supply them
4 to you.
5 CHAIRMAN BIRMELIN: I would
6 appreciate that. One last question. One of the
7 previous witnesses testified that she thought
8 condoms ought to be distributed in the prison
9 system. Do you have an opinion on that
10 recommendation?
11 MR. MAUE: My opinion in general is
12 that condoms always prevent the spread of disease
13 if people are engaging in sexual activity. There
14 is no way for us to measure.
15 (Announcement: Standing count.)
16 CHAIRMAN BIRMELIN: It is not
17 necessary for those of you here to stand. We're
18 not going to count you. I'm sorry for that
19 interruption. Go ahead.
20 MR. MAUE: There is no way for us to
21 measure exactly how much sexual activity is
22 occurring in prison.
23 The decision on whether condoms would
24 be distributed would have to be made between our
25 corrections leaders as well as the medical

1 department working on making a decision on that.
2 We can certainly address that question.
3 CHAIRMAN BIRMELIN: I'm sorry. That
4 did not pick up.
5 MR. MAUE: I said I can certainly
6 address that question in the future, whether or
7 not it should be considered. But we have no clear
8 policy answer on that right now.
9 CHAIRMAN BIRMELIN: I was asking for
10 your personal opinion.
11 MR. MAUE: My personal opinion is
12 that condoms would help to prevent the spread of
13 sexually transmitted diseases. And if in fact we
14 assume that some sexual activity is occurring in
15 prison, then condoms would help to prevent it.
16 CHAIRMAN BIRMELIN: Thank you.
17 Representative Manderino.
18 REPRESENTATIVE MANDERINO: The
19 figure in that testimony, 2.7 percent of the
20 population identified with mental illness, how is
21 that being defined? I just wondered how that is
22 defined. Is that defined by people who are
23 prescribed psychotropic drugs?
24 Is that defined by people who have
25 identified psychosis or other -- give me some

1 background.

2 MR. COUTURIER: We have a brochure

3 that provides the Department's definition of

4 serious mental illness. The definition which the

5 Department came to in following the indications,

6 it is basically described as a substantial

7 disorder of thought, mood, impairs judgment,

8 behavior, capacity to recognize reality and cope

9 with life.

10 And so essentially it is an -- it is

11 basically a different problem with the mind in

12 which basically reduces their capacity to be able

13 to cope with the institution. We haven't

14 specifically identified that with a particular

15 diagnosis.

16 REPRESENTATIVE MANDERINO: That's the

17 definition of 3.1 percent of the population.

18 MR. COUTURIER: Right.

19 REPRESENTATIVE MANDERINO: And then

20 the 13.7 percent --

21 MR. COUTURIER: The 13.7 percent are

22 those individuals who are followed by our mental

23 health staff. Each of these individuals have an

24 individual treatment plan.

25 They are in treatment. Many of them

1 are on psychotropic medications, and those are
2 actually the individuals who we track.
3 REPRESENTATIVE MANDERINO: I guess my
4 last question Representative Birmelin picked up on
5 some of it.
6 But there was a lot of -- at least a
7 number of different people testified with regard
8 to health care and suggestions or comments about
9 what we could be doing better with regard to from
10 a public health point of view and also which I
11 guess you commented on a little bit.
12 If anybody has any additional
13 comments, I would be interested in hearing them
14 and also the concerns expressed with regard to the
15 delivery of medications, medical interruptions,
16 and/or ability to get medications in a restricted
17 housing unit.
18 So if anybody has any comments that
19 they would like to make with regard to what we
20 heard, I would be interested in hearing it. Thank
21 you.
22 MR. MAUE: On the issue of -- the
23 second part, the issue of medications, medications
24 are delivered on a daily basis to the restrictive
25 housing unit.

1 On the issue of interruptions for I
2 believe it was -- the issue was HIV there, I
3 believe. Listening to that comes as a surprise to
4 me, and it is an issue with our vendors. As they
5 will testify, they represent the pharmaceutical
6 companies.
7 Most medications are interrupted
8 because the inmate elects to stop. It is
9 delivered daily by the pharmacy, and it is
10 available daily to be distributed to the inmate.
11 And we have very few interruptions of
12 that. It is coming from the pharmaceutical
13 company and then being administered by the nurses.
14 So I think that is a question -- a valid question.
15 If there are interruptions, we
16 certainly will investigate that more thoroughly.
17 We are not aware of that being a big problem right
18 now.
19 On the issue of linkage, Cathy, would
20 you like to talk about linkage, linkage to the
21 community?
22 MS. MCVEY: That is something that we
23 are very much committed to work with in the coming
24 area to improve. We recognize the issue, how very
25 important it is for continuity of care. We work

1 right now with Thom Rogosky and his staff as
2 inmates are transferred to the community
3 correctional centers.
4 We also feel a very strong obligation
5 to work with those inmates who go directly home to
6 the community.
7 Our limitations in successful linkage
8 is the limitations of the community to offer that
9 reciprocal care upon release. One of the things
10 we're working on to strengthen our linkage is a
11 task force.
12 And we will be meeting with the task
13 force in the coming month of May. And we put as
14 one of our priorities in the coming 18-month
15 period in the institution plan is to look at case
16 management and identify how best to work prior to
17 the inmate's release and prepare them through
18 self-education to working with the Parole Board
19 and referral to various community health
20 organizations. And we know we can do this, and we
21 need to continue to do a better job with it.
22 REPRESENTATIVE MANDERINO: One other
23 question with regard to distribution of
24 medication. I think this was mentioned with an
25 example used as one of the two women's prisons. I

1 don't know if that is the only place that it
2 happened.
3 But there was a concern raised about
4 the method, manner in which HIV-related drugs were
5 being distributed. And instead of being able to
6 get them kind of -- I don't know what the inside
7 terminology you use is.
8 But instead of being able to get them
9 distributed to you where you can take them when
10 everybody else is taking their medicine, you stand
11 in line and you had to stand in line and it was an
12 AIDS only line. And I'd like to hear some comment
13 about that.
14 MR. MAUE: The issues of HIV
15 medication, Hepatitis C medication, psychotropic
16 medication are received with direct observation
17 where the nurses are observing them taking it
18 either in the infirmary or cell block in which
19 they live or special needs units or whether they
20 should be allowed to obtain those prescriptions on
21 their own and receive a 30-day blister pack of
22 medication.
23 This is a real debate going on in the
24 correctional institute right now, as to which way
25 to allow it. We have a DOC task force studying

1 this issue very carefully right now. We have
2 piloted programs in several of our prisons with
3 some exceptions.
4 We allow certain inmates to continue
5 to house some of the medications. Those inmates
6 have been very compliant and are very stable. We
7 allow nighttime doses in their cells rather than
8 having to openly stand in a special med. line.
9 And the other thing is that it is not
10 just HIV patients that are coming for drug
11 observation. It is other diseases as well.
12 So when they come to the infirmary,
13 there are other patients with other diseases and
14 they do not know whether they are an HIV patient
15 or any other type of disease patient.
16 REPRESENTATIVE MANDERINO: So the
17 separate kind of fourth call of the day is the
18 AIDS call is not protocol as far as you know?
19 MR. MAUE: No, it is not. It is
20 being piloted in the prisons in different ways.
21 One more response to your previous question about
22 medications being interrupted.
23 We have an active quality improvement
24 program that monitors medication errors a month.
25 It is a new program we started about six months

1 ago where we monitor pharmacy errors and also
2 errors by nursing staff giving medications to
3 inmates.
4 We have -- we have put that process
5 in place. Our medication errors have gone down
6 dramatically. It is about 2 out of 10,000
7 medication doses that are administrated right now
8 are occurring with an error. And that process
9 will continue. We thought that was vitally
10 important to monitor whether proper medication is
11 being given to inmates.
12 And sometimes mistakes are made. We
13 have not made any mistakes where recent -- in the
14 last year where an inmate received the wrong
15 medication and felt they had a health problem with
16 it.
17 REPRESENTATIVE MANDERINO: Thank you,
18 Mr. Chairman.
19 CHAIRMAN BIRMELIN: I want to thank
20 you folks for your testimony today. Thank you
21 very much.
22 The next panel we have scheduled is
23 Dr. Bob Greifinger; Glen Jeffes, CPS/PHS Health
24 Systems; and Regis Dorsch, another man from PHS
25 Health Systems. I'll ask you to introduce

1 yourself and who you are associated with.

2 MR. GREIFINGER: I'm an independent

3 consultant. I'm a physician. I worked in

4 correctional health care for quite a long time

5 among other things.

6 I worked with quality medical care in

7 prisons and jails, worked in several jurisdictions

8 for federal judges, and am a principal

9 investigator in a justice department funding

10 project which is regularly reported to Congress

11 that will be out in a few weeks making

12 recommendations on the state of medical care for

13 inmates.

14 CHAIRMAN BIRMELIN: Thank you very

15 much. Would the other gentlemen please identify

16 yourself?

17 MR. JEFFES: Glen Jeffes with CPS

18 Health Systems.

19 MR. DORSCH: My name is Regis Dorsch.

20 I'm an Executive Vice President of Prison Health

21 Systems.

22 MR. HALLORAN: Kevin Halloran,

23 President of Wexford Health Systems.

24 CHAIRMAN BIRMELIN: We have before us

25 here written testimony by Jeff Halloran and Mr.

1 Jeffes.

2 MR. JEFFES: Correct.

3 CHAIRMAN BIRMELIN: The other two

4 gentlemen do not have prepared testimony; is that

5 correct? So I think what we will do is we'll ask

6 the two of them that have their testimony to

7 present that and then we'll call on the other two

8 gentlemen. So, Mr. Jeffes, why don't you begin?

9 MR. JEFFES: My name is Glen Jeffes.

10 I represent CPS and PHS. We currently are the

11 health care provider for the Eastern Region in

12 Pennsylvania which involves eight State prisons

13 starting with Waymart in the northeast boundary

14 through SCI Dallas, SCI Frackville, SCI Coal

15 Township, SCI Graterford, and SCI Chester.

16 We have been providing services in

17 the Commonwealth since 1990 and provided services

18 to the eight facilities since 1998 with the

19 awarding of the five-year contract which we

20 currently are in at this time.

21 In lieu of not reading my prepared

22 statement and just hitting some highlights, we

23 provide in seven of the institutions full medical

24 services with the exception of nursing, medical

25 records, and dental.

1 In Chester Prison we provide full
2 services with the exception of dental. Obviously,
3 our position is to provide the same standard of
4 care for inmates that we would expect physicians
5 to provide to their patients in the community.
6 Many of the physicians who work I
7 think for all three providers have private
8 practices, and obviously it does not make sense
9 for a physician to have one standard of care for
10 his patient and go into a prison setting and have
11 another level of care.
12 So from a corporate standpoint, we
13 insist that our physicians provide the same level
14 of care. Having been a Commissioner of
15 Corrections -- the first Commissioner of
16 Corrections for the Department of Corrections
17 under the Thornburgh administration, I think I can
18 speak for both sides, a Superintendent for two
19 State prisons.
20 I've been a consultant since leaving
21 the Department before being employed by CPS, and I
22 can assure this Committee that the level of health
23 care provided for inmates is second to none.
24 Inmates in the Pennsylvania prison
25 system can see a doctor seven days a week. I

1 don't think you could afford to see a physician
2 seven days a week.
3 We have an excellent specialist who
4 comes into the institutions. All our specialists
5 must be board eligible, board certified in the
6 respective medical specialty. And we insist that
7 the care be the same as in the private sector.
8 We meet regularly with the Department
9 of Corrections. Department of Corrections has an
10 excellent management review program. We meet
11 quarterly at each site with the Superintendent of
12 the State's health care program to review any
13 medical problems.
14 We meet quarterly to visit the
15 Department of Corrections at the Department level
16 to be sure that correctional health care is being
17 provided.
18 In order for this program to succeed,
19 there has to be a collaborative effort between the
20 private sector and corrections. In Pennsylvania,
21 in my opinion this is happening.
22 And I would just close by stating
23 that our cooperation is dependant upon their
24 corroboration with the agency. And that I think
25 is occurring. And I'd be willing to respond to

1 any questions at this time.

2 CHAIRMAN BIRMELIN: Mr. Halloran,

3 would you present your testimony at this point?

4 MR. HALLORAN: Thank you. I wasn't

5 really too sure exactly what to prepare. So bear

6 with me. I'll give you a quick overview of one of

7 the providers.

8 Wexford Health is one of the

9 providers of the Department of Corrections. A

10 little bit about what we've done within the past

11 three years.

12 Wexford Health Systems became

13 competitive in prisons in 1992. Corporate offices

14 are located in Pittsburgh, Pennsylvania. We have

15 over seven years experience providing in-depth,

16 competent medical, mental health services to

17 correctional facilities.

18 Management, including myself, have

19 many -- over 30 years in health care

20 administration in medical health care service

21 delivery. Currently the company is providing

22 contracted medical services for over 65,000

23 inmates nationwide.

