Chapter 1. Alleviating the Impact of Social Problems on Public Safety

Introduction of the Issue

PULL QUOTE: "It has never been the intention nor the design for law enforcement to be the sole solution to address homelessness, drug addiction, or the mentally ill. . . . Law enforcement should not be the strategy or the first face of government these individuals encounter or rely upon for help; law enforcement should be the last form of government these people encounter, and only when the intervention efforts have failed, resulting in a criminal violation of law." – Sheriff Don Barnes Orange County, CA Sheriff's Department[1]

Law enforcement, courts, and institutional and community corrections have become overly burdened with people who are mentally ill, substance dependent, or homeless, and law enforcement officers are often the first-line responders tasked with addressing these issues. Consequently, criminal justice systems have had to adapt and operate as shadow behavioral health system.

A look at three separate studies found that about 44 percent of jail inmates and 37 percent of prisoners were previously told they had a mental health disorder;[2] 63 percent of jail inmates and 58 percent of prisoners met the criteria for drug dependence or abuse;[3] and approximately 15 percent of those incarcerated had been homeless in the past year.[4] At the time of booking, the number of people in San Diego who reported being homeless in the last 30 days increased from 22 percent in 2014 to 39 percent in 2018; the number who reported being homeless at some point in the past increased from 60 percent in 2014 to 66 percent in 2018.[5]

Responding to and transporting those with mental illness accounts for an estimated 21 percent of a law enforcement officer's total time, which is staggering.[6] Sergeant Sarah Shimko, of the Madison, Wisconsin, police department, noted that her department investigated 44,623 distinct cases in 2019.[7] Among those, nearly 10 percent (4,275) had an element that involved mental health, and law enforcement officers spent approximately 33,895 hours addressing those cases. In calendar year 2019, Orange County, California, sheriff's department devoted approximately 11,600 hours to homeless-related calls for service, the equivalent of 6.5 patrol deputies working full time on these kinds of calls.[8]

These problems are intertwined. According to Sheriff Don Barnes of the Orange County Sheriff's Department, "We cannot make the mistake of looking at social problems impacting our communities in a silo. . . . Those we interact with who are homeless often have drug addiction; those who are drug addicted often have or will develop mental illness; and some of those who are experiencing mental illness are also homeless." [9]

This chapter provides recommendations to implement section four of the President's Executive Order on Safe Policing for Safe Communities, which states, "As a society, we must take steps to safely and humanely care

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[1] Barnes, *President's Commission on Law,* March 25, 2020.

[2] Jennifer Bronson, Ph.D. and Marcus Berzofsky, Dr. P.H., *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-2012* (Washington, DC: Bureau of Justice Statistics, 2017), 1, https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946.

[3] Jennifer Bronson, Ph.D., et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (Washington DC: Bureau of Justice Statistics, 2017), 27, https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.

[4] Greg A. Greenberg and Robert A. Rosenheck, "Jail Incarceration, Homelessness, and Mental Health: A National Study," *Psychiatric Services* 59, no. 2 (2008): 170–77.

[5] "Homelessness Among Justice System-Involved Individuals in San Diego County," *CJ Flash* 21, no. 9 (2019), https://www.sandag.org/uploads/publicationid/publicationid_4631_26706.pdf.

[6] E. Sinclair, *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey* (Arlington, VA: Treatment Advocacy Center, 2019), 9, https://www.treatmentadvocacycenter.org/road-runners.

[7] *President's Commission on Law Enforcement and the Administration of Justice: Hearings on Social Problems Impacting Public Safety* (March 24, 2020) (written statement of Sgt. Sarah Shimko, Madison, WI, police department, Mental Health Unit), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

[8] Raymond Grangoff, Chief of Staff, Orange County Sheriff's Office, Orange County, CA, email communication with the Social Problems Impacting Public Safety Working Group, May 26, 2020.

[9] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 25, 2020) (written statement of Don Barnes, Sheriff, Orange County, CA), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

for those who suffer from mental illness and substance abuse in a manner that addresses such individuals' needs and the needs of their communities."[10] The recommendations cover four points—the community, law enforcement, courts, and corrections—to address these social problems while easing the burden on law enforcement. They focus on rebuilding the community safety net of behavioral health treatment services to address such social problems at their roots, while simultaneously acknowledging that individuals in need still commit crimes and may become involved in the criminal justice system. Given this reality, numerous opportunities for community action exist to intervene and reduce these social problems, decrease recidivism, and ultimately lessen the burden on law enforcement and the criminal justice system as a whole. The commission's intent is to recommend methods to find the best outcome—in the most holistic and effective way possible—for those living with mental health issues, substance use disorder, and homelessness.

1.1 Rebuilding Behavioral Health Treatment Services in the Community

Background

PULL QUOTE: "Since the mid-twentieth century, America has witnessed a reduction in targeted mental health treatment. Ineffective policies have left more individuals with mental health needs on our nation's streets, which has expanded the responsibilities of law enforcement officers." – President Donald J. Trump, Executive Order[11]

Over the past 60 years, public policies have degraded the community's ability to understand, prioritize, and appropriately address mental illness, substance use disorders, and homelessness. One of the most significant impacts of these policies occurred in the 1960s with the shuttering (i.e., deinstitutionalization) of inpatient psychiatric treatment facilities. According to the *Psychiatric Times*, "In 1955 there were 558,239 state and county psychiatric beds available, or about 340 beds per 100,000 population. Currently, there are about 35,000 state psychiatric beds available, or about 11 beds per 100,000 population." [12] In addition to these closures, psychiatric drugs developed to treat many symptoms of mental illness became available, and patients' civil rights became more important—which helped reinforce the push toward outpatient care.[13]

Grecco and Chamber explain the bleak picture: "Unfortunately, deinstitutionalization was poorly organized and conducted without adequate build-up of supportive housing, social services, or outpatient community mental health infrastructure."[14] Many of those placed into communities became the least successful there. As addiction and mental illness are closely intertwined, the decrease in the community treatment options for mental health resulted in an increase in people with untreated mental illness and substance use disorders.

Additionally, in the 1970s, the public began to view drug use as a criminal justice problem instead of a biomedical problem. As a result, drug-related incarceration rates quadrupled from 1972 to 2012.[15] Simultaneously, correctional settings had little to no capability to treat substance use disorders.[16]

The decrease in community behavioral health treatment and the increase in housing costs also factor into an

[10] Executive Order 13929 of June 16, 2020, "Safe Policing for Safe Communities," Code of Federal Regulations, title 3 (2020): 37325-37328, https://www.federalregister.gov/documents/2020/06/19/2020-13449/safe-policing-for-safe-communities.
[11] Executive Order 13929, "Safe Policing for Safe Communities."
[12] E. Fuller Torrey, "A Dearth of Psychiatric Beds," *Psychiatric Times* 33, no. 2 (2016), https://www.psychiatrictimes.com/dearth-psychiatric-beds.
[13] Gregory G. Grecco and R. Andrew Chambers, "The Penrose Effect and Its Acceleration by the War on Drugs: A Crisis of Untranslated Neuroscience and Untreated Addiction and Mental Illness," *Translational Psychiatry* 9, no. 1 (2019): 2, https://doi.org/10.1038/s41398-019-0661-9.
[14] Gregory G. Grecco and R. Andrew Chambers, "The Penrose Effect and Its Acceleration by the War on Drugs: A Crisis of Untranslated Neuroscience and Untreated Addiction and Mental Illness," *Translational Psychiatry* 9, no. 1 (2019): 2, https://doi.org/10.1038/s41398-019-0661-9.
[15] National Reseach Council Committee on Causes and Consequences of High Rates of Incarceration, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington DC: National Academies Press, 2014), 2, https://www.nap.edu/read/18613/chapter/1.
[16] Redonna K. Chandler, Bennett W. Fletcher, and Nora D. Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," *Journal of the American Medical Association* 301, no. 2 (2009), https://doi.org/10.1001/jama.2008.976.

increase in the homeless population.[17] As a 2019 report on homelessness from the Council of Economic Advisors notes, "Due to decades of misguided and faulty policies, homelessness is a serious problem. Over half a million people go homeless on a single night in the United States. Approximately 65 percent are found in homeless shelters, and the other 35 percent—just under 200,000—are found unsheltered on our streets (in places not intended for human habitation, such as sidewalks, parks, cars, or abandoned buildings)."[18] Homelessness is often directly related to behavioral health disorders, physical health issues, and trauma, and the unsheltered homeless experience the worst health conditions and the longest period of homelessness.[19]

The longer one stays homeless, the more their health deteriorates.[20] Those who are mentally ill and reentering the community from correctional settings are especially high-risk of becoming homeless, as a criminal record makes it difficult to acquire housing or a job. [21]

As the homeless population has increased, so has the community's polarized response to an inability to address the problem. Faced with increased numbers of homeless campers and the quality-of-life offenses (e.g., loitering, panhandling, or littering) and victimization that result—especially in large encampments—some communities have attempted to pass laws to limit these activities, while others have attempted to provide the homeless encampments space (e.g., donated land) and other social programs.[22]

The intertwined nature of mental health disorder, substance use disorder, and homelessness highlights the need to find the best approach to address these complex social problems.

Current State of the Issue

PULL QUOTE: "Being homeless is not a crime. Having mental illness is not a crime. Having substance use disorder is not a crime."[23] – Mike Brown, Chief of Police Salt Lake City, Utah

Public perception about mental illness and drug use is changing; a change in perception often results in a change in practice. Currently, many insurance policies include mental health treatment options.[24] Increased evidence-based treatment protocols for mental health and substance use disorders, and co-occurring disorders, also exist, incorporating both medication-assisted and therapeutic treatments.[25] As more view addiction as a brain disorder and not an act of social disobedience, the stigma of drug use should decrease.[26]

The final report from the President's Commission on Opioids begins by reinforcing that "addiction is a disease" and provides a number of recommendations for addressing the opioid crisis in our nation.[27] The current opioid crisis has featured bipartisan attempts to address opioid addiction through government

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[17] The Council of Economic Advisers, *The State of Homelessness in America* (Washington, DC: Executive Office of the President, 2019), 41, https://www.whitehouse.gov/wp-content/uploads/2019/09/The-State-of-Homelessness-in-America.pdf.
[18] The Council of Economic Advisers, *The State of Homelessness in America, 1.*
[19] Janey Rountree, Nathan Hess, and Austin Lyke, *Health Conditions Among Unsheltered Adults in the U.S.* (Los Angeles, CA: California Policy Lab, 2019), 9 pages, https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf.
[20] Rountree, Hess, and Lyke, *Health Conditions Among Unsheltered Adults.*
[21] Harvard Health Publishing, "The homeless mentally ill," Harvard Health, accessed June 4, 2020, https://www.health.harvard.edu/newsletter_article/The_homeless_mentally_ill.
[22] National Law Center on Homelessness & Poverty, "Supreme Court Lets Martin v. Boise Stand: Homeless Persons Cannot Be Punished for Sleeping in Absence of Alternatives," December 16, 2019, https://nlchp.org/supreme-court-martin-v-boise/; Chris Herring, "Tent City, America," *Places Journal* (2015), https://placesjournal.org/article/tent-city-america/?gclid=CjwKCAjwssD0BRBIEiwA-JP5rBQ4BoDNLrDNQmaFmLV_w1PWrpj5QFxs-kpxmeCns-nHVwTRla2gPxoCLaAQAvD_BwE&cn-reloaded=1.
[23] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 31, 2020) (written statement of Michael Brown, Chief of Police, Salt Lake City, police department), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.
[24] "Health Insurance and Mental Health Services," MentalHealth.gov, accessed June 12, 2020, https://www.mentalhealth.gov/get-help/health-insurance.
[25] "Evidence-Based Practices Resource Center," Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, June 12, 2020, https://www.samhsa.gov/ebp-resource-center.
[26] Nora D. Volkow, George F. Koob, and A. Thomas McLellan, "Neurobiologic Advances from the Brain Disease Model of Addiction," *New England Journal of Medicine* 374, no. 4 (2016), https://doi.org/10.1056/NEJMra1511480.
[27] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

funding programs at the federal, state, and local levels. These programs are vast and varied, and they seek to improve community and criminal justice–related treatment capacity.[28]

There have also been changes in housing policies. Some communities have tailored homeless solutions to the needs of the individual, recognizing that trauma-informed care, supported housing programs, and affordable housing can be linked to achieve better solutions and outcomes.[29]

Steps have been made to improve the nation's community treatment capacity, yet there are still roadblocks. As described in a 2016 report from the Centers for Disease Control and Prevention (CDC), "Despite state and community planning efforts, behavioral healthcare systems lack sufficient capacity for addressing the needs of the population they serve. These systems were developed in the midst of funding shortages, shifting healthcare priorities, and decentralized planning efforts. . . . As a result, community behavioral healthcare systems have gaps in comprehensive care and redundancy of resource allocation."[30]

Although well intentioned, this system of care rarely prioritizes the needs of those who are involved in the criminal justice system.[31] Dr. Bruce Spangler, CEO of Volunteer Ministry Center, an organization that works with individuals experiencing homelessness, says, "Law enforcement and justice sectors have become the secondary and more times than not, the first line of engagement for individuals experiencing homelessness. Far too often, law enforcement officers are asked to possess on their utility belts: social work skills, mental health assessment tools, and the ability to respond to cases involving active addiction."[32]

Through the following recommendations, the commission offers solutions to help address the nation's lack of treatment capacity through improving treatment availability, quality, and ease of access; increasing prevention; removing barriers to treatment; and reducing the stigmas and increasing education. This system should also be able to serve the needs of people involved in the criminal justice system.

1.1.1 Local governments should provide a comprehensive system of care to screen, assess, and treat people with mental illness and substance use disorders that meets the demand of the community being served, including justice-involved individuals.

Through a comprehensive system of care, communities can respond to those referred by criminal justice professionals as well as those reentering society from correctional institutions to serve those in need before they interact with law enforcement,[33] creating positive outcomes for children, their families, and adults.[34]

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[28] Nancy La Vigne et al., *Comprehensive Opioid Abuse Program Assessment: Examining the Scope and Impact of America's Opioid Crisis Interim Report to Congress* (Washington, DC: Urban Institute, 2019), 87, https://www.urban.org/sites/default/files/publication/101990/comprehensive-opioid-abuse-program-assessment.pdf.; PLEASE ADD: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

[29] Heather Menzies Munthe-Kass, Rigmor C. Berg, and Nora Blaasvaer, "Effectiveness of Interventions to Reduce Homelessness: A Systematic Review and Meta-Analysis," Campbell Systematic Reviews 14, no. 1 (2018), https://onlinelibrary.wiley.com/doi/10.4073/csr.2018.3.

[30] Brandn Green, et al., "A Tool for Assessing a Community's Capacity for Substance Abuse Care," *Preventing Chronic Disease* 13 (2016), https://doi.org/10.5888/pcd13.160190.

[31] Natalie Bonfine, Ph.D., Amy Blank Wilson, Ph.D., L.S.W., Mark R. Munetz, M.D., "Meeting the Needs of Justice-Involved People With Serious Mental Illness Within Community Behavioral Health Systems," *Psychiatric Services* 71, no. 4 (2020), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900453.

