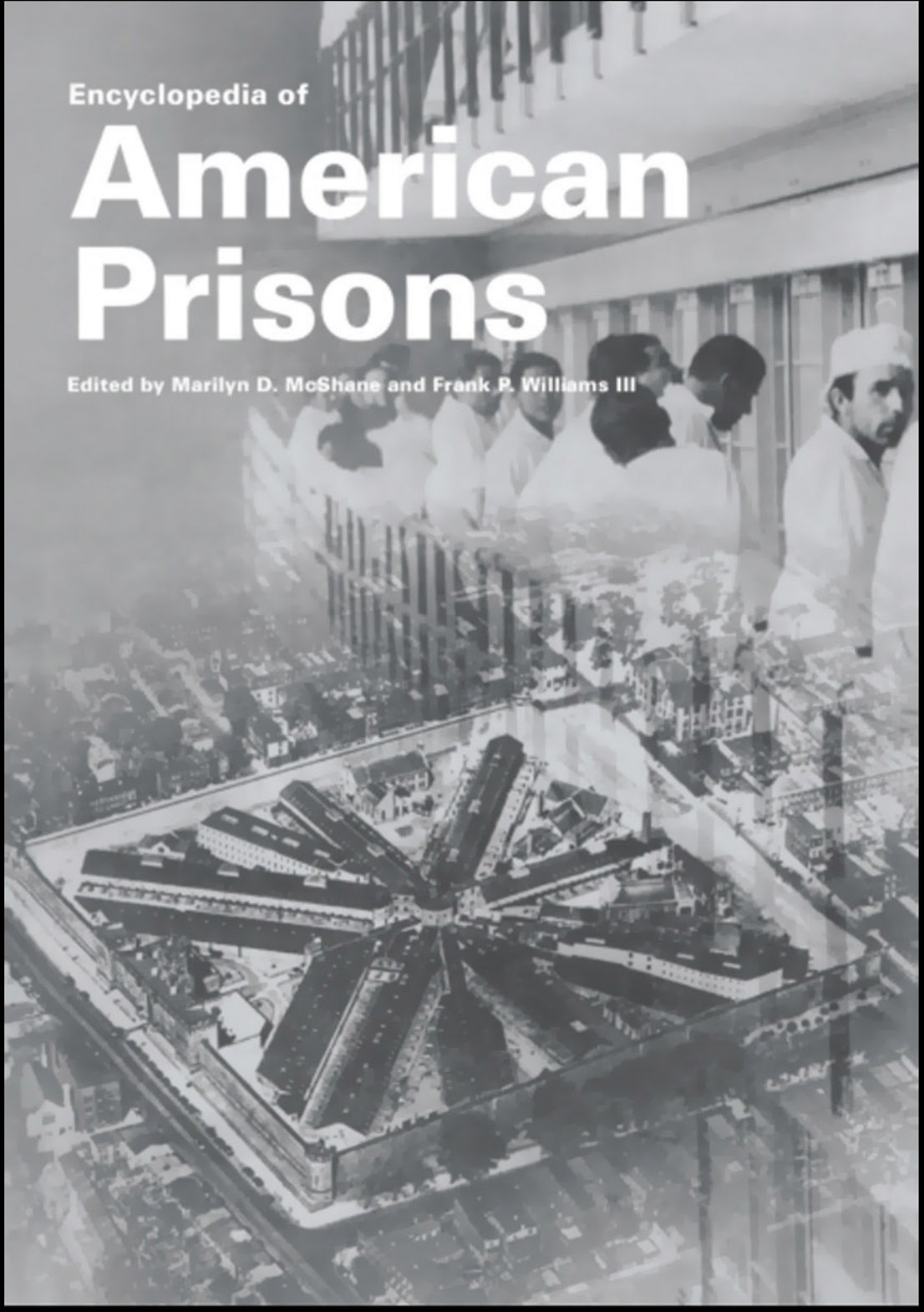

Encyclopedia of American Prisons

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Encyclopedia of American Prisons

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To Mary Rae Schmidt

On whom we have come to rely for so many things

Contents

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Finally, we express our heartfelt appreciation to all of our contributing authors, those who volunteered and those who answered the call. We are convinced that this collection of articles represents everything the general reader needs to know about prisons in America. The cooperation and team spirit the many authors brought to this project was inspiring, and we look forward to working with all of them again in the future.

Introduction

Although prisons were used in Europe as early as the twelfth and thirteenth centuries, they were not considered necessary by the founders of this country. A careful look at the development and use of prisons in the United States tells us much about ourselves, our view of humanity, our hopes and our fears. The literary and cinematic image of the prison has gripped the imagination of everyone who has ever contemplated punishment. Prisons, and those who live and work in them, have generated many stories, films, and legends.

The history of prisons is both colorful and full of controversy. Debates have raged over everything from philosophy to architecture. There have been miracles and setbacks, heroes and villains, in each state and in every institution. Most systems have a great deal in common; trends are easily discerned, and problems seem to transcend the decades.

There is something unmistakably American about the prison system we have created. Just as the solitary fortresses of the early 1900s attracted visitors from all over the world, American institutions are still drawing international attention. Today, over one million people are incarcerated—and we are not through yet. The money spent on building and running prison systems now exceeds that allocated to higher education in many states. The federal government and most states are presently engaged in a building program that will add over one hundred new prisons in the next ten years, and the budgetary allocations for incarceration will only increase. If statistics can be believed, the United States already incarcerates its citizens at a higher rate than any other country. Whether they be houses of darkness, warehouses for the socially unfit, “country clubs,” or models of reform, prisons continue to haunt our American dream.

This work was compiled in the belief that everyone should be familiar with the history and current operations of American prison systems. Many of the entries in this encyclopedia begin with a historical discussion to help frame the issues. Any understanding of contemporary problems must begin with an appreciation for where we have been. The more we know about prisons, the better we can plan for their design and future use.

The entries included here are by no means exhaustive. That would have taken a great many more entries than we had room for, and far more than one volume. These entries, however, are critical to an understanding of prisons in America. Each is written by an author who knows the subject matter well and, in many cases, is preeminent in the field. We believe that these entries compose a comprehensive collection that tells the story of the people, places, and ideas behind the American prison system.

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Chronology of American Prison History

1773	Connecticut converts copper mine to underground prison, called Newgate, in Simsbury
1787	The Pennsylvania Prison Society is founded
1790	Philadelphia's Walnut Street Jail, one of the country's first penal institutions, opens
1793	Mary Weed takes post as principal keeper of Walnut Street Jail, serving until 1796
1819	Auburn prison in New York opens, using silent, or congregate, system
1825	Auburn-style prison (Sing Sing) opens at Ossining, New York
1829	Eastern Penitentiary opens, designed by John Haviland, at Cherry Hill
1870	American Prison Association pub-lishes its guidelines as the *Declaration of Principles*
1873	First separate women's prison opens: Indiana Women's Prison, Indianapolis
1874	Fort Leavenworth prison opens for military offenders
1876	Nation's first reformatory opens under the direction of Zebulon Brockway at Elmira, New York
1891	Congress approves Three Prisons Act to build three Federal penitentiaries (USP Leavenworth, USP Atlanta, and McNeil Island, a former territorial jail, now a Washington state prison)
1901	The first separate reformatory is built exclusively for women at Bedford Hills (Westfield), New York
1906	Federal prison at Leavenworth opens
1914	Thomas Mott Osborne is appointed warden of Sing Sing Prison in Ossining, New York
1927	First woman serves as a federal warden: Mary Belle Harris, at Federal Institution for Women, Alderson, West Virginia
1929	Hawes-Cooper Act passes, placing restrictions on the sale of prisonmade goods
1930	Federal Bureau of Prisons is established

1930	First training school for federal prison guards opens in New York City
1933	Alcatraz becomes a federal penitentiary
1935	Ashurst-Sumners Act passes, prohibiting interstate shipment of prison-made products
1965	Prisoner Rehabilitation Act signed by President Johnson
1971	Riot at Attica, New York
1971	First African American to serve as a federal warden: Lee Jett, Federal Corrections Institution, Englewood, Colorado
1974	Robert Martinson publishes his controversial article on rehabilitation (“What Works:…”)
1977	*Dothard v. Rawlinson* strikes down minimum height and weight requirements for officers
1980	New Mexico Prison riot at Santa Fe
1980	The Civil Rights of Institutionalized Persons Act is passed
1987	Cuban detainees riot in federal facilities in Georgia and Louisiana
1993	First female director, Federal Bureau of Prisons: Kathleen Hawk

A

Accreditation

Up until the implementation of official standards, prison officials had little assistance in gauging the quality of their facility or the performance of their staff. In the late eighteenth century, the Philadelphia Prison Society constructed guidelines for the treatment of prisoners that included the separation of male and female inmates, the separation of children from adults, the implementation of a classification system, and the basics of prison industry. More recommendations and reforms followed. In 1870, the American Prison Association published its guidelines as the *Declaration of Prin-ciples.* Since that time, numerous commissions and councils have addressed the requirements of modern penal institutions and have developed model legislation, programs, and standards.

The acceptance of national professional standards or uniform policies has evolved into a recognized program of national accreditation, a process of peer review or review by outside audit teams. The major organization granting accreditation is the American Correctional Association (ACA). A similar program specific to the accreditation of medical services in corrections is conducted by the National Commission on Correctional Health Care (NCCHC).

The first American Correctional Association manuals of professional standards were published in the 1940s. The standards were revised periodically through 1966. The standards, which were principally for correctional institutions, were used by some agencies, but there was no objective method for verifying compliance. In the years that followed, the courts became more concerned about the deteriorating conditions of prisons and began a period of active intervention. As a result, prison administrators expressed a need for the existence of some type of performance criterion. The President's Crime Commission published standards in 1967 as part of its work, but no plan for implementation was included. In 1969, the Ford Foundation provided a grant to the American Correctional Association to study the desirability and feasibility of establishing an accreditation process that would address the concerns of prison administrators, prisoners, legislators, and the courts. That study both identified the need for new standards and published a plan for the review, evaluation, and measurement of compliance with the standards, documented in an "accreditation plan for corrections."

In 1970, national goals and standards for correctional institutions were published by the National Advisory Commission on Criminal Justice Standards and Goals. Those standards addressed prison and jail conditions but again provided no plan for

implementation, other than recommending a state-by-state effort to create, adopt, and apply similar standards. In 1974, the Law Enforcement Assistance Administration (LEAA) awarded a grant to the American Correctional Association to establish a Commission on Accreditation for Corrections (CAC). Several corporations and private funding sources participated in that effort. The existing standards proved insufficient for use in accreditation because of their overly comprehensive nature, lack of specificity in many areas, and narrow focus on prisons and jails. CAC staff recommended that the grant include the development of a comprehensive set of standards to cover all components of correctional services. An extensive program of drafting, field testing, revising, and approving thousands of standards was begun, addressing the entire field of corrections—prisons, jails, parole boards, probation and parole services, and community residential centers for both adults and juveniles.

The first manual of standards was published in 1976, containing 452 different standards. Ten manuals were produced by 1979 and all were revised by 1983. In 1978 the first accreditation awards were made to a parole board and four halfway houses. The first adult correctional institution achieved accreditation in 1978, the first jail accreditations were in 1980, and the first juvenile agency accreditations were awarded in 1981. Since accreditation is for a three-year period, the first reaccreditations were awarded in 1981. Over one thousand agencies in the United States and Canada have received or are involved in accreditation with the ACA.

Of all the standards, only about 10 percent are mandatory and must be met to achieve accreditation. Mandatory standards generally apply to conditions that ensure the health and safety of staff and inmates. Many mandatory standards simply direct compliance with local laws, such as building, fire, and sanitation codes. Other standards reflect implications or directives from the courts on constitutional issues such as rules, discipline, visitation, and mail privileges.

The original plan stipulated that correctional accreditation was to be performed by an independent commission, the CAC. That was the case from early 1979 through 1986. Although fees were charged for accreditation, they were not sufficient to cover the costs of administration, and placing the CAC within the ACA kept costs down. The commission members had always been elected by the membership of the ACA, which is still the case; the CAC operates independently in its decision-making about accreditation. The ACA has always had a Committee on Standards, which has the responsibility for developing the standards for approval by both groups. Accreditation certificates are awarded by the commission and presented by the ACA.

A similar accreditation effort has been undertaken for medical services. The NCCHC was established in 1983. It maintains nationally recognized standards that are similar to those of the ACA. That is the case because the American Medical Association, which began the process, worked with CAC staff during the initial development of the standards. By February of 1992, there were 301 jails, 75 prisons, and 31 juvenile correctional facilities accredited by the NCCHC (Briscoe and Kuhrt 1992).

A 1983 survey of the staff of accredited state and federal agencies found that 85 percent of the 566 respondents saw accreditation as a good management tool. About two-thirds felt that accreditation had helped staff members in organizing and following policies and procedures, all of which might eventually lead to improvements in

conditions and programs. Of the agencies surveyed, more than half agreed that being accredited would help them better defend against lawsuits. Most respondents said that accreditation had better prepared them for emergencies and that it had resulted in a safer, cleaner, and more healthful environment for inmates and staff (Farkas and Fosen 1983; Czajkowski et al. 1985). The impact on prison conditions, however, was questionable. Over half (57 percent) of the respondents were undecided or believed that there was no change in the number of violent incidents since accreditation; only 36 percent indicated that there had been fewer violent incidents in their facility. Forty-one percent did not see a drop in grievance or compensation claims by offenders. About 90 percent of all respondents found no improvements in programs such as visitation (91 percent), recreation (85 percent), meaningful work assignments (92 percent), or education (87 percent). A similar survey conducted in early 1989 revealed similar opinions about the value of accreditation, emphasizing improvements in management and staff performance, better fire safety, and increased funding (Washington 1989). There have been no findings regarding improved conditions or programs, in institutions or in the community.

A 1990 national survey of prison wardens and superintendents (McShane and Williams 1993) found that fewer than half of the respondents (46 percent) felt that accreditation guidelines had any influence on their personal management style. Factors such as budget constraints, legal requirements, the quality of staff, and overcrowding had more impact on their management routines. Some state legislators have cited the difficulty of meeting the standards, fearing the cost and the potential for inmate lawsuits. While compliance with the standards is sometimes seen as both expensive and difficult, their acceptance has nevertheless been quite high.

There is growing evidence of support for standards and accreditation in the courts and in some state legislatures, although court acceptance of the standards and the accreditation process is far from universal. As Miller (1992) states, “Courts have not adopted ACA standards as their primary yardstick for evaluating practices and conditions. In fact, they often establish standards significantly different from… [those of the] ACA.” Other concerns regarding accreditation, both within and without the field, relate to accreditation fees, the time involved, the massive paperwork demands, and the depth of accreditation. Is it a paper process with too little emphasis on the quality of performance? Are the standards specific enough to make a difference? Is its use as a management tool creating a better working environment for staff and improving services to inmates?

Other criticisms focus on how the standards impinge upon the director’s or warden’s authority. Also, there are cases in which an agency’s current policy or procedure is superior to that required by the standards, and clearly not a violation of the offender’s rights or good practice. In fact, the policy may be supported by internal audit findings. Administrators may question the authority of the standards to intercede.

Criticism of accreditation has also come from outside the field. The major concern is that the process needs to be more open and that increased public involvement is necessary. Criticism is often linked to “what the courts will do” or what the constitutional minimum for performance may be. Similar concerns have been expressed by the American Civil Liberties Union’s National Prison Project, which states that many of the standards fall short of common constitutional guarantees in several areas and that the

standards simply represent the status quo in corrections.