24 We are the holder of the contract for

25 the Central Region of Pennsylvania which is about

1 12,500 inmates and the largest provider of the
2 State of Illinois with over 23,000 inmates. And
3 we currently have a contract with the State of New
4 York approaching 20,000 inmates plus many other
5 facilities across several other states.
6 All our accredited clients -- pardon
7 me. For those seeking first time accreditation or
8 have had that goal satisfied by Wexford, we have
9 never lost an accreditation when seeking first
10 time accreditation. We've always been able to
11 come through for our clients.
12 Wexford's program is designed to
13 comply with the joint commission on the
14 accreditation of health care organizations, the
15 National Commission on Correction and Health Care
16 and the American Correctional Association
17 Standards for Medical Services in Jails and
18 Prisons.
19 Wexford provides comprehensive health
20 care programs that meet or exceed all federal,
21 state, and institutional requirements as well as
22 meet all applicable health care standards.
23 When requested, Wexford has
24 successfully obtained or maintained accreditation
25 with all of its clients throughout the country.

1 Our Pennsylvania contract began September 22,
2 1996. We are currently in the fourth year of the
3 five-year engagement.
4 During that period of time I think
5 that we have made several strides in cooperation
6 with the Department's staff in helping to bring
7 quality medicine and cost effectiveness to the
8 inmates and patients of our Department.
9 Wexford introduced the concept of
10 tele-medicine to the Department in 1996 through
11 the RFP proposal process.
12 Our pilot program was for one year
13 conducted at the Smithfield correctional facility
14 along with the University of Pittsburgh and
15 Western Psychiatric Hospital of Pittsburgh.
16 During that year, the program proved
17 to be very successful, very cost-effective, and
18 very high quality service.
19 Today we currently are completing
20 installation of a state of the art tele-medicine
21 system to all of the remaining sites in the
22 central region.
23 Wexford is underwriting the cost of
24 the equipment. We expect the installation to be
25 complete within 60 days. Once fully implemented,

1 we believe that not only savings will be great, we
2 think the opportunity for continued quality of
3 care will be assured with many medical sessions.
4 In another effort to help the
5 Department reduce costs and increase efficiency in
6 medical service, Wexford has arranged for dialysis
7 treatments to be done at the Muncy facility. It
8 will be done on-site at Muncy.
9 Previously inmates had to be
10 transported off-site as many as three times a week
11 for these services.
12 A typical dialysis patient may not
13 feel really good moving in and out of the
14 institution three times a week on transportation.
15 This has been a great aid not only to the patient
16 but also to the institution.
17 The treatment of HIV AIDS is very
18 expensive as has been noted a little bit earlier.
19 Through investigation, regulations, and
20 cooperation of our pharmacy supplier and in
21 conjunction with the cooperation of the Department
22 of Corrections, we have been able to institute a
23 medical -- a medication management program.
24 We estimate the savings to the
25 Department in upwards of $67,000 a month through a

1 re-labeling procedure. This procedure allows us
2 never to have a problem with the availability of
3 drugs for HIV patients.
4 There are always drugs on hand. And
5 with a simple phone call if a patient's drugs do
6 run out on its original prescription, a simple
7 phone call to our physician can immediately make
8 those drugs available if they are not in stock.
9 Wexford utilizes a very sophisticated
10 utilization management program for all off-site
11 medical care. This is the heart of the
12 organization.
13 The medical utilization management
14 program ensures timely access to care for all
15 patients is equal. It also makes sure that the
16 most appropriate, necessary care is rendered.
17 As part of the program, we can from
18 the utilization management office also offer the
19 on-site physician additional suggestions and ideas
20 for alternative care that seems appropriate.
21 The same department goes through a
22 retrospective review process to validate not only
23 the necessity for the care that has already been
24 given but it also validates the quality and the
25 cost-effectiveness of that care.

1 Our program not only monitors all
2 off-site medical care for costs but also for
3 quality. All requests for medical care outside of
4 the facility goes through the UM system. This
5 assures timely, appropriate, required medical care
6 is what the patient receives.
7 Wexford has and will continue to work
8 with the Department on all medical issues;
9 Hepatitis C, medical therapy intervention,
10 implementation and direct observation therapy,
11 medication for medication administration if that
12 program proves to be what the Department is going
13 to be supporting, the expansion of tele-medicine
14 services are a few of the current ongoing programs
15 and projects that are being developed and/or
16 implemented in cooperation and partnership between
17 Wexford and the Department of Corrections.
18 In closing, you should know what our
19 goals have been since the beginning. One, to
20 assure access to and quality of medical services
21 for all patients.
22 Two, to assure medical expense
23 management on behalf of Wexford and the Department
24 of Corrections. And, thirdly, the maintenance of
25 a cooperative partnership with the Department of

1 Corrections. Thank you very much.

2 CHAIRMAN BIRMELIN: I think the

3 testimony was improperly labeled by putting Mr.

4 Halloran's name on it. I apologize for thinking

5 that you didn't have yours, but you do.

6 I notice this one says Wexford and

7 that leaves you to have the third -- two-thirds of

8 the state covered. And I see you have the other

9 third. So you may begin.

10 MR. DORSCH: My name is Regis Dorsch.

11 I am the Executive Vice President of Operation,

12 Prison Health Services. Again, as my counterpart,

13 I was unsure what to bring with me today other

14 than what I have written before you.

15 I'm not going to read what you have

16 in front of you. I would like to kind of refer

17 back on what Mr. Jeffes said, and I'll be glad to

18 submit our marketing brochure to all of you once

19 we are finished. It says a lot of nice things.

20 I'm sure you guys have a lot of

21 questions, and I'm going to leave some time for

22 that. I'm just going to add, some of the things I

23 heard I felt good about today and some things

24 alarm me.

25 And I think to hash out some of the

1 testimony I've heard today, first of all, I think
2 Glen spoke well in terms of what we try to do in
3 conjunction with the Bureau of Health Care
4 Services.
5 And since I was formerly Regional
6 Vice President of the Western Region before I got
7 promoted, I was interested with that contract for
8 over five years.
9 And I just want to commend -- take
10 this time to commend Cathy McVey, Dr. Maue, and
11 his team. It's been the most communicative
12 client that I've ever been associated with. They
13 have a progressive thought process.
14 I think they are probably -- they are
15 certainly ahead of most states that I have been in
16 and had the opportunity to work with.
17 The fact that you know they have this
18 geriatric community is just one example of how the
19 Pennsylvania Department of Corrections has had a
20 lot of forethought into what is really happening
21 up there.
22 Do we make mistakes? Yeah, we do.
23 But I think there are systems in place and have
24 been in place for a quality improvement system
25 where once we were aware of them, there is a

1 method to improve and make sure they don't happen
2 again or don't happen as much.
3 Finally, there was a lot of testimony
4 about for-profit. And PHS is a public trade
5 company. Our financials are available through
6 NASDAQ and it is just as -- and I don't have my
7 financials here with me today or I would give them
8 to you, the earnings.
9 But let me just tell you what your
10 tax dollars goes into in terms of our company.
11 For every dollar that we receive, 90 cents of that
12 dollar is spent on medical care.
13 If you would like, I'll break that
14 down further. Four and a half cents is spent on
15 what is called ACO, Administrative Corporate
16 Overhead. Which leaves 5.5 cents profit before
17 taxes. And again you can verify those numbers if
18 you would like.
19 I just don't feel like I want to be
20 ashamed or embarrassed about a 5.5 percent profit
21 prior to 40 percent federal taxes. And with that,
22 I'll answer questions.
23 CHAIRMAN BIRMELIN: Dr. Greifinger.
24 MR. GREIFINGER: Mr. Chairman and
25 Committee members, I appreciate the opportunity to

1 testify today.
2 In 1995 when Secretary Horn took this
3 position, he got several things that he didn't
4 expect. He became a substitute Defendant in a
5 case called Austin and became a substitute in a
6 class action called Tillary.
7 Both of those lawsuits which have
8 been longstanding have been settled through a
9 court order because the federal courts had found
10 deliberate indifference to serious medical needs
11 for the inmates of the custody of the State
12 Department of Corrections.
13 And he called me soon after he got to
14 his position, hey, could you come and take a look
15 and tell me if we're in compliance with the court
16 orders or not. And I did and I came and I found
17 the medical care was very disorganized, no real
18 system of medical care.
19 There was a loose federation if you
20 will of prisons providing medical care and was
21 certainly not in compliance with these court
22 orders in these class action suits.
23 There was a very high degree of
24 variation in the quality of care for communicable
25 disease, mental illness, and with dental disease.

1 Secretary Horn asked me to sit with
2 him and do some strategic thinking, not just to
3 get out from under the duress of these court
4 orders but to develop an infrastructure for
5 medical care that would make sense.
6 Operating under the assumption that
7 there are very high rates of serious disease and
8 mental illness among prison inmates certainly in
9 Pennsylvania, that inmates with communicable
10 disease who are untreated are released into the
11 community may transmit these conditions to members
12 of the public at large.
13 With the knowledge that releasing
14 inmates with untreated serious chronic disease and
15 mental illness creates a burden on the community
16 in terms of strains on resources, community
17 resources certainly was a financial burden to the
18 local community's public health system.
19 Secretary Horn decided that he wanted
20 to seize the opportunity for establishing better
21 disease control in the community by providing good
22 health care to inmates while they are
23 incarcerated.
24 So he began to build a system. In
25 order to do that he had to get control. First bit

1 of control was beginning to measure -- if you
2 can't measure things, you can't manage them. That
3 is a basis of any business that operates or tends
4 to operate at a premium level of profit.
5 He began to place a system of
6 performance measurement, quality measurement,
7 clinical documents. Most of those you can see
8 here in the documents that were handed out to you.
9 Some of the performance measurement
10 was displayed over time. In health care, clinical
11 guidelines like the ones that is demonstrated for
12 you with Hepatitis C.
13 And let me just add to this issue the
14 fact that Hep. C which came up before -- while
15 the prevalence of Hep. C is very, very high, in
16 prisons across the United States, the
17 recommendations of the expert panels to
18 Congress -- the report that will be out in a few
19 weeks -- there will not be a recommendation for
20 widespread submitting for Hepatitis C because of
21 the tremendous controversy over the ability of the
22 existing treatments to improve survival.
23 It is very, very controversial.
24 There are arguments on both sides but still not
25 enough evidence. There is no evidence basis the

1 way that there is for sexually transmitted disease
2 or TB and HIV that screening would lead to
3 improved survival or better quality of life.
4 So the Department began to
5 standardize for these kinds of folks. I think we
6 can attest to how in the beginning four and five
7 years ago it was fine, right. We had some fun.
8 It was fun to introduce the cost analysis and have
9 them make sense.
10 In order to do that, Secretary Horn
11 had to provide leadership. He was able to engage
12 Fred Maue who you heard and Catherine McVey, two
13 of the right people to help incorporate this
14 public health and correctional responsibility in
15 the changing cost-effective integrity to the
16 system so it doesn't become a burden to taxpayers.
17 In the end, immediately to use the
18 day-to-day data from the performance measures,
19 quality assurance program to improve the care.
20 And in addition to that, they began to remove some
21 of the various special logistical areas.
22 Areas that everyone has in prison
23 systems across the United States. It is very
24 complicated, very difficult to get prescribed
25 doses of medication to each and every inmate at

1 the right time and facility.
2 It is difficult to get long-term care
3 to inmates who may be physically compromised or
4 otherwise compromised so they are in a long-term
5 facility like Laurel Highlands where they will
6 receive skilled care, lower levels of care.
7 It is very hard to get effective
8 mental health treatment to the most seriously
9 mentally ill, and they do this at Fargo State
10 Hospital which is incorporated in the hospital at
11 SCI Waymart. And it is very effective.
12 And because it is very hard to get,
13 particularly in some specialties, a consultation
14 to the inmate at the right time, they develop
15 programs like tele-medicine.
16 So they have done I think a very,
17 very effective job in reducing the logistical
18 barriers and reconciling the health care needs of
19 limited resources that they had.
20 And in fact, I think you have some
21 data before you that shows that per capita
22 increases in health care costs have been in low
23 single digits, 1 to 3 percent, during the last
24 several years.
25 If you just compare that to your

1 health insurance premiums for yourself and your
2 family, you will know that they are really doing a
3 remarkable job.
4 So in summary, my assessment is that
5 I am very impressed with the progress they have
6 made in five short years. They have a good solid
7 system.
8 They have an infrastructure that is
9 soundly based. They meet constitutional
10 requirements in terms of the criteria medical care
11 meets.
12 And I think that their position is to
13 respond to challenges that come up in the future
14 and are able to respond to any errors or any
15 absence in the medical care -- which of course
16 they would always do in any medical care system --
17 I think they are able to respond probably better
18 than almost any other state medical system that I
19 have seen across the country. Thank you.
20 CHAIRMAN BIRMELIN: Thank you for
21 your testimony. Mr. Jeffes, were you here for the
22 two ladies that testified from the Prison Society?
23 MR. JEFFES: Yes.
24 CHAIRMAN BIRMELIN: I assume you
25 heard what she had to say when she told of the

1 incident with one particular prisoner who had a
2 knee injury and then required surgery for an ACL.
3 Were you familiar with that situation or is today
4 the first time that you heard of it?
5 MR. JEFFES: I'm not familiar with
6 that specific case. So I certainly would be glad
7 to look into it with the Bureau of Health Care
8 Services with any documents that --
9 CHAIRMAN BIRMELIN: I don't
10 necessarily mean you need to announce it right
11 here. But my question is -- from a common sense
12 point of view that is where I'm coming from.
13 Since I'm not a medical health
14 professional, it would seem to me even if the --
15 if there were some delay originally in attending
16 to this particular prisoner's physical need, 18
17 months I believe it was for surgery seemed
18 inordinately long.
19 And I'm wondering why under your
20 health care system -- I'm assuming you had
21 Chester.
22 MR. JEFFES: We've had Chester since
23 opening April of 1998.
24 CHAIRMAN BIRMELIN: Service to your
25 system dealing with this.

