U.S. DEPARTMENT OF JUSTICE

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

Mental Illness and Mental Health

March 24 - 26, 2020

Teleconferences related to Social Problems Impacting Public Safety: Mental Illness

Panels:

- **March 24, 3:30pm to 4:30pm, Eastern Time – Panel on Mental Illness**
  - Sheriff John McMahon, San Bernardino County
  - John Snook, CEO, Treatment Advocacy Center
  - Sergeant Sarah Shimko, City of Madison Police Department Mental Health Unit (WI)

- **March 25, 4:00pm to 5:00pm, Eastern Time – Panel on Mental Illness**
  - Sheriff Donald Barnes, Orange County, CA
  - Dr. Shannon Robinson, Principal, Health Management Associates (former Chief Psychiatrist for California Department of Corrections and Rehabilitation)
  - Sheriff Paul Penzone, Maricopa County, AZ

- **March 26, 2:00pm to 3:00pm, Eastern Time – Panel on Mental Health**
  - Dr. Keith Humphreys, Professor and Section Director for Mental Health Policy in the Department of Psychiatry and Behavioral Sciences, Stanford University

Tuesday, March 24, 2020

Sheriff John McMahon

Bernardino County Sheriff's Department

John McMahon serves as the 35th elected Sheriff-Coroner of the San Bernardino County Sheriff's Department. On December 31, 2012, he was appointed Sheriff by the Board of Supervisors. The voters elected Sheriff McMahon to his first term in June of 2014. Sheriff McMahon has over 33-years of law enforcement experience, beginning his career in 1985, as a patrol deputy at the Needles Station. He has been promoted to every rank in the department and has worked at 15 stations throughout his career. Sheriff McMahon serves on the board of the California State Sheriff's Association, Major County Sheriff's Association, Cal Office of Emergency Services – Law Enforcement Mutual Aid. In November 2017, he was appointed by Governor Brown to the California Commission on Peace Officers' Standards & Training (POST) Commission. Sheriff McMahon has successfully led the department through several high-profile incidents. During his tenure, Sheriff McMahon has implemented long-term solutions to reduce crime and improve the quality of life for the residents of the county.

Written Testimony, Special Social Problems Hearing: March 19-20
Sheriff John McMahon
San Bernardino County Sheriff's Department

The Impact of Mental Illness on Law Enforcement and the Administration of Justice

As law enforcement officers, we are dedicated to ensuring public safety and enforcing the law. When a law enforcement officer encounters a person experiencing a mental health crisis, accomplishing these goals becomes infinitely more complex. We are called upon to aid the person in distress, and, at the same time, that person may present an imminent threat to us or the public. A person experiencing a mental health crisis may have committed a crime, or be committing a crime, but their ability to understand their circumstances or appreciate the consequences of their actions may be compromised. These situations can put a law enforcement officer in an impossible position.

I thank the Commission for taking up this important issue, and I look forward to the insights and recommendations of the others testifying on this topic. I would like to take this opportunity to provide the Commission with some information about our experiences in San Bernardino County, and give some examples of how we have tried to address the problems we've encountered.

Mental Illness and Suspects

When someone is experiencing a mental health crisis, many times it's law enforcement that gets the call—whether this is because the person is actively harming someone, people are frightened by behaviors they don't understand, or they simply don't know who else to call—we end up being first responders to what is, often times, a difficult, dangerous, mental health emergency.

During 2019, the San Bernardino County Sheriff's Department handled 5,812 mental health calls. This includes calls which resulted in temporary, involuntary psychiatric commitment of an individual who presented a danger to themself or others (5150 calls), crisis calls, and calls related to attempted suicide. These calls resulted in 2,692 deputy reports in 2019. Of course, this is just a small portion of total mental health related calls as many are received as disturbances, subject checks, or transient calls, and many reports end up being produced for associated criminal acts rather than solely for the mental health issue.

To better prepare our deputies to respond to these calls, we began offering Crisis Intervention Team ("CIT") training in around 2008. Initially this was a 32 hour course with an 8 hour add-on for supervisors. Since that time, the course has evolved into a 40 hour course that is mandatory for all trainees. We currently train all our deputies and offer the training to outside agencies as well.

