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Operator: Good day, and welcome to the mental health conference call. Today's conference is being recorded. At this time, I'd like to turn the conference over to Director Phil Keith. Please go ahead, sir.

Phil Keith: Thank you and good afternoon. Thank you for joining us to today. I'd like to call the President's Commission on Law Enforcement and Administration of Justice to order. On behalf of Attorney General Barr, we thank you for joining us today for this important Commission teleconference meeting. At this time, I'd like to ask the Commission's Executive Director Dean Kueter, for a rollcall of commissioners.

Dean Kueter: Thank you, Mr. Chairman. Commissioner Bowdich? Commissioner Clemmons?

James Clemmons: Present.

Dean Kueter: Commissioner Evans?

Christopher Evans: Here.

Dean Kueter: Commissioner Frazier?

Frederick Frazier: Present.

Dean Kueter: Commissioner Gualtieri? Commissioner Hawkins?

Gina Hawkins: Here.

Dean Kueter: Commissioner Lombardo? Commissioner MacDonald?

Erica MacDonald: Present.

Dean Kueter: Commissioner Moody?

Female 1: Good afternoon. This is Rachel ((inaudible)) from the Florida Office of Attorney General. General Moody may be joining us, and I'm here on her behalf.

Dean Kueter: Commissioner Parr?

Nancy Parr: Present.

Dean Kueter: Commissioner Price.

Craig Price: Present.

Dean Kueter: Commissioner Ramsay?

Gordon Ramsay: Present.

Dean Kueter: Commissioner Rausch?

David Rausch: I'm here.

Dean Kueter: Commissioner Samaniego?

John Samaniego: I'm here.

Dean Kueter: Commissioner Smallwood? Vice Chair, Sullivan?

Katharine Sullivan: Here.

Dean Kueter: And, Commissioner Washington?

Donald Washington: Here.

Dean Kueter: That completes the rollcall, Mr. Chairman.

Phil Keith: Thank you, Dean, we have a quorum.

Today, our focus continues to be on the social problems impacting public safety, the Mental Illness Panel. Our agenda will be slightly different than the two previous Commission conference calls we had previously this week. Today, we will have one witness providing testimony, followed by an opportunity for questions from the commissioners. All commissioners have had the opportunity to review the biography and testimony of Professor Keith Humphreys. Dr. Humphreys is uniquely qualified and is widely respected on the issues we will discuss today.

You're encouraged to take notes for questions and interactions with Dr. Humphreys. After his testimony, we'll move onto a question and answer period for the commissioners.

Just as a reminder to the commissioners, all of your mics are hot and open. I want to once again thank all the commissioners and our distinguished panelist for joining us today to continue the work of the President's Commission.

Professor Humphreys, you are recognized.

Dr. Keith Humphreys: Thank you, sir, and thanks to the Commission for your service and for asking me to speak to you today. May I just check, can everyone hear me okay?

Phil Keith: Yes, sir.

Dr. Keith Humphreys: Fantastic. All right. So, I'm going to start with a presentation about two topics that Judge Sullivan said might be of interest to you, and those are with the slides that were pre-distributed, and that'll take me maybe 15 or 20 minutes, and then we'll just have the time open to talk about anything that is helpful to you in your important work.

So, the slide packet there, ((inaudible)) 24/7 Sobriety and Alcoholics Anonymous Within the Criminal Justice System. Now, we're just going to have to page through together here.

So, I have a - the second slide there, call that the Stanford Stumper, and what that is, is I asked my Stanford students at the beginning of every year, which drug is it that is the most important to understand arrests, incarceration, crime, violence in America? And, they're very bright kids. Every year, they're smarter than me, but they always get it wrong. They always say marijuana, and then I say, "Nope, that’s not right," and then they say, "Well, is it cocaine?" I say, "No, no." "Heroin?" and they almost never get the right answer, which you all know what the right answer is, and it’s alcohol.

And, I bring that up partly as a framing point. Very commonly I work with law enforcement a lot, and many people who look at substances and crime often say, you know, "If drugs were just legal we wouldn't have all this in connection between substances and the criminal justice system." And, alcohol really disproves that point. It is legal, nonetheless, you know, there are very few - you ask a police officer how much your work after 6:00 each night has to do with alcohol? It's always a huge amount of what officers contend with, which is ((inaudible)) is what you see the most in incarceration, as well.

The next slide just makes that point. It is the number one association with arrests, violence, domestic violence, certainly, but also a plurality of homicides and assaults, you know, the offender, the victim, or both are intoxicated, and it's the most common substance used in studies that have gone into correctional facilities and diagnosed people. The most common substance use disorder is alcohol.