1 MR. JEFFES: It was our system that
2 would provide or did provide the health care, yes.
3 CHAIRMAN BIRMELIN: And in your
4 estimation, why would it have taken as long as
5 that for surgery to be provided?
6 MR. JEFFES: I can't answer that
7 without looking at the medical records. Not being
8 a medical person, I agree with you that 18 months
9 seems to be an inordinate amount of time.
10 But without looking at the medical
11 records and having a physician review exactly what
12 happened in the case which should be done, I can't
13 answer. And I'll be glad to get that information
14 for you.
15 CHAIRMAN BIRMELIN: Let's talk not
16 necessarily this specific case but in general
17 about services being provided to prisoners.
18 Do you have an internal system in
19 your own agencies that can prevent that from
20 happening? In most cases if you came to the
21 conclusion that this was way beyond the normal
22 limits and that actually should be changed?
23 In other words, can this happen over
24 and over again without anyone picking up on it and
25 being able to prevent it from happening again?

1 MR. JEFFES: No, it should not. It
2 should not happen. We have -- as mentioned by
3 Wexford, we have a strong utilization review
4 program.
5 In each of our prisons we have a
6 full-time medical director and he is the --
7 basically the health care foreman and he can
8 approve whatever tests or follow-up that he thinks
9 needs to be done in the case.
10 If we need the referral in this case
11 of maybe an orthopod, those services are available
12 to him and we expect him to use them.
13 So in terms of the delay without
14 looking at the case and without knowing all of the
15 specifics, I can't give you, you know, a definite
16 answer. But there is a system. There is systems
17 in place. And I'm sure that inmates who need
18 appropriate medical care receive it.
19 CHAIRMAN BIRMELIN: I'm not
20 suggesting that these types of situations occur on
21 a regular basis. I don't know if they do. I
22 don't have that experience.
23 But it just seemed like in that
24 particular case somewhere something failed. An
25 incident of this sort should have been attended to

1 much quicker than 18 months.

2 MR. JEFFES: You may well be correct.

3 I will go back and research the case and provide

4 your office with a follow-up response.

5 CHAIRMAN BIRMELIN: Thank you. Do

6 any of the members have any questions?

7 Representative Manderino.

8 REPRESENTATIVE MANDERINO: Very

9 briefly just following up on that question. You

10 referred to a medical director at each

11 institution. Is the medical director at each

12 institution your employee or a DOC employee?

13 MR. JEFFES: The medical director at

14 each site is an employee of the correctional

15 facility, Prison Health Services.

16 REPRESENTATIVE MANDERINO: I realize

17 that is who all of you gentlemen represent,

18 different aspects of people -- the services that

19 have contracts. Is there a -- you would know. Is

20 there a medical director that is a DOC employee?

21 MR. JEFFES: Yes.

22 REPRESENTATIVE MANDERINO: And that

23 is one for the whole system?

24 MR. JEFFES: And I think there is an

25 assistant doctor. I think they have two medical

1 doctors at the Department level that respond and
2 act as our counterparts in the field if our
3 medical directors have questions.
4 We employ also a regional medical
5 director or regional medical director who our site
6 medical director reports to. Then we also use
7 both Dr. Maue and Dr. Shapiro as resources if
8 there are questions they have regarding the
9 delivery of medical services at any particular
10 site.
11 REPRESENTATIVE MANDERINO: With
12 regard to a medical decision regarding an
13 individual inmate, who has the final determination
14 about the delivery of not the whole system but the
15 delivery of health care to a particular inmate?
16 And if it depends, tell me what the
17 factors are that make it depend on who is
18 making -- who has the final say.
19 MR. DORSCH: It is consistent through
20 all three. I would say in the physician delivery
21 system, I would say probably 98 percent of those
22 decisions are made by the medical director
23 on-site.
24 Consults for off-site services such
25 as when an inmate is sent to a regional medical

1 director that day, if he -- if he decides that
2 there is an alternative plan, it could be
3 approved.
4 However, if the doctor on-site says,
5 no, that is not the way I still want to do it,
6 they have -- really have the final authority and
7 things are scheduled.
8 There is also a corporate entity and
9 they use standards. And the doctor may be so
10 far -- and I'm not a doctor. There is a standard.
11 MR. JEFFES: I think you may not want
12 this much detail. But basically there are two
13 kinds of decisions.
14 One is a benefit decision where it
15 states this is a covered service. Say in -- for
16 those of us who have health insurance, there is a
17 medical appropriateness decision.
18 So the benefit decision, for example,
19 would be someone doesn't like the way their nose
20 is shaped. They want the shape changed. The
21 function is fine.
22 The benefit decision would be, no, we
23 don't do that. Prison system in Pennsylvania does
24 not do cosmetic surgery in that sense.
25 But if it is a medical

1 appropriateness decision, each of the directors
2 here uses nationally accepted criteria for making
3 those decisions.
4 And they have corporate medical
5 staff, physicians who help go through those
6 criteria to help the physician in the facility
7 decide if it is medically appropriate or not. If
8 it is a medical procedure that is appropriate,
9 then it would not be refused.
10 REPRESENTATIVE MANDERINO: Let me
11 just give a hypothetical using the example we
12 heard earlier. I'm not stating that this is what
13 happened in this case, but that is what raised my
14 question.
15 Somebody has an injury within the
16 prison and it is determined that outside services
17 are needed, whether it is outside services for an
18 MRI or outside services for an actual surgical
19 repair procedure.
20 Who approves the going outside to get
21 the MRI or not going outside to get the MRI and
22 who signs off on the final decision of getting the
23 surgery at the local hospital or not getting
24 surgery at the local hospital?
25 MR. JEFFES: I believe Dr. Greifinger

1 stated that 99 percent of that rests with the site
2 medical director. At each of our prisons we have
3 a contract with a local hospital. For example,
4 Chester we use Chester Community.
5 So when that inmate is sent out to a
6 specialist whatever that specialist is, whatever
7 his recommendations are, generally they come back
8 to the site medical director.
9 Depending on what those
10 recommendations are, in theory they may be
11 reviewed at the regional or corporate level with
12 the medical staff to ensure those fall within the
13 national acceptable guidelines. And then the
14 decision is made. If surgery is required, it is
15 approved and provided.
16 REPRESENTATIVE MANDERINO: Again, I
17 realize these are all questions since I assume you
18 have a standard or very similar contracts. So
19 whoever wants to take it has a shot. But my
20 question has to do with the money and the
21 contracts.
22 As health plans, you've negotiated
23 your contract with the Department of Corrections
24 based -- what, based on a per capita reimbursement
25 system?

1 And then all services needed to
2 provide for the population on which that contract
3 is negotiated as part of what you provide for that
4 flat contract fee if that is how it works or if it
5 is not, tell me otherwise.
6 And then are prescriptions and
7 medical devices and equipment add-ons included in
8 your contract price?
9 MR. HALLORAN: It is just one
10 capitated rate.
11 REPRESENTATIVE MANDERINO: So even
12 for prescriptions and medical. Okay. Do each of
13 your systems have in place a monitoring system
14 whereby you can look at either by an institution
15 or by an inmate -- I don't know which way you keep
16 that.
17 But you can look at information and
18 know and see the level of service being provided?
19 For example, in the case that we heard about the
20 alleged reuse of a catheter that is disposable or
21 maybe somebody with an insulin injection where it
22 is a disposable thing, can you look in your
23 system's files over the -- however you track these
24 and say we can tell there is an appropriate
25 utilization of the medical equipment that is

1 necessary to support the condition that we know we
2 are treating?
3 Or can we pick up and check in fact
4 if somebody who has to use a catheter would use it
5 more than once a day and has only utilized 150
6 over the course of a year? Are systems in place
7 to analyze that information?
8 MR. HALLORAN: Okay. I'll give it a
9 shot. The answer is our system is in place, but
10 it wouldn't come through the accounting
11 department. It could come from on-site management
12 and regional supervision. That is where it comes
13 from.
14 The quality assurance programs,
15 quality improvement programs, and your
16 retrospective review programs. We go back and
17 look at how did we treat these patients at this
18 time for things. Sample reviews, you have
19 committees, and you report and then say, look, we
20 think we can make some changes in this area by
21 handling this procedure or policy or method of
22 service.
23 Now we're going to go back and fix
24 that; or if we find it is working very well, we
25 are going to continue it. But through accounting

1 function you would never find catheters or
2 determine if they are being reused.
3 REPRESENTATIVE MANDERINO: Then I
4 think my only follow-up question would be to each
5 of you within how you administer each of your
6 health systems. Would there be -- reuse of
7 catheters, assuming what we heard today was true,
8 would that be appropriate medical procedure?
9 MR. HALLORAN: That certainly would
10 not. Quite frankly, the question begs a broader
11 answer and that is what are we about.
12 Well, you're looking at the three
13 largest companies in the United States sitting
14 before you. PHS -- I'm sorry. At least two, at
15 least two of the largest companies in the United
16 States who are professional medical managers in
17 the business of servicing government, whether it
18 be the Commonwealth of Pennsylvania through the
19 Department of Corrections, State of New York,
20 State of New Jersey. We are all over the country.
21 Our reputations are golden. Our
22 reputations are based on quality medical services
23 being delivered. We can't afford to reuse
24 catheters. We can't afford to reuse insulin
25 needles. We can only afford to offer the highest

1 quality care.

2 We are for-profit but we are in a
3 very competitive industry. And so our name, our
4 reputation, and the first inkling of poor quality
5 would crater the company in this business. This
6 is a very small, unique -- very small part of the
7 overall health care system in the United States
8 and one of the most difficult.

9 The level of communication that was
10 indicated a few moments ago between the vendor
11 servicing the Commonwealth and for the Department
12 of Corrections is one of the highest level of
13 communications that we're involved in.

14 The oversight and checking and
15 questioning back and forth whether it be treatment
16 of an individual's treatment who has requested
17 treatment and was denied and the vendor filed a
18 denial and was accurate. These things get
19 reviewed if they come up.

20 We have no interest in withholding
21 care or giving cheap care. Because in the end,
22 the only thing that is going to make health care
23 effective is the tremendous partnership,
24 cooperation between the vendor and the
25 Commonwealth. And quality service is the goal.

1 Otherwise, we would last about six months.

2 REPRESENTATIVE MANDERINO: Thank you.

3 Thank you, Mr. Chairman.

4 CHAIRMAN BIRMELIN: Thank you,

5 gentlemen.

6 MR. JEFFES: I just wanted to second

7 those comments. And one of the things that under

8 Secretary Horn's leadership and along with health

9 care services is a very intensive review program

10 with vendors where the Department and each prison

11 has a management review team from other prisons.

12 And frankly, there is a no holds barred situation.

13 You spend two days doing critical

14 review of the entire medical delivery system

15 starting with medical records and medication and

16 the whole nine yards.

17 Of course, that is one of the

18 management tools that we work with to ensure that

19 quality of health care stays at the highest level

20 possible.

21 CHAIRMAN BIRMELIN: Thank you,

22 gentlemen, for your testimony. I appreciate you

23 being here today.

24 Next we have one testifier who is the

25 Executive Director of the National Alliance for

1 the Mentally Ill. If you would, come forward
2 please.
3 MR. DINICH: Thank you, Mr. Chairman,
4 members of the Committee. It is terrific being
5 here all though not necessarily at this late hour
6 as it goes on. So I will be tremendously brief.
7 First of all, this is unusual for us
8 to be here. This is the first time. Normally we
9 would testify with those committees that would
10 work with the Office of Mental Health and the
11 Office of Mental Health and Substance Abuse.
12 But in 1997 here in the Commonwealth,
13 a change took place and the largest institutions
14 for people that have mental illness transferred
15 from being in our State mental hospitals to our
16 State prisons.
17 So it is with that that we come
18 together and started a relationship with the
19 Department of Corrections.
20 Those of you who may not know, we are
21 a membership organization. We have about 7,500
22 members throughout Pennsylvania, most of them
23 family members who have someone close that has a
24 serious mental illness.
25 And as we define serious mental

1 illness, we're talking about schizophrenia or
2 bipolar disorder which had been called manic
3 depression or major clinical depression. And that
4 is our term for serious mental illness.
5 And as I said, with the institutions
6 within the State prisons as I believe you already
7 know, the increase in the number of people in
8 prison mirrors the increase with the number of
9 people in prison that have a serious mental
10 illness.
11 The statistics -- the federal
12 statistics do talk about 16 percent of the
13 population across the country having a serious
14 mental illness. Here in Pennsylvania past
15 statistics from the Department of Corrections talk
16 about 20 percent, now 14 or 15 percent.
17 In any case it is, oh, 5-, 6,000
18 people that have serious mental illness. It was
19 in 1996 that we first went to Secretary Horn to
20 talk and begin a dialogue and begin a
21 conversation.
22 At that time, we started what we're
23 calling the forensic inner agency task force. And
24 I think it is a tremendous example of good
25 government.

