JOURNAL

THE NATIONAL PRISON PROJECT

ISSN 0748-7655 NUMBER 17, FALL 1988

INSIDE . . .

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.

–The Oath of Hippocrates

The death chamber in the Huntsville, Texas prison, where executions by lethal injection are carried out. Inset: The drugs are administered by medically trained technicians from behind a wall.

Cover: [illegible] Photo: Inset: Huntsville Item/Cammo-Liaison

A PROJECT OF THE AMERICAN CIVIL LIBERTIES UNION FOUNDATION, INC.

DO NO HARM

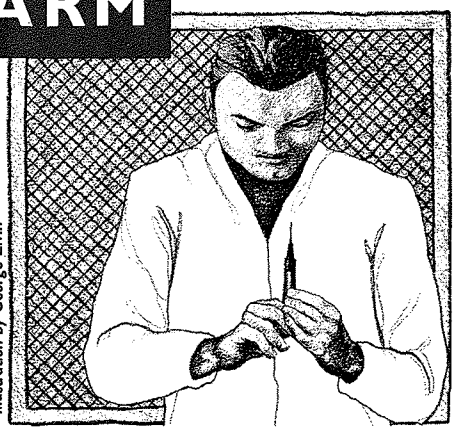


Illustration by George Elvin

The American public, more enthusiastic than ever in its demand for capital punishment for convicted murderers, has nonetheless demonstrated a certain discomfort with the agonizing details of death in the gas chamber and the electric chair. A desire to "euphemize the deed," as John Conrad expressed it, has led 17 states to authorize execution by lethal injection. Legislators seeking to avoid the appearance of primitive brutality are eager to blunt opposition to the death penalty by approving this new technology.

The growing acceptance of lethal injection as a more "humane" method of killing death-sentenced prisoners, however, has changed the dialogue about capital punishment. While physicians have always been involved in the administration of the death penalty, advising on the best method to ensure death and pronouncing death, the lethal injection method more directly involves medicine in deliberate killing. In an influential article which appeared in The New England Journal of Medicine *in 1980, William J. Curran, J.D., S.M. Hyg. and Ward Casscells, M.D., argued that lethal injection "presents the most serious and intimate challenge in modern American history to active medical participation in state-ordered killing of human beings . . . [since] this procedure requires the direct application of biomedical knowledge and skills in a corruption and exploitation of the healing profession's role in society."*

Most states which have authorized the lethal injection method of execution use what one corrections official calls "the firing squad approach." Volunteer medical technicians stand behind a barrier, and each injects a substance into a tube running through the barrier and into the prisoner's body. One of the substances is lethal; none of the volunteers knows who administers the lethal dose.

While the doctor does not personally inject the lethal dose into the prisoner, does he or she violate medical ethics by merely monitoring the death process? The writer Alexander Solzhenitsyn described the Soviet prison camp doctor in The Gulag Archipelago *as the interrogator's and the executioner's right hand man. "The beaten prisoner would come to on the floor only to hear the doctor's voice: you can continue, the pulse is normal."*

"The medical presence," wrote Casscells and Curran, "gives the impression of moral sanction by the healing professions. To be both present and performing a monitoring role is worse. It is similar to the physician who examines the prisoner intermittently during torture or prolonged interrogation and pronounces him physically fit to continue his ordeal. The 'continuous intravenous injection' ends only when the monitoring physician pronounces the condemned prisoner dead. The physician then becomes the instrument, the order, to stop the lethal action itself. There is no other way to describe this physician's role but as that of an active participant, a key human participant, in the execution."

There is reason to fear that death by lethal injection may not be as swift and painless as some would have us believe. The drugs used to sedate, anesthetize, and then paralyze have never been tested for this purpose. The prisoner may die in pain, aware of suffocating. Ironically, the FDA has insisted on proof of the safety and effectiveness of drugs used by veterinarians to kill domestic animals, to ensure they provide painless death. No such proof is required for the legalized killing of humans.

Newsweek *magazine reported that James Autry, executed in 1984 by lethal injection in Texas, "took at least ten minutes to die and throughout much of that time was conscious, moving about and complaining of pain." Stephen Morin was killed by lethal injection in Texas the following year, and technicians were reported to have taken more than 40 minutes searching the prisoner's limbs for a suitable vein in which to insert the needle.*

The larger question, of course, is that of the wisdom and morality of state-sanctioned killing, not the technical means by which it is accomplished. Why has a profession "dedicated to preserving life when there is hope of doing so" silently accepted capital punishment by any means, whether its members were directly involved or not?

In this issue of the JOURNAL, we present articles by two corrections medical professionals, Dr. Armond Start and Dr. Kim Thorburn, who discuss the ethics of medical involvement with executions. In addition, we invited Jennie Lancaster, former superintendent of the North Carolina Women's Prison where Velma Barfield was executed four years ago, to give her account of how that event affected her.—J.E.

Doctors' Involvement in Death Penalty Creates Ethical Dilemma

Kim Marie Thorburn, M.D.

A small group of physicians in Denmark, members of Amnesty International, devote all of their work in human rights toward protesting the death penalty. Convincing their United States colleagues that they should remove themselves from involvement in death sentencing and executions is their goal. Doctors are so involved in the application of the death penalty in the United States that there would probably be no executions without their participation.

Contradictions in Physicians' Roles

The development of new methods of execution has its roots in medical compassion. A doctor invented the guillotine because death by hanging seemed too cruel.[1] Doctors' protests of cruelty brought an end to flogging and other

Dr. Kim Thorburn is medical director for the Hawaii Department of Corrections.

[1]See, e.g., Albert Camus, "Reflections on the Guillotine," *Resistance, Rebellion, and Death*, (Vintage Books, 1974).

THE
JOURNAL
OF THE
NATIONAL PRISON PROJECT

Editor: Jan Elvin
Editorial Asst.: Betsy Bernat

Alvin J. Bronstein, Executive Director
The National Prison Project of the
American Civil Liberties Union Foundation
1616 P Street, N.W.
Washington, D.C. 20036
(202) 331-0500

The National Prison Project is a tax-exempt foundation-funded project of the ACLU Foundation which seeks to strengthen and protect the rights of adult and juvenile offenders; to improve overall conditions in correctional facilities by using existing administrative, legislative and judicial channels; and to develop alternatives to incarceration.

The reprinting of *JOURNAL* material is encouraged with the stipulation that the National Prison Project *JOURNAL* be credited with the reprint, and that a copy of the reprint be sent to the editor.

The *JOURNAL* is scheduled for publication quarterly by the National Prison Project. Materials and suggestions are welcome.

The National Prison Project *JOURNAL* is designed by James True, Inc.

corporal punishments,[2] yet doctors in the U.S. have not recognized the parallel cruelty of the death penalty. Many doctors (agreeing with 70-80% of the U.S. population) believe executions are necessary and that civic duty calls for their participation. Since executions do take place in the U.S., some physicians argue, the medical profession might as well ease the way.[3] This attitude among legislators ushered in lethal injection executions, maintained by some to be a humane death.[4] Others note the sense of

A doctor invented the guillotine because death by hanging seemed too cruel.

legitimacy which a professional medical procedure—administering intravenous drugs—confers on the act of killing.[5]

The contradictions of physician participation are not limited to attendance in the death chamber. Doctors are sometimes involved in capital trials, during the long wait on death row, and in the preparations for the execution. To save lives and relieve suffering are a physician's duties. Any involvement with condemned persons should be an ethical dilemma for doctors.[6]

—continued on next page

[2]See, e.g., Leo L. Stanley, *Men at Their Worst*, (D. Appleton Century Co., Inc., 1940).
[3]See Herbert G. Kersten, letter to the editor, *The New England Journal of Medicine* 302, (1980), p.971.
[4]See, e.g., Carol Cancila, "Court Stalls Lethal Injections: Physicians' Role in Executions Debated," *American Medical News*, (Oct. 28, 1983).

[5]See Ronald Bayer, "Lethal Injections and Capital Punishment: Medicine in the Service of the State," *Journal of Prison and Jail Health: Medicine, Law, Corrections and Ethics* 4 (1984), pp.7-15.

[6]In 1986, the Danish physicians led their Scandanavian colleagues in a strong statement about the dilemma: "From ancient times to the present, codes of medical ethics have recognized the basic premise that the purpose of medical knowledge and skill is to improve health and relieve human suffering.

"For a physician to prepare, administer or monitor any procedure with a view to [the] injuring of human beings or to train others to do so would be a perversion and corruption of medical knowledge and skill and of the physician's responsibility to and role in society.

"Thus, the medical associations of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) in recognition of human integrity declare it indefensible for any physician to participate in any act connected to and necessary for the administration of capital punishment."

"Nor Will I Prescribe a Deadly Drug . . ."

Armond H. Start, M.D., M.P.H.

In 1976, the state of Oklahoma passed legislation that required the death penalty be implemented by using an overdose of a short-acting barbiturate and a muscle paralyzing agent. Texas followed with similar legislation, becoming the first state to execute a person utilizing the lethal injection technique. Several states have subsequently passed legislation that requires the death penalty be carried out using a lethal overdose of commonly used anesthetic drugs. An ethical conflict arises when medical staff become involved in the process of execution using the lethal injection approach.

Medical ethics may be defined as a code of behavior that sets limits beyond which behavior will be unacceptable, and in general addresses areas not defined by law. In all states that have lethal injection laws, there is no requirement that medical personnel participate in the process. In some states the law requires a physician to pronounce death. Medical staff may legally refuse to participate in lethal injection procedures, including the preparation of policies and procedures.

Physicians and other medical personnel believe that the Hippocratic Oath generally defines the ethical professional behavior of health care staff. A portion of that oath states, "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death." It is obvious that anyone who swears to this oath cannot be involved in any way with the execution of a person utilizing the lethal injection method.

The Thirty-seventh Session of the United Nations General Assembly adopted a resolution on Principles of Medical Ethics relating to the treatment of prisoners. Principle Three states, "It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees, the purpose of which is not solely to evaluate, protect, or improve their physical and mental health."[1] It is absurd to take the position that involvement in the lethal injection process does not affect the prisoner's physical or mental health.

The American Medical Association in 1980 passed a resolution that defines proper physician behavior in this area. The resolution states, "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution."[2] In regard to the certification of death the resolution states, "A physician may make a determination or certification of death as currently provided by law in any situation." Some physicians have interpreted the certification of death allowance to mean that the physician may listen to a stethoscope attached to the prisoner's chest in order to determine the exact time of death. This practice must be condemned because it involves the physician in the procedures of execution. The physician may be called upon to certify death after non-medical personnel have determined that all evidence of life has disappeared.

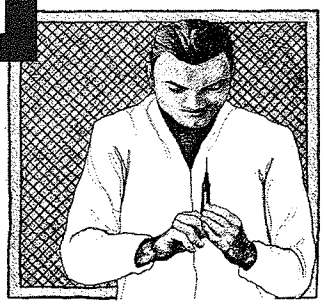
The mechanics of carrying out a judgment and sentence are the responsibility of the non-medical correctional administrator. That person is given the authority by state law to obtain the necessary drugs and equipment from conventional supply houses (pharmacies). It is not necessary for a physician to "write a prescription." The same state law that authorizes a physician to write prescriptions authorizes a non-medical correctional administrator to obtain the supplies needed to effect the death penalty. A non-medical person with average intelligence can determine an overdose of the lethal drugs called for in the law. There are many non-medical persons who are skilled in intravenous fluid administration that can be employed in a confidential manner to assist the designated correctional administrator in the administration of the lethal drugs. Examples of persons who possess these skills include technicians who work in animal laboratories, veterinarians, basic science physiologists and pharmacologists, ex-military paramedics, and ex-IV drug users.

The inmate patients served by the medical staff must believe that the medical staff is committed and dedicated to the preservation of life. ■

Armond Start, M.D., M.P.H., former medical director of the Oklahoma and Texas prison system, is a consultant in correctional health care and medicine. He received the National Commission on Correctional Health Care's Award of Merit for his fight to prohibit physicians from participating in capital punishment and for leadership in improving correctional health care.

[1]*Principles of Medical Ethics*, Proceedings of the Thirty-seventh Session of the United Nations General Assembly A/Res/37/194 (March 9, 1983).
[2]*AMA Judicial Council: Report to the House of Delegates—129th Annual Convention, Chicago*, American Medical Association, (1980).

DO NO HARM



—*continued from previous page*

Prior to an execution, medical contributions can make the difference between a life or death sentence, or between proceeding with or cancelling an execution. One blatant example is in determination of the defendant's competency to be executed. The Supreme Court held, in a 1985 decision, *Ford v. Wainwright*, that the execution of an insane person violated the Eighth Amendment.[7] Most death penalty states already prohibited execution of insane persons. Even so, *Ford* prompted considerable discussion in the psychiatric community.[8] Should psychiatrists be involved in competency-to-be-executed evaluations? If the doctor finds adequate insight or no mental illness, the condemned person will be killed. If the doctor finds mental illness, there is an obligation to treat in order to relieve suffering. Treatment can lead to improvement and then, probably, to death. Physician decisions and actions that lead to the intentional death of a person are the antithesis of the profession's purpose.

Forensic medical testimony may also have a deadly outcome by contributing to a verdict of capital murder or by presenting medical evidence of aggravating circumstances during the sentencing phase of a capital trial. Medical testimony is often the opinion of the forensic expert. Forensic pathologists can, and often do, testify in support of the death penalty.

Doctors in the Death Chamber

Besides competency [to-be-executed] evaluations, it is the appearance of doctors in the death chamber that has caused the most discussion within the profession. In 1977, Oklahoma and Texas became the first states to institute lethal injection as a method of execution. The Oklahoma Medical Association lobbied hard to remove doctors from the process.[9] The day the law passed in Texas,

[7]*Ford v. Wainwright*, 106 S.Ct. 2595 (1985).
[8]See, e.g., "The Death Penalty: Dilemmas for Physicians and Society, a Panel Discussion," *Pharos*, (1987), pp.23-27. Also, Diane M. Gianelli, "Death Penalty Ruling Creates Dilemma for Psychiatry," *American Medical News*, (July 11, 1986).
[9]See Robert Moore, "Doctor as Executioner: The Argument Over Death By Injection," *The New Physician*, (1980), pp.21-24.

