

In Need of Correction: The Prison Cycle of Health Care September 28, 2005

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GEORGE BENJAMIN, M.D., FACP: I'm George Benjamin and I'm the executive director of the American Public Health Association. We're here today to talk about prison health, a very important issue. We're also here to roll out this month's issue of *The American Journal of Public Health*, the issue being dedicated to prison health. I can tell you that the artwork on the cover is actually from an individual who is in jail, actually an extraordinary, extraordinary piece of work, but just wanted to point out that many of the articles and stuff we're talking about and the issue we're talking about today is being highlighted in this month's issue of *The Journal of American Public Health Association* is the publisher of *The American Journal of Public Health* and I certainly just want to publicly recognize our editor. If you would please stand Dr. Mary Northridge. Mary, thank you.

[Applause]

And your staff for all your hard work and I see many of the members of our publishing staff, Ellen Mayer and her staff and I would thank you very much for being here as well. I also want to thank Dr. Henry Treadwell and Joyce Nottingham who served as the guest editors of this special issue. Henry and Joyce thank you very much for your hard work and please stand and be recognized.

[Applause]

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I also want to thank the Community Voices Program and the National Center for Primary Care at the Morehouse School of Medicine for their partnership in this morning's event and of course I want to thank our panel of experts and speakers who we will be introducing to you very shortly. In addition I can't pass giving a plug to one of APHA's books. We have actually a book which we published on the Standards for Health Services in Correctional Institutes which we certainly believe is an essential reference for anyone that's doing correctional health care and just want to bring that to your attention. Of course you can take a look at that. There're some fliers out in the hallway as well as going to our website at www.apha.org.

I always get a little choked up when I make this introduction. I've known this gentleman for a long time. Actually the first time he met me, he may not remember me but he critiqued one of my presentations. I've become a much better presenter after that. It was an area near and dear to both his heart and mine which is sickle cell anemia. I'm always fascinated with Dr. Satcher's work. As you know Dr. Satcher has served in numerous positions in our nation. He is the 16th Surgeon General of the United States and the Assistant Secretary for Health, one of very few people who held those joint titles. He is now the interim president of the Morehouse School of Medicine in Atlanta and very clearly is one of our nation's leaders in health. I'd like to bring to the podium

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Dr. David Satcher.

[Applause]

DAVID SATCHER, M.D., Ph.D.: Thank you very much Dr. Benjamin. George this is really a pleasure to be with you and to partner with you in this very important issue of the Journal of American Public Health, also to Dr. Henrie Treadwell who heads our Community Voices Program at the Morehouse School of Medicine. It's always great to work with Henrie and to this distinguished panel. I think there are some very challenging issues that are facing us in this country as it relates to our health care system and our prison system. I believe this issue of *The American Journal of Public Health* brings those issues together as never before. It describes what is of course a really growing population of people in our correctional institutions, our jails, prisons. It is growing rapidly I mean like wildfire the number of people incarcerated in this country and it's something that we should all be concerned about the impact that it's having on our society, on families in this society. And so together we need to be asking ourselves why and what we can do about it.

Another issue here is of course our health care system again because what this issue will point out is that our health care system actually contributes to the growing prison population. I don't know if you've thought about that but I think clearly our health care system is a major culprit in the

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fact that so many of the people who end up in prison in this country end up there because they don't get the mental health care that they need outside. We as a nation have perhaps inadvertently used the prison system to deal with our mental health burden. It is a growing problem and I'm sure you've heard by now and I spent several years in California but people often say that the Los Angeles County Jail is the largest mental health system in this country. There's a lot of truth to that because so many of the people there are mentally ill and wouldn't be there if they were not mentally ill. The tendency is to immediately blame the criminal justice system and I just want to point out that I don't think that's fair. Former Senator Paul Simon started a program at Southern Illinois University after he left Congress and he invited me there to speak a few years before he died. What Paul was trying to do was very interesting. He was trying to bring the criminal justice system and the mental health system together. The people in the criminal justice system don't know how to deal with the mental health burden in our society. They shouldn't have that responsibility. There are towns in this country where sheriffs and police are faced with people who are mentally ill. They don't know how to recognize them. They don't know how to deal with them and so they have not alternative but to arrest them as any other criminals. It is the health care system that is the culprit here and we might as

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well acknowledge that. So we're dealing with the environment the people live and the health care system that does not provide access to mental health care. We're also dealing increasingly with the fact that it is an environment gives rise to increased mental illness. If you haven't read the Journal of Science and the article by Felton Earls from Harvard School of Public Health a few months ago in which after five years of studying children on the streets of Chicago clearly it demonstrated with very good science that children who witness violence when they're growing up are much more likely, twice as likely to commit violence regardless of socio-economic status he showed. Somebody who was not out there when they saw somebody shot to death on the street. The environment from which people come contributes to their mental problems. Their mental problems contribute to crime. They end up in our prison. Then of course they have to deal with the environment of prison. It is a misnomer to call our prisons the corrections system. Our prisons themselves are environments that breed crime. They breed violence. They make people more violent than when they entered prison. We know that because we have not yet come up with a system that actually rejuvenates people and make them better citizens when they get out. The other thing that the prisons do and these 15 articles point this out very clearly, the prison system is an environment where people are at increased risk for infectious diseases. It's interesting

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because our health care system because of the lack of access for so many people and especially the kind of people who end up in prison. Our health care system is such that you can argue this morning that the prison health system is much superior to what people have outside. So they go in prison and they actually have better access to, if they get injured ready access and maybe even the control of some chronic diseases. People who have never had a doctor before, in prison will have one. The dilemma here of course is that that same prison environment does not provide prevention so people in prison are much more susceptible to infectious diseases, contagious diseases. The rate of contagious diseases is so much greater in prison. HIV/AIDS is eight times greater in prison than in the rest of the population. TB is much greater so you're putting people in an environment where they're at greater risk. Most prisons don't do anything about that. They don't distributed condoms or you can count the number of states on a few hands that say that we don't people even though we can't protect people from sex in prison. We can't even protect them from rape. We're not going to distribute condoms to prevent them from getting infected with HIV or hepatitis. The prison system is a system where people are at greater risk for infectious diseases. This is another environment. Who do you blame for the fact that we have a system where people go in and become more susceptible to infectious diseases? We have to

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blame all of us. Then of course you see we're going through these different environments. If people are lucky and they survive prison or they may come out with a death sentence that they didn't go in with. They may have been sentenced to two years for stealing a car or loaf of bread but in prison if they get HIV/AIDS they now have a death sentence. They come back to the streets, back to their families in many cases. Believe me this is not the same environment they left. The families are not the same families they left. Children who have lived without parents for a few years are not the same children that the parents left when they went into prison so families all suffer when people are incarcerated. Some states and I want to really commend those states and those judges too who have gone to great effort to try to make sure families are considered when people are incarcerated. Those judges who've said if somebody comes to me with a mental health problem even substance abuse addiction I'm going to give them the option of going into a treatment program that is much less expensive than prison and I'm going to give them the option of going into that treatment program. I want to commend those judges and they are growing numbers throughout the country who are now doing that who are saying to people standing before them you need mental health care and I'm going to give you the option of getting that. And if you go into that I won't sentence you to prison. But then when people come out of prison and they

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reenter society there is no health care or public health system that deals with prisoners' reentry into society. There's no system that says we're going to monitor you. We're going to make sure your infectious diseases are controlled. We want to make sure that you don't spread them to your families and other people. We need a system that deals with reentry of our prisoners into society and we don't have one. I think we have raised some real challenges with this issue of *The American Journal of Public Health*. It should make all of us stop and think about what we stand for and what this all means. It doesn't make sense economically. We should know that. If we treated people with mental disorders as opposed to sending them to prison we would actually save. One of the articles estimates that we could save up to \$3 billion. We spend about \$60 billion on our prison system and that just by dealing with that issue alone we could save up to \$3 billion. What kind of mental health system could we provide for people who we're sending to prison if we invested that kind of money? Don't let anybody tell you that we're in this situation because we can't afford to better. We're in this situation because we refuse to make humane decisions, courageous decisions that would make our system. That goes back to our health care system in the first place which does not really make a lot of sense when you think about it. It's not a health care system as George Benjamin has said many times; it's a disease of your system. We invest in

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treating diseases that we could have prevented in the first place and treating their complications. The system is in great need. I don't want to paint an impossible situation. I'm actually an optimist. I believe we can do better and I believe that one of these days we will do better. Those who know me know I like to quote Benjamin Elijah Mays who was my mentor, president of Morehouse College when I went there in 1959 out of the cotton fields of Alabama. It is best to convince me and others that we were somebody and that we were supposed to be leaders. He used to say that it must be borne in mind that the great tragedy of life is not in failing to reach all your goals, it's in having no goals for which you're reaching. It's not a calamity if you somehow die with dreams unfulfilled but it's a calamity not to dream. It's not a disaster to fail to achieve your highest ideals but it's a disaster to have no high ideals for which you're striving. It's not a disgrace to fail to reach the stars but it's a disgrace if you have no stars for which you're reaching. In the final analysis he said not failure but low aim is sin. This issue of *The American Journal of Public Health* challenges us to dream and to work for a better health care system on the one hand. A system that would respond to the growing population of people with mental health problems in this country but a system that would also help young people to grow up with hope and not prone to crime in so many cases because of the experiences that they have out there

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on the street. It challenges us to aim high for a health care system that provides access to everybody and that focuses on health and not just disease. It challenges us to make the prison system a humane system where people who enter there come out better than they were when they went in and not at greater risk for crime, greater risk for dying of infectious diseases. It challenges us to have a reentry system into society that protects families and other people who come in contact with people who've been in prison. It's a challenging issue of *The American Journal of Public Health* but it's one that should lead us to higher ground as a nation and as a people. Thank you.

