Understanding and Addressing Disparities and Discrimination in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations

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Understanding and Addressing Disparities and Discrimination in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations

A Position Paper of the American College of Physicians

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Abstract

Racial and ethnic minority populations in the U.S. experience disparities in their health and health care that arise from a combination of interacting factors, including racism and discrimination, social drivers of health, health care access and quality, individual behavior, and biology. To ameliorate these disparities, the American College of Physicians (ACP) proposes a comprehensive policy framework that recognizes and confronts the many elements of U.S. society, some of which are intertwined and compounding, that contribute to poorer health outcomes. Discrimination, racism, and violence in criminal justice and law enforcement policies can negatively impact the health and well-being of racial and ethnic minorities and result in the loss of life. Hence, ACP asserts that addressing biases in criminal justice and law enforcement is integral to a comprehensive public policy approach to reduce and eliminate health and health care disparities. This ACP position paper calls for changes to criminal justice and law enforcement policies and practices that result in disproportionate rates of interactions, sentencing, incarceration, and harm for marginalized communities. ACP also supports research and adoption of evidence-based best practices for interactions involving homelessness and mental illness, with the goal of reducing the criminalization, injury, and death that results from such interactions. In addition, ACP calls for a more proactive approach to understand and address the socioeconomic factors associated with crime.

Introduction

In this position paper, the American College of Physicians (ACP) proposes recommendations for addressing discrimination and disparities in criminal justice and law enforcement and their impact on health for racial and ethnic minority populations at disproportionately high risk. These recommendations are made as part of ACP's comprehensive, interconnected, and evidence-based policy framework to address racial and ethnic health disparities. This framework, which is outlined in an accompanying proposal (1), includes 17 recommendations, one of which is expanded upon and discussed in more detail in this paper. The companion papers address specific issues affecting the health and health care of those populations most at risk (2) and disparities in education and the physician workforce and their impact on health (3). Together, these four papers provide a comprehensive and interconnected policy approach to addressing important issues cutting across clinics, hospitals, schools, universities, prisons, and various other elements of society to achieve ACP's holistic vision to eliminating health disparities.

There are wide-ranging racial and ethnic disparities throughout the criminal justice system, from law enforcement interactions to courtrooms and prisons. Those who are Black, Indigenous, and Latinx are stopped, searched, and arrested at disproportionately high rates (4). Unconscious associations between Blackness, criminality, and guilt have been found among the general public (5), potentially contributing to higher rates of incarceration and other sentencing disparities in the courtroom (6,7). The impact of incarceration and other interactions with the criminal justice and law enforcement systems on health is well documented. Incarceration is associated with high rates of numerous health conditions, mortality, and morbidity (8,9). The physical conditions of prison may worsen certain conditions (10) and treatment in correctional settings can result in poorer outcomes than in the community setting (11,12). Further, Black and Indigenous men and women and Latinx men are at higher risk of being victims of an officer-involved fatality (13) and racial and ethnic minorities are disproportionately represented in capital punishment sentences (14). ACP contends disparities and discrimination in criminal justice and law enforcement must be addressed as part of a comprehensive and interconnected approach to eliminating disparities in health and health care for racial and ethnic minorities given their demonstrated direct and indirect impact on health.

Methods

This position paper was drafted by ACP's Health and Public Policy Committee, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The authors reviewed available studies, reports, and surveys related to health, education, and criminal justice disparities from PubMed and Google Scholar between 1990 and 2020 and relevant news articles, policy documents, Web sites, and other sources. Recommendations were based on reviewed literature and input from ACP's Board of Regents; Diversity, Equity, and Inclusion Committee (DEI); Education Committee (EC); Ethics, Professionalism and Human Rights Committee (EPHRC); and other external experts. The position paper and related recommendations were reviewed and approved by the ACP Board of Regents on 7 November 2020. Financial support for the development of this position paper came exclusively from the ACP operating budget.