[32] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 24, 2020) (written statement of Bruce Spangler, CEO, Volunteer Ministry Center), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

[33] Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf.

[34] Emily Woltmann, et al., "Comparative Effectiveness Of Collaborative Chronic Care Models For Mental Health Conditions Across Primary, Specialty, And Behavioral Health Care Settings: Systematic Review And Meta-Analysis," *American Journal of Psychiatry* 169, no. 8 (2012), https://www.ncbi.nlm.nih.gov/pubmed/22772364; Child, Adolescent and Family Branch, Center for Mental Health Services, *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress, 2015* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf.

A local comprehensive system of care includes, but is not limited to, leadership; appropriate treatment capacity; professionals trained in evidence-based practices for appropriate screening, assessment, and treatment; availability of telehealth, particularly to support rural, tribal, and special populations; medications prescribed when appropriate (i.e., medication-assisted treatment (MAT)); integrated dual diagnosis disorder treatment for people with co-occurring substance use and mental health disorders; and sufficient funding to directly fund or reimburse services.[35]

[CROSS REFERENCE RURAL AND TRIBAL]

Funding opportunities in 2020 for Certified Community Behavioral Health Clinics (CCBHC) offer communities the opportunity to move toward this approach.[36] CCBHCs emphasize a wide range of services, including behavioral health provided in the community and correctional facilities, to treat the whole-person rather than disconnected parts of the person's needs.[37] CCBHCs have expanded access to care and increased the scope of services in the community to include those referred by the criminal justice system.[38]

The Office of Care Coordination in Orange County, California, developed an integrated service plan for community corrections.[39] In reference to the Orange County jail, Sheriff Don Barnes says, "Sadly, this population of inmates often cycle in and out of custody multiple times throughout a single year. The integrated services plan is the solution to this destructive cycle that has impacted the safety of neighborhoods and put a drain on our existing resources."[40] This plan offers a road map as a model, laying out a vision for increasing the capacity and quality of care by 2025 for both the community and those who are referred to the criminal justice system.

1.1.2 Local governments should develop multi-service centers to provide triage and connections to longer-term care for people with mental health disorders, with substance use disorders and who are homeless.

Sergeant Sarah Shimko of the Madison, Wisconsin, police department notes, "Another gap in our community's continuum of crisis care is the lack of a single entry point crisis resource center. Law enforcement officers are tasked with navigating a complex and vast array of possible services and facilities in their attempts to reach the best possible resolution. They are often met with any number of barriers to connecting individuals in crisis with appropriate levels of support in their moment of need."[41]

These one-stop centers of centralized care can serve as crisis receiving centers while also providing other

[35] "The Center of Excellence for Integrated Health Solutions," National Council for Behavioral Health, accessed June 14, 2020, https://www.thenationalcouncil.org/integrated-health-coe/.
[36] "Certified Community Behavioral Health Clinic Expansion Grants," The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, accessed June 4, 2020, https://www.samhsa.gov/grants/grant-announcements/sm-20-012.
[37] Center for Mental Health Services Community Support Programs Branch, *Certified Community Behavioral Health Clinics Demonstration Program, Report to Congress, 2017* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017), https://www.samhsa.gov/sites/default/files/ccbh_clinicdemonstrationprogram_071118.pdf ; Community Support Programs Branch, Center for Mental Health Services, *Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018* (U.S. Department of Health and Human Services, 2019), https://aspe.hhs.gov/report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018.
[38] *CCBHC Impact Survey* (Washington D.C: National Council for Behavioral Health, 2017), https://www.thenationalcouncil.org/wp-content/uploads/2019/09/National-CCBHC-Impact-Survey-FINAL-11-28-17.pdf?daf=375ateTbd56; *How Community Behavioral Health Providers Are Supporting Police and Reducing Recidivism* (Washington D.C: National Council for Behavioral Health, 2019), https://www.thenationalcouncil.org/wp-content/uploads/2019/09/CCBHC-Criminal-Justice-Full-Report-4.13.18.pdf?daf=375ateTbd56.
[39] *Integrated Services, 2025 Vision, a County of Orange Community Corrections Report* (Orange County, CA: County of Orange Community Corrections System, 2019), http://cams.ocgov.com/Web_Publisher_Sam/Agenda10_22_2019_files/images/ATTACHMENT%20A_INTEGRATED%20SERVICES%202025%20VISION%20-LS_9853914.PDF.
[40] County of Orange Community Corrections System, *Integrated Services, 2025 Vision,* 6.
[41] Shimko, *President's Commission on Law Enforcement*, March 24, 2020.

treatment and support services to those in the community.[42] Crisis stabilization centers improve mental health outcomes and alleviate strains on emergency departments.[43] Successful models are run by behavioral health agencies or hospitals who have direct access to providers and medications. Creating a receiving center for those who are experiencing homelessness or a mental health crisis offers both law enforcement and the community an alternative to jails and emergency rooms.[44]

The Crisis Response Center (CRC) in Tucson, Arizona—centrally located to collaborate with other local services—has a comprehensive approach that attempts to address every part of the crisis continuum: prevention, early intervention, response, and postvention. Since its inception, the CRC has provided programs encompassing such services as peer-run wraparound services to pet therapy. Its crisis line relieves the burden from 911 and allows those in need to speak with someone who is specially trained to help them.

The CRC works closely to serve the needs of the Tucson Police Department by providing 24/7 access with minimal turnaround time and ensuring that there are no clinical barriers to care. The police department can refer or divert persons in need to the CRC, or patients can enter the CRC in other ways, including voluntarily or involuntarily admissions, walk-ins, or delivery through crisis mobile teams, law enforcement, or specialty courts. As Dr. Margie Balfour from the CRC explains, "We like the agitated people. We want them here."[45]

Strong multi-service centers are an immeasurable partner to law enforcement and the criminal justice system. Rural areas should consider regional centers or parallel services using telehealth.

[CROSS REFERENCE RURAL AND TRIBAL]

1.1.3 Congress should eliminate Medicaid's institutions for mental disease exclusion.

Medicaid defines an institution for mental disease (IMD) as a facility with greater than 16 beds which provides services to treat behavioral health disorders.[46] When Medicaid was created, defunding IMD facilities ensured that states were responsible for treatment costs and encouraged treatment options for individuals within the community. In 2018, Congress partially waived these restrictions to allow limited payment to IMD facilities as a comprehensive approach to opioid use disorder.[47]

D.J. Jaffe, Executive Director of mentalillnesspolicy.org*: How the Mental Health Industry Fails the Mentally Ill*, says, "The IMD Exclusion precludes states from receiving Medicaid for adults in state hospitals which forces states to close the beds. . . . When an officer wants someone admitted they sometimes sit in the ER for hours only to have the hospital overrule the officer or discharge the person before they are stabilized because of the lack of beds. They become 'round-trippers' and 'frequent-flyers.'"[48]

Congress's exclusion of IMD has backfired and should be repealed; it hinders the integration of treatment

[42] Center for Mental Health Services, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[43] *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), 2014), https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848.

[44] SAMHSA, *Crisis Services: Effectiveness*.

[45] Balfour and Winsky, *Tucson's Model's Comprehensive Approach.*

[46] *Medidcaid's Institutions for Mental Disease (IMD) Exclusion*, (Washington, D.C.: Congressional Research Service, 2019), https://crsreports.congress.gov/product/pdf/IF/IF10222.

[47] Athena Mandros, "IMD Waivers Change The Behavioral Health Treatment Landscape – In Some States," *OPEN MINDS* (blog), December 12, 2019, https://www.openminds.com/market-intelligence/executive-briefings/imd-waivers-change-the-behavioral-health-treatment-landscape-in-some-states/; Centers for Medicare & Medicaid Services, "CMS Announces New Medicaid Demonstration Opportunity to Expand Mental Health Treatment Services: CMS letter to State Medicaid Directors outlines new opportunities for states to receive payment for residential treatment services" November 13, 2018, https://www.cms.gov/newsroom/press-releases/cms-announces-new-medicaid-demonstration-opportunity-expand-mental-health-treatment-services.

[48] D.J. Jaffe, Executive Director, Mentalillnesspolicy.Org, public comment to President's Commission on Law Enforcement and the Administration of Justice, March 26, 2020.

services into the healthcare system and limits available treatment beds.

1.1.4 Local governments should develop a systematic process of early intervention for youth. This process should provide screening and assessment tools that identify high-risk youth who would benefit from prevention services, which include wraparound services to reduce prevalence of mental health disorder, substance use disorder, and homelessness.

In 2018, Approximately 1 in 7 (14.4 percent) youth ages 12-17 reported having a major depressive disorder over the past year, and of these 41.1 percent reported receiving treatment.[49] Also In 2018, 1 in 6 youth (16.7 percent) reported using illicit drugs in the past year and 3.8 percent of youth overall reported needing substance use treatment, while only 0.6 percent of all youth surveyed reported receiving any substance use treatment.[50] Of the homeless population who were counted nationwide on a single night in 2019, 19 percent were children younger than age 18 (107,069 children).[51] Youth with mental health disorders, substance use disorders, and/or are homeless are at a greater risk of becoming victims of trafficking, reinforcing the need to identify and provide assistance to these children.[52]

The prevalence rate of youth with mental health and substance youth disorders is greater in the juvenile justice system than in the general population.[53] In addition, approximately 62 percent of homeless youth have been arrested at some point.[54] These challenges are multi-generational, so children with parents who suffer from behavioral health disorders or homelessness are more likely to experience these challenges.[55]

Using the juvenile justice system to meet the needs of juvenile mental health concerns signals that there is a missed opportunity to properly and appropriately identify at-risk juveniles. This, in turn, increases the probability that they will encounter law enforcement later in life.

As Wendy Sawyer writes for the Prison Policy Initiative, "An estimated 90 percent of justice-involved youth have experienced serious trauma in their lifetime. Understanding the impact of trauma on cognitive development and behavior, policymakers and practitioners have increasingly called for trauma-informed care—not punishment—for justice-involved youth."[56]

With early childhood screening and assessment of need, treatment protocols including cognitive behavioral therapy and wraparound services for the child and family will help prevent the juvenile from making behavior

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[49] *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), 2019), 2, 4, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[50] SAMHSA, *Key Substance Use and Mental Health Indicators*, 3,13, and 51.

[51] Meghan Henry, et al., *The 2019 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-In-Time Estimates Of Homelessness* (Washington DC: U.S. Department of Housing and Urban Development, 2020), 9, https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf.

[52] https://www.tandfonline.com/doi/abs/10.1080/01488376.2018.1428924; http://www.wunrn.org/news/2009/10_09/10_05_09/100509_trafficking.htm

[53] Lee A. Underwood and Aryssa Washington, "Mental Illness and Juvenile Offenders," *International Journal of Environmental Research and Public Health* 13, no. 2 (2016), https://doi.org/10.3390/ijerph13020228.

[54] *Administration for Children and Families Family and Youth Services Bureau Street Outreach Program Data Collection Study Final Report* (Washington DC: Administration on Children, Youth and Families, Family and Youth Services Bureau, 2016), 63. https://www.acf.hhs.gov/sites/default/files/fysb/data_collection_study_final_report_street_outreach_program.pdf.

[55] Myrna M. Weissman et al., "A 30-Year Study of 3 Generations at High Risk and Low Risk for Depression," *JAMA Psychiatry* 73, no. 9 (September 1, 2016), https://doi.org/10.1001/jamapsychiatry.2016.1586; Jennifer A. Bailey et al., "Associations Between Parental and Grandparental Marijuana Use and Child Substance Use Norms in a Prospective, Three-Generation Study," *Journal of Adolescent Health* 59, no. 3 (September 1, 2016), https://doi.org/10.1016/j.jadohealth.2016.04.010; Deborah Johnson, "Generational Homelessness in New York City Family Homeless Shelters," PhD thesis, Walden University, 2018, https://scholarworks.waldenu.edu/dissertations/4738; Magdalena Romanowicz et al., "The Effects of Parental Opioid Use on the Parent–Child Relationship and Children's Developmental and Behavioral Outcomes: A Systematic Review of Published Reports," *Child and Adolescent Psychiatry and Mental Health* 13, no. 1 (January 12, 2019), 5, https://doi.org/10.1186/s13034-019-0266-3.

[56] Wendy Sawyer, *Youth Confinement: The Whole Pie 2019* (Northampton, MA: Prison Policy Initiative, 2019), https://www.prisonpolicy.org/reports/youth2019.html.

choices that lead to justice-involved incidents.[57] One example is the Wraparound Milwaukee program, which incorporates a unique plan for each child in need, including the child's family unit, and integrates support services that are available to the child.[58]

[CROSS REFERENCE JUVENILE JUSTICE CHAPTER]

1.1.8 Federal, state, and local governments should increase the funding of short- and long-term supported housing for people who have behavioral health disorders and who are also homeless or at risk of becoming homeless.

As outlined in "The State of Homelessness in America" presented by the Council of Economic Advisors in 2019, homelessness may have many underling factors, including the lack of affordable housing due to the overregulation of housing markets; street conditions that are more comfortable for sleeping when not sheltered (e.g., warmer conditions); the availability of shelter beds; and individual-level factors of behavioral health disorders, past incarceration, few social ties, and low income.[59]

As noted, homelessness is often linked to behavioral health, physical health issues, and trauma. Homeless and unsheltered persons are more likely to interact with police, stay in emergency rooms, and spend time in jail.[60] Further, people who experienced prison are nearly 10 times more likely to be homeless than the general public,[61] and approximately 15 percent of those incarcerated had been homeless in the past year.[62]

Permanent housing is a predictor of health; an individual without stable housing is unlikely to comply with treatment. Supported housing will greatly benefit those who are most at risk of entering or reentering the system: persons who are homeless and who suffer from severe mental health and substance use disorders.[63]

Additional research should be conducted about the various supported housing models. A 43-study meta-analysis from the Campbell Collaboration, which promotes social and economic change through the production of systematic reviews, states, "We found that a range of housing programs and case management interventions appear to reduce homelessness and improve housing stability, compared to usual services."[64]

[BEGIN TEXT BOX]

"Trauma Informed Care + Affordable Housing = Housing Stability

Homelessness is often viewed as a single population. However, the best way to address homelessness is not a one size fits all approach, but rather the tailoring of services and support to an individual's needs."[65] - Dr. Robert Marbut, Jr., Executive Director, US Interagency Council on Homelessness

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[57] Jennifer Schurer Coldiron, Eric Jerome Bruns, and Henrietta Quick, "A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014," Abstract, *Journal of Child and Family Studies* 26, no. 5 (2017), https://link.springer.com/article/10.1007/s10826-016-0639-7; Dustin Pardini, "Empirically Based Strategies for Preventing Juvenile Delinquency," *Child and Adolescent Psychiatric Clinics* 25, no. 2 (2016), https://www.childpsych.theclinics.com/article/S1056-4993(15)00114-5/abstract.

