Mike Brown, Police Chief
Salt Lake City Police Department

Homelessness
Aiding the Unsheltered in Our Communities

In the 1960s, the U.S. population was 150 million people with 600,000 beds for in-patient mental health treatment. Today, the U.S. population has more than doubled to 320 million people with only 50,000 beds available for in-patient mental health treatment. Today's lack of mental health treatment beds has meant that the new treatment center options are incarceration and/or homelessness. Implementation of evidence-based interventions can have a benefit of more than $58 for every dollar spent; and studies show that every dollar spent on substance use disorder treatment saves $4 in health care costs and $7 in criminal justice costs[1].

Being homeless is not a crime. Having mental illness is not a crime. Having substance use disorder is not a crime. Yet, law enforcement across the country is consistently put in the position of triaging homelessness, which often is a symptom of underlying mental health and/or substance use issues. Law enforcement is the most expensive and least effective method of dealing with the social issues that drive individuals to live on the street and become shelter resistant.

In the absence of affordable housing, accessible treatment beds, and available health care, police officers have become the Swiss Army knife of social reform. Law enforcement across the country has come to the realization that we cannot arrest our way out of this issue. We are changing the way we approach the unsheltered population in order to provide connections to vital services that address the underlying issues in an individual's life. We are doing what we can to fill the gaps we see and work together in a holistic approach. We historically have connected people to the criminal justice system. But today we also connect people to mental health treatment, medical care, and health advocacy experts. In Salt Lake City, the Community Connection Center (CCC) is our gap insurance. When we can, we point people toward help, not jail.

The opposite of addiction is connection – Johann Hari

In 2011, the Salt Lake City Police Department (SLCPD) created its Homeless Outreach Services Team (HOST). This team of police officers was, and is, an innovative program developed in collaboration with homeless service providers aimed at disrupting the revolving criminal justice door and, instead, addressing the underlying causes of homelessness. Since the HOST program's inception, SLCPD has continued to innovate and expand service and collaboration in support of vulnerable populations. See more: https://www.slchost.org/

In 2016, SLCPD opened the CCC. The CCC is a joint effort of specially trained police officers and social workers, who provide a safe environment for individuals experiencing homelessness or a mental health crisis to access individualized care, support, and appropriate community services. The CCC houses three teams that work together – Community Connection Team (social workers), Homeless Outreach Service Team (HOST police officers), and Crisis Intervention

[1] Ettner SL, Huang D, Evans E, Ash DR, Hardy M, Jourabchi M, Hser YI. Benefit-cost in the California treatment outcome project: Does Substance abuse treatment "pay for itself" Health Services Research. 2006; 41(1):192-213.

Team (CIT police officers). Salt Lake City Police Department social workers support the officers by making connections with individuals in the community, to build rapport, in hopes of connecting them to services or treatment. See more: http://www.slcpd.com/resources/ccc/

The SLCPD CCC team of social workers is comprised of one program manager, one office technician, five case workers, and three therapists. These team members have a variety of specialties and have become liaisons between front line police work and the community. Services with this team include, but are not limited to: intermittent short-term therapeutic intervention, care coordination and case management, housing assistance, and employment resources. The CCC also provides reunification services, fulfills short-term transportation needs, as well as provides for life sustaining needs such as clothing and food.

In addition to office visits and referral services to other providers, staff at the CCC also support vulnerable individuals in the field by responding to calls for service with co-responder teams (social workers and police officers). These co-responder teams have been used since 2017 to do face-to-face outreach in the community, connecting clients with service providers. This co-response outreach provides individuals an opportunity to talk with a social worker with the end goal being diversion/deflection from other outcomes, such as, incarceration for minor crimes like trespassing and drug use. By responding to these types of calls using this model, SLCPD is attempting to identify the underlying reasons for the behavior and offer alternative treatment or a warm handoff to service providers. See more: https://cops.usdoj.gov/html/dispatch/11-2019/community_connection.html

Some of the scenarios in which the teams do co-response or outreach include responding to complaints about homeless camps, proactively searching for illegal encampments to talk with unsheltered individuals, referral and transport to a detox facility, response to mental health calls such as suicide attempts or threats, and mental health crises. We have even started expanding their involvement into situations like negotiating with a barricaded subject.

Another goal of SLCPD's CCC is to identify individuals in Salt Lake City who are the highest utilizers of emergency services, such as those with multiple nuisance offenses or untreated mental health issues. In 2018, the top 50 utilizers had a combined 571 calls for service and 595 arrests. The CCC staff maintained continual contact with these clients to build trust and work to address short-term and long-term needs. This particular program was selected as a national model for Police-Mental Health Collaboration programs. See more: https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/law-enforcement-mental-health-learning-sites/salt-lake-city-police-department/

> Jane Doe, a 42-year-old female, was identified as a high utilizer during meetings with multiple emergency service providers. Between 2013 and 2016, Jane was involved in 70 police-related events, had 69 emergency room visits, over 354 non-emergency related visits to hospitals or doctors, and over 1,000 notes in the hospital system. The estimated total cost for Jane's police and medical encounters was calculated to be over $248,000. With the case management and intervention of the CCC, Jane was eventually placed on the waitlist for the Utah State Hospital. While receiving treatment, Jane voluntarily decided to go to a long-term care center. She has not used any emergency medical services, or called for first responders assistance, since being placed into that care facility.

For one true measure of a nation is its success in fulfilling the promise of a better life for each of its members. Let this be the measure of our nation. – John F. Kennedy

These evidence-based interventions are directly affecting hundreds of the city's unsheltered individuals through various forms of assistance, such as a "warm hand-off" to a treatment facility, a ride to get identification, or assistance with applying for Social Security benefits.

> The CCC started working with a vet who was homeless for over seven years. Police had come to his hotel room to remove him after he refused to leave, for over one week, past his ability to pay for the room. He was experiencing severe anxiety to the point that he would have a panic attack if he walked outside of the room. He was transported to a local hospital and was admitted for inpatient psychiatric care. From the hospital he was discharged to the Road Home Shelter. The CCC provided therapy on a weekly basis and was able to connect him with Top Veterans Housing Services. The CCC then helped the client to complete his housing voucher and obtain an apartment and helped him complete his Social Security disability application. He was able to live in an apartment for three months until he was admitted to the hospital for medical issues. Unfortunately, he was terminally ill and later passed away in the hospital. In the weeks leading up to his death, the CCC met with him and provided mental health therapy and was able to help reunite him with his father, who he hadn't seen in 25 years, as well as his daughter. His family members were able to provide comfort and visit him in his final moments of his life.

According to a 2018 Brookings report[2], most people who cycle through our criminal justice system have serious health care needs. Three out of five state prisoners and sentenced jail inmates have a substance abuse problem. Half of state and federal prisoners and two-thirds of jail inmates are in serious psychological distress or have a history of mental illness. And two-thirds of those released from prison will be rearrested within three years. We have proven over and over that we cannot arrest our way out of the issues that lead to homelessness.

The report also estimated that each additional treatment facility in a county reduces the social costs of crime in that county by $4.2 million. Additionally, reducing drug abuse can reduce violent behavior fueled by addiction and the frequency of property crimes, like theft, which are often committed to fund those drug addictions.

> "I have been specifically impacted and mentored by the team at the Community Connection Center. I would not be where I am today without the support and encouragement I received from and through them. When I first came to be a client of the CCC, I was homeless (fresh out of jail) with criminal charges and on probation, waiting to get an assessment and referral for treatment, I had an open DCFS case with all odds of losing my children, coming out of drug addictions, domestic violence in my marriage, and in my support network. Since late 2016, when I linked into the CCC, I've been able and capable to continue in healthy life choices. I remain sober, I graduated probation, regained and maintain custody of my children, went from

[2] Doleac, Jennifer L. New evidence that access to health care reduces crime. Brookings, 2018, Jan. 3.

homelessness into singles transitional housing, to family transitional housing, to our own rental, that we've lived in for a year. I've continued to hold healthy boundaries from the domestically unhealthy people from my past, and through continuing in treatment I continue to learn new skills for being successful in self-sufficiency with a goal of self-reliance. This would not have been if not for the CCC team their efforts and the given resources. I appreciate and value the time, efforts, dedication, and resources that have been poured out to making and being the difference!" -Dani Andrus, client

In 2019, we co-responded 288 times and had over 1,700 outreach contacts. The teams also had over 500 contacts in the CCC, which often involve requests to help find housing, medical advocacy, and lining up services. Out of the 757 dispatched calls the teams responded to last year, only 3% resulted in involuntary placement into mental health treatment. The social workers alone made 1,521 contacts with clients, with 970 of them being field contacts. They provided transportation 39 times, got 620 people into housing, referred 214 to substance abuse treatment, connected 345 to mental health care, and referred 133 for medical issues.

The community, in solidarity and shared vision, has a stake in the outcome, provides bottom-up contributions, and shares responsibility for making this City both safer and more enjoyable. – SLCPD Community Supported Policing Philosophy

Change will not come if we wait for some other person or some other time.