We have also worked closely with our county's Department of Behavioral Health to develop collaborative solutions to better serve people with mental illnesses and to keep the community safe. Triage, Engagement and Support Teams known as TEST are an example of this partnership. As of March 10, 2020, all but one patrol station in our county has an embedded

TEST social worker at the station. TEST workers are able to respond to crisis calls in the field, help deputies defuse mental health situations, and offer resources to those in need. TEST workers also provide follow up care and case management to clients referred to them by patrol stations. TEST workers try to link these clients to mental health services. TEST workers can also transport some non-violent adult clients to services such as Crisis Stabilization Units and medical and mental health appointments. This frees up deputies for law enforcement duties. However, TEST workers are only available Monday through Friday during regular business hours. Many of these contacts occur during the night or on weekends. Additionally, many of these clients are also substance abusers, unpredictable and not safe for TEST workers to transport.

While TEST has been a great addition, the challenges associated with insufficient mental health treatment continue. Treatment is often temporary and voluntary. When treatment is discontinued, it is not uncommon for additional, repeated contacts with law enforcement to occur.

Eventually, these contacts with law enforcement can result in an arrest. Our deputies are not qualified to make a mental health diagnosis, and while they can transport someone to a hospital for evaluation, there are times when they are forced to arrest a person for behaviors that are dangerous and criminal. Unfortunately, this can result in a prolonged period of incarceration in the county jail.

Mental Illness and Defendants

In California, a criminal defendant cannot be tried for a criminal offense if, as a result of a mental disorder, the defendant is unable to understand the nature of the criminal proceedings, or assist their counsel in their defense in a rational manner. If a doubt is declared regarding a person's competency to stand trial, a sometimes lengthy civil court process begins. During this process the person is evaluated by one or more psychiatrists or psychologists, the evaluating mental health professionals write reports documenting their assessments, these reports are reviewed by attorneys, and a trial is conducted on the issue of competency. If the court determines that the defendant is not competent, then a community program director makes a placement recommendation. The goal is to select an appropriate treatment facility where mental health professionals can attempt to restore the defendant to competency through a combination of treatment and education. Even after this placement recommendation is made, there can be lengthy waiting periods for admission to the treatment facility. During this entire time—from the arrest, through the civil court proceedings, and until a bed is available at the treatment facility—the mentally ill defendant is in the jail, rather than a treatment facility.

Mental Illness and Inmates

On average, 3,600 inmates are being provided some form of mental health services. At any given time there are approximately 375 inmates who are considered seriously mentally ill . These are inmates who have psychiatric disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, and delusional disorder, or inmates with mental or emotional disorders, such as major depression, bipolar disorder, and posttraumatic stress disorder, when those disorders result in serious distress or functional impairment that substantially interferes with or limits one or more major life activities.

In order to provide appropriate care to these individuals, the Sheriff's Department has greatly expanded its mental health staffing. Between 2015 and 2019, we increased our budget by 9 million dollars to fund additional Correctional Mental Health staff. In the next year this cost is expected to double.

The California Department of State Hospitals is responsible for providing treatment to individuals deemed incompetent to stand trial, but they have a shortage of treatment beds. This shortage has created a tremendous backlog and as a result many wait 3 to 6 months to begin treatment. To help alleviate the backlog and provide timely treatment, the San Bernardino Sheriff's Department partnered with the California Department of State Hospitals and created the first jail-based Restoration of Competence (ROC) Program in the State of California in 2011. The ROC Program allows inmates who the court has determined are not competent to stand trial to receive restoration of competency treatment directly in the jail. In 2015 the California Department of State Hospitals decided to create a second ROC-like program in San Bernardino, the Jail-Based Competency Treatment (JBCT) Program, which was four times the size and serves inmates from other counties as well.

In January 2018, the ROC and JBCT programs combined to create one program, with a maximum capacity for 96 patients. In June 2018, a new contract was implemented, raising the capacity to 126. Most recently, at the beginning of August 2019, the capacity of the JBCT program increased to 146. The California Department of State Hospitals currently can pay in excess of 20 million dollars a year to cover the costs of the mental health services offered in the JBCT program.

