

**HEARING TWO (Days 1-3)
SOCIAL PROBLEMS IMPACTING
PUBLIC SAFETY**

March 24 – March 26, 2020

Summary

Call to Order and Welcome

Mr. Phil Keith, Chair, welcomed the attendees to the second hearing of the President's Commission on Law Enforcement and the Administration of Justice. On behalf of Attorney General Barr and his leadership team, Chair Keith expressed appreciation for everyone's ability to navigate through the various challenges due to the COVID-19 virus. As such, planned hearings are now being held via teleconference. Chair Keith greeted and thanked everyone for attending and supporting the teleconference.

Opening Statements by Commissioners

Chair Keith opened, explaining that the three days of hearings, March 24 through March 26, would focus on social problems impacting public safety, including how mental illness, substance use, and homelessness impact public safety. The first day's hearing focused on Mental Illness. Witnesses for the hearing include Sherriff John McMahon, San Bernardino County; Mr. John Snook, Executive Director, Treatment Advocacy Center; and Sergeant Sarah Shimko, Madison, Wisconsin Police Department, Mental Health Unit.

Note: Prior to the hearing, panelist biographies and written testimonies were delivered to the Commissioners for their consideration and review.

The Dilemma

"In 2018, my department led an effort to address a large homeless encampment on the Santa Ana riverbed. The encampment exceeded 1,000 people, many of whom were mentally ill and drug addicted. We worked with our Federal court to mitigate the issue and clean up the riverbed within a span of a few months. In remediating the riverbed, we collected 14,000 used hypodermic syringes. This staggering number is a direct result and consequence of the decriminalization of drugs."

Sheriff Barnes

Panel One-Mental Illness, March 24, 2020

First Panelist: Sheriff John McMahon, San Bernardino County, California

Highlights:

- This is the largest county in the continental United States – more than 20,000 square miles, with about 2.2 million people; 6,000 people in jail on any given day, and a department size of about 4,000 with 10 incorporated cities with their own police departments in the county.
- During 2019, San Bernardino County – just in Sheriff McMahon's department – handled 5,800 mental health calls.
 - This includes calls that resulted in temporary or involuntary psychiatric commitment – what are called 5150.
 - Out of that, 2,692 of those resulted in a deputy report.
- The transient and homeless population is a big problem, and they have a lot of mental health issues, as well.
 - Oftentimes, they're in the position that they're in because of their mental illness.
- Department started training all of the deputies in crisis intervention in 2008. Initially, it was a 32-hour course, and then added on an additional eight hours for supervisors.
 - It has evolved into a 40-hour course that's mandatory for all staff – because of the need to respond to more and more people with mental illness on the street – especially in the homeless population.
- All stations have a Triage, Engagement and Support Team. These teams consists of mental health employees that work for the Behavioral Health Department that are actually embedded into the stations.
 - They know those folks that have mental illness and have been involved in treatment over the last number of years or months. They are very familiar with them, their treatment, and their medication.
 - They can also transport, whether it be to a hospital for inpatient care, or to a facility just for triage or 23-hour commitment.
 - It would be a great program to offer to deputy sheriffs and communities 24 hours a day and seven days a week. It does free up deputy sheriffs to perform law enforcement duties.
 - While TEST has been a great addition, the challenges associated with insufficient mental health treatment continue. Treatment is often temporary and voluntary. When treatment is discontinued, it is not uncommon for additional, repeated contacts with law enforcement to occur.
 - Not able to offer the services that some need – resulting in, on occasion, in two-or-three-hour trips and a patrol car with one of those folks that need treatment, all the way to one of the bigger cities within the county.

“These inmates have no business being in jail with this severe mental illness, except they committed a crime and ended up there, and there’s no other place for them.”