[Applause]

GEORGE BENJAMIN, M.D., FACP: Thank you Dr. Satcher.

Our next speaker is Marguerite Johnson. She is the vice president for programs at the WK Kellogg Foundation and at the foundation she oversees program development, administration as well as program and project evaluation and dissemination and grant making. We're very pleased to have Miss Johnson with us here this morning and want to thank her and the Kellogg Foundation for its leadership in the health care arena. Miss Johnson.

[Applause]

MARGUERITE JOHNSON: Good morning. On behalf of the WK Kellogg Foundation I want to express our thanks and our appreciation to our partners at the National Center for Primary

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Care at the Morehouse School of Medicine and at the American Public Health Association for their attention to this crucial and also very challenging issue. When the WK Kellogg Foundation funded the Community Voices initiative almost ten years ago it was the Foundation's largest initiative to date and the Foundation's largest investment in improving health and health care. For the last 75 years the Kellogg Foundation has addressed the issues of health and health care from the community context and it really was the vision of Mr. Kellogg which is as relevant today as it was then that all people need to have access to quality primary and preventive care that they need in order to stay healthy. It was our fervent hope and is our fervent hope that community voices would become a voice for the underserved, the vulnerable and the forgotten. Truly this population of individuals in the criminal justice system is invisible and forgotten. As you've heard from Dr. Satcher and as you will hear they enter the system, the criminal justice system with a myriad of complex physical and emotional issues and they emerge with even more. I was really struck this by artist's rendition of what's going on in his head and in the minds of his peers within the prison system. I think it's a very powerful piece of artwork for all of us to have in front of us. But we know that when these individuals come home to our communities it's essential that they receive the physical and the behavioral health services that they need and that they

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receive them in a way that honors their dignity and their humanity. Once again the WK Kellogg Foundation is pleased and proud to be a supporter of this important work and of this edition of the American Public Health Journal. We also want to thank Dr. Satcher and Dr. Nottingham and Dr. Treadwell and their colleague at the Morehouse School of Medicine's National Center for Primary Care and the American Public Health Association for your leadership and for your courage to take on this very important issue. Thank you.

[Applause]

GEORGE BENJAMIN, M.D., FACP: Thanks again. I do want to remind everyone that we are filming this for web cast so if we could make sure everyone cuts off their phones and puts them on silent that would be very helpful. Of course none of us are stranger to the phenomenon that is courtroom television. From Judge Wopner to Judge Judy Americans have seen justice being served from the comfort of their very own living rooms and I think we've all learned some very important lessons about the criminal justice system. Our next speaker brings his own unique and compelling perspective to this morning's program. The Honorable Judge Greg Mathis is host of the award winning Judge Mathis show. He has an extraordinary and inspirational story having been a street youth who rose from jail to judge and provided hope to millions of his viewers. As a judge he currently serves in Michigan's 36th District Court and he's

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going to give us his thoughts and then serve as the moderator of our panel today. Judge Mathis thank you for joining us this morning.

[Applause]

GREG MATHIS: Thank you. Let me first thank those of you who had the wisdom to bring us together on this very important issue. Some of you who may be aware of my background should know that this is certainly a passionate subject for me having once been an incarcerated youth whom recently discovered after reading much about attention deficit disorder and many of the other bipolar diseases that we hear so much about that much of the reason I believe that I was expelled from four different schools before finally dropping out in the tenth grade, arrested five different times for juvenile and once as an adult, my final encounter with the law. After hearing and reading so much about attention deficit I finally realized that one of the reasons I was so defiant and rebellious is I went undiagnosed with adolescent attention deficit, perhaps a very minor form but nonetheless enough to cause me to be extremely rebellious against society, against any form of authority and yet have the ability to navigate through the educational system once I was able and committed to manage my life in a constructive way. I was perhaps more talented than most of my peers in the ability to once again manage and navigate mainstream society because I'm sure as all the esteemed

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physicians and doctors will tell you who are here with us today that those who suffer from attention deficit as juveniles if they're fortunate enough to make it through that as an adult from what I've read they are highly successful because of their ability to multitask.

[Laughter]

As we know that multitasking is a buzzword of the last couple of decades and the more you're able to multitask the more prosperous and successful you are in your careers and so certainly I can recall once leaving jail and getting a GED and going on to college it pained me to sit and listen to a lecture for an hour. Finally the only way I could stay there in class for an entire hour was to bring a magazine on one side, my notes in the middle perhaps some outside work on the right. As the professor would speak I'd be doing three other things but still able to maintain and to advance my education. This is certainly a passionate subject for me and I'm glad that I was invited. I also want to thank the Kellogg Foundation for their work. It was a Kellogg funded program that in Detroit that I went through to obtain my GED, a community based organization that was funded by Kellogg so I'm very grateful that they're still involved on the grass root level in making a difference in our community. Let me say that I'm just going to take a couple of minutes to talk about the subject and then introduce our panelists and allow them to speak on these subjects. I

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think it's very important today that we try and determine the connection between mental health, drugs, disease all relating to the criminal justice system. We know that one-sixth of the prison population have been diagnosed with a mental illness of some sort. I believe that many more have gone as I did as a youngster undiagnosed with any mental health issues whether it's attention deficit disorder and I think it's oppositional defiance is the other, connected mental health challenge to attention deficit, whether it's bipolar disease or whether it's some other type of psychosis we know that most of the prisoners that we encounter at least the ones I've encountered as a judge for ten years and particularly some that I encounter right now as a television judge. These by the way are real cases, real people. Folks come up to me and say all the time where do you get these people?

[Laughter]

I have to remind them that they come from every part of America and then have to challenge them to think long and hard about a few of their family members who are just like the ones they see on television.

[Laughter]

So I tell them as they say in the hood, don't get brand new you know you got some relatives [Laughter] that act just like these folks on my television show. But many of them are dealing with minor and sometimes major mental health challenges

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and the question becomes whether these mental health challenges are physiological and or environmental. Living in poverty and a drug and crime infested neighborhood where you're either a member of the street gang or a victim of the street gang, where guns and drugs have been dumped in your community and 90% of those young black males in that community are forced to either participate as a predator meaning selling the drugs or committing the crimes or as prey meaning using the drugs or otherwise being victimized. Some would suggest that that can create a syndrome similar to what soldiers encounter in a war. Indeed we know that we lose more men every year to gun violence in American than we lost, than we've lost in Iraq so certainly in many communities it's like a war zone. So the question becomes if soldiers can return home with post-traumatic syndrome after a year, 18 months of service on the front line what do you think a young street youth who deals with it for 10, 15 or 20 years of war in the inner cities of America is going to be like? That's one of our challenges. Is it environmental and physiological or is it all physiological? Then lastly we should know that much of what we observe in criminal behavior has its root in anger, rage and acting out inventing a pent up hopelessness, despair and denial and rejection by mainstream society. And so we must see how we can approach the root causes of the reactions that we see in many who encounter the criminal justice system. We must see how we

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can address the issue in a way where the poor don't automatically go to jail while the privileged get counseling and treatment. Our young people who encounter the criminal system who have displayed a history of defiance in school or otherwise somehow are immediately drafted into the prison industrial complex while the privileged youth is analyzed, treated and counseled without ever having touched the criminal justice system and without his record ever having been tarnished by that criminal justice system. Those are our challenges and I'm glad to be able to introduce our distinguished guests today.

First we're going to turn to Dr. Wright. Dr. Lester Wright is the deputy commission and chief medical officer for the New York State Department of Correctional Services, a public health practitioner and administrator. Dr. Wright oversees a system that provides health care to 63,000 inmates. I'd like to call Dr. Wright to bring to us today his analysis of the crisis that we face. Thank you Dr. Wright.

LESTER WRIGHT, M.D.: Corrections health has moved from an ignored backwater to an issue that's important enough to be given consideration in *The American Journal of Public Health*. From some standpoints that are positive, from some standpoints it's unfortunate. It's unfortunate because the interest has largely resulted from the continuing increase in the number of people incarcerated in this country and the associated costs.

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However the increased attention to corrections health is positive because people who did not receive needed health care prior to incarceration because of lack of resources or not knowing how to access the system can have their health problems professionally addressed while they are incarcerated. With patients who can be readily located and who have guaranteed access to health care, corrections health should be able to provide the care that society hasn't provided to them previously. In a well organized setting it should be possible to provide that care at lower cost than in the community. If this is done well we release people from prison in better health than when we received them and everybody in society benefits especially when our care includes a plan for continuity. The increased attention to corrections health is positive also because many of the conditions of public health significance share risk factors with criminal behavior. People who are willing to take inappropriate risks for whatever reason expect that they may skate around the law are also often willing to take inappropriate risks and expect that they'll skate around the health effects of smoking, use of dangerous substances, abuse of alcohol, unsafe sexual activity at all. Unfortunately all too often the health effects do occur and when incarceration is ordered and corrections health must help our inmates deal with the risks and health effects. By training and experience I'm a public health physician. I was hired

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because of that background to help transition New York State Corrections Health into a functioning system. I still believe I'm a public health physician providing public health services to a defined population. I simply define the population I serve differently from the more typical geographic distribution of a county or a state population. But if I were again a county or state public health administrator one of the first things that I'd look at is jails and prisons in my jurisdiction. I'd try to establish branch offices of my public health services in the jails and/or prisons because I know that would be one of the easiest places to find people who have the health problems, the communicable disease problems, the preventable health conditions my public health agency spends much of its resources trying to locate. Prison is far more a sentinel of health problems in the community than an incubator of ill health. We receive inmates with those conditions and if public is involved with corrections it's easier to arrange public health follow up care after release as well. But before establishing my branch office I'd start by learning something of the culture of corrections just as I'd want to learn the culture of any other new or different group in my community. There are several temptations to those of us in public health when it comes to corrections health. We tend to think of ourselves as knights on white horses riding out to save the victims of the system. We tend to think of ourselves as lone rangers in doing that. We