Forensic pathologists can, and often do, testify in support of the death penalty.

the state medical association passed a resolution prohibiting physician participation in executions, except to certify death.[10] After several states had established lethal injection executions, but before the first sentence was carried out in Texas in 1982 against Charlie Brooks, the American Medical Association (AMA) declared that no physician should participate in an execution, except to certify death.[11] "Participation" is defined by the AMA Judicial Council as the direct administration of the drugs or the supervising of other personnel.[12]

The AMA has no position on capital punishment. It has never censured physicians for involvement with the death penalty. Inquiries into physician participation in executions are met by mailing its resolution.[13]

The AMA Judicial Council's discussion and resolution were stimulated by implementation of lethal injection execution laws, an egregious medicalization of the death penalty. More subtle medicalization of the executions has become tradition; physician attendance in the death

[10]See, e.g., "Injection Death Laws Become Ethical Issue," *American Medical News*, (July 11, 1980). Also, Ward Casscells and William J. Curran, "Doctors, the Death Penalty and Lethal Injections," *The New England Journal of Medicine* 307, (1982), pp.1532-1533 .
[11]*AMA Judicial Council: Report to the House of Delegates—129th Annual Convention, Chicago*, American Medical Association, (1980). The resolution says, "An individual's opinion on capital punishment is the personal moral decision of the individual. A physician as a member of a profession dedicated to preserving life when there is hope of doing so should not be a participant in a legally authorized execution. A physician may make a determination or certification of death as currently provided by law in any situation." See also, *Opinions of the Ethics Committee on the Principles of Medical Ethics*, with annotations especially applicable to psychiatry, American Psychiatric Association, (1985); *Resolution on Physician Participation in Capital Punishment*, World Medical Association, (1981).
[12]See, e.g., William J. Curran and Ward Casscells, "The Ethics of Medical Participation in Capital Punishment by Intravenous Drug Injection," *The New England Journal of Medicine* 302, (1980), pp.226-230. Also, John H. Burkhart, "Legal Executions Raise Ethical Issues for MDs," *American Medical News*, (February 25, 1983).
[13]See, e.g., Doug Lefton, "Execution of Texas Prisoner Raises Ethical Issue for MDs," *American Medical News*, (December 17, 1982). Also, physicians who made inquiries to the AMA about the physician who directed further electrocutions during the 1985 Indiana execution of William Vandiver received a terse letter from AMA staff directing correspondents to the 1980 resolution.

Machine Administers Fatal Injection

Julia Cade

An enterprising businessman has developed a machine to administer lethal injections without the assistance of medical personnel. One satisfied customer, H. Brooke Laggner, explains, "It takes away the element that you don't have any Hippocratic Oath problems because all you need is someone to set up an IV" Laggner is the chief of administration and operation support for Delaware's Department of Corrections. Delaware is one of five states that have purchased the $30,000 lethal injection machine.

According to an Associated Press report, the injection machine is a 3-by-4-foot gray box with a row of switches and red lights. The device is mounted to the wall above the prisoner's gurney. Five to six feet of IV tubing—inserted into the prisoner's right arm by a medical technician—run through the wall to a computer control panel. The execution procedure consists of two executioners activating the machine by pushing a button—neither knows which one actually causes the 10-15 cubic centimeters of drugs to be injected.

Three rounds of drugs are administered over a four to six minute period, "as opposed to 25 minutes to a half an hour," says Norbert C. Lynch, president of American Engineering Company, located in Boston, which designed and manufactures the lethal injection machine. They also make electric chairs, gallows and gas chambers. It is believed to be the only company in the United States specializing in execution equipment. Lynch describes the machine's importance by saying, "This is the most humane way we know of today to carry out lethal injection. If they're going to carry it out, they should do it in the most humane way possible. The methodology that's used in the lethal injection on a manual system is barbaric." He explains that the basic complications in lethal injection executions are ruptured veins, inaccurate dosages and failure to immediately induce unconsciousness.

The lethal injection machine marketed by Lynch administers three layers of drugs. The first dosage of sodium thiopental brings on unconsciousness. The second dosage of pancuronium bromide (Pavulon) paralyzes body functions. The third dosage of potassium chloride stops the heart. ■

chamber is the procedure in many states. Death is often pronounced—not just certified—during electrocution or lethal gassing, by listening for the cessation of heartbeats through a long-tubed stethoscope. Frequently, in the case of electrocution, one high-voltage jolt is not enough to induce cardiac arrest. When the listening physician indicates continued survival, more shocks are delivered. The doctor directs the execution, even if he or she does not pull the switch.

Professional Conflicts

Prison doctors most directly confront the professional conflicts created by the death penalty. Besides the usual assumption by prison officials that institutional physicians should preside over an execution, prison doctors render care and treatment to condemned prisoners who often spend years in the destabilizing environment of death row. From the doctor's perspective, provision of care to condemned prisoners may be similar to attending patients with terminal illnesses. Physicians caring for condemned prisoners must make decisions about appropriate medical interventions, and deal with refusal of care[14] and suicide.[15] Medical care decisions may be influenced by the patient's scheduled death. Even without the burden of these difficult decisions, a caseload of "terminal" patients can be emotionally draining.

The prison doctor's caring role may be needed and requested by staff as well as prisoners, as corrections professionals are reticent to discuss the emotional shock of their duty to kill. For example, the American Correctional Association takes no position on the death penalty, but has begun to educate its members in death row management, acknowledging inherent difficulties which affect facility operations.[16] An execution has a dramatic and moving effect on a prison and its staff.[17] Prison administrators may turn to the facility's physician for emotional support.[18] Presence of a medical professional at an execution symbolically absolves the prison officials who carry out the killing.

The doctor directs the execution, even if he or she does not pull the switch.

The charitable role of a doctor at an execution may also go beyond the prison walls to reflect society's desire for release from responsibility. Our courts acknowledge that a society's standards of decency evolve.[19] Western democracies and many nonaligned nations believe the death penalty is indecent, and have abolished it. In the U.S., we persist in killing certain criminals, but in tacit acknowledgement of evolving standards of decency, there is evidence of some public discomfort about it.[20] It is our larger society which seeks medicalization of the death penalty. The public recognizes the medical profession's ethical duty of beneficence; participation by an altruistic profession in the process leading to the execution conveys a sense of decency to state killing.

As participants, and by assent of the profession, U.S. physicians are key players in the perpetuation of capital punishment. Therefore, they have a role in bringing about its abolition. In a 1973 text, Ralph Slovenko argued that medicalization of the death penalty was responsible for ending executions in the U.S.[21] The country was in the midst of a 10-year moratorium on executions. One year earlier the U.S. Supreme Court had, in *Furman v. Georgia*, overturned all extant death penalty laws.[22] Executions had, in fact, come to a halt by 1976; public opposition to the death penalty was at an all-time high. Slovenko noted that since competency was required for execution, it was the physician, not the warden or the sheriff or the politician, who was responsible for the decision to kill. Psychiatrists then, as now, were uncomfortable with that role. "The capacity-to-stand-execution procedure . . . ," says Slovenko, "achieved the functional abolition of the death penalty."[23] If his argument is correct, medical repugnance could again lead to abolition of the death penalty.

Medical research may be another way for the profession to contribute to the abolition of capital punishment in the U.S. To date, very little epidemiologic research has been done on death row. One small series demonstrated a high rate of neuropsychopathology among condemned prisoners.[24] The authors raised concerns about the significance of their findings on death sentencing: does the pathology preclude an adequate defense?

Discrimination in Death Sentencing

Despite the U.S. Supreme Court's disquietude about "arbitrary and capricious" death sentencing in *Furman*,[25] discrimination continues.[26] Racial discrimination was acknowledged in the Court's opinion in *McCleskey v. Georgia*;[27] discrimination against defendants with mental and neurologic diseases may also exist. Only the medical profession can affirm or deny a high prevalence of neuropsychopathology among death row populations. If the preliminary findings were confirmed, they would provide further evidence of discriminatory sentencing in death cases. Various states and the federal government have outlawed discrimination on the basis of race or medical handicap. This year, civil rights advocates introduced the Racial Justice Act in Congress which will permit use of statistics to determine racism and prohibit such discrimination in death sentencing. Once civil rights laws are applied to the death penalty, persons with medical handicaps should also be protected.

The distress of the Danish abolitionist physicians is justified. U.S. physicians must be convinced of the ethical problems of their involvement in the death penalty. They hold the keys to its abolition. ■

[14]See William Hoffer, "Medical Care on Death Row: Awaiting Execution, Manuel Quintana Refused Bypass Surgery," *American Medical News*, (March 9, 1984).

[15]See Kim Marie Thorburn, "Physicians and the Death Penalty," *The Western Journal of Medicine* 146, (1987), pp.638-640.

[16]See Charlotte A. Nesbitt, "Managing Death Row," *Corrections Today*, (July 1986).

[17]The BBC film "Execution: 14 days in May," which deals with a Mississippi prison's response to the execution of Edward Earl Johnson, demonstrates mounting tension as the execution date approaches. Also, at a workshop at the 1987 Congress on Correction, Warden Jennie Lancaster of the North Carolina Correctional Center for Women, told of her struggle and the pain of her staff caused by the execution of Velma Barfield.

[18]In my role as a prison physician, a warden once confided that he dreaded facing his task of executioner. "If you're my doctor [the prison doctor]," he said, "I'll want you at the execution for MY consolation and for my staff."

[19]*Trop v. Dulles*, 78 S.Ct. 590 (1958).

[20]In 1986, Amnesty International commissioned pollster Pat Caddell to evaluate public attitudes about the death penalty in Florida. The overwhelming majority of respondents answered positively to "Do you support the death penalty?," but in specific situations (e.g., executing juveniles, executing in lieu of life imprisonment without parole, executing mentally retarded individuals), the response was more negative.

[21]See Ralph Slovenko, "Competency to Be Executed," *Psychiatry and Law*, (Little, Brown, 1973), Chapter 7.

[22]*Furman v. Georgia*, 408 U.S. 238 (1972).

[23]See Ralph Slovenko, *supra*, p.125.

[24]See Dorothy Otnow Lewis, Jonathan H. Pincus, Marilyn Feldman, Lori Jackson and Barbara Bard, "Psychiatric, Neurological, and Psychoeducational Characteristics of 15 Death Row Inmates," *American Journal of Psychiatry* 143, (1986), pp.838-845.

[25]*Furman v. Georgia, supra* (J. Stewart concurring).

[26]See, e.g., *United States of America: The Death Penalty*, (Amnesty International Publications, 1987).

[27]*McClesky v. Kemp*, 107 S.Ct. 1756 (1987).

Corrections Staff Are "Silent Actors" in Executions

Jennie Lancaster

I began my career as a corrections professional 17 years ago. I wanted to do something to help somebody. I guess I was a typical child of the 60s who felt I had an obligation to help change the conditions of the world. My initial experience in working with offenders helped me see the different broken pieces of their lives and I felt challenged to do something about it. For a number of years, I felt I understood my role as an enabler of positive change. It was clear to me that society had expectations about what corrections people ought to be about. I knew that my first responsibility was to protect the public, but there was also an expectation that we, as corrections professionals, should do something to change people's lives in a positive manner. I lived and worked by these expectations for many years.

When I was made superintendent of the North Carolina Correctional Center for Women in July 1982, I did not realize that one of my responsibilities as a new superintendent would be to manage an execution. In November 1984, I was a part of the execution of the first woman in the United States in 22 years. Her name was Velma Barfield, and her execution became one of the most challenging and difficult experiences of my professional and personal life. It may seem unusual at this point for a corrections professional to be speaking about execution, as this has not been an open topic of discussion in correctional circles. Traditionally, capital punishment has remained a topic of emotional debate by special interest groups and the media. It is not my intent in this article to join that debate. I want to move beyond the headlines and speak about the experience corrections professionals face as they become silent actors behind the scenes, responsible for managing all the difficult realities an execution presents to staff.

It is also important for me to state clearly that these are my opinions about what I experienced in a women's facility. It is my hope that a discussion of what my staff experienced will help enlighten some and open up opportunities for communication among other corrections professionals who may face this experience. I also hope to change the stereotype that some may have of corrections staff as power-oriented, punitive and uncaring persons. Sometimes I think people feel we ended up in the prison system because we couldn't get a job in any other area. I have had the proud experience of working with some of the most dedicated professionals in the business who are committed to working to effect positive change in a challenging environment. These challenges have never been more difficult than in 1984, as we prepared for Velma's execution.

These challenges have never been more difficult than in 1984, as we prepared for Velma's execution.

As superintendent for the Correctional Center for Women, I had worked with Velma Barfield, the only woman on death row at my facility, for a number of years. During these years, I developed a relationship of mutual respect and cooperation with Velma's attorney. This professional relationship involved open and honest communication about the realities of Velma's case as it moved through the appeals process. As we entered the early spring of 1984, I realized that the possibility of Velma being executed that year was a reality that her attorney, Velma, and I had to face. I realized that I, my staff and our inmates would face a number of challenging questions. I became aware that I had to make some decisions about how I felt about the death penalty and, once I resolved this within myself, I had to clarify what my role would be in this process. I never discussed my personal opinion as a component of my role as a corrections professional. In thinking about my role as superintendent, I began to feel like a parent of a large family that would undergo a crisis together and that I needed to provide guidance, support and vision to the institution. I felt very strongly about the integrity of our daily operations and I did not want to compromise this integrity by losing our perspective of the reasons why we chose to work in corrections. I looked for guidance and found a void of information about what to do. The only helpful information to be found was the strictly technical data about how to implement an execution.

As I began to discuss the possibility of an execution with my top staff, I quickly saw what their dilemma would be. It has become an irony for those of us in the corrections profession who have to face executions. In general, what I heard from my staff was, "We got into this business because we thought we could make a difference in people's lives. We are not in it because of the money or the recognition. Every now and then, we think we can make a difference. We are not sure we know what it means to kill somebody."

Our job was to take care of people for numbers of years. During this period of time, there is the strong possibility that some inmates have opportunities to change their lives and to grow and accept responsibility for their actions and who they are. We are a part of that process; we are the ones who work with them, and encourage them to grow. We are the ones who are there to work with their families and try to maintain responsible and hopeful relationships between the inmate and the family. Many times we are there to hear the confessions that come from those who finally do accept responsibility for what they have done and want to move on with their lives in a positive manner, and maybe give back a little bit to the society from which they have taken so much. We are asked to take care of somebody in a humane, responsible manner. Then we are asked to prepare to take that person's life. It became a particular dilemma for my medical and mental health staffs who felt conflicts in their roles as treatment providers who help sustain life.

I found myself telling staff that we had a right to our individual opinions about the death penalty. I encouraged them to talk with me and with each other about how we felt and what our struggle was about, but I was emphatic that our role at the institution was to be support persons who brought integrity during this period. Integrity for me, at that time, meant that we performed our jobs in the same manner in which we did every day. We were to be reasonable, caring, responsible persons who help manage a very small community, but a community that was about to experience a tremendous emotional upheaval. I feel that an execution within a women's facility is probably one of the most highly emotional events that can occur in the life of the institution. This certainly became the case in 1984.

As I began to clearly address our responsibilities with my staff, I also began to try to solicit support and guidance from others in the correctional sys-

Jennie Lancaster has just been named Female Command Manager for the North Carolina Division of Prisons, a newly established position for all six women's facilities. She was formerly the superintendent of the North Carolina Correctional Center for Women.

We are asked to take care of somebody in a humane, responsible manner.

tem. The issue of execution has never received a lot of attention, except about the process. I was instructed to develop and implement new security procedures, and I was given specific directives about dealing with the tremendous amount of media interest in this case. I began to feel that my institution and my staff were an isolated island. Although surrounded by many people who were expressing very definite ideas about what was about to happen, we were not receiving a lot of support for the difficult process that this puts people through. There were few people around who said, "Hey, I understand what you must be feeling and I know it's tough and I want to help." I did get many questions about how I was managing everything at the institution. I particularly felt some intense scrutiny about a female institution preparing for this execution. Could we keep our feelings in perspective? Could we manage Velma? As an administrator, it became a daily challenge for me to walk a fine line in facing what I think is the greatest challenge to the integrity of our profession and how to do it.