So, what can we do about that?

Next slide lists lots of different things. There are public health kind of interventions around taxing, licensing, advertising. There are treatment interventions of different sorts. I'm just going to talk about two today for the sake of time.

The first one is called 24/7 Sobriety, and the second one is Alcoholics Anonymous, and I'll just go through a little bit on each one.

So, next slide, 24/7 Sobriety, this is a program invented in the great State of South Dakota, and I want you to know I - Secretary Price did not put me up to that. South Dakota is a great State. I went up there. It's beautiful, full of wonderful people. Had a great time there.

And, this was invented by someone who was a prosecutor at the time. His name was (Larry Long), and then he became state attorney general, and then a judge. And, this is the kind of thing he was dealing with, and this will be familiar to those of you have sat on the bench.

Who do you see if you're in a courtroom? People who come through have alcohol problems. What are their characteristics?

Well, they tend to have low impulse control. Lots of offenders have low impulse control, but they have particularly low impulse control. They have a present time orientation. What I mean by that is they're 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 is there, an oppositional mentality.

What they really need to change given that this is who they are, is they need clear, transparent, and consistent rules with frequent feedback over very short intervals. That’s what matches to who these folks are, but that is not generally what they get.

The next slide is by a - a quote by a famous criminologist who did a lot of policy work in the 1970s, and this was his example of, "If your criminal justice system were a parent who wanted it’s child to clean up the room, what would it say?" He said, "It would say, if you don’t clean up your room right now, there is a 40% chance that a month from now I will ground you for two years."

In other words, what our system tends to do is give people probalistic consequences, distant in time that are severe, in hopes that they will change, but this is the opposite of what this population actually needs.

So, if you go to the next slide, slide number eight, you - traditionally oftentimes the rules of, you know, how do you stay out of trouble, how you succeed on parole, how do you succeed on probation, what are the rules in a prison, are often complex and confusing, at least from the perspective of the offender, so we want to have them, instead, be simple and transparent.

Consequences are unpredictable, you know, with - in probation and parole, someone may do the same thing, and the officer may let it slide, one, two, three, four, five times, and then the fifth time they put down a penalty. What people really need to learn, in fact, is certain consequences. Every single time I do X, Y happens.

Consequences are often harsh in American criminal justice. We try to make up for the 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. And if you do that, they don't actually have to be that severe. You could think of like will a, you know, how often does a horse, if you have a ranch and you put a wire on it with just a mild current through it, it only is a mild shock, but horses will never touch it more than once, because they know it's going to happen every single time. It doesn't have to electrocute them, just a little buzz, little irritation. They move away from it. Same thing is true of people.

The last thing is that the consequences of the criminal justice system are usually delayed. You did something and it's a long time to a trial, and there's a lot of process and so on, and what we need to do is 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. So, go to the next slide.

This is what Judge Long came up with. So, it's simple and transparent. All the offenders, these are folks on probation generally. They get a very careful orientation to the rules. Judge tells them, "What we're going to do is you can, even though you've committed an alcohol-involved crime, say you've been drinking and driving three, four, five times, you've been convicted every time. We're not going to lock you up, but we're not going to let you drink. That's what's different about this program. We're not going to take your car away. You can still have your car. You can still get to your job, and so on, but you're 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. It couldn't be simpler, and we're going to monitor that. This not like orders that just tell people not to drink, we're actually going to check you."

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 sometimes it's done with a bracelet, which senses excretions of alcohol in perspiration. That's the other way you can run this program.

If somebody uses alcohol or doesn't show up for their appointment, they're arrested immediately - not later, immediately. Literally, if they come in, and I've actually seen this happen, they come in and they've been using alcohol, they test positive, right on the spot they arrest them, and they get punishment immediately that same day. They're put in jail, but it's not a serious punishment, it's just a night or two in jail.

You might think why would that matter? A lot of these folks have been in prison, surely a night or two in jail is not that intimidating, but the difference here, again, is that it's swift and it's certain.

You know, people don't quit smoking because they might get lung cancer in 30 years, but they will quit smoking if their spouse says, "I don't want to kiss you when you've been smoking," where we're oriented to things that are right there, right after our behavior.

People are offered treatment. They can go to Abraham Lincoln if they want to, but they're not required to. 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.