Sheriff John McMahon

- Jail has an average daily population of about 6,000 people.
 - In California, like other states, a criminal defendant cannot be tried for a criminal offense as a result of a mental disorder since they're unable to understand the nature of their charges.
 - Population in county jails just continue to swell – to the point where hundreds of inmates that were incompetent to stand trial are waiting to go to a state hospital.
 - Between 2015 and 2019, the Sheriff's Department budget was increased by \$9 million to fund additional correctional mental health staff.
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- The California Department of State Hospitals is responsible for providing treatment to individuals deemed incompetent to stand trial, but they have a shortage of treatment beds. This shortage has created a tremendous backlog and as a result many wait 3 to 6 months to begin treatment.
 - Through a partnership with the State, a jail-based competency program can get these inmates ready to stand trial.
 - The California Department of State Hospitals, currently can pay in excess of \$20 million a year to cover the costs of the mental health services offered in the program.
 - They stay in the program as long as needed to be restored to competency.
 - In 2019, 621 inmates were admitted into the program.
 - At the end of 2019, out of that 621, 601 were discharged and able to attend their court hearings. Their cases were ultimately adjudicated.
 - The National Association of Counties, along with the National Sheriffs' Association and the Major County Sheriffs of America, determined that about 64% of inmates in custody have some type of major mental health illness.
 - Fifty-three percent have drug dependency or abuse.
 - Forty-nine percent have a combination. And that is out of a total of 740,000 inmates that are in custody in this country on any given day.
 - Recent jail trends include more and more people with mental illness, with the spike in methamphetamine use and other illegal drugs.

Second Panelist: John Snook, Executive Director, Treatment Advocacy Center

Highlights:

- This pandemic puts into stark relief the consequences of forcing our law enforcement officers on the front lines of mental healthcare, and it makes clear that the answer is not a criminal justice system better able to address mental illness, but instead a mental illness treatment system that keeps people from being arrested in the first place.
- The reality is that the U.S. is in the midst of a mental illness crisis.

“There are an estimated 8.3 million adults in the United States who are living with a severe mental illness. Approximately half go untreated every year.”

John Snook

- What does going untreated look like? Families are told their loved ones have to be violent before they can access care. And when they do deteriorate to that point, they're told to call 9-1-1.
- Since 1999, we've lost 35% of the total psychiatric treatment beds in the United States. Now, only four countries in the developed world have fewer beds per capita than the United States. In context, we have about 20 public and private beds per hundred thousand population. The worldwide average is 71.
- So, what happens when those beds aren't available? Those in need fall to the systems that can't say no. They languish for weeks in our emergency departments waiting for a treatment bed.
 - They fill our homeless shelters – cycling in and out of crisis – and they overwhelm our law enforcement and our jails and prisons.
- It's important to recognize that approximately a third of people with serious mental illness have their first contact with mental health treatment through a law enforcement encounter.
- A 2019 survey, done with the National Sheriffs' Association, found that a fifth of law enforcement staff time is spent responding to and transporting people with serious mental illness at an annual cost of nearly \$1 billion dollars.
- There are now 10 times as many people with serious mental illness behind bars than are receiving treatment in a state hospital.
- We actually have fewer state hospital beds now than at any point since 1850.
 - That doesn't include the 90,000 pretrial inmates who've been found incompetent to stand trial, but who are sitting in jail waiting for one of the 9,000 forensic beds that can to serve them.

Recommendations:

- Resist the urge to force greater responsibilities on law enforcement.
- Require the mental health system to do its part to prioritize care for the most seriously ill, and end the use of jails and prisons as a pressure relief valve, especially for the most seriously ill. Treatment must come before arrest.
- Embrace Intercept Zero that ensures that systems are held accountable to serve those with serious mental illness before they are arrested.
 - Look to the example of states like Ohio, which has been a leader in this crisis and implementing the sequential intercept model, including focusing on Intercept Zero.
- Support the elimination of the Medicaid Institutions for Mental Disease (IMD) exclusion, which prevents the government from reimbursing States for treatment beds.
- Encourage the Trump administration's efforts to use the Medicaid 1115 Waiver Authority to allow states to fund treatment beds.
- Support federal grant funding for assisted outpatient treatment which provides for civil court-ordered care for individuals with a history of repeated hospitalizations.
- Support the creation of integrated crisis response systems that minimize law enforcement.

Third Panelist: Sergeant Sarah Shimko, Mental Health Unit, Madison, Wisconsin Police Department

Highlights:

- Officers must be knowledgeable of appropriate disposition options for people suffering mental health crises and of community mental health and social service resources.

“Crisis workers play a critical role in the safety of our community. It is essential that their efforts be compensated accordingly.”

Sergeant Sarah Shimko

- Mental health-related training is imperative for officers. This training should be tailored to the local mental health resources available and to the many unique factors each law enforcement jurisdiction faces.