Questions have been raised about whether the correctional facilities and community agencies being certified really meet the highest standards of performance. Judgments of the usefulness of the standards often depend on who is making the assessment. To the corrections practitioner, the standards are generally seen as realistic and challenging; to the reform-minded, they may appear weak and ineffective, perpetuating poor performance and injustice. The standards are adequate within the framework of what appears to be possible at present; they still, however, may not reflect the highest standards of good practice. Current standards can be supported by well-implemented internal program review and internal audit mechanisms, and improved local and national standards can also be developed through that process.

There is a growing literature on performance review in corrections. A study undertaken by Logan (1993:2) details specific "empirical indicators" in eight major areas, or "dimensions." Review of these indicators against organizational criteria is necessary to identify which areas of performance should be subject to review, and in order to develop review criteria. The eight indicators are security, safety, order, care, activity (programs), justice (fairness), (living) conditions, and (efficient) management; there are also a variety of "subindicators."

A procedure that encompasses both performance review and compliance measurement is program review or internal audit, a technique developed in business and industry that is relevant to all organizations concerned with quality assurance. It has already proven effective in the corrections profession and warrants further evaluation. As part of its program review process, the Federal Bureau of Prisons uses an automated key indicators/strategic support system that provides management with access to a great deal of information on organizational operations. It is an outstanding tool for strategic planning and the application of quality control principles. The data serve as indicators by allowing the user to observe and analyze system changes, such as levels of crowding and the distribution of inmates with regard to security and custody requirements (Saylor 1989). It is expected that program review/internal audit procedures will become part of ACA accreditation procedures in the near future.

The future of accreditation in corrections will be as good as the administrators who embrace it. Corrections cannot operate on intuition or experience alone, a fact that became apparent in the era of court intervention. National standards and accreditation, which required an agency's self-evaluation prior to the external audit, caused many departments of correction to initiate systematic internal reviews. That was, and still is, an excellent starting point; further development and participation, however, is needed.

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S*ee also* AMERICAN CORRECTIONAL ASSOCIATION

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Administration

Today's prison manager is responsible for planning, directing, controlling, and communicating not only with staff and inmates but also with related government agencies, state officials, and the general public. That public interaction may mean talking to the families of inmates who are worried about incarcerated loved ones, special interest groups that want certain problems or concerns addressed, the news media, or angry local residents with complaints about traffic around the prison.

To solve all of the daily problems that arise in a prison, management relies on modern technology, formal as well as informal rules and regulations, and a hierarchy of authority. While each individual prison within a state has its own management unit, the units all report to a centralized state system headquarters, usually referred to as a department of corrections. Likewise, each of the federal prisons in this country reports to a regional headquarters that in turn reports to the director of the Federal Bureau of Prisons. The director reports to the U.S. Attorney General, who is the head of the Department of Justice.

As there is no universally accepted vocabulary of management, there is no standardized language of correctional management. Among the states, and among state agencies, there is much variation and misinterpretation in titles, structures, and functions. For example, the chief executive of the state department of corrections may be called director, commissioner, superintendent, or secretary. The head of each individual facility or prison unit can be called a warden, director, assistant director, superintendent, or administrator.

The History of Prison Management

Prisons have historically been plagued by an unprofessional image. There are several reasons for that. First, prisons were located in rural, even remote, areas of farmland. Employees drawn from those regions were often undereducated and unsophisticated. The conflict of cultures that developed between the city-reared inmates and the country-reared guards usually resulted in power struggles and brutality. Another problem was that no training took place, and that guards had little understanding of the broader goals of penology. Salaries were low. In the 1840s, a guard in Missouri might earn $130 per year; one hundred years later, in Louisiana, the earnings were about $130 per month. An even greater problem, however, was that in many locations few if any guards were hired at all. In some systems, the largest and toughest prison inmates were selected to supervise and control the others.

Finally, one of the most damaging policies in prison operations was the use of management positions as gifts of political patronage. In many states, the job of running a prison was given as a reward to political supporters or as a gift to family members and friends. As a result, managers often had no qualifications or prior experience. Another consequence was that wardens or prison superintendents traditionally held office for only short periods of time. A short tenure often disrupts prison operations, destabilizes other employees, and impedes the progress of planned reforms.

In the past, prisons operated as closed systems. Leaders were promoted from within the ranks and little information was passed to the outside concerning daily operations. The prison resembled a paramilitary organization, using rank as authority and passing limited information through a chain of command. Guards were expected to follow orders with little explanation and no questions asked.

While the paramilitary model is still popular today, there now is more emphasis on training officers to make better decisions, rather than simply to follow orders. Concerns about liability and staff morale have meant improving communications between officers and their supervisors and more staff participation in decision-making. Corrections programs are also now viewed more as open systems with continuous interaction with the outside, including the news media, the courts, state legislatures, the governor, public interest groups, and corrections boards or commissions.

Prison Management Today

Prison Management as a Profession

Over the years, prison management has been professionalized. Public criticism arising over scandals, and the incorporation of administrative practices from the business world, have created demands for educated, trained, and accountable leadership that operates according to accepted norms within the field. Today's manager may belong to a number of professional organizations and spends more time interacting with the public and with political leaders. Professional organizations sponsor workshops and training seminars, issue opinion statements on current legislation, and compile standards for the operation of institutions in the form of accreditation criteria. Up until the implementation of accreditation standards, prison officials had little help in gauging the quality of their facility or the performance of their staff. Most modern corrections officials view accreditation as an effective management tool (although it may not be widely used). Other management tools include departmentally sponsored reviews, investigative services such as internal affairs, and an open line of communications between inmates, staff, and management.

Profile of Management

With prison management now recruiting more women and minorities, the profile of management has become more diverse. Both the riot at Attica and the civil rights movement of the sixties and seventies exposed the racial inequities between prison inmates and officers. Many departments, including the Federal Bureau of Prisons, embarked on campaigns to recruit more minorities into the corrections field.

In 1989 there were approximately forty women in charge of men's prisons. Approximately a dozen states have appointed women as commissioner or director of their department of corrections.

The Organizational Structure of Management

The organizational structures of prisons have grown both horizontally and vertically, to meet the demands of size and increased accountability. The complexity of prison organizations today means that they cannot be run, as in the past, on the authority of one leader. Rather, the organizational chart reflects a wide variety of technical assistants working in such areas as law, finance, public relations, government relations, treatment, industry, and classification.

The modern prison organization is structured into subsystems that perform various internal functions. Production and technical subsystems provide direct operations. Officers and supervisors, managed by the warden, deal directly with the inmates, maintaining security and control. Support subsystems obtain the materials necessary for the officers to do their work and for the inmates to receive necessary services. Support workers include finance officers who procure supplies and distribute the payroll, along with clerical, medical, and psychiatric staff. Maintenance subsystems ensure the proper distribution of staff throughout the department. Recruitment and personnel experts as well as training staff ensure that new officers will be available to replace any who may leave.

Adaptive subsystems allow the organization to respond to changing conditions. These include research departments, legal experts, and planning offices that all help to meet the evolving needs of the prison and keep it in compliance with standards and codes. For example, the Federal Bureau of Prisons has an Occupational Safety and Environmental Health Program, which is designed to guarantee a safe and healthful environment for officers. Safety managers at each facility are concerned with all aspects of safety and environmental health, and inspections make up an important part of the safety manager's routine. Inspections cover food service operations, living units, vehicles, and the prison

hospital. Proper use of equipment is a major concern, especially in industrial operations carried out by Federal Prison Industries (UNICOR).

Finally, managerial subsystems exist to coordinate and control the entire operation. Management is ultimately responsible for the allocation of resources within the system, the development of goals and programming to meet them, and the conduct of employees.

Centralization Versus Decentralization

One controversial area for prison administration is the degree to which each individual prison can make its own decisions or policies in day-to-day operations. This is referred to as decentralization. Prisons originally operated as independent units and wardens were considered the kings of their own empires, but that situation was perceived as leading to corruption, mismanagement, and inconsistent performance. Centralization, on the other hand, seemed to provide greater uniformity in policies and more monitoring of day-to-day activities. Often located far away at a central headquarters, however, officials found it impractical, costly, and time-consuming to keep close track of activities at the various facilities around a state. Prison employees often developed an "us-against-them" view of the officials from headquarters, who often did not seem to understand their daily problems. Still, for legal control purposes and for maintaining equitable distribution of resources, a centralized model has been preferred in many areas of public administration.

While there has been steady movement toward centralization over the last fifty to seventy-five years, recent shifts in correctional philosophy are bringing about a tolerance for decentralization in many management areas. That increased tolerance may be the result of several forces:

1. *A trend away from mega-institutions and toward smaller facilities:* The current trend of building smaller facilities has increased the number of facilities and resulted in the spread of power over additional layers of authority. These layers of authority may be geographical or based on the characteristics of the inmate population. Facilities with special inmate populations, such as AIDS patients, the mentally ill, or the elderly, see themselves as different from other units and in need of separate policies, procedures, staffing, and resources.
2. *Administrative interest in the concept of unit management:* Unit management has been defined as the leadership of small, self-contained (self-administered) sections or units within the confines of a larger facility. The units are formed by the creation of housing areas of fifty to one hundred inmates who spend the majority of their time together in a confined area. According to Farmer (1988), the groups are preferably supervised by a group-specific, multidisciplinary management team. The team is normally composed of at least a unit manager, a caseworker, a secretary, a correctional counselor, a correctional officer, an educator, and a psychologist or other mental health worker. The Unit Management teams have discipline, classification, and programmatic authority, and are guided by sets of common policies and procedures.

3. *DOC top administrators' being hired from outside of corrections, with back-grounds in political, legal, or business areas:* The expansion and sophistication of corrections systems has meant that administrative structures have experienced horizontal growth. The complexity of management operations calls for leaders with a wide variety of legal, business, and personnel skills. It is not uncommon to find top administrators with little, if any, background in corrections. In fact, a 1987 study of jail management in Maryland recommended that the department hire a deputy administrator with expertise in planning, budgeting, financial management, and record keeping. Similarly, Texas appointed a director of corrections whose employment history was in public finance. The strategy in cases like these is that subordinates, more experienced in corrections, will provide these technical experts with the information they need with which to make appropriate correctional decisions. Because top executives are now less experienced in corrections than in the past, and because they rely on their staffs, they are more likely to delegate authority to operate independently in routine institutional matters.
4. *The increased legal liability of wardens:* In many cases, the courts have found wardens and top administrators responsible for the violations of the rights of inmates on their units. For that reason, wardens have a strong interest not only in how policies are carried out, but also in how policies can be formulated to minimize or prevent liability.
5. *Competition among individual prison units for limited state resources:* Only recently have individual departments within systems had to compete against each other for state resources. As facilities are developed for distinct inmate populations, and thereby become differentiated, their needs change. Units that take on medical responsibilities or higher security levels will perceive a need for additional funds, as well as for separate policies or exemptions from traditional policies. Such exceptions are viewed as necessary for their specialized populations.

As the education and experience level of unit administrators increases, so will their expectations for autonomy within the institution. For officials at state headquarters, the desire for decentralized decision-making is not only a threat to their authority but also to the legal simplicity of uniform policies and procedures.

Regional Management

The establishment of regional management systems may offer a compromise between centralized and decentralized systems. Like many large private businesses, some large prison systems rely on regional management as an intermediary step between control by headquarters and the autonomous control of a single prison unit. For example, the Federal Bureau of Prisons (BOP) has adopted a regional organization to bring management support closer to its field locations. Each region conducts audits and management reviews, answers operational questions, and attempts to standardize procedures for its members. Regions are often geographical, as in the Texas Department of Corrections, where a supervisor from the north, south, central, and western regions reports directly to

the director of the Department of Corrections.

Management Tasks

There are many challenges for managers in corrections today. First, they must be sensitive to public opinion without operating at its whim. Facing serious overcrowding problems and restricted budgets, managers must devise creative strategies for maintaining adequate services and conditions that meet constitutional requirements. Prison administrators must be aware of all current regulations governing the hiring, management, and supervision of employees, as well as the standards of health care and general welfare that pertain to their inmates.

One of the difficulties in being a prison manager is that many of the aspects of the job are simply out of one's control. Many people do not understand the factors that may make one prison "better" than another, "safer," or "less expensive." That may lead to unfair criticism when people compare one facility with another. Prison architecture, the level of crowding, the inmate-to-staff ratio, and the limits of the budget are factors that administrators must deal with daily, yet they are also things that they cannot alter: forces outside the prison system, or from the past, have created them.

Management Styles

There is considerable debate over the best management style for operating prisons. Up until the 1960s, the most common management style was rooted in authoritarian dominance. The style most appropriate for today's institutions, however, is a controversial issue. Prisons, like other areas of public administration, have borrowed heavily from private business for techniques and policies. While some of those lessons are merely fads that come and go, it is clear that prison administrators are looking for answers that will apply from facility to facility and will last over time. Like managers in private business and in other areas of public administration, prison officials are faced with the problem of how to budget money and other resources, how to integrate the existing workforce with personnel who meet today's changing employee profile, and how to best use and adapt technological advances.

Many reformers have argued that a more democratic style of leadership, allowing staff and even some of the inmates some degree of participatory management, would be best. That was attempted by Thomas Murton at Arkansas in 1967 and by Howard Gill at Norfolk in 1927. To some degree, it was also the underlying theme at Walla Walla during the early 1970s.

Some people argue that true participatory management is not suited to prisons because

of the high degree of risk involved with most inmate populations. Indeed, work inside an institution has traditionally been viewed as being performed by less mature workers who do not require a high degree of skill or technical expertise. As corrections has developed into a more legally and technologically sophisticated operation, however, the skill requirements for officers have steadily increased.

There is some consensus that the style of management that administrators use with inmates is not the same style that will be effective with staff. It is believed that styles of management will vary with the level of security in a certain institution or the types of inmates held there. Most managers employ strategies such as walking around the facility, speaking with inmates and staff directly about their concerns, and taking a "hands on" approach to many details of daily operations.

The Future of Corrections Management

The limited attempts at expanding management information systems and improving staff/management relations may become more popular and may even become standard practices. The popularity of private sector techniques such as total quality management (TQM) may mean that management will become more consumer oriented, periodically surveying staff as well as inmates to ensure meaningful feedback that may identify problem areas early and avoid confrontations later. Technological improvement in on-line datasets will allow managers access to more information in daily decision- making. Management training is becoming more popular and more readily available. All of these factors may contribute to reduced liability and fewer potential lawsuits.

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S*ee also* WARDENS

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Administrative Segregation

Administrative segregation is a general term used in institutional corrections that refers to restrictive housing units, cell blocks, or facilities specially designed for disruptive inmates. It is a high maximum-security classification level that typically involves inmates living in single cells, the reduction or complete elimination of group activities among inmates, strengthened measures to control contraband, the use of additional security measures and equipment, and programs and services that are either not available or are restructured and brought to the inmates' housing areas.

Prisoners assigned to administrative segregation units spend most of each day in their cells. They frequently do not have work assignments; they are escorted out of their cells for periodic recreation, medical appointments, family and attorney visits, and scheduled meetings with correctional committees, such as the classification committee or the disciplinary committee. While some correctional systems refer to this highly restrictive classification as administrative segregation, other systems use different terminology; the Washington Corrections Center in Shelton uses the term intensive management.

Although placement of a prisoner in administrative segregation is a response to that prisoner's failure to abide by disciplinary regulations, segregation is typically considered an administrative placement; that is, it is not a punishment. Inmates classified into this restrictive status have been evaluated as being unable to live safely among even maximum security inmates.

Types of Prisoners Assigned to Administrative Segregation

Prison administrators assign inmates to an administrative segregation classification because their behavior is so disruptive that they are security risks to other inmates, the staff, or the facility itself. Some prisoners are assigned because they are escape risks. The restrictive living conditions and limited movement in administrative segregation significantly reduce the opportunities to escape or to threaten the security of others.