Here's what has happened. This is data from alcohol-involved road fatalities, and that’s kind of noisy data. It goes up and down, because it’s not a hugely populous state, but you can see before this program started in 2004, 2005, South Dakota was actually a particularly dangerous place to drive, two or three times the rate of death. As the program was piloted, rolled out across the counties, across the state, that rate has gone down and it's kept going down. South Dakota is now about as safe to drive as other states. That's pretty good.

If you go to the next slide, this is really nice work done by a group of researchers at the RAND Corporation, and they're looking at the county level. So, this rolled out across the state county by county, and as it was instituted, they looked at what happened in the counties that had it, compared to those who hadn’t gotten it yet, and they showed a 12% drop in drink driving arrest, and that's at the county level, by the way, not just at the individual level. If you looked at individuals, it would be a lot bigger, but literally, entire counties rate dropped.

Another important point is that domestic violence arrests also dropped, even though this program was not initially focused on domestic violence. It was initially focused on drink drivers. And why that matters is that when you take, you know, when you look at that population that say gets arrested for drink driving two, three, four, five times, they are - when you take alcohol out of their life, there are other benefits, radiating benefits, to other domains of criminal justice, but also other domains of just the community.

Most people who get arrested many times for one alcohol-involved offense, often do other things when they're drinking too much that they shouldn't do. So, you get those extra benefits.

The other kind of striking thing they showed is that the state-wide all-cause mortality dropped about 4%, and what's interesting about that is the biggest drops as it rolled out were among women, even though most of the people on this program are men. So, it's saving lives beyond the people who are monitored.

Go to the next slide, number 12. People say, "Well, sure while they're on it they drink way less, but don't they just go straight back to drinking?" And, the answer is they don't. It certainly turn everybody into a lifetime abstainer by any means, but if you look at even out three years, people who have been on 24/7 Sobriety versus typical probation, people with alcohol problems, far less likely to get rearrested.

And, honestly, we don't know fully why that is. It could be that, you know, when you don't - when you've been drinking a lot for a long time and you get the typical sense, about five months or so, that time off, maybe you reorganize your friendships, your family, maybe you start - you know, you get a job you care about, you know. 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.

This next slide is a map of the nation, and you can see there's been a - you know, it's certainly spread the most around, you know, people talk to people, sheriffs talk to sheriffs, judges talk to judges, governors talk to governors, and so the neighboring states around there have picked this up, but it's being, you know, experimented with in other states beyond that, as well.

There's money in the big highway bill that Congress appropriates every five years. 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.

Next slide. What could commission do? Well, you know, there's still a number of states that haven't passed enabling legislation to do this. You know, you could certainly recommend that they do that if you think this is worthwhile. You could also recommend that states access those federal funds. They are there. Every state gets some. They could certainly use that, and gain some public safety benefits.

Okay, now I'm going to go to a quite different program that everyone's heard of, Alcoholics Anonymous. The reason that I've included this is because just two weeks ago my colleagues and I put out the biggest review of Alcoholics Anonymous that's ever been done, and Judge Sullivan thought it would be useful to talk to you about it.

So, just to give you a little background, if you don't know much about this remarkable program, it comes from Ohio, Akron, Ohio was where it was started in 1935 by two alcoholic men who found they, in the community of each other, they were able to turn their lives around, and they founded it with the sole purpose of what they call alcoholics become sober. They offer group meetings. There's also a system of sponsorship where experienced members will help newer members find a path to recovery. They have various books, they've got a 12 Step Program. It's kind of an inventory where you go through and try to improve your relationships and be honest about your failings, become a better person and so on.

It doesn't cost any money. There's no forms to fill out. People can just go at any time, which is terrific, and it's the number one thing people reach out for in this country for help on alcohol. It's the most common source. It's not people like me, it's Alcoholics Anonymous.

So, does it work? I can send - I think I did send a copy of the review in. If I didn't, I will do that after this call. But, just to show you what we found, we had a review by myself and then John Kelly at Harvard, and Marica Ferri in Portugal, and we took ever rigorous study of AA that had ever been

done. There were studies from 145 different scientists in 67 institutions across five different countries. We only picked the crème de la crème, the best studies that gave us a real high bar to prove whether or not AA was effective.

And, this is what the key conclusions were. If you compare AA to other types of treatment and counseling, it actually did better at getting people into sustained abstinence, if you use that criteria of, you know, how people don't drink at all ever. It did better than that, like about 20% to 50% better depending on the study.

On other kinds of outcomes, like if you ask, "Well, do some people drink less, or maybe they - at least on the days they drank, did they drink fewer drinks per day?" It was about as good as other treatments, so it mostly is there to help abstinence, but also helps some people cut back.