What we have experienced in SLC informs the following recommendations through the boots-on-the-ground perspective we have gained while attempting to solve a social issue with law enforcement personnel. This is a 'system' issue, not just a 'person' issue – law enforcement is a small piece that gets brought in during a personal crisis or criminal act, which is often an underlying symptom of a bigger problem.

Recommendations

- **Receiving Centers:** Set up properly-funded, fully-staffed receiving centers so officers have a place to drop people off 24/7 that provides them wrap-around care to medical, mental health, substance use, and housing. Successful models are run by behavioral health agencies or hospitals who have direct access to medications and providers and are used as an alternative to jail. See more about SLCPD Operation Diversion: https://archive.sltrib.com/article.php?id=4924085&itype=CMSID
- **Detox and In-Patient Beds:** More detox facilities and more treatment beds need to be available. Jail beds can be a useful way to provide intervention and accountability but must be coupled with access to wrap-around care and onboarding people into treatment and services. Access to more in-patient psychiatric care is also needed. Access to affordable insurance, Medicaid expansion, or state-funded facilities is a key piece of addressing underlying issues.
- **Housing:** More housing, specifically, supportive housing options with social workers in the apartment complex or assigned to the person to help them maintain housing. Many people moving from the streets into housing need someone to help make sure their rent is paid on time or they don't break rules. Supportive options along with social supports are a best practice and result in more permanently housed outcomes.

- **Case Management:** All evidence-based interventions indicate that case managers are a critical component for unsheltered people to achieve the best outcome over time. Current best practice is to employ motivational interviewing techniques when working with clients. The most important element of managing clients is to ensure they are setting their own goals for success. Too often, law enforcement officers do not have the time or skill set to appropriately provide case management, thus necessitating the need for appropriately trained teams.
- **Public Education:** Homelessness is often seen as one single agency's failure. Blame is dished out on the police agencies without understanding the limitations of the agency, the social services, or the justice system. Through a robust education campaign, we need to educate our communities about the complex system of homeless outreach. Stakeholder engagement and coordination is crucial factor to achieve client advocacy. A municipal human services department or division could take functional authority over homeless mitigation through closely coordinated efforts across all stakeholders (law enforcement, health care providers, non-profits, etc.)

SLCPD conducted Operation Diversion over the space of a week in 2016. The operation, though short and focused, proved that when all the stakeholders work together, the outcome can be positive to those experiencing homelessness. SLCPD worked diligently to collaborate and build relationships with service providers and shelter administrators in advance of the operation.

This operation was a glimpse into the system-wide diversionary program that must be created in order to appropriately and humanely change the way society deals with the unsheltered members of the community. While police officers are often the first to make contact with people experiencing homelessness, none of the above recommendations are inherently a law enforcement function. However, if implemented and available, access to a coordinated diversionary program would fundamentally improve interactions between the community and law enforcement.

Written Testimonial

Provider: John Ashmen
Title: President/CEO
Organization: Citygate Network (formerly the Association of Gospel Rescue Missions)
Focus: The Impact of Homelessness on Law Enforcement and the Administration of Justice

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Thank you for the opportunity to address law enforcement and the administration of justice as they relate to our sheltered and unsheltered homeless population—a rapidly growing segment in many urban areas of our country. And in these locations, it's not just growing in size, but also in exigency, the combination of which has produced anxiety and outrage in other local residents and business owners, pushing law enforcement engagement off the charts.

I serve as the president of Citygate Network, North America's oldest and largest nexus of autonomous, faith-based crisis shelters and life-transformation centers. In most U.S. cities, one of our ± 300 member organizations is the largest homeless services provider, and in some cities, it is the *only* homeless services provider. In many communities, they are called gospel missions or rescue missions, although not all use these words in their name. Regardless of what name they go by, these places are open 365 days a year, 24 hours a day, offering help and hope to those who find themselves in destitute conditions and desperate situations.

To be more specific, Citygate Network member organizations work with chronically homeless individuals and families, as well as those simply experiencing homelessness for a brief time. We're talking about a segment of the population experiencing low self-esteem and high stress. Addiction and mental illness are common in these individuals. In fact, in some urban areas, our members report that upwards of 70 percent of the single adults seeking services are under the influence or recently under the influence of alcohol or drugs, and as many as half suffer from some form of mental illness. So, as you can imagine, many of the guests who turn to our member organizations have crossed paths with law enforcement.

The number of people who are homeless

Official 2019 data from the U.S. Department of Housing and Urban Development put the number of people experiencing homelessness in the United States at approximately 568,000. However, 2020 statistics from the U.S. Interagency Council on Homelessness (USICH) count every person who is on the streets or dependent on the government or a non-government entity for housing, and their number comes in at just over 1,000,000. This includes the unsheltered and those who are using emergency shelter beds, as well as transitional housing beds, Rapid Rehousing beds, and permanent-supportive housing beds. When these new statistics are seriously considered—and they should be if we want to see the complete picture—it confirms that homeless services providers and the law enforcement community need to collaborate like never before.

Reasons for homelessness

Entrenched bureaucrats in multiple agencies will primarily (and sometimes only) point to the lack of affordable housing as the reason for the homelessness epidemic in America. The solution that has gone hand-in-hand with this assessment is Housing First. At Citygate Network, we believe that the lack of affordable housing contributes to the problem, but equally to blame are the lack of education and job skills, wage disparity, mental illness, recreational marijuana, alcohol and drug addiction, human trafficking, family dysfunction, young people aging out of the foster care system (who do not have the ability, desire, or means to launch into the next phase of life), LGBTQ youth escaping domestic persecution, and the list goes on. One of the reasons elbowing its way to the front of the line is misplaced compassion leading to lax local laws. This is "creating a new class of 'untouchables,' permanently disconnected from the institutions of society."[1] The truth is, homelessness is a multifaceted problem that needs a multifaceted solution. And by not acknowledging that fact, we are making it worse.

[1] *The Moral Crisis of Skid Row*, *City Journal*, Winter 2020

To be clear, Citygate Network believes that Housing First is an important note on the solution scale, and that it saves lives every day. But the government, up until now, has pretty much only played that one note. We need rich chords to experience a symphony of success in our country. This really isn't an issue of partisan politics fighting for philosophical control. It has more to do with ability and capability to address underlying causes. You see, the government can do —and actually does—something about corporeal poverty; but it's not in the government's purview to address relational and spiritual poverty—which are why so many people fall into destitution in the first place or remain poor and powerless. The strong lines of supportive friends and a deep spiritual mooring can keep people from going adrift. This is what the faith community can bring to the table that the government can't.

The intersection of homelessness and law enforcement

The missions and similar ministries that make up Citygate Network interact with members of the law enforcement community every day. Police bring people wandering the streets to these facilities and help them get situated. They come back when there are disturbances inside or nearby. It goes with the territory. But so many of our members are saying that the type of work and the amount of work that law enforcement officers are now being asked to do because of the homelessness epidemic is wearing them down. They can see it in their faces. And I am not just talking about major cities in Southern California, it's becoming a concern everywhere.

Recommendations for the Commission

<u>Don't criminalize homelessness but do enforce the law.</u>
Not prosecuting quality of life crimes, as is now the practice in places like San Francisco, is nothing short of lunacy. Not to charge someone for public urination or defecation, prostitution, public camping, littering, and the like lowers the bar on acceptable behavior to a new low. It results in physical disease and can quickly lead to societal decay. Such ordinances have to be overturned, quickly.

And giving minor citations for major offences needs to be revisited. The leaders at many of our missions and ministries say it's not uncommon to see "slaps on the wrist" for obvious crimes. One mission CEO told me about a man beating a woman and dragging her by the hair down the street. The man received a misdemeanor charge and was back on the street threatening others within hours. This shouldn't happen in a civil society.

Look at establishing more Homeless Diversion Courts.
One model to consider was started in Dallas, Texas. It is primarily for those addicted to alcohol and drugs or who are mentally ill. It is intended to help such individuals stay out of jail and get the services they need. Participation is voluntary, but given the alternative, it's often chosen. Prior to appearance before a judge, an individual cited for public intoxication enrolls in an addiction recovery program; or perhaps undergoes a mental health assessment and medical treatment if the illegal behavior is being driven by a mental condition. A Homeless Diversion Court can be held in a social service agency or at one of our member missions or ministries, which would eliminate clogging the court system with homeless-related cases.

More police officers need to be trained in Trauma Informed Care.
When a disturbance requires police to show up at or near one of our member missions or ministries, it's not uncommon that the responding officers are not prepared to deal with or don't immediately recognize that the person is someone experiencing physical, emotional or mental health issues. Our members say that Crisis Intervention Team (CIT) training for more officers would help deescalate situations more quickly and eliminate the need for assistance from back-up units in many cases.

