

Plenary Address

# **Public Health, Public Safety and Prisoner Reentry: Challenges for the Future**

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Criminal Justice and Substance Abuse  
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# Public Health, Public Safety and Prisoner Reentry: Challenges for the Future

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Dear friends and colleagues:

It is truly wonderful to be here with you today – back home in New York, among friends who have been such an important part of my career in criminal justice. I am very grateful for the invitation to join you this afternoon and honored that you have asked me to offer some thoughts as you begin this important conference.

The assignment to give a keynote address is always a bit daunting. After all, you have all the experts in this room, you know the issues that you face better than anyone else, you have established the tradition of these annual conferences and have a sense of the opportunities and obstacles that mark your path. My hope is that I can help you place your deliberations in a larger context – and that I can suggest some directions where your discussion might be most productive.

## I. The Context: Crime and Punishment.

Let's step back from the issues you will be addressing to reflect briefly on this moment in the history of our crime policies. We live in a remarkable era, notable for the two milestones we have achieved. First, crime is at its lowest rate in a generation. After a sharp increase beginning in the mid-1980's, principally due to the introduction of crack cocaine into our inner cities, rates of violent crime have dropped steadily for seven years in a row to reach the lowest rate since the 1960's. Property crime rates have declined steadily for twenty years so they are now half the rate of a generation ago. Rates of intimate partner violence are also falling. Notably, rates of child fatalities and child abuse have not declined appreciably – an area of violence that still calls out for our creativity and attention.

Second, our rates of imprisonment are the highest 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 our prisons or jails; about four million are under community-based supervision. At the end of 1998, one in 34 adults – or about three percent of the adult population in this country – were either incarcerated, or on probation or parole.

Over the past year or so, I have detected a shift in our conversation about crime and punishment in this country. We have become accustomed to living in a time of declining crime rates. A decade ago, a mere one percent drop in crime rates was cause for celebration; now, a slight uptick in violent crime in New York City causes a new round of finger pointing, demonstrating, I would argue, that we now think declining crime rates are the norm. And we are now witnessing a slowdown in the growth of our prison populations – in fact, new commitments have remained virtually flat for the past two years, and most of the growth in state prison populations is now due to increased length of stay and a doubling (over twenty years) of our rate of parole revocations around the country.

So, we may be approaching a new equilibrium in our rate of imprisonment. This equilibrium, in turn, is allowing us to focus on the back end of our record prison expansion – the

issue of reentry. This year, about 585,000 individuals will be released from state and federal prisons to return to their communities – a remarkable number when we remember that twenty years ago there were only 320,000 people in state and federal prisons.

So, I think our trends in crime and punishment – the former on a downward trend, the latter flattening out – create interesting new challenges. The first is how to continue to bring crime rates down, and the second is what to do with the nearly two million people now in prison, how to prepare them for their inevitable return to live amongst us again.

I think your conference is poised to provide national leadership on both of these challenges.

## II. The Context: New Partnerships, New Approaches.

Fortunately, you are holding this conference – and considering these challenges – at a time when the policy environment is undergoing fundamental transformations. I think there are three broad historical undercurrents – in essence, new forms of partnership across the sectors of our society — that define this particular environment. I would like to briefly describe them before turning to the specific issue of the nexus between public health and public safety and the challenge of prisoner reentry.

### A. Research and Practice Partnerships.

First, there is a commendable openness to research in the world of practice these days. We like to think that the public health and medical community has always displayed an openness to research and the scientific method. It was that community, after all, that pioneered the concept of the teaching hospital that mixes cutting edge research with innovative practice. It was the public health discipline that proclaimed the philosophy of evidence-based medicine with its emphasis on the scientific basis for interventions. It has been the health professions that have used community epidemiology to characterize public health risks, to pinpoint outbreaks of new strains of diseases, and to contain and eliminate infectious diseases.

I think we in the criminal justice profession can now claim that we have adopted these ways of thinking and applied them to our practice as well. We have created partnerships between universities and police departments, corrections departments and other agencies of justice to bring the discipline and theoretical grounding of researchers to the development of innovative criminal justice strategies. We have embraced a new concern for the bottom line, for being accountable for crime reductions and for implementing programs that work according to the best scientific evidence. We have employed crime mapping software to focus our energies, analyzed communities according to their risk and protective factors to reduce juvenile delinquency, and identified “hot spots” with high rates of crime so that we could bring those crime rates down without allowing the crime epidemic to infect other communities.