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tend to think of the entire justice system as being unfair to those we think need our help and in seeing the justice system as unfair we tend to personify that as thinking that those who are in corrections are the barrier. Well let me indeed be the case at times it's usually not the case. Most people who work in corrections are there with good intentions trying to do their best at their jobs for society. It may come as somewhat of a surprise to some but I do not recruit for patients. My commissioner does not recruit for inmates. We in corrections in New York are pleased that our number of inmates is decreasing. While our prison population has decreased 5% in the past decade our medical care costs increase 107%. We treat and try to prevent health problems not numbers of inmates. We in public health have to understand that the culture of corrections is very different than the culture of public health and the culture of health care as a whole. Corrections health is one of the few settings in health care where health professionals are not working on our own turf. Hospitals, clinics, medical offices even public health departments and public health clinics are established to provide health care, that's their resonant fray but corrections, the place that correctional health must be provided is not set up for the purpose of providing health care. Health care is an important component but it's not the reason for a prison or a jail. They're established to provide secure housing. I think it may

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have been to my advantage that before I moved my public health practice focus to corrections I spent a number of years working cross-culturally in Africa. I learned the importance of understanding something about another culture and working within it. The tools needed to do effective health care in corrections are the same cultural understanding tools I used in Ethiopia and Zimbabwe. We in public health need to recognize the cross-cultural interface. It's impossible to do the best corrections health care unless one's willing to work with corrections. Security determines when things happen in corrections and how they happen. Security determines how easy or difficult it'll be for us to have our patients where we need them when we need them whether in the facility or at an outside medical provider. Unless we know how security operates and why it has the rules and patterns that it does unless we actively cultivate collaboration with security we will spend inordinate amounts of our time and effort battling security to get the care we think our patients need. All of us, corrections, health, public health, security and our patients will be frustrated. If we want to do good public health in corrections it'll be with not in spite of security. Respect between health professionals and security professionals does not happen by chance. It takes proactive effort in helping each other understand and meet each other's concerns. Focus on corrections offers advantages to public health. Think about

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communicable disease problems tuberculosis for instance. A dozen years ago tuberculosis was a major problem in New York state prisons. The rate of TB was over 200 per 100,000 and multi-drug resistant TB was responsible for the deaths of inmates and at least one staff member. A quarter of the people coming into prison were infected with TB. The rate of TB infection is still about one-fourth but in the past two years the rate of new cases of TB diagnosed in our prison system has been lower than the rate of tuberculosis in New York City. Less than 1/20 the case rate that we had. We haven't had any cases of multiple drug resistant TB for the last several years. We've done this in partnership with the State Department of Health. Consider the case of hepatitis B. Nowadays infants and children are given immunization against hepatitis B but our inmates were raised before the requirement. Few have had hepatitis B vaccine. While we've had very few acute cases of hepatitis B in inmates we know that most of our inmates previously used drugs and many will use them again remaining at high risk for hep B after they're released. We take the position that offering hepatitis B vaccine to all inmates need it and protect not only while they are inside but much more so can protect the community afterward. It's much easier to find those who need hepatitis B vaccine while they're in Sing Sing than it is in the South Bronx which brings us to the issue of substance abuse and alcohol abuse. 73% of our prison inmates

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have identified need for substance abuse treatment. While it may be as or more effective to treat their substance abuse issues rather than sending them to prison remember corrections didn't send them to prison. But if they are in prison then it's our responsibility to offer them high quality alcohol and substance abuse treatment while they are in prison. Each year approximately 33,000 participate in our alcohol and substance abuse treatment programs in New York State. People who come to jail or prison enter with higher rates of sexually transmissible diseases including HIV than the general community population has. Testing them for STDs and treating them while they are incarcerated is very efficient public health. Offering them HIV testing while they are incarcerated is now easier with the rapid test methods and it provides the testing to people with several times the risk than the general population. Together with the Department of Health we do over 15,000 voluntary HIV tests a year in our system. Another area where society can benefit from public health, corrections health collaboration is the care of incarcerated people with mental illness. Approximately 10% of inmates in New York prisons have significant mental illness. It's important to everyone in the prison system for those who need mental health therapy to receive it. It's equally important for these people to have a clearly defined referral to community mental health services when they're released. We release them with

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medications and prescriptions but we have also established programs to link inmate with outside services before they're released including the use of reach-in services and teleconference with agencies with which they will be working on the outside. Of course nearly all people who are incarcerated will be returning to their community, probably the same community in which they lived prior to jail or prison. If we've developed our partnerships between corrections health and the rest of public health we will have established referral mechanisms for those we identify with HIV or any other infectious or chronic disease so that they can continue to receive care. All of us in society can benefit from that. My staff and I provide care within a corrections system where the mantra is people who need health care should have the care they need. Some of us in corrections health recognize that it and understand the opportunities. We encourage the rest of society both corrections and the general society to use the same mantra. Thank you.

[Applause]

GREG MATHIS: Thank you Dr. Wright. Our next speaker is Judge Steven Leifman. He's an associate administrative judge of the Miami-Dade Court in the Criminal Division. Judge Leifman chairs the Mental Health Committee for 11th Judicial Circuit Court of Florida. He was responsible for creating the 11th Judicial Circuit Criminal Mental Health Project, a highly

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successful mental health intervention program. Judge Leifman.
Thank you.

[Applause]

STEVEN LEIFMAN, JD: Good morning. I also want to lend my thanks to Kellogg and Community Voices and Dr. Satcher for really helping us bring attention to an issue that unfortunately never really receives much which partially explains why we are where we are today.

On January 11th of this year, Miami-Dade County Grand Jury released a report. It was entitled "Mental Illness in the Criminal Justice System: A Recipe for Disaster, A Prescription for Improvement." After a year of investigation the Grand Jury of Miami-Dade County disclosed what most of us in the criminal justice system have known for many years, we have a mental health crisis in our communities, in our states and in this country. As Surgeon General, Dr. Satcher once called mental illness the silent epidemic of our times unless of course you were judged in a criminal court where everyday you are witness to the parade of misery brought on by the consequences of untreated mental illness. The problem began about 40 years ago with the best of intentions pursuant to a federal lawsuit that ended up in the United States Supreme Court. The US Supreme Court issued a wonderful opinion and it's in two parts. The first part of the opinion talks about the necessity of the deinstitutionalization. The second half of the opinion says if

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you're going to deinstitutionalize you must provide community based treatment. Unfortunately the state's only read the first half. They saved billions not millions billions of dollars by closing the state hospitals. And by not providing the community based treatment they basically shift the cost to local government through their correctional budgets. Remarkably over the last ten years we have closed twice as many hospitals as we did in the previous twenty. Just to give you a little idea of the impact these are numbers are quite profound. In 1955 we had some 560,000 people in state psychiatric hospitals. Today we have less than 40,000 people which in and of itself would be a wonderful thing. We knew that that population was being treated in a community mental health system. Last year more than 700,000 people with serious mental illnesses were arrested. Today between 300,000 and 400,000 people with severe mental illnesses are in jail and in prisons. Another 500,000 people with severe mental illnesses are on probation. Our jails have become the largest psychiatric warehouses. It's not fair to call them institutions because we do not provide treatment very well in this setting. Since conditions are not conducive in jail for treatment people with mental illnesses stay in jail on average eight times longer than someone without a mental illness for the exact same charge at a cost of seven times higher. We did an interesting study last year. We took 31 people who were arrested the most, who had severe mental

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illnesses and we figured out how much it was costing tax payers to provide acute care services only. 31 people cost \$540,000 in one year to do nothing because that is the case that you must pay to provide the acute care. By acute care we mean jail, crisis stabilization and emergency room care. It would cost about a quarter of that to provide them with actual treatment to keep them out of our system. The sad irony is that we did not deinstitutionalize. We allowed for the trans-institutionalization of this population. What in fact we have done is we have made our jails the asylum of the new millennium. The consequences of this system has been increased homelessness, increased police injuries, increased police shootings of people with mental illnesses, wasted critical tax dollars and the reality is that we have made mental illness a crime in this country. In Florida our police on average handle more mental health calls than burglaries, assaults and DUI cases yet the police rarely if ever receive any kind of training to deal with this population. While the justice system may not be responsible as Dr. Satcher said for this problem we clearly must be part of the solution. None of us created this problem alone and none of us will be able to fix this problem alone. It is going to take a huge collaborative effort between the traditional providers of mental health and us non-traditional stakeholders, the judiciary, corrections, the police, the state attorney, the public defenders to really

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come together to try to solve this problem. We've been fortunate in my community. It's interesting fortune comes at different reasons and we happen to have the largest percentage of people with mental illness of any urban area in the United States, 9.1% of our general population. That's over 210,000 people in our community suffer from a severe mental illness. Out of necessity we needed to come together and come up with some solutions. We had a two day summit about five years ago where I personally invited all these traditional and non-traditional stakeholders to a meeting. It's good to be a judge as they often come.

[Laughter]

For two days we analyzed our problem in our system and what we found was very interesting. A, we found that we were embarrassingly dysfunctional but more importantly what we found is that none of us were really participating in this problem out of any type of malice. It really was that we're also busy doing our jobs. No one was looking at the larger picture. The police were policing. The judges were judging. The prosecutors were prosecuting. What we realized after spending time and none of us had even met each other before. It was really the melding of the mental health community with the criminal justice system but what was happening is one individual with mental illness was accessing the services of everybody in that room. People with mental illness may be the most expensive

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population in our society because we treat them the way we treat them. So what we have to do is come up with collaborative efforts. We have to activate strategies that provide pre-arrest aversion programs. We need to teach our police how to identify people who have mental illnesses and deescalate situations and divert people to treatment. We need to work out post-arrest diversion programs in our criminal justice system. We are not very good at treating chronic illnesses as judges. We need to make sure that people who are ill get access to the treatment that is out there. By employing those types of strategies we can be extremely, extremely successful. In Miami-Dade County alone we were able to reduce our misdemeanor recidivism rate from over 70% to 18% last year. We have improved our public safety. We have significantly reduced police injuries. We're getting our police officers back to patrol in about half the time it took to make an arrest. We're saving our county over \$2.5 million a year by keeping people in the mental health system rather than the correction system. We're saving lives and more importantly we are decriminalizing mental illness. It is our hope that as we further develop and employ appropriate diversion strategies we can accomplish what the Supreme Court originally set out to do 40 years ago and also reverse this trend of criminalization.