Don't make police officers into sanitation workers.
We are hearing more reports from our member organizations saying that police officers are being ordered to follow the trail of homeless people and pick up clothing, trash, discarded needles, human waste, and more. This detracts from actual law enforcement and is demoralizing. Cities that allow homeless people to do as they please should be mandated to include street sanitation in their budgets. One of our member CEOs suggested that mayors and city officials should be required to serve on pick-up and sanitation patrols, which would likely result in laws to improve the situation being enacted rather quickly.

Examples of what's working

Mission familiarity visits.
In one city, newly employed officers spend an afternoon and evening at the local mission to observe intake and better understand the most common issues people have when they arrive. This first-hand homelessness awareness can prove invaluable.

"Man Down" program.
In another city, our member mission has two ambulances. When a homeless person is seen laying on the street—especially on cold evenings—the police respond to make sure a crime has not been committed. If not, and it's apparent that the person is inebriated, high or experiencing mental illness, they call the mission. Mission staff arrive with their ambulance and trained medical personnel to take the homeless person back to the mission for treatment and services.

Mission Drop-offs.
This program is similar to the above and happens in many cities because of an established partnership. Homeless people picked up by the police for minor infractions are given two options: the holding cell or the mission. The mission team is trained in counseling and can offer better alternatives for the future—which is why that option is selected four out of five times.

Show of affirmation.
When a formerly homeless person graduates from an addiction-recovery program or a new life program, they get a framed certificate from the mission showing their success. In one of our member organizations in the Midwest, the local police present a certificate of accomplishment and good citizenship at the same time. We're told that this certificate holds just as much meaning, especially when presented by the officer who initially arrested the individual or brought him or her to the mission.

Eliminating a barrier to cooperation

In some cities, the faith component at our missions makes city officials reluctant to engage with them. But faith-based organizations have been on the streets and dealing with these problems—successfully— for decades. Recent statements from within the administration or put forward by the administration show that there is a strong belief that if we are going to solve our homelessness crisis, the faith community will need to play a major role. As far as Citygate Network is concerned, the faith community is willing, able, and ready.

The life-transformation work that Citygate Network members do can be described with seven "S" words: **saved** (making choices that will keep them from chronic illness and physical death, and making the decision that will keep them from spiritual death); **sober** (no longer controlled by stimulants or depressants); **stable** (mentally and emotionally balanced and enjoying good health); **skilled** (being academically credentialed and set on a career path); **secure** (able to provide financially for themselves and their loved ones); **settled** (benefitting from having the same safe place of their own to stay every night); and **serving** (giving back to the community through missional living).

Thank you for this opportunity to give testimony. We look forward to bringing the faith community forward to assist as needed.

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Impact of Homelessness on Law Enforcement and the Administration of Justice

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Utah Department of Public Safety, State Bureau of Investigation

Presidential Commission Members, it is a privilege and honor to address you. Homelessness and social disorder are impacting communities and individual lives today. A walk through many of our cities across the United States will reveal individuals experiencing homelessness, substance use disorders, and mental health issues. Police are encountering these individuals at increasing frequency with limited options for addressing the concerns. Utah faces similar challenges and is attempting to address those challenges.

Operation Rio Grande

In 2017, political leaders from the state, Salt Lake County, and Salt Lake City met to address a growing crime problem in the Rio Grande District of downtown Salt Lake City near Utah's 1000 bed homeless shelter. An encampment of over 2,000 individuals formed around the downtown shelter. An open-air drug market also formed, fueling drug use, violence, victimization, and public health concerns. In the summer of 2017, several major incidents, including three murders in less than two weeks, led to an unprecedented collaboration between state and local leaders who developed Operation Rio Grande.

Operation Rio Grande was a three-pronged approach that included (1) a law enforcement response, (2) a treatment and housing focused response, and (3) a dignity of work response designed to help individuals become self-sufficient.[1] For the law enforcement response, the Utah State Legislature authorized an additional 46 state troopers to assist the Salt Lake City Police Department.

Impact/Results

- **Crime.** Operation Rio Grande led to a sustained decrease serious (part one crimes) between 40-50 percent in the Rio Grande District when compared to the three prior years before the operation.[2] During the same period, crime also generally decreased across all parts of Salt Lake City.[3]
- **The Area.** Today, the encampment around the Rio Grande District is gone, the large 1000 bed emergency shelter is closed, and three smaller resource centers are open and addressing long-term needs of clients. The Rio Grande District is safer and cleaner. Service providers continued to offer shelter and food to the same number of clients. While there was some movement of individuals to other areas, the decentralized nature of the problem makes it more manageable.

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[1] https://operationriogrande.utah.gov/
[2] https://operationriogrande.utah.gov/ORG_phase1.pdf
[3] http://www.slcpd.com/open-data/compstat/

- **Medicaid Waiver:** Utah obtained a waiver from the U.S. federal government to expand Medicaid health care coverage to individuals involved in the justice system, participating in mental health and drug courts, or experiencing chronic homelessness. To date, 4500 individuals have access to health, behavioral health, and dental care—over half associated with Operation Rio Grande.[4]
- **Treatment.** A second waiver was obtained allowing treatment facilities to expand bed count from "16-bed provision." Treatment beds in the Salt Lake County system have now increased from 170 prior to the operation to nearly 700 today. Private in-patient and out-patient services have also significantly increased.
- **Sober Living.** Salt Lake County started a sober living program to assist individuals with struggling with addiction to stay safe and sober. The program allowed for up to six months of housing with peer support specialists to help individuals with stabilization. Since 2018, more than 1000 individuals have been housed and connected to services.
- **Specialty Court.** A pilot Operation Rio Grande drug court was formed to support individuals who are often excluded from traditional specialty courts. These individuals typically have co-occurring chronic physical conditions, mental illness, and substance use disorders. The court capacity is 125 with 67 graduating since inception.
- **Unsheltered Homeless Toolkit.** A working group consisting of law enforcement, resource providers, and community leaders developed a practical guide for communities and law enforcement for addressing unsheltered homeless. The document was shared with cities around the state and is available on the Internet.[5]
- **Resource Centers Safety**. Law enforcement worked with service providers and community members to develop best practices for safety and security in the new resource centers. (Attachment A). On-going efforts are underway to adopt and implement recommendations from U.S. Interagency Council on Homelessness.[6]
- **System Alignment:** The Utah Highway Patrol and Salt Lake County Legal Defenders are piloting a program to support individuals who are highly involved in the criminal justice and crisis services systems. The program diverts individuals pre-trial to treatment and intensive care in an effort to stop the revolving door to the jail and improve outcomes for the individual and community. (Attachment B).
- **Automatic Expungement.** While not directly part of Operation Rio Grande, Utah was the second state in the nation to pass automatic expungement for lower level crimes, including misdemeanor drug possession. This effort is an important step in helping individuals gain access to housing and jobs. To qualify, individuals must meet minimum requirements (i.e. no felony, non-violent offenses, etc.), complete their sentence, pay all restitution, and remain crime free for a set period of time. Law enforcement and prosecutors continue to have access to the expunged records.

Efforts to date have laid a foundation for public safety and support to individuals in crisis. Challenges still exist in the new service delivery model, and there is more to do with individuals

[4] https://gallery.mailchimp.com/28cc4b4b52c06e4a40436d06f/files/549b1491-15c9-4517-86b5-e5ae1954ea36/ExpansionFAQ.pdf
[5] https://jobs.utah.gov/housing/homelessness/unsheltertoolkit.pdf
[6] https://www.usich.gov/resources/uploads/asset_library/Law-Enforcement-and-Homelessness-Service-Partnership-2019.pdf

who remain unsheltered or facing substance abuse or mental health concerns, but early results indicate those seeking services appreciate the new centers and resources available.

Lessons learned

Law enforcement approaches

The Utah Department of Public Safety and Salt Lake City Police, with support from the Department of Corrections and other law enforcement partners, led the law enforcement phase of Operation Rio Grande. An **increased foot patrol presence** in the area was foundational to the operation. Patrol officers were tasked with restoring order, connecting with the community, and offering services. The Utah Highway Patrol and Salt Lake City Police also used **specialized outreach teams** to help individuals connect to services. **Specialized criminal enforcement** teams were tasked with dismantling the open-air drug market and removing violent offenders.

Due to the complexity of this crisis, **no one entity or one approach is sufficient**. Solutions to crime reduction and support to the community range from prevention programs and criminal enforcement, to community outreach and government-wide coordination.[7] Place-based policing techniques, co-responder teams, foot patrol, community engagement and outreach, and specialized narcotics enforcement reduced crime significantly. Law enforcement also partnered with government and community partners to make lasting improvements to the area. Environmental improvements for the Rio Grande District included upgrades to Pioneer Park, refreshed landscaping, removal of old fencing and graffiti, and regular street cleanings.

Law enforcement engagement with homeless communities and encampments.

While many believe law enforcement should not be involved in addressing the concerns around encampments or areas of social disorder, we believe they are wrong. **We are the guardians of the community, including the vulnerable.** Victimization is a real issue in encampments and areas with a concentration of vulnerable individuals.