1 We've brought together people from
2 the Department of Corrections, from Pennsylvania
3 Probation and Parole, the Office of Mental Health
4 and Substance Abuse, the Department of Health
5 because the issue as we saw it was not one just of
6 the Department of Corrections.
7 Mr. Chairman, if you were to call
8 someone to testify because you wanted to know what
9 is the status of Pennsylvania of people with
10 mental illness that have intersected with the
11 criminal justice system, you couldn't find that
12 person because he doesn't exist. No one is in
13 charge.
14 The Department of Corrections is
15 doing more and more of an outstanding job and has
16 been providing leadership to this forensic inner
17 agency task force. But what about the people
18 before they get in prison and what about after
19 they are out? It is a community problem that
20 really encompasses all parts, all parts of
21 government.
22 Because we're not dealing with people
23 with mental illness, that is who we wanted to talk
24 about. The other statistic that is very important
25 when Dr. Maue came to the table, we realized that

1 we cannot just do that. That out of ten people in
2 prison that have mental illness, eight or more of
3 them also have drug and alcohol or other kinds of
4 issues.
5 And as a matter of fact, in the past
6 we used to call this a dual diagnosis, people
7 having two different conditions; say depression
8 and alcoholism. Now we're calling it co-occurring
9 disorders because there is a third or fourth
10 issue. And it makes really treatment one of the
11 most difficult groups of people to provide
12 treatment.
13 The Department did open this year and
14 I think I'd like to say due in part by the
15 cooperation with a number of departments in
16 Philadelphia the first program of this type in the
17 country for people coming out of prison with
18 mental illness and a drug or alcohol program.
19 The program is running very well.
20 They are -- part of the reason I think it is
21 running very well is because everyone realized why
22 the Department of Corrections took the leadership
23 and did a great job. Probation and Parole had a
24 role in it. The City of Philadelphia had a role
25 in it.

1 Because there are so many issues that
2 even with the policymakers coming to the table, it
3 took a while to figure out who pays for the case
4 work services if you have a felon that is not
5 eligible to get on medical assistance, things such
6 as this.
7 It is tricky. They did well. It is
8 something that we need to do much more. It was
9 noted earlier another such program is in Allegheny
10 County. I certainly hope that there will be three
11 or four and we'll start taking a look at this at
12 the county level.
13 The number of people at county
14 jails mirror -- with mental illness is the same
15 percentage at our State prisons. That is
16 really -- that really is my testimony.
17 It makes perfect sense to take a look
18 at mental health services in prisons, but that is
19 only one piece of the puzzle. And I'm certainly
20 encouraged by what the Department is doing. And I
21 hope that will continue.
22 CHAIRMAN BIRMELIN: Thank you. I
23 asked if there were any questions and you did such
24 a great job of explaining everything, they didn't
25 have one. Thank you very much for coming.

1 The next panel that we have is a
2 four-member panel based on the contract service
3 providers to the DOC. After they are seated, I
4 will try to introduce them.
5 I think I know who Mary Rose
6 Worthington is, Charles Folks. And that leaves
7 Mr. Harley as the gentleman on the left.
8 Is there one of you that wishes to go
9 first or some sequence that we will follow?
10 MS. WORTHINGTON: I'll go first.
11 CHAIRMAN BIRMELIN: Let me suggest
12 then that Ms. Worthington go and then we'll pass
13 the microphone down in an orderly basis, and Mr.
14 Harley you will get to finish with a bang. I'm
15 sorry, Mr. Roman.
16 MR. HARLEY: Depending on what he
17 says you can call him Mr. Harley.
18 CHAIRMAN BIRMELIN: Okay. Thank you
19 very much. Ms. Worthington, you may proceed.
20 MS. WORTHINGTON: Thank you very
21 much. I would like to begin today by thanking the
22 members of the House Judiciary Committee,
23 Subcommittee on Crimes and Corrections for this
24 opportunity and also to the SCI Chester
25 administration for hosting this public hearing.

1 I do want to comment that I've been
2 very impressed sitting here all afternoon. I'm
3 very impressed with the patience of the Committee
4 and very impressed with the process here -- this
5 is actually the first time that I've had this
6 opportunity -- and also the interest and level of
7 questions.
8 And obviously we have some very
9 serious issues and very good things happening in
10 our State Correctional Institutions.
11 My name is Mary Rose Worthington.
12 I'm Director of Program Services for CiviGenics.
13 In that capacity I'm responsible for all of the
14 drug and alcohol programs that we operate
15 associated with the community corrections
16 contracted facilities in Pennsylvania that we
17 operate as well as the RSAT program at Graterford
18 and soon to be the RSAT program at Somerset.
19 We also have therapeutic communities
20 at SCI Dallas, Berks County Prison, and Chester
21 County Prison.
22 I have had the opportunity over the
23 last 25 years to professionally be directly
24 involved with providing substance abuse services
25 within prisons as well as in the community.

1 And I must say having been around in
2 the early days of therapeutic communities, the
3 level that we're at at this point in terms of the
4 evolution of the TC is actually quite phenomenal.
5 I was very happy and excited to be
6 part of the RSAT program that is occurring right
7 now in Pennsylvania for a number of reasons.
8 Just to refresh your memory because
9 it was talked about earlier this morning -- or
10 this afternoon, that the RSAT program at this
11 point in time, those of us who are doing RSAT are
12 working with the technical parole violators.
13 The length of the program is 18
14 months; 12 months of that is residential meaning
15 there are 6 months spent in the institution
16 therapeutic community and 6 months in community
17 corrections with intensive outpatient substance
18 abuse counseling, and then 6 months under
19 intensive parole supervision with outpatient
20 counseling.
21 Just a brief note about our program,
22 CiviGenics provides a program called the
23 Correctional Recovery Academy. It is a model that
24 we use in our therapeutic communities, in prisons.
25 We have a juvenile version of this

1 program called the Straight Ahead program. It is
2 based on the cognitive behavior model with the
3 basic philosophy of recovery, not just from
4 addiction but also from crime.
5 I do want to mention that -- and I'll
6 talk specifically about the Graterford program.
7 We have been operating the Graterford program
8 since February of 1998. We feel there has been a
9 very positive impact on the community as a result
10 of that model.
11 We have admitted 284 clients with an
12 89 percent completion rate in Phase I and a 62
13 percent completion rate in Phase II. CiviGenics
14 is responsible for the treatment components in
15 Phase I which is this inpatient TC of the jail or
16 prison and the outpatient services -- intensive
17 outpatient services being provided in Phase II
18 community corrections.
19 Typically our clients are technical
20 parole violators who have been in institutions for
21 eight years. They are economically disadvantaged,
22 they are undereducated. They have pretty severe
23 addiction problems.
24 I think one of the things that works
25 so well with the RSAT design by the State is that

1 it is a volunteer program. All of us who manage
2 and run the RSATs run them in a very highly
3 structured manner, all of the folks at this table.
4 It is the kind of program that, as I
5 said to you earlier, has been an evolution in the
6 TCs and the biggest piece of this is the aftercare
7 component.
8 Years ago all we did was do services
9 in the jails. At this point in time, there is an
10 actual treatment transition that occurs between
11 the three phases which in and of itself is very
12 progressive.
13 I think it has shown a lot of vision
14 on the part of the representatives of the
15 Department of Corrections as well as the State
16 Board of Probation and Parole.
17 Now I've been around a long time and
18 I mentioned 25 years. I really -- the cooperation
19 between these two agencies have produced a program
20 that is a good investment for 18 months for a
21 client and also for the State.
22 The idea that we can provide at one
23 sitting folks at the table as were transitioning
24 clients with the first provider and second
25 provider and/or the third provider not only

1 treatment services but the State parole agents are
2 involved and the center staff is involved all
3 sitting together at meetings to process these
4 clients and move them through the system.
5 One of the things that has hurt our
6 system in terms of treating them as clients most
7 recently, of course, is managed care. We're in an
8 era where treating the addicted client under
9 managed care is very difficult.
10 So the fact that the funding for the
11 second phase and third phase of the outpatient
12 treatment is coming from the Department of
13 Corrections and the Board of Probation and Parole
14 is extremely credible and is probably one of the
15 things that makes RSAT so unique in being able to
16 make sure that the clients don't fall through the
17 cracks and get the services that they need.
18 Drug and alcohol clients, criminal
19 justice clients with addictions problems, any
20 interruption in treatment could mean that they
21 would not be successful.
22 And the idea that we would be able to
23 close those gaps after many years of working at
24 this model lies with us.
25 With that, I'm just going to kind of

1 end with that. And you heard this all day. As
2 you know, 75 to 80 percent of incarcerated men are
3 there as a result of a substance abuse problem,
4 probably nearly 90 percent of the incarcerated
5 females.
6 The impact their incarceration and
7 addiction has on their victims, children,
8 families, and their communities is like the
9 proverbial ripple effect of throwing a stone in a
10 pond.
11 It is my hope that as a result of
12 these hearings, more inmates will have the
13 opportunity to receive RSAT program services; and
14 that the next time, that ripple effect will be the
15 result of a successful treatment experience.
16 Thank you.
17 CHAIRMAN BIRMELIN: Mr. Folks.
18 MR. FOLKS: Thank you. I'm employed
19 by Eagleville Hospital. I'm also the chairperson
20 for the Forensic Subcommittee of the Pennsylvania
21 Community Providers Association.
22 I'm responsible at Eagleville for two
23 treatment programs that operate under the contract
24 of the Department of Corrections.
25 I want to just briefly describe both

1 of those programs, some key elements of them that
2 I think are important and then make a general
3 comment about the need for community-based
4 treatment services for the corrections'
5 population.
6 The first program I think you may
7 have heard about before is the SAVE program. The
8 program was started in January of '97.
9 The reason for starting it is
10 primarily that there were significant numbers of
11 technical parole violators who were in State
12 prison for substance abuse.
13 It was easier for a parole agent to
14 get someone back in prison than it was to get them
15 in treatment particularly since further changes
16 have occurred yet in managed care.
17 It was really difficult for parole
18 agents to get violators into residential treatment
19 in particular.
20 One of the unique aspects of this is
21 just as was described with the RSAT program, it
22 brings corrections and parole and the treatment
23 provider together. It is also similar to the RSAT
24 program.
25 It brings all of the phases of

1 treatment together; the residential treatment
2 phase, the intensive treatment -- intensive
3 outpatient phase, and the traditional outpatient
4 phase. It also brings parole agents and treatment
5 staff together on a regular basis.
6 The parole agents remain with the
7 client throughout the course of treatment as well.
8 What is important about that is that historically
9 treatment programs -- residential treatment
10 program providers, I was only concerned about what
11 happened while the client was in my care, if they
12 acted appropriately.
13 If I was having difficulty, I would
14 call the parole agent and say they are your
15 problem now. I'm throwing them out.
16 If they move from residential to
17 outpatient, I really didn't have to be concerned
18 about how well prepared they are to deal with
19 outpatient because they were out of my program and
20 I really didn't get much feedback about the
21 quality of work that I was doing in the
22 residential phase.
23 This design brings everyone together
24 on an ongoing basis so that we really have to look
25 at the quality of care that we provide from each

1 side, and we have to problem solve together so
2 that no one is left holding the bag. Because the
3 whole program has to work well for any one of us
4 to look good.
5 The program is exclusively for
6 technical parole violators. They are referred
7 exclusively to the treatment provider by State
8 parole.
9 The treatment is paid for by the
10 Department of Corrections and Bureau of Community
11 Corrections and it is a yearlong program.
12 Our clients spend approximately three
13 months in the residential phase, three months of
14 intensive outpatient phase, and gradually are
15 stepped down to once a week outpatient treatment.
16 Once they complete that yearlong program, they can
17 return to general supervision.
18 The other program that I am
19 responsible for is a relatively short-term
20 residential treatment program for offenders who
21 are exiting the State prison system.
22 It is located in Germantown, Lehigh
23 Avenue in North Philly. That program is designed
24 to try and help in some cases decompress the
25 person from prison life and begin to orient them

1 into life in the community.