Thank you.

[Applause]

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GREG MATHIS: Thank you Judge Leifman. That was some rather good news. Our final speaker is Dr. Nicholas Freudenberg. He's a distinguished professor of urban public health at Hunter College in New York. He is an author of one of the articles we are releasing this morning that appear in the October issue of *The American Journal of Public Health*. He has vast experience developing, implementing and evaluating interventions to promote health and prevent disease in low income communities in New York City and in the jail setting. Welcome if you will Dr. Freudenberg.

[Applause]

NICHOLAS FREUDENBERG, Ph.D.: Good morning. Each year more than ten million people are locked up in our municipal and county jails. The correctional facilities that hold detainees awaiting trial, those sentenced to less than one year and parole violators. In the last two decades the US jail population has increased by 265%. Most people return home from jail within a few days, weeks, or months of arrest giving jails a close connection to our nation's poorest communities. My message this morning is to encourage us to consider the role of jails as well as prisons public health. In the last 20 years police, drug, mental health, and employment policies have become a funnel into jail for our nation's least healthy populations. As we've heard people in jail now have substantially higher rates of HIV infection, hepatitis C,

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addiction, psychiatric conditions, asthma, serious dental problems and diabetes than comparable non-incarcerated populations. Since many of those in jail have difficulty gaining access to health and social services in their communities jails present a unique opportunity to connect people returning home with the help that will enable them to turn their lives around. Developing programs and policies to keep people out of jail rather than making it easier for those released to resume drug use, endanger their own health and return to jail have the potential to improve community health and public safety while saving taxpayer dollars. Unfortunately few people in US jails now get the services that could protect their health and the well being of their families and communities. In the study my colleagues and I published in today's issue of *The American Journal of Public Health* we followed for one year 491 male adolescents and 476 adult women released from jail in New York City between 1997 and 2002. This is one of the largest studies following a general population of people leaving jail for an extended period of time. What we found shows the difficult life circumstances people leaving jail face and the extent to which local, state and federal policies complicate rather than facilitate successful reentry from jail. Our study also shows that people leaving jail can make positive changes in their lives and that modifying Medicaid, employment and housing policies could

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contribute to significant reductions in recidivism. In the study we interviewed people in jail shortly after they were arrested and again one year after release from jail. We found that compared to the time of arrest one year after release the male adolescents reported that they were less likely to get money from illegal activities or to depend on families or friends for financial support however only a third were working, the same proportion as before arrest. Young men also reported substantial reductions in drug use in the year after release. One year after getting out the adult women were more likely to be enrolled in educational programs and reported significantly less use of heroin, cocaine and crack. More than half the women reported participating in drug treatment programs both before and after arrest suggesting that many women want help for their addiction. We also looked at factors associated with re-arrest in the year after release. We found that for young men, having a job in the period after release reduced the likelihood of re-arrest by two-thirds. Unexpectedly we found that having health insurance which for this population was primarily Medicaid reduced the likelihood of arrest by more than two-thirds. For the women having health insurance in the year after release lowered the risk of re-arrest by more than 80% and more job income was also associated with lower re-arrest rates such that each \$100 increase in weekly salary up to \$500 was associated with a 24% reduction in the likelihood

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of re-arrest. Our study also suggests that current federal and state policies of terminating Medicaid coverage upon incarceration endangers community health and public safety and costs rather than saves taxpayer dollars. Leaving jail without health insurance makes it more difficult for people to get prescription drugs for psychiatric conditions, HIV and other sexually transmitted illnesses, and chronic conditions like asthma and diabetes. It also makes it harder for people returning from jail to get the basic health care that can manage and prevent health problems and avoid expensive hospitalizations and emergency room visits. Federal law allows states and municipalities to suspend rather than terminate Medicaid coverage but most jurisdictions don't avail themselves of this option. In addition since employment is associated with lower re-arrest rates the many barriers people face leaving jail and finding work may increase recidivism. Reducing legal barriers to job discrimination against people returning from jail and prison and developing job training and placement programs for this population can also contribute to improved public safety. In 2002 the New York City Independent Budget Office found that the full cost for one year of incarceration in New York City jails for one individual was \$92,500. Lowering our nation's unacceptably high incarceration and recidivism rate does not require spending more money but rather redirecting the wave of money now being spent locking

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people up. By rethinking our national goals for people leaving jail and by focusing on health and employment we have the opportunity to improve the well-being of our nation's poorest communities to reduce the disparities in health that distinguish poorer communities from better off communities to sustain improvements in public safety over the long term and to make more money available for other pressing needs like public education, health care and rebuilding our infrastructures. It's time for public health to go to jail to help to achieve these goals. Thank you.

[Applause]

GREG MATHIS: Thank you. I think that all of our experts have brought some very enlightening information to us this morning. Would you agree?

[Applause]

We've been very fortunate to hear from them on the prison cycle in health care and I think we can all agree that it's in need of correction. I'd like to invite all of our speakers at this time to participate in a discussion to explore some of the more in-depth issues that we are dealing with here today. I'm going to begin with a question that I'd like all of our panelists to address and the first one is one that's kind of personal if you will. I'm really interested in knowing whether the mental health issues and challenges that so many urban youth and rural youth in poor and impoverished areas are

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challenged with you hear all the time attention deficit disorder, oppositional defiance, bipolar disorder, all of these things are what causes some of our young people to engage the criminal justice system at such an early age. It's chemical imbalance in the brain. As a result ultimately they can identify them at an early age as at risk for prison or put them in special ed if you will. My question is whether these are once again all physiological, biological disease that cannot be treated or they're born with or cannot be helped without treatment or are they born with it or is it partially environmental as a result of what I compared earlier to post traumatic syndrome? For example surely those victims of Hurricane Katrina have been traumatized particularly the children beyond measure. Many of them will grow up believing that they were left behind whether it's real or perceived by their government, friends and loved ones, feeling rejected by mainstream society in the most prevalent and public way. I can't help but think that they're going to be full of anger and unless treated we're going to see some of the same type of behavior that we see in other youth who come through very traumatic experiences. So is it physiological? Is it environmental or a mixture of both that causes some of the defiant mental challenges that we hear so much about? Dr. Satcher let's start with you.

DAVID SATCHER, M.D., Ph.D.: Well yes.

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[Laughter]

Seriously in the report that we did, the Surgeon General's report on mental health that came out in '99. What we tried to do was to summarize all the researches that have been done on the brain over the last 30 to 40 years. I think one of the major messages from that research is that we can no longer separate environment and biological. That in fact environmental experiences lead to changes in the brain. Now obviously some people are born just like with diabetes with a predisposition for some of these brain changes more so than other people but clearly we now know that having an experience and you gave a good example of about 15% of Vietnamese veterans have post traumatic stress syndrome. We know that. We know that many of the people coming back from Iraq will have post traumatic syndrome. We estimated that after 9-11-2001 I think about 9% of the people suffered post traumatic stress syndrome. The only problem is we don't know when people stop beginning to manifest post traumatic stress syndrome so some people feel that even the elderly will feel some post traumatic stress syndrome that they may not have experienced before. In other words not all of the people who are going to experience post traumatic stress syndrome from Vietnam have yet experienced it. I think I mentioned Felton Earl's study earlier that was published in the Journal of Science in which he studied children on the streets of Chicago. It's really consistent

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with what you said. Felton showed after five years of study and everybody really applauded the quality of his study that children who witness violence on the streets of Chicago especially murder were twice as likely to be involved in that kind of violence later regardless of socio-economic status. And then you try to explain what does that mean. It seems as if that kind of experience triggers changes in the brain, imprinting that people suffer from from then on but I think we also have to remember that not all of us come to any situation with the same biological makeup. If you're from a parent, from a family that has a history of diabetes you're gaining weight means that you're more likely to get diabetes. Whereas somebody else's gaining weight might get diabetes but might not be as likely as somebody who has a greater genetic predisposition. Clearly I think we've reached a new point in science where it is no longer possible to separate environment from biology as we did in the past and we now know that environmental experiences can lead to biological changes.

GREG MATHIS: Any other comments from our other panelists?

NICHOLAS FREUDENBERG, M.D., Ph.D.: [Inaudible] who were the [Inaudible] certainly there are I work with [Inaudible] certainly there are young men and [Inaudible] moderate to serious [Inaudible] much more struck by what that that could do with all younger people, pieces, tools [Inaudible] system with

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[Inaudible] over the last five years at the federal level
[Inaudible] \$5 billion [Inaudible]. It seems to me that our
first priority perhaps [Inaudible] school system for all young
people [Inaudible] jobs available [Inaudible]. Those in health
[Inaudible] there will be some looking for that but [Inaudible]

GREG MATHIS: Let me ask you Dr. Freudenberg, in New
York's school system is there an adequate number of social
workers there to deal with I'm sure the answer is no but if you
can expound on it to deal with the pathologies that the young
people are bringing from dysfunctional homes, where they're
coming from homes where the parents are drug or alcohol
addicted, impoverished and all the other things that we know
they experience, the human suffering that is experienced as a
result of poverty. I'm convinced and perhaps you can enlighten
me more that because mine is kind of bootleg research if you
will just personal observation but I think that in many
instances society has its head in the sand as it relates to
educating our young people. We see all this finger pointing in
our school system where the teachers want to blame the parents
and the parents want to blame the teacher and the
administrators want to blame the media and violence in the
media and of course everyone wants to blame the politicians.
I'm convinced however that one of the root causes of the
failure of the public school system is that we're dealing with
old models and old paradigms which no longer apply today where

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decades ago you didn't have to worry about a child coming to school with so much social dysfunction in his life and so much family breakdown. As we've seen the divorce rate increase, as we've seen drug and alcohol abuse increase over the decades we've seen dysfunction by students in school. Give us a little more insight on the correlation that you might have there in New York as it relates to the New York City School System.