In 2019, 621 inmates were admitted into the JBCT Program, and 601 were discharged. The JBCT Program results in shorter wait times to begin receiving services, expedited processing of cases through the court system, and is cost effective. This continued expansion is a testament to the JBCT program's ongoing success at providing competency restoration services. This program has become a model for the nation.

Conclusion

It is undeniable that addressing mental illness in the context of the criminal justice system is problematic. However, through programs like TEST, where we are partnering with social workers to deploy mental health resources on patrol, or JBCT, where we are ensuring that the court process and incarceration are not unnecessarily prolonged by mental illness, San Bernardino County is finding solutions. Again, I'd like to thank the Commission for confronting this serious problem, and we look forward to the Commission's findings and recommendations.

John Snook

Chief Executive Officer and President

John Snook serves as executive director of the Treatment Advocacy Center. The Treatment Advocacy Center's original research on issues such as the criminalization of mental illness has reshaped the national narrative on the treatment of severe mental illness. Mr. Snook has more than 15 years of policy and advocacy experience at both the federal and state levels. Prior to joining the Treatment Advocacy Center, John worked on policy issues at the Mortgage Bankers Association (MBA) and at Habitat for Humanity International. John's true passion has always been mental health reform. His focus on the issue began in law school, as he saw a loved one struggle with untreated mental illness. John championed mental illness reform, working first with the West Virginia Supreme Court on mental health issues and then at the Treatment Advocacy Center as an advocate for state mental health reform.

Written Testimony
John Snook, Executive Director
Treatment Advocacy Center

The impact of homelessness, mental illness, and/or substance use on law enforcement and the administration of justice.

The problem:

Sixty years of failed mental health policies and misplaced incentives have forced law enforcement onto the front lines of mental illness crisis response. Jails and prisons are now our de facto mental health institutions, as psychiatric bed capacity has reached its lowest point in our nation's history.

Law enforcement officers do not sign up to be mental health practitioners and using them as such wastes precious resources, damages law enforcement-community relationships, unnecessarily criminalizes a medical issue and ultimately ill serves both the person in need and the system attempting to provide care. Calls to "train our way out of the problem" are well intentioned, but fail to address the systematic issues that incentivize the neglect of those with the most severe mental illness.

The scope of the crisis:

An estimated 8.3 million adults in the United States live with a severe mental illness (SMI). Approximately half go untreated every year.[1] The consequences of failing to care for the most severely ill are devastating and have significant implications for law enforcement and the effective administration of justice.

As a result of limited community treatment options and a dire shortage of psychiatric treatment beds, those in need of mental illness care frequently only receive care once a crisis occurs that necessitates law enforcement involvement. Though numbering somewhat fewer than 4 in every 100 adults in America, individuals with SMI generate no less than 1 in 10 calls for police service.[2] Approximately one-third of individuals with SMI have their first contact with mental health treatment through a law enforcement encounter.[3]

People with SMI are also more likely to be arrested if they live in communities with limited treatment options. Officers sometimes resort to "mercy bookings" (using low-level misdemeanor charges) to get individuals in psychiatric crisis off the street and into treatment.[4] Studies have found that in some parts of the country, psychiatric treatment is more accessible in jail than in the community.[5]

Requiring law enforcement to respond to mental health crises raises a safety risk to both the officer and the individual in crisis. Our research shows that people with untreated mental illness are 16 times more likely to be killed during a police incident than for other civilians approached or stopped by officers.[6] Such incidents, especially when involving the use of deadly force, are also traumatic and damaging to officers and can impact police-community relations. No officer wants to resort to deadly force, especially in an incident involving someone obviously in the throes of untreated SMI.