It was evident early in the operation than not all people in the area were experiencing homelessness. There was **no one consistent profile of persons.** There were individuals experiencing homelessness. Many other individuals struggled with substance use disorders and mental health issues, but there were also violent criminals, drug dealers, and criminal gangs seeking to control the area and prey on the vulnerable. The varied situations made the operation complex.

As one colleague said of the situation in the Rio Grande District, "…**this was more of a lawlessness issue, not a homelessness issue."** Encampments become a vortex and crime and victimization if left unchecked. The very population that communities, advocacy groups, and

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[7] https://www.theiacp.org/sites/default/files/2018-09/iacp_reducing_violence_and_crime_web.pdf

police are trying to protect and support are being harmed by the disorder and crime. When police engage consistently with the community, criminals and drug dealers are unable to openly cause harm.

While arresting drug dealers and violent criminals is not typically controversial, other **enforcement efforts addressing misdemeanor drug use, assault, trespassing, and other lower level crimes can be controversial at times**. In Operation Rio Grande we were criticized by advocacy groups for the number of misdemeanor arrests. We felt they were too high as well, but without other options, necessary for the restoration of order. Communities cannot allow criminal activity and law violations to go unchecked. Diversion options for individuals, both pre-arrest and post-arrest, was a constant discussion. **Officers used discretion in how they handled each situation.** They were instructed to address law violations appropriately while giving equal or more attention to helping those struggling with a myriad of challenges. Several individuals in crisis indicated the presence of officers and improvements to the area made it safer for accessing services and more difficult to access drugs.

Law enforcement **used several strategies to support struggling individuals**. We formed specialized outreach teams with officers and social workers, held meetings with shelter clients, coordinated with service providers, and worked to align criminal justice and crisis services to build trust, gain legitimacy, and deliver better outcomes. **While enforcement of the law is important, equally or more important is the support we offer to communities**. An International Association of Chiefs of Police publication on Policing in Vulnerable Populations reads, *"Public safety and well-being cannot be attained without the community's belief that their well-being is at the heart of all law enforcement activities...it is critical to help community members see the police as allies rather than an occupying force."*[8]

Herein lies the challenge for law enforcement agencies—maintaining public safety and order while maintaining community support and trust. The issues surrounding unsheltered homelessness and social disorder are one of the greatest challenges communities and the police are facing today. While we know we are not able to arrest our way out of these social problems, we must also recognize that, in some cases, **the criminal justice system may be an appropriate entry point into treatment and services—though an expensive option**. Many individuals we spoke with who became sober as a result of Operation Rio Grande credited their arrest as a turning point. Because arrest and incarceration are expensive and can impact a person's ability to obtain work, housing, treatment, and benefits, **leaders of Operation Rio Grande worked on several programs to divert or assist justice-involved individuals.**

Current Efforts

As a result of Operation Rio Grande, law enforcement and the community are finding solutions. While perspectives vary and disagreements exist at times, the lines of communication

[8] https://www.theiacp.org/sites/default/files/2018-11/IACP_PMP_VulnerablePops.pdf

are open. Discussions are occurring at every level. The following efforts are underway to continue to address unsheltered homelessness and the associated social disorder.

- **University Study.** The Utah Department of Public Safety is currently working with the University of Utah to commission a study of justice-involved individuals associated with Operation Rio Grande. The purpose of the study is to identify the effect of the operation on those individuals and develop solutions for improved, system-wide response.
- **Data analysis and data sharing.** Salt Lake County is focused on understanding the intersection between homelessness and the criminal justice system. The workgroup is discussing how to improve data collection and sharing, both in the aggregate and for individuals, to improve outcomes.
- **Development of Crisis Receiving Centers.** Work is underway in the state to build receiving centers designed to divert individuals at the time of arrest, giving officers another option. The first receiving center in Utah opened in Davis County at the beginning of 2020. Sixty-four individuals have been diverted in the pilot. Of the 64 individuals, 52% would have gone to jail and 28 percent would have gone to the emergency department. To date, 60 percent have remained in treatment. Average drop off time for officers if 5.57 minutes. The two law enforcement agencies involved in the pilot are reporting improved officer morale and community relations.

Conclusion

Communities must come together to address the social disorder happening around the unsheltered homelessness. **Law enforcement must balance the need to maintain public safety while addressing the needs of the vulnerable. The continued need for more treatment and a lack of affordable housing are significant challenges which must continue to be addressed by political leaders and communities, but the crisis on our streets needs to be addressed now.** We cannot wait. Our police officers need the backing and support of their law enforcement administrators, political leaders, and the community in addressing immediate public safety concerns. If officers feel restrained or unsupported, morale and effectiveness will decline. Officers who are supported, well trained, and genuinely care are most effective in addressing social disorder.

We need to work as a criminal justice and crisis services community to align systems for effective delivery of both (1) prosecution and (2) treatment and recovery support services. Anything less, sends the wrong message to criminals and those in need. We need to support those who are emerging from incarceration or treatment with effective re-entry programs and evidence-based Medication-Assisted Treatment to reduce the likelihood of recidivism. We can do this through partnerships, data sharing, better system navigation, and collaboration. A disjointed system opens the door for recidivism and increases in crime. As we effectively work together in supporting our vulnerable populations, we will build legitimacy and trust within those communities. Our front-line law enforcement officers will feel supported and will effect meaningful change. Our vulnerable populations will feel safe, supported, and protected.

The President's Commission on Law Enforcement and the Administration of Justice

"Invited Witness Testimony"

Statement of Carson Fox
CEO, National Association of Drug Court Professionals

March 19, 2020

To Chairman Keith, Vice-Chair Sullivan, and distinguished members of the commission, thank you for your outstanding leadership on this issue and for the invitation to present today. I am honored to have the opportunity to submit my testimony on behalf of this nation's over 4,000 treatment courts and the 150,000 people who they will hold accountable in the form of close supervision and rigorous addiction and mental health treatment this year. For three decades, treatment courts, including adult, family, juvenile and tribal drug courts, DWI courts and veterans treatment courts, have proven that the administration of justice for people with substance use and mental health disorders is most effective when it combines accountability with evidence-based treatment and community-based support. Given the urgent and growing need for solutions to the addiction epidemic that promote both public safety and public health, it is my honor to share with you insight from my two-decade career in treatment courts.

I began my career as a prosecutor in rural South Carolina, where I 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.

The first drug court was established in 1989 in Miami-Dade, Florida by justice professionals experiencing similar frustrations. The court system was on the brink of collapse due to the overwhelming number of cases stemming from the crack cocaine epidemic. Drug court provided an alternative that used the leverage of the justice system to not only get people into treatment but keep them in treatment long enough to bring about real and permanent change. When I became prosecutor in South Carolina's first drug court in 1996, there were 139 programs across the country. In the three decades since the first generation of drug courts were established, the model has become not only the researched criminal justice intervention in American history, but it has proven to be among the most successful.

Drug courts are made up of teams represented by justice and treatment stakeholders. In drug court, the judge, prosecutor, defense attorney, probation officer, law enforcement, and case managers collaborate with counselors and treatment providers. Together, they identify the specific supervision and treatment needs for every individual in the program and work together to ensure they are followed. Drug court typically lasts 12-18 months, with participants appearing frequently in court for the team to assess their progress, modify their treatment, reward positive behavior, and sanction non-compliance. This community-based approach allows drug courts to identify and meet individual needs beyond clinical treatment, from education, employment, and housing assistance to family reunification, restitution and healthcare.

Law enforcement plays a critical role in the success of drug courts. Research shows that the involvement of law enforcement on a drug court team is associated with an 88 percent reduction in recidivism relative to courts that do not have law enforcement representation. As someone who has trained programs across the country and seen thousands of drug courts, law enforcement participation is not only necessary but a key indicator of program success. We see that working effectively in many of the counties you represent – Pinellas County, FL and Shelby County Alabama are just two of the many examples.

Over the last decade, research has confirmed the target population for drug courts. First and foremost, drug courts serve individuals who have extensive involvement in the justice system directly related to their addiction or mental health disorder. But it is important to note that low-level offenders, drug possession cases for example, are often best served by a less intensive program. Drug courts are designed for, and work best with, individuals whose substance use or mental health disorder has contributed to more serious crimes for which they face long-term incarceration. Typically, these charges include theft, burglary, forgery, and DWI. Before drug court, there were few sentencing options, and most of these cases resulted in continued recidivism at great cost to taxpayers and continued damage to offenders' families. Offenders in drug court often have longer criminal histories and repeated unsuccessful attempts at treatment.

By successfully diverting these cases from jail and prison, and transitioning individuals to lives of productivity, drug courts achieve their greatest impact. The Government Accountability Office, the non-partisan research arm of Congress, examined over 30 scientifically rigorous studies involving more than 50 drug courts throughout the country. They found re-arrest rates for drug court graduates to be up to 58 percent below comparison groups, and cost-benefit as high as $47,852 per participant.