And, then the last thing we found is it reduces healthcare costs significantly. So, 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. So, it actually is a real win for the public. It takes a significant burden off the healthcare system and doesn't cost really anything.

If you buy that, you know, some things, you know, you may want to consider recommending is that every correctional facility makes space available and the means available for onsite 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 included on the list of options in community sentencing for people on - with alcohol problems with constitutional bounds, and I say that last thing because I'm not a lawyer, so I'm not an expert here, but some districts have held that AA is religion. I don't quite think that's correct, but nonetheless, they believe that. So, it can't be the only thing in some parts of the country, but it could

be one of the options that, you know, judges recommend to people when they ask them to seek help for alcohol. So, to sum up these two programs here, 24/7 Sobriety has evidence of reducing alcohol consumption and alcohol-related injury and violence. Alcoholics Anonymous, the mutual help program, has evidence of reducing drinking and healthcare costs. So, in my opinion, criminal justice systems should be supporting both of those options throughout our country.

Last thing I just want to say that everything I've said is available on our policy website at Stanford, and a lot of other stuff besides. There's policy briefs and short videos, and things like that. It's particularly aimed at people who make policy decisions, and please make use of that free resource if it will help you in your work.

So, I'll leave it there. Thank you.

Phil Keith: Thank you, Dr. Humphreys for your testimony. We'll now open the session for commissioners with questions for Dr. Humphreys.

Craig Price: Director Keith, this is Craig Price.

Dr. Keith Humphreys: Hi, how you doing, sir?

Craig Price: I'm doing very good,

Dr. Keith Humphreys: Good.

Craig Price: Say, Dr. Humphreys, this is Craig Price, South Dakota. Appreciate your presentation this morning, and I've known Bill Nicholson for 25 years, and he just thinks the world of you.

Dr. Keith Humphreys: Oh, that's nice to hear.

Craig Price: And, I worked for Attorney General Long for several years, so I know him - I know him well as well. So, I can back up all of your compliments about the program in South Dakota. While I haven't personally had much to do with it, other than just coordinating a few things here and there over my years in law enforcement in the state, I can confirm the successes that you attribute to that program here in our state.

I was the ((inaudible)) for the last eight-and-a-half years, and you speak about fatalities and alcohol-related fatalities. And, last year in 2019 we had 19 of them, which is just remarkable, and it's a bit attributed to this program, quite a bit, I might add, and our fatalities on our highways have consistently gone down in five-year increments. I think 15 - 10 to 15 years ago, we had about 155 fatalities per year, six to ten we had 130 some, and then in the last five years we've had about 120, so it's a big part of that.

The question I would have, and you pointed out that some of the surrounding states catch on and have enacted some legislation in their states. Have you seen similar successes or other successes that those states have experienced from implementing 24/7?

Dr. Keith Humphreys: Yes, so, Dr. Beau Kilmer, who's the RAND researcher who led the work and worked with Bill and Larry on that, has done analyses showing similar benefits in Montana, and I just, by a strange coincidence, the Mayor of London heard about South Dakota, and set up a program and is running it there in South London, and had extremely high success rates. About 92% of people on probation completing all conditions perfectly, and a typical offender of that severity succeeded about 60% of the time.

So, it's not just a South Dakota effect, you know, it's a human effect, and to me it just makes perfect sense to me from a, you know, a psychological viewpoint of how people learn, you know, is similar

all over the world. And, so that's why I think it’s got a broad applicability beyond the place where it was founded.

Craig Price: Thank you.

Nancy Parr: Hi. This is Nancy Parr from Virginia, and thank you, Doctor, for that very interesting presentation. I appreciate it.

I have a couple of comments, and then I have a question I’d like for your input on. It’s really, I was very interested in the numbers in the decrease in the DV arrests, because another one of our workgroups is juveniles and juvenile delinquency, and, you know, when children are living in those homes, they're exposed to that, and so that's - I think that's very interesting, how the DV arrests went down, because so many of our juveniles are living in those homes. So, I think that's good information to carry over to our other working group.

And, the, you know, 24/7 and AA, which we're all, you know, we're familiar with and have been, for a lack of better word, vetted by you and other experts. What I have seen and seeing - not is so many of these pop-up support groups, fly-by-night corner shops where I think that they're just really taking advantage of people who - and of people's families who just are trying to get them as much help as they can. Is there - I don’t believe that there's any sort of a standardized vetting for these, like I said, for these fly-by-night treatment centers that will pop up and take advantage of people. Are you aware of any sort of national vetting?