NICHOLAS FREUDENBERG, M.D., Ph.D.: [Inaudible - No Audio] we're a city [Inaudible] I wanted to make one other point. The work I've done certainly there are people with [Inaudible] part of a [Inaudible] I watch a man who was struggling to [Inaudible] we kind of [Inaudible] Dale the first thing they all ask our staff is call my mom, tell her I'm okay, tell her I need this or tell her I need to call her. Any young [Inaudible] we do a very bad job of supporting families and helping families [Inaudible] public housing [Inaudible] we have two [Inaudible].

GREG MATHIS: Dr. Satcher.

DAVID SATCHER, M.D., Ph.D.: I just want to support that and I want to refer to our and I'm not advertising Surgeon General's reports but -

[Laughter]

But I know some of you didn't see some of the reports that we did and we did four reports on mental health. One of the reports I want to refer to is the Surgeon General's report

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on feeding children with mental illness and the other report was a youth violence prevention one that we did in 2001. All of these reports are available on the web through the National Library of Medicine, the Office of the Surgeon General. What struck me in the study on dealing with children with mental illness that we all know that children exist in this sort of web and that web includes home, school, for some of them church, community, maybe scouting but it's a web where all of these people interact with children. Basically what we said was that these are all opportunities for recognizing children who need help if you're talking about earlier diagnosis of mental disorders. Only about 20% of children get that help that they need according to our studies. What the people from the juvenile justice system said at that Surgeon General's workshop was that two out of three of the children who came through the juvenile justice system wouldn't be there if they had received the mental health care that they needed so two out of three children. The sad thing about that of course is that many of those children will get on this criminal justice track and they will never get off. So the contribution of mental disorders to people going to jail is very high indeed. In the report on youth violence prevention where we looked at all the things that Judge Mathis mentioned, video games, TV, all kinds of things. One of the things that we concluded of course was that what children probably need most in our society is funding.

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First and foremost is parent child bonding so when the homestead studies showed that when a nurse practitioner helped young teenage mothers bond with their babies violence was reduced by 50% in that population. By the same token children bond with community when children get involved in community and feel that they are part of it they are much less likely to end up in the criminal justice system. Finally we went to Australia and New Zealand before we released the first mental health report because I had heard that they had a very good system. One of the things that impressed me getting to Judge Leifman's point was that in Australia they deinstitutionalized the same as we did. The only difference was they actually established a community based mental health system. I mean home visits, community clinics, a very comprehensive system. They put the money into the community that had been in the institutions and they've had a much more successful outcome than we have because we didn't service that community based mental health system. They did.

GREG MATHIS: Benjamin. I'm sorry do you have? Go ahead.

LESTER WRIGHT, M.D.: I wanted to comment that we have looked at post traumatic stress particularly in the women and it's very high in imprisoned women. The other piece I would suggest is that we ought not single out mental health when we ought to talk about the entire person's health because I think

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they're totally related. To work only with physical or only with mental does a disservice to the individual we're trying to help be healthy.

DAVID SATCHER, M.D., Ph.D.: I agree with you. The problem is that we have ignored mental health. We are much more in our society people are much more likely to admit they have a physical health problem than a mental health problem because you get punished for being mentally ill so that was the point we were trying to make. You're absolutely right but where we start from is a system that will recognize physical health problems but where people feel embarrassed to even seek care for a mental health problem even for their children and so that was the point we were trying to make but I agree with you otherwise.

GREG MATHIS: Thank you Dr. Wright. I'd like to ask Judge Leifman who has brought us some very valuable positive information on the progress being made in Miami-Dade County. You've used the term we have not deinstitutionalized; we have re-institutionalized mental illness from state hospitals to jails. How do we more effectively treat mental illness? In the court system around the country for the last decade or so there's been drug courts. Those were popular and still are in many jurisdictions. I contributed to the starting of one in Detroit when I was elected. One of the I guess facets we neglected to address in drug court was the mental health facet

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and we know now that they are very intertwined and so should we begin pursuing mental health courts in and of themselves because in many instances a person drug addicted is self-medicating because of his mental challenges whether it be all the things we have mentioned or whether it be the environmental things that have caused him human suffering and therefore he's reaching out to cure the pain of that suffering. So should we have mental courts or are there some that I'm just not aware of. Go ahead.

STEVEN LEIFMAN, JD: Maybe.

GREG MATHIS: All right.

[Laughter]

STEVEN LEIFMAN, JD: First it's not exactly re-institutionalization because it's not exactly the same population that came out of the state hospital and has gone into jail. It's more trans-institutionalization. I want to be clear on that and not mislead anybody. I think I used trans-institutionalization. Drug courts are a wonderful model and they work extremely well but the problem is that drugs are illegal and therapeutic jurisprudence can be a very effective tool for someone who has a substance abuse disorder. You can put someone in jail, keep them off the drugs, and help give them incentive to stay off the substance abuse. You cannot do that with someone who has a mental health disorder. In fact sometimes keeping people in jail only adds to the mental health

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disorder so I think we have to be careful. We are seeing the beginning of mental health courts. It has a generic name but we're trying to use more of a diversion type model to do that. Mental illness is a chronic illness and I'm a judge. I'm a little dyslexic. I probably wouldn't make it in medical school. I don't want to be involved in prescribing medications and monitoring medications -

[Laughter]

Probably dangerous for them and me but I think what we should be doing is we should be helping setting up systems that access the mental health system and allowing the experts in the field to take care of this population and keep them out of our system. I think it's a good idea but we need to do it in a judicious way and I don't think we should apply the same old mental health court system. The other problem you face is you end up taking resources out of the community and putting it into the criminal justice system and creating another shift of funds. The funds are so limited in the mental health system I think we have to try to maximize those funds and put people back into those too.

GREG MATHIS: Any other comments on that subject, our panelists? All right. I would like to address an issue once again that's somewhat near to me and that is the reentry of prison inmates into society. 95% of the 1.4 million current prison inmates will eventually be released and our challenge is

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reentry into society. If they haven't been treated properly while incarcerated then they're going to come out sicker and slicker than they were when they went in because they're going to learn some new tricks from the old inmates and they're not going to change their ways. And we know unfortunately in the last few decades that our prisons have stopped rehabilitating for the most part and they're just efforts to punish and deter crime. When we do not set up a system of reentry into society we're really creating this cycle of a revolving door. I was fortunate in that and I use myself as an example because it kind of brings it home. I was fortunate to be able to have a mentor in my life who grabbed me by the hand and said hey we can take your GED that the judge ordered you to get as a condition of your parole and we can go and get you in a university because this university I attended my older cousin has an affirmative action program, plug for that, and you can get in with your 10th grade GED and went there and never turned back. By the way it cost that eight months I spent in jail it cost I'm told \$35,000 to house me in jail. That first year of college which was also taxpayer funded because I had no parents. My mother had died and didn't have a father, that was taxpayer once again sponsored and it only cost \$6,000 so I think it was a much better investment to educate me than to incarcerate me. But even upon completing college, completing law school, passing the bar exam I was not allowed to practice

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for three years because of my juvenile record. In many states as in the case of Michigan where I'm from it's discretionary, it's up to the state bar whether they will allow an ex-felon to practice. It's up to a committee of attorneys called the Ethics Board and they denied me for three years quite frankly. While others that I had known had committed very heinous crimes I saw them marching right through the state bar, getting their license, good luck Greg. It took me three years and so the door wasn't wide open and they weren't very welcoming as it relates to reentry into society. What can we do to facilitate reentry of inmates into society both from a mental health perspective and from a productivity perspective meaning we want to reduce the recidivism rate? Dr. Wright we'll start with you.

LESTER WRIGHT, M.D.: There are two separate issues. One of them is jails and one of them is prisons. In prison I've got the luxury that I can establish programs where we can build those referral networks and continuity of care. I actually give some of my budget to the Department of Health for HIV, the AIDS Institute put some of their budget and some Ryan White money and we hire community based organizations to help develop those kinds of plans. The problem is the very short cycle in jail. Somebody who is only going to be in less than a week, trying to establish a referral mechanism becomes very difficult however if public health has a presence there, if there is a

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collaboration so that even though we've only screened you here and you're getting out tomorrow morning we can give you a card and a phone number and a person that you can talk with and help them get in contact with you maybe we can do it but corrections can't do it on its own and public health can't do it on its own. It's got to be a collaboration.

GREG MATHIS: Judge Leifman.