The GAO identified the Department of Justice National Institute of Justice Multi-Site Drug Court Evaluation (MADCE) as "the most comprehensive study on drug courts to date." This five-year study confirmed drug courts reduce recidivism and save money, and identified additional benefits including increases in employment, education, family functioning and financial stability.

This success directly translates to more resources focused on community safety. For example, in 2011, Georgia expanded drug courts across the state. Following this expansion, the overall prison population in Georgia declined, even as the percentage of violent offenders in prison increased.

The adult drug court model has expanded to serve specialized communities, including repeat DWI offenders, parents whose children have been removed from the home due to substance abuse, juveniles facing criminal charges, tribal communities, and veterans. Together, these programs refer more people to treatment than any other intervention, approximately 150,000 each year.

Perhaps the most significant expansion came in 2008 when a judge in Buffalo, New York began seeing an increase in the number of veterans coming before the courts. The judge

recognized that many were struggling with substance use disorders, mental health disorders, and trauma, and not enough was being done to connect them to the local, state, and federal benefits they earned as servicemembers. Veterans treatment court economized resources by clustering veterans onto a single docket where they would go through the treatment court process surrounded by their peers. The single docket allowed representatives from the local VA medical center to be a part of the team and make immediate referrals to treatment.

To date, over 400 veterans treatment court programs have launched. They annually connect 15,000 veterans to treatment. In addition to reducing re-arrests and saving resources, an analysis by the Department of Veterans Affairs found veterans referred to VA services from veterans treatment court had better housing and employment outcomes as compared to other justice-involved veterans. These outcomes are crucial for ensuring long-term success.

The opioid epidemic has brought to the forefront the need for public-health oriented interventions. Like law enforcement and other first responders, the courts are on the front lines. Approximately 98 percent of drug courts currently service individuals with opioid use disorder. Drug courts have responded by improving access to FDA-approved medications to treat opioid addiction. By administering these medications under the watchful eye of the team, drug courts are able to limit diversion and reduce risk of fatal overdose.

In 2013, NADCP released the *Adult Drug Court Best Practice Standards*. The standards incorporate more than a quarter-century of research defining appropriate practice for drug courts across a spectrum of highly researched principles, including target populations, team member roles, equity and inclusion, evaluation and others.

Since their release, the effect of the standards on the drug court field has been profound. New drug courts are using the standards as the foundation for building a successful program, and existing courts are using them to adopt new policies, retool old ones, and expand capacity. A majority of states have adopted the standards, are receiving training and technical assistance from NADCP to do so or are incorporating them into their state guidelines for drug courts. Moreover, federal grants to treatment courts require fidelity to the standards as a condition of the award.

Approximately 95 percent of individuals with a substance use disorder return to drug use upon release from prison. For those in the community, evidence-based substance use disorder treatment can be expensive and too often unavailable, putting it out of reach of the people who need it most. Drug courts ensure that jurisdictions have an evidence-based response that promotes public health while reducing crime and protecting public safety. Moreover, drug courts prove that the justice system can provide an intervention that saves lives, reunites families, reduces crime, and strengthens communities.

With law enforcement on the front lines of this epidemic, NADCP has made it a priority to ensure they have the resources to effectively coordinate with drug courts. Armed with the research and guided by the standards, NADCP examined this issue and concluded it is critical that law enforcement identify standard operating procedures, recognize the importance of both

the multidisciplinary approach and the implementation of community policing, and understand the impact of vicarious trauma within the law enforcement community.

With support from the Bureau of Justice Assistance, last year we worked with law enforcement officers to develop and pilot test a new curriculum. We found an overwhelming response and interest in training and education in the following areas:

- The importance of cross-system linkages, identifying unmet needs outside of court and treatment services, and service referrals to enhance long-term recovery and reduce recidivism.
- The characteristics of a good working relationship with team members from probation, treatment, and community members struggling with opioid addiction or on the path to recovery.
- Understanding of the impact of secondary trauma and subsequently the importance of officer wellness systems.
- Using the Crisis Intervention Model as an evidence-based community engagement tool and look at its effectiveness with specialized populations such as combat veterans, trauma victims, and individuals diagnosed with a mental health disorder.

NADCP is implementing the curriculum across the country this year and look forward to sharing the results with BJA. However, it is clear from the response we have received that there is great interest and need for further education training in these areas.

My recommendation for the Commission is straightforward: Encourage law enforcement to be active members in their drug court and work closely with the prosecutors to ensure the target population is served; and encourage at the national level the continued education on drug court best practices.

NADCP stands ready to provide any additional information to the committee that may further understanding of drug courts and other treatment courts. Once again, I am honored to participate on this critical panel and look forward to ongoing collaboration.

STATEMENT FOR THE RECORD
Mike Sena
Executive Director
Northern California High Intensity Drug Trafficking Area
President's Commission on Law Enforcement & the Administration of Justice

Mr. Chairman and members of the Commission,

Thank you for inviting me to testify on the topic of the social problems impacting public safety related to substance abuse. This issue is at the core of our ongoing challenge to protect the public. Substance abuse negatively impacts the ability of law enforcement and our public safety partners to effectively protect the communities we serve.

My name is Mike Sena and I am testifying today in my capacity as the Executive Director of the Northern California High Intensity Drug Trafficking Area (HIDTA). The HIDTA Program was established within the White House's Office of National Drug Control Policy (ONDCP) under 21 U.S.C. §§ 1701. The HIDTA Program provides funding resources to joint initiatives of Federal, state, local, and tribal (FSLT) agencies in each of the America's 29 HIDTA designated areas to carry out activities that address the specific drug threats of those areas. The purpose of the HIDTA Program is to reduce drug trafficking and drug production in the United States by facilitating information sharing and cooperation among FSLT law enforcement agencies and implementing coordinated enforcement activities that includes enhancing law enforcement intelligence sharing, providing reliable law enforcement intelligence, and supporting coordinated law enforcement strategies that maximize the use of available resources.

Our nation has struggled with addiction and substance abuse since narcotics first came to America. We have moved from the opium dens of the 19th Century to the open-air street drug markets of today. We are living in an age where extremely addictive and deadly narcotics are available across our nation. The violence and quality of life crimes that accompany the sale and use of narcotics impact all of us.

STATEMENT FOR THE RECORD
Mike Sena
Executive Director
Northern California High Intensity Drug Trafficking Area
President's Commission on Law Enforcement & the Administration of Justice

Recommendations:

1. Reforms to the criminal justice system should reflect balanced perspectives, be informed by science and facts, and have public safety as their fundamental aim.

2. Drug courts that help individuals with substance use disorder by providing them with access to treatment must have the ability to separate the individual from the environment that perpetuates their addiction and cycle of crime.

3. The public safety community needs near real-time information sharing to identify overdose threats and reduce the loss of life. The Washington/Baltimore HIDTA's Overdose Detection Mapping Application Program (ODMAP) should be expanded nationwide.

In a growing number of American communities, law enforcement is not only challenged by the crimes and victimization associated with substance abuse, but by the criminal justice system itself. Some prosecutors are making decisions to not file charges for violations of selected sections of the law that elected representatives enacted in their jurisdiction, some states are reducing or eliminating penalties for committing crime, and some communities are focused on reducing jail and prison populations with little regard for the consequences.

In some parts of America, there are no major consequences related to criminal behavior, including the distribution of highly addictive and even deadly narcotics. These developments are troubling to those of us in public safety who must deal with the real consequences. Stating that

crime is going down because officers are not arresting those that violate the law or because prosecutors are not filing charges against defendants with the court may reduce crime statistically, but it does not make any community safer.

The Substance Abuse and Mental Health Service Administration's National Survey on Drug Use and Health for 2018 found that 1 in 5 people aged 12 and older used illicit drugs in the past year. The survey also found that approximately "20.3 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year, including 14.8 million people who had an alcohol use disorder and 8.1 million people who had an illicit drug use disorder."[1]

Several states have changed charging and sentencing guidelines, resulting in misdemeanor charges instead of felony charges. This has decreased our ability to connect justice-involved people with treatment services. The drug courts' ability to provide resources to those convicted of illicit narcotics related charges has eroded. Law enforcement's ability to develop sources of information has also been hampered as minimal to no jail or prison time results in fewer defendants choosing to cooperate and identify drug dealers and those engaged in other serious criminal activity.

Even though many addicts know that their next dose of drugs may be laced with fentanyl that will most likely kill them, they still take the drugs because feeding their addiction is so powerful that it overrides any rational decision making. Narcotics dealers also have little fear and

[1] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

knowingly sell potentially lethal drugs to their victims. This has resulted in 46,802 opioid related overdose deaths being reported in 2018.

The Washington/Baltimore HIDTA developed the Overdose Detection Mapping Application Program (ODMAP) to provide free suspected overdose surveillance data across jurisdictions to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events. ODMAP needs to be adopted nationwide and requires the support of the President to encourage every law enforcement, public safety, and public health agency in America to participate in the program.

