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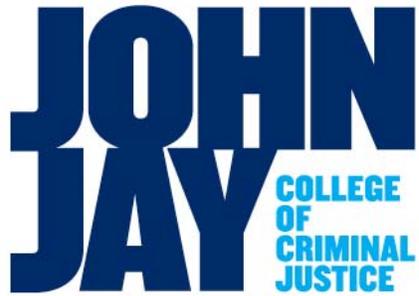
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**UNDERSTANDING THE PUBLIC HEALTH CHALLENGES
IN THE ERA OF MASS INCARCERATION**

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CITY UNIVERSITY OF NEW YORK**

**KEYNOTE SPEECH
FIFTH ANNUAL ACADEMIC AND HEALTH POLICY CONFERENCE
ON CORRECTIONAL HEALTH**

March 22, 2012
Marriott Airport Hotel
Atlanta, GA

Dear colleagues:

I am deeply honored by your invitation to join you at your fifth annual conference on correctional health care. I value this opportunity to engage with people who are exploring three topics I care about – first, the role of research in shaping public policy, second, the place of prisons in our society, and third, the unique perspective that comes from looking at the intersection of research and correctional policy through a public health lens. So, although I cannot claim to be one of you, I feel right at home at your conference and am humbled by this opportunity to share some of my thoughts on the important topics you plan to discuss.

My hope this morning is that I can provide a framework for the conversations that will unfold in the workshops, panels, restaurants, and hallways over the next two days. My bottom line assertion is that we are meeting at a critically important time in our nation's history. I hope to persuade you that the work you are doing – the issues you are discussing – the intellectual and policy challenges you are embracing – that this work is critical to the way our nation thinks about justice, our democracy, and the well-being of our citizens. Furthermore, I hope to convey a sense of urgency -- that now is the time to do some heavy lifting, to take on some big challenges. Most conferences present welcome opportunities to see old friends, refresh collegial networks, pick up some new ideas, check out a new city, and eat at good restaurants. I certainly hope that this conference provides you all of those social, intellectual and culinary opportunities. But I hope to persuade you that this year this conference bears the weight of history -- so mixed with the fun and stimulation should be a strong sense of commitment to leave Atlanta ready to make a difference.

Let's start by reciting some statistics that are certainly well known among this audience. We live in an era of unprecedented rates of incarceration. Some scholars have called this the era of "mass imprisonment."¹ The basic facts tell the story. For five decades from 1920 to the early 1970s, the incarceration rate in America was remarkably stable, so stable that two prominent criminologists, Al Blumstein and Jacqueline Cohen published an article in the early 1970s setting forth a theory that our society had found a level of consistency in incarceration rates such that, should crime rise or fall, or other social and economic conditions change, our incarceration rate would always remain the same.² That article was published in 1973.

Ironically, starting that year, and every year since, the incarceration rate in America has increased. I hasten to note that the number of people in prison in America has leveled off in the last few years and that in some states the number has gone down.³ Yet, before we celebrate this recent development, we should acknowledge the deeper truth: over the past forty years, no matter whether crime rates were increasing or decreasing, whether the economy was booming or falling, whether the nation was at war or peace, we put more people in prison. Our decision to use prisons as our preferred response to crime now appears to have a life of its own, disconnected from the historical forces that traditionally determine incarceration rates.

¹ Marc Mauer, *The Causes and Consequences of Prison Growth in the United States*, in *Mass Imprisonment: Social Causes and Consequences* (David Garland ed., Sage, 2001).

² Alfred Blumstein, Jacqueline Cohen, *A Theory of the Stability of Punishment* (*The Journal of Criminal Law and Criminology*, 64, 2, June, 1973).

³ Lauren E. Glaze, *Correctional Population in the United States, 2010* (US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, December 2011).

Here's the bottom line of this story. In our country, the rate of incarceration is now nearly quintuple that of 1972. We now have the highest incarceration rate in the world. Our prisons hold a quarter of all prisoners in the world, even though our country comprises only five percent of the world's population. This reality of "mass incarceration" places the American approach to punishment outside the experience of the rest of all other Western democracies.⁴