So, you are holding this conference – and bringing together the treatment, health and criminal justice professions – at a time when there is a new openness to research, to the evaluation of interventions, and to accountability for results. This new environment, shared across our professions, allows us to find language of common purpose and to experiment with new strategies.

B. Public Health and Criminal Justice Partnerships.

Second, I think that there is a new conversation these days between the worlds of health and criminal justice. This is certainly the case in the research professions. When I was at the National Institute of Justice, we found that some of our most productive partnerships were with our colleagues at the Centers for Disease Control and Prevention, particularly as we studied intimate partner violence, violence against women, and gun violence. Our new understandings of the workings of the brain, pioneered by scientists supported by the National Institute on Drug Abuse, have been highly instrumental in helping criminal justice professionals and treatment providers think differently about the types of interventions appropriate for drug users.

Practitioners in these two professions are also finding value in the perspectives of the other profession. I can speak best about the world of criminal justice practice – we are increasingly concentrating on the public health dimensions of our work. Last year, the White House hosted a conference on the mentally ill in the criminal justice system. The National Institute of Justice has funded the National Commission on Correctional Health Care to conduct a major review of the health concerns presented by the criminal justice population. The cutting edge work in the area of family violence prevention and intervention is being developed jointly by public health and criminal justice experts.

Although I leave final judgment to the health professionals in the audience, I suspect that the public health community has also found common purpose with the criminal justice community. I have had the occasion to speak recently with the boards of two major public health philanthropies dealing with substance abuse issues and the seriously mentally ill. Both had come to the same realization — if you want to address these health concerns in our society, you must work in the criminal justice context for the simple reason that this population reflects high health risks. A few quick examples make the point. According to the CDC, about 17 percent of the people living with AIDS passed through a correctional facility in 1996. Between 12 and 35 percent of the people with communicable diseases pass through a correctional facility each year. The Los Angeles County jail has the dubious distinction as the largest mental health facility in the country. So, we can say to the public health practitioners: If you are looking for your clients and your patients, we have them.

C. Problem-solving Partnerships.

The third trend that sets the stage for your conference is the movement within criminal justice practice toward a “problem-solving” methodology. In an area of public policy that has for too long been dominated by ideological debate, this new approach to crime policy is very pragmatic, not just in its emphasis on results demonstrated through good research, but also in its approach to community crime prevention and to the handling of specific cases.

This problem-solving approach began with the police. Properly understood, community policing has two dimensions – first, the active engagement of the community in setting the agenda for police activities, and second, the use of a problem-solving strategy. “Problem-solving” sounds so simple, but is really revolutionary. Rather than just make arrests, the police now hold themselves accountable, working with the community, for identifying a problem, designing a strategy for addressing the problem, and evaluating the results and modifying the strategy based on that assessment. So, just think about how this might work. If the problem is drug dealing on a street corner, then any number of strategies, including but not limited to arrests, could be employed – cleaning up the vacant lot where young people hang out, dealing with the irresponsible landlord who allows drug dealing out of his building, offering treatment to addicts, intervening with the young people through their families, churches, youth organizations or peer groups.

This problem-solving approach has spread beyond the police, with remarkable results. Think about drug courts – in essence, the judge is a problem-solver, not just an adjudicator. The “problem” is the offenders’s drug addiction, so the unit of work for the drug court is sobriety, not just another case disposed of. The intervention is treatment and testing, mixing the stick of the criminal sanction with the carrot of support. Now, as Judge Ferdinand told me when I visited her in the Brooklyn Treatment Court, judges have to understand the literature of relapse, in addition to the latest appellate court rulings. In addition to drug courts, we are now seeing the development of mental health courts, DUI courts, family treatment courts (with leadership from New York’s Chief Judge), gun courts, community courts (pioneered at the Midtown Community Court and replicated at the Harlem Community Court and the Red Hook Community Justice Center) and courts overseeing the reentry of prisoners into their community, with the Harlem Reentry Court, developed by the New York State Division of Parole and the Center for Court Innovation as one of the national leaders.

The problem-solving approach is springing up in prosecutors’ offices (look at DTAP, the Drug Treatment Alternatives Program, in Brooklyn), public defenders (look at the Harlem Neighborhood Defenders’ Office) and community corrections. This approach has the potential to transform many aspects of criminal justice practice, particularly when combined with the community partnerships that have been pioneered by the police and are now being emulated by their criminal justice colleagues.