Recommendations

1. **ACP recommends that policymakers understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices because they affect the physical health, mental health, and well-being of those disproportionately affected because of their personal identities. ACP supports the following policies:**
    a. **Study, implement, and fund alternative models that deploy social workers and other mental health professionals specially trained in violence interruption, mediation, homelessness outreach, and mental health, who are ancillary to law enforcement, when their intervention would be more appropriate and effective than law enforcement intervention alone.**
    b. **Additional funding and resources should be directed to and invested in addressing socioeconomic factors that are associated with crime, such as unemployment, homelessness, and poor educational opportunity, to proactively prevent criminal encounters.**
    c. **Policies should be implemented to address the impact of incarceration on health at the personal, familial, and community levels that disproportionately impact Black, Indigenous, and Latinx persons. Racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing, including capital offenses, should be tracked and reported at the local, federal, and state levels, and steps must be taken to eliminate them. Criminal justice law, policies, and practices should be examined and studied for racial impact and overhauled if they result in unnecessary or disproportionate harm. All persons should have access to high-quality and affordable legal defense and funding should be increased for public defender representation. Priority should be given to reducing the health risks associated with incarceration while ensuring public safety and justice by:**
        i. **Implementing safe alternatives to incarceration;**
        ii. **researching and adopting alternatives to cash bail that reduce pretrial detention inequities, while ensuring appropriate protection from harm for persons who may be a danger to themselves or others;**

iii. **ending inequities in sentencing for capital offenses related to structural racism, discrimination, and lack of access to high-quality and affordable legal defense, recognizing the resulting disproportionate harm to Black and Indigenous persons;**
iv. **re-establishing supervised parole where it has been eliminated;**
v. **reducing the length of sentences when appropriate, especially for nonviolent offenders;**
vi. **providing for supervised early release of those shown not likely to pose a substantial public safety risk;**
vii. **providing for job training and other support in prison and upon release to help inmates re-enter society and find meaningful employment upon release from prison; and**
viii. **removing financial barriers to accessing and enhancing quality of correctional health care.**

Conclusion

Incarceration is a social determinant of health and evidence shows the direct and indirect effects it and other interactions with the criminal justice system have on health at the personal, familial, and community levels. Incarceration is often associated with poorer health status and outcomes and access to quality care can be limited in correctional settings. For children with an incarcerated parent, this adverse childhood experience can follow them far into the future and is linked with various health problems and poor outcomes. Encounters with law enforcement can cause harm to health and well-being even if the interaction does not involve a criminal charge or result in incarceration, including encounters with those who have a mental illness or who are experiencing homelessness. Further, criminal convictions can have downstream cyclical effects, making it difficult to obtain employment, housing, education, and other opportunities and social drivers of health. Research finds that racial and ethnic minority communities may be disproportionately impacted by this issue due to disparities in traffic stops, searches, arrests, and sentencing. A two-pronged approach is required: In addition to reforming or eliminating policies and practices that results in these disparities, a more proactive approach to understand and address the socioeconomic factors that underlie crime is also needed. ACP contends that, given the demonstrated effect on health and social determinants of health, racial and ethnic disparities in criminal justice and law enforcement must be handled as a public health issue in order to effectively eliminate racial and ethnic disparities in health and health care.

Background and Rationale

1. **ACP recommends that policymakers understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices because they affect the physical health, mental health, and well-being of those disproportionately affected because of their personal identities. ACP supports the following policies:**
    a. **Study, implement, and fund alternative models that deploy social workers and other mental health professionals specially trained in violence interruption, mediation, homelessness outreach, and mental health, who are ancillary to law enforcement, when their intervention would be more appropriate and effective than law enforcement intervention alone.**

b. Additional funding and resources should be directed to and invested in addressing socioeconomic factors that are associated with crime, such as unemployment, homelessness, and poor educational opportunity, to proactively prevent criminal encounters.

c. Policies should be implemented to address the impact of incarceration on health at the personal, familial, and community levels that disproportionately impact Black, Indigenous, and Latinx persons. Racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing, including capital offenses, should be tracked and reported at the local, federal, and state levels, and steps must be taken to eliminate them. Criminal justice law, policies, and practices should be examined and studied for racial impact and overhauled if they result in unnecessary or disproportionate harm. All persons should have access to high-quality and affordable legal defense and funding should be increased for public defender representation. Priority should be given to reducing the health risks associated with incarceration while ensuring public safety and justice by:

- **i. Implementing safe alternatives to incarceration;**
- **ii. researching and adopting alternatives to cash bail that reduce pretrial detention inequities, while ensuring appropriate protection from harm for persons who may be a danger to themselves or others;**
- **iii. ending inequities in sentencing for capital offenses related to structural racism, discrimination, and lack of access to high-quality and affordable legal defense, recognizing the resulting disproportionate harm to Black and Indigenous persons;**
- **iv. re-establishing supervised parole where it has been eliminated;**
- **v. reducing the length of sentences when appropriate, especially for nonviolent offenders;**
- **vi. providing for supervised early release of those shown not likely to pose a substantial public safety risk;**
- **vii. providing for job training and other support in prison and upon release to help inmates re-enter society and find meaningful employment upon release from prison; and**
- **viii. removing financial barriers to accessing and enhancing quality of correctional health care.**