- There are also general concepts and established best practices that should be provided to law enforcement officers by way of training opportunities funded and facilitated at the Federal level. A model for this is FEMA's Center for Domestic Preparedness courses.

- An example is the three-day Field Force Extrication Tactics training, where best practices related to the extrication of protesters using protest devices is taught.

- Madison PD was able to establish a fully functional and well-prepared Field Force Extrication Unit because of this professional training opportunity.
- A similarly modeled mental health related training opportunity would benefit local law enforcement considering how frequently officers' respond to people in mental health-related crisis.
- One component currently missing from the crisis response model is reliable 24/7 mobile crisis and social service resources. Mobile response services related to active law enforcement patrol calls are currently limited to sporadic in-person crisis worker responses with the general purpose being to evaluate for involuntary hospitalization.
- Officers are overextended by serving as the sole 24/7 mobile mental health crisis response.
 - In 2019, the Madison Police Department investigated 44,623 distinct cases. Approximately 9.6% of those involved notable mental health components.
 - This translated to approximately 33,900 hours of officer time spent on mental health-related calls in 2019.
- Jail, emergency departments and detoxification facilities are not equipped to support people experiencing a mental health-related crisis and are often a more costly, higher level of support than is necessary.
 - Communities are in need of a single-entry point crisis resource center, equipped with 23-hour observation services capable of managing behaviorally challenging patients under the influence of alcohol or drugs.
- This facility must also have an intake process that is at least as efficient as booking a person into jail.

Question-and-Answer Period

- Q:** Can you put into context the cost for the inmates, in terms of their medication needs in your mental health unit?
- A:** We spend about \$250,000 a month in prescription medications.
- Q:** Should CIT be a specialized team?
- A:** CIT training is a must, as it is more than just training. It's an ability to coordinate with programs in the community and engage.
- Q:** In your written statement you stated that between 2015 and 2019 your budget was increased by \$9 million. Where did that money come from?
- A:** The \$9 million came from the county's general fund. As a result of overcrowding, California shifted the responsibility of a lot of inmates that used to go to the state prison system to the county jails. After that occurred in October 2011, those inmates began living in the county jails, which increased the length of stay past the year and also increased the medical mental health requirements.
- Q:** Regarding 5150, you mentioned that your officers came into contact with a large number of mentally ill persons, and many of them ended up with a civil commit. Is that the case?
- A:** Yes, a 5150 is a civil commitment, except that it's an application for a 72-hour hold. Those individuals were taken to one of the hospitals to be left with mental health professionals. The individuals may have a criminal hold, but often times they have no hold. They're just unable to care for themselves or are greatly disabled. We leave them at the hospital, and they treat them. Unfortunately, a person is usually out of the facility and back on the street before our deputies get back to their assigned beat and finalize their report.
- Q:** Are there proactive efforts of going out to check on individuals that are on your list to reduce the number of calls that come in to check to make sure that they're taking their medicines and going to their appointments?
- A:** Yes, the TEST program, where we have the behavioral health staff at each one of our patrol stations, are absolutely proactive and make contact with those that are known to have mental illness, been in treatment and are on medication. The Homeless Outreach Proactive Enforcement (HOPE) team also reaches out to the homeless population.
- Q:** Have there been efforts to expand that service to where those teams would be available by telephone to assist the deputies?
- A:** Yes, and there's a program where people were on call to respond in cases in which the person was not violent and willing to be transported to the psychiatric facility. It's a challenge in a department of 4,000 people to find staff that's willing to do that.

Additional Remarks:

On behalf of the Attorney General Barr and the President, Phil Keith thanked the panel for their testimony, as well as the Commissioners, and the FBI partner for their continued work to make their teleconference network available. Chair Keith reminded everyone about the dial-in procedures and the additional hearings that would take place on March 25th and March 26th.

Panel Two-Mental Illness, March 25, 2020

Mr. Phil Keith, Chair, discussed that the focus continues to be on social problems impacting public safety. Commissioners were encouraged to take notes for questions during the panelists' presentations. It was announced that Sheriff Donald Barnes would offer his testimony, immediately followed by questions from the Commission, and then leave the call. The session would then continue with the other panelists, who were Dr. Shannon Robinson and Sheriff Paul Penzone.