[58] Bruce Kamradt and Pnina Goldfarb, *Demonstrating Effectiveness of the Wraparound Model with Juvenile Justice Youth through Measuring and Achieving Lower Recidivism* (Baltimore, MD: The Technical Assistance Network for Children's Behavioral Health, 2015), https://nwi.pdx.edu/pdf/Wraparound-model-with-jj.pdf.

[59] The Council of Economic Advisers, *The State of Homelessness in America*.

[60] Rountree, Hess, and Lyke, *Health Conditions Among Unsheltered Adults, 3*.

[61] Lucius Couloute, *Nowhere to Go: Homelessness among Formerly Incarcerated People* (Northampton, MA: Prison Policy Initiative, 2018), https://www.prisonpolicy.org/reports/housing.html.

[62] Greg A. Greenberg and Robert A. Rosenheck, "Jail Incarceration, Homelessness, and Mental Health: A National Study," *Psychiatric Services* 59, no. 2 (2008):2, https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2008.59.2.170.

[63] Andrew J Baxter et al., "Effects of Housing First Approaches on Health and Well-Being of Adults Who Are Homeless or at Risk of Homelessness: Systematic Review and Meta-Analysis of Randomised Controlled Trials," *Journal of Epidemiology and Community Health* 73, no. 5 (2019), https://doi.org/10.1136/jech-2018-210981.

[64] Munthe-Kass, Berg, and Blaasvaer, *Effectiveness of Interventions to Reduce Homelessness*.

[65] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (April 1, 2020) (written statement of Dr. Robert Marbut, Jr., Executive Director, US Interagency Council on Homelessness), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

[END TEXT BOX]

Federal, state, and local governments must prioritize funding for these supported housing initiatives. The Department of Housing and Urban Development should provide additional support to local municipalities and federal and state governments should assist with funding to develop the program infrastructure. To have housing with supports for people who need it, physical housing units must first be identified and secured.[66]

1.1.9 Local government leaders should develop and implement a formal data-informed collaboration of criminal justice, public health, and social service agencies to reduce the communities' unmet behavioral health treatment and homeless service needs.

Local government should provide leadership and develop solutions supported by adequate funding to address these social problems and significantly reduce the burden on law enforcement. This collaboration should identify ways to optimize accountability and resources targeted on assessing and understanding the problem, planning and implementing collective community-supported strategies, using data-informed decision making, and working with evidence-based practices, when possible.

Maryland's Prince George's County initiated CountyStat, a layered approach to addressing social problems and crime in the county—sharing and examining data across multiple agencies and guiding and coordinating initiatives to improve the quality of life for county residents. The core understanding of CountyStat is that law enforcement is not solely suited to address the county's social problems. Through data-informed performance measures, CountyStat holds government agencies accountable by focusing on key indicators and providing the agencies the tools to improve their own performance.[67] This model also assumes that these social problems and crime converge at places and among individuals.[68]

CountyStat is currently part of an integrated services program focused on the needs of frequent users—those identified as "high-risk, high-utilizing Medicaid beneficiaries who have four or more emergency visits per year or have two or more chronic conditions—including mental illnesses and substance abuse disorders—and are at risk of institutional placement or homelessness following release from a publicly funded institution such as a health care facility, jail or other corrections program."[69] The county also works to share data among the jail, social services, and other health providers by focusing on identifying those incarcerated who need permanent housing upon reentry. Individuals incarcerated more than 90 days lose their federal benefits because they are no longer considered chronically homeless, so it is critical to identify such individuals early to ensure their housing needs are met prior to release.[70]

Chief Hank Stawinski, from the Prince George's County Police Department in Maryland, states, "We must acknowledge that we will never have limitless resources with which to effect change . . . we can demonstrate to the community that the investments that we are making with the resources that we do have will yield the greatest return . . . in terms of producing public safety and enhancing the quality of life for all persons."[71]

1.1.10 The Department of Justice should coordinate an interagency collaboration with the Substance

[66] For a similar recommendation please see recommendation 3.6 in Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works,* (Washington, DC: Interdepartmental Serious Mental Illness Coordinating Committee, 2017) https://store.samhsa.gov/product/The-Way-Forward-Federal-Action-for-a-System-That-Works-for-All-People-Living-With-SMI-and-SED-and-Their-Families-and-Caregivers-Full-Report/PEP17-ISMICC-RTC.

[67] Natalie Ortiz and Vernon Smith, "Building Data-Driven Justice in Prince George's County, MD," (Washington, DC: National Association of Counties, 2018), https://www.naco.org/resources/building-data-driven-justice-prince-georges-county-md.

[68] David Weisburd and Clair White, "Hot Spots of Crime Are Not Just Hot Spots of Crime: Examining Health Outcomes at Street Segments," *Journal of Contemporary Criminal Justice* 35, no. 2 (2019), https://doi.org/10.1177/1043986219832132; Anne Milgram et al., *Integrated Health Care and Criminal Justice Data — Viewing the Intersection of Public Safety, Public Health, and Public Policy Through a New Lens: Lessons from Camden, New Jersey* (papers, Program in Criminal Justice Policy and Management, Harvard Kennedy School, 2018), https://www.hks.harvard.edu/sites/default/files/centers/wiener/programs/pcj/files/integrated_healthcare_criminaljustice_data.pdf.

[69] Ortiz and Smith, "Building Data-Driven Justice in Prince George's County, MD."

[70] Ortiz and Smith, "Building Data-Driven Justice in Prince George's County, MD."

[71] Stawinski, email communication with Social Problems, May 21, 2020.

Abuse and Mental Health Services Administration and the Department of Veterans Affairs to conduct an awareness campaign for 988 and ensure appropriate resources to address the increased call volume when 988 is adopted as the National Suicide Prevention Lifeline.

PULL QUOTE: "From 2005 to 2017, there was a 43.6 percent increase in the number of suicide deaths in the general American population." - Matthew Miller, PhD, Director for Suicide Prevention, Department of Veterans Affairs[72]

On December 19, 2019, the Federal Communications Commission designated 988 as the new number for the National Suicide Prevention Lifeline.[73] Having a three-digit number akin to 911 will increase awareness and normalize requests for assistance during a mental health crisis.[74] The more people are aware of this lifeline, the more lives will be saved and the number of suicide-related calls to 911 will decrease.

SAMHSA currently funds the lifeline's administration through a 2018 grant totaling upwards of $18 million to the Mental Health Association of New York City.[75] When an individual calls the hotline, veterans are given the choice to be routed to a line run by the U.S. Department of Veterans Affairs (VA),[76] while all other calls will be routed to a call center close to their location. The veterans' calls are funded through the VA; the local call centers have different funding streams and are mostly staffed by specially trained volunteers.[77]

As 988 use increases, the Department of Justice should coordinate an interagency collaboration with SAMHSA and the VA to ensure appropriate planning, coordination, and resource allocation to increase awareness, match the increase in call volume, and improve the lifeline's effectiveness. John Draper, Director of Lifeline, says, "Lifeline administrators predict that calls could double to 5 million in the first year and keep growing to 12 to 16 million by the fifth. Meeting that need will require more funding and staff for the local call centers, many of which are already struggling to meet the demand for their services."[78]

[CROSS REFERENCE OFFICER HEALTH AND WELLNESS]

1.1.11 Congress should fund the Department of Health and Human Services to increase the awareness capacity, quality, uniformity, and coverage of 211 services nationwide to reduce the burden of call response in situations involving the police.

In 2000, the Federal Communications Commission designated 211 as a shortcut for community information and referral services at the local level, providing an alternative to calling 911 for non-emergency, community service assistance. [79] The local 211 call takers proactively assist those who needing behavioral health services, housing, food, or other local services, with specialized services for veterans.[80]

The San Diego 211 center serves as a model site with an integrated concierge approach. Well-trained call

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[72] *President's Commission on Law Enforcement and the Administration of Justice: Hearing* (April 1, 2020) (written statement of Dr. Matthew Miller, Director of Suicide Prevention, Department of Veterans Affairs), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

[73] Federal Communications Commission, "*FCC PROPOSES DESIGNATING 988 AS NATIONAL SUICIDE PREVENTION & MENTAL HEALTH HOTLINE NUMBER,*" December 12, 2019, https://docs.fcc.gov/public/attachments/DOC-361337A1.pdf.

[74] Ajit Pai, *Statement Of Chairman Ajit Pai, Re: Implementation of the National Suicide Hotline Improvement Act of 2018, WC Docket No. 18-336* (Washington, D.C: Federal Communications Commission, 2018), https://docs.fcc.gov/public/attachments/DOC-361337A2.pdf.

[75] The Substance Abuse and Mental Health Services Administration (SAMHSA), "SAMHSA awards $61.1 million in suicide prevention funding," September 21, 2018, https://www.samhsa.gov/newsroom/press-announcements/201809211000.

[76] "What to Expect," Veterans Crisis Line, accessed June 5, 2020, https://www.veteranscrisisline.net/about/what-to-expect.

[77] Greg Miller, "Can Three Numbers Stem the Tide of American Suicides?," *The Atlantic*, September 23, 2019, https://www.theatlantic.com/health/archive/2019/09/suicide-prevention-hotline-988/598588/.

[78] Miller, "Can Three Numbers Stem the Tide of American Suicides?"

[79] *2-1-1 Report to the Federal Communications Commission* (Washington, DC: Federal Communications Commission, 2000), https://ecfsapi.fcc.gov/file/6518190732.pdf.

[80] Cox, in discussion with Social Problems, April 23, 2020.

takers ask specific questions with the goal of improving the quality of life one individual at a time.[81] The call takers join the callers with services based on geography and need from a list of 1,500 service providers.[82] In fact, 211 has worked to create a thriving information exchange between community service providers.[83] The call-takers integrate a person-centered approach, tracking the referrals and following up with high-risk clients, while continuing to assist them.[84] Local police both refer individuals to 211 for services and use 211 to locate services for citizens, including open shelter beds.[85]

The 211 service is often run at the county or regional level and "is available to approximately 309 million people, which is 94.6 percent of the total U.S. population."[86] Funding and operation for centers is locally dependent, and 70 percent are partially funded and managed by the United Way.[87] These centers vary in funding strategies. San Diego 211 combines local and state funding with financial support from the service agencies who provide services to the callers.[88] Quality and scope vary greatly. Although 98.3 percent of California's population has access to 211 services, 13 counties received 211 services as recently as November 2019 for disaster-related services only, while 7 counties still do not have access to 211 services.[89]

Increased federal funding could support public advertising campaigns, technical assistance, and the establishment of model 211 sites, helping set standards for local 211 centers, improving services and awareness, and reducing involvement by law enforcement to address people who need community assistance. It would also help 211 centers decrease the burden on criminal justice professionals, encourage partnerships with law enforcement, and identify effective ways to fill service gaps in rural and tribal communities, such as increasing telehealth and video-enabled assistance.

[CROSS REFERENCE RURAL AND TRIBAL CHAPTER]

1.2 Law Enforcement's Role and Responsibilities to Address Social Problems

Background

Law enforcement has been forced to adapt to a different role than what they expected when they were hired or how they were trained in the police academy. If solving crime is their first priority, then social issues cannot simultaneously be the top priority.[90] Police officers must respond to these social problems while still conducting their normal job duties and taking on various other duties, as expected or assigned.[91]

Using law enforcement to address mental health or substance use is the most accessible solution, but it is not the best. Research by Charette, Crocker, and Billette found that such encounters use a greater level of

[81] William York, Preident and CEO, San Diego 211, San Diego, CA, in discussion with the Social Problems Impacting Public Safety Working Group, May 8, 2020; Karis Grounds, Vice President of Health and Community Impact, San Diego 211, San Diego, CA, in discussion with the Social Problems Impacting Public Safety Working Group, May 8, 2020.
[82] Cox, in discussion with Social Problems, April 23, 2020.
[83] "CIE Toolkit," Community Information Exchange (CIE) San Diego, accessed June 5, 2020, https://ciesandiego.org/toolkit/; "CIE Navigating the intersection of health and social services through information sharing and coordinated care," Community Information Exchange (CIE), accessed June 5, 2020, https://ciesandiego.org/.
[84] *Connecting the Unconnected Through 211 and Other Centralized Call Centers* (Washington, DC: National Association of Counties, 2019), https://www.naco.org/sites/default/files/documents/211-Toolkit.pdf.
[85] Cox, in discussion with Social Problems, April 23, 2020.
[86] "Dial 211 for Essential Community Services," Federal Communications Commission, December 31, 2019, https://www.fcc.gov/consumers/guides/dial-211-essential-community-services.
[87] "About 211," 211, accessed June 5, 2020, https://www.211.org/pages/about.
[88] William York, President and CEO, San Diego 211, San Diego, CA, in discussion with the Social Problems Impacting Public Safety Working Group, May 8, 2020.
[89] California Public Utilities Commission website, accessed April, 26, 2020, https://www.cpuc.ca.gov/General.aspx?id=7846.
[90] Judith Adelman, *Study in Blue and Grey, Police Interventions with People With Mental Illness: A Review of Challenges and Responses* (Vancouver, BC: Canadian Mental Health Association BC Division, 2003), https://cmha.bc.ca/wp-content/uploads/2016/07/policereport.pdf.
[91] *The Workforce Crisis, and What Police Agencies Are Doing About It*, (Washington, DC: Police Executive Research Forum, 2019), 7, https://www.policeforum.org/assets/WorkforceCrisis.pdf.

resources - 90 percent – as compared to encounters with individuals who are not mentally ill.[92]

The high frequency of interaction officers have with citizens with mental health or substance use disorders, or homeless with these disorders, puts officers at a higher risk of using force, thereby increasing risk of injury to the citizen and themselves.[93] The Los Angeles Police Department reported that as their homeless population has grown, use of force reports on homeless increased by 26 percent in the third quarter of 2019, as compared to the same time the year prior.[94] The Orange County, California, sheriff's department's 2019 use of force report illustrates the extent to which drug and alcohol abuse and mental illness are factors. Out of 456 subjects with whom officers used force, 215 of them (47 percent) were under the influence of drugs or alcohol, had mental health issues, or both.[95] At the national level, approximately a quarter of fatal police shootings are related to individuals with mental health disorders.[96] Further, individuals diagnosed with a mental illness have a 16 times greater chance to be killed by police than those without this disorder.[97]

Michael Stuart, U.S. Attorney for West Virginia, notes that these additional responsibilities directly impact officer morale, in particular "the seemingly tremendous fatigue among law enforcement and a general sense that the enforcement of substance abuse crimes is a way of life that will never really resolve itself."[98] A 2019 report from the Police Executive Research Forum found, "Police agencies need a more diverse set of officers who possess key skills such as interpersonal communications, problem-solving, basic technological expertise, critical thinking, empathy, and 'community-mindedness,' along with the traditional law enforcement skills required of all officers."[99]

[CROSS REFERENCE POLICE OFFICER RECRUITMENT AND TRAINING]

Current State of the Issue

Society expects law enforcement to be the first and primary responder to the immediate crisis, regardless of the presence of a crime. Changing the culture, enacting policy changes to match that new culture, and building a community service infrastructure can take decades. At present, this leaves law enforcement as the first responders and problem-solvers to incidents they lack the training or expertise to address. For some incidents, unfortunately, the officer is left with no other avenue for resolution and must choose arrest.