A national survey of the disruptive maximum security population was conducted in 1988 by the National Institute of Corrections. A questionnaire was sent by researchers to fifty state correctional agencies, the District of Columbia, and the Federal Bureau of Prisons. Thirty-five agencies responded. At the time of the questionnaire, disruptive inmates constituted 3.8 percent of the overall prisoner population and 54.8 percent of the maximum security population. Approximately 25 percent of the disruptive inmate population had a history of escape or attempted escape, compared with 11 percent of the

general population inmates.

Respondents identified murder and hostage-taking as the two actions of primary importance in determining administrative segregation status, followed closely by deadly assault, and the manufacturing, possessing, or smuggling of firearms, explosives, incendiary devices, or poison gas. Other types of behavior that often result in a prisoner's being assigned to administrative segregation include aggravated sexual assault, sodomy, organizing or instigat- ing a riot, work stoppage, or slowdown, and participating in the distribution, smuggling, or manufacture of drugs. In response to the growing problem of prison gang violence, many correctional systems also assign gang leaders to administrative segregation. A few states, such as Texas, house all confirmed prison gang members in segregation.

Another and different type of prisoner that may be housed in administrative segregation are inmates needing protective custody, not because they are disruptive but because their safety is threatened by other inmates. Their security needs may be so great that they must be single-celled and made ineligible for work. Although not in the same housing areas with disruptive inmates, some protective custody prisoners are completely segregated from the general population and live highly restrictive lives.

A major criticism of administrative segregation is that far too often it is used by administrators to house disruptive inmates who suffer from severe mental disorders. Instead of receiving appropriate mental health care, these mentally disabled, troublesome prisoners are managed in administrative segregation, even though for some of them, the isolation in segregated housing can be detrimental.

Management of Administrative Segregation Prisoners

Most correctional systems concentrate all of their segregated disruptive inmates in one or a limited number of facilities, to eliminate duplication of services and programs and to enhance the development of specialized management techniques and staff training. Another advantage of concentration is that it helps create a safer and more orderly environment in prisons that do not house disruptive inmates.

In addition to concentrating their segregated prisoners in a limited number of facilities and housing them in single cells, correctional systems use a number of other methods to manage the disruptive population. Administrative segregation inmates are transported to and from their cells with an officer escort. The inmate is in handcuffs and perhaps in waist or leg restraints. Inmates are usually handcuffed whenever they are out of their cells, except during recreation and visits. Prisoners may be required to take their recreation alone or in small groups during limited time periods.

Correctional officers who work with disruptive inmates often wear protective vests and have additional training in the safe and effective use of physical force, batons, and chemical agents. Videotape records of the use of force are made whenever possible.

Officers may be equipped with body alarms and two-way radios. Administrative cell blocks may be fitted with closed-circuit television and paging systems. Depending on the design of the housing unit, additional staffing is usually required. A well-designed administrative segregation unit or cell block includes recreation areas, medical stations, and meeting rooms that are located close to segregated prisoners so that movement is curtailed and contact with general population inmates is avoided.

The length of time a prisoner spends in an administrative segregation classification will vary according to the policies of the correctional system. It will also depend on the number of beds available in restrictive housing and the demand for those beds at any particular time. Some systems have specific written criteria for determining when an inmate should be released to a less restrictive classification. The most common considerations for release include a prisoner's number of rule infractions while segregated and their severity and recency, the amount of time served in segregation, the number of previous segregated confinements, the reason for classification to segregation, the inmate's cooperation with staff, general adjustment, and gang affiliation.

The United States Penitentiary at Marion, Illinois, is an example of an entire prison that houses disruptive inmates. Marion is the Federal Bureau of Prison's highest-security institution (Level 6). Prisoners who have been disruptive in other federal facilities or who were sent from state systems as a result of serious disciplinary problems are concentrated in the Marion facility. After Marion was shifted to Level 6 in 1979, the increase in seriously disruptive inmates resulted in a significant increase in violence. Gradually, the bureau found it necessary to implement tighter control measures. In 1980, all industrial operations were transferred from Marion and the movement of inmates was further restricted. All maintenance work assignments were eliminated. After a fatal assault on two officers, the serious injury of two other officers, and the murder of a prisoner, all in 1983, an indefinite state of emergency was declared at Marion, which continues at this time.

General population inmates, as they are defined at Marion, have very limited recreation and are restricted to their cells, where they take meals. General population inmates who maintain a clear record are eligible for transfer to the intermediate level, where inmates are fed in small groups and are afforded greater privileges and more recreation. The pretransfer unit is a transitional phase before transfer to a less secure facility; it resembles a more traditional penitentiary environment. Prisoners must spend a minimum of twelve months in general population and a minimum of six months in both the intermediate and pretransfer levels.

Legal Issues Surrounding Administrative Segregation

The prisoners' rights revolution that began in the late 1960s has also had an impact on the manner in which correctional systems manage disruptive inmates. Two-thirds of the

respondents to the 1988 National Institute of Corrections survey reported that they are involved in litigation pertaining to disruptive inmates. Onefourth reported that they are under court orders affecting the management of disruptive inmates, and one-third are under consent decrees.

In general, courts have upheld the right of officials to segregate inmates who are threats to the order and security of institutions. Judges have ruled that segregation does not violate the Eighth Amendment's prohibitions against cruel and unusual punishment.

The constitutionality of the living conditions in segregation has also been examined in numerous cases. Courts have examined such conditions as the level of hygiene and sanitation, the adequacy of heating, ventilation, plumbing, and lighting, the inmates' opportunity for recreation and other activities, the size of the cells, the use of closed-door cells, and the noise level. Judges have considered each challenge to the legality of living conditions on a case-by-case basis, considering whether any one or a combination of conditions violates the Eighth Amendment.

A class-action lawsuit challenged the living conditions at the Marion federal facility following a lockdown that was initiated in 1983 (*Bruscino v. Carlson,* 1988). Charges included allegations of physical and verbal abuse of inmates by officers, the abuse of strip and digital searches, abuse of physical restraints and chemical agents, lack of recreation, limited visiting privileges, severe restrictions on religious rights, lack of jobs for inmates, and limited access to the courts. The court ruled that the totality of conditions did not violate the Eighth Amendment and the Seventh Circuit Court of Appeals affirmed.

There is little consistency in the courts' rulings concerning the length of time officials may legally segregate prisoners. In *Hewitt v. Helms* (1983), the United States Supreme Court stated that administrative segregation status cannot be used by administrators as a pretext for indefinitely confining an inmate. Lower courts have differed considerably, however, in determining when the length of a particular confinement violates the Constitution. As long as two years has been held constitutional, and thirty days has been held unconstitutional. The decisions seem to depend on the living conditions in segregation and the reasons for the confinement (*Graham v. Willingham,* 1967; *Knuckles v. Prasse,* 1971; *Hutto v. Finney,* 1978).

The other major constitutional issue concerns the process by which inmates are initially classified to administrative segregation. In *Hewitt v. Helms,* the Supreme Court decided that the Constitution's due process requirements do not apply to inmates transferred to administrative segregation because segregation is a status that any prisoner can expect at some point during confinement. Prisoners are not entitled to due process protections under the Fourteenth Amendment alone, as they have no constitutional right to remain in general population. The court went on to say, however, that states may create a right to due process by enacting statutes, regulations, or policies that restrict the discretion of prison officials to place an inmate in segregation. If a state has enacted guidelines or criteria concerning the circumstances under which an inmate can be segregated, that inmate has a right to a notice of transfer and a limited opportunity to present a case against that transfer. The institution is required to follow the regulations it has enacted.

In response to the litigation, many correctional systems provide prisoners with notice

and an opportunity to contest their placement in the restrictive administrative segregation environment. In addition, most jurisdictions periodically review an inmate's segregated status, to make certain that the inmate continues to meet the criteria for placement and to provide inmates with assessments of their behavior.

Summary

Administrative segregation is a valuable man-agement tool with which to deal with inmates who require a high level of security, whether they are a threat to others or are in serious danger from others. Its disadvantages include the expense of maintaining segregated housing areas that are specially equipped with extra security devices and are intensively staffed. Also, the inmate population is often difficult to manage. Because of the restrictive nature and the potential for abuse of administrative segregation, inmates are usually provided with significant due process protections.

Barbara Belbot

S*ee also* DISCIPLINE

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AIDS

AIDS (Acquired Immune Deficiency Syndrome) represents the final stage in a spectrum of disease caused by infection with HIV (Human Immunodeficiency Virus). HIV assaults and impairs the immune system, exposing the sufferer to a broad variety of unusual illnesses that rarely occur in people with healthy immune systems.

The original Centers for Disease Control (CDC) national case definition of AIDS was as follows:

> an illness characterized by evidence of HIV infection and the presence of one or more "indicator" diseases to include: certain opportunistic infections and illnesses, which take advantage of an individual's compromised immune system such as pneumocystis carinii pneumonia (PCP), toxoplasmosis of the brain, cytomegalovirus, and other viruses and bacterial infections, certain opportunistic cancers like Kaposi's Sarcoma, and central nervous system disorders which also affect the brain and cause a variety of neurologic complications (National Academy of Sciences, 1988).

As of 1 January 1993, the CDC expanded this case definition of AIDS to include individuals over twelve years of age with a CD4+ (T-cell or T4 lymphode cell receptor) count lower than two hundred cells per cubic millimeter of blood, recurrent pneumonia within a one-year period, tuberculosis of the lungs, or cancer of the cervix, when accompanied by HIV infection.

While a case definition is important in order to track the epidemiology of AIDS in the nation, the Presidential HIV Commission in 1988 concluded that the term AIDS was obsolete and that the term HIV infection more correctly defined the problem, thereby focusing on the full course of HIV infection rather than concentrating on the later stages of the disease.

HIV Transmission

There are two known types of HIV: HIV-1, associated with the majority of AIDS cases in the United States, Europe, and Africa; and HIV-2, which is found primarily in West Africa. HIV belongs to a class of viruses called retroviruses. Evidence continues to indicate that there are three primary modes of HIV transmission: sexual contact, with the exchange of genital secretions (that is, semen or vaginal and cervical secretions); intravenous drug use by means of contaminated needles or syringes; and perinatally, through the passage of HIV from infected mother to child, either across the placenta,

during delivery, or by breast feeding.

Prior to 1985, the receipt of blood and blood products (blood transfusions) was a major route of transmission, but, because of stricter safeguards regarding blood donation, that is now considered a secondary means of transmission. Transmission occurs less commonly when an uninfected individual is exposed to the transplanted tissue or body organs from an HIV-infected donor. Although rare, HIV transmission can also occur through occupational exposure. The health-care profession is the only place where occupational transmission of HIV has been documented to date. Cases of HIV seroconversion following occupational exposure reflect a low but ever-present risk. Studies have shown seroconversion rates of zero to less than one percent among health-care workers with documented percutaneous injuries (needle-stick or puncture wound), sustained contact with nonintact skin, and mucous membrane exposure to blood or body fluids from HIV-infected individuals.

Stages of HIV Infection and Disease

In order to more accurately define HIV infection and AIDS, the CDC has described a four-stage process, based on the presence or absence of various symptoms.

Stage I—Acute HIV Infection

Soon after the initial infection with HIV, there is a short period of HIV replication in the body. The manufacture of HIV antibodies by the body's immune system normally begins to occur as a means of defense to counter the HIV replication. Within two to twelve weeks of exposure and in conjunction with antibody production, acute response symptoms to HIV infection may appear. Symptoms last from two to fourteen days and include fever, swollen glands, poor appetite, and general weakness. These symptoms are often misdiagnosed as mononucleosis. Although some people get quite ill and require medical attention, others may have few or no discernible symptoms. The immune systems of all HIV-infected people respond with HIV antibody production. Within a one- to three-month period, the HIV antibodies begin to circulate in the bloodstream and become detectable. This process is defined as "seroconversion." HIV antibodies are detected via serological testing, and individuals are considered HIV seropositive when they have two positive Enzyme Linked Immunosorbant Assay (ELISA) tests for HIV antibodies, confirmed by a more reliable Western Blot test. Public health officials recommend that HIV seroconverted individuals take appropriate behavioral precautions in order to prevent transmission of the virus to others.

Stage II—Asymptomatic HIV Infection

After acute infection, HIV enters into a period of relative inactivity. Individuals in this stage are referred to as HIV asymptomatic. This stage can last from a few months to several years, with the possibility that some will never develop symptoms at this stage. Tuberculosis (TB), sexually transmitted diseases (STDs), other viruses, alcohol and substance abuse, and aging are conditions that challenge and may further weaken the immune system's ability to hold HIV in check. These cofactors can hasten the progression from asymptomatic HIV infection to symptomatic HIV disease.

Stage III—Symptomatic HIV Infection

Stage III begins when individuals exhibit mild to severe medical conditions and clinical symptoms caused by their HIV infection, but have not yet exhibited any of the formal case definition categories of AIDS. In the past, a more common yet unofficial term used to describe such a category was AIDS-Related Complex (ARC). Leading public health officials advocated the abolishment of that term because of its ambiguity in regard to the life-threatening aspects of the disease at this stage. Persistent Generalized Lymphadenopathy (PGL), which is a painless swelling (two centimeters or more in size) of lymph nodes in two or more sites on the body excluding the groin, that persists for more than three months, is the most accurate indicator of this stage of HIV infection. Other indicators include the non-AIDS manifestations of oral (thrush) and vaginal (candidiasis) yeast infections, cervical dysplasia (the abnormal growth of cervical cells), and chronic, recurrent bouts with herpes simplex virus and Human Papillomavirus (HPV) or genital warts.

Stage IV—AIDS

AIDS is diagnosed when three elements exist: (1) HIV infection; (2) resulting immune suppression; and (3) one or more of the indicator diseases. AIDS indicator diseases include HIV Wasting, HIV dementia, a variety of opportunistic infections caused by four categories of microorganisms, (parasites, viruses, fungi, and bacteria) and the cancers and lymphomas associated with AIDS. Individuals with advanced, severe, clinical illness, whose immune systems are nearly depleted, may lose detectable HIV antibodies as a

terminal event. The terminal stage of HIV infection is relatively short and normally lasts only about one year, during which time untreated patients rapidly and invariably progress toward death.

Correlation between HIV/AIDS in Prisons and Injecting Drug Use

Hearings conducted by the National Institute of Corrections (NIC) Advisory Board in 1993 included correctional officials and administrators representing every region of the nation. Prison health care was identified as the most critical current and future issue within the profession. Although there are many important issues related to the correctional health-care crisis, the key contributing factor to the crisis has been AIDS and the correlation between preincarceration injecting drug use (IDU) and HIV infection.

At the start of the decade, twenty-four percent of new AIDS cases in the United States were attributed to IDUs. The concentration of substance abusers in our nation's state and federal prisons is high. A 1991 national survey of over 700,000 inmates in state correctional facilities found that 79.4 percent acknowledged having used drugs. Twenty-five percent admitted the use of cocaine or crack, and 10 percent admitted using heroin or other opiates in the month prior to their imprisonment. Another 25 percent acknowledged IDU at some time during their lives (Snell 1993; Harlow 1993). A previous survey found that 30 percent of those reporting IDU admitted to sharing needles (National Institute of Justice [NIJ] 1990). The large percentages of inmates admitting IDU and the sharing of injection paraphernalia were reflected in the findings of the National Prison Project, where IDUs represented the majority of inmates with AIDS.

An example of the relationship between IDU and HIV infection exists in New York State. The Rockefeller Drug Laws, implementing determinant sentencing for drug offenders in the late 1970s, affected the New York State Department of Correctional Services (NYSDOCS) by the 1980s and 1990s. The state inmate population grew to fifty-nine thousand in 1991 from twenty thousand in 1979. The increase of court commitments to prison for drug offenses increased the percentage of the state inmate population's IDU (estimated to be as high as 85 percent), which further increased the percentage of HIV-infected inmates. The chief medical officer for the NYSDOCS reported that by the fall of 1989 approximately one inmate per day was dying of AIDS-related illnesses. In 1992, the NYSDOCS estimated that one out of every eight inmates in New York prisons were HIV infected (Glaser and Greifinger 1993).