Like, right now here in my city, we rely on our probation and parole to vet these programs, and they're already stressed to do that, because we have no other - we have nobody else to vet them. So, I just thought if you could - what your thoughts on that?

Dr. Keith Humphreys: Okay, you've raised two really important points. So, first I appreciate the domestic violence and children's well-being point, and that makes me want to mention something else I learned when I was in South Dakota is family court judges love 24/7 Sobriety, because the toughest decision they have to make is, "Do I remove this child from the home or not?" And, someone can pledge, "I promise I won't drink, I promise," but now you can actually verify, and that's good for the judge to make that decision, it's good for the kid, because you know immediately when something's gone wrong. But, it's also good for the parent who is abstaining, because they have a way to prove, "Yes, in fact, I am doing what I said I would do."

On the second issue raised, this is hugely important. There is - there are significant quality issues in addiction treatment throughout the United States. There are - fly by night is a very good term. We have some terrific programs, and we have some really lousy ones. Part of that has to do with, you know, relative to other parts of healthcare, it is a much more weakly funded segment, so the quality of staff is often lower. I mean, you pay less, you get less.

Also, regulators are often asleep at the switch. I mean, it's kind of amazing to me sometimes. The things, you know, you read stories about scandals in these programs, and you wonder where were the people who inspect treatment and programs?

So, that is a really significant problem, and it's - I think it's pretty difficult for individual judges to really be on top of that. They don't have the resources to do that. I think that really needs to come from the states. States are the hub of medical regulation in - under the arrangements we have in the U.S. The Federal Government can do some stuff, but, you know, licensing of doctors, of healthcare professionals, of programs is done by state.

And, so there needs to be significant capacity there, and then you need to also have to motivate them to look at those addiction programs, which are often not the highest priority among things regulators look at, but it really need to be.

Katharine Sullivan: Dr. Humphreys, it's Katie. How are you?

Dr. Keith Humphreys: Very well, nice to talk to you.

Katharine Sullivan: You too. It was wonderful, thank you. I love your study. I love what you're doing. I - but let me get to it. I have two questions. One's kind of tough, but the other one is off-topic, off what we talked about, but came up yesterday with two different presenters, and that's the idea of a warm handoff.

And, actually Dr. Drew talked about - you are the one who did a study that mentioned a warm handoff, and that that phrase maybe has gotten - it takes on a lot of different meaning, and a lot of different - for too, a lot of different people. So, can you help us with a definition of that, when it's appropriate. Is it appropriate to - for law enforcement to be deciding who has the warm handoff and who doesn't?

You know, if they approach someone, a crime has been committed, you know, and idea of warm handoff centers, things like that, if you know and have done those studies.

Dr. Keith Humphreys: Sure. So, the work Drew is referring to - so, I'm here at the University. I'm also in the Veterans Hospital in Palo Alto, and that's where we started doing this. So, with veterans who are in alcohol treatment, if you just say to them, "You know, there's this group called AA. Here's a pamphlet, you know, here's a list of meetings. You might want to check it out." Some of them go, but not a lot of them. But if you say, "I want to take," you know, a staff member says, "I want to take half an hour time in treatment to tell you about Alcoholics Anonymous and what it is, what the first meeting is like, talk about any worries you might have about it, and 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, dramatically higher, like from 20% to 60%, 70%.

So, it is definitely true to get over that anxiety, of first off, admitting you have a problem, reaching out for help, other people knowing you have a problem, that warm - warm handoffs can really make a substantial difference.

I think that's going to be hard structurally, though, for, you know, an officer to do that, you know, at the scene of an incident. You know, it would seem to me that might be the kind of thing that to the extent there are, you know, they are called different things in different departments, but, you know, the people who do the sort of, you know, the more social work side, you know, community support officers, is what they're most often called. They might be able to do that afterwards. You know, and the easiest way to do that is to take advantage of the fact that if the fellowships, if you call them and say, "I would like to, or we have some people we think we might benefit, I would like to have some names of people who could take them to their first meeting, or I'd like to know about newcomers meetings where they would be particularly comfortable." They'll help you do that, and, I think, that's the place where you might be able to make that link.

Katharine Sullivan: Warm handoff is really a 12-step call with - through some behavioral health person that you're in contact with, right? I mean, is that what I'm hearing?

Dr. Keith Humphreys: It's kind of like that, except that the person initiating it doesn't have to be in the program.