2 In addition to drug and alcohol

3 treatment, we provide an educational program and

4 some vocational counseling. Normally one of the

5 questions is, why should someone need to be in an

6 intensive residential treatment program for

7 awhile?

8 From my perspective, it is very

9 important. Because with addiction -- first of

10 all, most of these clients have problems with

11 addiction. They also have chronic problems in

12 living, made bad choices for themselves.

13 They -- the aspect of denial in

14 addiction and becoming a citizen is deeply

15 profound.

16 When people have been in a protected

17 environment for awhile, some of them completely

18 believe that they are going to be able to return

19 to the community and not be tempted to use

20 substances.

21 However, we have found when we put

22 them back in the community, it is almost an

23 automatic urge that gets in and they resume some

24 substance abuse.

25 There are others who because they

1 haven't been out for awhile feel it is their
2 chance to get high. And I think the work that we
3 do is important to help them be thoroughly aware
4 of their addiction and potential for relapse when
5 they get back out into the community.
6 Again, I wanted to be brief to this
7 point because you do have some other comments. I
8 just would like to emphasize once again that most
9 of the drug and alcohol problems with individuals
10 serving State sentence are chronic. They had this
11 problem for a long time. Most of them have a
12 self-destructive pattern of behavior.
13 And I think it is really crucial that
14 we continue to build the community-based treatment
15 system.
16 Even if we're doing the best quality
17 drug and alcohol treatment that we can within the
18 prisons, if the transitional piece isn't handled
19 well, if we don't have parole supervision and
20 treatment working very closely together, we won't
21 be successful. Thank you again for an opportunity
22 to speak.
23 CHAIRMAN BIRMELIN: Mr. Harley.
24 MR. HARLEY: You already know my
25 name. I'm the President of Gaudenzia. We provide

1 treatment services in 22 different programs in 8
2 counties in the State of Pennsylvania.
3 To give you a sample of that, we're
4 the largest referral to treatment of lawyers in
5 the State of Pennsylvania. We have more lawyers
6 in treatment than anyone else. We have more
7 inmates than anyone else, too.
8 So we don't care where they come
9 from. If they come from Yale or jail, it doesn't
10 really matter to us.
11 Our mission is to treat addiction
12 wherever it may be. And we've been doing that
13 since 1968. Our experience in working with the
14 criminal justice system began at the same time we
15 began. Because in those days that's where most
16 people who had addictions were.
17 And it is funny that 20, 30 years
18 later we have come full circle and that is where
19 most addicts are today, in jail. So we have made
20 some great progress public policy-wise to get back
21 to where we started.
22 We provide drug and alcohol treatment
23 for the Department of Corrections, seven separate
24 programs in the community. We also provide
25 services in two State Correctional Institutions,

1 one is SCI Cambridge Springs and the other is
2 here.
3 We have two on-site programs that are
4 different in county prisons. And we have numerous
5 programs for State parole and probation in
6 different places in the state.
7 Most importantly we just are the
8 operator of a brand new one-of-a-kind program for
9 people that are mentally ill. I just want to let
10 you know how important it is. Not how important
11 it is to me, but how important it is to these
12 people.
13 What we have done is really moved the
14 State hospital system into the State correctional
15 system. And folks there that are really seriously
16 persistently mentally ill, one of the major
17 problems for them is getting out.
18 When they do, they don't get out.
19 Community corrections in general are places where
20 they can go. And in most cases they end up having
21 to max out. They do their whole sentence.
22 And a lot of times it has to do with
23 being an advocate for these folks. I think it is
24 very important to speak for people that can't all
25 of the time speak for themselves.

1 I'll move on. Just to let you know
2 where you are right now and what we do here. This
3 program started April 27, two years ago. It is
4 pretty brand new, and we started in the garage.
5 There was a garage back there before the building
6 was started. And we tried to start working on
7 getting the program underground.
8 We are now at the point where the
9 program has 1,000 -- about 1,000 inmates, all of
10 them chemically dependent. This is one of two
11 programs like this in the nation. The other one
12 is a program in California. It is a thousand bed
13 facility.
14 I'll give you the differences between
15 the two programs. That program was broken into
16 two 500 bed units, two different programs. The
17 difference is they have what is called voluntary
18 aftercare.
19 And in this State we have what is
20 called mandatory aftercare. That is a significant
21 difference, very significant difference. And the
22 people in California have told me they would love
23 to have what we have here.
24 So we're kind of keeping track of
25 what we're doing better or I think we are doing

1 better and they think they are. But what they
2 really appreciate is the fact that we have a
3 Department of Corrections here that really does
4 understand addiction.
5 If you understand addiction, you do
6 make aftercare mandatory. There are 250 inmates
7 at Graterford in four units. And there is about
8 46 inmates in different levels of outpatient care.
9 Some people are being seen more often than others.
10 But they are all in the services.
11 People are here because they realize
12 most people are moving out of here fairly quickly.
13 The institution has a very high turnover rate
14 which we think is a good thing that people come
15 here and get treatment and this at the end of
16 their sentence.
17 Most of the inmates here have less
18 than 30 months. That is one of the requirements
19 for Gaudenzia. Another thing that is unique about
20 this prison is it is smoke free. There is no
21 smoking here. That is the only program like this
22 in the correction institution.
23 And we were glad to know that this is
24 going to be a voluntary drug and alcohol program
25 where you could smoke. And then we found out

1 three weeks into the program we changed our mind.
2 There are two things we want to tell
3 you. It is no longer voluntary, and they can't
4 smoke. So we were really looking forward to that
5 first bus load coming in. They were really pretty
6 cranky but you know it worked. It worked very
7 well. It is working very well and stabilized and
8 it is a wonderful thing.
9 Some of the stuff you've already
10 heard, so I will not go over it. I wanted to --
11 you already heard the amount of people coming into
12 the system and statistics from 91 to 97 percent
13 coming into the system have drug and alcohol
14 problems.
15 One of the concerns we have is that
16 we also provide services in the community. And
17 let me tell you a very clear statement.
18 We watch people because we do
19 programs at a community-based level. We do at the
20 county level and the State level.
21 We watch people not get served in
22 commercial managed care. The same people end up
23 in county services on a waiting list because they
24 have no money and end up in the city jail. Okay.
25 Then they go get arrested and three

1 times they get bench warrants. Because when they
2 get arrested there, just up until recently they
3 didn't even chase you for a bench warrant. So you
4 could get arrested three times in three weeks and
5 not even still get ROR, released on your own
6 recognizance. Then you have State time and now
7 you are here.
8 It is much cheaper, much cheaper to
9 treat somebody in the beginning than it is in the
10 end and leave this program.
11 By the way, some people will not
12 respond to treatment. They need to come to jail
13 for treatment but not everybody, not some folks.
14 It doesn't make any sense while we can start
15 tracking.
16 We're getting to where they are kind
17 of like an endangered species. I start to track
18 them. I think we can track them through the
19 system.
20 And what I'm really worried about is
21 letting some of them die that don't get that far.
22 With all of the crime and violence, things happen
23 before they get the opportunity. It doesn't make
24 any sense. We need to stop this.
25 And I think you've heard all of the

1 other stuff. I'll answer some of the whys. Why
2 do people do this? 80 percent of folks here have
3 children. And it's something we don't talk about
4 a lot.
5 And if we don't get them services,
6 we're going to have some problems. We have a
7 hundred kids more than 12 years old outside. We
8 know children of the folks here are the highest
9 risk to end up in here. Highest risk
10 statistically, we know that.
11 That doesn't mean that some of these
12 kids don't have really strong wills and are not
13 going to make it through this. And people are
14 strong. We know that human nature is strong.
15 But most of them are going to
16 probably have a high risk chance of being back
17 here. If we don't start working with them, we're
18 going to have some problems.
19 We applaud Secretary Horn's insight
20 into this problem, not only his insight but his
21 actual actions. He really has changed things.
22 And I think -- I'm not going to use
23 my statistics. I think this thing here, five
24 years of community, you look at the increase in
25 drug treatment in prisons, about 200 percent and

1 you look at the decrease in assaults, misconducts,
2 contraband, positive drug tests, and everything
3 else. There is a direct correlation and this
4 follows the research.
5 So this is not accidental that this
6 happens. It is not unique to Pennsylvania. When
7 there is good solid programs in prison, this stuff
8 works. But we still have these kids, and we need
9 to do something for these children.
10 And I'll quote something that
11 Secretary Horn said. "Making amends to those that
12 the inmates have hurt, especially the children, is
13 an important step in each inmate's journey of
14 sobriety."
15 This is an important thing. And I
16 think it needs to be enforced. We cannot throw
17 these folks away. We're going to throw away our
18 next two or three generations.
19 There are some reasons why people
20 would attack you for trying to provide treatment.
21 A couple of them is there is some idea treatment
22 solves employment.
23 What you need to know is if we have
24 people that don't that get transferred out of
25 here -- they would rather not be in treatment.

1 Treatment is not easy. It is tough. We make
2 demands on folks. Just the fact how difficult
3 treatment is, it keeps people away from me.
4 There is another belief that they
5 don't deserve treatment. We can't get it out in
6 the community, so why should they be able to get
7 treatment or better treatment than we can. It
8 doesn't have anything to do with deserving it.
9 It really gets down to common sense
10 and dollars and cents. It is very stupid not to
11 treat these folks, not only for the social
12 reasons, but the quality of treatment and all of
13 those reasons.
14 For dollars and cents, $1 out of
15 every $7. For every dollar you spend here, you
16 save $7 reducing particularly criminal justice
17 costs. It's not just incarceration.
18 Do you know how much it costs to run
19 somebody through the system three or four times,
20 get court appointed lawyers, writs of habeas
21 corpus? It is very expensive. We can save that
22 money. I'm going to go right to the bottom line.
23 You gave me a microphone, so I'm
24 taking every opportunity even though it is late.
25 The bottom line is I think we need to look at

1 intervening at all levels of the criminal justice
2 system, not just the jails.
3 It is easy to say we should lock them
4 up. People should not have to commit a crime and
5 go to jail to get treatment. There are a lot of
6 other alternatives.
7 I can tell you the Department of
8 Corrections is the place where the most creative
9 work is being done. So you must be really proud
10 of what they have done. Because they have done a
11 lot in the States.
12 The reason I know that is because I
13 am the Vice President of Therapeutic Communities
14 of America. I travel all over the country. I
15 work on standard programs like this. It is
16 really -- there is real work going on here and it
17 shows.
18 The other issue is to prevent the
19 problem. We need to invest in the children. We
20 have a captive audience here. Let's work with
21 them now. Let's start to help them rebuild those
22 relationships. We need to get people into
23 treatment that they need, not any treatment.
24 Sending an inmate back to his cell
25 and giving him a workbook and saying fill this in

1 and call it drug treatment is bogus. Tell them
2 here is a list of AA meetings and go is bogus. It
3 is not treatment.
4 And there is a lot of folks that need
5 treatment and a lot of them have dual problems.
6 If you don't match them with the right treatment,
7 they are a failure one more time. A lot of
8 treatment to a lot of people doesn't work.
9 I'd rather provide less treatment for
10 less people that works, because you can build on
11 that. I have another dream. There are two
12 dreams.
13 One of them is that there is services
14 for women who have mental health problems.
15 Sometimes we leave women in the system because
16 they are such a small part of the whole system.
17 They are usually an afterthought.
18 And that there be a program for women
19 who have young children to bring their children
20 into the program -- since I have you here, I'll
21 tell you what that dream is -- and I think that
22 would be particularly pregnant women in the
23 justice system.
24 CHAIRMAN BIRMELIN: Mr. Roman.
25 MR. ROMAN: You be the judge if I

1 finish with a bang. I do appreciate the
2 opportunity to talk about the relationship that we
3 at Gateway have, and I think of it personally as a
4 really important one.
5 We point to the relationship that we
6 have with the Department of Corrections. It is
7 among our most productive and the work we have
8 done is among our best.
9 I think there is a public health
10 initiative. I went to the University of
11 Pittsburgh and have a public health background.
12 And I think I can recognize a public health
13 initiative and this is one.
14 Everybody that you heard today is
15 describing a public health initiative that is
16 working. And I want to touch on some of the
17 aspects of that.
18 Before I met Secretary Horn, I
19 actually read about him. And someone asked what
20 do you need to do to make it through as an inmate
21 in the Pennsylvania correction system. And he
22 said you have to not drink, not use other drugs.
23 You have to learn how to read and write. You have
24 to learn sobriety, education, and work.
25 That's been a recurring theme for

1 today. You'll notice that sobriety heads the list
2 and there is some rationale to that. Because
3 unless you're staying sober, everything else
4 fails.
5 So when 90 percent of the population
6 of the correction system has got a problem, we've
7 got to respond to this.
8 Gateway has been a long-term provider
9 of addiction treatment services. We looked at
10 that and saw what was most appropriate.
11 Some notes for you about who we are.
12 We were founded in 1972 by Dr, Abraham Twerski.
13 If you have ever seen Dr. Twerski, he is hard to
14 forget.
15 He is a Rabbi and is an
16 internationally known expert on addiction
17 treatment. You see him in his frock coat and his
18 hat and beard and yarmulke, the whole thing. It
19 is tough to forget this guy. He makes an
20 impression on patients as well.
21 We happen to be Western
22 Pennsylvania's largest provider of addiction
23 treatment services. Some numbers: 30 locations,
24 7,500 admissions, 125,000 patient days/units of
25 service annually. We do a lot of work in Western

1 Pennsylvania, and we do a lot with the Department
2 of Corrections.
3 Interestingly enough, we didn't have
4 a contract with the Department of Corrections
5 until 1995. We had always worked with courts. We
6 had always worked with the corrections agency but
7 not formally.
8 We started very modestly with a
9 contract for only eight beds in the primary
10 treatment services in the Aliquippa location.
11 Almost immediately we got a call from our contract
12 facility coordinator who said, you know, I think I
13 could use you for some more work.
14 Things expanded rapidly after that
15 point. In fact, it expanded to the point where we
16 opened two new corrections facilities this year,
17 one in Braddock to serve the Pittsburgh area and
18 another one in Harborcreek Township to serve the
19 Erie area.
20 At the moment we are operating
21 programs Behind-the-Walls counseling at SCI
22 Greensburg and Pittsburgh. Behind-the-Walls
23 counseling they have primary treatment and work
24 release counseling at the Aliquippa site, Braddock
25 site, and the Erie site.