Nationally, the state and federal prison population increased from 329,821 in 1980 to 823,414 in 1991, primarily the result of a nationwide policy of mandatory minimum sentencing for drug offenses, such as the National Drug Control Strategy (NDCS), implemented in 1989. The dramatic impact of such policies are reflected by the AIDS incidence rate in the prison population, rising from 181/100,000 in 1990 to 362/100,000 in 1992/1993 (Hammett et al. 1993). Additionally, the Federal Bureau of Prisons

estimates that by 1995, 70 percent of all new federal court commitments will be for drug offenses (up from forty-seven percent in 1991). Thus, the ongoing "get tough" policy on drugs, with stricter sentencing, will have a great impact on American prisons into the twenty-first century, with a proportional increase in AIDS cases and mortality.

AIDS Policy in American Prisons

Policy concerning AIDS in United States prisons varies greatly according to the jurisdiction in which the prison resides. Policies and procedures regarding education, training, counseling and testing, confidentiality, and health care, continue to be formulated as knowledge about HIV/AIDS increases. AIDS policy and management in the penal setting are two dimensional, in that they represent both criminal justice and health concerns.

HIV/AIDS prevalence surveys of inmates provide data that is helpful in making decisions regarding manpower, personnel, and resources in regard to HIV prevention, detection of HIV/ AIDS, special housing and security needs, medical care, treatment, and psychosocial services. Surveys of specific inmate cohorts can later be repeated to measure the effectiveness of programs and to help officials evaluate strategies for preventing HIV infection. Seroprevalence surveys also provide public health officials with useful data about HIV infection rates and the evolution of the AIDS epidemic.

AIDS Epidemiology in American Prisons to Date

In November of 1981, the first confirmed case of AIDS among United States prison inmates appeared in a New York State Department of Correctional Service's facility; just six months after the CDC announced the existence of the disease. By the end of March 1993, only the states of West Virginia and South Dakota had not reported an AIDS case within their correctional systems. The total number of AIDS cases reported by the other forty-eight states and the Federal Bureau of Prisons was 8,525. Of those, there have been 2,858 inmate deaths from AIDS, 39 percent of which occurred after 1990 (Hammett et al. 1993). In 1989, the percentage of cumulative AIDS cases in United States prisons began to exceed the increases in AIDS cases in the general population (Hammett and Moini 1990). Further seroepidemiological surveys established that HIV infection rates in prisons exceeded the general population by as much as five or six to one (Lurigio et al. 1991). The 1992/1993 NIJ/CDC survey reflected an AIDS incidence rate in prison that was twenty times higher than that of the 1992 U.S. general population (362 cases per 100,000 versus 18 cases per 100,000, respectively) (Hammett et al. 1993).

Most of the cumulative AIDS cases in prisons have occurred in urban centers of a million or more residents along the Atlantic coast. The Middle Atlantic states of New York, New Jersey, and Pennsylvania account for 50 percent of the total cumulative inmate AIDS cases; 20 percent have occurred in the South Atlantic region, consisting of Delaware, Maryland, the District of Columbia, Virginia, West Virginia, North Carolina, Georgia, and Florida (Hammett et al. 1993). Although the distribution of AIDS cases was uneven—29 percent of state and federal systems account for 90 percent of the cases reported in the NIJ/CDC survey—it is important to note that the Middle Atlantic region's share of inmate AIDS cases decreased from 75 percent in 1985, while that of all other regions nationwide increased during that time (Hammett et al. 1993).

Forty-four percent of the infected inmates in the NIJ/CDC survey were black, 42 percent were Hispanic, and 14 percent were white (Hammett et al. 1993). Considering that African-Americans and Hispanics constitute approximately 70 percent of our nation's reported drug abusers and are also proportionally over-represented as inmates within our criminal justice system, those figures are not surprising.

The best estimate of the overall HIV seroprevalence rate in American prisons is 2.2 percent, as reported by the U.S. Department of Justice (Harlow 1993). There is great state-by-state variance in this figure, however. A nationwide study conducted in ten correctional systems with moderate to high rates of HIV infection assessed 10,944 prisoners and found the seroprevalence rate ranging from 2.1 to 14.7 percent. Nine of the ten correctional facilities reported higher rates of HIV infection for women (Vlahov et al. 1991).

Prevention of HIV Transmission Through Education

Although the discovery and initial findings on AIDS led to considerable public panic, by 1993 much of the initial reaction to the epidemic appeared to have dissipated. Many of the original concerns of correctional administrators—such as intraprison transmission by homosexual contact or by the sharing of needles (acknowledged to occur within prisons, Nacci and Kane 1983)—have proved unfounded. Longitudinal research on both federal and state inmates via serological studies has established that HIV transmission within the prison is likely to be rare, at less than 0.5 percent (Vlahov et al. 1991). Today, leading public health officials and researchers still advocate education as the best method to combat the spread of HIV infection. As discussed, the groups from which the American penal population is drawn are at high risk for HIV/AIDS. That population consists of individuals who have had little or no access to health care. For many young adults, the prison is the dominant social institution in their lives, and it can offer an excellent setting for HIV prevention, education, counseling, testing, and effective medical intervention.

HIV/AIDS Education in the American Penal Setting

A recent survey of state correctional departments in the U.S. found that forty-eight states have some type of AIDS education for inmates. Forty-five of those state correctional agencies have AIDS educational programs upon intake, with twenty-two of those also conducting AIDS education upon release. The majority of states (80.9 percent) implemented their programs between the years 1985 and 1989. In rank order, their main reasons for doing so were: (1) to enhance institutional safety for both inmates and staff, (2) to meet their commitment to public health, (3) to improve the prison environment, and (4) to protect the institution from inmate litigation (Martin et al. 1993).

Education is now recognized as the foundation to all HIV prevention efforts in the nation, but it takes on even more significance with inmates. Because our nation's correctional facilities contain such large concentrations of acknowledged IDUs, the AIDS education given to this captive population is key in fostering behavioral changes aimed at reducing HIV transmission. Because IDUs in the general population are difficult for AIDS educators to reach, those in prison are more likely to benefit from AIDS education. The education received by inmates, and particularly drug injectors, is likely to be remembered upon release. AIDS education and training within the correctional setting also help to alleviate concern about the transmission of HIV to either inmates or staff.

HIV/AIDS education in the nation's prisons reinforces a commitment to public health by realizing that it is not solely a criminal justice issue. HIV/AIDS education is important public health information that every citizen should have, and prisoners should not be over-looked. In fact, litigation against the correctional departments of Alabama and Connecticut has been initiated by inmates to ensure that those departments provide adequate AIDS education.

In order for HIV education to be considered truly preventive in the prison setting, it must be up to date and scientifically accurate, appropriate for the educational and cultural level of the inmates, and presented in all the languages necessary to reach the prison population. The content of the educational material should include the modes of HIV transmission, the signs of HIV infection and progression, the implications of the HIV antibody test, the symptoms and signs of AIDS, HIV infection control procedures and confidentiality requirements, and information on assistance for those inmates testing positive for HIV. The education should be mandatory and ongoing for both staff and prisoners (Dubler et al. 1990). HIV/AIDS education is often presented both before and after HIV antibody testing.

HIV Testing in American Prisons

The advent of a blood test for HIV antibodies in 1985 ignited intense national debate concerning HIV testing. The debate centered on the moral and legal issues of mandatory testing used as a tool for policy rather than for medical purposes. Advocates of mandatory testing argue that, by testing everyone, identified HIV seropositives will have the necessary access to life-prolonging treatments, and behavioral changes can be stressed in an effort to protect society as a whole. Civil rights proponents point out that mandatory testing violates an individual's right to privacy, and that those identified as HIV positive may be subjected to such discriminatory practices as quarantine. A further argument against mandatory testing is that a false sense of security may be created, because those with negative test results may not yet have seroconverted (it can take up to six months after infection for HIV antibodies to be detected).

In the nation's general population, voluntary HIV counseling and testing is the norm, with the exception of mandatory testing for U.S. military personnel and for foreign nationals applying for permanent resident status. Because prison inmates tend to demonstrate high HIV infection rates and because inmates have diminished privacy rights under the constitution, however, many lawmakers and correctional administrators have advocated mandatory testing among prison populations. Opinion polls have found that the public overwhelmingly supports mandatory HIV testing of prisoners. The order for mandatory testing for the Federal Bureau of Prisons came in 1987 from President Reagan. In 1993, NIJ/CDC survey results indicated that sixteen state correctional systems had policies requiring all inmates to be screened for HIV (Hammett et al. 1993).

A number of state and federal systems also have voluntary testing that is available to inmates upon request. Approximately 80 percent of the prison systems in the United States employ that method as their primary type of HIV testing (Hammett et al. 1993). Other testing methods used by prisons include targeting risk groups, routine testing of all but those inmates who refuse the test, testing of inmates if clinical manifestations of HIV/AIDS surface, and the testing of inmates who may have been exposed to blood, mucus, or other body fluids, commonly referred to as "incident" testing (Hammett et al. 1993). HIV testing can also originate in the judicial system, and court-ordered HIV testing has occurred in the state correctional departments of Arizona, California, Kansas, and Washington (Lillis 1993).

Regardless of the testing policy adopted by individual prison systems, public health officials deem the following elements crucial to any HIV screening program: (1) pretest counseling focusing on the significance of the test; (2) HIV/AIDS education stressing risk-reduction behaviors; (3) referrals for any medical needs; (4) confidentiality measures, especially regarding test results; (5) support for HIV seropositive inmates, to include medical, mental, and social services; and (6) HIV counseling and education following testing for all inmates, to encourage behavioral changes (Freudenberg 1989). These elements give prison inmates the opportunity to personally benefit from HIV

screening within the correctional setting and, more important, to meet their moral obligations to the other prisoners.

The public health model of HIV prevention has had and will continue to have an impact on correctional facilities in this nation. The NIJ/CDC survey indicated that over four hundred correctional institutions have their HIV counseling and testing conducted either by local or state public health departments (Hammett et al. 1993). In 1992, the Centers for Disease Control, via funding lines known as Cooperative Agreements for HIV Prevention Projects, urged departments of health nationwide to work together to provide HIV prevention programs. In 1993, the CDC mandated that all state or local health department requests for such funding include (among others in the criminal justice system) all inmates. This assistance comes as a welcome relief to the nation's correctional system, where the cost for testing and treatment of inmates with HIV/AIDS continues to rise. A report issued in mid 1993 found that 76 percent of the state correctional systems in this nation reported that their health care budgets had increased in the past year and that, on average, 10 percent of the total correctional budget was now allotted for health care (Lillis 1993).

Correctional Policy and the Special Needs of HIV-Infected Inmates

The establishment of HIV/AIDS counseling and testing programs in correctional facilities has done much to alleviate the crisis atmosphere that first surrounded the AIDS epidemic in American prisons. These education and risk-reduction programs provide inmates with information about their HIV serostatus and identify the prisoners who require treatment. Yet HIV and AIDS still pose several serious and unique challenges to correctional administrators. The coming decade will see many more changes aimed at meeting the special needs of the HIV-infected inmate. Specific issues that require attention include the special needs of women infected with HIV, housing and security for inmates with HIV/AIDS, AIDS focused psychological and social services, and medical care and treatment for the inmate with HIV/AIDS.

Female Inmates

Women constitute only 7 percent of the nation's state and federal prison population, but the percentage increase in female commitments between 1980 and 1990 was almost double that of men (a 202.2 percent increase for women compared with a 111.6 percent increase for men). Correctional administrators have been building new women's facilities at record rates. They must keep in mind the necessary requirements for the HIV-afflicted

female inmate when constructing new facilities. Incarcerated women have higher rates of HIV seroprevalence than do men, 2.5 to 14.7 percent versus 2.1 to 7.6 percent (Vlahov et al. 1991). That is attributed to higher rates of intravenous drug use among female prisoners, as large numbers are incarcerated for drug crimes or prostitution. Among the special needs of female inmates with HIV/AIDS is access to drug treatment, especially for the female prostitute who is often also an IDU. Women's AIDS education in the prison should stress safe sex via the use of condoms with spermicide, and should include discussions of the potential for IDU lesbians to infect their partners through sexual transmission. Prison HIV/AIDS programs for women must also include such issues as the perinatal transmission of HIV and the availability of HIV testing and counseling for pregnant inmates (Freudenberg 1989).

Housing and Security

As the number of inmates with HIV/AIDS grows, correctional administrators in the nation are increasingly faced with the issue of where to place them. In the beginning of the AIDS epidemic, segregation policies in prison were favored in order to protect uninfected inmates from HIV-infected inmates, who were considered contagious. There has been a shift in policy over time, however, and HIV-seropositive prisoners now tend to be mainstreamed into the general prison population. The NIJ/CDC survey found that 42 percent of state and federal systems had some sort of segregation policy for HIV-infected inmates in 1985, but that the percentage had decreased to just 8 percent in 1993 (Hammett et al. 1993). The new approach to the special housing for prisoners with HIV/AIDS appears to be a case-by-case approach, one contingent on the stage of the inmate's disease. In 1985, 35 percent of the systems favored the case-by-case approach; in 1993, that method was used by 92 percent of the state and federal prison systems (Hammett et al. 1993).

The demise of segregation as an AIDS policy within prisons has come about for several reasons. One important reason is that segregation policies can compound the problem of prison overcrowding for correctional administrators. Sentencing practices in the 1970s and 1980s helped to create an overcrowded penal system by the time AIDS was discovered. The creation of separate HIV/AIDS units within prisons put further demands on the already limited space available for inmate populations.

Certainly, the great majority of HIV asymptomatic prisoners do not require special housing. The need for special housing or hospice services occurs at the termination of the disease, when full-blown AIDS is present. The shift in policy toward a case-by-case approach has ensured that correctional resources can be targeted for effective HIV prevention programs, the purchase of life-sustaining medicines, and the development of special AIDS wards or long-term medical care facilities.

Consideration of AIDS-afflicted inmates on a case-by-case basis has resulted in the emergence of early-release policies by prisons, allowing terminally ill inmates to die at home. This compassionate approach by the penal system toward the dying inmate is

workable, provided that necessary health care is available after release. Many inmates are poor and may not have access to medical care outside prison walls. It is therefore imperative that prison officials make sure that they are not releasing a dying inmate into a precarious situation; the case-bycase approach is the best way to ensure a humanitarian and dignified death.

Health Care, Medical Treatment, and Psychosocial Services

Once a correctional system has identified an inmate as HIV infected, it has a duty, imposed by the Constitution, to protect the prisoner and provide adequate medical care (see *Estelle v. Gamble*, 1976, wherein the U.S. Supreme Court held that "deliberate indifference to serious medical needs" violates the Eighth Amendment). Ideally, penal institutions should provide this health care in the least restrictive environment, given security or custodial needs. Health care should begin immediately after the notification of a positive test result. The HIV counselor has an obligation to inform the inmate of the significance of a positive test and to refer the inmate to medical, psychological, and social services. The medical staff should respond with the treatment appropriate for the particular stage of the disease and should work toward preventing further transmission. An early diagnosis of HIV by prison medical staff is crucial to the development of the most comprehensive treatment plan for the inmate.