Katharine Sullivan: Yes, it says, "The behavioral health person, then the 12-step call basically, yes."

Dr. Keith Humphreys: That's right, yes.

Katharine Sullivan: And, then my second question is something that also came up yesterday to tie in some of the testimony that we're getting. And, that is that the person who, I believe, runs the LA County jail, I could be wrong about that, but said with these flash incarcerations, so that is the - I'm very troubled by this - because of this idea that, you know, short, quick sanctions through either drug court programs or maybe 24/7 programs like you're discussing, that criminal enterprise, criminals are using that in order to send people into jails with contraband, including drugs, and where drugs are decriminalized, even if you catch someone with a drug, it's not really a crime.

So, they're having this huge problem and increase of crime in the jail in - that's getting out of control. So, you have any thoughts about that, how this could end up - this idea of quick, swift sanctions, how could - any thoughts about that? It was an angle I've never considered before.

Dr. Keith Humphreys: Yes, well first off, I'd want to know the evidence. Like, how systematic it is. So, you know, we're all shaped by vivid anecdotes, right? So, is this happening a lot? How serious is it, that kind of thing?

In terms of where it's decriminalized, of course, alcohol's not illegal anywhere, right, and you can still run these kinds of programs just, because as we all know, you can subject people to - who are on probation or parole, to tighter conditions than apply to other citizens.

So, there isn't a legal problem where, in a decriminalization district, to still say, "Yes," but if you are like say with cannabis or something, I mean, you know, if you're on parole they're more restrictive. If there is a problem with people brining contraband in, I would think that's a more general problem, and not specific just to flash incarceration, because 24/7 Sobriety doesn't send many people to jail. You know, about maybe of the - I'm not sure how many tests. Maybe Secretary Price knows how many tests have been conducted so far in South Dakota. It's probably near 10,000,000. The rate at which people have shown up and blown negative is 99.1%.

So, even though the threat of flash incarceration is there, it’s very rarely used. So, I wouldn’t think these programs are the source of quick turnover into jails.

Craig Price: This is Craig Price. I don’t know if I'm off mute or not.

Phil Keith: You're live, Craig.

Craig Price: Okay. The - I don’t have those numbers handy. There is a Sheriff, Kevin Thom from Panton County on the phone, and if there's value in him speaking a little bit about this from the sheriff's perspective in the jails, I'm pretty sure he'd be willing to speak up, but if anybody in the Commission is interested in hearing that perspective.

John Clemmons: This is Sheriff Clemmons. I apologize. I missed that question. What was that comment? I had tried to get off of mute.

Dr. Keith Humphreys: Oh, no, Sheriff Kevin Thom from South Dakota can give the sheriff's perspective on this 24/7 as it relates to some of that jail stuff if anyone's in hearing that.

John Clemmons: Okay, all right. Sorry about that.

John Samaniego: This is Sheriff John Samaniego. I would be interested in it.

Smallwood: This is Commissioner Smallwood. I would also be interested.

Dr. Keith Humphreys: Okay. Kevin, are you able to speak up?

Phil Keith: I don't know if there's a way for the operator to get the sheriff the ability to speak or maybe that's not option. Maybe I spoke too soon.

Operator: He might have himself on mute, or he may have disconnected.

Phil Keith: And if he's on the other line just by chance, can you just let him know to press star one.

Operator: Yes, sir. Again, if you are on the participant side, you mind pressing the star one to signal.

Phil Keith: For the sheriff.

Operator: Sheriff, again, if you are on the participant side, press star one.

Craig Price: He's trying to do that. He just called me on the cell phone. He's trying to dial in.

Operator: Okay. We do have someone who's pressing star one. It could be him. I'll go ahead and open up his line. Your line is live.

Kevin Thom: Hello, this is Sheriff Kevin Thom. Can you hear me?

Phil Keith: Yes, sir.

Kevin Thom: Okay, well thank you. Sorry about the confusion getting connected. Secretary Price, thank you for the ((inaudible)) comment. Like Secretary Price, my roots go back with Larry Long when he was the Attorney General, and as the Director of our State Division of Criminal Investigation at the time, when Larry first started to put this program in place. So, my history goes back to its beginning, and now as sheriff, the last nine years, we administer the program, and I won't go through all the stuff the other presenter talked about in terms of success of the program.

We run probably 450 to 500 people a day on the program. It is offender pay, so there's no tax dollars that support it from our budget. The pass rate on the PVTs last year was 99.59% and on the UAs that we performed was 98.82%, so a high pass rate in terms of pass/fail. We're using the PVTs, the SCRAM bracelets, remote breath testing, the drug patch, a variety of things in conjunction with it.