As highlighted in the College's previous work, *Racism and Health in the United States* (15), Black, Indigenous, and Latinx persons are disproportionately the subjects of law enforcement interactions like traffic stops, searches, and arrests (4). Black and American Indian/Alaska Native women and men and Latinx men experience loss of life at the hands of law enforcement at rates higher than those who are White (13). Specifically, Black men are 2.5 times more likely to be killed by law enforcement than White men, making law enforcement violence one of the leading causes of death for young men alongside accidents, suicide, homicide, heart disease, and cancer (16).

Given this disproportionate impact of law enforcement violence, there have been growing calls to reduce the incidence of law enforcement encounters where possible, particularly around areas of mental health emergencies and homelessness. Estimates suggest that anywhere between 90% and 96% of emergency service calls are for nonviolent encounters (17,18). Many of these calls are for minor disturbances and other noncrime emergencies like traffic accidents that may not need an armed response and could potentially

be more appropriately handled by a professional other than an armed law enforcement officer.

It is estimated that between 25% and 50% of fatal law enforcement encounters involve individuals with mental illness and that 20% of patients hospitalized for mental illness were apprehended by law enforcement for a suspected crime in the previous 4 months (19). One analysis found that 27% of law enforcement shootings involved a mental health crisis and in 36% of those cases, law enforcement was initially called to assist in getting medical treatment (20). Another survey found that 21% of an officer's time was spent responding to or transporting those with mental illness and that 45% of officers feel ill-equipped to handle a mental health crisis (21). Law enforcement officers may lack the training to assess and respond to mental health emergencies, which could harm the physical well-being of those with mental illness.

Similar concerns have been expressed around efforts that criminalize symptoms of poverty like homelessness, which disproportionately affects Black and American Indian and Alaska Native individuals (22), and the police response they entail. An analysis of calls to emergency and nonemergency request lines in San Francisco in 2017 found that, 98,793 calls were for "quality of life violations involving the unhoused," while 84,486 were for "homeless concerns" and that between 4% and 9% of these complaints are referred for law enforcement response (23). Those with housing insecurity could be better served by social workers who are equipped with the skills and knowledge to connect them to nutrition, housing, health, substance use disorder treatment, and employment resources. Addressing the root causes of homelessness must be prioritized to mitigate the harms associated with the policing of this community.

Alternative emergency response programs have existed for decades, including the Crisis Assistance Helping Out on the Streets (CAHOOTS) program in Eugene, Oregon (24). CAHOOTS shares a central dispatch with the Eugene Police Department (EPD) and responds to calls regarding non-criminal substance abuse, poverty-related issues like homelessness, and mental health crises with unarmed civilian responders, nurses, and emergency medical technicians. CAHOOTS responds to roughly 17% of EPD calls, or 24,000 a year, and operates on a budget roughly 2.3% that of EPD (25).

As a percentage of GDP, the U.S. spends more on policing and less on social services compared to other nations (26,27) and incarcerates more people total and per capita than any other country in the world (28). There is an opportunity to reduce the potential for violent law enforcement encounters by funding programs that address the social drivers of health that underlie the propensity to commit a crime. Things like education (29), employment (30), housing (31), and income (32) are all socioeconomic factors that are associated with crime rates. By redirecting investments into communities to mitigate some of the root causes of crime, the origins of potential violent interactions with law enforcement could be eliminated.

Beyond law enforcement violence, racial disparities exist throughout the U.S. criminal justice system. As law enforcement departments begin to deploy facial recognition surveillance technologies, racial biases embedded in the algorithms that power many of these technologies have been found (33). Research has identified an unconscious association between Blackness, criminality, dangerousness, and guilt among both police officers and the general public (5). Reports from the Sentencing Project identify disparities in incarceration rates, prosecution, and sentencing (6,7). At current trends, 1 out of every 3 Black males and 1 out of every 6 Latino males will end up incarcerated, compared to 1 in 17 White males. While stopped by police at similar rates, Black drivers were 2.5 times as likely and Hispanic drivers 2 times as likely as White drivers to be searched. Racial and ethnic minorities are often subject to harsher sentences and prosecution for similar crimes as well. An analysis of state sentencing processes found that even after accounting for the degree of crime and past record, race and ethnicity are a factor in sentencing. The U.S. Sentencing Commission found that for cases of mandatory minimum sentences,

White defendants were more likely than Black and Latinx defendants to receive a plea deal below the mandatory minimum. Certain "race-neutral" sentencing policies, such as drug policies and habitual offender statutes, end up impacting racial and ethnic minorities more. The use of three-strikes laws exacerbate disparities in a biased criminal justice system.