Treatment for HIV infection involves trying to manage the disease with prophylactic and therapeutic drugs in the hope of increasing the life expectancy of the inmate. It is important to note that early treatment with zidovudine (AZT), thought to prevent the onset of AIDS by asymptomatic HIV-sero-positive patients, has recently been questioned by the "Concorde Study" (Aboulker and Swart 1993). That type of drug is very expensive and requires intensive therapy to administer, thereby having a large impact on correctional health care budgets nationwide. Because of the expense, most inmates are not given AZT until they meet Federal Drug Administration (FDA) eligibility criteria [a CD4 (T4) cell count below 500] (Hammett and Moini 1990). The NIJ/CDC survey found that the treatment is available to HIV-infected inmates within 98 percent of the nation's correctional facilities. Approximately 80 percent of the prisons in the survey also offer the antiretroviral drug ddI and Bactrim/Septra or aerosolized pentamidine to treat pneumocystis carinii pneumonia (PCP) (Hammett et al. 1993).

Treatment needs differ by gender; for example, women with AIDS are more likely to develop PCP but rarely develop Kaposi's Sarcoma (KS), which is much more frequent among men. Additionally, pregnant inmates with HIV infection should be monitored closely, as they are more susceptible to opportunistic infections during their pregnancies (Lawson and Fawkes 1993). Research findings from a new study, yet to be corroborated, have found that the risk of perinatal transmission may be cut drastically by administering AZT to HIV-infected women in the weeks immediately preceding delivery.

The need for psychological and social support services for those suffering with AIDS is compounded by the prison environment. At the very least, individual psychological therapy should be available for inmates to help them deal with the anger, denial, and fear that generally follow the notification of a positive test result. If group therapy is available, it can be used to help them deal with the stigmatization that many HIV-infected inmates experience in the penal setting. Inmate-run group therapy has been derived from HIV peer counseling programs like the AIDS Counseling and Education (ACE) program at the Bedford Hills women's prison in New York. Substance abuse programs offered by prisons can help to address the needs of addicted HIV-infected inmates and are extremely important in preventing further transmission of HIV. Lastly, religious support through pastoral counseling is valuable to those prisoners facing death.

The Legal Aspects of AIDS in American Prisons

Litigation concerning HIV/AIDS issues in correctional facilities began to appear in the nation's courts in the mid to late 1980s. The majority of cases were inmate initiated, questioning the constitutionality of AIDS policies in state correctional systems. The litigation has been based primarily on the constitutional prohibition against cruel and unusual punishments (Eighth Amendment), protections against the taking of life, liberty, or property without due process (the Fourteenth Amendment), and the equal protection clause (the Fourteenth Amendment).

Inmate litigation has challenged the adequacy of medical care in prisons and alleged negligence on the part of correctional health care staff (for example, *Botero Gomez v. U.S., Harris v. Thigpen, Hawley v. Evans, Maynard v. New Jersey* and *Weaver v. Reagan*). HIV-infected inmates have brought cases questioning the right to segregate them from the general prison population and the legality of subjecting them to mandatory HIV testing (for example, *Cordero v. Coughlin, Dunn v. White, Harris v. Thigpen, Judd v. Packard, Powell v. Dept. of Corrections*). Uninfected inmates have challenged penal systems on their failure to protect them from HIV-seropositive inmates and have asked for mandatory testing and segregation (for example, *Feigley v. Fulcomer, Glick v. Henderson, Jarrett v. Faulkner, Myers v. Maryland Division of Corrections,* and *Traufler v. Thompson*). Cases have arisen regarding the disclosure of inmates' HIV serostatus (for example, *Doe v. Coughlin, Harris v.Thigpen,* and *Woods v. White*). HIV-infected inmates have petitioned the court for access to denied programs (for example, *Casey v. Lewis* and *Farmer v. Moritsugu*). Cases have also come forth alleging the failure of correctional systems to protect inmates, correctional staff, and medical personnel from assault by seropositive inmates (for example, *Cameron v. Metcuz, Doe v. State of New York,* and *United States v. Moore*) (Belbot and del Carmen 1991; Hammett et al. 1993).

Some of these cases are under appeal, and definitive resolutions around these legal issues could be years in the making. Most inmate-initiated AIDS litigation has been

resolved, without full trials, in favor of the correctional systems or their administrators. The courts have generally found that the AIDS policies of correctional institutions are based on a legitimate penological interest and have not violated prisoners' constitutional rights. Regardless, many of the legal problems associated with prisoners infected with HIV/AIDS have just recently emerged, and other issues have not yet been resolved. In view of the rapidity of changes in the field (for example, the advent of AZT therapy), correctional administrators, health care providers, and legal staff should make an effort to stay abreast of developments in AIDS case and statutory law.

Summary

HIV infection and AIDS, which inevitably results from it, pose a tremendous health threat to all of society. Even before the outbreak of AIDS, the American prison system was facing severe overcrowding compounded by a lack of funding and a history of inadequate medical care. In conjunction with HIV/AIDS, which now presents itself in large numbers of prison- ers requiring specialized treatment and care, the problem has created a health care crisis within penal institutions of this nation. Add to that the projected rise in HIV-seropositive inmates in the next decade and the continuing threat of inmate litigation, and it appears that the correctional health care crisis will continue for some time. The medical and custodial needs of HIV/AIDS inmates will be one of the most important considerations for correctional administrators well into the twenty-first century.

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S*ee also* HEALTH CARE

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Alcatraz Federal Penitentiary

Alcatraz Prison, the Rock, was known as one of the most secure and isolated federal penitentiaries of the twentieth century. The stark, rocky island was created over fifteen thousand years ago, at the end of the last ice age, by melting glaciers, which separated the island in San Francisco Bay from any other land by more than a mile. It is believed that the first humans to ever set foot on Alcatraz were the Native Americans of the San Francisco area, who would sail to the island looking for eggs produced by the vast number of birds that made their home there. Alcatraz did not receive its name, however, until 1775, when Juan Manual Ayala, a Spaniard commissioned to survey the harbor, observed the nesting pelicans on the island and named it “Isla de Los Alcatraces,” or “Island of the Pelicans.”

The Early Years

In 1850, California had become a state and the gold rush was in full bloom. The U.S. Army determined that Alcatraz Island would make an excellent location for a military fortress and lighthouse to protect the settlers and the abundant gold found in the bay area. Construction of the fortress known as the Post of Alcatraz began in 1853, and the army’s first objective was the building of batteries of cannon around the island. Although the cannon are long gone, several of the bunkers remain on Alcatraz today.

The lighthouse was completed in 1854 and became the first operational lighthouse on the West Coast. The original lighthouse was in operation for fifty-five years before being replaced in 1909 by a more modern version. In 1970 the lighthouse was destroyed by fire, although the tower remained and since 1963 has been fully automated.

In the 1850s, the army built the Citadel at the top of the island to house military personnel. Guardhouses were also constructed, resulting in the first jail on Alcatraz. It housed soldiers with disciplinary problems and Californians sympathetic to the Confederate cause.

By the 1860s Alcatraz held over one hundred prisoners, and the number increased to more than four hundred by the 1870s. Because the Fort of Alcatraz had been designed as a fortress, the increasing prison population caused both manning and housing problems for the army. Soldiers had to be removed from their posts to guard the prisoners, and additional housing was needed to manage the growing population. By 1880, the Post of Alcatraz had been transformed into a military prison.

The conditions for prisoners were appalling. Each inmate was required to “carry the baby,” a 24-pound ball that was chained to his leg. The ball was too heavy to drag

behind, requiring each prisoner to pick it up and carry it around with him.

By 1907, the U.S. War Department decided to make Alcatraz a permanent military prison, and conditions for the prisoners improved significantly. The top floors of the Citadel were torn down and new cell houses were constructed. Much of this new construction was completed by the inmates. By 1915, the prison was officially opened as a military disciplinary barracks housing five hundred military prisoners. The new philosophy of the prison focused less on retribution and more on rehabilitation. Alcatraz served in that capacity for the next nineteen years and, during that time, the army continued to add new buildings to the island.

The Federal Penitentiary

Alcatraz Island became a federal penitentiary in 1933, when the Department of Justice took over authority of the island. J.Edgar Hoover and the Department of Justice had been looking for a new federal prison in which to house the most dangerous criminals and troublemakers in the federal prison system, “the worst of the worst.” At the time, organized crime was flourishing because of Prohibition and the Depression. The media sensationalized these crimes, making such criminals as Al Capone and “Machine Gun” Kelly appear as frightening villains who must be safely locked away. Alcatraz prison would accept the “troublemakers” or “escape artists” from other federal prisons who interfered with the rehabilitative goals of those institutions.

The first warden of Alcatraz Federal Penitentiary, appointed in 1933, was James Johnston. Warden Johnston supervised the complete refurbishing of the island prison to ensure that it was tight enough to hold notorious escape artists, to deflate “big shots,” to disrupt prison gangs (whose leaders would be sent there), and to control those who defied rules and abused privileges. Every modern innovation was used, including full-body metal detectors. All areas were enclosed with cyclone and barbed wire, and sewer and utility tunnels were blocked; the soft-steel cell was replaced with tool-proof steel.

Alcatraz Federal Penitentiary opened in 1934. The first prisoners were thirty-two soldier-inmates left over by the military. Next came inmates from McNeal Island in Washington. Most of Alcatraz’s inmate population came from other prisons, although there were some exceptions: Morton Sobell was one. He was convicted of espionage along with Julius and Ethel Rosenberg in the 1950s. The Rosenbergs were executed, and Sobell went directly to Alcatraz to serve his sentence.

Alcatraz developed into a “test” prison, one that would deal with a small population of “hardcore” inmates. The directive of the prison was not to rehabilitate inmates but to force them to conform. The staff-to-inmate ratio on Alcatraz was one to three, ensuring maximum control. Each prisoner occupied a five by nine foot cell, and all he could expect were food, shelter, clothing, and medical care. Inmates were informed upon entering the prison that they were there to serve time only; there was no pretense of rehabilitation. Each inmate was issued a book of rules and regulations upon arrival and was locked in his cell for approximately thirteen hours each day. Privileges could be

earned by “conducting yourself properly,” which included good conduct and a good work record. Inmates who earned the privilege could acquire a job in the laundry or carpentry shops where they were expected to work five days per week, eight hours per day. The exercise yard was a privilege available to qualified inmates on Saturdays, Sundays, and holidays. Activities included baseball, handball, and table games. In later years, movies were shown twice per month. Inmates were not allowed to have money. Additionally, cigarettes or any other contraband was also forbidden for use as “jail money.” Caps could not be worn in the cell house.

The food on Alcatraz was said to be the best throughout the prison system. When Warden Johnston refurbished Alcatraz, he had tear gas canisters installed in the ceiling above the dining room tables. There was a protected area next to the dining room that was manned by an officer who could release the canisters automatically if a disturbance developed. Meals were served three times per day and inmates were given twenty minutes in which to eat. Inmates were allowed to take all they could eat within the allotted time.

A library existed on Alcatraz when it opened as a federal prison, and by 1960 it contained fifteen thousand books. Each inmate was allowed three library books, a Bible, a dictionary, and a maximum of twelve study books and twenty-four pamphlets in his cell at one time. In addition to library privileges, prisoners in good standing could also play musical instruments or paint in their cells.

During the first years after Alcatraz opened as a federal prison, inmates were not allowed to speak with each other, or to have visits during the first three months after arrival. In later years, quiet talking between inmates was allowed and each inmate was permitted one visit per month.

Those prisoners who were unable to conform with the rules and regulations of Alcatraz were sent to the Isolation Unit on D-Block, known as “the hole.” A stay in the Isolation Unit of D-Block meant a complete loss of privileges and total isolation for a maximum of nineteen days. There was no light, sound, or human contact, and most inmates found this punishment almost unbearable.

No inmate was ever released directly from Alcatraz. The administration had decided that, to lessen tensions between the prison and the citizens of the bay area, prior to each inmate’s release he would be transferred to another federal prison. Prisoners were informed when they arrived at Alcatraz that transfer to another federal institution would occur only if they could show a better than average conduct record for several years.

The population of Alcatraz consisted of hardened inmates who had not adjusted well in other prisons. Many of them were famous criminals who had ended up at Alcatraz after causing trouble at other federal facilities. This resulted in an increasingly elderly population of long-term inmates with extensive prior records and growing medical problems. The administrators of Alcatraz solved the problem by transferring those inmates to other facilities. Robert Stroud, the “Birdman,” was transferred from Alcatraz in 1959 to a federal medical facility in Springfield, Missouri, when his health began to deteriorate. Interestingly, Stroud had cared for canaries at Leavenworth Penitentiary but never had any birds when he was transferred to Alcatraz in 1942. Another famous inmate, Al Capone, served only five years at Alcatraz before being transferred to Terminal Island Federal Prison when the syphilis he suffered from reached advanced stages. “Machine

Gun" Kelly was transferred to Leavenworth in 1951 because of a heart condition.

During the Alcatraz Federal Penitentiary era, thirty-six men tried to escape in fourteen separate attempts. Five are still missing, six were shot and killed, two drowned, two were later executed, and twenty-one were recaptured. To even attempt an escape from Alcatraz was an exceptional feat. The security measures combined with the prison's location made an escape almost impossible. Bay water temperatures range from 45 to 50 degrees Fahrenheit, and the currents surrounding the island move at four to eight miles per hour (three to five knots) and extend out from the island for two hundred yards. Within the current is an extremely dangerous undertow caused by Alcatraz's position in the channel. Six guard towers watched over the facility at all times, and inmate counts were taken at frequent and unpredictable intervals throughout the day.

The most famous of the escapes was made by Frank Morris, John Anglin, and Clarence Anglin, and portrayed in the movie *Escape from Alcatraz.* By chipping out the rotted plaster around the vents at the rear of their cells, the three men managed to escape by placing dum-my heads in their bunks. It is believed that they may have had a boat pick them up, or they may somehow have managed to float to shore at San Francisco or Angel Island. Or they may have drowned. At any rate, they were never seen again.

The Closing of Alcatraz

The cost of maintaining high-risk inmates, coupled with the massive deterioration of the prison, resulted in its closing in 1963, just one year after Frank Morris's escape. The cost of transporting the necessities to run the prison (water, food, and supplies) made Alcatraz's budget almost twice that of other federal prisons. Additionally, the absence of a formal rehabilitation program in the midst of the public outcry in the 1960s for reform led to political pressure to close the prison. Attorney General Robert Kennedy announced the closing of Alcatraz, which officially took place on March 21, 1963.

Alcatraz was transferred to the authority of the General Service Administration of the U.S. government in 1964. Several options were considered, including making the island into a University for Native Americans or a casino, or selling it to oil millionaire Lamar Hunt for $4 million. Mr. Hunt was planning to develop a combination space museum, apartment and condominium complex, and mall, but he with-drew his offer because of public pressure. By the A late 1960s, no decision had been made concerning the disposition of the island.

In 1969 a group of American Indians moved onto the island, citing an 1868 treaty with the federal government that allowed nonreservation Indians to claim land that the government had taken for forts or other uses and later abandoned. In actuality, the first takeover had occurred five years earlier when a group of Sioux Indians held Alcatraz for four hours before the acting warden, Richard J.Willard, threatened them with felony charges.

Alcatraz became a major symbol of resistance and hope for the Native Americans, who were aided by extensive news media coverage. The goal was to establish a cultural,

spiritual, and educational center on the island; Richard Oakes was a prominent leader and spokesman for the group. The beginning of the end of the occupation occurred when Oakes's thirteen-year-old daughter, Yvonne, was killed after falling down three flights of stairs in the officers' quarters. Soon after, Oakes left the island and the remaining groups split into increasingly dissentious factions. Drugs, alcohol, and fighting added to the eventual breakdown of the island society, and in May of 1970 a fire destroyed a number of buildings on Alcatraz. On June 11, 1971, twenty U.S. marshals removed anyone still left on Alcatraz and the island was once again put into the authority of the General Services Administration.