So, these three new dimensions in the policy environment –the openness to research, the dialogue between health and justice practitioners, and the pragmatism of problem-solving – create a rich environment for innovation at the cutting edge of alcohol and substance abuse and crime. I would like to suggest that you are poised to take on two very broad, but very specific challenges – first, to look at the public health issues posed by the criminal justice population, second, to focus on the issue of prisoner reentry. There are obvious overlaps between these two initiatives, but I would like to discuss them as distinct efforts.

### III. First Challenge: Health and Justice.

When we think of the health issues of the criminal justice population, we quickly tend to think of specific health needs – the mental health needs, the substance abuse needs, the HIV and AIDS needs. And even more quickly, we focus on the programs that we have created to serve those needs – we point with pride to the number of slots for drug treatment, the linkages to community mental health centers, the referrals to AIDS treatment facilities. Unfortunately, however, we tend to lose sight of this particular forest because it is easier to focus on the trees.

Let's look at the forest for a second. I mentioned before the statistics that I think are compelling about AIDS – that 17 percent of the people living with AIDS passed through a correctional facility in 1996. Or the statistic that between 12 and 35 percent of people with communicable diseases pass through a correctional facility each year, even though only three percent of the overall population spent time in a prison or jail

Let's add some more data to this particular forest. 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 people incarcerated have histories of substance abuse. Sixty percent of mentally ill offenders reported that they were under the influence of alcohol or drugs at the time of their offense.

Let's focus specifically on the nexus between alcohol and crime. One third of violent victimizations in this country involve alcohol – about 3 million a year. About one third of the convicted offenders under correctional supervision stated that they were under the influence of alcohol at the time of their arrest – that is about 2 million people. Alcohol is associated with more violent crime than all illicit drugs put together – over the years 1992 to 1995, out of eleven million victims of violence, 2.2 million perceived the offenders to be under the influence of alcohol; yet only half a million said the offender was on alcohol and drugs, and 600,000 perceived the offender to be using drugs alone.

The link between alcohol and crime is more pronounced when we look deeper at certain types of crimes. Domestic violence is particularly troubling – nearly two thirds of violent victimizations among intimates involve alcohol. By comparison, only 21 percent involved drugs, either alone or combined with alcohol. If we take one more step into intimate violence, we see that three quarters of the spousal assault incidents involve alcohol, while only 16 percent involve drugs, either alone or combined with alcohol.

So, the message here is clear: if we hope to address the issue of violence in America – particularly violence between intimates – we have to address the link between that violence and alcohol.

Now, let's look at the forest of drug abuse. We know from the reports of NIJ's Arrestee Drug Abuse Monitoring Program — the ADAM data – that between half and three quarters of all arrestees have drugs in their system at the time of arrest. About a fifth of them test positive for more than one drug. About half of all defendants charged with violent crimes, or income producing crimes such as robbery, burglary or theft test positive for more than one drug.

We also know that this population is not in treatment when they come to the courthouse door in the back of the police van. Only a quarter of drug users arrested were previously in drug treatment. According to one estimate, the number of drug-using arrestees who are in need of treatment exceeds 2 million a year. We also know that periods of incarceration alone do not change the drug use behavior – between 60 and 75 percent of untreated parolees who have histories of cocaine and/or heroin use are reported to return to those drugs within three months after release, if they are untreated.

When I look at this forest, I can only conclude that we have failed in our obligations to the public if we have not made maximum use of the criminal justice system as an opportunity to intervene in the lives of these offenders to reduce the health risks – not to mention the safety risks – that they pose to society. To take the most simple example: How can we not treat inmates with highly communicable diseases while they are in our custody? For me, it is not a stretch of logic to ask the same question about drug addiction: How can we not treat inmates with history of drug addiction while they are in our custody? Or, the mentally ill offender. Or the alcoholic. Or the HIV sufferer. I know that there are those who say that criminals should not benefit from their crimes, that prisons are only for punishment, and inmates should not get medical treatments that are not available universally, but I take a different view and think we have an obligation, precisely because these folks are in public custody, to reduce the health risks they pose upon release.