First Panelist: Sheriff Donald Barnes, Orange County, California

Highlights:

- The intervention strategies and services necessary to address social issues have become virtually non-existent.
- The gap in social service strategies has had a trickle-down effect with these social failures eventually landing on the shoulders of law enforcement to address them.
- We cannot make the mistake of looking at social problems impacting our communities in a silo. These issues cannot be addressed independently. They are interconnected and must be addressed concurrently.
- On any given day, up to 2,000 of the approximately 5,000 county jail inmates have a daily nexus to mental health treatment – an increase of more than 50%, over the past five years.
- In 2018, 9,200 individuals, routinely cycled through jail.
- Two-thousand were designated as Severely and Persistently Mentally Ill (SPMI) , and 7,000 were mild or moderately mentally ill.

“Treating mentally ill individuals in jail is not the best option.”

Sheriff Donald Barnes

- Those in custody with mental illness or co-occurring substance use disorders have costly medical expenses that put a drain on limited county resources.
- One in five people in jail are self-declared as being homeless.
- These populations have specific medical and mental health needs, while in custody and even more so, upon release.
- Orange County employs Medication-Assisted Treatment (MAT) for the drug addicted.
- Currently, 535 inmates participate in the MAT program at a cost of \$174,000 per month, or more than \$2 million per year.
- The criminal gangs who traffic narcotics into jails are threatening and intimidating inmates because participation in this program negatively impacts the gang's profits.
- For clarity, in California after the implementation of AB109 or state prison realignment in 2011, drug trafficking into my jails increased by 300% in the first two years.

Recommendations:

- Implement crisis stabilization units or law enforcement friendly mental health drop-off centers.
- Have a system of care that provides, not only prevention on the front end, but post-custody services upon release for sustained success.

- End the Medicaid Inmate Exclusion Policy. For inmates with serious behavioral and public health conditions, the current Federal policy of not allowing reimbursement for Medicaid reimbursable services and treatment for individuals detained but in pretrial status results in poor health outcomes and hinders efforts to maintain health, and mental health stability, thus creating an environment for decline, relapse, and ultimately, return to custody.
 - Ending this exclusion policy, particularly for pre-trial inmates, will enhance efforts to reduce recidivism.
- End the decriminalization of drugs.
 - California's experiment with drug decriminalization has resulted in tragic consequences.
 - In California, possession of drugs results in nothing more than a misdemeanor citation.
 - This minimal criminal consequence and the criminal justice system perpetuates addiction, resulting in more dangerous health consequences for the users and impacts upon the community.
- Treatment programs during incarceration have proven to change behavior.
- Systems that lack individual accountability exacerbate the problem by encouraging bad behavior.
- Remove marijuana as a Schedule 1 narcotic so that its negative effects can be better researched and understood.

Second Panelist: Dr. Shannon Robinson, Principal Consultant at Health Management Associates

Highlights:

- Trauma, mental illness, substance use disorders and homelessness have bidirectional influences upon each other.
- To stop the multi-generational effects of these issues and the ever-increasing resource utilization, treat mental health and all substance use disorders with evidence-based treatments, including motivational interviewing, cognitive behavior therapy, contingency management, and medications for addiction treatment.
 - Sixty-three percent of jail inmates have drug-use disorder, but only about 25% of them get treatment while they're incarcerated.
 - Traditionally, risk and needs assessments have been used to place patients in treatment programs, while incarcerated.
 - These assessments look at criminal history and are designed for law-enforcement supervision purposes.
 - Risk and needs assessments are not diagnostic tools and shouldn't be used to determine clinical treatment needs.
- Legal child services and correctional partners must allow decisions about medication and level of care or treatment to be determined by clinical providers with shared decision-making from the patient and that specific medications not be listed in legislation as new medications are FDA-approved all the time and there are evidence-based changes over time.
- Eighty-five percent of people in an abstinence-based treatment program for opioid use disorder relapse within a year.

“The current risk of death upon release from incarceration is 129 times that of the general population.”

Dr. Shannon Robinson

- Historically, we forced people to withdraw from medications for addiction treatment when incarcerated, despite knowing that patients remaining on methadone, while incarcerated, are twice as likely to attend a narcotic treatment program, post release.
- Patients who are started on methadone, while incarcerated, are more likely to attend a narcotic treatment post release than those who have not started on medications and are referred to that same narcotic treatment program.