Incarceration can function as a social determinant of health and impact health at the personal, familial, and community levels (34). Studies have found that incarceration is associated with higher mortality and morbidity rates (8); increased risk of preterm birth (35); as well as elevated prevalence of hypertension, diabetes, heart problems, asthma, kidney problems, stroke, arthritis, and sexually transmitted infection (9). Correctional health resources can be limited; food is often of low nutrition; and physical facility conditions, such as overcrowding or solitary confinement, may worsen chronic and mental health conditions (10). Evidence suggests those with mental illness (11) and substance use disorders (12) experience better outcomes when treated in a community rather than a correctional setting. At the familial level, nearly 2.7 million children in the U.S. have an incarcerated parent (36), an adverse childhood event that is associated with poorer mental and physical health later in adulthood (37).

Large racial and ethnic disparities are also found in death penalty sentencing. As of 2020, capital punishment for the most serious of crimes is permitted in 28 states, as well as the federal government. An analysis of capital punishment cases since 1976 found that racial and ethnic minorities made up 60% of those sentenced to death (14). Of these cases, roughly one third of the cases were resentenced due to flawed prosecutions, resulting in the release of at least 333 people and exoneration of 132. Capital punishment has clear health implications through the loss of life for the defendant and experiences of anxiety, depression, and posttraumatic stress disorder for family members (38). Roughly 3% of executions in the U.S. since the 1900s have been botched, resulting in prolonged suffering and pain (39). As a profession dedicated to preserving life, physicians face ethical quandaries around state-sanctioned executions. The ACP Ethics Manual condemns the participation of physicians in the execution of prisoners and states that "physicians must fulfill the profession's collective responsibility to advocate for the health, human rights, and well-being of the public" (40). Given the irreversible consequences of capital punishment; inequities, bias, and racism in sentencing for capital offenses and in access to qualified defense representation; the frequency of innocent individuals sentenced to death row; and general biases throughout the criminal justice system, the College supports an examination of the use of capital punishment and its impact on health. Where capital punishment remains in effect, it is essential that racism and inequities in sentencing and legal representation be addressed and eliminated.

In light of racial disparities and demonstrated impact on health, changes are needed to the U.S. criminal justice system in order to reduce the burden on Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons affected by discrimination because of their race or ethnicity. ACP calls for the implementation of alternatives to incarceration and other criminal penalties and the study of the impact of reducing the criminal penalties associated with some crimes, particularly nonviolent drug offenses (41). The College emphasizes the need to treat addiction as a medical, rather than criminal, condition requiring appropriate treatment. In assessing the reduction or elimination of criminal penalties for a drug offense, ACP recommends policymakers consider the risk for misuse and harm to the individual, effect on individual and population health, barriers to preventing and treating substance use disorders, consequences of criminalization for an individual, and disproportionate adverse effects on specific populations.

In most jurisdictions throughout the country, cash bail systems are utilized for those who have been charged with a crime, where a court sets an amount of money a defendant must pay in order to be released from pretrial detention. Bail is used as a form of collateral to ensure that those charged with crimes show

up to court for trial. As a result, 65% of the jail population in the U.S. is made up of unconvicted defendants awaiting trial, or nearly 500,000 people per day (42), 43% of whom are Black and 20% Hispanic (43). Roughly 76% of criminal cases in state trial courts are for misdemeanor crimes that typically carry fines or short jail sentences (44). Further, 65% of those held in pretrial detention were held on nonviolent charges and 20% were held on minor public-order offenses (43). Bail criminalizes poverty by jailing those who cannot afford to pay and disproportionately impacts racial and ethnic minority communities. Racial disparities in law enforcement practices can result in disproportionate arrest rates, translating to higher rates of pretrial detention given lower access to credit and wealth. Black persons and Latinx persons receive bail amounts that are 35% and 19%, respectively, higher on average and are more likely to be detained than White persons under similar circumstances, and Black persons are less likely to receive alternatives to cash bail (45,46,47).