There are people who say that we are simply following the law and that we are not actually involved in taking someone's life. I disagree. For several months prior to the execution, I was involved in many specific things that clearly were about the planning and the process of the ending of Velma Barfield's life. I became very focused on the individual and the family that I had worked with over the years. There was a sense of helplessness and dependency that I felt from Velma and her family. As staff, we had developed relationships with her family that involved an active process of listening, care and support for the unbelievable stress and pressure they experienced because a person they loved lived on death row and faced execution.

We corrections professionals are quiet about what we are and what we do, but we are at a point of silence when facing an execution. It's as if we feel that we have to fulfill some sort of myth in society's mind that we have no feelings about the people we work with; I find this to be totally incorrect. To have feelings and concern for those persons under our care doesn't mean that we absolve them of responsibility for what they did or that we deal sympathetically with them. Rather, for me it means that we realistically approach them as human beings, human beings who have used poor judgment in their lives. We are placed in a guardianship role. This role also proves to be confusing to the inmates.

I think an idea exists that might be supported by some in the general public, that you should not deal with inmates as people, you simply deal with them as bodies who do what you tell them to do. My philosophy has always been to treat inmates as they respond to the environment and to allow them some limited control over their own lives. I was fully aware that Velma's pending execution was raising various issues and concerns in our inmate population and I wanted to acknowledge this reality. The general comment I heard from inmates was, "You people tell us to change our lives. You tell us that if we change our lives and ask for forgiveness, that we can find a place in this society. We see Ms. Barfield as an inmate who has helped many of us while we were in segregation. She always encouraged us to change our lives. What does her execution mean for the rest of us? How do we understand the words we heard from staff about changing our lives? We don't understand." I saw fear and anxiety and allowed them to express their feelings in a responsible manner. I asked the staff to listen and not to interject their own personal opinions when they heard the women's concerns and feelings. The month prior to the execution, we used the Sunday Morning chapel times to face the fact that an execution was probably going to occur and that it was going to cause a great deal of feeling within the small community in which we worked and they lived. I felt the tension and emotion build up until the time of the execution. The first visible event for the inmates was when we moved Velma to Central Prison, the actual site of the execution chamber, several days before her scheduled death at 2:00 a.m. on November 2.

My staff had spent much time considering and planning what our efforts would be on the actual night of the execution. Our plans included using every employee in some manner over a 24-hour period. We stationed treatment staff as teams in the dorms to work with the correctional officer who was assigned to that post. So often the custodial officers feel they are on the "firing line" alone when a crisis occurs. We allowed inmates to express feelings and grief, and the one individual who began acting out was managed appropriately. The treatment teams were in place all night. I made the statement after the execution that Velma was executed at Central Prison, but she died at Women's Prison. We got through the night and subsequent days without any major incidents.

Could we keep our feelings in perspective? Could we manage Velma?

In summary, I feel we faced several dilemmas:

1. Corrections staff are generally caring people who care for inmates, see them daily and work with their families. We are the *real* actors in the prison. Then we are asked to prepare to kill someone. I have talked with several persons who have been directly involved in executions in other states, and it was a powerful personal experience for them also.

2. Some corrections staff have personal opinions about the death penalty. Whatever their opinion, they must move beyond it to carry out the process, and their involvement can cause emotional upheaval. Executions can affect all staff, however minimal their active involvement.

3. As the reality of an execution approaches, the event becomes a political and public event that brings much attention. The corrections staff feel that they are under a microscope of scrutiny and this places additional pressure. They feel more isolated.

4. Corrections staff involved in managing executions receive much direction about process. They need support before and after the execution that recognizes the dilemmas they may face. There needs to be follow-up support with staff involved, although many others may assume the experience is over and forgotten. It stays with you.

5. Finally, corrections staff who must manage and treat death row inmates and who must be involved in all levels of planning and implementing executions get caught up in the volatile emotional disagreement about capital punishment. This indirect involvement can mirror conflict about our mission.

Personally, I have felt the dilemma of being a silent actor stepping into the public arena. My hope is to encourage dialogue and understanding. ■

AIDS Policies Tested in Alabama Prison Case

Nancy Ortega

The nurse sits in silence as the syringe fills with blood being drawn from the arm of the new prisoner. Unaware that he is about to be tested for AIDS, the prisoner asks no questions, makes no objections.

Only a few days after testing, this prisoner will be approached by a guard, told to gather his things and not to speak with the other prisoners. He is locked in isolation at first, without explanation. Two weeks later a passing comment from a guard will bring the news that he is dying, the victim of a fatal, dread disease. Over a month passes before he finds out he does not actually have AIDS.

Currently, the Department of Corrections in Alabama requires testing of all state prisoners for exposure to the Human Immunodeficiency Virus (HIV).[1] HIV must be present in order for AIDS to develop; but its presence does not necessarily mean that one will develop AIDS.[2]

For Alabama prisoners, the consequences of mandatory testing are especially dire. Those who refuse to submit to the test are isolated from the general population and subjected to punitive sanctions. Those who submit to the test and test positive are subjected to harmful, humiliating and unconstitutional practices and conditions.

Law and policy dealing with AIDS discrimination outside the prison setting are just beginning to develop.[3] Thus, it is not surprising that many legal issues created by AIDS in a prison setting have yet to be addressed, much less developed. A suit recently filed on behalf of all Alabama state prisoners, *Harris v. Thigpen*,[4] is the first challenge to mass mandatory testing of state prisoners for exposure to HIV and the policy of segregation and ostracism associated with that testing.[5]

While several prisoner lawsuits have challenged the discriminatory treatment of those who test positive for HIV exposure, *Harris*, pending in the United States District Court, Middle District of Alabama, is the first to challenge mandatory mass testing. Originally filed as a *pro se* complaint, *Harris* also challenges policies and practices arising from forced testing, including the isolation of prisoners who test positive into segregated housing units.

Treatment of HIV Positive Prisoners in Alabama

The blood test administered by the Alabama Department of Corrections does not test for AIDS. It merely tests for the presence of HIV antibodies using a test known as the enzyme linked immunoabsorbent assay (ELISA).

A positive ELISA result, indicating the presence of HIV antibodies, does not mean that the individual has AIDS. In fact, the Centers for Disease Control (CDC) recommend that a second blood test be given when an individual initially tests positive on ELISA, because of the high risk that the first test may be falsely positive. Even if that second test is positive, the CDC further recommends that a third and more accurate blood test, the Western Blot, be given to confirm or contradict the ELISA result. Even the accuracy of the Western Blot depends, however, upon the skill of the laboratory conducting the test.

Many Alabama prisoners are not told for what purpose they are being tested; they are only told they will be placed in isolation if they refuse to submit to the test. The Alabama Department of Corrections does not provide information or counseling to the prisoners about the test before or after it is administered. Corrections staff is no better informed about AIDS transmission than prisoners, since the Department of Corrections conducts no staff education on AIDS.

In Alabama, a prisoner is transferred to a segregation unit upon the first positive ELISA result, totally disrupting the fabric of that prisoner's life.[6] Prisoners participating in community programs at the time they test positive are removed from these programs, returned to prison and placed in the segregation unit. As a result of their segregation status, these prisoners lose the opportunity to participate in any vocational and most educational programs; they are not allowed to work. Thus, they cannot use their time in prison to learn additional job skills or improve existing job skills which would increase economic opportunities upon release. In addition, unlike prisoners in the general population, these inmates cannot earn money for themselves or their families.

The inmates are not allowed to participate in religious services with the rest of the general population. There is no access to the gym or recreation yards. The HIV positive inmates must exercise separately from the general population. Access to the law library, if allowed, is limited to one late hour a week after the library is closed to the general population. Thus, no inmate legal aides are available to assist the HIV positive inmates. HIV positive prisoners cannot go to the prison beauty or barber shop. They can only go to the canteen at a time separate from the general population, if at all. Even then, they are escorted by guards.

Prisoners in the HIV units must eat off plates with plastic utensils or wooden sticks. Any reusable plates are washed separately from plates used by the general population. Sheets and towels are marked with inmates' names and are placed in red garbage bags and washed separately.

These inmates are not allowed to participate in drug or alcohol rehabilitation programs with the general population. The Department of Corrections also denies them access to pre-release programs, community based programs and furloughs. This policy denies the opportunity to make any meaningful transition back to society. In short, HIV positive prisoners are not allowed to participate in any activity where they will be in the same room with other prisoners.

This change in classification occurs

—continued on page fourteen

Nancy Ortega is an attorney with the Southern Prisoners' Defense Committee in Atlanta, GA, and is counsel for the prisoners on the Harris *case.*

[1]Under a recently enacted state statute, all Alabama state prisoners must submit to a blood test for HIV antibodies upon admission to prison. Prisoners must also submit to another test 30 days prior to their release. 1987 Ala. Acts 574. The Alabama Department of Corrections has extended mandatory testing to all prisoners by administrative edict.

[2]See "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," 36 *MMWR* 509, (Aug. 14, 1987).

[3]A recent article that discusses developments in AIDS law outside the prison setting is Weisenhaus, "The Shaping of AIDS Law," *National Law Journal*, (Aug. 1, 1988), p.1.

[4]*Harris v. Thigpen*, No. 87-V-1109-N (M.D. Ala., filed November 5, 1987).

[5]The prisoners are represented by attorneys from the National Prison Project in Washington D.C., local Alabama attorneys, and attorneys from Southern Prisoners' Defense Committee in Atlanta, Georgia.

[6]Alabama is among a small minority of states that does not distinguish between prisoners with positive antibody tests and prisoners who have AIDS in its segregation policy. "NPP Gathers Statistics on AIDS," *NPP JOURNAL*, Number 16, (Summer 1988).

JOURNAL
THE NATIONAL PRISON PROJECT
NUMBERS 1 THROUGH 16
FALL 1984-SUMMER 1988

Index to Articles:

B

K

L

M

N

O

—continued from page eight
without a hearing, despite the fact that the consequences are similar to or more severe than those imposed upon prisoners placed in disciplinary segregation.

Some of the prisoners were led to believe that they were suffering from AIDS, when in reality they had at most tested positive for exposure to HIV. No program exists to educate the prisoners about the differences between testing positive and actually having AIDS. Most suffer from severe emotional distress and depression after being informed that they have tested positive. The idleness resulting from the policy of total segregation aggravates the depression that already exists because of the prisoners' misguided belief that they have a fatal disease.

The failure by the Alabama Department of Corrections to educate and counsel continues, despite warnings by leading medical authorities that overwhelming psychological devastation can result from an AIDS diagnosis, and calls for counseling to be an essential component of HIV testing.

By housing these prisoners in the "AIDS unit," the prison immediately identifies, and effectively publicizes to other prisoners and staff, those prisoners who have tested positive. Lack of concern for confidentiality is also demonstrated by officials who permit the casual public disclosure of the names of those who test positive.

These conditions persist despite the overwhelming medical evidence that AIDS is not spread by casual contact, including breathing the same air, sneezing, coughing, sharing razors or eating utensils, touching the same objects, playing sports together, shaking hands, hugging or kissing. AIDS is only spread specifically through contact with HIV-infected blood or semen, or perinatally (mother to unborn child).

Upon release, these prisoners will be stigmatized as AIDS carriers. Such a stigma is likely to affect their ability to find a job, housing or insurance, among other things. In addition, the stigma of AIDS isolates them in their own community. One of the HIV positive inmates likened herself and the others to Hester Prynne in *The Scarlet Letter,* who wore the scarlet letter "A" to signal to the community that she was to be ostracized. Now, she says, that scarlet letter "A" stands for AIDS.

Mickey Welsh, The Alabama Journal

Prisoners at Tutwiler stare from behind locked doors of isolation unit.

This testing and its consequent segregation raise a wide variety of legal issues, some of which have never been litigated. *Harris* challenges both mandatory testing and segregation on a number of legal grounds.

Mandatory Testing

The challenge to mandatory testing in *Harris* is based on three legal arguments. First, the prisoners allege that the mandatory testing program violates even the limited Fourth Amendment protections available to prisoners. Second, they allege that mandatory testing violates their constitutional right to privacy. The Supreme Court in *Hudson v. Palmer,* 468 U.S. 517 (1984), held that prisoners receive only limited protection against searches; in *Bell v. Wolfish,* 441 U.S. 520 (1979), the Court made clear that even those searches must be conducted in a reasonable manner. The blood test is an unreasonable search in that it is an invasion of bodily privacy and a public dissemination of confidential medical information. The unreliability of the blood test prevents it from significantly increasing prison security.

The prisoners' second argument is that the inevitable dissemination of this stigmatizing information violates their right of privacy. Mandatory testing, by its very nature, is a form of forced disclosure, thus raising the question of to whom the results of the test are to be disclosed.

The Supreme Court's holding in *Houchins v. KQED,* 438 U.S. 1, 5, n.2

(1978) (plurality opinion), was based on the assumption that prisoners do retain some right to privacy. This right to privacy in their person is to be balanced against the legitimate security interests of the prison. See *Bell, supra.* The privacy interest implicated in *Harris* is the right to avoid governmental dissemination of stigmatizing information. The leading case on this privacy right, *Whalen v. Roe*, 429 U.S. 589 (1977), upheld the constitutionality of a reporting statute requiring identification of all individuals to whom narcotics had been prescribed. The statute, however, was upheld only after careful analysis of the safeguards against public disclosure built into it.

Thus, any program of testing must at least be balanced by reasonable precautions to protect the confidentiality of the results. Forced disclosure must also be limited if it is to accord with the right of privacy.

The degree of protection which courts will afford to the HIV positive prisoner's right of privacy remains an open question. An example of a case in which a court provided little protection to prisoners' right of privacy is *State Department of Correction v. Public Employees Council 82*, Civil Action No. 8462 (Del. Ch., 1987). In that case, correctional staff sought to obtain lists of all HIV positive inmates in their system. The suit was brought after several inmates were voluntarily tested with the guarantee of confidentiality. Correctional officers sought access to the results of these tests on the basis of a provision in their employment contract that they would be notified of all names of inmates suspected of having communicable diseases. An arbitrator determined that the Department of Corrections had to allow access to the test results, and the court upheld the arbitrator's decision.

A recent case involving the casual disclosure of a prisoner's positive test for the AIDS virus illustrates, however, that prisoners do have a right to privacy in information about their medical condition. In *Woods v. White*, No. 86-C-701-C, WD Wis., July 27, 1988, the court held that a prisoner "retains his right to privacy, although he is incarcerated. The right to privacy is not terminated by conviction for a crime." The casual disclosure of a prisoner's positive test results to non-medical personnel was held to violate that prisoner's constitutional right to privacy. Additionally, the court noted "that public disclosure of test results for the AIDS virus may implicate the other aspect of the right to privacy mentioned in *Whalen*: the right of autonomy in making certain fundamental decisions pertaining to such matters as family, procreation, and medical treatment." *Woods*, Slip Op. at 5, n.1.

While there is, as yet, no consensus on the issue, recognition of the importance of privacy safeguards is growing as understanding, awareness and experience of AIDS increases. Two prison cases in which mandatory testing has been prohibited have been based on state laws prohibiting disclosure of test results without the informed consent of the subject. *See Dean v. Bowie*, Civil Action No. 87-4745 (Suffolk Sup. Ct., Mass.) (trial judge ruled that an inmate accused of scratching and spitting at a guard could not be involuntarily tested to learn if he was HIV positive. The court took note of strong medical evidence against transmission of HIV through saliva); *Barlow v. Superior Court*, 236 Cal. Rptr. 134 (Cal. App. 4th Dist. 1987) (court invalidated a search warrant authorizing HIV testing of defendant charged with biting a police officer while resisting arrest).[7]

One example of federal legislation coming to grips with the confidentiality issues raised by testing is the recently enacted Veterans Benefits and Services Act.[8] The legislation deals with confidentiality of information, discrimination against persons who have tested positive for exposure to HIV, educational efforts, and voluntary versus mandatory testing.