- There have been significant decreases in death rates, both during incarceration and post-incarceration, when medications are continued or initiated during incarceration.
- With the release of the Jail-based Medication Assisted Treatment Promising Practice Guidelines, and litigation that has mandated medications for addiction treatment in some jurisdictions, many jails and prisons are successfully starting MAT programs.
- Most are focused on opioid use disorder, not opioid use disorder and alcohol use disorder, despite the fact that alcohol use disorder kills way more people over the long term.

Recommendations:

- Implement substance use disorder treatment programs, not just opioid use disorder treatment programs.
- Decrease the influence of gangs, which currently are inhibiting members from accessing medications for addiction treatment while incarcerated.
- Work outside of incarceration.
- Stop the practice in some jurisdictions in which judges, lawyers and child-service workers recommend and even mandate discontinuation of medications for addiction treatment.
- Eliminate unnecessary barriers to MAT.
- Streamline the process of certification for jails and prisons to narcotic treatment providers.
- Mandate training programs for all healthcare providers, including currently licensed providers and for correctional custody, judicial and child support service staff.
- Stop Federal, state, and local funding of alcohol and substance use disorder treatment and care, which is not evidence-based.
- Incentivize in-reach into jails and prisons to prepare for smooth transitions to the community.
- Increased access to evidence-based treatment for substance use disorders and mental health disorders will lead to huge improvements in health with resulting decreases in homelessness and recidivism.

Third Panelist: Sheriff Paul Penzone, Maricopa County, Arizona

Highlights:

- Law enforcement has inadvertently become the primary respondent to these complex issues, responsible for de-escalating, mitigating, resolving, restraining, investigating, and providing ongoing care for the ill, unhealthy and unwell members of our society while in custody.
- The demands have long ago exceeded law enforcement abilities, resources and its core mission.

“Our training has been more about Band-Aids. Our training is we teach officers to run, to shoot, to drive, to investigate traffic accidents and crimes, and when we have a need for additional training because of an issue that is relevant to our community’s best interest, we will put a Band-Aid on it and add an additional ten hours.”

Sheriff Paul Penzone

- Every state has different standards, different expectations, and different training regimens although the social issues and the criminal issues are very similar in nature.
 - Need more of a standardized process on how we evaluate the data and the challenges that law enforcement faces and then make a determination as to our best practices to train them to be successful in this area.
 - Inside the jails, we expect detention officers, no different than law enforcement professionals, to become experts in the field of mental health and mental wellness.
 - Individuals who require additional comprehensive care, need to be separated, not just in pods or in jail systems, but separate them from the system itself, to address their core issue, which is mental health disorder or drug addiction.
- Connect inmates with care providers to include practitioners, because the cost to care for the mentally ill in our jail system and the demand on our first responder services, by far, outweighs the amount of money that we invest in prevention programs and education for our children.
 - If we want to reduce recidivism and address the issue of mental health and mental wellness, we can triage it in the current generation. Or we can invest in the future generations with the hopes that recidivism means, if you don't go to jail the first time, you're not coming back the second.

Question-and-Answer Period

Q: Why should we be investing in medication assisted treatment for people in the justice system?

A: When someone comes in and they have Type II diabetes, we follow a protocol and do dietary education when the person is first diagnosed and we talk to them about medication options. Based on the severity of their illness, we determine if they need a medication right away or if we're just going to use dietary interventions, what I refer to as psychosocial interventions or lifestyle changes. The same thing happens if you get someone into treatment early enough for opioid use disorder. If you bring somebody in who has a mild opioid use disorder, your first thought isn't to put them on buprenorphine. We know there are neural chemical changes in the brain that happen when a person has been using substances of abuse. It takes a couple of years for those changes to stabilize in your brain. Once stabilized, you can engage them in cognitive behavior therapy, contingency management, and motivational enhancement. We need a combination approach. But then if you take the medication away, the disorder is likely to come back. You must do psychosocial treatment, along with the medications.

Q: Could you talk about the Medicaid Inmate Exclusion Policy and how that impact local practices?

A: There is a rule that says Medicaid dollars cannot be used to reimburse for otherwise Medicaid reimbursable costs for incarcerated persons, even those who are detained in pretrial status. Unfortunately, that means there is no incentive from a community provider to do in-reach into the incarcerated population. So, that rule impairs the warm hand-offs that we strive for.

Q: What is a warm hand-off?