Given the negative externalities associated with incarceration, governments should research and adopt alternatives to cash bail in a manner that appropriately balances the goals of reducing pretrial detention inequities and maintaining public safety. Shifting from a "resource-based" to a "risk-based" system, which conditions pretrial release on the defendant's risk of fleeing or causing harm rather than wealth through the use of actuarial risk assessments, has been offered as an approach to reduce disparities (48). Those who are at low risk of missing their trial date or committing pretrial crimes, as well as those for which lower-cost alternatives would sufficiently mitigate risk (49), should be eligible for release without bail. Evidence suggests the use of electronic monitoring for those who pose some risk if released pretrial has been effective in reducing the likelihood of technical violations and reoffending (50), but other studies have found no impact for high-risk, violent offenders (51). Additional short-term approaches to reducing pretrial inequities include the use of citations rather than arrest, allowing for more careful deliberation of one's risk and personal situation at the bail hearing, providing defense counsel at bail hearings, and the use of court reminders.

Some states and municipalities have already successfully eliminated cash bail or reformed the pretrial system, with court appearance and rearrest rates similar to better than prereform rates (45,52,53). In Washington, DC, the criminal justice system operates under the presumption of release with a strict timeline for assessing a defendant and procedural protections. As a result, 94% of defendants in DC are released pretrial, 98% are not arrested for a violent crime during the pretrial period, and 91% appear for their court date (52). New York City implemented the Supervised Release Program in 2016, which allowed judges to release defendants without bail and require them to check-in with social workers. Under the program, 88% appeared for their court date, and in 2020 the state eliminated bail for certain misdemeanors, nonviolent felonies, and several violent felonies (45).

Appendix: Glossary

Black: The term *Black* is used rather than *African American* to capture the shared and distinct experiences of both those who are descended from enslaved Africans brought to North America who have a long history in the United States as well as others who have more recently immigrated from African, Caribbean, and other countries and who may not as strongly identify with the American identity.

Latinx: Gender-neutral term to refer to those living in the United States who are of Latin American descent, rather than *Hispanic*, which refers to those who share Spanish as a common language. While respecting the views of those who do not prefer to be called Latinx, we conclude that *Latinx* captures power and privilege dynamics in the United States better than *Hispanic*, which would include those of Spanish descent who would identify as White but would exclude those of Brazilian descent and other non–Spanish-speaking Latin American countries. When referencing other sources, we use the descriptors the authors used. We recognize the controversy over the use of *Latinx*: Some argue that the term imposes American and Anglocentric ideals, encompasses a broad and diverse group, is incomprehensible to native Spanish speakers without any fluency in English—some of the very people the term is meant to serve—and is not a term that most persons of Latin American descent identify with. Although an imperfect solution, we choose to use the gender-neutral *Latinx* over Latino (in Spanish, many nouns and adjectives are gendered, with nouns ending in -o typically using masculine pronouns) in an effort to be as inclusive as possible.

Social drivers of health: The terms *social drivers of health* and *social determinants of health* are used interchangeably. When discussing the social and economic factors that contribute to health, we prefer to use the term *social drivers of health* to emphasize that these factors are changeable drivers that can be influenced rather than fixed determinants that are immutable. However, given the predominant use of the term *social determinants of health* in the literature, we use that term in this article when referencing other sources that used the term.

Cultural Humility: Self-reflection and self-critique of one's own beliefs, values, biases, and cultures in an effort to increase awareness for others, with an emphasis on openness and readiness to learn.

Racism: Prejudice, discrimination, hate, or bias toward a person or group on the basis of their actual or perceived race/ethnicity. Racism can exist at various levels, from the individual, to the interpersonal, to the institutional, to the structural. It can also manifest in both overt/explicit and covert/implicit manners.

Individual Racism: Privately held biases, beliefs, and actions that perpetuate racism and are often informed by culture.

Interpersonal Racism: Public expressions of racism that arise when interacting with others.

Institutional Racism: Policies and practices within institutions (for example, education or criminal justice system) that, regardless of intent, result in different outcomes for different racial or ethnic groups.

Structural Racism: "Macrolevel systems, social forces, institutions, ideologies, and processes…[that] interact with one another to generate and reinforce inequities among racial and ethnic groups" that can persist even in the absence of interpersonal discrimination and without regard to individual action or intent (23, 24). In this article, *structural racism* and *systemic racism* are used interchangeably.

Anti-Racism: The intentional and conscious effort to take action to oppose racism and racial inequities in all realms of society.

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