Many individuals who are battling behavioral health issues or who are without a home still commit crimes, either because of their illness or current need for everyday necessities (e.g., food or shelter). Regardless of illness or need, some people simply have a greater propensity to commit crime, and those individuals should be held accountable. These criminogenic needs should be addressed while providing behavioral and physical

[92] Yanick Charette, Anne G. Crocker, and Isabelle Billette, "Police Encounters Involving Citizens With Mental Illness: Use of Resources and Outcomes," *Psychiatric Services* 65, no. 4 (2014): 515, https://doi.org/10.1176/appi.ps.201300053.

[93] Michael T. Compton et al., "Use of Force Preferences and Perceived Effectiveness of Actions Among Crisis Intervention Team (CIT) Police Officers and Non-CIT Officers in an Escalating Psychiatric Crisis Involving a Subject With Schizophrenia," *Schizophrenia Bulletin* 37, no. 4 (2011), https://doi.org/10.1093/schbul/sbp146 ; Joel H. Garner and Christopher D. Maxwell, "Measuring the Amount of Force Used by and against the Police in Six Jurisdictions," in *Use of Force by Police: Overview of National and Local Data* (Washington, DC: National Institute of Justice, 1999), 25–44, https://www.ncjrs.gov/pdffiles1/nij/176330-2.pdf.

[94] Leila Miller, "Use-of-Force Incidents against Homeless People Are up, LAPD Reports," Los Angeles Times, January 21, 2020, https://www.latimes.com/science/story/2020-01-21/use-of-force-incidents-against-homeless-people-are-up-lapd-reports.

[95] Don Barnes, Sheriff, Orange County Sheriff's Office, Orange County, CA, email communication with the Social Problems Impacting Public Safety Working Group, April 20, 2020.

[96] Kimberly Kindy and Kennedy Elliott, "Six Important Takeaways from The Washington Post's Police Shootings Investigation," Washington Post, December 26, 2015, https://www.washingtonpost.com/graphics/national/police-shootings-year-end/.

[97] "Overlooked in the Undercounted," Treatment Advocacy Center, December 2015, https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted.

[98] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (April 2, 2020) (written statement of Michael Stuart, United States Attorney of West Virginia), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

[100] Jennifer L. Skeem, Sarah Manchak, and Jillian K Peterson, "Correctional Policy for Offenders With Mental Illness: Creating a New Paradigm for Recidivism Reduction," *Law and Human Behavior* 35, no. 2 (2011), https://pubmed.ncbi.nlm.nih.gov/20390443/.

health treatment, employment training, education, and housing assistance.[100]

The community safety net needs repair; yet, law enforcement continues to bear a significant burden to respond to and determine the next steps for those who are mentally ill, substance involved, or homeless. Often lacking external community support, law enforcement has created innovative strategies to respond to individuals with those issues, most notably by forming partnerships with trained professionals.

When law enforcement must take a person in need into custody, innovative police agencies have developed processes that depend on strong partnerships with treatment service providers to provide help, such as referral, delivery to crisis care, or pre-arrest diversion strategies.[101] These behavioral health and services partnerships allow a way to provide care without arrest when a crime is not committed. They also allow a way to provide care through diversion at other stages within the criminal justice process, considering the treatment need and the charge of the crime, if a crime has occurred.

These recommendations recognize that law enforcement will continue to respond to incidents involving individuals who suffer from mental health disorders, substance use disorders, or homelessness. They call upon law enforcement strengths, such as ensuring strong policies and procedures, while relying on community experts and services to invest in strong partnerships with law enforcement. The recommendations seek to diffuse these policies, procedures, and partnerships more fully across the nation.

1.2.1 States should develop model policies and base-line training for local call takers for all N11 codes (e.g., 911, 211, 411, or 311). These policies should include procedures to optimally handle and assign calls for individuals experiencing mental illness, substance use disorders, and homelessness during a crisis or a non-crisis situation.

Recognizing that the numbers and services connected to them vary by locality, governments and call centers should tailor the policies and training to best fit the N11 exchange codes (e.g., 911, 211, 411, or 311 exchanges) and needs of their geographic coverage. A state model for policy and training should provide a base level of consistency; ensure high standards for all call taking centers and specialized numbers; provide basic knowledge for all call takers on how to best assist callers in a professional, compassionate manner regarding these social problems; and ensure collaboration and coordination cross the exchanges.

The first priority when individuals call any local exchange is to ensure they are directed to the correct service and level of response. The standard emergency number, 911, not only receives emergency calls, but also responds to calls better handled by non-emergency exchanges. Alternatively, an individual who calls 211 for a service referral may be in immediate crisis. With proper training, the 211 call taker should understand how to best assist this person by handing a crime-call off to 911 or a non-crime call to a specialized crisis line. As 988, the National Suicide Prevention Lifeline, transitions into use, the 911, 211 and other call-exchange operators should have a standard operating procedure for when to use this resource and provide a warm hand-off to the specialty trained call-takers.[102]

PULL QUOTE: "911 call takers can be trained to triage crisis calls and identify whether the person in crisis is a danger to themselves or an immediate threat to someone else. If not, then the call can be transferred to

[100] Jennifer L. Skeem, Sarah Manchak, and Jillian K Peterson, "Correctional Policy for Offenders With Mental Illness: Creating a New Paradigm for Recidivism Reduction," *Law and Human Behavior* 35, no. 2 (2011), https://pubmed.ncbi.nlm.nih.gov/20390443/.

[101] David B. Wilson, Iain Brennan, and Ajima Olaghere, "Police-Initiated Diversion for Youth to Prevent Future Delinquent Behavior," *Campbell Systematic Reviews* 14, no. 1 (2018), https://onlinelibrary.wiley.com/doi/10.4073/csr.2018.5; Carolyn S. Dewa et al., "Evidence for the Effectiveness of Police-Based Pre-Booking Diversion Programs in Decriminalizing Mental Illness: A Systematic Literature Review," *PLOS ONE* 13, no. 6, (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6007921/; David B. Wilson, Iain Brennan, and Ajima Olaghere, "Police-Initiated Diversion for Youth to Prevent Future Delinquent Behavior," Campbell Collaboration, June 1, 2018, https://campbellcollaboration.org/better-evidence/police-initiated-diversion-to-prevent-future-delinquent-behaviour.html; Michael S. Rogers, Dale E. McNiel, and Renée L. Binder, "Effectiveness of Police Crisis Intervention Training Programs," *Journal of the American Academy of Psychiatry and the Law Online* 48, no. 2 (2019), http://jaapl.org/content/early/2019/09/24/JAAPL.003863-19.

[102] https://www.fcc.gov/document/fcc-designates-988-national-suicide-prevention-lifeline

appropriate care in the mental health crisis system through a warm hand-off to a crisis line."- Ron Bruno, Executive Director, CIT International[103]

Model state policy and training for 911 call takers on these issues should include, but not be limited to, education on the unique needs and optimal responses—including hand-offs to other exchanges. This way, the call taker can triage the call and ensure all needed information is provided to those who are responding to the call while also preparing the caller for the arrival of the responding agency or service. The model state policy should provide guidance on proper data collection, including how to appropriately record and code calls that involve individuals who have behavioral health challenges or are experiencing homelessness.[104]

In Prince George's County, Maryland, all new 911 and dispatch employees receive eight weeks of academic training that includes the completion of six certifications. This is followed by four months of hands-on, practical training in the performance of their duties.[105] A standardized state or local mandate for minimum requirements would help ensure that all 911 personnel possess the same critical life safety skills.

1.2.2 Law enforcement agencies should have a policy that specifies officer response protocols for calls for service that involve individuals with a mental health disorder or substance use disorder or those who are homeless.

In 2019, the Council on State Governments Justice Center (CSGJC) issued "Police-Mental Health Collaborations," a framework to help law enforcement implement effective responses to people with mental health needs. The report notes, "Written policies and procedures that are communicated clearly to staff are critical to the overall success of a Police Mental Health Collaboration (PMHC) and empower officers to take actions that can enhance their safety and the safety of others. . . . The PMHC will only realize success, and policies and procedures will only be effective, when these policies and procedures are disseminated, followed, and enforced by leaders in both the law enforcement and behavioral health agencies."[106]

The CSGJC framework applies to developing a policy response to those individuals with mental health needs, but can also be applied to policy development for individuals who are substance-use dependent or homeless.[107] The framework recommends a study and improvement of the agency's current process flow, including strengthening agency procedures and improving connections to community resources (e.g., behavioral health providers).[108] Through clear policies and training, officers should be fully aware of the process to follow and resources available (e.g., crisis intervention officers or social workers) when assisting an individual who has a behavioral health need or is homeless, regardless of if a crime was committed. Officers should have the knowledge to make an optimal decision when answering a call, knowing when to refer or seek care for an individual, arrest an individual, or ask a supervisor for guidance.

1.2.3 Law enforcement agencies should have policies and procedures that integrate behavioral health professionals and community service providers when responding to service calls that involve individuals with a mental health disorder or substance use disorder or those who are homeless.

Law enforcement partnerships with behavioral health professionals and community services comprise an integral part of effective policies and procedures used to respond to calls for service involving individuals with a mental health or substance use disorder or those who are homeless. The interrelated nature of the problems law enforcement face responding to such calls results in the same treatment and service partners coordinating to address these problems. As such, the policy and procedures for institutionalizing the

[103] Ron Bruno, Executive Director, CIT International, public comment communication to President's Commission on Law Enforcement and the Administration of Justice, March 30, 2020.
[104] Council of State Governments Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs* (New York: Council of State Governments, 2019), https://csgjusticecenter.org/wp-content/uploads/2020/02/Police-Mental-Health-Collaborations-Framework.pdf.
[105] Flaherty, email message to President's Commission on Law, April 28, 2020.
[106] Council of State Governments, *Police-Mental Health Collaborations: A Framework,* 8.
[107] Council of State Governments, *Police-Mental Health Collaborations: A Framework*.
[108] Council of State Governments, *Police-Mental Health Collaborations: A Framework.*

collaboration of these partners should be integrated across these social problems.

The President's Executive Order on Safe Policing for Safe Communities reinforces the integral role of behavioral health professionals in addressing social problems, stating, "The Attorney General shall, in consultation with the Secretary of Health and Human Services as appropriate, identify and develop opportunities to train law enforcement officers with respect to encounters with individuals suffering from impaired mental health, homelessness, and addiction; to increase the capacity of social workers working directly with law enforcement agencies; and to provide guidance regarding the development and implementation of co-responder programs, which involve social workers or other mental health professionals working alongside law enforcement officers so that they arrive and address situations together."[109]

Collaborative or co-response models offer alternatives to jail and treat the underlying issues in frequent users of the criminal justice system.[110] The purpose of the partnerships is to connect individuals to services for immediate help and allow officers to be more responsive to other calls.[111] As Jessica Waters, Director of Social Work Program at Salt Lake City Police Department (SLCPD), says, "This allows us to reach the most vulnerable individuals, living on the fringe, who are often service and shelter resistant."[112] The SLCPD has a team of social workers who work in a co-responder model, responding to 911 calls that are social issue-related (e.g., mental health, suicide, substance use, homelessness).

A number of response models across law enforcement agencies have been developed dependent on the resources and needs of the jurisdiction.[113] Crisis intervention teams have specific training of how to de-escalate those in crisis and divert individuals to treatment;[114] the co-responder team, such as the one used by SLCPD, include responses conducted by an officer in conjunction with a treatment professional. A mobile crisis team has treatment professionals who assist with stabilizing the crisis. Case management teams are behavioral health professionals or service providers who often focus on high-service users or specific places (e.g., tent cities), working with officers to solve the problem. Case managers take a person-centered approach, assisting with services such as lining up stable housing, obtaining essential documents, and following through on treatment plans.[115]

The work conducted by the Tucson Police Department and the Crisis Response Center serves as a model for other jurisdictions nationwide. The department "uses a multilayered approach employing a co-responder program that pairs Mental Health Support Team officers with mental health clinicians; Crisis Mobile Teams that work in tandem with the crisis line; and a Crisis Response Center. Multitier training is open to all levels of law enforcement, mental health workers, call takers and dispatchers, emergency medical technicians, paramedics, and firefighters."[116]

The CSGJC's framework states, in part,

> Communities … are learning that small-scale or standalone approaches—such as just providing mental health training or having a specialized team that is only available on certain shifts or in

[109] Executive Order 13929, "Safe Policing for Safe Communities."
[110] Jessica Waters, Director of Social Work Program at Salt Lake City Police Department, email communication with Social Problems Impacting Public Safety Working Group, April 29, 2020.
[111] Stephen Puntis et al., "A Systematic Review of Co-Responder Models of Police Mental Health 'Street' Triage,"(Abstract) *BMC Psychiatry* 18, no. 256 (2018), https://doi.org/10.1186/s12888-018-1836-2.
[112] Jessica Waters, Director of Social Work Program at Salt Lake City Police Department, email communication with Social Problems Impacting Public Safety Working Group, April 29, 2020.
[113] Council of State Governments, *Police-Mental Health Collaborations: A Framework.*
[114] Rogers, McNiel, and Binder, "Effectiveness of Police Crisis Intervention Training Programs."
[115] Jessica Waters, Director of Social Work Program at Salt Lake City Police Department, email communication with Social Problems Impacting Public Safety Working Group, May 22, 2020.
[116] *Justice & Mental Health Collaboration Program* (Washington, D.C.: Bureau of Justice Assistance, 2019), 2, https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/jmhcp-program.pdf; *Overview of Law Enforcement Mental Health Resources*, Bureau of Justice Assistance Fact Sheet (Washington, D.C.: Bureau of Justice Assistance, August 2018), https://bja.ojp.gov/sites/g/files/xyckuh186/files/Publications/JMHCP-Learning-Sites_2018.pdf.

certain geographical areas—are not adequate to achieve community-wide and long-lasting impacts. They have also learned that even the most effective law enforcement responses cannot succeed without mental health services that provide immediate crisis stabilization, follow up, and longer-term support.[117]

Support for this policy development and the success of the responses that result requires collaborative partnerships from experts in behavioral health treatment and homeless assistance. Those partnerships, in turn, are dependent on community and government resources.[118] Yet, treatment providers tell stories of the slow cultural change needed from law enforcement agencies to gain acceptance of a collaboration and a referral or deferral process.[119] In contrast, law enforcement professionals who are frustrated with the lack of treatment providers and services available to them ask, "Defer to what?"[120]

This recommendation requires a significant culture change and expects that federal and local governments will invest in and build up the capacity of treatment and community services actively available to partner with law enforcement. The focus should be on enhancing the treatment and service infrastructure in the community. Most importantly, responses should move away from specialized programs and toward partnerships in which behavioral health and service providers take on the weight of the response. Examples of this include crisis call lines and crisis mobile teams that are staffed and run by behavioral health professionals and call in law enforcement to assist, if needed.[121]

1.2.4 Law enforcement agencies should develop a thorough training program for contact with individuals with a mental health disorder or substance use disorder or those who are homeless.

