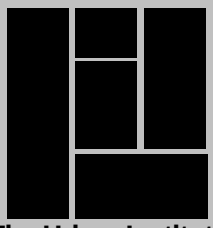
Criminal Justice and Public Health: Opportunities Across Systems

Address to the Board of Directors of The Health Foundation of Greater Cincinnati



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Members of the Board of Directors; staff of the Foundation; invited guests:

Allow me first to express my thanks for the invitation to speak with you as you begin this strategic planning retreat. As Jan Bogner can tell you, when you first extended the invitation to me, I quickly responded that I was about to leave the National Institute of Justice to join the Urban Institute as the latest refugee from federal service to find a safe haven in a Washington think tank. Perhaps the Foundation would rather invite my successor, or someone else within NIJ. No, Jan replied, the Foundation really wanted to invite me, not someone representing the Department of Justice. So, I thank you for that well-timed affirmation that I would have a life after my government service ended.

On a more serious note, however, I would like to express my admiration for your willingness to undertake this strategic planning activity. I have watched foundation boards for the better part of my career — some up close, some at a distance. Not many are willing to take the time to challenge the foundation's investment strategy, nor are they willing to go through the hard work of asking whether a new strategy is right. Typically, boards of directors either think complacently that their foundation is going in the right direction; or, if not, think they have all the answers; or, more likely, are far too willing to delegate this important assignment to the executive director and staff to figure it out themselves. So I find it commendable that you have gathered in this format to grapple with this question of a new strategic undertaking.

I would also like to commend you for taking on this particular strategic challenge. As you already know from the superb background document prepared by the staff, you have decided to take on an issue that is timely and difficult — the intersection between the criminal justice and health systems and the populations they serve at that intersection. In my experience, philanthropic organizations involved in investing in health issues shy away from the criminal justice arena, and those involved in criminal justice issues are reluctant to get too involved in health and mental health issues. So, the willingness of a major foundation such as this one to take this issue on directly — and particularly to look at it from the perspective of a single community — is very refreshing.

Now, let's get down to the business at hand.

I. National Trends.

I would like to define six national trends that I think provide the context for your deliberations — three trends that directly influence any discussion of bringing criminal justice and public health policies together, and three trends that provide important social policy backdrop.

Although these may not define the precise investment strategy you choose as you move down this path, these trends do, in my view, underscore the importance of your investment choices and frame the principles that might guide your discussion. If you are

successful here, your investment strategy can influence a large number of communities, practitioners, government agencies and foundations — and through them the individuals affected by these policies.

Major Trend No. 1. Crime is at the lowest level in a generation. After a sharp increase beginning in the mid-1980's, principally due to the introduction of crack into our inner cities, rates of violent crime have dropped steadily for seven years in a row to reach the lowest levels since the 1960's. Property crime rates have declined steadily for twenty years so they are now half the rate of a generation ago. Notably, rates of child fatalities and child abuse have not declined appreciatively.

Major Trend No. 2. Imprisonment is at the highest level in a generation. After decades of stability, the per capita rate of imprisonment started to go up in the early 1970's to the point where the rate is now four times higher than it was in 1972. Nearly two million people are in prisons or jails; about four million are under community supervision. One consequence of the growth in imprisonment is that larger numbers of people are returning from prisons to their communities. This year, 570,000 individuals will leave state and federal prisons to go back to their communities. Compare this to 1980 when there were 320,000 people IN state and federal prison.

Major Trend No. 3. Institutionalization of the mentally ill in health facilities is at the lowest level in a generation. In 1955, there were 560,000 mentally ill individuals in hospitals; today there are about 70,000. Over the same period, the institutionalization of mentally ill in prisons and jails has increased. In 1998, about a quarter of a million offenders in prisons and jails were identified as mentally ill. Approximately three quarters of the two million incarcerated individuals have histories of substance abuse. And 60 percent of incarcerated mentally ill offenders reported that they were under the influence of alcohol or drugs at the time of their offense.

Major Trend No. 4. The economy has never been better; the welfare state has been fundamentally redefined; governments are flush with cash. Unemployment rates have fallen below four percent, by definition a "full employment" economy, generating enormous tax revenues and providing enhanced job opportunities across the board. The relationship between the government and the poor has been redefined as welfare caseloads have plummeted. Unprecedented surpluses are being generated at the national, state and local levels of government. Yet, according to the Bazelon Center for Mental Health Law, total state spending for treatment of the seriously mentally ill is now one third the rate of the 1950's.

Major Trend No. 5. The health care system of this nation is undergoing profound redefinition as managed care providers are responsible for ever greater shares of the health care market. This has consequences for the population you are concerned with today. For example, the research shows that individuals who participate in residential or outpatient drug treatment have greater chances of success if they stay in treatment for at least 90 days. But many managed care programs do not provide that length of coverage.