STEVEN LEIFMAN, JD: A couple things, one is we really need to address some of these issues with policy makers because there're a lot ridiculous systems in place that don't work. Medicaid is a wonderful benefit for people who have mental illnesses however once you're arrested and you're in for more than 30 days your benefits are stopped. If you've been off the Medicaid for more than a year or you never applied it takes six months to get your first check. When you're coming out of jail or prison you need the benefit that day particularly if you have a serious mental illness. You need medication. You need housing. You need case management services. To allow people to leave a jail setting or a prison setting without that benefit immediately is ridiculous. One of the things that we can do which I think would be very cost effective would be to provide some type gap funding because the Medicaid benefit is actually retroactive so it may take six months to get a check but you get six months' worth of monies once the money is released. So what communities can and should be doing I believe is they

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should provide that benefit immediately upon release to the individual. They should sign an agreement with their local Social Security office and the consumer. Once they qualify for the money, the money should come back to the person providing that fund. You have a revolving fund. It stays whole. You don't have to go back every year to get more funding and you provide housing, medication and case management upon release. The other thing that you should be doing I believe is and Dr. Wright is correct. You need collaborative efforts. We've been fortunate. We've convinced our state to give us an "in case" case management specialist who's in court and they're linking benefits for the individual before they're released. We're finding housing. We're finding treatment facilities for people. You just can't let them walk out the door without taking them by the hand particularly the mental health population and getting them appropriately located. It's a waste of resources. Your recidivism rates go sky-high if you don't provide those kind of facilities and it's dirt cheap to do.

GREG MATHIS: So it sounds like it's really shortsightedness on behalf of society and our policy makers.

STEVEN LEIFMAN, M.D.: It's malicious like. I just think we have roles and there never has been someone in place to overlook that part of the system. People are doing their jobs. We just never created the job to take care of that part of the problem and I don't think we when we set up these

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institutions, corrections, police, etc. we never anticipated that we would become the primary receivers of people's mental illness so there was no system in place. We weren't prepared for this problem. No one warned us that they were going to release 500,000 people on the street. It happened and it's happened more quickly than people realized and we weren't prepared and now we have to catch up and put into place those systems that would protect this population.

GREG MATHIS: Dr. Freudenberg.

NICHOLAS FREUDENBERG, Ph.D.: [Inaudible] or supervise [Inaudible] just needing to discuss a legislative proposal that would remove the requirement for seeking employment [Inaudible] to disclose their felony conviction [Inaudible] drive a bus [Inaudible] not every job [Inaudible] requires disclosing [Inaudible] and I think that teaming of legal discrimination by these people who have never been [Inaudible] deterrent which is [Inaudible] dozens of occupations, barber, many people learn how to be a barber in prison and can't practice [Inaudible] then really [Inaudible] I think ultimately the real solution to our reentry problem is to lock up fewer people. We have the highest incarceration rate in the world [Inaudible]. There are too many people in prison [Inaudible] most people return to [Inaudible] disrupted and disorganized [Inaudible] let's say people less healthy using alternatives to incarceration, emerging programs, community boards, community sentencing,

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improving schools to keep people out of jail would actually be better for our society.

GREG MATHIS: And I think as I mentioned in my example it's certainly more cost efficient to rehabilitate and educate than to incarcerate. Certainly we want our violent criminals off the street but the overwhelming majority of those in our prison system today are not violent criminals. They are drug; they are in violation of drug laws, drug dealers if you will, essentially economic crimes, many of them first time offenders.

STEVEN LEIFMAN, JD: If I could just follow up quickly. We did a study of our jail population, those that had mental illness and we were actually struck by the numbers that actually came out. We had presumed that there'd be a lot more misdemeanors, people with misdemeanors with mental illness. But the reality is that the majority about 55% were third degree felons and in Florida that would be our least serious level of felonies. Only 35% of those were in drug direct felons, 65% which is about 1,000 people were in jail because of avoidable charges, resisting with violence and battery on a law enforcement officer. So what had happened is the officer wasn't trained appropriately to deal with someone who had a mental illness. The situation escalated because the officers are trained to become aggressive when someone's aggressive which is a good thing if they're dealing with someone who is not paranoid but it's a dangerous thing if they are and the

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incident would end up in altercation between the officer and the individual and they would arrest them on a felony. That's a lot of people you can take out of the system rather quickly and divert into appropriate treatment which would save everybody a lot of time and money.

DAVID SATCHER, M.D., Ph.D.: That's some very encouraging models of judges doing the right thing. There are also some models of police forces. I was in Rockford, Illinois, last year and somehow the police chief there took it on himself to say that he was going to train his policemen in enough mental health to work with the system and to deal with people with mental disorders. I think he's now working in some other city doing the same thing.

STEVEN LEIFMAN, JD: The program's called Crisis Intervention Team Policing. It's a model that comes out of Memphis, Tennessee. It's a phenomenal program. You cannot train every officer in the force. The best model works where train a percentage of the officers who are patrol officers. They become the experts in the field. You train your dispatchers on dispatching them on an appropriate call and you just train the other officers to bring them in when they're needed. The city of Miami had a horrible raid of shooting before CIT. We have about 100 CIT officers just in the city of Miami. They handle about 3600 mental health calls per year. They haven't fired a bullet in three years. They haven't had a police injury in

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three years. It is remarkable and their arrest rates have plummeted. We're keeping statistics for them because we don't want them to be systematically harmed by doing the right thing. We need to show that they're still working because they use the rest for benefits and it really is a wonderful program.

DAVID SATCHER, M.D., Ph.D.: Dr. Wright's program, connecting people to the public health system before they leave is a potential model that could be very helpful in other areas.

GREG MATHIS: I'm going to take my seat shortly and allow you all to give closing two minute remarks on how do we fix the public prison health system and very succinctly let us know what your viewpoints are on fixing this broken system. But I'd like to wrap-up my own remarks by stating that once again I think that our society and our policymakers must recognize that it is shortsighted to wait and invest huge sums of money to people on the back side of life when on the front side of life whether it's Head Start, whether it's preschool, whether it's mental health, whether it's counseling and treatment centers more prevalent and available in areas where poverty and human suffering is occurring it's a lot less expensive to treat on the front side than on the back side of life where prison population of nearly two million men and women costing taxpayers in excess of \$60,000 per person to care for. It's ironic that we pay on average around the country \$7,000 to educate our K-12 yet \$60,000 for our juvenile

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detention centers per year. Lastly I think we must reassess the approach we've taken to locking our young people up. I keep referring to youth because the average age of prisoners ranged from 19 to 25 so they come young. The approach to locking them up and abandoning rehabilitation began in the late 70s with this law and order push by legislators around the country who wanted to be elected and then reelected and the best way to do that was to scare the public and tell them to vote me, I'll lock them up and throw away the key. I'll implement mandatory sentencing and they'll never come home again. Well they did come home and they continue to come home. They come home as I said without having been rehabilitated and it's more costly to our society. I think that a better approach would be that once again we invest in educating and rehabilitating and treating those who are in need so that we don't have to continue spending that amount. I think once again I am the best example of having spent \$6,000 a year taxpayer money to educate me after having spent \$35,000 for an eight month incarceration period. Taxpayers paid a lot less and now I'm fortunate to be one of the highest taxpayers in my state as a result of your investment.

[Laughter]

Let me allow once again our panelists to give their final remarks if you would please.

DAVID SATCHER, M.D., Ph.D.: Well I want to take part

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of my two minutes and say how inspiring your life story is.
I've heard some of it before but.

[Applause]

Somehow we've got to make sure more of our children hear your story and stories like it because we just don't hear many stories like that and it's just a tremendous story. We thank you for all that you've done and you continue to do. I believe that we need to start with our children. I believe that we need to invest more in children in this country. I think it would be the greatest investment that we could make. The returns on that investment would not only prevent a lot of crime and other problems but it would help to produce a lot of people who could contribute significantly. Unfortunately we haven't said it but African American and other minority children are much more likely to end up in the juvenile justice system than majority children. Certainly some majority children do too but we know the disproportionate impact of this environment if you will on our children. You can see it in every city in this country, certainly in Atlanta if you look at the prison population. So these children who are less likely to have access to health care, basic positive environments to grow up in are more likely to be the victims and to end up populating our jails and prisons. I think we should all push for investing more in our children. We should all push the development of a health care system that meets the needs of all

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people. A prison system that is actually there to help people regain their stability in life and to go back and be productive. Again if we invested in that and I'm really happy about some of the things happening in New York State, I think we would reap the benefit. I just appreciated being involved in this and I also want to thank the Kellogg Foundation that's done so many great things in this country and in the world for support of this effort.

MARGUERITE JOHNSON: I want to echo something that Dr. Wright said which is that we need to think of folks that are returning to communities from the criminal justice system. We need to remember that they are whole people so that no matter where they reenter into a community whether it's they appear at a community health center or a men's health clinic and thanks to Community Voices we have several models of clinics that are set up just for men. Wherever they show that they are able to get all of their needs met so whether it's they have a clinic visit they should be directed towards housing assistance. If they go to a job assistance office they should be directed to mental health treatment if they need it. I think that we need to be able to serve the needs of people in a holistic way and make sure that by working together and developing these collaborations between service providers and also taking down some of those public policy barriers that prevent us from doing that we can be able to provide people with all the things that

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they need and help them access those services in an easy way. After all as we've been hearing it's only when we have all of those needs met when we take care of all of the needs that someone brings back to the community with them will they be successful in staying out of the criminal justice system.

LESTER WRIGHT, M.D.: I appreciate being able to be a part of this as well as it's been helpful to me and I hope for others. I appreciate APHA and the Center putting this together. I was reflecting on the difference again between prisons and our opportunities and jails. My newest unit that I'll be starting shortly is a unit for people with dementia. If you put people in for the rest of their life and throw away the key you're going to have people with Alzheimer's in prison. I've got them. I've got enough to fill that unit right now. I think what we've got to do is and my average population by the way is 35 in our system but what we've got to do is two pieces. One I think we've got to work all of us in society to change the conditions that send people down a path that gets them into corrections. Secondly we recognize we've got to recognize that we've got a large number of people who are already down that road and we've got to work together all of us together, corrections, health, public health, mental health to make sure that we get them the care they need while we have and when they leave. Thank you.