1 In addition, we are participating in
2 the County SAVE program with the Board of
3 Probation and Parole and the RSAT aftercare
4 program also with the Board of Probation and
5 Parole.
6 And we're just about to start May 1
7 the new RSAT program at SCI Camp Hill and then
8 that will be followed one month later on June 1
9 with the new RSAT program at SCI Albion.
10 That one will be a little bit
11 different because RSAT will not accept as
12 admissions only technical parole violators. There
13 will also be some admissions from the general
14 population which in and of itself will be a new
15 challenge.
16 During the last fiscal year, about
17 50,000 days of service were provided by Gateway to
18 the Department of Corrections. With that
19 background, I would like to make three points for
20 you.
21 First of all, I'd like to say that I
22 think the current array of programs that the
23 Department of Corrections operates is correctly
24 targeted. Programs are at the right level. They
25 are where they need to be.

1 The second point is the current
2 effort has a high level of expertise on both sides
3 of the equation, from us, the vendors, and on the
4 DOC side as well.
5 Finally, I'd like to say the current
6 effort has become much more sophisticated as we
7 develop programs and learn more day-to-day
8 operations.
9 I was talking to one of our contract
10 facility coordinators just recently. And he said
11 we started this 25 years ago, we didn't know what
12 we were doing but we learned.
13 And we now know how to do this. We
14 know how to deliver services, and we know how to
15 control populations. And I think he is right
16 about that.
17 Just a couple of things on correct
18 targeting of programs. Probably one size does not
19 fit all. We need a way to deal with people who
20 got serious problems but in different ways. So we
21 need to do counseling Behind-the-Walls. That is
22 necessary.
23 We need something that is at a very
24 high intensity level such as the RSAT program. In
25 this case you're coming into a residence with a

1 therapeutic community for six months.

2 Then you're going to leave that and
3 go live at the community correction center and do
4 intensive outpatient services on top of that.

5 Then you're going to spend six months
6 in aftercare services, a very intensive program.
7 We need a way to bring you back in if you had been
8 out on parole and experienced problems. We have
9 such a way.

10 We need a way to let you out of the
11 prison system in as controlled a manner as is
12 possible. We have pre-release programs for that.

13 We ask two questions when we place
14 somebody in a program. Can the inmate tolerate
15 the program? Can the inmate benefit from the
16 program?

17 If the answer to those questions is
18 yes, everybody wins. The inmate wins, the public
19 safety is well served, and the correction system
20 as well.

21 High level of expertise on both sides
22 of the equation. I think in view of such as you
23 have before us, you have an awful lot of years of
24 experience. On Gateway's side almost 30 years of
25 institutional experience doing addiction

1 treatment. I think that speaks for itself.
2 But interestingly, we benefit a lot
3 from the input we get from the Department of
4 Corrections. I mention the contract facility
5 coordinators. These are individuals for us who
6 are assigned to work with us to deliver services
7 in the best way possible.
8 Sometimes their input is routine.
9 How do you submit an invoice, that sort of thing.
10 But oftentimes it is more than routine. They help
11 us with custody control issues. They help us to
12 understand the impact of thinking errors because
13 of criminal personalities. All those things go
14 into making the program much more effective.
15 Finally, I would like to make a point
16 that we're experiencing increasing sophistication
17 in the way that we deliver services.
18 I'll give you an example of this.
19 When we began the RSAT program nearly three years
20 ago, the guise of the treatment was all managed in
21 our RSAT program.
22 And six months after they started,
23 they began to get out and began moving to the
24 second phase. We immediately saw a high failure
25 rate for some reason. We didn't know exactly why.

1 But we got really good responses from three --
2 Deputy Love himself was involved in the process,
3 Directors Belcik and Rogosky also joined.
4 And we made three very significant
5 adjustments to the program. The first thing we
6 did, we changed and improved the screening tool.
7 This immediately placed the proper inmate in the
8 program. So this guy was likely to benefit from
9 the program as well as tolerate the program.
10 Secondly, we increased the intensity
11 of the therapeutic community. We didn't think we
12 had hit it quite right when we opened the program.
13 We had to make some adjustments to that.
14 And then finally we began
15 coordination meetings so that the transfer from
16 the one level to the next coming from the
17 therapeutic community to community corrections
18 phase and were receiving intensive outpatient
19 program had to be as seamlessly as possible.
20 What we experienced was that the
21 failure rate was cut in half. This kind of
22 cooperation is very typical for us, and we're
23 pleased to participate in that sort of
24 partnership.
25 One last note I want to tell you

1 about. You've heard that placing programs in the
2 communities is very difficult to do. We can come
3 forward with all kinds of information, statistics,
4 community needs, the whole thing and there will
5 always be some resistance on the part of the
6 community and sometimes opposition.
7 We ran into a little bit of that when
8 we opened the program in Erie. Interestingly
9 enough, in Braddock the community did not respond
10 that way; and that program opened very easily.
11 But the Erie situation involved a
12 zoning meeting or two. It involved us in some
13 pretty serious discussions with the community, and
14 it slowed the opening of the program down for
15 about six months.
16 But the program was badly needed. We
17 didn't just pick Erie out of a hat. We went there
18 because our contract facility coordinator said I
19 really need beds in here. It would help me if you
20 had a program here.
21 I just want to tell you we, at
22 Gateway, were delighted to spend our time and
23 energy on that process. The program is now open.
24 It is approaching capacity. It is co-existing
25 very quietly with its neighbors. And we would be

1 pleased to do it again. Thank you.
2 CHAIRMAN BIRMELIN: Thank you, Mr.
3 Roman, and other members of the panel. I have one
4 quick question that I would like one of you to
5 respond to. It doesn't matter which one, whoever
6 thinks they are best capable to do that.
7 When we talk about success and
8 failure in these programs, I'm assuming that
9 success means they never re-offend, never go back
10 to institutions. I don't know if that is true.
11 And secondly, the second part of that
12 question is, do you have some mechanism in which
13 you know whether or not people have re-offended
14 and/or re-entered back into their addiction other
15 than being back in your care?
16 MR. HARLEY: We do have baseline
17 statistics of what good programs should look like,
18 what the percentage of recidivism rate should be,
19 how it should change.
20 No, we don't get a hundred percent.
21 We are not looking at a hundred percent. If we
22 had that, we'd have many -- I'd be a drug czar and
23 we could all go home. That is not the case.
24 In our case what we try to do using
25 multiple ways of monitoring patients, one is

1 urinalysis. We are -- keep in mind that we have
2 different -- when you speak about recidivism you
3 have relapse.
4 They use some chemical and it doesn't
5 matter which chemical they use. If it is legal or
6 another, any chemical to us is a problem. We
7 would monitor that through self-report, report of
8 other people, and urinalysis.
9 More importantly, usually it is
10 behavioral; drug use affects some kind of behavior
11 and it brings that to the forefront. Some people
12 can hide that and some people are better at it
13 than others. But generally we find out.
14 The other thing is peer support.
15 They are with peers. Probably more than anything
16 if they want to get over on you, they could. But
17 when they are with peers -- that is why they are
18 put out in the community.
19 It is so important. You're
20 developing culture and drug abuse is not the
21 appropriate thing to do. That we don't see as
22 recidivism. We see that as relapse.
23 And I think that we can be in
24 agreement on that. What is recidivism is when
25 they are rearrested. And we don't see it that

1 way. The part we see as a rearrest would be a
2 crime that would lead them back to the system.
3 And the Department of Corrections
4 would look at whether they have returned. And the
5 main reason would be a technical violation which
6 may not be drug use or crime. It may be failure
7 to report.
8 And we believe it is very important
9 that the Department stay very, very focused
10 because they do usually lead up to something else.
11 So you should intervene when somebody says they
12 are at work and they are not really there. There
13 is an intervention level.
14 For example, the first 75 people we
15 had come out, five of them returned. One was
16 returned for drug use without any crime, but just
17 drug use alone for urine. The other three were
18 returned for technical violations. For example,
19 saying they were somewhere they were not at. One
20 was rearrested and returned.
21 That will give you an idea of the
22 reasons how we look at how people get caught. We
23 know it is not a hundred percent. The person is
24 not only with us as an outpatient but also with
25 the community corrections facility and is

1 monitored and uses ACA standards.
2 They are monitoring patients also.
3 And there is a lot of documentation and I think
4 that is really important between those two places.
5 So that when we see something, we ask them are you
6 seeing the same thing and vice versa.
7 And I think that is a very, very
8 important thing. Because as quickly as somebody
9 relapses, there could be a week or three weeks or
10 four weeks and really maybe even a year and just
11 before you know it, we're talking crack. And then
12 before you know it, we're on a little bit of a
13 crime spree.
14 So the Department looks at that very
15 closely, so do we. Because you can't afford to
16 have one or two people ruin it for everyone. I
17 know that is a long answer and you may get a
18 different one. But relapse is not recidivism.
19 MR. ROMAN: Maybe since I have the
20 microphone I'd like to make a couple of notes on
21 that. You've touched on a critical consideration
22 for the addiction treatment field generally.
23 Research has been going back for 50
24 years and it is only now being strengthened. We
25 are doing outpatient studies that now follow

1 inpatient studies that we did ten years ago.
2 About three-quarters of our
3 inpatients were sober at the end of three years
4 but only half of the outpatients are. What we
5 need to do is complete the trial where we randomly
6 assigned one person to this treatment and then the
7 next person to the other treatment to see whether
8 it is the treatment or the individuals. And that
9 is going on but slowly.
10 The RSAT program is doing research.
11 And it is going to have very good access to data
12 because it can take information right out of
13 whether or not people have been rearrested, and
14 that is the bottom line for this.
15 In truth, we know for a fact that
16 some people are going to lose their sobriety.
17 They are going to start with the best intentions
18 in the world and we're going to lose them.
19 What we must do is be available to be
20 there to provide treatment intervention when they
21 need it. If you don't seek it, now you're not
22 going to get it.
23 This is a chronic disease. It is
24 treatable. We need to be there with treatment.
25 It is good public policy.

1 MR. FOLKS: I'll try and be very
2 quick. We've only recently come to accept that
3 some people are addicted to cigarettes. And all
4 of us probably know people who died from lung
5 cancer. They just couldn't quit.
6 The substances that our clients
7 abuse, there is no difference between that and
8 nicotine on some very basic kind of level.
9 I mentioned chronic problems, if you
10 buy the notion addiction is a disease, we help
11 people maintain their recovery. We never cure it.
12 How do I define success? Are we -- it almost
13 would be very similar to how we may define success
14 with another disease or mental illness.
15 Are we reducing the number of most
16 intensive -- you know reducing numbers of time
17 they end up in jail? Are we reducing the
18 frequency in which they commit the crime? Are we
19 helping them stay clean? Is the community at risk
20 for longer periods of time?
21 We may have to on some level
22 recognize that that is success. I know that is
23 not an easy thing for everybody to accept. But I
24 think it is important for me to try and have that
25 be heard.