Interestingly enough, with COVID-19, we stopped the PVTs. It's obviously someone coming in and blowing through a PVT tube into a closed environment with other participants and your staff, it was not recommended in COVID-19, so we've made some pretty dramatic changes to accommodate for COVID-19 currently. So, once this passes, we'll gin back to where we were pre-COVID-19.

But, anyway, that's a little bit of background, if anybody is ever interested in more data, they're certainly welcome to reach out to our office, and we're in Western South Dakota, home to Mount Rushmore National Monument. If you're looking for a landmark, that's where we're at. So, I'll stay on for any questions, thank you.

Phil Keith: Thank you, sheriff. Other questions from commissioners.

David Rausch: Yes, this is Director Rausch. Can you hear me? Thanks. So, curious, he brought up an interesting point that I want to just see if Dr. Humphreys has any insight on, and that is with the current situation we're in with the limited contacts, how do we foresee AA and 24/7, and those types of programs working? Will they be able to do something virtual, or smaller groups, or how do we see those continuing as we start in on this new phase we're in, and who knows how long this will last. We certainly don't want to see those types of programs go away, because we can't be in the same room with each other.

Dr. Keith Humphreys: Yes, you've raised a really important question. I know, because of the research. I've done, I know a lot of people in the program, and they are all kind of trying to figure out how to deal

with this, because they, you know, as some of them would say it, you know, "I feel like I might die if I go to a meeting, but I feel like I'm going to die if I don't get to a meeting." And, so it's really tough particularly for people in the early recovery where they need that support, and, you know, and most meetings are closing, you know, is what I've heard.

Out here, you know, pretty tech savvy place. People are moving them onto, you know, Zoom, and Skype, and those kind of things, but that's not an option everywhere, and not everyone has a good network and so on. So, you know, I've been suggesting to people, you know, talk to your sponsor, you know, try to reach out to people. Don't get isolated. That's usually bad. Lots of people who are in the program have maybe a tendency to brood a bit when they get isolated, and that's not good for them, so, to encourage them to reach out that way.

The other thing I say is just to give them some perspective is when AA started, there were so few people that, you know, if you were in rural Montana and there was no meeting, they actually wrote letters to the New York Office, and they would assign an experienced member somewhere else in the country to write them back and forth, and you would get a response, you know, a week later or two weeks later. So, it's not impossible for us to, you know, support each other in this environment. It's a lot harder, but, you know, people have done harder things, and allow - at least we do have the telephone and some parts of the country do have these, you know, amazing, you know, computer applications that can let us connect.

I'm hopeful this will not go on so long that it will undermine a lot of people in recovery, but those are the kind of interim things I've been suggesting to people as strategies until we get to that happy place.

Phil Keith: Other questions from commissioners?

Erica MacDonald: This is Erica MacDonald. I have a question regarding the 24/7 legislation. Being from one of the states, one of the - more than half the states that doesn't have a pilot program underway or 24 legislation passed, 24/7 legislation passed. Can you give me a little more information about what are the barriers to passing that kind of legislation? Are there costs associated? You know, if we're going to try to push this in my state or mandate it, or recommend it to other states, can you give us a little more information on that?

Dr. Keith Humphreys: Yes, it's not financial for a couple reasons. One, is like I say, there's federal dollars in the highway bill, but even beyond that, you know, in South Dakota you pay, I think it's a buck, at least it used to be a buck, when you get the breathalyzer, so the offenders are putting the money in, and it pays for itself.

So, the barriers don't tend to be fiscal. I think they tend to be - there's inertia, you know. We've all worked with state legislatures. They always have a lot to do. They may not have heard about it, or it works somewhere else, but it won't work here, you know, that sort of mentality sometimes.

Also, sometimes there are, you know, very strong faith and other types of things like Interlock technology and their committed to that, or DWI courts, and they're committed to that. And, not saying those things are bad, but it may make them less open to trying this thing they haven't heard of before.

I also never - I've learned never to underestimate just the power of poor dissemination. I mean, even though this program has, you know, spread to some states, and it's got a lot of good results, and it's gotten some nice news coverage, I still talk to people who've never heard of it. So, that could also be the case, especially as you move further away from the part of the country where it's concentrated, is, you know, folks just don't know about it.

And, you know, so I think what you guys, you know, if you choose to as a commission, that's I say something you could help with is just by highlighting it, you know, letting people know about it, State AGs, and legislators, and governors, because I suspect there's some folks out there who haven't heard of it, who if they did, would be excited to grab hold and give it a try.