[BEGIN TEXT BOX]

"It is the policy of the United States to promote the use of appropriate social services as the primary response to individuals who suffer from impaired mental health, homelessness, and addiction, recognizing that, because law enforcement officers often encounter such individuals suffering from these conditions in the course of their duties, all officers should be properly trained for such encounters."[122] - President Donald J. Trump, Executive Order

[END TEXT BOX]

To respond to people with these social problems, law enforcement agencies should have a base training program in the academy, a booster training as an in-service option, and training for officers and specialized units according to the law enforcement agency policy. An important part of the base training should include a basic understanding of the root causes of behavioral health disorders and homelessness, how to recognize a need or crisis, when and how to include community partners (e.g., behavioral health experts), how to de-escalate a crisis, and how to stay safe in a response.

[CROSS REFERENCE OFFICER SAFETY AND WELLNESS]

The Tucson Police Department (TPD) has an easily replicable stratified training program for how to respond to incidents involving mental illness. Agencies that adopt this model can add modules on substance use disorder and homelessness. TPD's training model has an eight-hour academy training using MHFA.[123] MHFA for Public Safety Officers teaches law enforcement how to identify and respond to signs and how to better

[117] Council of State Governments, *Police-Mental Health Collaborations: A Framework, 2.*
[118] International Association of Police Chiefs, *Improving Police Response to Persons Affected by Mental Illness.*
[119] Candace Allen, M.S., and Captain Don Jones, "Behavioral Health Urgent Care Center: Law Enforcement and Behavioral Health Working Together," (Webinar, SAMHSA GAINS Center, April 22, 2020).
[120] Michael Brown, Chief of Police, Salt Lake City, Utah, Police Department, Social Problems Impacting Public Safety Working Co-Chair, in discussion with Social Problems Impacting Public Safety Working Group, virtual meeting, March 6, 2020.
[121] Center for Mental Health Services, *National Guidelines for Behavioral Health Crisis Care.*
[122] Executive Order 13929, "Safe Policing for Safe Communities."
[123] Balfour and Winsky, 'Tucson's Model's Comprehensive Approach to Crisis and Public Safety."

understand mental health disorders.[124] TPD also offers officers and call takers a voluntary in-depth 40-hour CIT training based on the program components set forth by CIT international,[125] and a majority (80 percent) of officers and call takers have attended the training.[126] It covers policies and procedures, community partnerships and programs, de-escalation techniques, and how to handle a call for service involving an individual with a mental health or substance use disorder from the point of the call to the disposition. All specialized units in TPD must complete CIT training, and they must also take part in the advanced booster sessions.

[CROSS REFERENCE POLICE OFFICER RECRUITMENT AND TRAINING; RURAL AND TRIBAL]

1.2.5 Local law enforcement agencies, in collaboration with behavioral health and homeless service providers, should use data and analysis to proactively identify, tailor treatment, and address high-frequency users of emergency services, high call locations, and problem places.

Progressive police agencies have become adept at using crime analysis to proactively identify and target problem people and places. To do so, they focus on repeat calls for service locations, hotspots, and repeat offenders.[127] Crime reduction interventions that target crime by person or place may help reduce the calls and incidents for mental health, substance use, and homelessness. For instance, repeat calls for service and arrests independently or linked with other data sources can identify high-frequency users for individuals who have behavioral health disorders or who are homeless.[128] Mental health-related police calls also cluster at specific places (e.g., certain street segments) or, on a smaller proportion of places in rural areas, and they may be even more clustered than criminal events.[129]

Weisburd and White note, "Both physical and mental health problems are much more likely to be found on hot spot streets than streets with little crime."[130] As data analysis becomes more valued and takes center stage, agencies are beginning to determine how they can use data collection to better understand the problem and allocate resources.

In Orange County, California, the sheriff's department adopted an app the enables Homeless Outreach Team Deputies to collect field information during their contacts with homeless individuals. This includes homeless status, their desire for assistance, and the deputy's assessment of their mental and medical health. This data repository is a rich standalone source that can be used in conjunction with other available date sets. Joining data from law enforcement agencies (e.g., the field information from contacts with homeless individuals) and other service delivery agencies (e.g., emergency rooms, emergency psychiatric services, jails, and homeless shelters) would allow law enforcement and their treatment and service partners to understand these relationships more fully and to target resources more effectively.[131] A Harvard Kennedy School report from the Program in Criminal Justice Policy and Management notes,

> By analyzing these cross-sector data, Coalition researchers found that a small number of Camden

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[124] Erica Hoffman, "Police Need More Mental Health Training," Mental Health First Aid USA, February 22, 2018, https://www.mentalhealthfirstaid.org/2018/02/police-need-mental-health-training/.

[125] *Mental Health First Aid Or Cit: What Should Law Enforcement Do?*; Balfour and Winsky, 'Tucson's Model's Comprehensive Approach to Crisis and Public Safety."

[126] Balfour and Winsky , 'Tucson's Model's Comprehensive Approach to Crisis and Public Safety.

[127] Santos, *Crime Analysis with Crime Mapping*.

[128] Milgram, et al., *Integrated Health Care and Criminal Justice Data.*

[129] Adam D. Vaughan et al., "Concentrations and Specialization of Mental Health–Related Calls for Police Service," *Victims & Offenders* 13, no. 8 (2018), https://doi.org/10.1080/15564886.2018.1512539; Clair White and Victoria Goldberg, "Hot Spots of Mental Health Crises: A Look at the Concentration of Mental Health Calls and Future Directions for Policing," *Policing: A an International Journal of Police Strategies and Management*, ResearchGate 41, no. 3 (May 2018), https://www.researchgate.net/publication/324954366_Hot_spots_of_mental_health_crises_A_look_at_the_concentration_of_mental_health_calls_and_future_directions_for_policing.; Sue-Ming Yang et al., I*mproving Police Response to Mental Health Crisis in a Rural Area*, Final Report (Washington, D.C.: Bureau of Justice Assistance, 2020), 1, http://dls.virginia.gov/groups/mhs/policeresponse.pdf.

[130] David Weisburd and Clair White, "Hot Spots of Crime," 91.

[131] Milgram et al., *Integrated Health Care and Criminal Justice Data.*

> residents have an enormous and disproportionate impact on the healthcare and criminal justice sectors, neither of which is designed to address the underlying problems they face: housing instability, inconsistent or insufficient income, trauma, inadequate nutrition, lack of supportive social networks, mental illness, and substance abuse disorders. These unaddressed social determinants of behavior appear to drive a cycle of repeated arrests and hospitalizations. [132]

Connecting medical service call data and crime incident data has also provided a wider scope of "hot places" than using crime data alone.[133] The layering of different data sources allows analysts to reach conclusions that are more informed and complete, which in turn allows for a more targeted intervention.

The stratified policing framework translates well to the analysis, identification, and accountability of response to social problems by providing a way to identify and place problems by length, complexity, and rank into immediate (i.e., critical incidents), short-term (i.e., repeat incidents or patterns), and long-term problems (i.e., hotspots).[134] Each of these problems include analytical techniques to identify them and strategies to triage and address them. Most importantly, the framework matches problem complexity and length by rank structure, with officers of higher ranks being responsible for more complex and longer-term problems. This model demands strong and committed command staff who apply systematic accountability and support through regular meetings and standard processes, including set expectations for strategies, appropriate resource allocation, and transparent and timely communication.[135]

[CROSS REFERENCE DATA AND REPORTING]

1.3 Improving State Court Responses to Social Problems

Background

While the impact of local law enforcement's high rate of arrests of individuals with mental health disorders, substance use disorders, and homelessness falls predominantly on state and local courts, prosecutors and judges do not traditionally or typically address behavioral health, housing, or treatment services for these defendants. As a result, sentencing options for individuals in need are limited, treatment needs are unmet, and those who work in the courts see these individuals repeatedly.[136] This revolving door not only creates a financial burden on the system and community but also reinforces the reality that, without an increase in community services, crimes associated with these illnesses or circumstance will continue.[137]

Carson Fox, Chief Executive Officer of the National Association of Drug Court Professionals, expressed his frustration with revolving-door justice: "I began my career as a prosecutor in rural South Carolina, where I

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[132] Milgram et al., *Integrated Health Care and Criminal Justice Data, 1-2.*

[133] Hibdon, J and Groff, E. G., "What You Find Depends on Where You Look: Using Emergency Medical Services Call Data to Target Illicit Drug Use Hot Spots" *Journal of Contemporary Justice* 30, no. 2 (2014), https://journals.sagepub.com/doi/full/10.1177/1043986214525077.

[134] Roberto Santos and Rachel Santos, *Stratified Policing an Organizational Model for Proactive Crime Reduction* (Lanham, MD: Rowman & Littlefield Publishers, forthcoming 2020), https://rowman.com/ISBN/9781538126561/Stratified-Policing-An-Organizational-Model-for-Proactive-Crime-Reduction.

[135] Dr. Rachel Santo and Dr. Roberto Santos, Radford University, Radford, Virginia "Stratified Policing: An Organizational Model for Proactive Crime Reduction," (PowerPoint Presentation, Social Problems Impacting Public Safety Working Group, virtual meeting), April 17, 2020.

[136] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety (April 2, 2020) (written statement of Carson Fox, CEO, National Association of Drug Court Professionals).* https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings

[137] KiDeuk Kim, Miriam Becker-Cohen, and Maria Serakos, *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System* (Washington, D.C.: Urban Institute, April 7, 2015), https://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system/view/full_report; Joye C. Anestis and Joyce L. Carbonell, "Stopping the Revolving Door: Effectiveness of Mental Health Court in Reducing Recidivism by Mentally Ill Offenders," *Psychiatric Services* 65, no. 5 (2014), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300305; Tara D. Warner and John H. Kramer, "Closing the Revolving Door?: Substance Abuse Treatment as an Alternative to Traditional Sentencing for Drug-Dependent Offenders," *Criminal Justice and Behavior* 36, no. 1 (2009), https://doi.org/10.1177/0093854808326743; Fred L. Cheesman II et al., "Drug Court Effectiveness and Efficiency: Findings for Virginia," *Alcoholism Treatment Quarterly* 34, no. 2 (2016), https://doi.org/10.1080/07347324.2016.1148486.

saw firsthand the devastation, crime, and exorbitant cost associated with addiction. Time and again, the same individuals would appear before the courts for crimes committed in service of their addiction, with the courts, law enforcement, and taxpayers bearing the greatest burden. It was clear that this cycle needed to change, but there was no remedy."[138]

Current State of the Issue

Recognizing that the criminal justice system may not appropriately serve those with behavioral health disorders or those experiencing homelessness, state courts can divert individuals who commit minor crimes from entering the system into community treatment.[139] In a March 2019 national survey, prosecutors office's indicated, a large percentage of those who complete diversion programs do not have the charges filed (69 percent) or have the charges dismissed (42 percent).[140] According to this survey, their most important goals for diversion are "hold participants accountable for their criminal behavior; reduce participant recidivism; rehabilitate participants by treating underlying problems; and use resources more efficiently."[141]

State court diversion programs have been shown to effectively reduce recidivism and time in jail and improve the quality of life of defendants, while not increasing risk to the public.[142] The success of diversion programs lies in early (preferably at booking) assessments to ascertain need. For those defendants who would qualify, treatment—or problem-solving—courts provide an alternative, with drug courts being the most prominent.[143]

[CROSS REFERENCE INTERSECTION OF CRIMINAL JUSTICE PERSONNEL]

According to a 2015 survey, there are 4,368 problem-solving courts; 70 percent (3,057) reported as drug courts, 10 percent (429) reported as mental health courts, and 0.5 percent (22) reported as homelessness courts.[144] More recent national data are not available for the number of problem-solving courts; however, California had 384 problem-solving courts in 2014 [145] compared to 450 in July 2019,[146] a 17 percent increase in problem-solving courts in less than five years.[147]

In addition to reducing recidivism, drug courts are cost effective.[148] In one overview of multiple studies, Mitchell et al. find, "There is a large, significant mean average effect from both adult and DWI drug courts. Overall, recidivism rates were just over one third (38 percent) for program participants, compared to half (50

[138] Carson, *President's Commission on Law,* April 2, 2020.
[139] *Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center* (Delmar, NY: Center for Mental Health Services GAINS Center, Substance Abuse and Mental Health Services Administration, 2007), http://www.pacenterofexcellence.pitt.edu/documents/PracticalAdviceOnJailDiversion.pdf.
[140] Michela Lowry and Ashmini Kerodal, *Prosecutor-Led Diversion: A National Survey* (New York, NY: Center for Court Innovation, 2019), 22, https://www.courtinnovation.org/sites/default/files/media/document/2019/prosecutor-led_diversion.pdf.
[141] Lowry and Kerodal, *Prosecutor-Led Diversion*.
[142] Linda K. Frisman et al., "Outcomes of Court-Based Jail Diversion Programs for People with Co-Occurring Disorders," *Journal of Dual Diagnosis* 2, no. 2 (2006), https://doi.org/10.1300/J374v02n02_02.; Henry J. Steadman and Michelle Naples, "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders," *Behavioral Sciences & the Law* 23, no. 2 (2005), https://doi.org/10.1002/bsl.640.
[143] SAMHSA, *Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), https://store.samhsa.gov/product/Municipal-Courts-An-Effective-Tool-for-Diverting-People-with-Mental-and-Substance-Use-Disorders-from-the-Criminal-Justice-System/SMA15-4929.
[144] Douglas B. Marlowe, Carolyn D. Hardin, and Carson L. Fox, *Painting the Current Picture A National Report on Drug Courts and Other Problem-Solving Courts in the United States* (Alexandria, VA: National Drug Court Institute, 2016), 57, https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf.
[145] Douglas B. Marlowe et al., *Painting the Current Picture, 57.*
[146] Douglas B. Marlowe et al., *Painting the Current Picture, 57; Collaborative Justice Courts,* (San Francisco, CA: Judicial Council of California, 2019), https://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf.
[147] Data from different sources and separate data collections were used for this comparison and calculation; however, the definitions of these courts were comparable, providing confidence in the comparison.
[148] Ryan S. King and Jill Pasquarella, *Drug Courts: A Review of the Evidence* (Washington, D.C.: The Sentencing Project, 2009), 22. http://biblioteca.cejamericas.org/bitstream/handle/2015/1822/drugcourts_areviewoftheevidence.pdf?sequence=1&isAllowed=y.

percent) for comparable nonparticipants. This effect endures for at least three years."[149] Courts that address drug use disorders are most effective when they focus on offenders who have committed serious crimes and have a long history of offending, especially if their crimes are linked to their drug use. Persons who are high-risk and high-need are more likely to be on a fixed trajectory, and treatment courts provide specific resources to intervene. In comparison, traditional court processes and programs may more easily serve those who are lower in need or risk and who are more likely to change trajectories.[150]

The drug court model has been adapted to many different specialty area courts—homelessness, mental health, domestic violence, and veterans. Kaiser and Rhodes find that these specialty courts (i.e., mental health and homelessness courts) have comparable attributes to the drug courts model, "such as specialization and services, staff training, and procedures."[151]