Major Trend No. 6. Science is rapidly advancing, particularly our understanding of brain functioning and the mapping of the human genome, opening up revolutionary new possibilities for scientific interventions. New technologies have enabled us to think quite differently about the delivery of health care. New research has validated the effectiveness of various treatments, in particular treatments for drug involved individuals.

II. Nexus Between National Trends and The Proposed Strategy.

I do not pretend expertise in all of these major social forces, but I hope you will agree that, combined, they provide a major opportunity for creative interventions at the intersection of the health and justice systems. The low crime rate has reduced the pressure on the police to respond to epidemic levels of violence; they can now focus more attention on lower level offenses and be more responsive to other concerns of the community. In particular, the introduction of community policing philosophies — with the focus on problem solving to prevent crime as the preferred methodology — means that the police are much more open to working with communities, and working with other sectors, particularly the health sector of our society. For example, I have observed around the country a new willingness of the police to work in partnership with the health professions on the problems of mentally ill persons on our streets, on the issue of family violence, on responding to at risk youth.

The increased use of imprisonment presents a different opportunity. State and local governments are acutely aware of the costs of incarceration, even though the robust economy has made it possible for our society to support all these new prisons. Most jurisdictions are acutely aware of the irony that their prisons are major service delivery systems — for health, education and training services. For example, the Los Angeles County jail is known as the largest mental health facility in the country.

More sophisticated jurisdictions also recognize that their prisons and jails process lots of people in and out who pose serious health risks to the community. Some quick examples make the point. According to the Centers for Disease Control and Prevention, 17 percent of the people living with AIDS in 1996 passed through a correctional facility that year. About 1.4 million people released from prison or jail that year were infected with hepatitis C. According to the National Commission on Correctional Health Care, during 1996 about 3 percent of the U. S. population spent time in prison or jail, but between 12 and 35 percent of the total number of people with selected communicable diseases passed through a correctional facility the same year.

So, sadly, our prison growth has created new opportunities to deliver health care services to those who need them. And, if effective, those new services could reduce imprisonment (by providing judges with alternatives to incarceration), reduce crime (by reducing, for example, drug addiction) and enhance public health (by, for example, reducing TB prevalence).

The history of deinstitutionalization of the mentally ill — and the growth of the mentally ill in the criminal justice system — presents a different challenge. Many observers

think the deinstitutionalization movement failed because it was not matched by effective, well-funded community mental health resources. People tend to make those arguments with greatest urgency when a mentally ill person living in the community who might otherwise be in a hospital does something that is socially unacceptable — commits a crime, harasses people on the street. So, a strategy that develops effective treatments that do not result in recommitment to either institution — hospital or jail — could take some of the edge off the deinstitutionalization debate.

The final three trends combine to make the investment you are considering particularly timely. Having a full economy, but solid government funding, and declining welfare caseloads means that employment opportunities are there for the hard to employ, governments are better situated to develop new programs for needy populations, and state governments have been freed up to experiment with different forms of welfare reform. The health care revolution is also challenging traditional assumptions, and many critics are acutely aware of the holes in the health care safety net, so a focus on the least well served is timely. And the advances in science and technology mean that the medical community may be interested in testing new ways of delivering services. One example comes to mind, telemedicine, which is increasingly providing ways to bring health care to individuals in prison.

So, in sum, it is harder to imagine a better time in our recent history to focus on the health care needs of individuals caught up in the criminal justice system. They represent one of society's most vulnerable populations and, even though we are not living in an era of new, Great Society-like programs for such populations, the convergence of these trends makes a focused, practical, results-oriented intervention on their behalf highly likely to succeed.

III. The Logic of the Investment Strategy.

So, let's think through the logic of the proposed investment strategy. The logic might go like this:

First, the criminal justice system has become a major repository for individuals who suffer health problems, particularly mental health and substance abuse problems.

Second, the criminal justice system, because of its underlying philosophy and purpose, is poorly equipped to respond to those health problems. The focus on case processing, punishment, security, and adversarial proceedings mitigate against appropriate care for those problems.

Third, mounting a health response in a criminal justice setting would serve the goals of health policy. The public health system would be able to reach a hard-to-reach population. Health care services could be delivered much more efficiently, through economies of scale if nothing else. And there might be some ways in which the use of criminal justice sanctions could achieve therapeutic purposes. For example, there is a growing body of literature, coming from evaluations of therapeutic communities in prisons and drug courts, that the

proper use of the coercive powers of the criminal justice system can enhance treatment outcomes.

Fourth, mounting a health response in a criminal justice setting would serve the goals of justice policy. People who should not be prosecuted, for example, because their behavior was not truly criminal, could be diverted from the system. Community based supervision could allow judges to release individuals who might otherwise be incarcerated. Reoffending rates could be reduced through effective treatment. Successful reintegration of offenders with families and communities could be encouraged. All of these outcomes are criminal justice goals that could be achieved through partnership with the health system.