Two weeks ago, HIDTA Task Force Commanders from across Northern California and I had the opportunity to meet with two individuals that had spent most of their lives fighting addiction and dealing with the consequences of their drug abuse. Those consequences included spending considerable portions of their lives incarcerated.

During our meeting, I asked them what had helped them change their lives for the better and what were their greatest concerns about addiction and the criminal justice system. I was told that going to prison and commitment to treatment saved their lives. Their greatest fear was for the youth and young adults of today, as they believe that the next generation will have nothing to help them break free of the cycle of drug addiction.

We should not make changes to the criminal justice system with a broad brush. Law enforcement should also not be responsible for solving all the social problems of today, but they must be

allowed to have the tools they need to reduce the impacts of substance abuse that are exacerbating social problems across the country. I understand that incarceration alone is not the solution, but too many lives are lost every day because we can't get people into the treatment they need.

Drug courts need to be empowered to help individuals with substance use disorder receive the treatment they need to break their cycle of addiction. That cycle of addiction often leads to a life of crime, homelessness, and in some cases, it also aggravates mental health issues.

In 2018, drugs caused 67,367 reported deaths in the United States[2]. We must promote and successfully execute near real-time overdose information sharing to address this lethal threat. The Washington/Baltimore HIDTA's Overdose Detection Mapping Application Program (ODMAP) must be expanded nationwide to help us save lives. We must also expand our ability analyze and disseminate overdose data through the HIDTAs integration of public health analysts, drug intelligence officers, and prevention initiatives.

I again want to thank the Commission for this opportunity to discuss some best practices, lessons learned, challenges, and successful programs that the HIDTAs and our partners are using to address and enhance law enforcement and the administration of justice.

[2] https://www.cdc.gov/nchs/products/databriefs/db356.htm

Sheriff Peter J. Koutoujian
Middlesex County Sheriff's Office, Massachusetts

Commission Focus Area: Importance of Substance Use and Addiction on Law Enforcement and the Administration of Justice

Topic: Corrections-based Medication Assisted Treatment (MAT)

Overview

The opioid epidemic is one of the most pressing public policy issues confronting the United States today. From town halls, to state capitol buildings, to the United States Congress, all levels of government have been impacted. At a more intimate level, the epidemic has borne a heavy toll on individuals, families, neighborhoods, and communities, causing widespread despair and leaving destruction in its path. Lives lost. Grief-stricken families. Communities forever scarred.

Compounding the problem is the confluence of public safety and public health dynamics. These dynamics present immense challenges and heighten the urgency to find solutions while, at the same time, making solutions harder to realize. In Middlesex County, Massachusetts, the Middlesex Sheriff's Office (MSO) has advanced a comprehensive, corrections-based approach to improving individual, community, and systems-based outcomes. At the core of this effort is Medication Assisted Treatment (MAT), which involves more than medication alone. Through a robust behavioral health focus, we have created a continuum of care that extends beyond the period of incarceration. We have accomplished this by building community capacity and investing in post-release services. All of our work in this regard is grounded in data and informed by performance metrics.

Scope of the Opioid Problem

Middlesex County is the most populous county in the Commonwealth of Massachusetts and the twenty-third most populous county in the United States, spanning 54 cities and towns with over 1.6 million residents. The county is geographically, demographically, and economically diverse; marked by dense urban centers, affluent suburbs, rural communities, and 25 colleges and universities, the county is very much a microcosm of America. Important to note, however, is that we do not operate under a singular governmental structure; as each municipality relies on its own resources, combatting the opioid epidemic has required cross-communal collaboration. What we have experienced with the opioid epidemic -- and the manner in which we have addressed it -- can thus be instructive to national policymaking efforts. In short, through the momentous change that we have made to date, Middlesex has paved a pathway for other communities to follow.

Massachusetts was once the epicenter of the opioid epidemic. In 2017, the state experienced 28.2 opioid deaths per 100,000 persons, two times higher than the national rate. More than

12,000 people died from an opioid overdose in our state between 2010 and 2018.[1] Of that number, 18% (2,183 people) were Middlesex County residents. But our strong mobilization efforts and rigorous response have resulted in a decline in deaths for three consecutive years now.

Profile of MSO Inmates

Of all the risk factors for a fatal overdose, recent release from incarceration is one of the most significant; individuals recently released from jail are 120 times more likely than the general population to succumb to an overdose. In fact, the likelihood of death within the first month of release is six times higher than at any other post-incarceration period.[2] Sadly, many decedents had little, if any, help prior to their incarceration. Whether because of inadequate community-based systems or a dearth of providers in the community (or a combination of both), interventions at the community level have failed (and continue to fail) those who need them most.

Fundamentally, no one should ever have to become incarcerated to obtain the help they deserve. Although I am incredibly proud of the cutting-edge programs and first-class treatment system we offer at the MSO, it is unconscionable to think that incarceration is arguably the easiest -- and sometimes only -- access point to dependable care; but without adequate community-based treatment options, corrections agencies have been left to fill this vacuum. Although jail may not be the ideal setting to receive treatment for opioid use disorder, it nonetheless offers a reliable window for intervention. More specifically, by not being subjected to the kind of social influences and external stressors that drive opioid misuse in the community, incarcerated individuals are often more amenable to treatment.

In Middlesex County, this begins with assessing individual and group-specific needs and planning for reentry on day one. From a group perspective, 40-42% of inmates require a medical detox at admission. An overwhelming majority of our population (70-80%) have co-occurring mental health diagnosis. Many of these inmates have been mired in the criminal justice systems for years -- so much so that a granular look at their respective histories sheds light on the indisputable link between substance use disorder and criminality. Intuitively, this speaks to the importance of corrections-based treatment modalities, as well as the need for community supports and services to carry over post release.

Medicated Assisted Treatment and Directed Opioid Recovery Program (MATADOR)

The seeds of the MATADOR program were planted in 2012 in what we now refer to as MATADOR 1.0. Initially, on-site MAT was offered to inmates in the form of extended release injectable naltrexone prior to their discharge from custody. In retrospect, our first version of the program was an abject failure -- a sobering experience from which lessons can be learned. After embarking on a deep and earnest self-assessment process, we uncovered a series of internal and external barriers to operational efficacy. These included, but were not limited to the following: contravening value systems among stakeholders; divergent priorities and general mistrust; and a disconnected "system" of treatment providers. Compounding this was a

widespread lack of motivation among key stakeholders -- particularly from the healthcare community -- to seek progressive change. To account for the institutional barriers that hindered the success of MATADOR 1.0, we set out to forge relationships with an overarching aim: creating a seamless continuum of care. But even in a resource rich county like Middlesex, achieving buy-in was a difficult endeavor; and obtaining the willingness of some stakeholders to be part of a bold and complex undertaking was equally hard. Nevertheless, our persistence has paid dividends.

Matador 2.0

As a result of the program shortfalls we identified, I suspended the pilot program and launched a comprehensive review. In doing so, it became apparent that 1) additional resources were needed, 2) community capacity had to be built, and 3) scientifically-sound research methods had to exist. Accordingly, we set out to do all three, formalizing relationships with community resources, vastly expanding our bullpen of local service providers, hiring a full-time navigator, improving communication across systems, educating stakeholders, and establishing a comprehensive research arm.

These measures have created a blue print for offering MAT in a correctional setting -- what has since become a national model recognized by Substance Abuse and Mental Health Services Association (SAMHSA), National Sheriff's Association (NSA), National Commission on Correctional Health Care (NCCHC), and the National Governor's Association (NGA).

Matador 3.0

The third and current iteration of the program saw an expansion of MAT to include Methadone and buprenorphine. Expanding pharmacological therapy to the three FDA-approved forms of MAT allows for patient-centered prescribing. This three-year pilot program, which we developed collaboratively with the Massachusetts Legislature, took effect on September 1, 2019. The post-release navigation and data collection elements codified by the new law are -- I am proud to say -- modeled after the approach we launched in Middlesex County.

The new law allows jails and houses of correction to provide maintenance therapy to both sentenced inmates and pretrial detainees who enter the facility with a verifiable MAT prescription. Additionally, it allows for MAT induction 30 days prior to release for inmates who began serving a sentence before the program became available. Prescriptions and dosages are determined by a qualified addition specialist and tailored to individual needs.

Successful Outcomes

Although MATADOR 3.0 remains in its infancy stages, analysis through the first 120 days reveals that the program has generated significant interest among inmates. In fact, the daily number of doses administered per day has risen during this period of time to approximately 70.

A closer look at this population shows that 82.24% of inmates enrolled in the program had a prior MAT prescription at one point in their lives, but lacked any semblance of structured, coordinated care at the community level. By creating community capacity, we have looked to change that experience. And to measure the impact of our approach, short-term, intermediate, and long-term outcomes will serve as post-release program measures moving forward.

As we have provided naltrexone treatment at the Middlesex Sheriff's Office for the last five years now, we have, however, been able to assess the impact of *this* particular form of MAT. Using a statistical matching technique known as propensity matching, we commenced a study in which treatment recipients were compared with a control group. To achieve statistical precision, demographic characteristics of the control group were closely matched to the treatment group.