1 It is very nice when someone with a
2 very serious chemical dependency problem and very
3 serious criminal activity, something clicks for
4 them and they stop and, you know, they stay clean
5 for the next 20 or 30 years. But it is also very
6 rare. I think research is important as well.
7 But I think it is important to accept
8 the reality of these problems will not be solved
9 with one treatment.
10 MS. WORTHINGTON: Just real quickly,
11 with the RSAT program there are statistics being
12 kept. All of our programs really operate in
13 phases in terms of how clients have to meet
14 certain criteria to complete programs to move on
15 to the next phase.
16 Urinalysis is always something that
17 we pay a lot of attention to in terms of
18 monitoring the clients as well as their attendance
19 at treatment and whether they are progressing.
20 Again, one of the things working for
21 the Department of Corrections is the relationship
22 between community corrections facilities and
23 prisons and the outpatient treatment providers.
24 One of the things that I think we can
25 probably be doing a better job at in terms of

1 clients actually getting into the State parole
2 phase is working more with their family and also
3 Phase II of the RSAT program being able to access
4 and hopefully some day bridge the gap with managed
5 care to be able to help entities that would
6 hopefully support the families of those seeking
7 treatment and the clients when they are in the
8 second phase of the program.
9 None of that is going to happen. It
10 is something we should probably pursue. It is
11 very important. The idea of a support system
12 matters greatly where someone successfully
13 returns.
14 So I think that we have a lot of the
15 players in place. And as I said, this has evolved
16 to quite the comprehensive treatment approach. I
17 also think that we can go a step further in
18 working with the family in Phase II and Phase III
19 which are probably very critical for that success.
20 CHAIRMAN BIRMELIN: Well, I want to
21 thank all of you for your answers and for your
22 testimony today. We appreciate your being here.
23 All though he is not on the schedule,
24 we have another person who is going to testify
25 today who is a prisoner here at SCI Chester. His

1 name is Eric Ponder.

2 I want to thank you, Mr. Ponder, for

3 coming in to testify. It is not that often that a

4 prisoner gets that opportunity for the microphone.

5 You were not here for most of the hearing.

6 I want you to know that the members

7 of the House Judiciary Committee who are not here

8 today will have copies of your testimony and it

9 will be part of the record. You need to push that

10 red button on the microphone.

11 MR. PONDER: Okay. Thank you very

12 much. I'm happy for -- I'd like to say this is

13 the very first time that I've been afforded an

14 opportunity to speak at a gathering such as this.

15 I don't want to mislead anyone. I'm

16 here because I committed a crime and I was

17 convicted of a crime, a violent offense.

18 Upon my incarceration, it wasn't

19 important to me just to finish my time and get

20 back into society. It was important for me to do

21 my time and obtain necessary tools that I needed

22 to be functional once I was in society.

23 I have with me in my possession

24 approximately 30 folders of programs that I have

25 taken; self-help programs, drug and alcohol

1 programs, psychotherapy programs to ensure myself
2 once I got back out into society that my actions
3 will be different.
4 I recently saw the Parole Board. And
5 after hearing my story, they issued a 16-month
6 hit. I would like to go back for a minute because
7 I said that I was thankful for being here. I have
8 to say I am thankful for being in this type of
9 institution.
10 I believe that anyone who is serious
11 about getting their life together or doing
12 something with themselves that would assure them
13 when they go back out into society they will be
14 functional, should be in an institution like this.
15 I believe that the staff here -- I
16 believe that the warden himself takes great care
17 in making sure that an inmate has what is needed
18 for them to better themselves.
19 And I believe to successfully
20 complete the programs that they have here and then
21 to receive parole time and going in front of the
22 Parole Board and receive a hit from the Parole
23 Board that extensive for no reason other than the
24 nature of the crime is undermining the exact
25 reason that this institution was built.

1 And I believe that if possible, this
2 type of offense should be looked into. Because
3 inmates like myself -- I can seriously sit here in
4 front of you and feel good about myself. There
5 was a time that I couldn't say that.
6 People who meet me say how did you
7 even get into jail. But had they met me eight
8 years ago at the time I committed this crime, they
9 may have said this individual was going to wind up
10 in jail.
11 So these certificates don't mean
12 anything. What means the most is my ability to go
13 back into society and be functional, to be a
14 father to my children, to be a son to my mother,
15 and to just be a functional member of society.
16 That is what is important. And I'm
17 ready to do that. I believe other individuals in
18 jail are ready to do that because they have been
19 afforded the opportunity by this institution. And
20 they had a chance to go before the Parole Board
21 and they so affected them because of the nature of
22 the crime.
23 CHAIRMAN BIRMELIN: Did you have a
24 drug and alcohol problem when you came here?
25 MR. PONDER: Yes, I did.

1 CHAIRMAN BIRMELIN: And have you been
2 in therapy or some sort of counseling situation to
3 deal with that?
4 MR. PONDER: Yes, I have, sir.
5 CHAIRMAN BIRMELIN: How long have you
6 been in SCI Chester?
7 MR. PONDER: I've been in SCI Chester
8 for approximately two years. April the 28th will
9 be two years.
10 CHAIRMAN BIRMELIN: So you were one
11 of the first people that came here when it opened
12 up. It was about that time.
13 MR. PONDER: That's correct, sir.
14 CHAIRMAN BIRMELIN: So you were
15 eligible for parole in terms of your minimum
16 sentence; is that correct?
17 MR. PONDER: That's correct, sir.
18 CHAIRMAN BIRMELIN: And when was your
19 minimum sentence up?
20 MR. PONDER: December 8th, 1999.
21 CHAIRMAN BIRMELIN: Your minimum
22 sentence was up. Now the 16 months are in
23 addition to your minimum sentence, I guess that's
24 what you mean by the word hit.
25 MR. PONDER: Yes, sir.

1 CHAIRMAN BIRMELIN: The 16 months is
2 in addition to your minimum sentence. That would
3 have been given to you by the Parole Board. And
4 the only reason they gave you was, in fact, that
5 you committed a certain offense that they didn't
6 feel that you should get out at that time?
7 MR. PONDER: Actually, on the green
8 sheet there was no reason. The green sheet being
9 the denial of parole that you receive when you are
10 unaccepted or denied. They didn't give me any
11 reason outside of to ensure justice and to protect
12 the safety of the public.
13 CHAIRMAN BIRMELIN: Where did you
14 make the assumption that it was because of the
15 crime that you had committed that you were not
16 allowed out?
17 MR. PONDER: Upon my interview, I
18 was asked about the nature of my crime. And once
19 I informed them of the nature of my crime, the
20 questions stopped.
21 CHAIRMAN BIRMELIN: What happened?
22 MR. PONDER: The questions stopped
23 after I informed them of the nature of my crime.
24 CHAIRMAN BIRMELIN: What exactly do
25 you do when you are involved in the therapy

1 programs that you've had here for chemical
2 dependency? How often do you meet by the
3 way?
4 MR. PONDER: The alcohol -- the drug
5 and alcohol meet at least two times a week.
6 However, I was in the intensive program which is a
7 treatment module that goes on on a daily basis.
8 So we would meet from 8:00 up until 6:00 in the
9 evening outside of the times that we were locked
10 in our cells for count as well as feeding time.
11 So this was intensified. And during
12 the meetings we had, we would receive educational
13 information as well as interact with one another
14 as far as sharing, getting the opportunity to tell
15 our stories. So we can go from someone else's
16 experience and someone can go from our experience.
17 CHAIRMAN BIRMELIN: Now, assuming
18 that you've had been granted parole after your two
19 year stay here in December, you would have been
20 out on the street by now and on parole. But since
21 you're going to be here 16 months -- I assume they
22 will keep you here -- will you continue in those
23 treatment programs?
24 MR. PONDER: Yes, I am.
25 CHAIRMAN BIRMELIN: And is that your

1 choice or the institution's choice?

2 MR. PONDER: That is at my choice.

3 CHAIRMAN BIRMELIN: So you could

4 withdraw from it if you wished to?

5 MR. PONDER: That is correct, sir.

6 CHAIRMAN BIRMELIN: Thank you very

7 much. Representative Manderino, do you have any

8 questions?

9 REPRESENTATIVE MANDERINO: I'm just

10 sitting here wondering whether you should be

11 blaming the Board of Probation and Parole or

12 whether you should be blaming the legislature.

13 But without knowing the nature of

14 your underlying crime, I can't decide if it is one

15 of numerous pieces of legislation we passed in the

16 past couple of years that deal with either

17 conditions upon which someone can be paroled.

18 So if you wanted to tell me more, I

19 would be interested. Because quite frankly, I

20 can't figure out if we created your problem or if

21 it is a problem at the Board.

22 MR. PONDER: Okay. First let me say

23 that this isn't a situation that I'm proud of.

24 But my charges are kidnapping, burglary,

25 possession of instrument of crime, and conspiracy.

1 My cousin who was also a co-Defendant
2 in my case and myself went into a residential
3 area, took the victim whose name is Anthony Wydel
4 and shot Anthony three times as retaliation for
5 Anthony Wydel going into my aunt's house and
6 robbing her and assaulting her. And that is the
7 nature of the crime that I'm here for serving 6 to
8 12 years.
9 REPRESENTATIVE MANDERINO: I'd have
10 to go back and look at the law and think about it
11 but thank you.
12 MR. PONDER: I would like to say as
13 well, once again, you know, it is not a situation
14 that I'm proud of.
15 REPRESENTATIVE MANDERINO: I
16 understand.
17 CHAIRMAN BIRMELIN: In lieu of
18 Representative Manderino's question, I would be
19 inclined to think it is not a legislature problem.
20 REPRESENTATIVE MANDERINO: Well,
21 okay. Thank you. Again, I think -- I guess I'm
22 assuming this otherwise there might have been a
23 different sentence. I'm assuming that the victim
24 in that case did not die.
25 MR. PONDER: No, ma'am. He is

1 deceased.

2 REPRESENTATIVE MANDERINO: Oh, he is

3 deceased.

4 MR. PONDER: Yes, ma'am.

5 REPRESENTATIVE MANDERINO: That may

6 make a difference because it may make a difference

7 in terms of whether the parole decision needs to

8 be -- I can't remember how we did the law. But

9 the parole decision needs to be unanimous. The

10 law changed.

11 We had made it so that elected

12 officials or someone having to make the decision

13 whether somebody should be released must be

14 unanimous when they would be released. I don't

15 know if that is your situation or not. I

16 appreciate your sharing those facts.

17 CHAIRMAN BIRMELIN: Thank you very

18 much.

19 REPRESENTATIVE MANDERINO: I'm

20 confused on this.

21 CHAIRMAN BIRMELIN: Representative

22 James.

23 REPRESENTATIVE JAMES: Thank you,

24 Mr. Chairman. So I can be clear, you served 6 to

25 12.

1 MR. PONDER: That is correct, sir.
2 REPRESENTATIVE JAMES: And the
3 minimum sentence you served ended in December in
4 the recent past.
5 MR. PONDER: Correct, sir.
6 REPRESENTATIVE JAMES: How do you get
7 16 months? Did they say that you have to do 16
8 months or come back in 16 months?
9 MR. PONDER: They reviewed -- stated
10 for the future and review date on my parole sheet
11 is for April 2001, on or about.
12 REPRESENTATIVE JAMES: So it seems as
13 though -- because I've gotten a lot of letters
14 from inmates as a result of the fact that they
15 finished their minimum sentence and the same kind
16 of problem that you stated.
17 Since you've been here, in terms of
18 have you been involved in any medical treatments
19 where you were not satisfied with any doctor in
20 the institution, you wanted to get another outside
21 doctor or outside medical treatment?
22 MR. PONDER: Not since I've been in
23 this institution or at my previous institution
24 which was Graterford.
25 REPRESENTATIVE JAMES: Okay. Thank

1 you.

2 CHAIRMAN BIRMELIN: Well, I want to

3 thank you for coming here. And I hope it was a

4 very nice experience.

5 Well, we are getting near the finish

6 line. And I am proud of those of you who have not

7 left yet and stuck around with us so far in the

8 hearing. We have two more time slots of people

9 testifying.

10 And at this point in time we have

11 Greg Griffin, vice president of the Pennsylvania

12 State Corrections Officer's Association to come

13 forward along with John Henderson. Welcome to our

14 Committee meeting and you may begin.

15 MR. GRIFFIN: Good afternoon, members

16 of the House Judiciary Committee. I'm Greg

17 Griffin, vice president of the Pennsylvania State

18 Corrections Officer's Association. With me is

19 fellow State Corrections Officer John Henderson.

20 State corrections officers are a

21 vital part of the treatment and rehabilitation

22 process. We are here today to offer suggestions

23 to difficult changes inside our 24 State

24 Correctional Institutions.

25 I believe inmates should receive

1 treatment and counseling so that when they join
2 the community, as most of them will, the inmate
3 will be able to adapt and be a productive citizen
4 rather than another crime statistic with a victim.
5 Our title is corrections officer.
6 And one of the responsibilities is to correct the
7 inmate if necessary and to be a positive role
8 model.
9 The point that should not be argued
10 is that the better trained the drug and alcohol
11 treatment specialists are, the more chances you
12 will have a successful treatment program.
13 Corrections officers are part of the
14 treatment team and are with the inmates 24 hours
15 per day, 7 days per week.
16 It would also make sense to train the
17 corrections officers to a higher degree.
18 Unfortunately, the level of training corrections
19 officers receive is lacking in several key areas.
20 The United States Department of
21 Labor recently adopted a national corrections
22 officer's curriculum that recommends 520 hours
23 training for new corrections officers at the
24 training academy.
25 Unfortunately, Pennsylvania State

1 corrections officers receive only 200 hours. We
2 are eight weeks short of the United States
3 Department of Labor's recommended corrections
4 officer's curriculum.
5 State corrections officers need
6 additional training in anger management, use of
7 force, and communication skills. It has been ten
8 years since I graduated from the Academy, and I
9 have not received any updated training in anger
10 management or communication skills.
11 According to the Criminal Justice
12 Institute in Connecticut, the Pennsylvania
13 Department of Corrections ranks fourth in assaults
14 of corrections officers by inmates, fourth in
15 overcrowding, third in inmate-to-inmate homicide,
16 and 39th in inmate to corrections officer staffing
17 ratio.
18 On a positive note, the legislature
19 is responding to the violent conditions inside our
20 State institution by introduction of Senate Bill
21 1047, the Institutional Sexual Assault bill, which
22 would upgrade sexual assault in our institutions
23 to a felony charge.
24 Still more must be done to provide a
25 safe rehabilitative treatment atmosphere inside

1 our State institutions.