Unconsidered costs:

Utilizing law enforcement to address what are medical crises also exacts massive, often unconsidered, costs for law enforcement and county budgets. Such encounters use at least 90% more resources than encounters not involving mental illness, even when statistically controlling for type of response.[7] Our 2019 survey with the National Sheriffs Association on the role and impact on law enforcement of transporting individuals with SMI found that at least one-fifth of total law enforcement staff time was used to respond to and transport individuals with mental illness, at an estimated cost of $918 million.[8] The survey showed that law enforcement

officers drove a total of 5,424,212 miles to transporting individuals with serious mental illness in 2017 — **the equivalent of driving around the Earth's equator more than 217 times**.[9]

Officers transporting someone in crisis are forced to travel an average of five times farther to reach a medical facility than a jail. If officers do reach a medical facility, they wait significantly longer — almost 2.5 hours longer, per our survey results.[10]

As a consequence, it is unsurprising that jails have a steady churn of people with SMI coming through their doors. It is estimated that two million people with serious mental illness are booked into jails each year, part of a revolving door of criminalization, homelessness, and emergency department visits, with the insurmountable costs associated.[11]

Jails as de facto mental health institutions:

As officers find treatment facilities unavailable or unwilling to accept those in need, jails have become our de facto mental health institutions. People with SMI occupy at least 1 in 5 of America's corrections beds.[12] There are now 10 times more people with severe mental illness behind bars than receiving treatment in a hospital.[13]

In 44 states, a jail or prison holds more mentally ill individuals than the largest remaining state psychiatric hospital; in every county in the U.S. with both a county jail and a county psychiatric facility, more seriously mentally ill individuals are incarcerated than hospitalized.[14]

This poses a significant financial burden on law enforcement and county budgets. Mentally ill inmates cost more than other prisoners for a variety of reasons, including increased staffing needs. In Broward County, FL in 2007, it cost $80 a day to house a regular inmate but $130 a day for an inmate with mental illness. In Texas prisons in 2003, "the average prisoner costs the state about $22,000 a year," but "prisoners with mental illness range from $30,000 to $50,000 a year."[15] Psychiatric medications are a significant part of the increased costs. The cost of settling or losing lawsuits stemming from the treatment of mentally ill inmates also adds considerable costs.

In addition, jails across the country are grappling with a deluge of at least 90,000 pretrial defendants every year who have been found incompetent to stand trial (IST), but who remain in jail owing to a lack of available beds.[16] Pretrial inmates represent the largest and fastest-growing segment of the US jail population and at least a fifth have a mental illness.[17] However, in 2016, state psychiatric hospitals reported having just 5.5 forensic beds per 100,000 population. Approximately half of those were reserved for patients found not guilty by reason of insanity, leaving just 8,800 beds for all other forensic patients, including the 90,000 IST defendants.[18] As a result, states across the country have seen litigation challenging bed waits, hospital facing loss of accreditation, or state officials being threatened with contempt of court for delays in bed availability for this population.[19]

The underlying causes of the crisis:

Misplaced incentives discourage serving the most severely ill, forcing law enforcement to pick up the slack. Chief among these is the elimination of necessary treatment beds. Without the availability of beds as part of a full continuum of treatment options, those with SMI have effectively been trans-institutionalized, moving from long-term stays in institutions to jails and prisons.

A primary factor in the loss of treatment beds is the discriminatory IMD exclusion, which prevents Medicaid reimbursement for adult psychiatric care in facilities with more than 16 beds. This preclusion effectively

makes inpatient treatment a cost borne wholly by the state. As a result, such beds have experienced devastating cuts since the 1970s.

In 2016, the Treatment Advocacy Center documented that the US now has fewer state hospital beds per capita than at any point since 1850.[20] Since 1999, there has been a 35% decrease in the number of total psychiatric beds in the US. The US now has 20 public or private beds per 100,000 population -- only four countries in the developed world have fewer beds. The worldwide average is 71 beds per 100,000 population.[21]

That shortage has given rise to a host of problems beyond direct criminalization, including what Dr. Steven Sharfstein termed "micro-hospitalizations" or exceedingly short stays in inpatient facilities that diminish opportunities for full recovery, contributes to the high-risk of suicide after hospitalization, and hampers transition to the community that may lead to increased contact with law enforcement as a consequence of symptomatic behaviors.[22]

Without treatment beds, those with SMI frequently wait in emergency departments receiving limited or no treatment. According to a survey by the American College of Emergency Physicians, over 90% of emergency physicians say psychiatric patients board in their emergency departments. And more than 21% of these physicians reported waits of two to five days for an inpatient bed.[23]

As detailed by HHS Assistant Secretary Elinore McCance-Katz, mental health treatment standards that require crisis or violence also directly contribute to the criminalization of those with SMI. Such outdated standards unnecessarily force individuals who are non-violent to decompensate before receiving care, leaving families helpless until their loved one poses a risk of harm to themselves or others. At that point, law enforcement intervention is often required, heightening the risk to the officer and the individual and increasing the likelihood of arrest.