In 1972, administered by the National Park Service, Alcatraz Island was made a part of the newly formed Golden Gate National Recreation Area. The island is now an international biosphere reserve that displays a wide array of birds, flowers, trees, and tide pools surrounding the island. Additionally, 750,000 people visit Alcatraz each year, and the Park Service continues to pursue its goal of maintaining and restoring the historic buildings on Alcatraz. Ironically, the Bureau of Prisons currently provides inmate labor from other federal prisons in the area to repair prison buildings and do land-scaping work on the island.

Laura Davis

S*ee also* FEDERAL BUREAU OF PRISONS

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Alcohol Treatment Programs in Prison

The relationship between alcohol use and crime is well established. There are crimes that, by their definition, involve alcohol use: possession of alcohol by a minor (about half of those aged twelve to seventeen admit to this offense), drunkenness (for which about three-quarters of a million people are arrested annually), and driving under the influence of alcohol (for which more than one million people are arrested and as a result of which about twenty thousand accidental fatalities occur annually).

Other criminal acts are committed by persons who are under the influence of alcohol. Excluding the offenses mentioned above, about a third of jail and prison inmates admit to having been under the influence of alcohol at the time of their offense. Slightly more than two-fifths of jail and prison inmates convicted of homicide, rape, or assault admitted to committing their crime while alcoholically intoxicated, as did about a third of robbery and property offenders. The average amount of alcohol ingested by these inmates immediately prior to their offense was almost nine ounces of ethanol, the equivalent of about three six-packs of beer or two quarts of wine. About a seventh of incarcerated offenders admit to ingesting illegal drugs along with alcohol.

There are two competing hypotheses that attempt to explain the strong relationship between alcohol and crime. The dominant hypothesis is the disinhibition hypothesis, which states that alcohol intoxication causes aggressive behavior because alcohol breaks down cognitive filters that normally prevent such aggression. Thus, this approach posits that a person who is under the influence of alcohol may violate laws that would not be violated if the person were not intoxicated. From a correctional treatment standpoint, this hypothesis implies that if alcohol-abusing criminals can stay sober, they will remain law-abiding. This is the treatment approach that prevails in American prisons.

The second, and more recent, approach to explaining the relationship between alcohol and crime is the low self-control hypothesis, which states that both alcohol use and criminal behavior are symptoms of a personality tendency toward immediate gratification. This hypothesis also states that one's propensity for immediate gratification is generally stable from early adolescence through adulthood. Persons who want immediate gratification will seek it through both intoxicating substances and crime (stealing gives one immediate money and violence gives one immediate revenge). Rather than expecting criminals to refrain from crime simply by keeping them away from alcohol, the low self-control hypothesis asserts that one's entire personality must be altered in order to discourage criminal behavior. That is a much more difficult, if not impossible, task for correctional specialists; the general tendency toward low self-control is said to be rarely alterable after adolescence.

Prison Programs

Many criminals with an alcohol problem have participated in some kind of treatment. About three-fifths of drinking inmates have been in at least one alcohol-abuse program during their lifetimes, and about a fifth of drinking inmates join alcohol treatment groups while they are in prison.

Prison alcohol treatment programs differ from other programs in several respects. First, prison programs seek to prepare inmates to stay sober once they leave prison; programs outside prison seek to focus on the present. Second, prisoners do not have access to alcohol, although they do have limited opportunities to drink their own "homebrew," made from bread, juice, and scraps of fresh produce, alcoholic beverages smuggled in from outside, and over-the-counter products such as mouthwash and hair tonic. Alcoholics outside prison are not denied access to drink. Third, participating in an alcohol program outside of prison is voluntary (except as a condition of parole or probation), whereas prison alcohol programs are often perceived by inmates as necessary to gain early release. Thus, although program participation is supposedly voluntary, correctional administrators indirectly coerce many inmates (through promise for parole) into programs in which they otherwise would not participate. Such participation is known as "programming out," and it is done for the wrong reason—getting out of prison rather than selfhelp.

The most prevalent prison alcohol treatment program is Alcoholics Anonymous. A.A. was founded outside of prison in 1935 by "Dr. Bob" and "Bill W." By 1993 there were more than eighteen hundred such groups in correctional facilities throughout the United States and Canada. Each has a local arrangement with an A.A. chapter outside the prison. According to a recent survey by A.A., institutions participating in A.A. have an average of 1.25 groups per facility; some facilities have as many as ten groups. Prison administrators report that attendance at A.A. meetings is "voluntary" at 90 percent of the institutions.

The conditions under which an inmate group functions are at the discretion of the institutional administrators. Prison A.A. chapters pose only a slight inconvenience to the functioning of an institution. Visits by outside A.A. sponsors are minimal after the prison group becomes established. As with any treatment program in prison, however, correctional officers will have to accommodate the movement of inmates to and from A.A. meetings, which may pose custody problems. Optimally, A.A. prison programs should operate unconnected to religious groups or other therapies or rehabilitation programs.

According to A.A. prison literature, the program consists of a fellowship of men and women who attempt to solve a common problem and help others do the same. The only requirement for membership is a desire to cease drinking. Its primary purpose is to achieve sobriety for its members and other alcohol abusers. The basic approach of A.A. is to create an *esprit de corps* of mutual caring, thus enabling the participants to realize that

their problems are not unique. While A.A. in prison has been likened to “milieu therapy” because of a prevailing attitude fostering the goals of A.A., the program setting is actually much less controlled than in milieu therapy. Because of the similar experiences of members and their mutual support, however, participants are unlikely to fool each other; a sort of “honesty milieu” does exist. This peer review/role-model aspect of A.A. has been imitated by several substance abuse programs.

The core of A.A. is its famous “12 Steps.” With the help of a higher force that is individu-ally interpreted by each participant, these steps move one from confronting the problem through changes in behavior and to restitution to those previously harmed. The steps culminate in a spiritual awakening and continuing personal introspection that keep one sober. There is a generally monotheistic emphasis in A.A., but there is no affiliation with a particular religion. Thus, the spirituality in A.A. is compatible with the teachings of the spectrum of religions represented in American prisons, Christianity, Judaism, or Islam. A.A. subsidiary programs in prison include Al-Anon (for families of alcohol abusers) and Ala-teen (for youngsters with drinking problems). Some incarcerated alcohol abusers have also participated as paraprofessionals in youth counseling programs, with the prisoners speaking about the problems associated with drugs and alcohol; examples have included Florida’s “Operation Reach Out,” California’s “Prison Preventers,” and New Jersey’s “Lifers’ Program.”

Other alcohol treatment programs have been established in prisons. Many of them practice what might be called a responsibility-privilege system, in which the inmate progressively assumes more privileges according to the degree of responsibility for personal behavior that is demonstrated. Group and individual counseling are mainstays of such programs, particularly “reality therapy” (developed by William Glasser in 1965). Rather than using mental health labels like “neurotic,” “personality disorder,” or “psychotic,” reality therapy simply considers the individual to be irresponsible. This type of counseling should sequentially lead inmates to: (1) face the consequences of their antisocial behavior; (2) examine why they choose to act that way; and (3) stop the behavior. As in A.A., the most important aspect of reality therapy is that excuses for behavior are unacceptable.

Maintaining Alcohol Treatment Continuity into Community Release

Because alcohol is seen by correctional specialists as an integral part of the decision to violate the law, every effort is made to maintain an inmate’s sobriety after release into community supervision. Thus, alcohol treatment is often mandated in conditions of parole for alcohol-abusing criminals. Rather than wait until the prisoner is released, it is best to coordinate al cohol treatment in the community prior to parole. A.A. cautions that inmates who do not report immediately to a local chapter after their release are less likely to continue in A.A. Forms of aversive therapy can also be used as conditions of release,

including the mandated ingestion of disulfiram, or antabuse (which causes an adverse physical reaction when mixed with alcohol). Aversive therapy is not always successful, however, because parolees often fail to ingest antabuse regularly and because some persons go on drinking anyway.

Community correctional specialists should practice both patience (long-term dependence on an altered state of mind is not easily changed) and confrontation (to force the client to be responsible). Additionally, community corrections specialists should try to keep clients from returning to the same environment in which the offender drank prior to prison. Parolees may have their parole revoked on technical grounds if they fail to maintain sobriety, and that threat alone may be sufficient to keep some from reverting to destructive drinking habits. If one believes in the disinhibition hypothesis, sobriety may be all that is necessary to keep a criminal alcohol abuser from further transgressions. If one believes in the low self-control hypothesis, however, removing alcohol from an offender's life will not by itself change the propensity for criminal behavior.

Evaluating Prison Alcohol Treatment Programs

Most evaluations of alcohol treatment address programs administered in the community (for probationers, parolees, and noncriminals) and in nonprison institutional settings (such as hospitals and clinics). There appears to have been no study that has rigorously evaluated a prison alcohol program. A rigorous and scientific evaluation is the only way to determine which prison alcohol treatment programs are best. In the classic scientific experiment, the success of the group receiving the treatment is compared with that of a similar group that did not receive the treatment (the control group). Alcohol treatment programs in prisons, however, introduce several specific problems for the classic experiment.

The first problem is that community follow-up treatment for alcohol is an integral part of the inmate's total rehabilitation program. It becomes necessary, then, for the evaluator to be able to differentiate between the effects of the in-prison alcohol program and those of the community alcohol program. To do so, the evaluator must look at the recidivism rates of four groups (rather than the two outlined in the classic experiment): (1) the Treatment Group (those who receive both the prison alcohol program and the community alcohol program); (2) Control Group #1 (those who receive the prison alcohol program only); (3) Control Group #2 (those who receive the community alcohol program only); and (4) Control Group #3 (those who receive no treatment). By comparing the recidivism rates of these four groups, the evaluator will be able to isolate the effects of the overall treatment plan (combination of prison and community programs) from the effects of the individual components of the plan.

The people in each of the four groups must be exactly similar according to two dimensions. First, they must be alike in the degree to which alcohol abuse was a factor in

their criminality prior to entering prison, because the theoretical underpinning of offering alcohol treatment programs to these inmates is the strong relationship between their alcohol use and their criminal behavior. Determining the extent of that relationship for a particular individual is a difficult task, but it is even more difficult to equalize the factor across all four groups. Subjects who are placed in the four groups must be more than simply criminals who use alcohol; they must be criminals whose alcohol abuse led them to crime.

The second dimension by which persons in the four groups must be equalized is in their general propensity to commit crimes that are unrelated to alcohol use. If the four groups are not equivalent in these ways, the success rates of the groups will be affected by their differing propensities to commit crime rather than only the differences in the treatments that the four groups receive. It will be very difficult for the evaluator to be certain that known predictors of crime (such as age, sex, other substance abuse, crime specialization, and previous failure on parole) are equally distributed across the four groups. Persons in the four groups should also be equalized in terms of the amount of time they have spent in prison for their current offense, to control for nonrecidivism caused by deterrence. Last, the evaluator must equalize the four groups in terms of the conditions the subjects experienced in prison (particularly prison rehabilitation programs that do not relate to alcohol abuse, such as education and job train ing), to control for nonrecidivism resulting from those factors. While a near-perfect equalization of the four groups across all of these categories is necessary for a sound experimental design, the task is almost insurmountable for the evaluator, and it may never be achieved.

The drinking behavior of the four groups can be tracked after their release, although the commission of further crimes is more important to the overall treatment goal. Members of the four groups must receive equal amounts of community supervision, such as equal numbers of contacts and equal conditions of release. Those in the Treatment Group (who participate in both prison and community programs) and in Control Group #2 (who participate in community programs only) will be the only ones to receive additional alcohol treatment after release, and that treatment must be the same for both groups. When the success rates for the four groups are finally tallied, the evaluator must be certain that individuals in all groups were deemed failures for actions of equal severity (such as conviction for a new crime, chronic drunkenness, or other technical violations of parole).

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S*ee also* DRUG AND ALCOHOL USE IN PRISON, REHABILITATION PROGRAMS

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American Correctional Association

The largest private organization in corrections is the American Correctional Association (ACA), a nonprofit organization committed to evaluation and research as well as the formulation of correctional policies and standards. The ACA has existed for over 130 years, creating national policies related to the effective operations of adult and juvenile correctional facilities, local detention centers, and probation and parole departments. It represents the field of corrections at the federal, state, and county levels. As such, it is the largest organization of its kind.

The ACA consists of twenty-three thousand members and sixty-seven affiliated organizations representing states and professional specialties. The membership of the ACA consists of practitioners, academics, agencies, and organizations involved in all parts of the corrections field. The official magazine of the ACA is *Corrections Today.*

Historical Background

The original name of the organization was the National Prison Association (NPA). The NPA was established in 1870 under the leadership of Rutherford B.Hayes, the first president of the association. In spite of the fact that the idea of penal reform was unpopular at the time, Hayes led a reform effort that included E.C. Wines, W.W.F.Round, Z.R.Brockway, Roeliff Brinkerhoff, and Frank Sanborn (Pippin 1989).

The Association's first meeting was held in Cincinnati, Ohio, in 1870. That meeting was suggested by Enoch Cobb Wines, then secretary of the New York Prison Association and a student of penology (Keve 1991). Wines had become an effective voice for reform within that state agency, and he wanted to expand the idea of reform to the national level. There were over 130 delegates from twenty-four states, Canada, and South America at the Cincinnati Congress (Pippin 1989). Wines invited Hayes, then governor of Ohio, to serve as presiding officer at the meeting.

One year before the meeting, Wines and Hayes had corresponded over prison issues. In his State of the State message to the Ohio legislature in 1868, Hayes had publicized the con cept of the indeterminate sentence of the Irish system. Wines included that segment of Hayes's speech in his 1869 report. With Wines's support, Hayes's recommendations were adopted by the Ohio assembly.

A number of issues were discussed at the Cincinnati meeting in 1870, including indeterminate sentencing, graded classification, promotion of an international meeting on penal reform, executive pardons, jails, and hygiene (Pippin 1989). As a result, a declaration of principles was developed. The declaration stated that "moral regeneration"

was possible through the penitentiary. These principles became the accepted guidelines for corrections in the United States and Europe. There was a subsequent revision of the principles in order to reflect advances in theory and practice. In 1982 the principles were expanded, but the basic ideals have not changed significantly since the original ones were established in 1870 (Keve 1991).

After Wines died in 1879, the NPA became inactive (Hayes became president of the United States in 1877). The organization was revived in 1883, two years after Hayes's term as president had ended. Hayes became president of the NPA in 1883 and continued in that post until his death in 1893. His status as a criminal lawyer and former president added tremendous credibility and publicity to his crusade. As a result, he was able to voice unpopular issues and bring them before the public. In addition to stressing the need for reform practices, Hayes emphasized the idea that crime originated from social and personal causes. There is no doubt that the revitalization of the NPA was solely the result of his efforts (Pippin 1989).

After Hayes's death, Roeliff Brinkerhoff became president of the NPA, serving until 1897. Brinkerhoff was actively concerned about social and political issues. He became knowledgeable about prison problems when, on his own initiative, he visited prisons in other states (ACA Committees Caucus 1992). Brinkerhoff was probably the most effective supporter of a new federal role in corrections. He advocated a nonpartisan administration of prisons even though that was an unpopular view at the time. He ultimately was not very successful in his opposition to political patronage.

The National Prison Association subsequently became the American Prison Association. As a result of changing perspectives on punishment and on the goals of crime control, in 1954 the name of the American Prison Association was changed to the American Correctional Association.

Other historical meetings of the ACA include the Williamsburg conferences of 1971 and 1986 (Keve 1991). The 1971 conference addressed questions related to inmate rights and the need for new directions within the changing correctional environment. The 1986 meeting served as a review of the first twenty-one ratified and completed policies of the association. Members of the association met to create a strategy for the dissemination and acceptance of the policies by all systems in the country.