Erica MacDonald: I agree. Thank you for that. I appreciate it.

John Samaniego: Dr. Humphreys, this is Sheriff John Samaniego from the Birmingham area of Alabama, and I have about a 500-inmate jail. Can you comment on the - how effective the AA would be within a jail facility?

Dr. Keith Humphreys: Thank you for that question, sir. So, in the short - I mean, jail's kind of unusual, right? People do sometimes, we know, slip alcohol into jail, but, you know, for the most part, people are not going to be able to drink, so that's a different task than the face when they get out. You know, it’s easy to abstain when alcohol's not available.

So, what I think you're getting when you have, you know, 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. And, that’s when they're going to have the real challenge, because out there in the world, of course, alcohol is available everywhere. And, we all know an enormous number of people, the first thing they do when they leave a correctional facility is get drunk.

And, so I think that's probably the outcome I would hope for folks is you know about it, you're linked to it, and then you have a different option when you get out, to get on a better path than just going straight back to liquor.

John Samaniego: Thank you, doctor. I've got a follow-up. We also have a very robust mental health application to our inmates, and we also have an 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.

So, I was just wondering if any - if you'd heard anything like that.

Dr. Keith Humphreys: You know, that's terrific. You know, I think that we could do a lot more of that than we do. I heard the warden of the Cook County Jail in Chicago say that she ran the world's biggest mental health facility, and I think a lot of people who run jails feel that way and with good reason. I mean, there's very high representation. I mean, what happened, if you look, if you go out broader to, over the last 60 years, is state mental hospitals used to have lots and lots of beds, and as they have shrunk, that population of people has now ended up incarcerated. And, they're very difficult to manage, it's hard for them, hard on the staff, and the facility.

So, the extent to which those alliances can be made, like you're making, you know, between corrections and mental health, I think it's all to the good. The country is very variable on this point. There are, you know, here in Santa Clara County we're fortunate. We have a fair amount of resources. We have a really good mental health facility in our jail. There are a lot of counties in California which that is not true, and in which they don't even have a good referral link that they can at least connect someone to when they leave. So, I think it's quite uneven.

John Samaniego: Thank you. I appreciate that.

Phil Keith: Other commissioners with questions. Okay, we're hearing no questions.

Let me close by thanking you, Dr. Humphreys, for your time and most valuable testimony, and certainly the responses to the questions from commissioners. On behalf of General Barr, his

leadership team of Rachel Bissex and Jeff Favitta, as well as all the commissioners, your contributions provided today, is sincerely appreciated, and will assist this commission in their deliberations, decisions, and recommendations.

Dr. Keith Humphreys: Thank you very much for having me. It was an honor. Good luck to all of you.

Phil Keith: Thank you, doctor.

Male: Thank you, doctor.

Erica MacDonald: Thank you.

Katharine Sullivan: Yes.

Male: Thank you.

Operator: This concludes today's call. Thank you for your participation. You may now disconnect.

Phil Keith: Well, we're not finished. We're not finished yet.

Operator: Go ahead.

Phil Keith: If you just, okay, thank you. Before we end the call, a quick preview of our schedule for next week, which we'll be sending out to you later today or tomorrow. Next week the Commission will be focusing on homelessness and substance abuse. We have ((inaudible)) call scheduled for Tuesday, March 31 at 2:00 pm Eastern Time. We have another call scheduled for Wednesday, April 1 at 3:00 pm. And, then our third call will be on Thursday, April the 2nd at 2:00 PM Eastern Time again.

Again, we'll make sure you have this information in both your calendar invites and a weekly wrap-up email that I'll send for the week - end of the week. Is there other business for the Commission?

Ashley Moody: Chairman Keith, this is Ashley Moody. I just wanted to let you know I missed the rollcall earlier, but I've been on the line since about 2:05.

Phil Keith: Yes, ma'am, thank you, and we're glad you joined us today. Any other business for the Commission? If there's no further business for us today, the President's Commission is adjourned. Thank you, again, commissioners, for your continued dedication and commitment.

Male: Thank you, sir.

Katharine Sullivan: Yes.

Male: Thanks, Phil.

Female: Thank you, Phil.

Male: Thanks, Phil.

Male: Thanks, Phil

Phil Keith: Operator, I think that does it for us. Thank you.

Operator: Okay, thank you, sir. Ladies and gentlemen, this concludes today's call. Thank you for your participation. You may now disconnect.