More recently, the U.S. House of Representatives approved the Fair Housing Act, which prohibits discrimination against people with disabilities, including carriers of the AIDS virus. Heightened awareness of the problems created by mandatory testing has been provided by the Report of the President's Commission on AIDS which calls for voluntary testing and anti-discrimination laws.[9]

Medical Care

The plaintiffs in *Harris* allege that the lack of medical care in the AIDS unit violates the standards established by the Supreme Court in *Estelle v. Gamble*, 429 U.S. 97(1976). They claim that they are being treated with deliberate indifference to serious medical needs and therefore subject to cruel and unusual punishment. For example, the prisoners claim that the prison doctor who visits the men's AIDS unit refuses to touch the prisoners while making his examination. The prisoner, of course, is unable to seek medical care from another doctor outside the prison walls.

Segregation

Alabama's policy of segregation of HIV positive prisoners is challenged in *Harris* on numerous grounds. First, plaintiffs argue that the conditions of segregation constitute cruel and unusual punishment in violation of the Eighth Amendment. Second, the suit claims that the automatic transfer of all HIV positive prisoners to the segregation unit denies them due process. Third, the reduced or eliminated access of segregated prisoners to law libraries denies these prisoners the constitutional right of access to courts. Fourth, the discriminatory treatment of HIV positive prisoners, the irrational denial of access to programs in which they could participate and from which they could benefit, is alleged to violate Section 504 of the Amended Rehabilitation Act of 1973.[10] Finally, attorneys for the prisoners allege that the discriminatory treatment of the HIV positive prisoners denies them equal protection of the law.

Harris is the first case to offer such a broad-based challenge to a policy of segregation, where all those who test positive for HIV antibodies are separated from the rest of the prison population. In addition, it will be the first case in which expert testimony will be presented and used to show the lack of any medical or penological justification for segregation of those testing positive.[11]

AIDS still represents a very new phenomenon. As scientific knowledge concerning AIDS advances, and as it is brought before the courts, the decisions of the courts are bound to be affected.

Most of the legal theories on which the *Harris* suit is based will be familiar to those experienced in prisoner civil rights litigation, although these legal theories have not been fully tested or explored in the context of segregation of HIV positive prisoners. One legal theory that is not yet been tested is the Section 504 cause of action. *Harris* contends that discriminatory treatment of HIV positive prisoners violates Section 504 of the Amended Rehabilitation Act of 1973.[12]

—continued on next page

[7]Summaries of these two cases taken from Hammett, "AIDS in Correctional Facilities: Issues and Options," National Institute of Justice, (April 1988), p. 106.

[8]Veterans Benefits and Services Act. Act of May 20, 1988. Pub. L. No. 100-322, 1988 U.S. Code Cong. and Admin. News (102 Stat.) 487, to be codified at 31 USC 101, *et seq.*

[9]Report of Presidential Commission on the Human Immunodeficiency Virus Epidemic, (June 24, 1988).

[10]29 U.S.C. §794 (as amended by the Civil Rights Restoration Act of 1987).

[11]In *Maberry v. Martin*, C.A. No. 86-341-CRT (E.D.N.C. 1987), in a *pro se* suit, an inmate raised the issue of mandatory testing and separation of HIV positive inmates. In March of 1987, the defendants' motion for summary judgment was granted.

[12]For discussions of Section 504's application to discrimination against victims of AIDS and those who test positive for the HIV virus, see generally, "Note, Protection of AIDS Victims from Employment Discrimination under the Rehabilitation Act,"

—continued from previous page
The Rehabilitation Act prohibits discrimination against handicapped individuals by anyone receiving federal financial assistance. In *School Board of Nassau County v. Arline*,[13] the Supreme Court held that individuals who suffer from a contagious disease are covered by the Act. In *Arline*, the plaintiff had tuberculosis. The holding in *Arline* was recently applied in favor of a California teacher with AIDS seeking a preliminary injunction reinstating him to classroom duty.[14] As yet, Section 504 has not been used as a basis for challenging the treatment of HIV positive prisoners.

One case involving a context closely analogous to prison, however, is *Doe v. Centinela Hospital*, No. 87-2114 (C.D.Cal. June 30, 1988). In *Centinela*, an individual was excluded from an alcohol and drug rehabilitation program because he tested positive for the presence of the HIV. Participants in the program, like prisoners, lived under constant supervision in a controlled environment. The sponsors of the program, like prison officials, expressed concern that, without screening, participants would risk exposure to the virus, because the environment is conducive to sexual encounters between participants. The court ruled that the individual in this case who tested positive was perceived to be handicapped within the meaning of Section 504, but declined to rule prior to trial on whether the individual was otherwise qualified to participate in the program and whether reasonable accommodations had been made for him.

If it was true in *Centinela* that the plaintiff was handicapped by perceptions, how much more true is it in *Harris* that the plaintiffs are handicapped by perceptions? Categorically denied access to normal rehabilitation programs, forced to undergo humiliating and degrading procedures totally unrelated to any legitimate medical concerns, required to wear masks and denied access to courts and legal materials, the plaintiffs are victims of the "myths and fears" of prison officials. ■

1987 *U. of Ill. L. Rev.* 355 (1987); Fagot-Diaz, "Employment Discrimination against AIDS Victims: Rights and Remedies under the Federal Rehabilitation Act of 1973," 39 *Labor L.J.* 148 (March 1988); "Comment, Running from Fear Itself: Analyzing Employment Discrimination against Persons with AIDS and Other Communicable Diseases under Section 504 of the Rehabilitation Act of 1973," 23 *Willamette L. Rev.* 857 (1987); Note, Asymptomatic Infection with the AIDS Virus as a Handicap under the Rehabilitation Act of 1973, 88 *Col. L. Rev.* 563 (1988).

[13]170 S. Ct. 1123 (1987).

[14]*Chalk v. United States District Court, Central District of California*, 832 F.2d 1158 (9th Cir. 1987) (order), 840 F.2d 701 (9th Cir. 1988) (opinion). Other published opinions dealing with AIDS discrimination challenges outside the prison setting based on §504 are *Thomas v. Atascadero Unified School Dist.*, 662 F. Supp. 376 (C.D.Cal. 1987) (the court granted a preliminary injunction prohibiting the school district from excluding a child with AIDS from the classroom); *Ray v. School Dist. of Desoto County*, 666 F. Supp. 1524 (M.D.Fla. 1987) (preliminary injunction granted prohibiting the district from excluding three seropositive brothers from the classroom); *Dist. 27 Community School Board v. Board of Educ.*, 502 N.Y.S.2d 325 (Sup.Ct. 1986) (exclusion of AIDS victim because of theoretical possibility of transmission of AIDS in classroom held to violate §504).

Minnesota's Newest Prison Provides Humane Environment

Judy Greenspan

Mean faces—darker mood, pale faces in shadowed rooms.
Metal door slamming, tramping of the feet . . .
Voices on a loud speaker—lock in, lock down to the beat.
Dirt everywhere—cigarette butts and paper . . .
candy wrappers, plastic, food.
Some things that would shame the maker.[1]

Sandwiched between two public schools, the town swim club and a row of houses sits the Minnesota Correctional Facility at Shakopee, Minnesota. If you travel down that winding suburban road too fast, you might miss it. It looks like a junior college or high school campus rather than a prison. Glaringly missing are the guard towers, the heavily fortified perimeter, the uniformed armed guards, the double fence or wall that encircles most penal institutions. In fact, there is no wall or fence around Shakopee.

The Minnesota Correctional Facility-Shakopee is the state's newest prison and the only institution housing women prisoners. The prison, which opened in 1986, sits in a suburban neighborhood approximately 15 miles from the Twin Cities. The seven gray and brown brick buildings include an administration building which houses a gym, dining room and visitor's area, three minimum/medium security dormitory style living units, one high security living unit and one independent living center for women to be released in the relatively near future.

A walkway surrounds the correctional facility and crisscrosses an attractive courtyard between the buildings. Located in the middle of the courtyard is a swing set for children visiting their mothers on the weekends. Newly planted trees line the pathways.

The interior of the administration building (which also houses the educational and job training centers) is brightly painted and tiled, and carpeted. Indeed, almost the entire prison including the main dining room is carpeted, thereby reducing noise levels and providing a warm atmosphere. The rooms are sunny and clean and filled with oak chairs, tables, and couches (handmade at one of the Minnesota men's correctional facilities). A toy-equipped children's playroom is adjacent to the vistor's center. The library contains a large collection of feminist literature focusing on the problems of motherhood, battered women and child abuse. A large law section helps to fill the library.

The three medium security living units, surprisingly named for Susan B. Anthony, Harriet Tubman and Eleanor Roosevelt, are modular-style buildings where the women are housed in single rooms. Each room has a wooden door. The units contain a large kitchenette (equipped with a microwave oven, stove, and refrigerator) and living room area. There is a bathtub in each wing of the unit and every room has a bathroom equipped with a toilet separated from the living area by a door (a rarity in most prison cells).

The place to be is the Independent Living Center, an attractively designed unit of apartments for women who have attained a Level 4 security rating (minimum or community) and are awaiting release. The apartments have separate bedrooms, living rooms and kitchen-dining areas. Here the women are able to leave the prison grounds twice a month to shop for groceries. There is supervision only at night and the women are able to let themselves in and out during the day and at night until 10:30 p.m.

The Higbee unit houses those women in administrative detention, segregation or protective custody. This building, with its metal cell doors, caged-in recreation yard and severely limited outside hours, is the closest to real

Judy Greenspan is the Prison Project's AIDS information coordinator.

[1]Julie Barnes Wilt, "Prison . . . From the Inside," The Maryland Correctional Institution for Women, *This is It! The Last Stop!*", (June 1988).

prison life. However, even women in segregation status are permitted to congregate in dayrooms for part of the day based upon behavior in the unit.

The food service area of the cafeteria (where both prisoners and corrections staff eat) is spotless and equipped with modern industrial sinks and counters. The cafeteria is spacious, clean and comfortable. The meals are more diversified and healthy than the average prison meal program. A salad bar is offered twice a day. Prisoners are issued weekly menus and must sign up for each meal. Women are given the option of eating either in the unit or in the cafeteria. Unit eating, however, is discouraged by the prison staff, as those meals tend to consist of "junk food."

Too hot in summer, too cold in winter—
wait for this, run for that, clean your cage, but with what?
Where's the mail? Where's a book?
I don't know why don't you "just" look?[2]

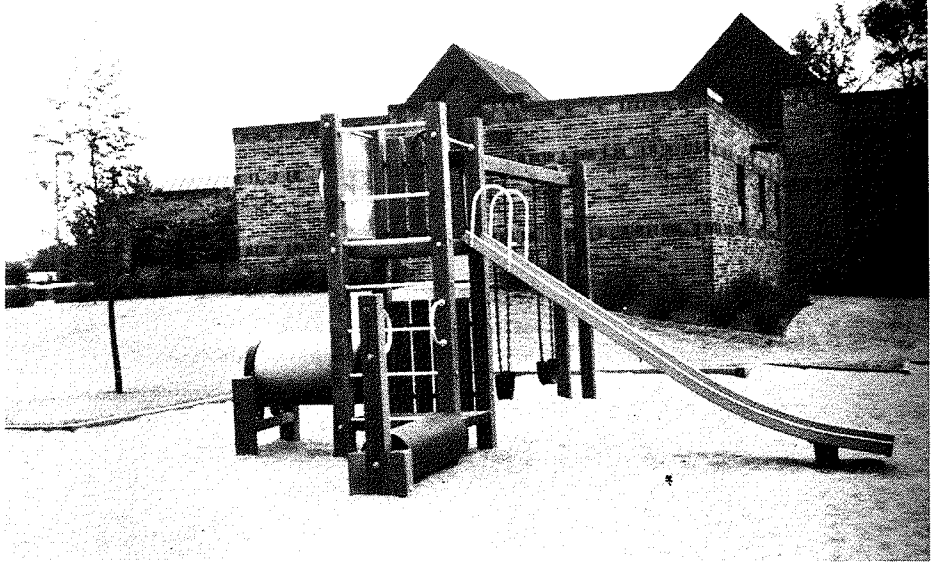
In mid-June 1988, at the time of this author's visit, there were 128 women incarcerated at the Shakopee correctional facility. Of these women, 32% were Black, 9% were Native American, and 57% were white. Over 46% of the women were convicted of theft or forgery, 10% had drug related offenses, and 20% were convicted of homicide. The women's prison has a capacity of 132. According to Jacqueline Fleming, the superintendent with a 30-year background in mental health and social work, if the institution's population were to reach 135, they would place more women in work release positions.

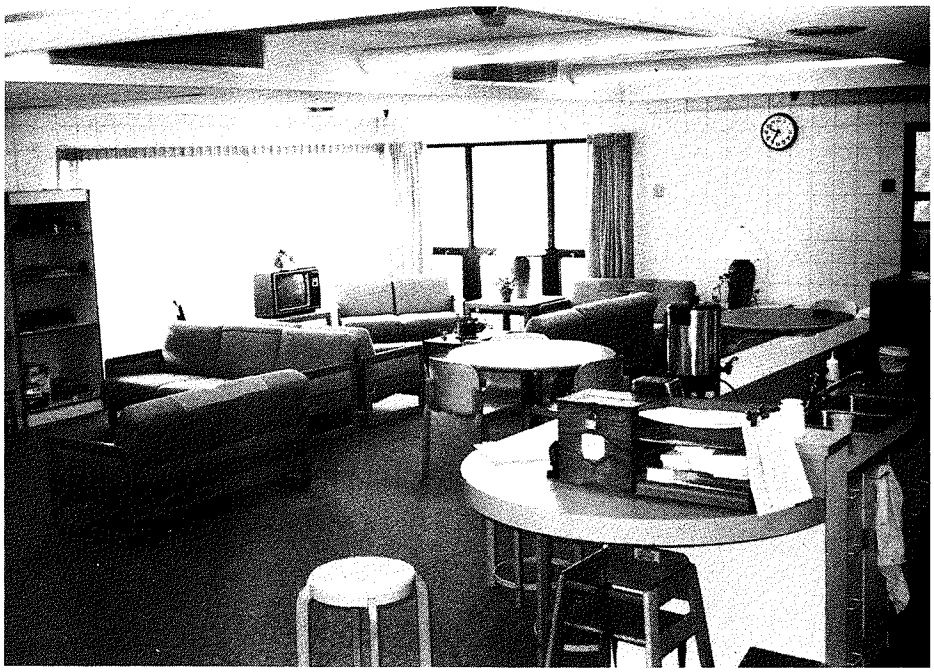
When the women first come to the institution, they are all classified Level 3, regardless of the crime for which they were convicted. Warden Fleming explains that at Shakopee, the women are not prejudged, and they can move up and down the classification scale based on their behavior. This policy stands in sharp contrast to most prison classification systems that start all prisoners at the lowest level.