STEVEN LEIFMAN, JD: I think everyone agrees that when

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someone commits a crime they probably should be punished but as we've become more sophisticated and we're understanding more we're finding things particularly that have really struck us in our research. We're finding that minority women who are in jail with mental illnesses have an extraordinary high rate of trauma induced psychosis. Many of them have been sexually abused as children. It manifested itself as some type of mental disorder resulting in incarceration. We need to be sensitive to these issues and deal with them appropriately because we're compounding the problem at this point by re-incarcerating them. I suppose if I had a magic wand what I would do is what I'm finding is that the disease itself is highly complicated but the solutions really are not. I would require every community to hold a summit one or two days with all their traditional and non-traditional stakeholders in their communities. I'd have them map out their system where the criminal justice system intersects with the mental health system and come up with solutions to provide strategies such as the pre-arrest diversion strategy such as the Crisis Intervention Team police models. I would also employ post-stress strategies within the jail system for lower level felonies and all misdemeanors. I think if we started to do that you would see a significant reduction in the problem but more important I think what you would see is you would build a political coalition that is extremely powerful between the judiciary and law enforcement

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that can have a larger impact on policy makers because it's a different set of people approaching policy makers on an issue that really certain brands of conservatism have made it a little bit more difficult to address. I think you bring in these new partners of police officers and they're talking to their legislatures about these issues in a different way. It really changes the picture and I think we could be a lot more effective.

NICHOLAS FREUDENBERG, Ph.D.: [Inaudible] short term [Inaudible] I think it's that [Inaudible] the long term goal I'd like to see [Inaudible] incarceration [Inaudible] long term the less you lock up for [Inaudible]

GREG MATHIS: Thank you. I would like to once again thank our distinguished panelists. As well we want to say a very special thank you to Community Voices for bringing us together. Give them a hand.

[Applause]

As we leave I just want to remind everyone once again that Hurricane Katrina in a real way exposed to us the challenges brought on by poverty, no access to health care, no bank account, little social support, and coincidentally or not that is the same population, high risk population that we find in our prison system overwhelmingly majority Black and Latino who have lived in poverty and have no access to health care and no access to all the other functioning systems that are

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necessary to live productive lives. So as we move forward we hope that each and every one of you will take that message back to your policy makers. Thank you all once again.

GEORGE BENJAMIN, M.D., FACP: I know that Dr. Satcher has to run. I want to take a few questions from the audience if David you could take a couple. Yes.

FEMALE SPEAKER 1: I'd like the doctor from New York to speak to the contracted medical services. There have been reports in New York Times about horrendous events because patient symptoms were disregarded in the early stages.

LESTER WRIGHT, M.D.: I can speak to that by saying that New York State prison system does not use contracted services of that kind. The only contracts we have are with individual physicians and medical groups around the state who are the same people who are treating everybody else in the community. We have chosen not to use the contract niche marketers in the state. The Times was writing about New York City jails. There's a big difference.

[Laughter]

JACKIE WALKER: Hi. Jackie Walker ACLU National Prison Project. We know that the rates of incarceration among women have been increasing since the 90s and oftentimes outpace HIV rates in women are higher, oftentimes rates of hepatitis C. Could the panel talk a little bit more about some of the unique challenges facing incarcerated women, the health care problems

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facing incarcerated women?

NICHOLAS FREUDENBERG, Ph.D.: [Inaudible] in a program we rolled out [Inaudible] in city jails [Inaudible] a quarter of the women who were a patient. [Inaudible] sky high [Inaudible] the primary reason for that is that the more of the women in jail [Inaudible] so that's when women need special services around addiction [Inaudible] gay women in jail have children [Inaudible] to balance their own [Inaudible]

GEORGE BENJAMIN, M.D., FACP: Let me also refer you to an editorial in the Journal by Dr. Braithwaite [misspelled?] and her colleagues that talks about the health disparities and incarcerated women which I think is an extraordinary editorial. Yes sir.

MALE SPEAKER 1: Potential costs [Inaudible] possibility of health care [Inaudible]

[Laughter]

STEVEN LEIFMAN, JD: I'm a judge I have no party affiliation.

[Laughter]

MALE SPEAKER 1: But I just think that it wouldn't and know [Inaudible] am incarcerated and finally that a warden could pick up a phone and say I've got a problem, here help me. And the neighbor had an officer of correctional education but then the US Department of Education Committee year had been highly successful in [Inaudible] model and so I'm hoping that a

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call to action of the Surgeon General that we're all waiting for to happen would include this. I hope that you could maybe give us any update or any progress report or any advice that we could begin that should make [Inaudible] reality.

GEORGE BENJAMIN, M.D., FACP: Thank you, Charlie. Dr. Satcher.

DAVID SATCHER, M.D., Ph.D.: Well I think the Surgeon General's report would help. We had because of your visit we had on our list of reports to do a report on prison health. We didn't because we had an election so that's changed things. But Richard Karmona [misspelled?] is working on a report on prison health and I just started with him the day before yesterday so I'm hoping that we will have this Surgeon General's report on prison health. I agree with you. I think there's so much we can do to solve many of the problems that we're talking about and especially the reentry issues and the partnership between public health and criminal justice. I appreciate your leadership in this area and I remember very well your visit.

GEORGE BENJAMIN, M.D., FACP: I want to make sure we get folks that have the mikes because we are trying to record this. And we will get a mike over to you.

FEMALE SPEAKER 2: I have a question at the risk of being sensationalistic. It's about what's happening in Louisiana and if the American Public Health Association or the

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community groups are pushing for transparency about the disappeared prisoners. I guess there's over 300 disappeared prisoners from New Orleans and apparently the local and the federal people have been in. The state hasn't been in and we haven't heard anything about it. I was wondering if anybody knew anything about it.

GEORGE BENJAMIN, M.D., FACP: I'm not sure what you mean. Why don't you describe disappeared. I know we pulled the

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FEMALE SPEAKER 2: There are over 300 prisoners that haven't been accounted for in New Orleans. It was reported last night on Pacifica. I haven't heard it anywhere else and I was wondering if public health groups are pushing for transparency and accountability.

GEORGE BENJAMIN, M.D., FACP: I can tell you that we certainly went and pulled all the press accounts and asked the critical question what happened to the prisoners. As you know there was a lot of concern because they like many of the other people in the area were in effect sheltered in place. There are several news stories about their transport and the health care that they received. We will look into we'll ask that question.

FEMALE SPEAKER 2: There hasn't been any accounting about the cells that were not unlocked in New Orleans. There has been no accounting of the bodies there.

GEORGE BENJAMIN, M.D., FACP: I think those questions

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need to be asked. That's a good question.

NICOLE RENZI: Hi. I'm Nicole Renzi [misspelled?] from ASTHO, the Association of State and Territorial of Health Officials. We're planning a multi-state roundtable on correctional health for this coming November and mostly focusing on HIV, substance abuse and mental health issues in the correction system involving people from the local jails, the community, state public health, the prison systems and probation and parole and what these states are intending to work on at this meeting is to develop plans to create systems that work on prevention and care of all of these issues across the corrections continuum is what we're calling it. We're hoping to, excuse me, we're hoping to bridge community and correction system prevention and care services. I was wondering, this question is for anybody on the panel, if you all have any advice for states who are taking on that type of task or what they can do in order to encourage collaboration and bridge all of these different systems?

STEVEN LEIFMAN, JD: I would strongly advise that you contact the Council of State Government. They have a report that they released last year. I'll give you an individual name when we're done. Also the Gaines Center out of Delmar, New York, is probably the Lexus or Cadillac of forensic mental health in diversion programs. Those two agencies are working very hard right now with policy makers to help make that

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happen.

GEORGE BENJAMIN, M.D., FACP: Yes there was a lady up here who's raised her hand several times.

BONNIE SOSAN: I'm Bonnie Sosan [misspelled?]. I'm the CIT coordinator from NAMI. I wanted to thank the panelists that were praising our program. I certainly appreciate it. I guess my main question would be in our field of health care and corrections we always seem to have a retroactive way of looking at our problems for example now that we have the deinstitutionalization of the mentally ill what are we going to do and so far and so forth so what would you say as someone who's in charge as the CIT program what's the best way to look at this proactively? And what's the best way to get communities involved instead of having to wait ten years, show them the statistics of look at the trouble we're in now. What's a more positive way and refreshing way of looking at this and starting off on the right foot instead of waiting five years down the line?

STEVEN LEIFMAN, JD: Public safety, it saves taxes and it reduces police injury.

LESTER WRIGHT, M.D.: I don't think you have to wait five years. The data are there at this point.

STEVEN LEIFMAN, JD: Right we can give ours.

LESTER WRIGHT, M.D.: But you've got to do both the retrospective because that's a real problem as well as starting

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on the other.

BONNIE SOSAN: and having more people come in and comment they feel as if they are being corrected, things of that sort. There's always going to be bureaucracies so what do you what's perhaps a new language that we can set forth?

NICHOLAS FREUDENBERG, Ph.D.: [Inaudible] civil rights organizations [Inaudible] this isn't only a technical issue for our criminal justice and public health problem [Inaudible] New York City shows most families [Inaudible] strong support especially [Inaudible] communities for rehabilitation [Inaudible] mobilize the reports [Inaudible] organize them put pressure both on the managers and the elected officials [Inaudible]

LESTER WRIGHT, M.D.: I'd also suggest none of us really react well to somebody saying I'm from Washington. I'm here to help you. I'm from Albany I'm here to help you.

[Laughter]

What we need to do is to find a way to say we've got a problem in society what can we do together rather than something that sounds like an attack.

STEVEN LEIFMAN, JD: Also in the way we ask and one of the things of our collaborative effort is we found the judiciary's in a wonderful position to bring the police in to even have the dialogue. We've started a judge's initiative with the Council of State Government and Gaines Center to get

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more judges involved to help lead this effort. It's a good place to go. Go talk to your judges they're elected to.