2 From a corrections officer's point of

3 view, meaningful inmate jobs must be created in

4 order to eliminate idle time and the work ethic

5 should be instilled so that inmates can put it to

6 use when they have served their time.

7 Currently, the Senate is considering

8 Senate Bill 837 that encourages industries inside

9 the institutions and at the same time allows for

10 safeguards against loss of civilian jobs.

11 State corrections officers recommend

12 increased training for corrections officers along

13 with many more inmate jobs. Hard work is

14 respectable and a positive rehabilitative program.

15 Thank you. Officer Henderson would

16 also like to add some comments.

17 MR. HENDERSON: Good afternoon. I'm

18 John Henderson, a member of the Pennsylvania

19 Corrections Officer's Association. I also would

20 like to thank the Judiciary Committee for giving

21 me an opportunity to speak today.

22 As a corrections officer, my

23 responsibilities include care, custody, and

24 control of the inmates.

25 On our tour of duty, correctional

1 officer observes inmates on a daily basis. We are
2 the eyes and ears of the institutions.
3 Officers work hand in hand with the
4 medical department. When reporting medical
5 emergencies, it is the responsibility of
6 correctional officers to ensure that the area is
7 safe for medical personnel to respond and to
8 report unusual behavior to our supervisors.
9 My personal opinion of the medical
10 departments of the two institutions that I have
11 worked are equal or exceed medical services
12 outside the wire.
13 Inmates receive similar treatment as
14 soldiers do in the United States Army. They have
15 got the opportunity to sign up for sick call and
16 treatment programs.
17 Their dental and prescription plans
18 exceeds the plans that are provided to our senior
19 citizens. Also, the medical department is staffed
20 24 hours a day.
21 The only problem I foresee is not the
22 fault of Department of Corrections. It is a
23 statewide problem of overcrowded institutions.
24 When an institution is designed to accommodate 480
25 inmates and 800 are housed, it creates a burden on

1 all staff and members.
2 Treatment programs have limited
3 amounts of slots for inmates. Due to security
4 reasons and size of the classrooms, inmates have
5 to wait for the next available session which
6 creates idle time. This is where the inmate gets
7 inpatient and problems arise.
8 Again, I would like to thank you and
9 am available for any questions.
10 CHAIRMAN BIRMELIN: Thank you,
11 gentlemen. There are some attachments to your
12 testimony. I'm not sure if everyone here has
13 copies of your testimony.
14 There is one sheet on working and it
15 is the first time I've seen that in this format.
16 And I agree with it whole heartedly and the Senate
17 bill that you have referenced, Senate bill 837
18 dealing with private sector prison industry
19 concept that I supported over the years and has
20 run into a lot of problems with that in
21 legislature from unions in particular who think
22 that they are taking away jobs from people who are
23 not behind bars which I will not debate that
24 issue.
25 We will have an opportunity to talk

1 about work tomorrow at Graterford prison. I want
2 to thank you for your testimony.
3 If there is no one else here who is
4 going to ask you any questions, I would just put
5 this question to you and each of you may answer
6 this if you would like.
7 In your dealings with prisoners
8 who -- I'm sure you've been in the system long
9 enough and you've seen this.
10 How long have you been working in the
11 prisons?
12 MR. GRIFFIN: Ten years, sir.
13 CHAIRMAN BIRMELIN: And how long have
14 you been working in prisons, Mr. Henderson?
15 MR. HENDERSON: Six years.
16 CHAIRMAN BIRMELIN: You've seen some
17 guys from the day that you started that have been
18 in treatment. I am particularly concerned about
19 drug and alcohol treatment.
20 In your six to ten years that you've
21 been here, by in large do you think that is
22 helpful to those prisoners as being a better
23 person, kept them from re-offending, coming back
24 into the system in that six or ten years?
25 MR. GRIFFIN: It has been effective

1 and should be expanded. I have reservations about
2 parole violators being admitted into the program.
3 They had their chance. Maybe they should wait at
4 the end of the line. There is cost
5 considerations.
6 I think it is generally helpful. But
7 when you put a parolee back into the environment
8 and they are rearrested, it is a very negative
9 atmosphere.
10 I have to go back to the work ethic.
11 If we provide decent jobs for these inmates and
12 there is safeguards in Senate Bill 837, local
13 labor would have to agree on the industry.
14 Inmates must be provided I think with
15 very good jobs and that. But the drug and alcohol
16 treatment programs I think are positive and should
17 be expanded.
18 CHAIRMAN BIRMELIN: Mr. Henderson.
19 MR. HENDERSON: I feel that the
20 community has to be willing to go through with the
21 program, you know.
22 CHAIRMAN BIRMELIN: So obviously no
23 one is going to -- you can see no one wants to
24 be -- I guess my question would be narrowed. But
25 those that are willing, you know, participants in

1 the program, do you see a positive change in their
2 attitudes while they are in prison?
3 MR. HENDERSON: If things are going
4 their way, yes, sir.
5 CHAIRMAN BIRMELIN: Very qualified
6 answer. Okay. Thank you very much, gentlemen.
7 Our last person to appear is Secretary Martin
8 Horn, Department of Corrections.
9 Normally we would have asked
10 Secretary Horn to come on first and then have our
11 other people testifying. At today and tomorrow's
12 hearing, I asked Secretary Horn to come last.
13 But we've asked Secretary Horn to
14 come last today to give us his take on what he has
15 heard before him and answer any questions that he
16 felt perhaps were not answered.
17 Mr. Horn, you have free reign to tell
18 us what you want to tell us.
19 MR. HORN: Thank you very much.
20 Mr. Chairman, Representative James, and members of
21 the Committee, I want to compliment you on your
22 tenacity staying today.
23 And I appreciate the attention that
24 the Committee is giving to these issues as well as
25 all of the time that the Committee has spent over

1 the preceding months looking at our Department,
2 both after the escapes as well as before the
3 escapes and during your visits to our prisons this
4 summer.
5 I have two thoughts sitting here
6 listening today. The first is that I am
7 enormously proud of the 14,000 men and women in
8 the Pennsylvania Department of Corrections. We're
9 not perfect. We make errors. It is a large
10 system.
11 We deal with 44,000 people each year,
12 36,000 on the first day of January and 8,000 new
13 people who come through, as well as 8,000 of those
14 36,000 who leave each year. And prison stinks.
15 Let's face it.
16 We endeavor to run a good,
17 thoughtful, constitutionally adequate prison
18 system. And I think that we do it through the
19 dedicated, conscientious, professional work of
20 those 14,000 men and women. I'm very proud of
21 them today.
22 And by in large I won't bore you with
23 whatever minor gripes I may have with any comments
24 from my staff. I'm also immensely proud of our
25 private sector partners, drug and alcohol

1 treatment providers, and private sector medical
2 partners. They are professional.
3 They add a great deal to what we do.
4 Because they specialize in their areas of
5 expertise, I think they do it better than if we
6 did it ourselves.
7 Running prison medical care is a
8 full-time, highly complex undertaking. And having
9 come from a state where the State did it, I will
10 tell you we do it better here this way. Making a
11 5 percent profit as I think Regis Dorsch was
12 saying is hardly criminal.
13 The other emotion that I have is one
14 of enormous humility. I am humbled by the things
15 that were said by our colleagues, from the
16 District Attorney, from the treatment providers,
17 from our private sector providers who endeavor to
18 run this system.
19 As I say, we make errors. It is a
20 big system. People fall through the cracks. When
21 that happens, we try to fix it. I know that there
22 are people who had you believe that the system is
23 benevolent and we go out of our way to hurt
24 inmates and people.
25 It is easy to raise cries of

1 retaliation and racism. I come from New York. My
2 boss in New York was Mario Cuomo. Mario Cuomo
3 used to say any jackass can kick down a barn. And
4 it is very true. It is very difficult to run a
5 system like this.
6 I think today you heard from men and
7 women who believe that we're on the right path.
8 We've come a long way in the last five years. We
9 have a long way to go. I won't bore you with
10 statistics. You've heard it before.
11 I am prepared to answer any
12 additional questions that you may have, anything
13 that you feel has to be addressed by myself or has
14 not already been answered.
15 CHAIRMAN BIRMELIN: Representative
16 James.
17 REPRESENTATIVE JAMES: Thank you,
18 Mr. Chairman. I thank you, Superintendent -- oh,
19 dear, Secretary. I'm trying to think of all of
20 these things. It seems like you should be here
21 for life.
22 MR. HORN: I'd like to get paroled,
23 too.
24 REPRESENTATIVE JAMES: One of the
25 policies I wanted to ask you about is in terms of

1 medical treatment, if -- and I want to know what
2 the Department's policy is.
3 If, in fact, inmates feel as though
4 they are not being given adequate medical
5 treatment because of something that them and their
6 family feel that they don't believe or trust or
7 for whatever reason happens, what is the policy --
8 if there is a policy -- on asking outside doctors?
9 Does the inmate do that?
10 MR. HORN: No. They can ask.
11 Inmates can file a grievance, but we provide
12 full-service medical care. An inmate can ask for
13 a second opinion.
14 And that decision, as our medical
15 provider said, is made by the on-site medical
16 director who is there. There is no question there
17 is a difference between your situation in prison
18 and on the outside.
19 If you or I want a second opinion and
20 the insurance company won't pay, we're free to
21 obtain and pay for it ourselves. That is not
22 available to inmates.
23 REPRESENTATIVE JAMES: Okay. Now in
24 terms of the -- I guess when inmates meet their
25 minimum and they are going for parole, go before

1 the Board, your policy and the Parole Board policy
2 don't have nothing to do with anything like the
3 boy was saying if they have misconducts and no
4 misconducts and then it is up to the Parole Board
5 to make a decision they are going to spend a
6 certain period of time. Do you make
7 recommendations?
8 MR. HORN: Yes. We make a
9 recommendation on every individual who appears
10 before the Parole Board. We are required by law
11 to make a recommendation. That recommendation is
12 made by the unit management team; that is, the
13 counselors, officers, unit manager on the housing
14 unit where the inmate lives. Then they vote.
15 They make recommendations that then
16 go to the Deputy Superintendent and the
17 Superintendent goes to the Parole Board. The
18 Parole Board is not obligated to abide by our
19 recommendations.
20 I think the reality is that where the
21 Department recommends against parole, it is likely
22 that individual won't get parole.
23 It is also true that where the
24 Department recommends in favor of parole as it did
25 in Mr. Ponder's case, the Parole Board is

1 nonetheless free to deny parole. They are
2 absolutely independent in decision making.
3 REPRESENTATIVE JAMES: Okay. My
4 final question. In terms of the vendors doing the
5 medical services, are there any guidelines that
6 you use as it relates to minority vendors in terms
7 of the medical field?
8 MR. HORN: We award those contracts
9 in accordance with the State's procurement code
10 and the competitive procedures that are
11 established by the State Controller's office and a
12 vendor earns -- it is a scoring system.
13 You earn so many points for low cost
14 and so many points for high quality. You also
15 earn points for being a qualified minority-owned
16 business. So yes, minority firms do again benefit
17 that way.
18 REPRESENTATIVE JAMES: Thank you.
19 Thank you, Mr. Chairman.
20 CHAIRMAN BIRMELIN: Representative
21 Manderino. I think that's it.
22 MR. HORN: Thank you very much. I
23 look forward to seeing you tomorrow at Graterford.
24 CHAIRMAN BIRMELIN: We will be
25 meeting at 9 a.m. tomorrow at Graterford. The

1 subject of that meeting will be working
2 opportunities for prisoners in the State
3 Correctional Institutions. This meeting is
4 adjourned. Thank you.
5 (The hearing concluded at 6:15 p.m.)
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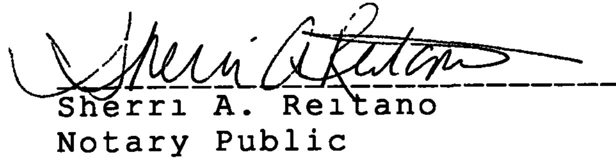
I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me in the proceedings of the above cause and that this copy is a correct transcript of the same.



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