As in most prisons, the women entering the institution are expected to participate in prison work programs. At Shakopee, women prisoners put in 180 hours of work in prison-related jobs, i.e., food service, grounds maintenance and general clean-up. After completing this initial work period, the women are then free to move into other areas such as sewing, telemarketing, data processing, and an electronic office machine program. The women earn between $.50

—continued on next page

[2]*Id.*





Photos by Judy Greenspan

—continued from previous page

and $5.50 an hour (not necessarily minimum wage, but more than most prisons pay), depending upon the position. The prison so far has been unable to recruit sufficient job orders to provide steady employment for the women. Warden Fleming freely admits that job opportunities are lacking and should be expanded to include other fields.

In mid-June, there was no work in the data-processing shop, and most women were participating in other jobs. Some had joined the telemarketing group and were busily selling tickets to an upcoming country music concert. Groups of women are put to work outside clearing away rocks and pebbles from the prison property. The women are expected to put in 55 hours of work, education and programming every two weeks. The typical work day begins at 7:30 a.m. and ends around 3:00 p.m. A little after 3:00 p.m., dorm business meetings are held in the housing units, and the daily count is taken. The women prisoners spend their evenings attending an assortment of workshops, meetings and recreational programs. There is also some work and visits at night.

Since many of the women in the Shakopee correctional facility are mothers, a great deal of the programming is geared toward them. A weekly "positive parenting support group" is held for all those interested. Weekly classes on understanding relationships and image improvement are scheduled. Perhaps the most humane and innovative part of the parenting program is the institution's policy of allowing prisoners' children to spend the weekend at Shakopee. Each mother is housed in a private room with a pull-out trundle bed for her children. Daughters 14 years-old or younger and sons 11 years-old or younger are allowed to spend the weekend with their mothers.

Some mothers who are eight months pregnant are sent to a halfway house for the final duration of their pregnancy. The mother is given three months to make arrangements for the care of her child outside the institution, and she is then returned to Shakopee.

Chemical dependency is another area addressed by the programming staff. Weekly education programs are supplemented by support groups for the women involved in this program.

A battered women's support group is also scheduled on a weekly basis, as well as a group for women who have abused their children. Other group programs offered include a weekly Black culture seminar and an Indian culture group. Native American women at the prison have set up a sweat lodge on the lawn behind one of the housing units but

Each mother is housed in a private room with a pull-out trundle bed for her children.

are having difficulty locating Native elders to perform the traditional Indian ritual.

Ladina Montgomery, a young Black woman living in the Susan B. Anthony housing unit, speaks honestly about her experiences at Shakopee. Montgomery, who is scheduled to get out at the end of June, says she feels Shakopee prepared her for her release. "You know prison is prison and sometimes I don't agree with the staff but I don't let that get in my way. I think this place does a lot for your self esteem," the young mother explains. Montgomery attends many of the programs designed for young mothers, in addition to going to Weight Watchers and career development groups. "This place has helped me pull my life together," she says.

Jackie Fleming sits behind her desk in the warden's office in the administration building. Warden Fleming was also in charge of the old abandoned women's prison across the street. She is personally responsible for the many changes that have taken place in the prison. She explains that when she first became warden in 1970, she was struck by the silence of the old prison. No one was talking to each other. There were many outmoded rules and policies. Women incarcerated at the facility could not wear pants, because that meant they were going to escape. Fleming put together a committee of corrections staff and prisoners to change all this. Before long, many of the women were wearing pants and communication was greatly improved.

Fleming is unique in the corrections field because her original training was in mental health, not criminal justice. She is proud of Shakopee but speaks frankly about some of its major problems, problems she is not sure she can solve.

"If I could do anything, I would have some kind of perimeter security around the prison," Fleming says. Because of the lack of fencing around Shakopee, there is little real freedom of movement for the women prisoners. The women are expected to move from building to building only at certain times, usually on the hour and half-hour. Staff, which Fleming complains is already short-handed, is tied up administratively dealing with the controlled movement. "I don't want a wall, but if we had some electronic security system, the women could be freer and the staff could relax," she explains. The large residential community around the prison is also opposed to the construction of any walls or visible fortified perimeters.

> *2-5170. Written policy and procedure provide that staff regulate inmate movement. (Detention-Essential, Holding-Essential)*[3]

Many of the women complain about the lack of free movement in the institution. To them, Shakopee seems too secure. Several federal prisoners now housed at Shakopee (Minnesota, which in the past has rarely filled its state prisons to capacity, routinely rents space to the Federal Bureau of Prisons) want the freedom of movement available in the larger, more heavily guarded federal institutions.

Sharon Anderson, the editor of the Shakopee prison newsletter, *The Reflector*, is a federal prisoner who has been incarcerated both across the street at the old women's prison and currently at the more modern facility. Anderson has seen a lot of changes happen at the institution. She says she often longs for the more informal, "homey" atmosphere of the old institution. Although she is quick to add that the new one has more modern conveniences and better programming.

> *Looking back to my times of incarceration across the street, a number of important things have seemingly fallen by the wayside to . . . a new modern facility.*
>
> ***
>
> *Large population necessitates tightening of security and more paper work to be handled.*
> *. . . Staff always had time to sit down and have a cup of coffee. . . . or discuss personal problems.*[4]

When Fleming first began as warden, the old institution was smaller, allowing more contact with the prisoners. "Women could always come down to my office and speak with me. I was more accessible," she says. Now, there are several locked doors that prisoners have to get through to visit Warden Fleming. The superintendent, who is in the midst of preparing Shakopee for accreditation by the American Correctional Association (ACA)(it is the only Minnesota correctional facility not accredited), regrets the depersonalization of the new, larger institution. Because of

[3]*Standards for Adult Local Detention Facilities*, American Correctional Association, 2nd ed., (April 1987), p.46.
[4]Excerpted from "Reflections by Sharon Anderson," appearing in *The Reflector*.

the accreditation process, occuring at the same time as the tedious preparation of her annual budget, she has been overwhelmed with work. Her assistant has also been consumed by the upcoming audit.

Fleming, who is called "Jackie" by just about everyone at the correctional facility, regrets that the programming is inadequate for the women's needs. She very much wants to expand the educational and job training centers of the institution, but is hampered by lack of funds.

Shakopee is suffering from a population explosion. The institution is operating at or beyond capacity most of the time. Because of its reputation for quality programming and a humane approach to incarceration, Fleming says judges are sending more women to the institution, including short-termers—women who in the past would be given probation and returned to the community. Fleming says programming doesn't work for women who are serving such short terms. There's not enough time to help them, and Shakopee is becoming more and more crowded.

Another problem that the warden is now wrestling with is a staff shortage and the difficulty in hiring and retaining Black, Latin and other minority correctional counselors (the Minnesota term for corrections officers). There is a frequent turnover in counselor staff. Staff shortages have accounted for shorter gym hours and fewer arts and crafts workshops. It is tragic to see the modern gym equipped with the latest in universal equipment, volleyball and basketball facilities and a small bowling alley, locked up most of the day because of staff shortages and conflict with other program activities. The women prisoners complain bitterly about the restricted gym time.

Several of the Black and Native American women point out that the corrections staff is almost all white and that their concerns are not being dealt with adequately. Fleming says she has had difficulty hiring minority staff and is aware of the problem.

> *2-5350. Written policy and precedure specify the personal property inmates can retain in their possession. (Detention-Essential, Holding-Essential)*[5]

Shakopee is a young institution, possibly the most decent and humane prison in the country for either men or women. What permanent changes ACA accreditation will bring to the institution remain to be seen; however, it already has led to restrictions in the women's lives. ACA accreditation requires strict control measures over prisoners' personal property. During the NPP visit, both prisoners and staff were immersed in an agonizing count of each woman's personal belongings. Anything over the count has to be shipped from the institution to friends and relatives.

> *I am seeing the progress now as a federal transferee from Lexington, Kentucky and that institution was not at all a humane place!*
>
> *So pardon me if I don't complain about a few petty rules or controlled movements! I can handle every rule here because at least I'm treated as a person and called by my first name.*[6]

Almost twenty years ago, Jackie Fleming brought a bold non-corrections perspective to the Minnesota women's prison, an approach that greatly changed the institution. Shakopee again needs a fresh, innovative shot in the arm, one that can transcend both the administrative bureaucracy and the likely effects of accreditation. Despite its weaknesses and problems, however, Shakopee is an example of a humane approach to corrections and imprisonment, one that should be followed in all prisons and jails across the country. ■

[5] *Standards for Adult Local Detention Facilities*, American Correctional Association, 2nd ed., (April 1987), p.92.

[6] *Id.*

Baraldini v. Meese

Court Denounces Practices at Lexington Control Unit

Julia Cade

The following is a summary of the facts submitted as evidence and compiled by several organizations which investigated the High Security Unit at Lexington, Kentucky.

Nine electronically controlled gates slammed shut behind you descending into the underground High Security Unit (HSU) at the Federal Correctional Institution in Lexington, Kentucky. This small prison-within-a-prison, designed for repression, opened in October 1986. The first three women placed in the unit were assigned there by the Bureau of Prisons (BOP) because of their leftist political affiliations—denied the rights and privileges of general population without any precipitating disciplinary incident, without any written reason, without any hearing. The only way for these women to get out of the Unit was to renounce their political beliefs, serve the greater portion of 40-year or more sentences, or die.

Surveillance cameras mounted in every room and hallway zoomed in and out, recording every activity—including a view of the shower area. Male staff stood immediately outside the shower for "security" purposes—a shower which did not even have a curtain until the National Prison Project intervened in July 1987 on behalf of the women. To escape the eyes of the male staff the women would either shower with their clothes on or not bathe at all. At times the women would choose to bathe in a mop sink in the laundry room for "privacy" and, in the winter, for warmth.

For one three-month time period, the staff banged on the doors and gates clanged throughout the night, depriving women of sleep. Some of the women would use their hour in the exercise yard, their only chance to be outdoors, to lie down and nap during the day. Until the intervention of groups like the National Prison Project in July-August, 1987, the prisoners were strip-searched every time they came from the exercise yard; then the strip-searches became random. The effect was the same: the women had to decide whether to exercise and chance being strip-searched, although double fences, a camera and a guard secured the yard. In spite of the fact that the women were required to remain in shackles while visiting the prison dentist or doctor, they were frequently subjected to a strip-search after being returned to the HSU.

The women were stripped of the personal belongings allowed in other federal prisons and issued a khaki culottes uniform.

Recreational and programming staff developed no personal relationships with the women; they dropped off materials and then left the unit. Women's religious beliefs were ridiculed by staff, including the prison chaplains.

The unit is small, stark and self-con-

—continued on next page

Julia Cade is a paralegal and public information assistant with the National Prison Project.

—*continued from previous page*
tained, with room for 16 prisoners. Only seven women have occupied the unit since it opened in October 1986. Visitation was restricted. Only one woman could receive a visit, whether social or legal, at any one time; due to the administration's scheduling errors, women would have their visitors, including lawyers, refused. On one occasion, the women were told to choose among themselves which lawyer would visit when the administration had scheduled two.

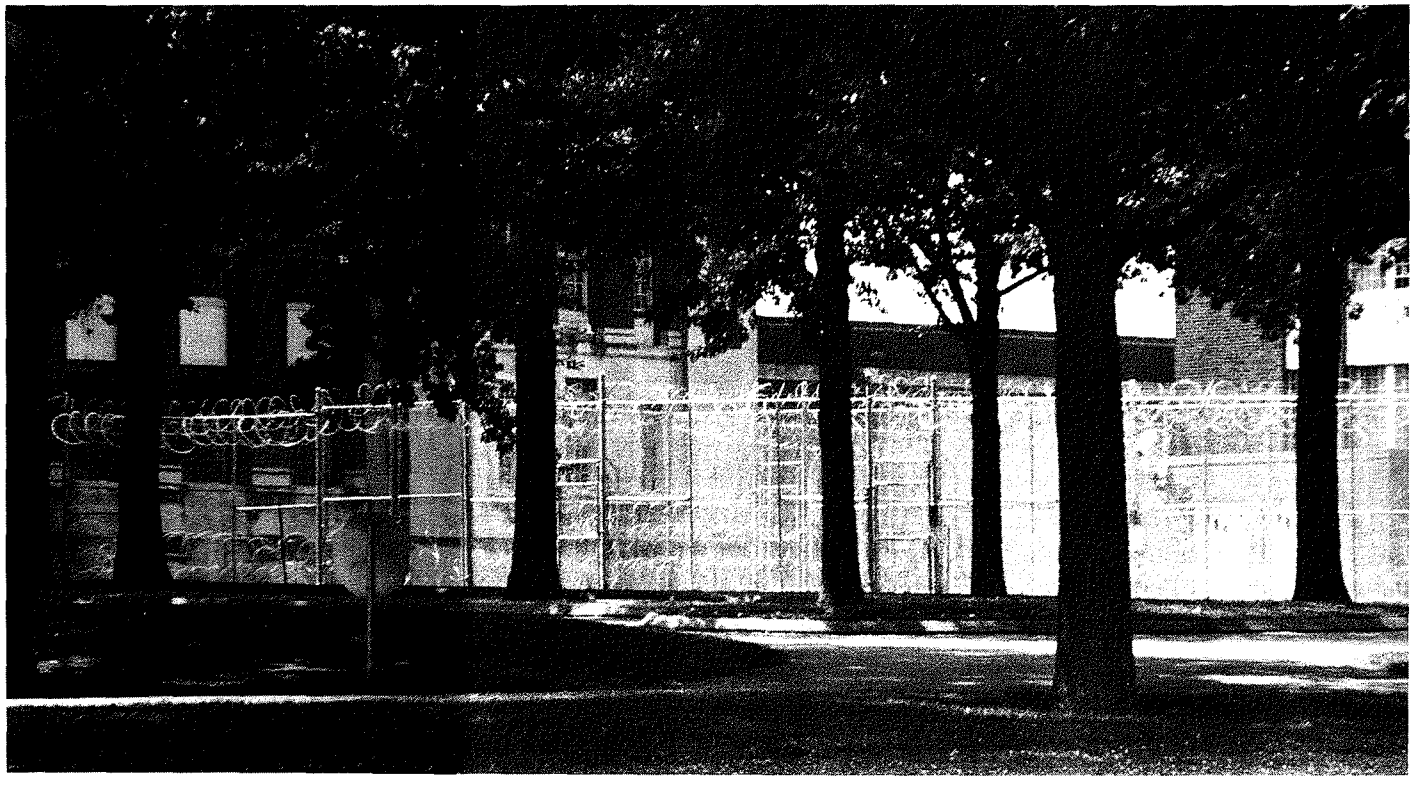
One attorney who visited her client in the HSU described the experience as the sensation of "being buried alive." The women felt they were in an experimental prison with the intent to break their spirit and personal identity—or cause them to kill themselves out of desperation.

* * *

In March 1988 the National Prison Project, the Center for Constitutional Rights, People's Law Office, Elizabeth Fink and Mary O'Melveny, both attorneys in private practice, brought suit against the federal Bureau of Prisons on behalf of three of the five women then confined in the HSU at FCI-Lexington in *Baraldini, et al. v. Meese, et al.** As a result of discussions between the National Prison Project staff and Bureau of Prison officials during the Fall of 1987, some changes in the unit were made but it

Plaintiffs Sylvia Baraldini and Susan Rosenberg under the watchful eye of the video camera in the Lexington High Security Unit.