We should remind ourselves that the impact of our justice policies – basically our decisions, taken through our legislative process, to be more punitive – extends far beyond our nation's prisons. The reach of the criminal justice system into daily life in our communities is unprecedented. We have more people coming in and out of jail – 9 million individuals, 12 million annual admissions.⁵ Following a peak in community supervision in 2007, the number of people under community supervision dropped slightly to 4.8 million in 2010, so that approximately 850,000 are now on parole, and about 4 million are on probation.⁶ Our retributive policies have also shaped our approach to juvenile justice and our policies on school discipline so that millions of young people are growing up in an atmosphere where adolescent misconduct is criminalized, or treated with undue severity.⁷ The same impulse has resulted in increased use of criminal deportations, severe restrictions in judicial review of deportation orders, and a new, largely invisible network of immigration detention facilities.⁸ Our legislatures have enacted hundreds of statutes that impose short term or even lifelong restrictions on individuals with criminal records, consigning millions of our fellow citizens to lives on the margins of our society, closed out of entire sectors of the labor market, removed from public benefits, evicted from public housing, and disqualified from voting.⁹

To understand the full impact of these policies on our democracy – and in particular on our commitment to racial justice and equality of opportunity – we must also remind ourselves that these hyper-punitive policies are not spread evenly across our society. Rather, they are felt most acutely in a small number of urban communities, mostly communities of color, where families and individuals in those communities are already struggling with poor schools, inadequate housing, weak labor markets, and poor health care. These communities must now cope with three problematic dynamics -- high rates of incarceration, high rates of crime, and a highly intrusive system of criminal justice supervision. We have entered a new chapter in our history. In this new future, a majority of the men in these neighborhoods will have criminal records. Everyone will know a friend or relative in prison or jail. Family budgets will be stretched as never before to pay for prison commissary, underwrite collect calls from incarcerated relatives, pay for long trips to prison on visiting day, and make up for the lost wages when a family member is arrested and sent away and can no longer put a paycheck in the bank. In short, our

⁴ The Pew Charitable Trust Center, *1 in 100: Behind Bars in America 2008*. (retrieved from the world wide web on March 16, 2012: http://www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf).

⁵ Amy L. Solomon, Jenny W.L. Osborne, Stefan F. LoBuglio, Jeff Mellow, Debbie A. Mukamal, *Life After Lockup: Improving Reentry from Jail to the Community* (The Urban Institute, May 2008).

⁶ Lauren E. Glaze, Thomas P. Bonczar, *Probation and Parole in the United States, 2010* (US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, November 2011).

⁷ Deborah Fowler, Rebecca Lightsey, Janis Monger, Elyshai Aseltine, *Texas' School-to-Prison Pipeline: Ticketing, Arrest & Use of Force in Schools* (Texas Appleseed Report, 2010). Tony Fabelo, Michael D. Thompson, Martha Plotkin, Dottie Carmichael, Miner P. Marchbanks, Eric A. Booth, *Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement* (Justice Center & Public Policy Research Institute, 2011).

⁸ The Pew Hispanic Center, *As Deportations Rise to Record Levels, Most Latinos Oppose Obama's Policy* (The Pew Research Center, 2011).

⁹ Jeremy Travis, *Invisible Punishment: An Instrument of Social Exclusion*, in *Invisible Punishment: The Collateral Consequences of Mass Imprisonment* (Marc Mauer, Meda Chesney-Lind eds., NY, The New Press, 2002).

incarceration policies now constitute an unprecedented deadweight on poor communities of color. Seen through the lens of our nation's struggle to achieve racial justice, we can fully understand why Michelle Alexander calls this reality "The New Jim Crow."¹⁰

As you may know, in my writing and speaking on this topic, I look at the realities of high rates of incarceration through a lens called "prisoner reentry." I approach the phenomenon of "mass incarceration" by reminding people of the "iron law of corrections" – namely, that with the exception of those individuals who die in prison, either of natural causes or because they are executed, everyone we incarcerate returns home. This inevitable consequence of incarceration is captured in the title of my book, "But They All Come Back."¹¹ This perspective generates a different set of important numbers that capture the unprecedented nature of our use of prisons. Whereas in 1980 there were 150,000 people leaving our state and federal prisons each year, now there are over 730,000 making this journey home each year – or about 2,000 a day. Nine out of ten of these are men; most return to a small number of communities facing historically high rates of incarceration; most – four of five – will be placed on criminal justice supervision for one to three years; and most – two of three – will be rearrested for one or more serious crimes in the three years following their return home.¹²

In important ways, the reentry perspective on the realities of mass incarceration resembles the public health perspective on mass incarceration. When looking at prisons – and jails for that matter – through a reentry lens, one asks two simple questions: given that the individual will be in prison for a period of time, first, what should be done to maximize the value of that time in terms of the person's well-being, and second, what should be done to maximize the chances of success on the outside after release?