IV. Obstacles.

One needs to be mindful of the many obstacles to success when considering interventions at the intersections of the health and criminal justice systems. There are enormous "cultural" differences between these two systems. Just consider the language differences — one system's client or patient is another system's suspect, offender, inmate, "perp" or worse. It is even hard to find the common language of common purpose — when the rehabilitation ideal reigned supreme in the criminal justice system, that "linguistic crosswalk" came in handy, but it is hard to find similar bridging concepts today. Safety is one; justice is another; but these are very hard to operationalize. The environment of the criminal justice system could not be more anti-therapeutic — prison cells, isolation, deprivation of liberty, stress about the future, physical restraints, body searches, and sparse contacts with families and psychological support systems.

Notwithstanding these obstacles of culture, language and environment, I think the greatest obstacles to successful collaboration between the criminal justice and public health systems can be found within the two professions. Lawyers, law enforcement officers, judges and correctional personnel live in a world unto themselves, with their focus on winning cases, moving cases, personal safety, and community safety. In this world, the needs and concerns of defendants, victims and their families have difficulty getting a hearing. So, these professions are poorly prepared to think about health care, particularly long term health care; mental illness outside of the limited instances of insanity defenses and mental competency; communicable diseases, except as they might threaten the correctional institution; therapy or other interventions. In most criminal justice systems, this is a foreign way of thinking about the individuals who present themselves at the front door.

Unfortunately, I have found a similar difficulty in convincing the health professions to look at the criminal justice system as a vehicle for providing health care. Doctors, nurses and other health professionals do not like to work in police lock-ups and prisons. The folks who are involved in criminal activities are often very difficult clients and patients. They lead very complicated lives. The levels of reimbursement for health care services are usually below other rates. The social standing associated with this work is not high. And there are important equity issues here as well. Health policy analysts could rightly ask why someone locked up in prison should get drug treatment when his neighbor who did not commit a crime has to wait

months to get that service, if ever.

So, I think the greatest challenge is to bring these professions together to talk about these issue, to find common purpose and common language, to think together about ways to provide services of greatest benefit to the larger community. This is highly ironic, because the same individuals cross the boundaries between the two systems. We found in Winston Salem, North Carolina, for example, that sixty percent of the violent juveniles had at least one contact with the mental health system. So, our "clients" know how to navigate both worlds, we just need to find ways to align our professions in ways that follow their lead.

V. The Strategic Opportunity.

These observations about trends, obstacles and opportunities lead me to a final thought for your deliberations. You are about to consider a new initiative at this intersection and presumably have many options. One would be to offer health services to individuals caught up in the criminal justice system. You could offer health care services to a sector of the population with certain health needs — for example, mental health, substance abuse, or both, i.e., co-occurring mental health and substance abuse. You could offer those services to individuals in custody, or to those in the community but under supervision, or both. You could offer services to individuals as a form of diversion, an intervention that would presumable reduce levels of incarceration and prosecution.

I would like to urge you to do something quite different. Offering services to the currently unserved is a worthy goal, but is a goal for government, or a charitable institution, but less appropriately a goal for foundation, in my view. A foundation such as yours has an opportunity to reframe the public policy debate in this area by challenging the assumptions that result in the underserved population. By challenging the cultural obstacles that make it difficult for criminal justice and health professionals to work together. By challenging the traditional ways of doing business. By showing a different way.

My hope is that you would use this opportunity to examine the nexus, to unpack it, to shed light on it. In my view, the best way to do that is to look at every individual who comes into one or more sectors of the criminal justice system to understand the health care needs of that individual. In this approach, you would challenge the public health institutions in your community to embrace the broader issue. You would invite them to the table — the hospitals, the medical community, the mental health providers, the insurance companies, the HMOs — to review, for example, one month's intake at the county jail, or a random sample of those detained in the prison, or all women who appear at the domestic violence shelter. Take a slice through the criminal justice population and look at their health care needs, without considering the fiscal or policy or operational constraints, and ask whether they are getting the health care they deserve. Then, armed with this information, challenge the policies and budgets of the governments and institutions by asking why the world is organized the way it is. This is not a study for study's sake; it is, rather, a study to stimulate immediate action.

The net effect of this approach would be to change the framework for the policy

debate within your community, and by extension throughout the country. It would also provide you with a better sense of a next step, a more specific intervention perhaps, a demonstration program in a particular area to serve a particular population. But by taking that first step, you would have stirred up the pot and leveraged existing capacity in Greater Cincinnati — not your capacity, but latent capacity — to enhance the level of services delivered to this population. You would have made significant progress toward the Health Foundation's mission to ensure that "people of this region will have access to appropriate healthcare, be able to practice health behavior, and live in communities that support good health."