Correctional Standards and Accreditation

One of the major accomplishments of the ACA has been the development and ongoing evaluation and modification of standards for juvenile and adult correctional facilities, local detention centers, and probation and parole departments (Travisono 1990). The ACA published its first standards nearly fifty years ago. In 1968 the association established an accreditation process through the use of those standards. A standards committee was created with representation from correctional practitioners, the courts, and other criminal justice agencies.

The ACA's standards and accreditation program establishes nationally recognized

standards for the field. The program has served to create, implement, and evaluate standards for juvenile and adult facilities; establish the Commission on Accreditation for Corrections as well as the procedures for evaluating the achievement of goals; and publish policy guide-lines and operating manuals (Travisono 1990).

In 1987, the Commission on Accreditation for Corrections (CAC) was realigned with the American Correctional Association (Cerquone 1987). The membership of the ACA felt that there was a need to firmly establish the CAC within the ACA. This merger has permitted greater efficiency in the monitoring of accreditation costs, greater efficiency in the accreditation process itself, and a more effective and accurate balancing of the commission's budget.

Accreditation involves a series of reviews, evaluations, surveys, and audits designed to ensure that correctional facilities comply with the national standards created by the American Correctional Association. The accreditation process allows a facility's management the opportunity to identify the strengths and weak-nesses of the facility, identify goals, learn how to implement new policies and procedures, establish guidelines for daily operations, learn how to construct defenses against frivolous lawsuits, learn how to increase community support, and increase professionalism and morale among staff.

As the ACA Standards Committee revises standards, it examines court decisions in which judges have made references to existing standards. The purpose is to examine how standards are actually interpreted and applied in practice. The committee recognizes that standards do not exist in a vacuum, so this evaluation serves to inform the committee on problems of clarity in existing standards and difficulties with implementation (Miller 1992).

The first review of the relationship between court decisions and standards came in 1986. The authors of the report concluded that "specific findings of courts should not be used as the foundation for the development of professional standards" (Miller 1992). The review indicated that standards should not simply be evaluated one at a time without considering the entire correctional setting and the interactions between existing policies, how one policy affects others, and the necessity of using discretion in a correctional environment. Examining one standard at a time without considering the entire picture can be misleading. As a result, the latest standards recognize these restrictions and the interactions between different groups and standards.

In 1990, the ACA examined the ways standards have been used by the courts (Miller 1992). The conclusions were as follows:

1. Courts often consult ACA standards when determining standards of behavior in a correctional setting.
2. Courts sometimes cite ACA standards when deriving a court standard or when arriving at a decision.
3. Courts sometimes use ACA standards and accreditation as part of a court order or consent agreement.

Because of the evolution of case law, the evaluation and revision of correctional standards is an ongoing project for the ACA. The continued focus on court decisions is necessary in order to identify changes in judicial views of corrections and to make certain that the ACA standards meet court-established minimums (Miller 1992).

The ACA's Standards and Accreditation Division currently hopes to increase the number of cities, counties, and states that participate in the process of accreditation (Travisono 1990). It also hopes to reduce the number of required standards to a more manageable level.

Future issues being researched by the ACA's Standards and Accreditation Division include the creation of new standards for jail facilities with fewer than one hundred inmates, the development of individual certification, and the development of correctional unit certification. Over time there has been an increase in the number of juvenile facilities interested in achieving accreditation, although the number of adult facilities interested in accreditation has remained constant.

Correctional agencies have recently turned to peer group review for ongoing evaluation. As a result, the accreditation of correctional agencies has reached an all-time high (Travisono 1990). Over 1,140 correctional facilities and programs have engaged in the accreditation process since it began in 1978. Active participants in the process include 80 percent of all state departments of correction as well as numerous facilities operated by the Federal Bureau of Prisons, the U.S. Parole Commission, and the District of Columbia.

Correctional administrators who have engaged in the accreditation process have noted an improvement in management practices and an increase in staff accountability and credibility. They also claim that the accreditation process helps to create safer and more humane environments for both officers and personnel. It also provides measurable criteria for improving correctional programs, personnel, and facilities. ACA standards are also used by state and federal courts to determine whether confinement conditions are humane.

Professional Affiliates

The ACA is supported by its many professional affiliates. These affiliate organizations range from associations of correctional administrators to associations concerned with prison food, health, and educational services (Tyler and Smalley 1989). They are national organizations dedicated to serving specific groups of professionals in the field. The ACA adopts a broad approach to corrections, but the individual professional affiliates are highly focused. The purpose of each affiliate is to serve as a resource to the members of its group.

Examples of affiliates include the North American Association of Wardens and Superintendents, the Association of Paroling Authorities, the American Probation and Parole Association, the American Correctional Health Services Association, the Correctional Accreditation Manager's Association, the American Institute of Architects, and the American Jail Association (one of ACA's larger affiliates).

The process of becoming an ACA affiliate takes approximately a year and a half. In order to qualify, professional associations must be represented in twenty-five states, must have at least 125 members, and must be approved by the ACA's Committee on

Membership and Chapter/Affiliate Relations (Tyler and Smalley 1989). Exceptions can be made for membership size, as in the case of the Association of State Correctional Administrators and the Parole and Probation Compact Administrators, which enroll one administrator per state. Current memberships of the ACA affiliates range from fifty to twenty-five thousand.

A requirement of affiliation is that each organization's constitution and bylaws be similar to the ACA's. Most affiliates operate on a volunteer basis, with officers and a board of directors, but some affiliates are large enough to hire staff members and an executive director (Tyler and Smalley 1989).

Some professional affiliates apply for grant money to supplement the organization's income (Irving 1992). Foundation grants have become more popular over the years as the availability of federal funds has decreased. For example, the Edna McConnell Clark Foundation is currently being administered by the National Council on Crime and Delinquency (NCCD). NCCD seeks to develop alternatives to incarceration, stimulating community-based programs for crime prevention.

The Association for Correctional Research and Information Management (ACRIM) is another foundation dedicated to correctional research. It funds studies predominantly related to correctional management. ACRIM has served to create an information exchange for the correctional field at large.

A few of the ACA's professional affiliates were founded as volunteer organizations. Examples include Volunteers of America and the Salvation Army. These organizations include professionals not involved in corrections who work in communities influenced by correctional issues. Another example is the Prison Fellowship, an organization set up as a ministry organization to aid inmates and their families.

There are also several affiliated organizations that are international in scope. Founded in 1946, the Correctional Education Association (CEA) is one of the ACA's largest affiliates. The CEA's twenty-seven hundred members are located in Australia, Canada, England, Germany, New Zealand, and the United States.

The ACA also includes affiliates that focus on women and minorities. For example, the Association on Programs for Female Offenders (APFO) was created to examine and assist programs for female prisoners. The National Association of Blacks in Criminal Justice (NABCJ) was founded fifteen years ago. Today, it has more than three hundred members and thirtynine state and local chapters across the United States (Tyler and Smalley 1989).

Many of the affiliated organizations work inside institutions. An example is the National Correctional Recreation Association (NCRA), the purpose of which is to promote professional programs and services to aid inmates, as well as to enhance leisure opportunities and skills. NCRA also attempts to improve institutional life by providing a safer, healthier environment, and teaches inmates about the use of leisure time after their release from prison.

The American Correctional Food Service Association (ACFSA) has been an ACA affiliate since 1970. ACFSA began a certification program for food service professionals. The program has increased professionalism in correctional food services and has also encouraged the interdisciplinary exchange of information and ideas. The ACFSA has also established standards of excellence in food service and has recognized achievements in

food service.

Policy Development

One of the biggest challenges to the ACA and to the corrections field in general is the development of effective and realistic policies that can be implemented relatively easily (American Correctional Association 1991). In 1981, the ACA Policy/Resolutions Committee was charged with the task of developing a Public Correctional Policy Proposal. After the proposal was adopted, the ACA's president established a Public Correctional Policy Advisory Committee composed of outstanding practitioners. The committee's membership included judges, academics, and leading figures from community-based services as well as local and state departments of corrections.

Public correctional policies on twenty-one major issues were ratified between 1983 and 1985. Recognizing that there were additional issues that needed to be addressed, the ACA Executive Committee adopted the policy development process as a permanent function of the association. The responsibilities of the ACA Advisory Committee on Resolutions and Policy included an ongoing identification of major issues in corrections and the designing of policy statements for consideration.

The policy development process has continued since 1986. In addition, the committee has been heavily involved in the review of existing national correctional policies. For example, in 1991 several policies dealing with community corrections were passed by the ACA Board of Governors and the Delegate Assembly during the 1991 Congress of Correction (Keve 1991). These policies included the following:

1. Seeking authority and funding (public and private) for community programs and services.
2. Developing and ensuring access to residential and nonresidential services that address offender and community needs.
3. Educating the public and offenders about the reasons for community programs and services, how the selection process for these programs operates, and in the idea that these programs constitute punishment.
4. Developing a system to monitor an agency's performance regarding the enforcement of standards and professional practice.
5. Recognizing that the public will be more likely to accept a program that contains elements such as victim restitution, community service, conciliation programs, and adequate supervision of the offender.
6. Seeking input from citizen boards and volunteers regarding community corrections issues.

The policy development process is based on the belief that major issues and their ramifications must be identified, and that public policy decisions must have direction (American Correctional Association 1991).

Research and Practice

Some of the many research topics explored by the ACA include crime prevention, the threat of AIDS in correctional settings, and prison gangs (ACA Committees Caucus 1989). Furthermore, the ACA's Women's Task Force has taken on many challenges, including sexual harassment, issues regarding women officers in male facilities, and domestic violence (ACA Committees Caucus 1990).

In addition to research, the ACA is heavily involved in efforts to educate correctional practitioners. Corrections personnel at all levels require a variety of skills for planning, conducting, and evaluating correctional programs. The ACA conducts training workshops that provide on-site training and educate practitioners about individualized programs that will meet the specific needs of an institution and the members of its population.

The ACA also provides technical assistance for correctional industries personnel through the Correctional Industries Information Clearinghouse (CI-Net). CI-Net offers a computer network, a quarterly newsletter, seminars, and a videotape library.

The ACA also provides juvenile justice administrators with a national forum, a newsletter and resource materials, technical assistance, private sector options for juvenile corrections, regional juvenile justice workshops, research in juvenile detention drug testing, and information on cultural diversity programs. Current projects of the ACA's Contracts Department include training and technical assistance for juvenile corrections, a study of costeffective confinement for prisons and jails, correctional development services for the U.S. Department of the Navy Corrections System, evaluation of the Model State Prison Industry/ Drug Rehabilitation Project, and the development of correctional standards for jails with populations of fifty or less (ACA Committees Caucus 1988, 1989; Huskey 1988).

Membership and Annual Meetings

Membership in the American Correctional Association continues to increase (ACA Committees Caucus 1988). Campaigns have been designed to expand membership within specific groups, such as probation and parole officers, juvenile case workers, and minorities.

The ACA sponsors two annual meetings, the Congress of Correction in August and the winter conference in January. These are interna tional meetings that provide opportunities for discussions of current issues in the field. The meetings include lectures, seminars, workshops, and exhibits addressing all aspects of corrections (Cerquone 1988).

In the years to come, the ACA will continue to address issues related to crowding in correctional facilities, problems in attracting qualified staff, the need for more rigorous training at all service levels, and the growth of laws that will increase prison populations and community caseloads (ACA Committees Caucus 1989).

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S*ee also* ACCREDITATION

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Angola (Louisiana State Penitentiary)

Angola, the Louisiana State Penitentiary, is the largest medium-maximum security prison in the United States. Located sixty miles north of Baton Rouge in southwest Louisiana and situated on eighteen thousand acres of floodplain along the east bank of the Mississippi River, Angola occupies an area of twenty-eight square miles. Bordered on three sides by the Mississippi and to the northeast by the Tunica Hills, Angola is often referred to as the "Alcatraz of the South" because of its naturally secure location.

Angola is home to approximately five thousand male inmates, ranging in age from seventeen to eighty-three, and 1,845 staff members. Two-thirds of the inmate population are serving life sentences in a state where life means life. Angola also houses Louisiana's death row population. Capital punishment in Louisiana is administered by lethal injection. As of December 1993, Louisiana has executed twenty-one inmates since the death penalty was reestablished in 1983.

The first penitentiary ever constructed in Louisiana was established in Baton Rouge. Completed in 1834, the facility was modeled after the traditional Auburn design, with small, one-man cells. Inmates spent their nights in solitary confinement and their days at work stations producing assorted leather, cotton, and woolen products. Prior to that time, the state had housed both men and women, as well as children, in the deplorable conditions of the New Orleans Jail (the same jail that was decried by the visiting French statesman Alexis de Tocqueville).

Prior to the Civil War, Louisiana leased its inmate population to various private businesses. The primary motive behind the convict-lease system was profit, and no efforts were made to reform or rehabilitate the prisoners. The leased inmates were hired primarily to perform physical labor on plantations and farms. Inmates worked under harsh conditions and were subjected to regular floggings by landowners. As many as three thousand inmates died under the convict-lease system.

The state abandoned the convict-lease system for a brief period during the Civil War. The program was reinstated in 1868, however, to make up for a labor shortage resulting from the abolishment of slavery. At that time there were 222 prisoners, most of whom were black and under the age of twenty-five (Carleton 1971). In addition to performing labor on private farms and plantations, inmates were required to work on such public projects as railroads and levees.

The land occupied by Angola was purchased by the state in 1901 from the heirs of former inmate lessor Samuel L. James, with the intention of constructing a prison on the site. The original purchase included the eight thousand-acre Angola cotton plantation, as well as three smaller sugarcane plantations and four levee camps. One of the first camps built at Angola, and one of the most notorious, was the Red Hat Camp, designed to hold Angola's most dangerous inmates. Angola existed as the only state-operated prison for most of this century.

During the early part of the twentieth century, maintaining custody over the inmate

population was the only concern of correctional administrators. The first classification system divided prisoners into four classes according to their ability to perform physical labor. Farming has always been and still remains the primary industry at Angola. It was also during this time that Henry L.Fuqua, general manager of the penal system, turned over the responsibility of supervising the prisoners to a select group of inmates (Carleton 1971). These "convict guards" were armed and authorized to administer punishment at their own discretion.

In the 1930s, 194 prisoners escaped from Angola in an attempt to flee the abusive working conditions and brutal corporal punishment. In response, the institution sought to improve its safety measures by constructing heavily armed guard towers and by increasing the number of bloodhounds used for tracking the escaped convicts (Foster, Rideau, and Wikberg 1989).

For most of Angola's history, the abuses associated with the penitentiary were either not known or were not the concern of the general public. That all changed in 1951, when thirtyseven inmates at Angola severed their left heel tendons in protest of the working and living conditions (Butler and Henderson 1990). The incident brought numerous reporters and special-interest groups to the facility, shedding light on the abuses of the system. The problems that were identified included the use of armed inmate guards and untrained civilian personnel, and a lack of formal, written policies and procedures. As a result, several of the old camps were dismantled and new guidelines were instituted, but not before Angola was named "America's worst prison" by *Collier's* magazine (Carleton 1971).

The United States Supreme Court intervened in 1975 by declaring the facility at Angola unconstitutional. A court order forbidding Angola to accept any more inmates forced the institution and the state legislature to address some of the problems; many more, however, remained.

Angola today is confronted with the same challenges encountered by prisons across the United States. Increases in the crime rate coupled with a sentencing philosophy based on retribution and deterrence have had an effect on both the number of incarcerated criminals and the lengths of their sentences. Louisiana alone has tripled its prison population during the past twenty years and prison construction is at an all-time high.

