

Wilbur went back in time with us Monday and told us he started working at the hatchery in 1936 and bought the store from Edgar Brockman in 1955. During the war years Wilbur said the hatchery produced thousands of chicks. Wilbur continued to turn out chicks until last year when he had to start turning orders down for the first time in 64 years.

The times when the hatchery ran 24 hours per day was nerve wracking, Wilbur said. You'd never know when a fuse might blow as it did one night, resulting in the loss of 4,000 chickens.

There's a lot of history attached to the building that houses the hatchery. The building has housed a grocery store and barbershop and Wilbur says he can remember coming uptown to see the toys in the window around Christmas.

Wilbur is a little concerned about what he's going to do when he retires. He says he has some things he has to dispose of and the hatchery has been the home to a number of card players for years and Wilbur feels a responsibility to "keep them off the streets".

**BILL TO ESTABLISH OFFICE OF
CORRECTIONAL HEALTH**

HON. TED STRICKLAND

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 2000

Mr. STRICKLAND. Mr. Speaker, today I am introducing legislation which would establish an Office of Correctional Health within the Department of Health and Human Services.

According to the Department of Justice (DOJ), the United States is second only to Russia among industrialized nations in incarceration rates with nearly 2 million people in jail or prison. The fuel that feeds this prison population explosion is comprised of several components. Mandatory minimum and "three-strikes" sentencing laws have resulted in longer sentences and more frequent incarcerations. A look at the changing demographics in American prisons and jails sheds light on the challenges correction facilities face at the beginning of the 21st century.

According to DOJ, 57 percent of state prisoners and 45 percent of federal prisoners surveyed in 1997 said they had used drugs in the month before their offense. A whopping 83 percent of state prisoners and 73 percent of federal prisoners had used drugs at some time in the past. It is estimated that about three-quarters of all inmates can be characterized as being involving in alcohol or drug abuse in the time leading to their arrest.

In the first comprehensive report on mental illness in correctional facilities, the Bureau of Justice Statistics (BJS) found that seven percent of federal inmates and 16 percent of those in state prisons or local jails or on probation said they either had a mental condition or had stayed over night in a mental hospital unit or treatment program. The highest rate of mental illness was among white females in state prisons at 29 percent. For white females age 24 or younger this level rose to almost 40 percent. When compared to other inmates, mentally ill inmates and probationers reported higher rates of prior physical and sexual abuse. According to BJS, nearly 6 in 10 mentally ill offenders reported they were under the

influence of alcohol and drugs at the time of their current offense. Many people do not know that the Los Angeles City jail is now the largest mental institution in the United States, holding 3,300 seriously mentally ill inmates on any given night.

The increased incarceration rate of women also presents new health care challenges to correctional facilities. According to BJS, in 1998 an estimated 950,000 women were under custody, care or control of correctional agencies. Nearly 6 in 10 women in state prisons had experienced physical or sexual abuse in the past. This statistic, coupled with the reality that 7 in 10 women under correctional sanction have minor children, points to the acute need for counseling services. Women inmates utilize health care services at higher rates than men. Because of their need for reproductive health care, including sexually transmitted diseases, and the possibility of pregnancy either upon entry into the correction system or during, women's special health care needs must be addressed in a comprehensive fashion.

The health care needs of inmates have expanded as the incarcerated population has aged. As inmates grow old in prison they succumb to the same ailments which afflict the elderly in the outside world—diabetes, heart disease and stroke. These geriatric health care needs represent another challenge to correctional agencies in providing adequate care.

In 1996, the Centers for Disease Control and Prevention's National Center for HIV, STD, and TB Prevention formed an ad hoc working group, the Cross Centers Correctional Work Group made up of health professionals from across CDC. The purpose of the group is to focus attention on the complex health needs of incarcerated men, women, and youth in the United States. I commend the work of this group and the fine efforts of CDC in addressing the very complex health issues associated with correctional facilities.

According to CDC, in 1994 AIDS diagnoses were almost six times more prevalent among the incarcerated population than among the general U.S. population. Further, inmates coming into correctional facilities are increasingly at risk for HIV infection through risk behaviors such as needle sharing and unprotected sex. Also, tuberculosis (TB) is another important public health issue in prisons and jails according to CDC. TB infection rates are substantially higher among inmates because conditions associated with TB (poverty, drug use, HIV infection, etc.) are more common in the incarcerated population than the general U.S. population.

Rates of infectious disease are known to be higher among inmates than in the general population and because most inmates are released after they've served their time, without treatment, these infected inmates threaten the public health of the community upon release.

All of these alarming statistics contribute to the need for the establishment of an Office of Correctional Health with HHS. Such an office would coordinate all correctional health programs within HHS; provide technical support to State and local correctional agencies on correctional health; cooperate with other Federal agencies carrying out correctional health programs to ensure coordination; provide out-

reach to State directors of correctional health and providers; and facilitate the exchange of information regarding correctional health activities.

Mr. Speaker, with a growing diverse and medically complex population in America's prisons and jails, we must ensure that inmates are provided the health care they need, that staff members operate in a safe working environment, and as a result, public safety is enhanced.

PERSONAL EXPLANATION

HON. CAROLYN C. KILPATRICK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 2000

Ms. KILPATRICK. Mr. Speaker, due to official business at the White House, I was unable to record my vote on rollcall No. 154, raising a point of order against the consideration of H.R. 3709 as an unfunded mandate. Had I been present, I would have voted "nay"—against consideration of H.R. 3709.

**CONGRATULATING THE COMMUNITY
HEALTHCARE NETWORK OF
THE COLUMBUS, GEORGIA, RE-
GIONAL HEALTHCARE SYSTEM**

HON. MAC COLLINS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 2000

Mr. COLLINS. Mr. Speaker, today, during National Hospital Week, I honor accomplishments of the Community Healthcare Network. Earlier this week, the American Hospital Association presented its prestigious NOVA award to the Community Healthcare Network, which was established by Columbus Regional Healthcare System of Columbus, Georgia. This award recognizes hospitals' innovative and collaborative efforts to improve the health of their communities. I congratulate the dedicated health care workers of the Community Healthcare Network for achieving this important recognition.

The Community Healthcare Network—a collaboration of public and private entities serving 19 counties in west Georgia and east Alabama—exemplifies the dedication of health care workers, professionals, and volunteers who are there 24 hours a day, 365 days a year, curing and caring for their neighbors in need. Using the results of each county's baseline health status surveys, the Community Healthcare Network developed programs to meet each community's specific health needs. For example, primary health care centers were opened to serve children and adults in three rural counties. To increase accessibility, fees are based on the patients' abilities to pay.

The Community Care Mobile Unit travels throughout the service area providing primary case services to the homeless and indigent. Once a week, the unit visits locations selected by teens to provide teen health services. In other collaborative projects, the network has led the way to establish a children's dental