Even with the similarities to drug courts, mental health court participants normally suffer from severe mental health disorders and are less likely to have felony offenses.[152] These courts have a primary goal to divert such persons to mental health treatment, which includes a case-management approach with wraparound services from an interdisciplinary team of treatment and service providers. Mental health courts provide participants incentives for success and sanctions when warranted[153] and have a positive impact on reducing recidivism, although additional research should examine the impact on mental health outcomes.[154]

Homeless courts, which apply alternative sanctions to misdemeanor crimes, vary in practice and have limited empirical research.[155] The limited research shows a positive impact on the use of transitional and permanent housing for participants[156] as well as a reduction in recidivism.[157] A popular model places the homeless court in a shelter that focuses on individuals who were referred to the court by shelter case workers.[158] Participants sign-up voluntarily and normally go through a screening and assessment process to be accepted. Generally, these courts center on collaboration among the courts, law enforcement, treatment providers, and services (e.g., shelters) to move participants into stable housing while treating any underlying needs, often related to behavioral health. [159] If the individual demonstrates positive success in treatment, the court drops the misdemeanor cases and warrants, which are viewed as an impediment to success.[160] In the San Diego homeless court, cases are often resolved in one hearing; approximately 90 percent of offenses are dismissed.[161] A variation of this model focuses on homeless veterans. In this model, veterans participate in a three-day "stand-down" event where they stay in military type tents; receive food; are connected with an

[149] Ojmarrh Mitchell et al., "Drug Courts' Effects on Criminal Offending for Juveniles and Adults," Campbell Collaboration, 2012, https://campbellcollaboration.org/better-evidence/drug-courts-effects-on-criminal-offending.html.
[150] Mitchell et al., "Drug Courts' Effects on Criminal Offending."
[151] Kimberly A. Kaiser and Kirby Rhodes, "A Drug Court by Any Other Name? An Analysis of Problem-Solving Court Programs," *Law and Human Behavior* 43, no. 3 (2019), https://psycnet.apa.org/record/2019-16224-001.
[152] Kaiser and Rhodes, "A Drug Court by Any Other Name?"
[153] Douglas B. Marlowe, Carolyn D. Hardin, and Carson L. Fox, *Painting the Current Picture A National Report on Drug Courts and Other Problem-Solving Courts in the United States* (Alexandria, VA: National Drug Court Institute, 2016), https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf.
[154] Brittany Cross, "Mental Health Courts Effectiveness in Reducing Recidivism and Improving Clinical Outcomes: A Meta-Analysis" (PhD diss., University of South Florida, 2011), https://scholarcommons.usf.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=4247&context=etd; Christine M. Sarteschi, Michael G. Vaughn, and Kevin Kim, "Assessing the Effectiveness of Mental Health Courts: A Quantitative Review," *Journal of Criminal Justice* 39, no. 1 (2011), https://doi.org/10.1016/j.jcrimjus.2010.11.003.
[155] Maya Buenaventura, *Treatment Not Custody: Process and Impact Evaluation of the Santa Monica Homeless Community Court* (Washington, DC: RAND, 2018), https://www.rand.org/content/dam/rand/pubs/rgs_dissertations/RGSD400/RGSD418/RAND_RGSD418.pdf.
[156] Buenaventura, *Treatment Not Custody.*
[157] Nancy Kerry and Susan Pennell, *San Diego Homeless Court Program: A Process and Impact Evaluation* (San Diego, CA: Association of Governments, 2001), https://www.courts.ca.gov/documents/2001SANDAGHomelessCourtEvaluation.pdf.
[158] Commission on Homelessness & Poverty, *Homeless Courts: Taking the Court to the Street* (Washington, D.C.: American Bar Association, 2004), https://www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/one-pagers/homeless-court-one-pager.pdf.
[159] "Boston's Homeless Court Helps Overcome Barriers," Substance Abuse and Mental Health Services Administration, last updated April 30, 2020, https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/homeless-court-helps-overcome-barriers.
[160] *Homeless Court Facts & Best Practices* (Washington, D.C.: American Bar Association, n.d.), 1. https://www.americanbar.org/content/dam/aba/administrative/homelessness_poverty/homeless-courts/hlc-best-practices.pdf.
[161] Commission on Homelessness and Poverty, *Homeless Courts*.

array of services, including housing, health, treatment, behavioral health treatment, family counseling; and work with the courts to address misdemeanor charges.[162]

Although diversion programs and treatment address these social problems, the need is greater than the supply. A March 2019 survey of state prosecutors' offices found that 45 percent of prosecutors' offices did not have prosecutor-led diversion programs.[163] Focusing on treatment courts, the National Drug Court Institute estimates only 10 percent of potential drug court candidates were being served in drug courts.[164] As such, traditional courts, which mostly lack diversion programs, remain the primary receptor of those in need.

The following recommendations focus on the opportunities provided by diversion programs and expanding these programs, the importance of improving the application of state treatment court practices to best serve the needs of these special populations, and the need to take into account both the barriers and the challenges in providing services to these individuals.

1.3.1 States should expand their use of treatment courts, provide oversight to ensure program fidelity, and provide funding for treatment and service specialists.

Properly functioning treatment courts rely on evidence-based practices and established frameworks, which reduce recidivism and increase positive treatment outcomes while decreasing the burden on law enforcement and the criminal justice system.[165] Treatment courts expand the available options to handle defendants who come through the criminal justice system.

Bhati et al. note that they "estimate that there are about twice as many arrestees eligible for drug court (109,922) than there are available drug court treatment slots (55,365)."[166] The large number of defendants who have behavioral health disorders or are homeless entering the correctional system and who are recidivating suggests that these courts should expand and thus serve a much greater population.

Even while increasing the number of treatment courts, officials must keep program fidelity based on evidence-based practices, including establishing standards and documented procedures with an unbiased selection process; identifying and adding treatment and service specialists as part of the court's team; establishing systematic assessments to ensure the courts maintain these standards; and prioritizing quality evaluations of processes and impact.[167]

Although treatment courts are built on a framework, some stray from evidence-based practices, including variations of the model based on local resources and well-intentioned innovation.[168] This may explain the parallel differences in the effect size of recidivism found in research.[169] Different types of treatment courts vary in their focus, target population, and evidence base, which reinforces the need to have practices and policies that are built upon evidence-based and best practices.

Notably, local jurisdictions should ensure funding for quality treatment and service specialists who serve the needs of the treatment court's population. These specialists should be an equal member and voice within the court team; the court should ensure that they can provide or connect defendants to an array of treatment

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[162] *Stand Down Promising Practices* (Washington, D.C.: National Coalition for Homeless Veterans, 2014),http://www.nchv.org/images/uploads/Stand_Down_Promising_Practices_Guide_Final_-_Sept_2014.pdf.
[163] Lowry and Kerodal, *Prosecutor-Led Diversion, iv*.
[164] Celinda Franco, *Drug Courts: Background, Effectiveness, and Policy Issues for Congress* (Washington, D.C.: Congressional Research Service, 2010), https://fas.org/sgp/crs/misc/R41448.pdf.
[165] Mitchell et al., "Drug Courts' Effects on Criminal Offending."
[166] Avi Bhati, John Roman, and Aaron Chalfin, *To Treat or Not to Treat* (Washington, D.C.: Urban Institute, 2008), xv, https://www.urban.org/research/publication/treat-or-not-treat.
[167] National Association of Drug Court Professionals, *Defining Drug Courts: The Key Components* (Washington, D.C.: Bureau of Justice Assistance, 2004), https://www.ncjrs.gov/pdffiles1/bja/205621.pdf.
[168] Shannon Portillo, Danielle S. Rudes, and Faye S. Taxman, "The Transportability of Contingency Management in Problem-Solving Courts," *Justice Quarterly* 33, no. 2 (2016), https://doi.org/10.1080/07418825.2014.902490.
[169] Deborah Koetzle Shaffer, "Looking Inside the Black Box of Drug Courts: A Meta-Analytic Review," *Justice Quarterly* 28, no. 3 (2011), https://doi.org/10.1080/07418825.2010.525222.

based on their specialized needs.

Drug, mental health, and homeless courts each target a specific population; however, there is little research on the selection process for problem-solving courts.[170] This lack, combined with variation in selection criteria, makes it difficult to describe the true impact of and best practices for these courts, or to standardize those practices.[171] For all treatment courts, however, selection criteria should be transparent and inclusive, based on the specific domain of the court (e.g., drug court, high-risk and high-need).

Treatment courts should also incorporate a quality assurance and improvement process. Team members should remain up-to-date on innovative and best practices by reading the research and attending training. Treatment courts should systematically examine their own practices through regular assessments using data-informed methods and by partnering with trained researchers to evaluate the fidelity of their processes (e.g., selection procedures and efficiency) and the impact of their work, which should examine recidivism and treatment outcomes and cost savings.[172] Improving the understanding of the processes (e.g., selection criteria), cost-effectiveness, and other impacts (e.g., net widening) of treatment courts through additional research would advance how state courts best implement these different models.

[CROSS REFERENCE INTERSECTION OF CRIMINAL JUSTICE PERSONNEL CHAPTER]

1.3.2 States should adopt programs to reduce the bottleneck of the process for competency restoration to stand trial.

An individual who has an active mental or intellectual disability and who is arrested for committing a crime may be deemed not competent to stand trial. The clause to the Sixth Amendment for a speedy trial is superseded by an individual's Fifth Amendment right to due process. "Competency" is a legal term that focuses on the need of the criminal justice system; it is not necessarily focused on the need to provide treatment to assist the individual.

This process can be lengthy. An analysis of 68 studies found that competency restoration, which took 90-120 days, was eventually successful for 81 percent of the individuals.[173] The length of stay varies by state, with 25 of the 30 states holding individuals for competency restoration for 60 or more days, 13 holding individuals for more than 120 days, and 2 holding individuals more than 360 days.[174]

Hallie Fader-Towe and Ethan Kelley of the Council for State Governments Justice Center note the lack of an effective national conversation around how to address and relieve the competency restoration process across state and local jurisdictions.[175] This "elephant" has many parts, such as treatment considerations, availability of treatment space, and local standards for commitment. These and other elements make the barriers to restoration to competency difficult to study, understand, and address.

Individuals court-ordered to a competency restoration require treatment to regain competency, but there is

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[170] Nancy Wolff, Nicole Fabrikant, and Steven Belenko, "Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency," *Law and Human Behavior* 35, no. 5 (2011), https://doi.org/10.1007/s10979-010-9250-4.; Christopher P. Krebs et al., "Assessing the Long-Term Impact of Drug Court Participation on Recidivism with Generalized Estimating Equations," *Drug and Alcohol Dependence* 91, no. 1 (November 2, 2007), https://doi.org/10.1016/j.drugalcdep.2007.05.011.

[171] Christopher P. Krebs et al., "Assessing the Long-Term Impact of Drug Court.".

[172] "Center for Research Partnerships and Program Evaluation (CRPPE), Overview," Bureau of Justice Assistance, December 9, 2019, https://bja.ojp.gov/program/crppe/overview.

[173] Gianni Pirelli, William H. Gottdiener, and Patricia A. Zapf, "A Meta-Analytic Review of Competency to Stand Trial Research," *Psychology, Public Policy, and Law* 17, no. 1 (2011), https://doi.org/10.1037/a0021713.

[174] W. Lawrence Fitch, *Forensic Mental Health Services in the United States: 2014* (Alexandria, VA: National Association of State Mental Health Program Directors, 2014), https://nasmhpd.org/sites/default/files/Assessment%203%20-%20Updated%20Forensic%20Mental%20Health%20Services.pdf.

[175] Hallie Fader-Towe and Ethan Kelly, Titles, The Council of State Governments Justice Center, San Diego, California "Restoration to Competency and Data-Driven Practices" (PowerPoint Presentation, Social Problems Impacting Public Safety Working Group, Teleconference, May 15, 2020).

a critical shortage of state treatment beds, especially for those justice-involved. A study by Danzer et al. states,

> It appears that hospital beds used for competency restoration might be best reserved for defendants facing serious and violent charges, with psychotic disorders, cognitive impairment, medication non-adherence, and lesser concern about malingering. . . . If defendants are suspected of malingering, refuse to participate in hospital-based services, or show that volitional, antisocial, or aggressive behavior is clearly the major impediment to restoration, jail may be more appropriate and, in some cases, incentivizing.[176]

The burden to restore individuals to competency and the accompanying system backlog is costly to the community, frustrating for victims and criminal justice practitioners, and devastating to the individual and their family. Individuals who are part of this process often spend more time at each stage of the criminal justice system, which ultimately decreases their chances for a positive outcome.[177] Because of this frustration, the settlement in Trueblood et al. vs. Washington State Department of Social and Human Services resulted in a phased implementation plan, which included an increase in treatment services, training for court and correctional staff, and a more timely restoration process.[178]

Increasing the community behavioral health treatment capacity so people either do not enter the system or, when possible, are diverted to the community, would reduce this bottleneck. When diversion is not possible, courts may consider different factors and alternatives to ordering competency restoration, including reviewing the severity of the charges and the severity of the disability.

State and local jurisdictions should collaborate to understand the nature of their competency restoration process and any impediments and barriers. To have a healthy improvement strategy, jurisdictions must conduct a data-informed improvement process, incorporate goals, move resources to meet those goals, and hold institutions and people accountable.

1.3.3 The Department of Justice should examine how the laws and local policies that decriminalize or reduce sanctions for drug use or activities related to homelessness have affected recidivism and the outcomes of court-mandated treatment or services.

Public compassion and a public health perspective both drive policies and laws that decriminalize and reduce sanctions for drug use and activities related to homelessness (e.g., panhandling or camping in public places). As Tamera Kohler, CEO, San Diego's Regional Task Force on the Homeless, explains, "Municipalities can support law enforcement by reviewing current laws that may impede individuals' progress toward exiting homelessness and consider amending as necessary. Laws that limit activities such as sitting, sleeping outside or in vehicles, or eating in public spaces have a disproportionate impact on people living on the streets, who may not have any other option, and do not end homelessness."[179]

In contrast, Deputy Sheriff Tyrone S. Enriquez from Orange County says, "While I agree that homelessness should not be criminalized or punished simply for their homeless status, Martin v. City of Boise has inherently made enforcing laws such as trespassing more difficult. While mandating shelters for the homeless in a 1-1

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[176] Graham S. Danzer et al., "Competency Restoration for Adult Defendants in Different Treatment Environments," *Journal of the American Academy of Psychiatry and the Law Online*, (2019), 13, http://jaapl.org/content/early/2019/02/08/JAAPL.003819-19.

[177] Lisa Callahan and Debra A. Pinals, "Challenges to Reforming the Competence to Stand Trial and Competence Restoration System," *Psychiatric Services,* (2020), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900483.

[178] "A.B. by and through Trueblood v. DSHS," *Disability Rights Washington* (blog), accessed June 7, 2020, https://www.disabilityrightswa.org/cases/trueblood/.; A.B., by and through TRUEBLOOD, et al., v. DSHS, et al., Amended Joint Motion for Preliminary Approval of Settlement Agreement, No. 14- cv- 01178- MJP (October 25, 2018); https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2018Trueblood/599_1_AmendedAgreement.pdf.