Additionally, a majority of treatment systems have yet to develop integrated crisis response care. As a consequence, individuals often find that care is separated into sick enough for the hospital or on-your-own on the street. When released from a facility, individuals often report difficulty in finding housing, coordinating care in the community or even securing appointments for treatment.

Similarly, communities are just beginning to adopt a zero-intercept philosophy for law enforcement engagement. Zero-intercept incorporates the idea that diversion following arrest is too late and that resources and efforts should be marshalled to deflect people with SMI from being arrested in the first place, by limiting the involvement of law enforcement and increasing access to crisis services and the availability of treatment beds.

Recommendations & identifying promising practices:

First, I strongly recommend this honorable Commission review the recommendations of the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), on which I serve. In addition, the recommendations of the All Sheriffs' Authority mental health report should strongly be considered as a concurrent roadmap to reform.

My overarching recommendation is to support polices that allow a person with SMI who is in crisis to receive adequate mental health care without requiring law enforcement contact. The recommendations below further that goal.

<u>Eliminate the IMD Exclusion</u>: The Commission should also strongly support the wholesale elimination of the IMD exclusion to increase the availability of treatment beds, as recommended by both the ISMICC and the

All Sheriffs' Authority. In the interim, the Commission should recommend that every state pursue IMD 1115 waiver authority made available by President Trump's Administration.

Support grant funding for Assisted Outpatient Treatment (AOT) programs: To support the treatment of individuals who have a history of repeated hospitalizations and incarceration, this Commission should strongly support AOT grants funded by SAMHSA and recommend their national expansion to all 50 states.

Data from the first 17 AOT grantees across the country showed reductions in rates of incarceration, in incidents of repeated hospitalization, substance abuse and homelessness. Both Reno, Nevada and Baldwin County, Alabama reported more than $1M in savings after implementing the program.[24] These results echo those of communities across the country, from Bexar County, TX to Brooklyn, NY to Nevada County, CA. The American Psychiatric Association will be launching free AOT training modules through its SMI Adviser tool later this year, which will provide law enforcement and communities with free training tools to learn about and implement the program.[25]

Support zero-intercept efforts nationally: Both the DOJ and HHS have prioritized programs that support zero-intercept strategies as a means of reducing law enforcement involvement in mental illness treatment.

Support the creation of integrated crisis response systems that minimize law enforcement response: As recommended by both ISMICC and CIT International, a crisis response system should include services such as 24/7 access to crisis line services staffed by clinicians; warm lines staffed by certified peer specialists; non-law enforcement crisis response teams able to respond independently to nonviolent crisis situations and to co-respond with law enforcement when needed; and dedicated crisis triage centers.

Support a change to the MIEP policy: The federal Medicaid Inmate Exclusion Policy (MIEP) should be updated to allow pretrial detainees to receive their federal benefits while in jail. Currently, pretrial detainees are denied federal benefits, including Medicaid, Medicare, CHIPS and access to Veteran's benefits, despite their pretrial status and presumption of innocence.

Support a non-law enforcement response to crisis as called for by the evidence: Ideally, crises involving individuals with SMI can and should be resolved without the need for law enforcement involvement. Especially as communities adopt treatment standards that shift away from requiring a finding of danger to self or others, all possible efforts should be made to remove law enforcement from response whenever possible.

This change is supported by the evidence. Law enforcement respondents to our 2019 survey reported that in 65% of all law enforcement transports in 2017, the officer did not perceive the individual to be a risk of harm to others.[26] Presumably, the majority of those responses could have been provided by non-law enforcement resources. This finding is echoed in CIT International's 2019 Best Practice Guide, "The majority of mental health calls for service received by emergency communication centers do not require a law enforcement response."[27]

Ensure law enforcement is prepared to respond when warranted: Recognizing that even the perfect crisis system will not address every mental health issue, law enforcement and other first responders should be prepared to respond safely and effectively when the situation warrants. Every member of law enforcement should receive training on mental illness and on how to de-escalate emotionally charged situations. Just as officers receive training on blood-borne pathogens or domestic abuse, training on mental illness should begin in the academy and continue throughout the career of the officer. We strongly support combining this baseline of training with additional training and specialization as recommended by CIT International.