The results of the study are extremely promising and can be seen under two distinct rubrics: **A)** ***Crime Outcomes*** and **B)** ***Health Outcomes***. Beginning with the former, the one-year post-release recidivism rate for those receiving naltrexone (as part of MATADOR 2.0) was 10.87%; the recidivism rate for the control group was more than two-times that at 24.75%. 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% *have not* succumbed to fatal overdose. As this population is 120 times more likely than the general population to experience a fatal overdose, we know that the program has been highly efficacious. It is here that we see the intersection of both outcomes: when individuals abstain from drug use, the propensity for crime commission dissipates. Overall, our experiences with MATADOR 1.0 and 2.0 changed the scope of understanding as to the necessity for broad-based, cross sector collaboration to effect change.

<u>Recommendations</u>

The reason I am so passionate about data is because I believe it can answer the single most important question before this working group and indeed this whole commission: where do we go from here? How precisely do we intend to improve the administration of justice -- and the experience of law enforcement -- in this country? In terms of expanding and enhancing MAT, the data lead us to some clear and compelling answers.

We can start by strengthening the two pillars on which a successful MAT program rests: treatment and access to medication. The damage caused by outmoded regulations can be seen at both pillars. Currently, individuals lose access to their federal health care benefits upon entering a correctional institution, even if they are awaiting trial.[3] This exclusion creates an obstacle towards the continuous provision of MAT upon reentry, and serves as a hidden punishment to those who ought to be presumed innocent. Those with private insurance face barriers, too. While the Health Insurance Portability and Accountability Act (HIPAA) allows for the sharing of protected health information between correctional institutions and health providers for the purposes of treatment,[4] records created as part of substance use treatment typically require

consent authorization.[5] As such, inflexible privacy laws can be incongruous with patient-centered care by not allowing for information sharing between providers -- a critical element to continuity of care.

Moreover, hardships also exist in the form of regional-specific interpretations of Drug Enforcement Agency (DEA) regulations and guidelines --challenges relative to providing buprenorphine and methadone inside a correctional facility. These include operational concerns about diversion and staff monitoring, but some of the most significant barriers are posed by impervious federal regulations. That is, existing regulations were developed as a needed safeguard for community-level dispensing of MAT; however, applying the same regulatory standard to correctional agencies -- where stringent security provisions exist by the very ethos of the field -- is an overly burdensome requirement. Removing the regulatory barricades surrounding MAT is a targeted, bipartisan solution that would have a significant impact on how widely and how well we can provide treatment for our incarcerated population. If the various agencies involved can work together to create a cohesive structure to these regulations, I believe we can quickly increase access to treatment and provide reinforcement to the fight against addiction.

The second thing we can do is invest in MAT programs that are demonstrating, through data, that they are bending the curve on the opioid epidemic. The provision of MAT is a wholly new mission for corrections, and I spoke earlier about how failure is to be expected as we work to fill this gap in the continuum of care. However as more agencies start MAT programs and more established programs show their efficacy over several years, we are beginning to identify best practices nationwide. Common to these promising initiatives is a rigorous commitment to data collection. For example, I sought an academic partner to evaluate our MATADOR program as an independent, third party. I found one in the University of Massachusetts Medical School, and the data from that partnership guided me as I chose to expand our program last fall.[6] Additional collaborations to externally validate our data and implementation plans have included Brandeis University, Baystate Health, and the University of Massachusetts Amherst.

This working group can help accelerate the development of MAT programs by encouraging federal stakeholders to invest in programs that can prove they are effective, and to provide technical assistance to new initiatives coming through the pipeline. Direct grants for jail-based MAT programs could help establish a universal standard of care which will benefit sheriffs, their staff, their facilities, and their patients.

However, the most critical assistance this presidential commission can provide the field of MAT -- and one it is uniquely qualified to deliver -- is to bolster community-based treatment services far beyond their current capacity. I am incredibly proud of my office's MAT program, and the MAT programs occurring in sheriffs' offices across the country. But without community-based services to continue these treatments upon reentry, we will never achieve our goal of reducing the harm and recidivism caused by substance use. It has taken significant effort to establish a

continuity of care in my county, and we are home to some of the greatest hospitals and universities in the world. The problem is only magnified for a rural community where the nearest methadone clinic may be many miles away.[7]

Conclusion

Establishing, testing, and sustaining a MAT program is hard work. It is also not the type of assignment many of us in law enforcement envisioned being our responsibility. However, our mission is to protect and serve the public, and substance use disorder remains a critical threat to our communities.

MAT programs are an important avenue through which we can address this crisis; and I believe our data shows that clearly. I also believe that the evolution of our MATADOR program, as seen through its initial failure and subsequent success, offers a learning lens from which other agencies can look, should they wish to pilot a similar program.

I appreciate the opportunity to share my thoughts with this working group, and look forward to working with all of you and with the full Commission in the days ahead. Thank you for your consideration of these recommendations, and for your service and commitment to the issue of social problems facing law enforcement in the United States.

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[2] Ibid

[3] National Association of Counties & National Sheriff's Association Joint Task Force Report. (2020). Addressing the federal Medicaid exclusion policy. Retrieved March 12, 2020 from https://www.naco.org/resources/featured/naco-nsa-joint-task-force-report-addressing-federal-medicaid-inmate-exclusion-policy.

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Written Testimony

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Topic: The Impact of Substance Use on Law Enforcement and the Administration of Justice

Overview: Orange County (OC) is the sixth most-populated county in the United States, with approximately 3.1 million residents who call OC home. The Orange County Sheriff's Department (OCSD) operates the nation's fifth most-populated jail system, housing an average of 5,700 inmates on a daily basis. Between May 1, 2018 and April 30, 2019, approximately 43,000 unique individuals were booked on a total of 60,431 bookings. Of those 43,000 individuals who self-reported or were diagnosed while in-custody approximately 40% suffered from a SUD. OCSD and the County of Orange (County) agree that the number of inmates in need of treatment is actually higher, since the 40% represents only those that were reported or diagnosed while in jail. During that same timeframe, 1,193 individuals were booked into the County's Juvenile Hall. Of those who were 17 years of age or younger and self-reported or were diagnosed while in-custody approximately 43% of male youth and approximately 50% of female youth were diagnosed with substance use disorder. The percentage of Transitional Age Youth (TAY age 18-20 years) increased to approximately 57% of male TAY and approximately 72% of TAY. Best Practices and Guidelines for Jail-Based Medication-Assisted Treatment is outlined in this National Commission on Correctional Health Care document.
https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf

The Orange County Health Care Agency's Correctional Health Services Division (CHS) provides the medical, dental, mental health and substance use treatments to those individuals incarcerated at a County Jail facility. Services are performed at a community standard-of-care on a 24-hour, 7-days a week basis. Upon intake into the jail facility, CHS triages and screens the individuals to determine their medical, mental health, and dental needs and identify subsequent treatment and medication plans. Following the *Expanding MAT in County Criminal Justice Settings: A Learning Collaborative*, CHS has expanded the population eligible for MAT along with a variety of treatment options. CHS works collaboratively with the Health Care Agency's Behavioral Health (BHS) Division to identify those individuals who are chemically dependent and/or are incarcerated for alcohol- and/or drug- related crimes to participate in MAT following incarceration.

In 2011, Assembly Bill (AB) 109 (Realignment) was enacted to address the overcrowding in California's 33 prisons and alleviate the State's financial crisis. The law, effective October 1, 2011, also known as 2011 Public Safety Realignment, mandates that individuals sentenced to non-serious, non-violent or non-sex offenses serve their sentences in county jails instead of state prison. During FY 2018-19, a total of 130 AB 109 clients were referred for Vivitrol by HCA's Correctional Health Services (CHS) and BHS AB 109 Screeners. Of those referrals, 85 completed a medical evaluation by a physician with 65 of those clients approved to receive Vivitrol. Forty-eight clients received their initial Vivitrol shot in-custody and 17 clients received their initial Vivitrol shot in the community. Additionally, 36 clients who received their first shot either in-custody or in the community received their second shot in the community.

Of the 48 clients who were evaluated and received their first Vivitrol injections in-custody, 100% were engaged in outpatient services initially upon release. Of the 36 clients who received their second shot in the community, 100% tested negative for opiates during the course of their treatment. Those who tested positive for substances, tested positive for methamphetamine and not opioids and/or alcohol. In addition, of the 36 clients who received their second shot in the community, 81% of clients reported obtaining employment and/or attending school within 30 days of receiving their second shot of Vivitrol.

Collaborative Court Programs are specialized Court tracks that combine judicial supervision with rigorously monitored rehabilitation services. They include integrated treatment and social services, strict oversight and accountability, a team approach to decision-making, and frequent interaction between the judicial officer and the participants. Collaborative Courts increase public safety and save money by stopping the revolving door of incarceration and re-arrest for many offenders. They also provide profound human and social benefits.