[179] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 24, 2020) (written statement of Tamera Kohler, CEO, San Diego's Regional Task Force on Homeless), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.

ratio is a noble idea, the applicability of the mandate must be questioned considering Los Angeles County alone has around 50,000 homeless people."[180]

Similar arguments are made for and against the reduction in sanctions of drug use. Vermont U.S. Attorney Christina E. Nolan explains, "When something is decriminalized, it takes a tool away from law enforcement, signals that the behavior is OK and will not have consequences, and logically will lead to more of the undesirable behavior. . . . Decriminalization of drugs will lead to more use, more related crime, and more drain on law enforcement resources and morale."[181]

Decriminalization and reduction in sanctions merely raise the bar for law enforcement arrests, but they do not account for the reality that law enforcement officers still must address the complaints about these individuals from unsympathetic community members; respond to the non-criminal results of untreated substance use problems (e.g., overdoses); or interact with large homeless populations. This often results in an increase in the number of people in need who intersect with law enforcement, while the mechanisms to sanction these behaviors and shepherd people into court-mandated treatment programs are removed. This may have a greater cost to the community, including escalation and long-term drug use.

Compounding this problem, many criminal justice professionals believe that only the "stick" of increasing sanctions of the courts help push individuals into treatment and to take the "carrot" of a life in recovery and greater stability. In fact, treatment programs (e.g., drug courts) can provide a turning point in an offender's life, putting them on a new life path.[182]

Sheriff Don Barnes of Orange County, California, states, "In 2018, my department led an effort to address a large homeless encampment on the Santa Ana Riverbed. The encampment approached 1,000 people, many of whom were mentally ill and drug addicted . . . In remediating the riverbed we collected 13,950 used hypodermic syringes. This staggering number is a direct result of the decriminalization of drugs. In California, possession of drugs results in nothing more than a misdemeanor citation." Sheriff Barnes emphasized that he was not advocating incarcerating drug-addicted individuals. Instead, he notes, "Crimes committed without consequence invite more crime, negatively impacting the community and systems that lack individual accountability exacerbate the problem by encouraging bad behavior."[183]

While for the homeless population, substance use and homelessness are closely intertwined, the effects of reducing sanctions on substance use and activities related to homelessness may be considered separately as well. In both cases, the same questions may be asked:

- What impact have decriminalization and the reduction in sanctions had on the community in general?
- How have decriminalization and the reduction in sanctions changed the communities' ability to move individuals to recovery and stable housing?
- What happens to people who have not sought treatment voluntarily if they are no longer compelled into treatment?
- What impact have these policies had on the demographics—including the history of behavioral health disorders, homelessness, and crime—of those who enter the system, go to treatment courts, receive treatment, or receive services?
- What impact have these policy changes had on treatment outcomes and recidivism for those in

[180] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 24, 2020) (written statement of Tyrone S. Enriquez, Deputy, Orange County Sheriff's Department), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.
[181] Christina E. Nolan, United States Attorney, Vermont, email communication, May 22, 2020.
[182] Sarah Messer, Ryan Patten, and Kimberlee Candela, "Drug Courts and the Facilitation of Turning Points: An Expansion of Life Course Theory," *Contemporary Drug Problems* 43, no. 1 (2016), https://doi.org/10.1177/0091450916632545.
[183] Barnes, *President's Commission on Law,* March 25, 2020.

treatment courts, compared to those in traditional courts?

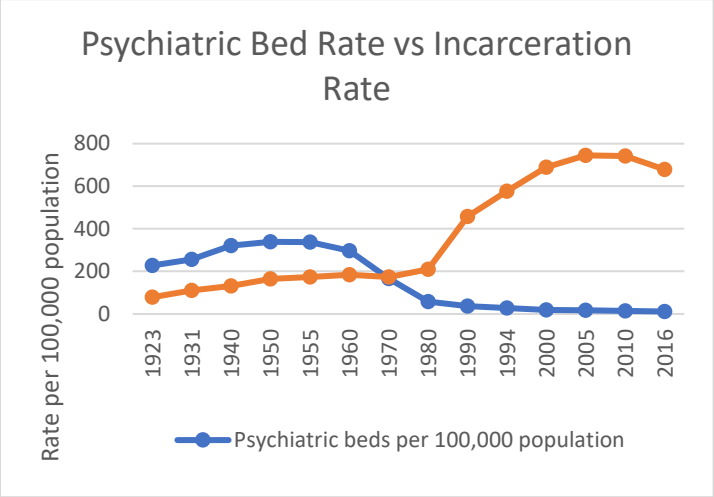
- Should the treatment court model change or adapt in communities where sanctions have changed?

The Department of Justice should study these and associated questions for local and state jurisdictions to better understand the impact and side effects such policies have on their community and criminal justice system and better inform legislation, community services planning, and directing resources.

1.4 Prioritizing Treatment in Corrections

Background

From 1960 to as recently as the 2007 economic recession, the nation's safety net altered dramatically. Resources for community treatment capacity for mental health disorder, substance use disorder, and homelessness dwindled; psychiatric treatment institutions released their residents; substance use disorder became a justice issue; and the nation's population grew, while housing availability did not.[184] The number of treatments beds fell from 1960 to 2016, with a percentage change decrease of 92 percent in the number of psychiatric beds per 100,000 population. For the same time period, the incarceration rate per 100,000 increased 290 percent.[185]



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Source: Hancq, email communication with the Social Problems, April 30, 2020; Doris A. Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016* (Arlington, VA: Treatment Advocacy Center, 2016), https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf; E. Fuller Torrey et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005–2010* (Arlington, VA: Treatment Advocacy Center, 2012),

[184] Gregory G. Grecco and R. Andrew Chambers, "The Penrose Effect and Its Acceleration by the War on Drugs: A Crisis of Untranslated Neuroscience and Untreated Addiction and Mental Illness," *Translational Psychiatry* 9, no. 1 (2019): 2, https://www.nature.com/articles/s41398-019-0661-9; Chris Herring, "Tent City, America."

[185] Elizabeth Sinclair Hancq, Director of Research, Treatment Advocacy Center, Arlington, Virginia, email communication with the Social Problems Impacting Public Safety Working Group, April 30, 2020.; https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf; E. Fuller Torrey et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005 – 2010* (Arlington, VA: Treatment Advocacy Center, 2012), https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf; Prison Population Counts," Bureau of Justice Statistics, 2020, https://www.bjs.gov/index.cfm?ty=tp&tid=131; Barnes, *President's Commission on Law, March 25, 2020.*

[186] Hancq, email communication with the Social Problems, April 30, 2020; Doris A. Fuller et al., *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds, 2016* (Arlington, VA: Treatment Advocacy Center, 2016), https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf; E. Fuller Torrey et al., *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005–2010* (Arlington, VA: Treatment Advocacy Center, 2012), https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf; Prison Population Counts," Bureau of Justice Statistics, 2020, https://www.bjs.gov/index.cfm?ty=tp&tid=131; Barnes, *President's Commission on Law, March 25, 2020.*

https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf; Prison Population Counts," Bureau of Justice Statistics, 2020, https://www.bjs.gov/index.cfm?ty=tp&tid=131; Barnes, *President's Commission on Law, March 25, 2020.*

It is difficult to be precise about the prevalence of mental health, substance use, and co-occurring disorders in jails and prisons, especially compared to the prevalence in the community. **Table X** provides estimates from a 2016 SAMHSA publication, indicating that the prevalence rates for all three disorders are greater in correctional settings than in the community.[187]

Table X: Prevalence of Serious Mental Illness, Substance Use Disorder, and Co-occuring Disorder in the Community, Jails, and Prisons

	Community	Jail	Prison
Serious Mental Illness	5 percent	17 percent	16 percent
Substance Use Disorder	9 percent	68 percent	53 percent
Co-Occurring Disorder	14–25 percent	33–60 percent	33–60 percent

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Source: Estimates compiled by SAMHSA after a review of literature. See original source for more information. *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017), 3, https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998.

Individuals with behavioral health disorders stay in jail longer, have more trouble coping with the correctional settings, and have more behavioral problems.[189] Correctional facilities should address an individual's need for behavioral health treatment and assess them for housing instability. Approximately 15 percent of those incarcerated had been homeless in the past year.[190] Upon release, they are 10 times as likely to be homeless then the general public.[191]

Current State of the Issue

To reduce recidivism and decrease the burden on the criminal justice system, communities should build treatment and service capacity and provide needed treatment and services for the incarcerated population. Provision of services should begin in the corrections facility and follow individuals into the community to ensure stable housing and treatment. An integrated case management system and network of formalized partnerships—sharing individual level data and integrated program plans across law enforcement, corrections, behavioral health, service providers, and program partners—is key to assuring a seamless system of care spanning the correctional system and the community.

[CROSS REFERENCE REENTRY]

Treatment in jails and prisons not only increases positive outcomes but also reduces recidivism, especially if

[187] Estimates compiled by SAMHSA after a review of literature. See original source for more information. *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017), 3, https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998.
[188] SAMHSA*, Guidelines for Successful Transition, 3.*
[189] Kimberly A. Houser, Steven Belenko, and Pauline K. Brennan, "The Effects of Mental Health and Substance Abuse Disorders on Institutional Misconduct Among Female Inmates," *Justice Quarterly* 29, no. 6 (2012), https://doi.org/10.1080/07418825.2011.641026; Council of State Governments Justice Center, *Improving Outcomes for People With Mental Illnesses Involved With New York City's Criminal Court And Correction Systems*, (New York: Author, 2012), https://csgjusticecenter.org/publications/improving-outcomes-for-people-with-mental-illnesses-involved-with-new-york-citys-criminal-court-and-correction-systems/.
[190] Greenberg and Rosenheck, "Jail Incarceration, Homelessness, and Mental Health: A National Study," *Psychiatric Services,* 59, no. 2 (2008): 170, https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2008.59.2.170.
[191] Couloute, *Nowhere to Go: Homelessness among.*

this treatment coincides with reentering the community.[192] Although studies estimate that more than 60 percent of inmates have a substance use disorder, only about 22–28 percent are treated for it.[193]

While cost is a major barrier to implementing treatment capacity, other challenges also exist, including the lack of standards of care in correctional settings and the shortage of treatment specialists who are willing to work in such settings.[194] In addition, programs that fit within the short time frames of jail sentences may be difficult to find.[195] As individuals leave the institution and reenter the community, they may have trouble connecting with needed services.[196]

Court cases have established precedent for individuals to receive this care; without it, the individual's underlying needs and associated problems will remain, regardless if they are incarcerated or living in the community. Without this care, they will likely reoffend. From both a financial and a humane perspective, communities would see positive results from expanding care options to these individuals.[197]

Sheriff Paul Penzone says, "In Maricopa County [Arizona] . . . the daily rate once booked into the jail is $125 per day. The reason . . . [incarceration] fees are so high is due to all the complex medical and mental health services and supplies needed to provide care for inmates. Because of liability, case law and institutional history, inmate services directly contributing to these fees is mandated and outside of the control of the sheriff to adjust. To provide some perspective on the investment into the inmate population, according to Arizona's Revised Statutes,[198] Arizona's base amount is $23 per day to educate our children and provide for their care in public institutions."[199]

Leaders in the field, such as Orange County, California or Maricopa County, Arizona, have begun to integrate treatment into facilities and provide the necessary assistance both to ensure that this treatment continues upon an individual's reentry and that housing will be made available. These facilities implement screening and assessment tools to identify behavioral health disorders and whether inmates are at risk for homelessness.[200] This information provides direct paths to treatment plans: MAT, talk therapies that incorporate cognitive behavioral therapy and motivational interviewing, and peer-group support models (e.g., alcoholics anonymous and narcotics anonymous).[201]

Innovative leaders are integrating training for their staff to understand the root causes of these disorders so

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[192] SAMHSA, *Principles of Community-Based Behavioral Health Services*;
Grant Duwe, *The Use and Impact of Correctional Programming for Inmates on Pre- and Post-Release Outcomes* (Washington, D.C.: National Institute of Justice, 2017), 41, https://www.ncjrs.gov/pdffiles1/nij/250476.pdf.

[193] Jennifer Bronson, *Drug Use, Dependence, and Abuse, 2007-2009, 1.*

[194] Susan Pollitt and Luke Woollard, "Barriers to Access and Inadequate Levels of Care in North Carolina Jails," *North Carolina Medical Journal* 80, no. 6 (2019), https://doi.org/10.18043/ncm.80.6.345.

[195] Center for Substance Abuse Treatment, "8 Treatment Issues Specific to Jails," in *Substance Abuse Treatment for Adults in the Criminal Justice System* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005), https://www.ncbi.nlm.nih.gov/books/NBK64145/.

[196] Ingrid A Binswanger et al., "'From the Prison Door Right to the Sidewalk, Everything Went Downhill,' A Qualitative Study of the Health Experiences of Recently Released Inmates," *International Journal of Law and Psychiatry* 34, no. 4 (2011), https://pubmed.ncbi.nlm.nih.gov/21802731/.

[197] Willis R. Arnold, "Setting Precedent, A Federal Court Rules Jail Must Give Inmate Addiction Treatment," NPR, May 4, 2019, https://www.npr.org/sections/health-shots/2019/05/04/719805278/setting-precedent-a-federal-court-rules-jail-must-give-inmate-addiction-treatment.

[198] Ariz. Rev. Stat. Ann. 15–941 (2019) - Teacher experience index, https://www.azleg.gov/viewDocument/?docName=http://www.azleg.gov/ars/15/00941.htm.

[199] Penzone, *President's Commission on Law, March 25, 2020.*

[200] Balicki and Winger, PowerPoint Presentation, Social Problems, May 19, 2020.

[201] Raymond Chip Tafrate, Damon Mitchell, and David J. Simourd, *CBT with Justice-Involved Clients: Interventions for Antisocial and Self-Destructive Behaviors* (New York: Guilford Publications, 2018), https://books.google.com/books?hl=en&lr=&id=Tk9UDwAAQBAJ&oi=fnd&pg=PP1&dq=justice+involved+and+cbt+and+review&ots=HBIwsSAmlC&sig=EHRZeXRwz83m88AVqUiomntVsA8#v=onepage&q=jusice%20involved%20and%20cbt%20and%20review&f=false; *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 26, 2020) (statement of Dr. Keith Humphreys, Professor and Section Director for Mental Health Policy in the Department of Psychiatry and Behavioral Services, Stanford University, Stanford, California), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings; Balicki and Winger, PowerPoint Presentation, Social Problems, May 19, 2020.

they can better assist those in their custody. In Orange County, Sheriff's Deputy training to apply Naloxone for overdoses saved 70 lives in the jail in 2019.[202]

Shannon Robinson, MD, an expert in addiction issues who is currently with Health Management Associates, provides additional explanation, "Trauma, mental illness, substance use disorders and homelessness have bidirectional influences upon each other. To stop the multi-generational effects of these issues and ever-increasing resource utilization, we can treat MH and SUDs with evidence-based treatments including motivational interviewing, cognitive behavioral therapy, contingency management, and MAT."[203]

Although these types of practices have progressed, institutionalized settings do not often use treatment programs. The following recommendations, promoting both higher expectations and implementing these programs in correctional institutions, focus on the importance of structurally organizing treatment as part of everyday practice, assisting jurisdictions with the cost of treatment, managing data to improve outcomes, and helping those in custody and returning to the community using a case management approach. The most effective method of ensuring positive outcomes and reducing recidivism requires a seamless system of treatment and plentiful wraparound services for individuals reentering the community.