**Baraldini v.* Meese, Slip opinion at 30.



Photos courtesy of the film "High Security Unit," Producer, Nina Rosenblum.

was too little, too late. The Bureau refused to end the small group isolation of the women and to reassign prisoners to general population who had been placed in this unit for their political beliefs. A preliminary injunction was requested due to the emergency nature of the situation: correctional psychologists advised the attorneys and prisoners that the deterioration of the physical and mental conditions of the women was life-threatening.

On July 15, 1988, Judge Barrington D. Parker ruled that the criteria for assignment to the unit were unconstitutionally vague and overbroad. He also ruled that, "Baraldini and Rosenberg were singled out and placed in the High Security Unit for their alleged past connections with leftist groups promoting ideas that some government officials did not favor." He granted declaratory and permanent injunctive relief.

"It was a victory," said Sylvia Baraldini. "It acknowledged the political nature of our treatment."

Susan Rosenberg, one of the other plaintiffs granted relief, mirrored Baraldini's feelings: "The most exhilarating moment was when the judge said, 'You can't treat human beings like that!' I started to cry in the courtroom. I felt there was recognition by someone in power that what we were saying was right. His ruling is important because it recognizes that there are people in prison in this country for their political activities."

Judge Parker enjoined Attorney General Edwin Meese, along with BOP Director Michael Quinlan and various BOP officials, from further violating prisoners' First Amendment rights of political affiliation and belief. He directed them to designate and to transfer plaintiffs Baraldini and Rosenberg from the HSU to the general population of an appropriate federal correctional institution.

Judge Parker further enjoined the BOP from considering any prisoner's past political associations or personal political beliefs in assignment to prison facilities, specifically the medium-high security facility recently opened in Marianna, Florida, and developed to replace the High Security Unit in Lexington.

"It is one thing," wrote Judge Parker, "to place persons under greater security because they have escape histories and pose special risks to our correctional institutions. But consigning anyone to a high security unit for past political associations they will never shed unless forced to renounce them is a dangerous mission for this country's prison system to continue."

While denying relief on the Eighth Amendment claim because of the imminent completion of the medium and high security facility for women at Marianna, Judge Parker retained jurisdiction over the new facility after the HSU in Lexington closes.

"The Court is greatly troubled," wrote Parker, "about the previous conditions within the Unit and the defendants' gross insensitivity and belated response to those conditions. The Unit at best meets the bare Eighth Amendment standards but at times the treatment of plaintiffs has skirted elemental standards of human decency. The exaggerated security, small group isolation, and staff harassment serve to constantly undermine the inmates' morale."

The Court was also critical of the cavalier response the federal government made to the numerous complaints of gross insensitivity and psychological harm:

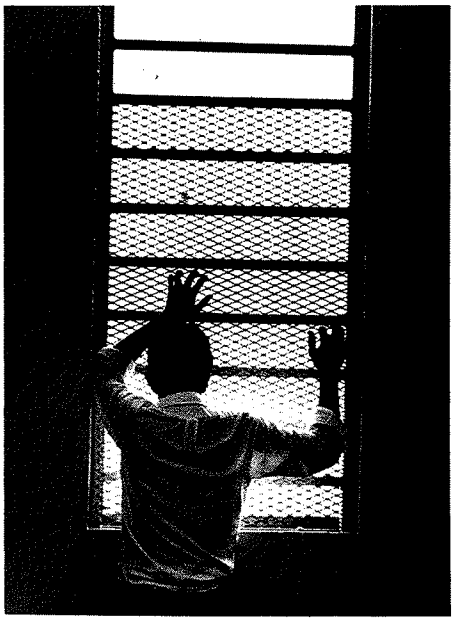
Defendants' response to many of plaintiffs' charges is not a denial or that they are groundless, but rather that the Bureau has attempted to and has indeed rectified a large number of the complaints before this lawsuit was filed. That, however, is a sorry response to the complaint and is a shameful reflection on the Bureau's administration. Only after repeated complaints by plaintiffs and their counsel, were minimal efforts expended to install shower curtains, to extend the list of visitors, to outlaw strip searches following outdoor exercise, and to relocate plaintiffs on the side of the building which afforded more daylight exposure and to repair broken exercise equipment. Even though those concessions had been made, the Bureau still operates a unit that in many respects, measures below acceptable standards for federal prisons. ■

Despite New Laws, Juveniles Still Locked in Adult Jails

Russ Immarigeon

"The Council of Judges of the National Council of Crime and Delinquency . . . concludes that it is not *appropriate to incarcerate minors with adults . . . ample evidence [exists] of the dangers faced by minors who are detained in jails or lockups for adults. . . . [T]he position of the Council of Judges is that state laws and local practice should prohibit the incarceration of juveniles in jails and lockups for adults.*[1]

—NCCD Council of Judges, 1987



The NCCD Council of Judges' support for removing all juveniles from adult jails and police lockups is the latest in a long series of policy statements on this matter. For the past 15 years, state, local and federal officials, spurred on by citizen and legal advocates, have been trying to abolish the incarceration of juvenile offenders in these facilities. By December 1988, according to the law, all 52 states and territories receiving federal funding through the U.S. Office of Juvenile Justice must be in full compliance with the 1980 amendments to the 1974 Juvenile Justice and Delinquency Prevention Act. As this date draws near, however, significant disagreement exists over how far states have advanced.

"For the first time in over a century," Ira Schwartz, former director of the Office of Juvenile Justice and Delinquency Prevention (OJJDP), observed recently, "the prospect of having no ju-

—continued on next page

Russ Immarigeon, a regular contributor to the NPP JOURNAL, is the director of public policy research for the Maine Council of Churches' Criminal Justice Committee.

[1]The 12-member NCCD Council of Judges is chaired by The Honorable William J. Brennan Jr., Associate Justice of the U.S. Supreme Court, and by The Honorable Frank Orlando, of the Broward County (Fort Lauderdale), Florida Circuit Court. The Council's complete policy statement, "Children in Jails and Lockups for Adults," is available from: NCCD, 77 Maiden Lane, Fourth Floor, San Francisco, CA 94108, 415/956-5651.

For the first time in over a century, the prospect of having no juveniles in adult jails or lockups is within grasp.

—continued from previous page

veniles in adult jails or lockups is within grasp." However, few observers—Schwartz among them—expect that most states will achieve the legislation's December 1988 objective. For example, Mark Soler, executive director of the Youth Law Center, a San Francisco-based legal advocacy center specializing in juvenile justice issues, feels that as many as 30 states or territories will remain out of compliance at the end of the year.

Jail Removal

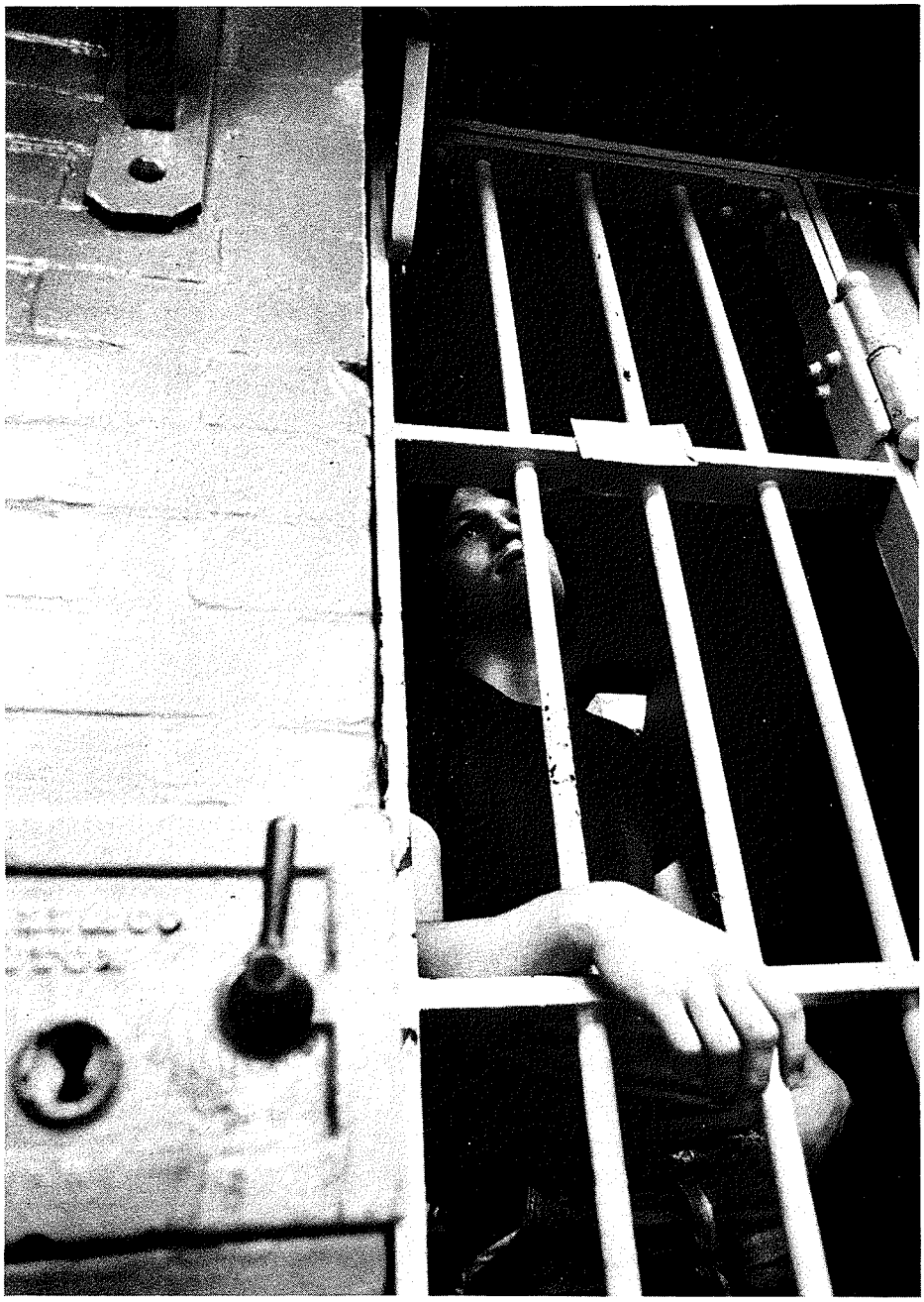
The Juvenile Justice and Delinquency Prevention Act of 1974 originally stated that status offenders (a juvenile who has been adjudicated for conduct which would not be a crime if he or she were an adult) should be removed from jails and lockups, while juvenile offenders should simply be separated from adults. Some states—Maine for instance—moved quickly to remove status offenders from jails; others delayed action. In addition, some states made serious efforts to separate juvenile offenders from adult criminals, while others simply placed juveniles in "isolation" cells, which frequently resulted in increased sensory deprivation and higher rates of juvenile suicides and suicide attempts.

Several years after the Act was implemented, the Children's Defense Fund (CDF), a Washington, D.C. public interest group, studied the jailing of children across the country. CDF found children in jails in every state they visited. Moreover, they also found that most of these juveniles were not detained for violent crimes and were not a public safety risk; a disproportionate number of the children were minorities; juveniles were detained for periods of time and for reasons that violated state laws; and conditions in the jails were generally "abysmal, subjecting them to cruel and unusual punishment through physical neglect and abuse."[2]

In 1980, findings such as these caused the U.S. Congress to amend the original 1974 Act, mandating that juveniles be totally separated from adult offenders. Moreover, the amended Act called for "substantial compliance" with the Act by December 1985 and "full compliance" by December 1988. In brief, substantial compliance requires a 75% reduction in the number of violations, i.e., adolescents in local jails or lockups, and an "unequivocal" commitment to achieving full compliance. Full compliance, in turn, now means having no violations over a 12-month period, demonstrating that the number of violations are lower than a *de minimus* rate devised by OJJDP, and showing that all instances of non-compliance are in violation of state law. In other words, some enforcement mechanism must be in place.

After 15 years of heightened and innovative program and policy efforts to remove juveniles from adult jails and lockups, however, available statistics paint an unclear picture about how far states have advanced on this issue.

Federal statistics suggest, for instance, that the number of juveniles incarcerated in adult jails has remained surprisingly stable. In 1978, according to July and October 1987 publications from the U.S. Bureau of Justice Statistics, a one-day count (February 15, 1978) found 1,611 juveniles being held in adult jails (an average daily population of 1,740). Nearly a decade later, another one-day count (June 30, 1986) found that about the same number, 1,708 juveniles, were being held in adult jails (an average daily population of 1,404). In July 1987, the U.S. Bureau of Justice Statistics reported that 1,740 juveniles were held in adult jails in 1978; about the same number—1,736 juveniles—were



Tony O'Brien, Frost Publishing Group, Ltd.

[2]Children's Defense Fund, *Children in Adult Jails*, (Washington, D.C.: Washington Research Project, Inc., December 1976), p.4.

Juveniles are slowly—very slowly—being removed from adult jails and police lockups.

held nearly a decade later.

Ira Schwartz, now director of the Center for the Study of Youth Policy at the University of Michigan, may have made the most accurate estimate of what progress has been made when he recently told the *NPP JOURNAL* that some states have reached compliance (Delaware, New York, Oregon, Pennsylvania); others have come close (California, Colorado, Oklahoma, Tennessee); some have remained unexpectedly resistant to full compliance (Maine, Minnesota, Wisconsin); and still others have actually regressed in their efforts (Alabama, Indiana, Ohio, South Carolina).

Support remains strong, however, for the full removal of juveniles from jails and lockups. In 1981, the broad-based National Coalition for Jail Reform (NCJR), which included such organizations as the American Bar Association, the American Civil Liberties Union, and the National Sheriffs' Association, said flatly and boldly that "no juvenile should be held in an adult jail."[3]

Most recently, the National Coalition of State Juvenile Justice Advisory Groups (NCSJJAG), in its 1987 report to the President, restated its steadfast and continued support of the Act's jail removal objective. NCSJJAG's reasons for opposing the jailing of juveniles in adult jails and lockups sum up years of research and experience:

- jails and lockups cannot provide adequate treatment for juvenile offenders;
- juveniles currently held in these facilities do not commit offenses which require that they be held for public safety reasons;
- juveniles housed in adult jails and lockups are subject to physical, mental and emotional abuse;
- expensive, limited jail space and services should be used primarily for dangerous adult offenders;
- jailed juveniles have a higher rate of suicide than juveniles in the general population or juveniles held in detention centers;
- jailing juveniles involves serious liability issues;
- many existing jails and lockups do not meet minimum correctional confinement standards; and
- jailing boys and girls is contrary to the Juvenile Justice and Delinquency Prevention Act, and is ethically wrong.[4]

[3]National Coalition for Jail Reform, "Inappropriate Confinement of Juveniles in Adult Jails," (Washington, D.C.: National Coalition for Jail Reform, 1981), p.1.

Progress Has Been Made

A federal review of 1986 state monitoring reports showed that eight states or territories had achieved full compliance, 13 had achieved substantial compliance, 21 states or territories were in non-compliance, while 10 others were mired in unresolved issues and their compliance status has not been determined (four states—North Dakota, South Dakota, Wyoming, and Hawaii—are considered non-participating states).