My thinking on these questions has been influenced in profound ways by my interactions with public health scholars and practitioners over the years. In my book, I pay a special tribute to Bob Greifinger and his seminal 1993 article that calls correctional health care a "public health opportunity."¹³ I have learned from the work of Nick Freudenberg, a Distinguished Professor at Hunter College, as he explored the linkages between the health systems in jails and communities. When I was Director of the National Institute of Justice, NIJ funded the landmark study by the National Commission on Correctional Health Care (NCCHC), which documented the elevated levels of a wide variety of health concerns – including mental illness, communicable diseases such as HIV/AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and histories of substance abuse – among the prison populations. Now, at John Jay College, I am honored to be affiliated with Professors Hung-En Sung, Jeff Mellow, and Frank Pezzella who are managing an NIH grant titled *Institutional Development Program for Correctional Health & Healthcare Research*.

This body of work underscores the importance of bringing public health professionals to the criminal justice table, in particular to the table discussing new approaches to reentry and

¹⁰ Michelle Alexander, *The New Jim Crow* (New York, The New Press, 2010).

¹¹ Jeremy Travis, *But They All Come Back*, (Washington DC, Urban Institute Press, 2005).

¹² Patrick A. Langan, David J. Levin, *Recidivism of Prisoners Released in 1994* (US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, June 2002).

¹³ J. Glaser and Robert B. Greifinger, *Correctional Health Care: A Public Health Opportunity* (Annals of Internal Medicine, 118, 2 1993).

reintegration. Your discipline has helped me and thousands like me understand the world of incarceration and reentry in new and creative ways. You have given us the language of discharge planning, the tools of transfer of medical records, and perhaps most importantly the posture of looking at incarcerated individuals as just that, individuals, without moral judgment, stigma, or rejection. Speaking with you this morning provides me an opportunity to acknowledge that debt.

As I look at the policy environment and think about our American experiment with high rates of incarceration, I am actually very optimistic. The financial crisis facing our states has caused many governors and legislators to decide that the era of prison growth is over, and that we should cut back on the rates of incarceration.¹⁴ The concept of “justice reinvestment” has taken root, and policy makers are thinking about new ways to use precious public funds that are now being spent, with little public safety benefit, on prisons.¹⁵ The public discourse has shifted as both liberals and conservative are talking about cutting back on the level of criminal justice intrusion in the lives of our citizens.¹⁶

Major national publications are shining a critical spotlight on abuses in the juvenile justice system, the criminalization of school misconduct, and the increases in solitary confinement and supermax prisons, a particularly horrific and troubling feature of our penal policies.^{17,18,19,20} The Committee on Law and Justice of the National Academy of Sciences, which I chair, has just launched a panel to examine the “causes and consequences of high rates of incarceration in America,” with a report due in 18 months. Finally, we should note that our Supreme Court, in the landmark case of *Brown v. Plata*, upheld a lower court order to decrease the California prison system by 37,000, based on a finding that the overcrowding in those prisons constituted cruel and unusual punishment.²¹ Of particular relevance to this conference, the fundamental constitutional violation was the impact of these overcrowding conditions on the health and wellbeing of the prisoners. As Justice Kennedy noted in his opinion for the majority, “A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”²²

So, if one views this particular glass as half full, there are reasons to be optimistic. But there is another reason for optimism, one that presents historic opportunities, and one that imposes unique obligations on this audience and the community of scholars and practitioners who work on issues of correctional health. I refer, of course, to the enactment of the Patient Protection and Affordable Care Act. This landmark piece of legislation has the potential to shift, in

¹⁴ Vera Institute of Justice, *The Price of Prisons: What Incarceration Costs Taxpayers* (January 2012).

¹⁵ Justice Center, The Council of State Governments, *The Justice Reinvestment Act* (Retrieved from the world wide web on March 20 at <http://justicereinvestment.org/>).

¹⁶ Texas Public Policy Foundation, *Right on Crime: The Conservative Case for Reform* (Retrieved from the world wide web on March 20, 2012 at <http://www.rightoncrime.com/>).

¹⁷ Deborah Fowler, Rebecca Lightsey, Janis Monger, Elyshai Aseltine, *Texas' School-to-Prison Pipeline: Ticketing, Arrest & Use of Force in Schools* (Texas Appleseed Report, 2010). Tony Fabelo, Michael D. Thompson, Martha Plotkin, Dottie Carmichael, Miner P. Marchbanks, Eric A. Booth, *Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement* (Justice Center & Public Policy Research Institute, 2011).