A: I first used the word warm hand-off when I was an inpatient psychiatrist. I expected my residents to communicate with the doctor who was going to receive their patient when the patient left the locked inpatient psychiatric unit. The same thing occurred in prison. In an ideal world, the jail doesn't send a patient to the prison without records. If there is anything that needs to be

addressed on day one, you know that you have the medication that the patient needs when the patient arrives. A warm hand-off means that the person who's caring for the patient right now is actually in communication with a person who is going to care for the patient tomorrow.

- Q:** Are they able to differentiate between the use of marijuana, meth, and other drugs that marijuana is the overriding problem that is causing some of this psychosis?
- A:** New studies are coming out about the direct correlation between the use of high toxicity cannabis or THC to psychosis. There is a direct correlation between marijuana use and other narcotics. We saw what happened with the narcotic analgesics OxyContin and hydrocodone that has morphed into the use of heroin and fentanyl throughout the nation. We are losing thousands of people to overdose every year and it's not seen as a pandemic, which underestimates the impact of this problem.
- Q:** Can you clarify that with the decriminalization of drugs, you have seen more drug use in your jail?
- A:** Yes. A criminal enterprise exists within jails and the prison system. The legislation created an environment for people to traffic in narcotics. AB109 presents an opportunity called the flash incarceration, which is like a time out for people who aren't following the rules. The criminal enterprises deliberately get people violated with a flash incarceration with the intent of mulling in narcotics. We have significantly changed our screening processes. We have drug-detection canines, TSA-level body scanners, and a county-wide naloxone program in the Sheriff's department. I would advocate the need for a national naloxone program that equips every first responder with this life-saving medication. Last year, we saved 70 people from overdosing within our jails.

Closing Comments

A reminder was made that the last call of the week would be Thursday, March 26, starting at 2:00 pm and would conclude at 3:00 pm Eastern Time. Dr. Keith Humphreys, Professor and Section Director for Mental Health Policy in the Department of Psychiatry and Behavioral Sciences at Stanford University will be providing testimony. The commissioners were thanked for their dedication and commitment. The President's Commission was adjourned at 4pm.

Expert Testimony - Mental Illness, March 26, 2020

Mr. Phil Keith, Chair, discussed that the focus continues to be on public safety and Mental Illness. One witness was scheduled to testify, Professor Keith Humphreys.

Expert: Dr. Keith Humphreys, Stanford University, and Senior Research Career Scientist at Veterans Health Administration

Highlights:

- Alcohol is the number one drug associated with arrests, violence, and domestic violence. In homicides and assaults, the offender, the victim, or both are intoxicated. In studies that have looked into correctional facilities the most common substance use disorder is alcohol use disorder.
- Those with alcohol problems tend to have low impulse control. They have a present time orientation; they are concerned about what's going to happen today, or what's going to happen soon. They're not people who think five, ten years ahead, not even five, ten days ahead. Frequently not well educated, some are not native speakers, they may not even understand the rules of probation and parole, or understand what a judge is saying. They frequently have a negative history with the criminal justice system, and they feel distrustful, angry towards it, maybe sometimes justified, maybe not, but the point is that there is an oppositional mentality.
- Consequences are often harsh in American criminal justice. We try to make up for not applying them often by having tough penalties, but, in fact, what people respond to the most are penalties that are consistent, and swift, and certain. The penalties don't actually have to be that severe.
- The consequences of the criminal justice system are usually delayed. We need to move into a system where consequences are swift, so that the person makes the connection between their behavior, and the consequence they experienced.
- Those principles apply to lots of different good programs in criminal justice, but they particularly apply to 24/7 Sobriety program.
- 24/7 Sobriety program is simple and transparent. All the offenders get a very careful orientation to the rules. The judge tells them they can still get to your job, and so on, but they are not going to be allowed to drink. If you don't drink, you're going to be fine; and if you drink, you're going to get in trouble.
- How that's done usually is by twice daily breath testing. Somebody comes in in the morning to a testing station and they blow into a breathalyzer, and if it's negative, they say, "Well done, you can go throughout your day." And, then they come in the evening and do the same thing. The other way this is done is with a bracelet, which senses excretions of alcohol in perspiration.
- If somebody uses alcohol or doesn't show up for their appointment, they're arrested immediately - not later, immediately. They're put in jail, but it's not a serious punishment, it's just a night or two in jail.
- This is different than what happens, say in a drug court or a DWI court, where they're ordered to treatment. Here, the focus is on changing the alcohol use behavior. So, you're allowed to obviously seek treatment if you need it, but you win the game by changing your behavior, by not drinking.
- South Dakota was actually a particularly dangerous place to drive, two or three times the rate of death. After this program was introduced, South Dakota is now about as safe to drive in as other states.