Louisiana State Penitentiary is currently divided into the main prison and six outcamps. Industries include a license tag plant, a silk screen shop, a mattress factory, a broom and mop factory, and a telephone disassembly plant. The law library at Angola includes three main libraries and three outcamp libraries. The prison subscribes to all of the standard legal volumes necessary to assist inmates with their legal needs. Louisiana has shifted away from the rehabilitation-oriented programs found in its institutions during the 1960s and 1970s to a renewed interest in security and in providing inmates with a broad range of work and recreational opportunities.

Angola offers its inmates a wide variety of sports and recreational activities, including organized baseball, football, volleyball, and basketball. Each October, the prison sponsors a rodeo that the prison magazine calls the "wildest show in the South." Close to two hundred inmates perform in the event before some five thousand spectators. In addition, inmates are permitted to participate in various clubs and organizations, such as the Angola Jaycees and the American Boxing Association. The first organization formed

at Angola was the Sober Group of Alcoholics Anonymous back in 1953 (Foster, Rideau, and Wikberg 1989).

Angola's prison magazine, the *Angolite*, has received national recognition. It was the first prison magazine to receive the Robert F. Kennedy journalism award and the George Polk award. Published bimonthly, the *Angolite* is circulated to more than one thousand subscribers across the United States and Canada. As editor of the *Angolite* since 1975, Wilbert Rideau turned the magazine into a major contributor to the struggle for prison reform. Rideau himself has been called "the most rehabilitated man in American prison today," yet he has served more time than the vast majority of prison inmates (Butler and Henderson 1990).

Inmates at Angola also operate the only prison radio station licensed by the Federal Communications Commission. *KLSP* broadcasts from noon until midnight, seven days per week, over a thirty-mile listening range. The station consists of outdated equipment donated by local church groups and record albums donated by former prisoners; it is supported by funds received from inmate blood donations. *KSLP* offers the inmates at Angola musical entertainment, as well as news updates, legal advice, and religious programming.

Over the years, Angola has served as home for some well-known inmates. Famous entertainers such as blues singer Leadbelly, Freddie Fender, and Charles Neville have all served time at Angola. James Smith, former president of Louisiana State University, was sent to Angola after being convicted of tax evasion and embezzlement. Framed for the murder of a north Louisiana couple, four-time world champion steer wrestler Jack Favor was sentenced to Angola in 1967, only to be retried and acquitted for the same offense nine years later (Butler and Henderson 1990).

Angola's infamous and chaotic history, combined with its many unique attributes, is an informative subject for examination. Angola has had, and will continue to have, a significant impact on corrections in America.

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Architecture

Quaker Influence and the First Penitentiaries Contemporary prison architecture reflects most of the same concerns that have guided prison design for the past two centuries—the need to carry out the wishes of the citizens and their elected representatives to punish criminals, to deter potential criminals, and to try to change the conduct of lawbreakers for the better, all at the same time. The first penitentiary in America, the Walnut Street Jail in Philadelphia, was initially a facility for holding minor offenders. There was no separation of the inmates by sex, age, seriousness of crime, or length of criminal career. In 1790, however, various reforms were introduced by the Quakers that called for the separation of witnesses and debtors from convicted criminals, the segregation of men from women, imprisonment "at hard labor," and the construction of a block of solitary confinement cells to house "more hardened offenders." This later feature became known as "the penitentiary."

The state of New Jersey opened a penitentiary in 1799. It had an inscription over the entrance that illustrated the influence of the Quakers, who believed that the purpose of imprisonment was "labor, silence, penitence." In 1826, the first prison that reflected the influence of the English social reformer Jeremy Bentham was constructed in Pennsylvania. Bentham's design called for a huge dome made of metal and glass with cells arrayed on the outer edges. In the middle was a central tower from which guards could look into every cell and at every walkway. Bentham's plan was put into stone in the Western Penitentiary at Pittsburgh in 1926, but its ninety solitary-confinement cells were too small to allow prisoners to engage in the hard labor that was required of them. In 1933 the original design was abandoned in favor of a plan calling for larger cells, implemented in the Eastern State Penitentiary at Philadelphia. That prison was constructed with rows of cells, some four and some two levels high, that radiated out from a central rotunda like spokes from a wheel.

The earliest American prisons thus had rehabilitation as one of their goals, even though the reform occurred in a harsh and punitive setting. The cells were large, 11 feet 9 inches long by 7 feet 6 inches wide by 16 feet high, with a separate door that allowed access to a small exercise yard surrounded by a stone wall. Prisoners were allowed one hour of solitary exercise each day, just as today's federal court judges have mandated for prisoners locked up in disciplinary segregation units. Each convict worked alone in his cell on a variety of tasks, from shoe making and weaving to carpentry and brush making. Prisoners who worked on general maintenance tasks outside their cells wore hoods or masks to ensure their isolation. When religious services were held the other solid door to each inmate's cell was opened, leaving the inner grill door locked; a curtain was run down the center of the cell block so that no inmate could see his fellow prisoners in the cells across the way. Ministers conducted services from a point in the hall at which even they remained out of sight.

The design of Eastern State Penitentiary and the rules that governed prison life were

based on the Quaker assertion that during their days, weeks, and months in isolation, free from all worldly distractions, prisoners would seek solace in the Bible, reflect upon their sins, and repent.

As so often is the case in criminology, theory produced undesired results. Critics pointed out that some prisoners became insane, that the work produced by individual workers in individual cells was not cost effective, that the prisoners were clever in finding ways to communicate with each other, and that overcrowding was forcing the staff to place more than one man in a cell, destroying the whole notion of isolation.

The Auburn and Pennsylvania Prison Systems

Meanwhile, in the state of New York, a new system of organizing, controlling, and treating criminals was installed in 1819. Under the Auburn Prison plan, inmates were allowed out of their cells to work together in silence during the day but were locked up in individual cells at night. Auburn was designed with rows of cells five tiers high, backed up to each other. Any light or air that came into the small 7×3½×7-foot cells came through the barred windows of the outer walls of the cell house. While inmates got some relief from the close confines of their cells in the workshops, Auburn authorities also began the practice of locking up “the most heinous offenders” in solitary confinement.

The Auburn and Pennsylvania prison designs, which emphasized control and the rehabilitation of prisoners by silent labor by day and solitary confinement at night (enforced by flogging, bread and water diets, the removal of bedding, and other harsh punishments), provided the model that most American states used in constructing their prisons and determining the regimes within them well into the twentieth century. Even when, in the 1870s, prison reformers began to urge that prisons and prison staff turn to rehabilitation as the main purpose of imprisonment, the new policies and practices that followed were generally implemented in the old prisons. A typical penitentiary at the end of the nineteenth century and in the early decades of the twentieth could be easily identified by a wall, usually thirty feet high with guard towers at the corners and over the gates, that surrounded a massive cell house with back-to-back rows of cells stacked three, four, or five levels high. The economy of confining many hundreds or even thousands of prisoners in what came to be called “fortress” prisons carried the day in prison construction. Perhaps the best—or worst—example of that type of massive prison is the penitentiary at Jackson, Michigan. It is still in use, and as many as six thousand inmates at a time have been locked up inside.

Alcatraz: Prototype of the "Last Resort" Penitentiary

The number of inmates returning after committing new offenses made it clear to both the prison administration and prison reformers that the harshness of prison life was not having the effect of deterring further misconduct. Thus, the nation experienced a crime wave in the 1920s and 1930s related to the failure of Prohibition and the rise of gangsters, calls were heard to lock up the hoodlums in an escape-proof prison simply for purposes of punishment and incapacitation. There was no presumption that the inmates would be better off for the experience. In August of 1934, the Federal Bureau of Prisons sent the first "habitual intractable" offenders to a newly remodeled former military prison on an island in San Francisco Bay.

Alcatraz incorporated some important features of American penology. First, it represented the recognition that, in any prison system, a relatively small number of inmates—something like 1 percent or fewer of the inmate population—were so disruptive and posed such serious management problems that whole prisons had to be devoted to controlling them. The solution was to identify and remove the worst offenders from federal prisons across the country and concentrate them in one small, super-maximum-security penitentiary; the "putting all the rotten apples in one barrel" theory.

Alcatraz held only some 275 inmates at any one time, all in individual cells, on an island thoroughly separated from the rest of the world. Part of Alcatraz's perimeter security system, therefore, was the cold, fast currents of San Francisco Bay. Another part of the system involved limiting inmate activity by locking the prisoners up from 4:50 each afternoon until breakfast the next morning, and a third element was assigning some 150 guards, lieutenants, and other custodial personnel to watch this small group of prisoners closely. Despite the fact that Alcatraz had a limited function and housed only a handful of federal prisoners, it quickly became highly publicized and controversial, because it was established with no pretense at rehabilitation. The prison consisted of only one building, which contained two cell blocks back to back, and a separate "special treatment unit" to isolate even further the worst of the island's troublemakers and escape artists.

Prison architecture and the regimes within them are symbols of governmental authority and of the core presumption of deterrence that is an element of criminal penalties. But prisons like Alcatraz have always had the problem of punishing or appearing to punish so severely that public sympathy can be developed for the offenders within—even when those offenders are some of the nation's most notorious lawbreakers. The sight of an island fortress called "the Rock" not far from a highly populated urban area, combined with horror stories from inmates and sensational speculation by the press, who were always barred from visiting, created a public relations headache for the Bureau of Prisons that lasted for thirty years.

The end of Alcatraz coincided with the growth of the "medical model," which began to influence California policy and practice in the late 1950s and early 1960s. The theory that each offender was the product of arrested or imperfect psychological development and disadvantaged social conditions gave the Federal Bureau of Prisons, which saw itself as a national leader in penology, the justification it needed to abandon Alcatraz. The bureau was then able to jump on the "corrections" bandwagon, which disavowed punishment as a means of changing the behavior of offenders and clearly rejected the notion that some lawbreakers were "hopeless incorrigibles."

New Purposes for New Prisons

The federal prison at Marion, Illinois, opened in 1964 as a replacement of sorts for Alcatraz. Therefore it featured a structure that was designed along the familiar telephone pole style of architecture, which called for cell houses, work-shops, recreational facilities, chapels, and social service and dining areas to extend from each side of a long central corridor. Marion was programmed to provide the same educational, vocational, and counseling services found in other federal prisons. Rehabilitation of the most serious and persistent offenders was reestablished as a goal of imprisonment, even in maximum security penitentiaries.

In California, the ever-present concerns about the cost of prison operations and overcrowding came under the influence of the new treatment philosophy. California Mens Colony, East, in San Luis Obispo, put into concrete all of these elements. It was composed of four six-hundred-man quadrangles, each with its own housing, dining, recreation, and social service areas. A core of central services was delivered to the entire population of twenty-four hundred inmates, including a hospital and chapels, a disciplinary segregation unit, and industrial operations. The prison walls were painted in pastel colors to get away from the old prison grey, and its "L" shape, or "over-under" cell construction, was designed to prevent later overcrowding by making it impossible to replace one bed in a cell with a double bunk.

Psychologically based treatment programs prevailed, with inmates meeting in groups with other residents in their housing area. Each quadrangle was composed of two buildings of three floors, constructed in an "L" shape, with some floors further subdivided by grills into fifty-man units to accommodate that variety of group counseling called "community living."

But Mens Colony, Marion, and most of the other prisons in America were soon beset by new problems—problems that became life-threatening for inmates and staff. The civil rights movement and racial confrontations in cities and towns across the country produced the inmate rights movement, but had the unintended consequence that prisoners began to divide themselves up along lines of race and ethnicity. Verbal confrontations became threats, which became physical confrontations. At the same time that violence was increasing, evaluations of the effectiveness of the psychologically based programs that constituted the heart of the medical model—the offender has a problem, the experts

diagnose it, apply treatment, and then, through the indeterminate sentencing system, release the patient/client/resident when his problem has been corrected—proved to be disappointing.

In California, Minnesota, and other states, the penal pendulum swung back to the traditional purposes of imprisonment: the punishment and isolation of serious offenders. Treatment, it was now argued, was best accomplished with offenders in the community. Imprisonment was to be used as a last resort for those convicted of crimes of violence or property offenders who had repeatedly failed on probation or in community corrections programs.

The Prototype of a "New Generation" Prison: Oak Park Heights

With racial and ethnic conflict a major consideration and confinement in most state and federal prisons reserved for violent offenders who would be sent to prison for long periods, American penologists began to consider new designs in prison construction and the remodeling of old buildings. The most notable prisons in the first category produced what came to be called "new generation" prisons, of which Oak Park Heights in Minnesota is the best example. This "correctional facility," with a name that suggests a housing development or a senior citizens' complex, was constructed to provide maximum security and maximum separation of different types of inmates. Yet it differed from the standard penitentiary look of Folsom Prison in California; Attica in New York; Jackson, Michigan; Walla Walla, Washington; Leavenworth, Kansas; Joliet, Illinois; Canon City, Colorado; and the other fortress prisons that Americans had become so accustomed to seeing in the movies.

Oak Park Heights features no gun towers; it is, in fact, built into a hillside, earth sheltered, and largely invisible to the surrounding community. Its roughly circular design calls for eight forty-eight-man units that are completely self-contained and separated from each other, with all units connected by a security "spine" of two corridors—one for inmate movement and one for staff. Each unit has its own dining, recreational, and laundry facilities, with several units containing industrial operations and several others devoted to education or chemical dependency and sex offender treatment. A separate mental health unit and a "control unit," the new term for the solitary confinement area of the prison, used to isolate prisoners for reasons of misconduct, serve all units.

Oak Park Heights and other new modular construction designs provide many options to prison managers who wish to break up cliques or gangs, to conduct shakedown (search) operations, or to discipline one unit while allowing normal business to be carried on in other units. The two tiers of cells in each unit face a control room surrounded by security-glass windows through which an officer can observe traffic in and out of every inmate's room and activities in the dining, recreation, and laundry areas—in short, all interactions between inmates and between inmates and staff.

The Return to the Alcatraz Regime

The Federal Bureau of Prisons, however, had no new-generation prison with which to deal with the problems its inmates began to pose at Marion, Illinois. In late October of 1983, after dozens of assaults on inmates and staff culminated in the murder of two officers in separate incidents on the same day and the twenty-sixth inmate killing occurred on the following day, federal officials instituted a "lockdown" that remains in effect at Marion to this day. All congregate activity ceased and inmates remained in their individual cells for twenty-three hours a day, leaving them only in handcuffs and leg chains for their hour of solitary exercise. All services, including confession, communion, counseling, and correspondence courses, were conducted through cell bars. The busy, tense, action-packed days of an open movement penitentiary ended with the reestablishment of the maximum punishment, minimum privilege regime from "the Rock."

The press renamed Marion the New Alcatraz, and the familiar controversies about the nature and degree of the deprivation and restraints on the inmates quickly reappeared. After the inmates tested the constitutionality of the lockdown on the grounds of cruel and unusual psychological punishment and lost, however, what the Bureau of Prisons called "indefinite administrative segregation" soon became a feature of American prison life. Officials from state prison systems visited Marion to learn about its highly controlled regimen, and by the early 1990s some thirty-six states had moved to build new maximum security "facilities" or to remodel units within existing prisons to accommodate "the Marion Model." Some of these new prisons added the lockdown regime to the modular design of Oak Park Heights. Several of these prisons—Pelican Bay in California and New York's "maxi-maxi" prison at Southport—have experienced inmate protests and challenges in federal courts regarding the constitutionality of variations they have instituted, in design and programming, from the Marion model.

Correctional Complexes

The latest development in prison architecture is to be found in the new federal "correctional complexes," the first of which opened in 1994 in Florence, Colorado. The Florence complex is composed of a minimum-security prison featuring dormitory living, a medium-security prison with double bunked cells, a maximum-security penitentiary designed roughly along the Oak Park Heights modular design, with each inmate locked up in a single cell and all units facing the interior of the prison, and the federal government's replacement for Marion, called "administrative maximum." Admin-max