¹⁸ Erica Goode, *Prisons Rethink Isolation, Saving Money, Lives and Sanity* (The New York Times, March 10, 2012).

¹⁹ The Dart Society, *The Gray Box: An Investigative Look at Solitary Confinement* (2012 report retrieved from the World Wide Web on March 16, 2012: <http://www.dartsocietyreports.org/cms/>).

²⁰ Atul Gawande, *Hellhole*, The New Yorker, 2009)

²¹ *Brown v. Plata*, 09-1233, 131 S. Ct. 2011.

²² *Ibid.*

fundamental ways, our country's approach to correctional health care, broadly defined. It can profoundly alter the way we provide health care in prisons and jails. And, seen through the reentry lens, it can profoundly alter the connection between health care in those institutions, and health care in our communities.

This last point bears emphasis. Because of this connection across the prison walls, the Affordable Care Act (ACA) can, in my view, improve the lives of hundreds of thousands of men and women who pass through our prisons – and the millions who pass through our jails – and thereby raise the health standards of our nation's poorest communities. If approached with sober recognition of its potential, the ACA, as applied to the criminal justice context, could help our nation address the issue of health disparities, the high incidence of communicable diseases in poor communities of color, the connection between mental illness and criminal justice involvement, and the high rates of morbidity following release from prison. Please do not misunderstand me – I am not celebrating the fact that we have so many people in prison as a way to improve public health. Yet it is ironic, or actually tragic, but nonetheless true, that the reality of mass incarceration, in the era of the ACA, could have positive effects on the communities most adversely affected by our criminal justice policies.

Let me take a moment to revisit the basic facts of the ACA – facts you understand well, but ones that I wish to connect with the larger opportunity before us. As you know, under current federal law, incarcerated individuals are not eligible for Medicaid. The ACA does not change this fact. Even though the ACA generally requires states to cover all individuals under age 65 who have incomes below 133 percent of the federal poverty level, those individuals who are incarcerated in prison are exempted from this requirement.²³ So why should we be so optimistic that the ACA will result in improvements in health care for incarcerated individuals? Remember the “iron law of corrections” – everyone in prison and jail comes back, unless they die while in custody. If we view prisons and jails as a stop on one's life journey, rather than a place of permanent exile, then we ask ourselves whether the ACA will change the communities from which incarcerated individuals come, and to which they return. This in turn requires us to ask whether this new external reality will change the provision of health care internal to the prisons and jails of America. I would submit to you that the answer to both questions is resoundingly “yes.”

Let's begin again with the essential facts: under the ACA, by 2014, all individuals under 65 must be covered by Medicaid if their income is below 133 percent of the poverty level. Applied to the prison population, this means that some percentage – we need research to arrive at this estimate – of incoming prisoners after 2014 will already be enrolled in Medicaid. The policy challenge then becomes to make sure that, upon release, everyone who is Medicaid eligible is enrolled as part of their reentry plan. As you know, in 2004, the Department of Health and Human Services issued a letter encouraging states to “suspend” rather than “terminate” Medicaid benefits for the incarcerated population. So, the public health opportunity is clear: state corrections agencies, working with their counterparts in the state agencies overseeing Medicaid, should ensure that, for those already on Medicaid, eligibility is suspended upon entry to prison, and for the entire reentry cohort, eligibility is determined well prior to release. I certainly recognize that some

²³ Patricia Blair, Robert Greifinger, T. Howard Stone, Sarah Somers, *Increasing Access to Health Insurance Coverage for Pre-trial Detainees and Individuals Transitioning from Correctional Facilities Under the Patient Protection and Affordable Care Act* (Community Oriented Correctional Health Services, Issue Paper, 2011).

advocates may have preferred that the Affordable Care Act would require continuity of Medicaid eligibility during time in prison. But in this case, second best is pretty good: increased Medicaid eligibility before, and after, prison will bring us pretty close to the concept of “throughcare” in health services for a substantial portion – the poorest portion -- of the incarcerated population.

The concept of “throughcare” gets another boost from the Affordable Care Act. As you know, the ACA places a high premium on the development of health care records that follow the individual. States are required to develop a “single, streamlined form” for applications for health coverage. They must develop a “secure, electronic interface allowing an exchange of data ... that allows a determination of eligibility for all [health subsidy] programs based on a single application.”²⁴ This requirement puts a system of continuity of care within reach. The community of correctional health care providers and scholars should jump at this opportunity to enter into data-sharing arrangements with health care providers in the community. The individuals being treated in prison will benefit, of course; they will also benefit upon release; and our ability to understand the changing health profile of this population through careful research will also be enhanced enormously by the availability of these data.