- Domestic violence arrests also dropped, even though this program was not initially focused on domestic violence. It was initially focused on drunk drivers.
- If you look three years out, people who have been on 24/7 Sobriety versus typical probation are far less likely to get rearrested.
- We're not exactly sure why, but nonetheless, it's a good thing that the effects just don't disappear the moment the person gets off 24/7 Sobriety.
- There's some money for 24/7 Sobriety that states can use as part of their work on keeping interstates safe. That's the rationale for it from a Federal viewpoint.
- A review of Alcoholics Anonymous was just done.
- If you compare AA to other types of treatment and counseling, it actually did better at getting people into sustained abstinence.
- AA reduces healthcare costs significantly. If someone leaves a treatment program, they get involved in AA, they're less likely to come back in need for the treatment, they're less likely to need for the mental health services and so on.
- A recommendation to consider is that every correctional facility makes space available and the means available for onsite AA meetings. People who are in AA have outreach folks who are available to go into the correctional facilities, tell people their story, and host meetings.
- AA could also be one of the options that judges recommend to people when they ask them to seek help for alcohol.

Question-and-Answer Period

Q: Is there a standardized vetting for fly-by-night treatment centers that pop up and take advantage of people?

A: There are significant quality issues in addiction treatment throughout the United States. We have some terrific programs, and we have some really lousy ones. Part of that has to do with it being a weaker-funded segment, so the quality of staff is often lower. You pay less, you get less. You also need to motivate the regulators to look at addiction programs, which are often not the highest priority.

Q: Can you help us with a definition of warm hand-off and when it's appropriate for law enforcement to decide who has it?

A: We started doing this at the Veterans Hospital in Palo Alto with Veterans in alcohol treatment. If a staff member says, "I want to take half an hour in treatment to tell you about Alcoholics Anonymous and what it is, what the first meeting is like, and talk about any worries you might have about it. At the end, with your permission, I'm going to call an experienced member of that group and ask them to take you to your first meeting." You get dramatically higher attendance rates. If someone gets over that anxiety of admitting that there is a problem, reaching out for help, and having other people know you have a problem, warm hand-offs can make a substantial difference.

Q: Regarding limited contacts, how do we foresee AA, 24/7, and those types of programs working?

A: It's tough, particularly for people in the early recovery where they need that support, and meetings are closing. People are moving them to Zoom and Skype, but that's not an option everywhere. I've been suggesting that people talk to their sponsor, and don't get isolated.

Q: Can you provide more information about the barriers to passing that kind of legislation? Are there costs associated?

A: Federal dollars are in the highway bill. Beyond that, people in South Dakota pay approximately a dollar, when they are administered a breathalyzer test. Therefore, the offenders are putting the money in, and it pays for itself.

Q: Can you comment on how effective AA would be within a jail facility?

A: For the most part, people are not going to be able to drink in jail, and it's easy to abstain when it's not available. What I think you're getting when you have the AA outreach groups coming into the jail, is the possibility of linking people into the fellowship. Something catches their imagination or maybe there's a person that they connect with, they want to stay in touch with, so that they will stay engaged when they get out of jail. The real world is where they will have the real challenge, because alcohol is available everywhere.

Q: We have a robust mental health application to our inmates, and we also have electronic record sharing between the local mental health facility, the courts, and the sheriff's office, and the medical provider within the jail to try to keep contact with the inmate that has problems as they leave the facility. Have you seen anything like that?

A: I think that we could do a lot more than we do. The warden of the Cook County Jail in Chicago said that she ran the world's biggest mental health facility, and a lot of people who run jails feel that way. Over the last 60 years, state mental hospitals used to have lots of beds. As they have shrunk, that population of people has now ended up incarcerated, and they are difficult to manage. It's hard for them, hard on the staff, and the facility.

Additional comments:

N/A

Closing Comments

Chair Keith thanked the Commissioners, the witnesses, and the other attendees for their time and support. The Commission meeting was adjourned.