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Sarah Shimko

Madison Police Department

Sergeant Sarah Shimko leads the Madison, Wisconsin Police Department's Mental Health Unit. The mission of the Madison Police Department Mental Health Unit is to provide a coordinated, professional and compassionate police response to individuals affected by mental illness and their families. The Mental Health Unit works collaboratively with partner agencies to achieve improved outcomes for individuals affected by mental illnesses or suffering a crisis by connecting them to needed services and diverting them away from the criminal justice system whenever possible. The work of the Mental Health Unit aims to reduce calls for police service related to mental illness issues and to improve safety for officers and all members of the community.

Sergeant Sarah Shimko, City of Madison (WI) Police Department - Mental Health Unit (MPD/MHU)
The Impact of Mental Illness of Law Enforcement and the Administration of Justice

Focus – MPD's MHU Program, Lengthy Involuntary Hospitalization Process, Continuum of Care Gaps, Standardization of/Funding for Mental Health Related Training, Constraints of Current Civil Commitment Statute

Madison Police Department Mental Health Program: MPD's response to calls involving mental health has evolved over many decades. We have long recognized the value and necessity of professional partnerships to achieve the best possible resolutions for our community. In the 1980s, MPD and the Journey Mental Health Center (JMHC) began establishing professional collaborations to address individuals experiencing significant mental health crisis. JMHC is a non-profit contracted by Dane County to provide emergency and routine mental health care. JMHC responsibilities include the government oversight function of approving involuntary commitments. This collaborative approach allowed for increased information sharing, improved inter-agency communication, and a deeper appreciation for the roles of each entity. Over the years, MPD has succeeded in building relationships throughout the community with other providers, advocates and individuals.

The foundation of MPD's mental health program is our well-trained patrol officers. These first responders receive more training in the MPD academy on mental health topics than the national standard for Crisis Intervention Training. MPD established a Mental Health Liaison (MHL) Program in 2004 and initially consisted of five patrol officers, one to represent each of the five geographical districts MPD had at the time. The MHL program, which has grown to include 37 officers in a variety of assignments throughout the department. These MHLs remain in their primary assignments, but receive additional training throughout the year. MHLs serve to supplement their peers in a variety of ways, including being conduits with MHOs and LECWs, reviewing mental health related reports and safety bulletins, and when possible, by responding to mental health calls for service.

We established the full-time Mental Health Officer (MHO) position in 2015 and welcomed an embedded Law Enforcement Crisis Worker (LECW) to MHU in 2016. Today, the MHU consists of six MHOs (one for each of the six police districts), three embedded LECWs, the above-mentioned MHLs, and one Sergeant. The MHU falls under the command of the Captain of Community Outreach.

These layers comprise MPD's Police-Mental Health Collaboration Program (PMHC), a nationally recognized example of how community partners can collaborate to provide improved police services to people living with mental illness. It is one of only ten Law Enforcement-Mental Health learning sites selected by the Council of State Governments Justice Center and the U.S. Department of Justice's Bureau of Justice Assistance. Despite our progress in this area, there are a number of gaps in our current system that continue to unreasonably contribute to the criminalization of mental illness and overburden police officers with the responsibility of

responding to and resolving, in the short term, issues that social service, mental health, and medical professionals are better equipped to handle.

Mental Health Related Call for Service Data: In 2019, MPD investigated 44,623 distinct cases, 4,275 (approximately 9.6%) of those cases involved a notable mental health component. This translates to approximately 33,895 hours of total officer hours spent on mental health related in 2019. Mental health related calls for service data were consistent between 2018 and 2019. In 2018, 46,192 cases were investigated overall and 4,572 (approximately 9.9%) were mental health related. MPD officers spent approximately 30,501 total hours on calls involving a significant mental health component.