I would extend this logic to some, but not all, cases being handled in a community setting. I do not believe that we should extend the control of the state (even if that control is court ordered treatment) over people just because they have been arrested – there should be some balance between the severity of the case and the extent of services and supervision. But for those offenders with significant alcohol or drug abuse problems, who are engaged in destructive behavior, I think we should find ways to expand our drug courts, our DUI courts, our mental health courts to use the power of criminal justice supervision to help these individuals gain access to treatment, stay in treatment, and complete treatment.

Please do not misunderstand me – I know that most of these things are being tried, in high quality programs across New York State. My point is simply that we do not think systematically about the criminal justice system as a point of intervention for health policy, and we should. You have the opportunity at this conference to do that. You could, for example, commission a survey that would define the health concerns of your populations. You could estimate the treatment needs of that population. You could project the crime reduction potential of providing drug treatment to all who need it in prison. You could engage the great medical universities and health organizations of this state in a public dialogue on the health challenges posed by the criminal justice population. You can take advantage of this unique moment in history and shift the framework for discussion if you think about the forest and not the trees. The result will be both an improvement in health outcomes, and an increase in public safety.

#### IV. Second Challenge: Prisoner Reentry.

The second challenge that I would place before you is the challenge of prisoner reentry. The inevitable, predictable consequence of the buildup of our prison populations is that a large number of individuals are now returning to their communities, having served their time and standing ready for the processes of reintegration. This year, about 25,000 people will return to New York City from the state's prisons; in the early 1970's, the entire state prison population was about half that number.

The consequences of this massive flow of individuals in and out of prison are profound: The reconnection to family, to work, to community, to peer groups. The large numbers of individuals with disqualifying criminal records and breaks in their work histories that are hard to explain to prospective employers. The risks of relapse and reoffending.

And these consequences are felt particularly harshly in communities of color, and the flows of returning prisoners are experienced by communities already at highest risk of crime and disadvantage. A black male child born this year faces a thirty percent chance that he will spend at least a year in a correctional facility. So the consequences for our democracy are profound.

Ironically, we are experiencing this massive increase in returning prisoners at a time when we have diminished our capacity to manage the reentry process well. By capacity, I mean both our resource capacity, our legal capacity and our conceptual capacity. We have underfunded, defunded or abolished parole in states across the country. We have implemented truth in sentencing laws that reduce the amount of time of post-release supervision to a maximum of 15 percent of the sentence for violent offenders. Nearly twenty percent of the people being released this year – over 100,000 – are being released with NO supervision. In California, there are stories in the press of inmates being released from supermax confinement to the street with no supervision.

I would encourage this conference to think about the challenges of reentry. This is not a rehash of the debate over whether to abolish parole in the sense that we would move from discretionary release decisions to fixed release dates (although parole — both in terms of release decisionmaking and post-release supervision — is an important part of this discussion). And I hope we are not moving toward a world where all post-release supervision is abolished and everyone is shown the prison door on the last day of their sentence and merely told to go and sin no more. I think the responsible policy debate – and one you can have here – is how we as a society should manage the reintegration of this large number of offenders. How do we engage the communities where these prisoners will be returned? How do we ensure that they have a place to sleep on their first night of release? How do we make sure that if they need drug treatment they get registered right away and do not have to go on a waiting list? How do we take advantage of our full employment economy and bring the private sector into the prisons to hold job fairs as a number of states are doing?

The public health and treatment communities have a particularly critical role to play in the reentry management process. Because of the high number of prisoners with histories of drug use, alcohol use, mental illness, and communicable diseases, part of the reentry planning process

should involve the community health and treatment providers who should be encouraged, through state regulations and policies, to make room for these returning prisoners in their programs. There is great irony in the reality that someone waits for two years in state prison to be released back to the community, spends the last year in prison in a drug treatment program, then is out on the street again, at the moment of greatest risk of relapse, waiting for months to be admitted to another state funded drug treatment program, this one outside the prison. And during that time he goes out and commits some terrible crime. No wonder the public looks at us and wonders why we can't get our act together!

So, I urge all of you to get your hands – and minds – around the reentry challenges posed in this state. No other state, to my knowledge, has created a state agenda on this issue, and you are ready to take it on and demonstrate the leadership that has always characterized the state of New York. If you do it right, you will reduce crime in this state, improve health outcomes, and increase the contributions that ex-offenders can make to their communities.

I thank you for your invitation to speak to you, your openness to these ideas and your continuing good work on behalf of the citizens of this state. They are lucky to have you.