These figures suggest, at best, the slow pace of change. Nonetheless, the literature on jail removal is rich with options available to communities and states to help them achieve full removal. Among these options are: family court community aide programs, evening report centers, day treatment centers, family crisis intervention, foster homes, volunteer foster homes, proctor programs, agency-operated boarding homes, and attendant care.[5]

Individual states have made significant reductions in recent years. In Michigan, court-ordered home detention and temporary youth shelters have solved problems which centered on the long and expensive distances over which juveniles were transported in rural counties.[6] In Colorado, the Sheriff's Association and the Colorado Division of Youth Services were instrumental in developing plans for rural counties for the use of locally-based detention criteria, intake screening procedures, transportation to secure detention facilities and non-secure treatment services.[7] Finally, in Kentucky, government and public interest groups have worked together to devise "strict, objective and specific detention criteria" which distinguish between juveniles needing secure and non-secure detention.[8]

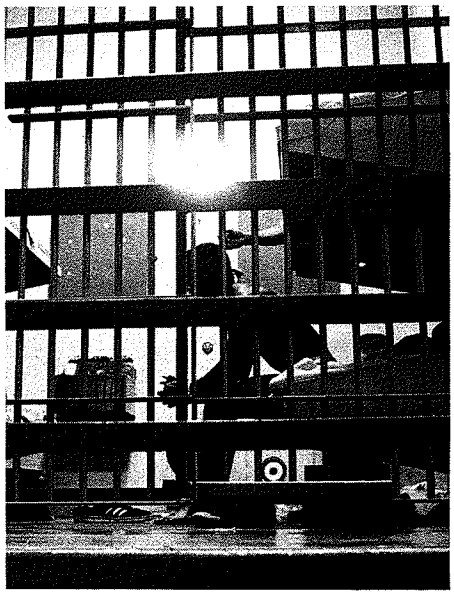
[4]*The National Coalition of State Juvenile Justice Advisory Groups, An Act of Empowerment: The Third Report to the President, the Congress, and the Administrator of the Office of Juvenile Justice and Delinquency Prevention*, (Bethesda, MD: National Coalition of State Juvenile Justice Advisory Groups, December 1987), p.8.

[5]See, for example, *Removing Children from Adult Jails: A Guide to Action prepared for the U.S. Office of Juvenile Justice and Delinquency Prevention by the Community Research Forum of the University of Illinois at Urbana-Champaign*, (May 1980).

[6]See Community Research Associates, "The Michigan Holdover Network: Short-Term Supervision Strategies for Rural Counties," (Washington, D.C.: U.S. Office of Juvenile Justice and Delinquency Prevention, 1986).

[7]See Christine Carty, "The Sheriff's Dilemma: Juveniles in Jail: The Jail Removal Initiative in Colorado," (Washington, D.C.: U.S. Office of Juvenile Justice and Delinquency Prevention, 1986).

[8]See Community Research Center, "A Community Response to a Crisis: The Effective Use of Detention and Alternatives to Detention in Jefferson County, Kentucky," (Washington, D.C.: U.S. Office of Juvenile Justice and Delinquency Prevention, December 1983); also see, Debra Miller, "A Part of the Answer: The Effect of Juvenile Court Worker Programs on the Incarceration of Juveniles in County Jails and Juvenile Detention Centers," (Louisville, KY: Kentucky Youth Advocates, Inc., September 1984). This last report is available from: KYA, Inc., 2024 Woodford Pl., Louisville, KY 40205, 502/456-2140.



Los Angeles Times

More Can Be Done

Juveniles are slowly—very slowly—being removed from adult jails and police lockups. Suitable models for alternatives to confinement exist so that total removal of children from these institutions remains a possibility, but few long-time observers feel that OJJDP's deadline will be met by even a majority of states. By December 1988, as many as 30 states are likely to remain out of compliance with OJJDP's jail removal mandate. Moreover, while states have at least addressed the issue of juveniles locked up in adult jails, many of them have not yet begun to examine and act on the problem of juveniles detained in police lockups.[9]

—continued on next page

[9]A recent report prepared by the Crime and Justice Foundation (CJF) for the Massachusetts Committee on Criminal Justice examines the issue of how to remove juveniles from police lockups. Massachusetts does not have any juveniles confined in its adult jails—or houses of correction—but 1,336 kids were detained in local police lockups in 1985. CJF's report recommends that the Commonwealth establish policy regarding the detention of pre-arraignment juveniles, legislation alleviating and regulating the short-term detention of juveniles, training procedures for police, probation and Department of Social Services professionals involved with intake programs, and a demonstration project which targets a specific site. "Juveniles in Massachusetts Police Lockups: Analysis and Recommendations" is available from: CJF, 20 West St., Boston, MA 02111, 617/426-9800.

In the end, what may be missing is the political will to go about getting the job done properly.

—*continued from previous page*

Advocates of full removal offer numerous suggestions about what can be done to improve the current situation. These suggestions recommend changes that focus on recalcitrance at the local, state and federal levels.

The Youth Law Center's Mark Soler, for example, suggests several changes which can be made at the federal level:

- *Better monitoring.* Currently, he says, OJJDP doesn't offer on-site inspection and monitoring services; instead, they rely on state-submitted reports which are, he claims, often inaccurate.
- *More funds for legal advocacy groups.* In 1979, Soler points out, the federal government funded two national organizations—the Youth Law Center in San Francisco and the National Juvenile Law Center in St. Louis—and four state-level organizations—Greater Boston Legal Services in Boston and the Youth Policy and Law Center in Madison, among them—to press their states to remove juveniles from adult jails. Today, only the Youth Law Center receives any OJJDP funds for this purpose.
- *Stricter enforcement of the jail removal mandate.* Soler says that instead of forcing states to comply, federal officials allow them to delay the amount of time they have to comply. Lax enforcement, he suggests, creates an absence of strong federal guidance.
- *More funds for alternative, non-incarcerative programs.* Soler argues that substantial program funding has been missing during the Reagan administration, part of a strategy, perhaps, to eliminate OJJDP altogether.

Soler also identified a number of state and local barriers to full removal of juveniles from jails and police lockups: state-level juvenile justice specialists have not received sufficient support or guidance from the federal government; state juvenile justice advisory groups have been "hamstrung" by increased federal efforts to prosecute and incarcerate more children; many local jurisdictions have strong "lock-up-kids" traditions which make local officials reluctant to act, and local judges often see that locking up kids is politically popular; and states and counties frequently do not put much effort into creating community-based alternatives. These barriers, he advises, need addressing.

Conclusion

Sufficient tools and strategies are available to finally remove all juveniles from adult jails and police lockups. Jim Brown, project director of Community Resource Associates which provides OJJDP's technical assistance to the states, says that OJJDP's technical assistance efforts over the years have identified key factors in achieving full removal. "Where jail removal has worked," he has found, "there's always legislation, some type of state-local sharing relationship, access to secure detention, some means of transportation services for rural areas, a strong network of alternatives to detention, and close attention to policy guidelines and procedures concerning admissions criteria, so that a clear understanding exists between police, the courts and citizens."

Jeff Allison, compliance monitoring coordinator for the OJJDP, agrees with Brown's observations. "Jail removal is successful," he says, "when states have appropriate legislation, objective detention criteria, 24-hour intake services, and secure and non-secure alternatives to locking kids up with adults."

In the end, what may be missing is the political will to go about getting the job done properly. The Youth Law Center's Mark Soler acknowledges that OJJDP's recent technical assistance efforts are "probably good," but he regrets that they have taken 14 years to emerge. Still, "they could be needed for a long time," Soler suggests, "because there are still a lot of terrible jails with kids in them." In the end, he says, legal efforts will remain important. "In one sense," he notes, "litigation is a good complement to what OJJDP is doing." On the other hand, he adds, litigation could well achieve what OJJDP is not likely, at least now, to push for. A new administration in Washington, he finally suggests, might bring the depth and breadth of leadership—especially a firm and well-supported commitment to removing all kids from adult jails and police lockups—that has been missing for the past eight years. ■

Today there are still approximately 3,000 Mariel Cubans in prisons, jails, and Immigration and Naturalization detention centers across the United States. These individuals are not serving prison terms, but are being held under the designation of "excludable aliens." In November 1987, when notified of the U.S.'s intent to return them to Cuba, the detainees in Atlanta, Georgia and Oakdale, Louisiana began rioting in protest. The Department of Justice then agreed to review each case individually to determine eligibility for release. Many Mariel Cubans remain in detention, uncertain of the future. In this article, O.J. Keller tells us more about the frustration and unfair treatment of the Marielitos.

Cuban Detainees Face Further Frustration, Unfair Treatment

O.J. Keller

Why is it that the Cuban prisoners held by the United States government are treated so cruelly? Suppose these immigrant inmates had come from northern Europe instead of Cuba. Does anyone believe that Norwegian, Swedish, English, or German offenders would have been confined under the same conditions the Marielitos have faced?

Just what are the confinement conditions? For the most part, ever since the riots at Oakdale, Louisiana, and Atlanta, Georgia, the Cubans have been confined to their cells 24 hours a day, seven days a week, month after month. Two men usually share a cell designed for one. The food, generally cold, is brought to their cells. When the Cubans leave their cells, they are handcuffed, with the cuffs attached to a belt at their waists. There is nothing for them to do—no TV, nothing to read, no education, no activity except one hour (or less) a week walking in the prison yard. Lock-down is the Bureau of Prisons' (BOP) prescription for the Marielitos.

The Coalition to Support the Cuban Detainees, an Atlanta-based group, attempting to obtain some measure of fairness for the Cubans, hears from detainees confined throughout the country. Although the roughly 3,000 Marielitos have been scattered to 33 different BOP facilities, as well as 64 county jails or Immigration and Naturalization Service (INS) detention centers, the messages from the Cubans are much the same.

From Petersburg, Virginia comes the cry, "I am going crazy in this place. We get out for recreation one hour per week. There's no basketball; so we just walk around. The staff pays no attention to us. Only if we scream and pound on

O.J. Keller, former president of the American Correctional Association, has also served as U.S. Parole Commissioner and a member of the National Appeals Board.

"All my family photos were gone. Those pictures were all I had."

the door of our cell does anyone come. I can't see the doctor. The temperature inside the cell is 97 degrees."

From Leavenworth, Kansas come these comments: "A person cannot shower and shave in five minutes. That's what these people give you three times a week. We can make only one five-minute phone call every three months. They put two men in cells built for one. The noise is so bad you can't hear the radio or the other guy's conversation. You can't sleep at night."

Another, writing from Talladega, Alabama, said, "We got an hour last week for recreation. But, when I came back to my cell, the officers had been searching it. All my family photos were gone. Those pictures are the only ones I had. I know I may never see my family again. I was mad, and threw my food. So, they came in, handcuffed me, and bounced my head against the wall. That was days ago, but my head still hurts."

One wonders who's crazy—the Cuban detainees or the federal Bureau of Prisons (BOP).

Some of the Cubans whose behavior is considered bizarre by the BOP are shipped to St. Elizabeth's Hospital in Washington, D.C. These transfers are often the detainees who shout, who pound on cell doors, who stuff their toilets and flood the cellblocks. They're the ones who go on hunger strikes. They are sent to St. Elizabeth's for mental health examinations.

Once the Cubans get to St. Elizabeth's their behavior often changes dramatically. They no longer shout and cause problems. Could the explanation be that, in contrast to the inhumane conditions to which the BOP subjects them, the Cubans at St. Elizabeth's can shower every day, have regular exercise, can enjoy arts and crafts, can watch TV, and read a variety of books and magazines? They can even wear civilian clothes, are called by their own names rather than prison numbers, and can make outside telephone calls with the points they earn through good behavior.

Frankly, the conditions under which the Cubans suffer within the BOP are sufficient to drive most men to madness. By contrast, the conditions at St. Elizabeth's demonstrate some basic understanding of human needs. Many supporters of the Cuban detainees believe the BOP's hierarchy is the group in need of mental health assistance. —O.J.K.

If you look at the offenses these Cubans have committed, you find they range from minor parole violations to the most serious felonies. But the same thing can be said of American prisoners in those BOP facilities and county jails. Yet, the Americans are not treated as the Marielitos are. Some effort is made to classify American offenders by degree of dangerousness. Why is it that the Cubans are all tarred with the same brush? Why has the BOP's classification system been thrown out the window in their cases?

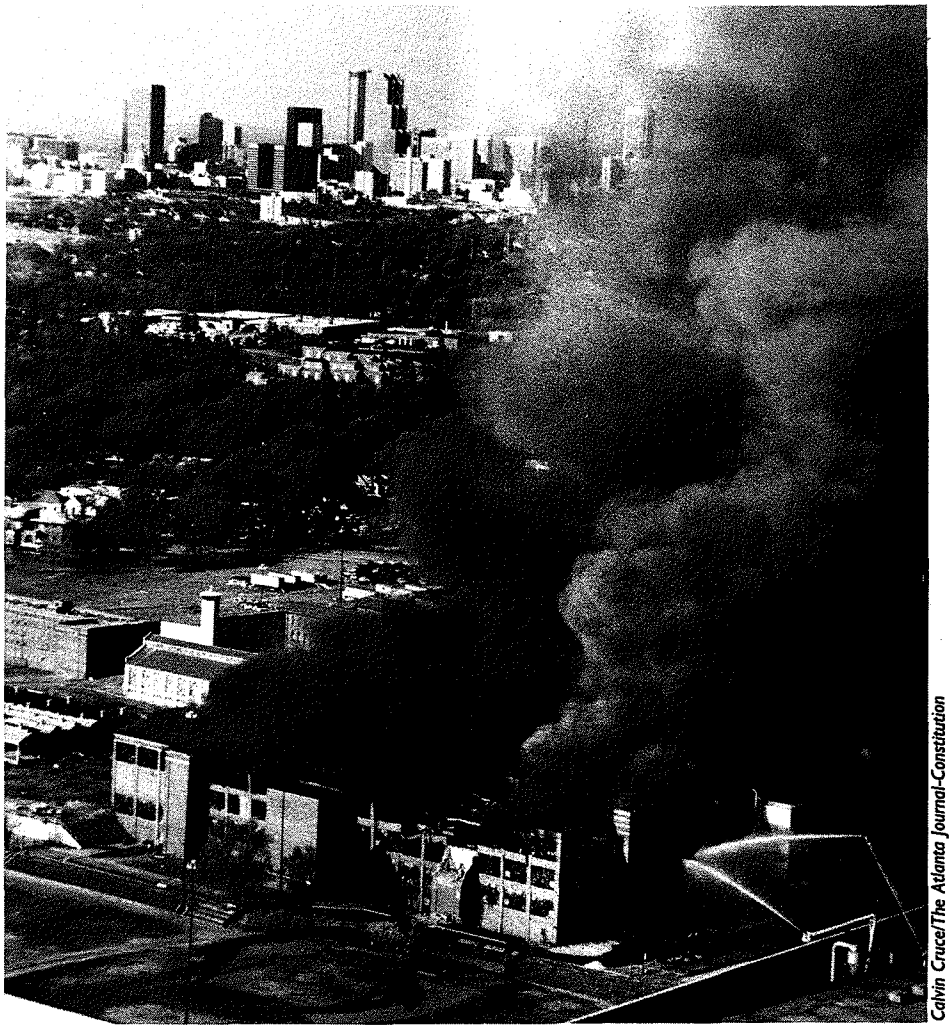
The answer appears to be that the BOP sees all the Cubans as particularly dangerous. The fear is that, when some of the Cubans receive notification from the INS denying their release into American society, they will rise up and start another Atlanta- or Oakdale-type riot. So, it's essential the Cubans be scattered in small groups throughout the United States. And, to be doubly secure, they must be locked down in their cells 24 hours a day.