Lengthy Involuntary Hospitalization Process: Officer involvement in the civil commitment process (Chapter 51 Wis. Stats.) is by far the most resource intensive mental health related activity. MPD completed 266 Chapter 51 related activities in 2019 and 252 in 2018. Chapter 51 related activities include initial Emergency Detentions, Three Party Petitions, Alcohol Petitions, returns to more restrictive environments reference a Commitment Order, and returns to a more restrictive environments for non-compliance with Settlement Agreements. Most of the time spent on these cases, specifically cases requiring a transport to Winnebago, is generally related to medical clearance requirements and transport.

In 2019, MPD dedicated 7,062 hours of officer time to Chapter 51 related activities and 6,459 hours in 2018. MPD officers had to transport in-custody patients to the principal state hospital, Winnebago Mental Health Institute, 166 times, which represented approximately 62.4% of these cases. According to Google Maps it is 93 miles from Downtown Madison to Winnebago Mental Health Institute and estimates the drive time to be approximately 1 hour 51 minutes one way (3 hours 42 minutes round trip) this represents a total of more than 30,000 miles travelled, enough to travel from Anchorage to Key West nearly six times. Winnebago transports require two MPD Officers to ensure the safe transfer of custody of the individual.

From start to finish, calls for service that result in involuntary hospitalizations for Chapter 51 related cases last anywhere from approximately 4 hours to two and a half to three days in extreme cases (dangerous road conditions, significant medical clearance complexities, etc.). On average, these cases usually last between eight to 12 hours.

One gap in our continuum of mental health care services is a lack of reliable mobile social service and crisis resources that are available 24/7. Mobile response services in our community, related to active law enforcement patrol calls for services, are currently limited to sporadic mental health crisis worker responses with the general purpose being an evaluation for involuntary hospitalization.

Continuum of Crisis Care Gaps: Another gap in our community's continuum of crisis care is the lack of a single entry point crisis resource center. Law enforcement officers are tasked with navigating a complex and vast array of possible services and facilities in their attempts to reach the best possible resolution. They are often met with any number of barriers to connecting

individuals in crisis with appropriate levels of support in their moment of need. As it currently stands, a subject of a police call who is suicidal and intoxicated (deemed incapacitated per Wis. Stat.) is conveyed to the county detoxification facility where they receive a mental health evaluation once sober. That facility is often at capacity which results in the subject being transported to a local hospital. One of the most frequent frustrations expressed by officers is how frequently the detoxification facility is closed. This raises concerns regarding the ability and willingness of the local emergency departments to admit the subject in a timely manner and to ensure that the subject remain there without further police calls.

The county jail is the most common disposition facility for a subject in crisis, who is under the influence of drugs and/or alcohol (not to the point of incapacitation), and has committed a crime. This is due to the requirement that the subject be sober in order for their mental health to be evaluated and the only other locked facility currently available is the detoxification facility which requires the subject to be incapacitated. There is a process in place for JMHC Crisis Workers to respond to the jail once the person is able to be evaluated and, with the cooperation of the arresting agency, divert the subject from the criminal justice process whenever possible.

Jail, emergency departments and detoxification facilities are often not the optimal facilities to support people experiencing a mental health related crisis. Our community is in need of a crisis resource center equipped with 23-hour observation services, capable of managing behaviorally challenging patients under the influence of alcohol and/or drugs. This facility must also have an intake process that is at least as efficient as booking a person into jail. Officers would then have the option, when appropriate, to efficiently connect a subject with care providers who could provide a safe environment and ample time to appropriately evaluate a subject prior to them being booked into jail to ensure the most appropriate disposition. This facility would not only help with diverting mentally ill people from the criminal justice system, it would also decrease involuntary hospitalizations.