FEMALE SPEAKER 3: Good morning. I come from another perspective in terms of looking at the HIV issue and the transmission and what's happened in prison and how that impacts people once they reenter society. What I've noticed in looking at the data over the years we've seen broadly speaking HIV rates have gone down in this country but if you look at what's happened within the African American community it's literally exploded particularly among African American women who make up about 70% of new HIV cases. If we look at this issue of what has happened as a result of the war on drugs which one may argue has largely targeted Black men to use Judge Mathis' war analogy I would argue that Black women are in many respects the collateral damage of this war because what happens to these men when they come out and they go back into their communities after being in a situation where they have increased likelihood with being in contact with virus is they get out and then they spread it within the community. I'm wondering do you see that connection. Has your research really covered up a connection there and is it just something that anecdotally I'm just seeing, I'm just noticing that it's happening at around the same time? If so what should be done about it?

NICHOLAS FREUDENBERG, Ph.D.: [Inaudible] the program called Real Man we engage 16 to 19 year old guys thinking about

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what are the facts of manhood particularly for young African American and Latino men. What's [Inaudible] man that protects your own health and we're putting this in partnership with a certain organization that also provides GED, school programs, employment programs, etc, etc. I think the need to bring the analysis this has brought to women and HIV also to men. Look at how [Inaudible] and a notion that one of these [Inaudible] women and play out how we can work with the health people in other ways of fulfilling those roles.

GEORGE BENJAMIN, M.D., FACP: Someone back here.

EVANDER ROBINSON: Evander Robinson, Bureau of Rehabilitation. Most of your discussion this morning has centered on local and state jails. I'd like to have some insight, your insight, on contrast and comparison of health care issues and mental health within the federal system.

GREG MATHIS: Certainly I was a state [Inaudible] in Michigan, didn't have much contact with the federal court system there or its probation or prison populations however as I travel throughout the country it's been my assessment that certainly we need federal policies that follow the federal mandatory sentencing that we've seen over the last two decades that have caused the skyrocketing prison population particularly among Black and Latino men who the overwhelming majority are there for selling drugs quite frankly. We find that the federal prison system has fallen short on addressing

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once again the aftermath. It just addresses any rehabilitation and education portion. It addresses primarily just the arrest and incarceration and sentencing and has kind of thrown its hands up and has had very little, made very little effort to provide for rehabilitation and reentry to society so I think that's one of our challenges that we need to pursue on the federal level. For example in the last two decades and I keep referring to that because it really changed around the late 70s and the 80s. Our whole approach to incarceration and the penal system and the de-emphasis on rehabilitation changed around that time. Since that time we've seen for example our federal education budget has barely kept up with the rate of inflation. Indeed some in the 80s wanted to eliminate the Federal Education Department altogether saying that it was a state's rights issue. On the other hand in those two decades the prison funding for the US Prison Bureau has tripled, went up by 300%. Lastly in every state in America we found that in the last two decades once again the prison budget has been nearly ten times that of the education budget. The increase in prison spending has been nearly ten times that of the increase in the education budget and that's in every state. Where I'm from, Michigan, which prides itself as an education state that doesn't mind spending for education, well our education budget has increased by only 23% in the last two decades while our prison budget has increased by 227%. So once again we have

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found this misplaced priority investing more in incarcerating than in educating and rehabilitating so it's both state and federal level. The federal government in my opinion has done a worse job than the state has.

GEORGE BENJAMIN, M.D., FACP: Thanks Judge Mathis.

Right here.

RAYMOND KRULL: Raymond Krull [misspelled?] National Mental Health Association. I first want to thank APHA for this issue and for addressing this issue and for the panelists for being here today. Two part question for me, the first part has to do what are the and this goes directly to what you were just saying Judge Mathis, what are the factors that have led to and continue to support the criminalization of mental illness and poverty in this country because we seem to be talking about an issue of poverty very much here. I think we haven't had a discussion on poverty in this country in 20 years. This may be about time. The other piece is that what do you all see as opportunities emerging opportunities to push for change beyond the development of pilots and models so it's a meaningful and lasting change in how we address these issues?

JUDGE MATHIS: As a former political operative if you will I kind of made my bones running campaigns when I was in college and after leaving college I learned a lot about how public policy is affected by public opinion. All our elected officials and policy makers swear they don't govern by public

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opinion polls but they're lying.

[Laughter]

They do. All the ones I've worked for, the congress people, the council people, the mayors and presidential candidates whom I've worked for they all made their policy decisions based on public opinion polls so may I just worked for all the guys who don't tell the truth, I don't know. In any event so my answer is public opinion needs to be affected in a way where it's one put on the forefront. If these issues are brought to the forefront of society and then society makes their opinions known to the policy makers. Unfortunately it may be a byproduct of what we've just seen with Hurricane Katrina. A byproduct of that might be that if there's any good to be taken from that experience is that now poverty will be on the front burner of American society and public opinion toward addressing poverty will once again be favorable. I think in my opinion we will see the public more concerned, more considerate and more compassionate toward the poor in addressing poverty as it were throughout America.

LESTER WRIGHT, M.D.: Longer than two weeks?

[Laughter]

GREG MATHIS: I hope so. I think we can if our community leaders continue to remind our public of what poverty does in this country.

GEORGE BENJAMIN, M.D., FACP: Judge Leifman.

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STEVEN LEIFMAN, JD: There's a specific piece of legislation that was recently passed on a bipartisan level between Senator DeWine and Congressman Strickland the mental health offender rehabilitation act it may be called. Now they're trying to get it appropriated. I think that would be a good start to get your constituencies to urge their local senators and congress persons to help get this funded because it would go a long way. It puts money in for diversion and creating collaborative efforts in communities to do what we're doing locally.

GEORGE BENJAMIN, M.D., FACP: I think we have time for one final question, back there.

MARNA GELLAR: Good morning my name is Marna [misspelled?] Gellar [misspelled?] I'm with the National Center for Primary Care. I think that it's well known that the majority of the populations in prisons are African American males but I don't think it's well known that as early as the second grade the majority of children in special ed classes are African American boys. So my question becomes has there been any studies to show such a correlation? And the second part is has there been any movement for departments of education or correction systems to work together to prevent that link in terms of African American boys being tracked into special ed and then eventually ending up in the juvenile system and thus the prison system?

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NICHOLAS FREUDENBERG, Ph.D.: There's a very good report put out by the Harvard Civil Rights Project called the School to Jail Pipeline that documents the tracking system from the earliest grades and how it systematically pushes African Americans and as you say particularly males into a tract that leads into jail and prison. I think the report is available on their website and it's worth looking at. I've also had encounters with community groups particularly in the South who are doing community education and organizing around the connections between the school system and criminal justice system. If you talk to me afterwards, I can suggest some people you might want to talk to.

GEORGE BENJAMIN, M.D., FACP: Thank you. I'd like to make one other introduction just to note that the chair of the board for the American Public Health Association, Dr. Linda Degudis [misspelled?] is in the audience and Linda would you please stand and be recognized.

[Applause]

With that I'd like to bring our final speaker to the podium for some closing remarks, Dr. Henrie Treadwell. Dr. Treadwell is the senior social scientist and the associate director of development at the National Center for Primary Care at the Morehouse School of Medicine. Of course is our major collaborator with this project. Dr. Treadwell.

[Applause]

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HENRIE TREADWELL, Ph.D.: Thank you Dr. Benjamin and Dr. Northridge the editor and to all staff, panelists, writers. This has been a labor of love for us. It is my job but with Kellogg funding to work every day to provide access to health care for the underserved and for the poor with my staff from the National Center and with many from around the nation. We did not decide that we really wanted to focus necessarily on people in prison, adolescent care, the juvenile justice system but we've learned that we cannot provide access to health care in this country for everyone unless we pay attention to our men and the impact that their health and their being removed from our communities has on the rest of us. We are a nation that professes to love women and children but we have forgotten the important ingredient the men in our community, in our lives, our sons. This issue addresses a topic that has been implied today but that is politically incorrect. We are hoping that with the shoulders of so many of you to stand upon that today we will have more support as we speak on this important perhaps no more important issue in our nations history than this one. The people displaced by Katrina pale in comparison to the people displaced by our criminal justice system. I'm a shameless promoter of materials and one is this journal.

[Laughter]

I think the artwork is fantastic and I encourage you to really share it with many. The pictures portray the horror that

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people in prisons face and that we in communities face as a result of injustice. We've talked about Katrina today and I want to refer you to the annual report from the National Center for Primary Care that's on the table there. On page 14 Judge Leifman's community is portrayed. I don't want you to look at this picture and think about Katrina. This is a day in the life of poor people in Miami so we have many Katrina's that are going on now and these are people that we seek to cover and there is no federal program to help us do so. We have heard many times in the past few days about the federal government doing its part to help in the recovery of the states in the southeast. We need for the federal government and the state government to do its part in helping us in communities cover the uninsured, the poor men in prison and in fact the work of Community Voices is not only to provide coverage and connect people to services but also to help strengthen our safety nets our hospitals, our clinics which are being decimated by the burden of caring for the uninsured. I urge you to work on all levels, research, programs in communities and with our policy makers. There are some high level solutions that are needed and there are some simple solutions such as patient navigators simply to take people who have lost their way by the hands from the doors of prison to other places. We have legislation like this before the Congress now for people with cancer. Being incarcerated is also a chronic disease in some of our

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populations and simple things such as that can help those of who work in community such as Community Voices do our work and not be evaluated as failing when in fact we need partners. I want to thank everyone again, Dr. Nottingham and Dr. Northridge particularly. We were joined head and hip for many months having this come together. It would not have come together without the writers the authors and all of you who are supportive and we hope that from this day forward the topic of prison health, working with those who have been prison will no longer be one that we fear to talk about for retribution but in fact one that we must talk about because we are in fact all American whether having been in prison or not. I thank you all so very much for being here today.

[Applause]

GREG MATHIS: With that court is adjourned.

[Laughter] [Applause]

[END RECORDING]