[CROSS REFERENCE REENTRY]

1.4.1 Jails should screen every individual booked into the facility for substance use disorder, mental health disorder, housing instability, and homelessness. Jails should follow up with a full assessment for anyone who screens positive.

Jails that systematically screen every inmate can help identify and properly diagnose mental health or substance use disorders and also identify the risk for housing instability or homelessness while in the community.[204] Screening and assessment tools should be valid, reliable, and developed from evidence-based research.[205] This information can inform programming and improve efforts to reduce recidivism.

[CROSS REFERENCE REENTRY]

Screening should assess risk factors that may lead to homelessness, such as social supports, trauma, and depression related to behavioral health disorders.[206] Assessments should also consider criminogenic risks, such as attitudes toward committing crime, associates who commit crime, and low self-control.[207] Those needs should be addressed in conjunction with other behavioral health and services to encourage recovery, mental health stability, and housing stability.

Regarding Maricopa County, Sheriff Paul Penzone says,

> Every detainee goes through a comprehensive evaluation upon entering our custody. On average, between 3,000-3,500 detainees will have a comprehensive mental health evaluation. Approximately 28 percent of those evaluated will be classified as having some level of mental illness. Additionally, 8-

[202] Balicki and Winger, PowerPoint Presentation, Social Problems, May 19, 2020.
[203] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 25, 2020) (statement of Dr. Shannon Robinson, Principal, Health Management Associates, Cosa Mesa, CA), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.
[204] SAMHSA, *Key Substance Use and Mental Health Indicators*; Keith Scott and Pat Tucker, "Housing Instability Risk: How to Recognize It and What to Do When You See It," (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/slides-homelessness1_20171004.pdf; SAMHSA, *Principles of Community-Based Behavioral Health Services*; Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works.*
[205] *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019), https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS.
[206] Duwe, *The Use and Impact of Correctional Programming for Inmates*; SAMHSA, *Principles of Community-Based Behavioral Health Services*.
[207] Peterson et al., "Analyzing Offense Patterns as a Function of Mental Illness;" Bonfine, Wilson, and Munetz, "Meeting the Needs of Justice-Involved People With Serious Mental Illness;" Skeem, Manchak, and Peterson, "Correctional Policy for Offenders With Mental Illness;" Skeem et al., "Offenders with Mental Illness Have Criminogenic Needs."

10 percent will be designated as seriously mentally ill (SMI). Of the SMI population, 28 percent will report some level of homelessness or home instability. An estimated 34 percent of SMI self-report some degree of substance abuse as an additional factor complicating the behaviors and threat to safety.[208]

The Sheriff's Department in Orange County uses screened data to design comprehensive programing that will inform Orange County as it helps inmates achieve mental health stability, maintain sobriety, and avoid returning to custody upon release. The overall jail population and subsequent crime rates will decline when the department successfully addresses these high utilizers.

1.4.2 Correctional facilities should provide evidence-based treatment for inmates with behavioral health disorders while they also address the inmates' criminogenic needs. Tailored treatment should include medication-assisted treatment for people with opioid addiction and solutions for other drug or alcohol disorders. Correctional facilities should programmatically and structurally organize their facilities to provide optimal behavioral health in addition to other health services.

The use of evidence-based treatment and services has had a positive impact on curtailing substance use disorders, increasing stability for those who have mental health disorders, and assisting those who are homeless to gain more stable housing.[209] In addition, treatment and services should incorporate the risk-need-responsivity (RNR) model.[210] The basis of the RNR model is that the treatment level should match the risk level: those at a high risk level for recidivism being more likely to benefit from high levels of treatment, and those at low risk of recidivating possibly being more likely to recidivate if provided high levels of treatment. Importantly, treatment should target such criminogenic needs as criminal history; attitudes supportive of crime; friends who are antisocial; and low self-control.[211] Treatment should also be responsive to an individual's learning style, abilities, and other individual characteristics, such as gender or language.[212] Relying on this total model has a better recidivism outcome than relying on elements of it.[213] Finally, having a person-centered case management approach and data-sharing system within correctional institutions and reaching into the community improves coordination, continuity of services, as well as recidivism and treatment outcomes.[214]

[CROSS REFERENCE REENTRY]

As Dr. Robinson expresses, "An opportune time to [treat mental health and substance abuse issues] is while persons are involved in the criminal justice system." She outlined a number of steps to provide the optimal response to treatment, including supporting clinical providers and patients sharing decision making about medication and level of care treatment, as well as the need to "eliminate unnecessary barriers to MAT; stop federal, state and local funding of care which is not evidence based; and incentivize in outreach to prepare for smooth transitions to the community. These steps will improve outcomes, including decreases in recidivism, and improve morale of providers, patients, family and law enforcement, and ultimately decrease

[208] Penzone, *President's Commission on Law,* March 25, 2020.
[209] Steven Belenko, Matthew Hiller, and Leah Hamilton, "Treating Substance Use Disorders in the Criminal Justice System," *Current Psychiatry Reports* 15, no. 11 (2013), https://doi.org/10.1007/s11920-013-0414-z; Munthe-Kass, Berg, and Blaasvaer, *Effectiveness of Interventions to Reduce Homelessness, 28, 87.*
[210] Grant Duwe and KiDeuk Kim, "The Neglected 'R' in the Risk-Needs-Responsivity Model: A New Approach for Assessing Responsivity to Correctional Interventions," *Justice Evaluation Journal* 1, no. 2 (2018), https://doi.org/10.1080/24751979.2018.1502622.
[211] Skeem et al., "Offenders with Mental Illness Have Criminogenic Needs."
[212] Ryan M. Labrecque, "Specialized or Segregated Housing Units," *Routledge Handbook on Offenders with Special Needs* (New York: Routledge, 2018), Pt. I, 5, https://books.google.com/books?hl=en&lr=&id=jX1aDwAAQBAJ&oi=fnd&pg=PT119&dq=risk+needs+responsivity&ots=wDfghcbCdD&sig=2LM0mDNmrLEY9HFFT8-z5H-IRE#v=onepage&q=risk%20needs%20responsivity&f=false.
[213] D. A. Andrews and James Bonta, "Rehabilitating Criminal Justice Policy and Practice," *Psychology, Public Policy, and Law* 16, no. 1 (2010), https://psycnet.apa.org/record/2010-01480-002.
[214] Gregory Theurer and David Lovell, "Recidivism of Offenders with Mental Illness Released from Prison to an Intensive Community Treatment Program," *Journal of Offender Rehabilitation* 47, no. 4, (2008), https://doi.org/10.1080/10509670801995023.

costs to our federal, state and local governments."[215]

As agencies work to adopt these programs and implement best practices, costs and resources can deter progress. Regardless, they must be fiscally prioritized as their success speaks for itself. Evidence-based services, like MAT, are effective and necessary tools to achieve sobriety and mental health stability and reduce recidivism. Resources should also be prioritized to assure seamless care into the community. For instance, when appropriate, people leaving the institutions should be prescribed a 90-day supply of medications by institution health officials, to ensure there is no gap in medication delivery.

[CROSS REFERENCE REENTRY]

[BEGIN TEXT BOX]

According to data presented by Middlesex County, Massachusetts, Sheriff Peter Koutoujian, during the first three months of the Middlesex jail's expanded medication-assisted treatment (MAT) program, 58 percent of individuals at the jail tested positive for illicit drug use at the time of intake.[216] Noting that community-based overdose deaths increased over six consecutive years, the sheriff's office developed an MAT program known as the Medication-Assisted Treatment and Directed Opioid Recovery (MATADOR), which combines pharmaceutical and behavioral interventions. The program also uses "navigators" who work with individuals upon reentry and coordinate with community health care providers. The program has seen a one-year post-release recidivism rate of 10.87 percent for inmates treated with naltrexone, while the recidivism rate for a control group was more than twice that (24.75 percent). With respect to health outcomes, of the more than 500 inmates who received one or more naltrexone treatments since the program's inception, 95.44 percent have not succumbed to fatal overdose. MATADOR, which began initially with Vivitrol treatments, expanded in September of 2019 to include Methadone and Buprenorphine.[217]

[END TEXT BOX]

Physical changes may need to be made to correctional facilitates in order to accommodate the environment and space needed to achieve the level of service demand and needs of the incarcerated population.

PULL **QUOTE:** "By default, the Orange County Jail has become the largest mental health hospital in our county. As I have made clear many times, if our jail system is going to function as a mental health hospital, then it is going to be a good one." – Sheriff Don Barnes, Orange County, California[218]

The challenges faced by Orange County, California, highlight what correctional facilities face nationwide and provide an insight into potential solutions. Of the 5,000 inmates housed in the Orange County Jail, up to 2,000 require mental health treatment. To meet this challenge, the jail implemented a new jail classification system that enhances out-of-cell time with increased access to necessary and critical programming; eliminated late-night releases; constructed new mental health housing modules; increased and enhanced staffing ratios for those units, which includes specific staff being trained in CIT; expanded the use of MAT programs to treat 500-600 people per day, implementing medically supervised substance use disorder (SUD) step down units to treat the 100-120 people per day who are detoxing off alcohol or drugs; and created a housing unit for military veterans, connecting them to services and care.[219]

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[215] Dr. Robinson, *President's Commission on Law,* March 25, 2020.

[216] Middlesex Sheriff's Office, *Opioid Treatment Program: 120-Day Fact Sheet (September 1 – December 31, 2019)* (Medford, MA: Middlesex Sheriff's Office, 2020).

[217] Shawn MacMaster, Director of Strategic Development and Project Planning, Middlesex County, MA, sheriff's office, email communication with Robbye Braxton, Federal Program Manager, Reentry Programs and Initiatives Working Group, May 28, 2020.

[218] County of Orange Community Corrections Report, *Integrated Services, 2025 Vision*, 6.

[219] Barnes, email communication to Social Problems, April 28, 2020; Balicki and Winger, PowerPoint, Social Problems, May 19, 2020.

1.4.3 Congress should eliminate Medicaid's prisoner exclusion policy.

PULL QUOTE: This policy has become a significant driver for the over-incarceration of those suffering from mental health and substance use disorders. Placing them in jails without Medicaid coverage drains valuable crime fighting dollars, places an unfair and dangerous burden on county jails, and, ultimately, places detainees who need continuity of care at greater risk of returning to jail.[220]

A policy brief by the National Sheriffs' Association and the National Association of Counties states, "Approximately two-thirds of the local jail population are being held prior to trial and have not been convicted of a crime. On any given day, local jails house approximately 465,000 non-convicted individuals."[221] Behavioral health programs in a correctional setting have proven to help inmates conquer addiction and reduce recidivism; however, some gaps must be addressed to help facilitate treatment options across the correctional settings.

Persons in pretrial custody with a substance use or mental illness disorder (or both) have costly medical expenses that burden limited county resources. Orange County, California, uses MAT for drug-addicted inmates. While it is successful, it is also expensive. In March 2020, the cost of participation by 535 inmates was approximately $174,000 per month, or more than $2 million per year.[222]
As Sheriff Don Barnes of Orange County, CA Sheriff's Department states,

> The Social Security Act prohibits the use of federal funds and services, such as Medicaid, from being provided to "inmates of a public institutions." While this language was intended to prevent state governments from shifting the health care costs of convicted prison inmates to federal health and disability programs, it has an unintended impact on local jail inmates who are in a pretrial status. For inmates with serious behavioral and public health conditions, the current federal policy of terminating or suspending the federal healthcare coverage for these individuals results in poorer health outcomes and hinders efforts to prevent individuals from committing new crimes upon release.[223]

To help reduce recidivism, Congress should enact legislation that addresses this exclusion policy.

Dianne C. Harris, a steering committee member of the National Shattering Silence Coalition, notes, "Eliminate Medicaid's Prison Exclusion and make those mentally ill being discharged from incarceration eligible for Medicaid prior to final release. Using Medicaid funds to care for seriously mentally ill adults who are incarcerated would provide adequate treatment and thereby reduce danger to corrections officers. Preapproval for Medicaid prior to release allows those mentally ill to maintain uninterrupted treatment and less likely to recidivate."[224]

1.4.4 Congress should pass legislation to amend regulations in the Health Insurance Portability and Accountability Act that prohibit sharing records relating to treatment and health information for individuals in correctional settings.

While HIPAA allows for protected health information to be shared between correctional institutions and

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[220] Jonathan F. Thompson, Executive Director and CEO, National Sheriffs' Association, public comment to President's Commission on Law Enforcement and the Administration of Justice, May 20, 2020.
[221] https://www.sheriffs.org/sites/default/files/NACo%20Medicaid%20and%20Jails%20One-Pager_wNSA.pdf
[222] Barnes, *President's Commission on Law Enforcement,* March 25, 2020.
[223] *President's Commission on Law Enforcement and the Administration of Justice: Hearing on Social Problems Impacting Public Safety* (March 25, 2020) (written statement of Don Barnes, Sheriff, Orange County, CA), https://www.justice.gov/ag/presidential-commission-law-enforcement-and-administration-justice/hearings.
[224] Dianne C. Harris, Steering Committee Member, National Shattering Silence Coalition, public comment to President's Commission on Law Enforcement and the Administration of Justice, March 31, 2020.

health providers for the purposes of treatment,[225] records created as part of substance use treatment typically require consent authorization.[226] As a result, inflexible privacy laws can deter patient-centered care if relevant information cannot be shared between providers. Other state and federal medical record confidentiality laws may further constrain this type of sharing. HIPAA regulations preempt state laws that are less stringent than HIPAA, but HIPAA is then preempted by state laws that are more stringent. In the context of information disclosure, these state laws are more protective of privacy (45 C.F.R. § 160.203(b)).

It is difficult for treatment and service providers to make a comprehensive recommendation without sufficient information regarding a defendant's substance abuse history. This information helps providers coordinate with correctional staff to address an individuals' specific needs, inform the probability that the individual is willing or able to comply with court orders, and evaluate an individual's likelihood for success while on supervision, in a correctional setting, or in the community.

Regarding individuals in correctional facilities, Congress should update HIPAA laws to provide clearer statutes that consider basic information sharing among first responders, criminal justice practitioners, and service partners to support successful outcomes.

[CROSS REFERENCE REENTRY]

[225] Christina Abernathy, *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing* (Lexington, KY: Council of State Governments, American Probation and Parole Association, 2014), http://www.appa-net.org/eweb/docs/APPA/pubs/CRPHIPFIS.pdf .

[226] Department of Health and Human Services; Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6,052 (January 18, 2017), https://www.govinfo.gov/content/pkg/FR-2017-01-18/pdf/2017-00719.pdf.