The Orange County Collaborative Courts, which began in 1995, with one Drug Court at the Central Justice Center, have expanded to include a variety of programs based on the Drug Court model at five Justice Centers. In addition to Drug Court, we currently have DUI Treatment Court; Veterans Treatment Court; Recovery Court, Opportunity Court along with Whatever It Takes Court that deals with chronic mental illness and homelessness.

As a result of these programs, thousands of County residents have been rehabilitated: addicted criminal offenders transformed into responsible taxpayers; repeat offense drunk drivers changed into dedicated advocates of sobriety; deeply troubled combat veterans helped to re-integrate into society; mentally ill offenders now leading stable, productive lives; homeless people given the tools they need to regain their self-sufficiency; at-risk youth steered from the path of delinquent behavior; reformed parents proud to have had drug-free babies. re, Behavioral Health, Benefits & Support Services, and Housing. Following the *Expanding MAT in County Criminal Justice Settings: A Learning Collaborative* Drug Court expanded their MAT services to include Methadone, Antabuse, Suboxone, Naltrexone and Vivitrol. [1]

Current Probation Services: The Orange County Probation Department (Probation) provides community supervision for approximately 15,000 adult and juvenile offenders on court-ordered probation or in diversion programs. With the 2011 Public Safety Realignment, Probation was tasked with the supervision of the Post-Release Community Supervision (PCS) population and individuals under Mandatory Supervision (MS) who would have been sentenced to state prison but complete their sentence through a combination of local incarceration and a period of community supervision. As with formal probation, each Deputy Probation Officer (DPO) works with these populations to ensure compliance with the court's terms of their probation and assists with their reintegration into society by identifying constructive social outlets like jobs, school, and community activities to help rehabilitate offenders so that future anti-social behavior does not occur.

[1] http://calhps.com/wp-content/uploads/2018/11/mat-collaborative-courts-policy-brief-10.30.2018-.pdf

Probation utilizes evidence-based practices and collaborates with other County and community partners to best address the needs of their clients. An objective risk/needs assessment tool is utilized to determine the appropriate level of supervision that is necessary and to identify the type of evidence-based treatments and services that are needed to be successful on supervision; thereby, reducing the risk of reoffending and increasing pro-social functioning and self-sufficiency. The risk/needs assessment tool assigns weighted scores to each factor on the instrument in order to obtain an overall risk classification. Risk classification is assigned as high, medium or low. There are ten risk factors on the assessment tool. Five of these factors carry the highest correlation of risk with subsequent new law violations. They include prior probation violations, substance use, age at first conviction, number of prior periods of probation supervision, and the number of prior felony convictions

In practice, the Deputy Probation Officer (DPO) completes a risk/needs assessment on every client on their caseload and develops a comprehensive case management plan addressing criminogenic factors, as well as treatment services and basic needs/support services. Approximately every six months, the DPO conducts a reassessment and updates the supervisory case management plan based on any changes in the risk level and/or in the identified needs for services. [2]

Response: The United States is facing an epidemic of opioid addiction and overdose deaths. Drug overdose is now the leading cause of accidental death in America. Orange County's overdose mortality rate is higher than the State average. In an effort to address this crisis, the County applied and was awarded a grant to participate in the *Expanding MAT in County Criminal Justice Settings: A Learning Collaborative*. The team had representatives from The Health Care Agency-Correctional Health Services and Behavioral Health Services, Orange County Sheriff Department, Orange County Probation Department, Orange County Superior Courts and County Executive Office.

Medication Assisted Treatment (MAT) is the leading evidence-based method for treating addiction. It involves both medication and behavioral health interventions. MAT has been clinically effective to alleviate symptoms of withdrawal, reduce cravings, and block the brain's ability to experience the opiate's effect. Experts also endorse MAT due to its societal benefits, such as MAT's capacity to reduce treatment costs and recidivism.[3]

Over the past several months, our team has implemented a variety of practices county wide that increases the use of MAT using evidence-based practices. The attached "MAT Learning Collaborative" poster highlights our efforts and goals. Recognizing that the role of Probation is critical, it is only through collaboration and partnerships that we achieve the ultimate goal of MAT which is full recovery for our clients with a substance use disorder (SUD) and the ability to live a self-directed life.

Collaboration/Integration of Services: Within the field of Probation, we have the unique ability and responsibility to build relationships with our law enforcement, correctional and behavioral health, county, state and community-based partners. Following the enactment of Assembly Bill

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[2] https://portal.prob.ocgoventerprise.com/Download/ProbNet/UserManuals/RiskNeeds/Adult_Risk_Needs_Coding_Guide.pdf

[3] https://www.samhsa.gov/sites/default/files/mat-criminal-justice-panel-2011.pdf

(AB) 109, we had the opportunity to strengthen the relationships we had with some of our partners, along with the need to seek out additional resources and providers to better serve our mutual clients. The collaboration and ability to share information, assessments and diagnosis between agencies dealing with shared clients is critical to addressing the impact of substance use on law enforcement and the administration of justice.

In 2019, the Orange County Criminal Justice Coordinating Council (OCCJCC), with First District Supervisor Andrew Do as Chairman and Fourth District Supervisor Doug Chaffee as Vice Chair, and with the leadership of Sheriff Don Barnes, assumed the task of reexamining the Stepping Up Initiative and developing its implementation plan, the Integrated Services Strategy (Integrated Services), to ensure it will address the most urgent needs in the Community Corrections System. Integrated Services is a collaborative success strategy focused on implementing enhanced care coordination for the County's highest utilizers of the County's Community Corrections System. Integrated Services is broken down into Five Pillars of Service that mirror the County's Corrections system: Prevention, Courts, In-Custody, Reentry and Juvenile/Transitional Age Youth. The Community Corrections System is one of the five County Systems of Care. The other systems of care are: Health Care, Behavioral Health, Benefits and Support Services, and Housing.

Identified Need #1 - Sharing of Information: The inability to share critical information between collaborative partners could lead to decisions that are made using false assumptions and unreliable date. Providing information to agencies with shared clients will ensure that everyone is acting on the right information and making informed decisions.

One of the primary functions of the Probation Department is to provide information to the Courts by preparing Court-ordered reports, including social history reports on defendants. Without sufficient information regarding a defendant's substance abuse history, it is difficult to make a comprehensive recommendation that would address specific needs and the probability of an offender's willingness or ability to comply with Court orders and be successful on supervision and in the community. Treatment and rehabilitation options are reliant upon such information as recency and frequency of use, type of substance and how it was used (intravenously, etc.) in order to provide a sufficient plan of action that addresses the psychology behind the use and the needs of each individual client.

Identified Need #2 - Lack of Funding Opportunities for MAT Medications: Now that the County has expanded the capacity for the number of individuals with opioid use disorder (OUD) receiving MAT we have identified the need for additional funding for the purchase of FDA-approved medications for the maintenance treatment of opioid use disorders.

Identified Need #3 – Additional services and strategies to address the AB 109 population: Realignment made some of the largest and most pivotal changes to the criminal justice system in California. Realignment established the Post-Release Community Supervision (PCS) classification of supervision; altered the parole revocation process placing more responsibility in local jurisdictions; gave local law enforcement the opportunity to manage offenders in a more cost-effective manner; and, as of July 1, 2013, parole violations are housed, prosecuted and tried locally. Realignment created an unprecedented opportunity for all 58 California counties to determine an appropriate level of supervision and services to address both the needs and risks of individuals

released from prison and local jails into the community. This increase in individuals under the care and supervision at the local level has created the need for additional services and strategies to address individuals with substance use issues.

Recommendations:

- Consider legislation that will address 42 CFR regulations in a manner to assist in the sharing of information between key partners involved in drug and alcohol abuse treatment and prevention. This would maximize the efforts of the multiple agencies providing services to an individual client.

- Provide federal funding opportunities for the purchase of FDA-approved medications for the maintenance treatment of OUD (e.g. methadone, buprenorphine, naltrexone, etc.) in conjunction with comprehensive OUD psychosocial services.

- At the state level, the County of Orange submitted a proposal for SB 665, a state bill sponsored by Tom Umberg to allow for Mental Health Services Act funds to be used inside jails for mental health treatment those who are Severely and Persistently Mentally Ill. However, there is no allocated source of state or federal funding for substance use treatment. The U.S. Department of Justice recently released the announcement for the Residential Substance Abuse Treatment for State Prisoners Program; however, only state entities can apply to this grant despite its stated intent to also impact local jails.

- To continue fidelity to the "whatever it takes" model of recovery and integrated care, counties seek additional flexibility to integrate MHSA funding for substance use disorder services, including prevention and outreach efforts. Substance use disorders are widely classified as a mental illness, and the Journal of the American Medical Association estimates that roughly 50 percent of individuals with serious mental illness are also living with a substance use disorder. Additional flexibility will reduce rigid funding barriers and bolster counties' ability to make progress on new accountability metrics by allowing counties to more comprehensively serve our most critical and complicated populations with MHSA-funded services.