The BOP's reasoning is fallacious, just as it was in November of 1984. That's when the first riot took place at the U.S. Penitentiary (USP) in Atlanta, involving the Marielitos. The BOP and the Department of Justice contended that the riot had been sparked by two Cuban hoodlums. The Justice Department took the men to trial in federal district court. The trial went on for a week, but the jury, composed of north Georgia citizens, soon returned with a verdict the BOP did not appreciate. The jury found the two Cubans innocent on all counts, and said the riot was spontaneous, triggered by the intolerable conditions of confinement at the penitentiary.

Although the jurors expressed both dismay and shame at what our government had done to the Marielitos, the BOP has learned nothing from the 1984 riot. It would still argue that it's the nature of the Cubans to cause disruption, not the conditions of confinement. So, the BOP is still on the same track: lock 'em up; provide no programming; hold men in idleness; treat them with an iron hand.

—continued on next page

Smoke rises from the Atlanta Federal Penitentiary as Mariel prisoners, who feared being returned to Cuba, rioted and held hostages to draw attention to their plight.



Calvin Cruce/The Atlanta Journal-Constitution

Wide World Photos, Inc.

A Cuban prisoner raises the American flag during the riot at Oakdale, Louisiana.

—*continued from previous page*

But, surely, there can be no excuse for the riots at Atlanta and Oakdale in November of 1987. After all, Warden Joseph Petrovsky at USP-Atlanta had greatly improved living conditions, and the Oakdale facility was a far cry from the old fortress prison in Atlanta. The difference lies in the device that triggered the 1987 riots. It wasn't the conditions of confinement; it was the stupidity of the U.S. State Department.

Congressman John Lewis from Atlanta explains the Atlanta-Oakdale riots of 1987 succinctly: "When men are held in indefinite detention with no hope of minimal due process, and then not apprised of an international agreement which may deport them to a country against their will, it should be less than surprising when they revolt against this system of justice. The announcement by the State Department only triggered the waiting time bomb." Lewis is right. When over one thousand Cubans, approved for release into the United States, learned overnight that they were to be shipped back to Castro's Cuba, it should have surprised no one, even the BOP, that the reaction would be violent.

Almost since Day One, the BOP, as well as the INS, has attempted to portray the Cuban detainees as an unusually dangerous group of offenders. The fact is that the Marielitos are much like their American counterparts. A few are dangerous; the majority are not.

During the Atlanta and Oakdale riots, while property destruction was terrible, responsible Cuban prisoners made sure the hostages were shielded from harm. The very fact that the Cubans acted responsibly during riots causes concern now that our own government is acting irresponsibly. When the agreement between the Department of Justice and the Marielitos was reached, and the riots ended, one of the major participants was Gary Leshaw of Atlanta Legal Aid. Leshaw points out that the BOP pledged to improve mental health care for the detainees. "There was a specific section included in the agreements ending the uprisings," said Leshaw. Not only has the BOP done nothing to improve the Marielitos' access to mental health care within the prison system, but the present conditions of confinement in fact *invite* mental illness or violence (or both). Suicides, attempted and completed, as well as self-mutilations, are typical by-products of the detainees' lock-down situation.

The United States House of Representatives will soon be considering H.R. 4330, jointly sponsored by Congressmen Romano Mazzoli (D-Ky.), Robert Kastenmeier (D-Wis.), and Pat Swindall (R-Ga.). This bill would provide the Marielitos with some basic due process in their deportation hearings—something that has been denied by the U.S. Court of Appeals for the Eleventh Circuit and the Supreme Court. What a shame it is that the House Subcommittee on Courts, Civil Liberties, and the Administration of Justice, although chaired by Rep. Kastenmeier, no longer seems to have equal concern about the conditions of confinement. Two and a half years ago, Rep. Kastenmeier personally visited USP-Atlanta and reported to Congress his chagrin about the deplorable situation there. Although the Cubans are now scattered in jails and prisons throughout the country, the conditions of imprisonment are still deplorable but no members of Congress seem to care.

Which brings us back to the original question. If these illegal aliens had come to our shores from northern Europe, would they receive the sub-human treatment we accord the Cubans?

For more information on the Cubans, contact the Coalition to Support Cuban Detainees, P.O. Box 935, Decatur, GA 30030. ■

For The Record

Dear Adjoa and Alexa:

I read about your extraordinary victory (see *Baraldini,* p. 19) in the *New York Times* over the weekend. You deserve to be congratulated for seeing and framing the issues so skillfully. I have always believed that the key to victory in that case was to ensure the court saw the extent to which these particular women were being kept in segregation as a result of their political views.

I have just finished reading *Life and Death in Shanghai,* a true story of a woman persecuted during the Cultural Revolution who was kept in solitary confinement and tortured until she would relinquish her beliefs. It is an extraordinary book which is well worth reading. The analogy to the situation you exposed in the Federal Bureau of Prisons is not as far-fetched as some in our country would have you believe.

The importance of victories such as you have won go far beyond the particular women and the particular case. You and your colleagues at the Prison Project are to be congratulated.

Sincerely,
Matthew L. Myers
Asbill, Junkin,
Myers & Buffone

■ The ACLU National Prison Project announces the release of three new publications on AIDS in Prisons: a new booklet, *AIDS in Prisons: The Facts for Inmates and Officers*; the 1988 *AIDS in Prison Bibliography;* and the summer 1988 issue of the *NPP JOURNAL* which contains an up-to-date survey on AIDS in prison.

AIDS in Prison, a 14-page factual booklet, is a simply written educational tool for prisoners, corrections staff, and AIDS service providers. The most commonly asked questions concerning the meaning of AIDS, the medical treatment available, and legal rights and responsibilities are presented and answered in an easy-to-read format.

The Prison Project hopes to distribute this pamphlet widely in jails and prisons throughout the country. Sample copies are free. Bulk orders are available for:

100 copies— $ 25
500 copies— $100
1,000 copies—$150

The *Bibliography* offers a list of resources on AIDS in prison that are available from the National Prison Project and other sources.

It includes an extensive list of corrections policies on AIDS; a list of educational materials; a section on AIDS litigation covering both prison and non-prison cases; and a directory of medical and legal articles and recent AIDS studies. The 31-page *Bibliography* is available for $5.00.

In addition, the summer 1988 issue of the *JOURNAL* contains a 1988 national survey of AIDS in prison. This survey,

which includes a full-page chart, gives a state-by-state breakdown of prison policies and procedures regarding the treatment of AIDS-infected prisoners.

The survey focuses on mandatory testing, housing and segregation, confidentiality, education and medical care, and also provides the latest population figures of HIV-infected prisoners in this nation's prisons. The special *JOURNAL* issue is available for $5.00.

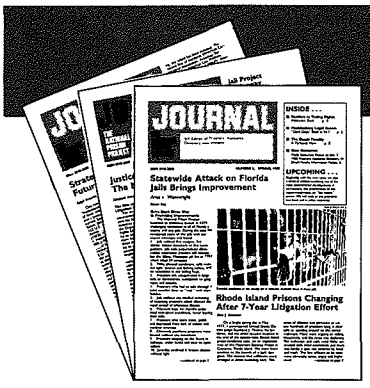
The AIDS booklet and survey are free to all prisoners. Address all inquiries to Judy Greenspan, National Prison Project, 1616 P Street, N.W., Suite 340, Washington, D.C. 20036; 202/331-0500.

■ **The National Coalition to Abolish the Death Penalty** will hold its Seventh Annual Conference from Friday, November 18 to Sunday, November 20, 1988 at Southern Methodist University in Dallas, TX. Keynote speaker will be columnist and commentator Molly Ivins with the *Dallas Times Herald*. Workshops and plenary sessions will include: trial monitoring, speaking against the death penalty, working with victims organizations, grant writing and legislative action. The Conference will also include a demonstration or vigil against the death penalty. For more information contact the NCADP at 1419 V St. N.W., Washington, D.C. 20009 or call 202/797-7090.

■ The Pennsylvania State University will conduct a seminar on **"Legal Issues for Corrections Personnel,"** November 14-16, 1988, and again April 24-26, 1989, in University Park, PA. The course is designed for prison wardens, officers and other supervisory personnel, as well as those responsible for establishing personnel policy within correctional institutions. Tuition is $245. For more information, contact: Kathy Karchner, Coordinator, 410 Keller Building, The Pennsylvania State University, University Park, PA 16802. Phone: 814/863-3551.

■ In an article which appeared in the last issue of the *JOURNAL*, "Health Professionals and A Preventable Death at Butner," we listed Dr. Steven Miles as its sole author. The article was, however, co-authored by Dr. Miles, Michael McCally, M.D., and John La Puma, M.D. The *JOURNAL* regrets the omission.

PUBLICATIONS



QTY. COST

_____ **The National Prison Project *JOURNAL,*** $25/yr. $2/yr. to prisoners.

_____ **The Prisoners' Assistance Directory,** the result of a national survey, identifies and describes various organizations and agencies that provide assistance to prisoners. Lists national, state, and local organizations and sources of assistance including legal, library, medical, educational, employment and financial aid. 7th Edition, published April 1986. Paperback, $25 prepaid from NPP.

_____ **Offender Rights Litigation: Historical and Future Developments.** A book chapter by Alvin J. Bronstein published in the **Prisoners' Rights Sourcebook** (1980). Traces the history of the prisoners' rights movement and surveys the state of the law on various prison issues (many case citations). 24 pages, $2.50 prepaid from NPP.

QTY. COST

_____ **The National Prison Project Status Report** lists by state those presently under court order, or those which have pending litigation either involving the entire state prison system or major institutions within the state. Lists only cases which deal with overcrowding and/or the total conditions of confinement. (No jails except District of Columbia). Periodically updated. $3 prepaid from NPP.

_____ **Bibliography of Women in Prison Issues.** A bibliography of all the information on this subject contained in our files. Includes information on abortion, behavior modification programs, lists of other bibliographies, Bureau of Prison policies affecting women in prison, juvenile girls, women in jail, the problem of incarcerated mothers, health care, and general articles and books. $5 prepaid from NPP.

QTY. COST

_____ **A Primer For Jail Litigators** is a detailed manual with practical suggestions for jail litigation. It includes chapters on legal analysis, the use of expert witnesses, class actions, attorneys' fees, enforcement, discovery, defenses' proof, remedies, and many practical suggestions. Relevant case citations and correctional standards. 1st edition, February 1984. 180 pages, paperback, $15 prepaid from NPP.

_____ The **Jail Litigation Status Report** gives a state-by-state listing of cases involving jail conditions in both federal and state courts. The **Report** covers unpublished opinions, consent decrees and cases in progress as well as published decisions. The **Report** is the first nation-wide compilation of litigation involving jails. It will be updated regularly by the National Jail Project. 1st Edition, published September 1985. $15 prepaid from NJP.

QTY. COST

Fill out and send with check payable to

The National Prison Project
1616 P Street, NW
Washington, D.C. 20036

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HIGHLIGHTS

The following are major developments in the Prison Project's litigation program since May 1, 1988. Further details of any of the listed cases may be obtained by writing the Project.

West v. Atkins—The Supreme Court unanimously adopted our amicus position that a private physician, hired by a state prison to provide medical care, was engaged in state action and could be sued by a prisoner in federal court under the Civil Rights Act.

Abbott v. Thornburgh—This is the national class action which challenges the mail and literature policies of the Federal Bureau of Prisons. Plaintiffs have filed their brief on the merits in the Supreme Court and argument is expected to be scheduled for fall of 1988.

Palmigiano v. DiPrete—This case challenges conditions in the Rhode Island State Prison system. Early in May, we learned that defendants were exceeding the population cap at the Intake Center and were ignoring the court orders. Late in June, we filed an application for a show cause order and a contempt hearing was held in July.

U.S. v. Michigan/Knop v. Johnson—This is a statewide Michigan prison conditions case. In *Knop*, the trial court issued a favorable decision on remedial plans. The defendants have now appealed that order and the Rule 11 order. The Prison Project has been appointed litigating amicus by the court; defendants have appealed that decision. The court also dismissed the other claims without prejudice on the condition that if the circuit court of appeals upholds the order, the dismissal will be with prejudice.

Maryland Jails: Hendrickson v. Welch, Macer v. DiNisio, Dotson v. Satterfield—These cases, filed by the Prison Project and the Maryland ACLU, challenge conditions and practices in three jails on Maryland's Eastern Shore. In *Hendrickson*, defendants failed to carry out the terms of the agreement reached in January, and plaintiffs have petitioned the court to reschedule the hearing on preliminary injunction. In *Dotson*, the court granted a preliminary injunction which will allow plaintiffs to receive newspapers and magazines. A federal magistrate also recommended court approval of a preliminary injunction to end triple-celling and sleeping on mattresses on the floor, and reduce overcrowding in the women's section.

Duran v. Carruthers—This case challenges conditions in the New Mexico state prison system. The Supreme Court denied defendants' petition for *certiorari* on the issue of attorneys' fees. We are now proceeding in the district court on all open fee claims. In response to the defendants' appeal motion to modify or vacate the consent decree, parties met with the Special Master in an attempt to negotiate their differences.

Plyler v. Leeke—This case challenges overcrowding and conditions in the South Carolina prison system. In response to the circuit court's decision favoring defendants on their motion to modify the consent decree and ease population requirements, we filed a petition for a rehearing *en banc* in May. The petition was denied in June and we will be filing a petition for *certiorari* in the Supreme Court. In August, we received a favorable decision on attorneys' fees dating back to the beginning of the case.

Harris v. Thigpen—This case challenges the Alabama Department of Corrections' program to test all prisoners for HIV antibodies, and to segregate those who test HIV positive. Plaintiffs filed an amended complaint in June. Defendants moved to dismiss, and a hearing was held in August. The court has denied the the motion to dismiss, although it will consider the testing issue separately. The court also agreed to certify the case as a class action.

Baraldini v. Meese—This case alleges that the Federal Bureau of Prisons assigned plaintiffs to the High Security Unit in the Lexington Federal Penitentiary in violation of their First, Eighth and Fifth Amendment rights. A hearing was held in June, and the court granted plaintiffs a highly favorable decision in August.

Dickerson v. DuPont—For the last year, the NPP has been investigating conditions in the Delaware prison system in cooperation with Community Legal Aid in Delaware and the ACLU of Delaware. Following intensive negotiations beginning in March, we reached agreement with the state on a settlement of issues involving overcrowding, medical and psychiatric care, physical plant and sanitation, access to courts and monitoring. This settlement will be incorporated into a consent decree in an existing case pending in the Delaware Court of Chancery. ■

National Prison Project
American Civil Liberties Union Foundation
1616 P Street, NW, Suite 340
Washington, D.C. 20036
(202) 331-0500

Nonprofit Org.
U.S. Postage
PAID
Washington, D.C.
Permit No. 5248

Being a former farmer and horse raiser, I know what it's like to try to eliminate an injured horse by shooting him. Now you can call the veterinarian and the vet gives it a shot and the horse goes to sleep—that's it. I myself have wondered if maybe this isn't part of our problem [with capital punishment], if maybe we should review and see if there aren't even more humane methods now—the simple shot or tranquilizer. —**Ronald Reagan**