Other provisions of the ACA will have significant impact on the well-being of incarcerated individuals and our nation’s approach to health services for this population. For example, states are given the option of creating “standard health plans” (SHPs) for low income individuals who are not eligible for Medicaid, but whose income is less than 200 percent of the federal poverty level. States may also establish exchanges through which individuals may purchase “qualified health plans” (QHPs). Incarcerated individuals are NOT eligible for these two programs, unless the individual is incarcerated “pending the disposition of charges.”²⁵ This means that the ACA will have significant implications for jail-based health care, where millions of individuals are held “pending the disposition of charges.” Finally, the ACA states that individuals are ineligible for QHP and SHP coverage if they are incarcerated “at the time of enrollment.” This language precludes coverage for those not already covered when they are incarcerated, but would allow jail administrators to establish eligibility during the period of incarceration so that enrollment in a QHP and SHP can be activated at the moment of discharge.²⁶

Taken together, these provisions of the Affordable Care Act imply that the world of correctional health care is about to enter an exciting, yet uncharted, new terrain. And this new voyage is coming quickly – 2014 is right around the corner. The challenge for this conference is to seize the opportunity. The opportunity is enormous – new financial resources, new networks of colleagues in the community, new access to data. Let’s think about the possibilities. Let’s imagine a world in which correctional health care is linked, in important and new ways, to an improved level of health care in the communities from which incarcerated individuals come, and to which they return. Let’s imagine that correctional health care providers have access to patient records they have never had before, and can link to community health services in new ways. Let’s imagine that we could set new benchmarks for the quality and effectiveness of health care in prisons, using common databases and metrics. Let’s imagine that we created

²⁴ Ibid., 5.

²⁵ Ibid., 2

²⁶ Ibid., 2

enforceable standards for health services in prisons and jails that were open to public and professional scrutiny. How would that world be different from our current reality?

Some differences are clear. At the individual level, the quality of care in the institutions will be improved with new resources and new data. At the institutional level, we will be able to demonstrate lower prevalence of disease and disability, higher levels of function and health. But my hope is that we think more globally than the individual and institutional level – that we think about this opportunity in terms of some of the overarching aspirations of public health practitioners. The public health literature speaks in inspirational ways about the goal of reducing social and racial disparities in health.²⁷ This literature talks about the social determinants of health, and the role that prisons play in contributing to illness and disease in our society.²⁸ I do not pretend to know this literature well, but I find the theoretical construct to be elevating – namely that by approaching issues of health at a societal, not just an individual, level, we can address some of the inequalities that define our society. This challenge is particularly compelling at the intersection of incarceration and public health because the population in question is overwhelmingly male, minority, and poor. So, if we get this challenge right, it means that we can reduce inequalities in health along the lines of gender, race and class. It is hard to think of a public policy opportunity that is more compelling.

So, it's time to get to work. It's time to think big and to set high goals. It's time to view correctional health care as more than simply an institution-based health care delivery system. We should also view correctional health care as a platform for leveraging significant changes in community well-being. It's time to look outside the walls of our prisons and jails to create common cause with health care providers in the community and to demand that they see the same big picture that we see. It's time to set goals for our institutional systems that are in synch with the health goals of our communities, and measure our progress in terms of those external yardsticks. We should set as a goal that every person in our care is treated as a patient first, with the same expectations of quality care and probability of recovery, as if that individual came into a primary care practice on the outside. We should look at each individual in our custody as a messenger for healthy behavior, an ambassador for personal responsibility, an educated consumer of best health care practices, and an emissary to family and friends to support an epidemic of good health.

We face two truths today. Unfortunately we live in an era of mass incarceration. I count myself among those here who are trying to change that reality. But we also live in an era when the national approach to health care is changing in profound ways. Ironically, the first truth means that the second truth has the power to change our most vulnerable communities for the better. I hope you will leave this conference more convinced than ever that you should seize this unprecedented moment in our history to advance the wellbeing and the quality of justice of our country.

Thank you.

²⁷ Michael Marmot, *Social Determinants of Health Inequalities* (The Lancet, 365, 2005).

²⁸ Niyi Awofeso, *Prisons as Social Determinants of Hepatitis C Virus and Tuberculosis Infections* (Public Health Reports, 125, 4, 2010).