Standardization of/Funding for Crisis Management Training: Mental Health related training at the local level is imperative due to the many unique factors each law enforcement jurisdiction faces. MPD pre-service training academy has robust Crisis Management curriculum that far exceeds the minimum state requirements. MHL's receive a minimum 16 hours of Crisis Management training annually, while full-time MHOs receive additional training beyond those 16 hours. There are, however, basic concepts and established best practices that should be provided to local law enforcement officers by way of training opportunities funded and facilitated at the federal level. A parallel example can be seen in FEMA's Center for Domestic Preparedness courses. I had the opportunity to attend a three day Field Force Extrication (FFE) Tactics training in Anniston, AL where I learned national best practices related to the extrication of protesters from protest devices. In a relatively short time, our department was able to establish a fully functional and well-prepared FFE unit because of this generous professional training opportunity. Another program offered to law enforcement through the Center for Domestic Preparedness is the Active Shooter Threat Training Program. This is a four-day program geared towards responding to and managing Active Shooter incidents. Local law

enforcement agencies would benefit greatly to have a similar mental health related training opportunity. Topics included in this course could include Identifying and Responding to People in Crisis, the Civil Commitment Process vs. Competency Proceedings, Elements of Effective Police-Mental Health Collaborations, Principals of Threat Assessment and Management, the Human and Fiscal Impact of Criminalizing Mental Illness – Principals of Effective Jail Diversion, etc.

Constraints of Current Civil Commitment Statute: We need to re-evaluate statutory language that dictates involuntary mental health treatment. Improved language would consider that significant mental illness can impair a person's insight. It is commonly stated that it is not illegal to be mentally ill. I agree with this statement and also believe that it is inhuman to allow people with gravely impaired insight to remain ill. The current standards for involuntary hospitalization are based largely on imminent and substantial danger to physical safety of the individual and/or others. The standards fail to account for the impact of potential long-term physical issues, detrimental effects on personal relationships, employment, quality of life issues, the increased likelihood of victimization, incarceration, accidents, substance abuse and increased rates of suicide. Purposeful safe guards and diligent oversight would be necessary to protect individual rights if the statue was to be amended, but exploration of that possibility is long overdue.

Conclusion: Local Law Enforcement Officers will always have a role in responding to mental health related crises. Initial academy-level crisis training that equips all officers to identify people who are likely experiencing a crisis, skills for how to respond, and appropriate disposition options is imperative. Additional higher level training like Crisis Intervention Team (CIT) Training for at least some officers is also very important, as is building and maintaining relationships with social service and mental health service providers. Federal level, standardization of basic, transferrable concepts should be provided in a similar manner as the current FEMA offerings mentioned above.

Continuum of crisis care gaps need to be filled. A Crisis Resource Center, equipped with 23-hour observation beds is an integral part of the community response. This model has been proved effective in other states in reducing more lengthy hospitalizations and unnecessary incarceration. A concerted, multi-disciplinary review of Civil Commitment Statutes should occur with specific focus on how impaired judgement is evaluated.

Resources: National Guidelines for Behavioral Health Crisis Care – Best Practices Toolkit, SAMHSA (Substance Abuse and Mental Health Services Administration), 2020
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Police-Mental Health Collaboration Programs: Checklist for Law Enforcement Program Managers, CSG/BJA
https://pmhctoolkit.bja.gov/ojpasset/Documents/Checklist_Law%20Enforcement%20Program%20Managers_final.pdf

Wednesday, March 25, 2020

Sheriff Donald (Don) Barnes

Orange County Sheriff's Department

Don Barnes was appointed Sheriff-Coroner of Orange County, CA in January, 2019, which is the nation's 5th largest sheriff's department serving a population of 3.1 million residents. Sheriff Barnes has more than 30 years of law enforcement experience as an Undersheriff, Commander, Captain, Lieutenant, and Sergeant for the Orange County Sheriff's Department. He is a graduate of the FBI National Academy. As Orange County Undersheriff, Don Barnes was second in command and was the Chief Operating Officer, overseeing the daily operations of the Department's 24 divisions comprised of 3,900 sworn and professional employees. Sheriff Barnes helped create the Sheriff's Homeless Outreach Team to mitigate the impacts of homelessness and worked to bolster community policing through the Sheriff's Interfaith Council and Citizens' Academy.

Sheriff Don Barnes
Orange County Sheriff's Department
Social Problems Impacting Public Safety – Mental Illness
March 19, 2020

It has never been the intention nor the design for law enforcement to be the sole solution to address homelessness, drug addiction, or the mentally ill. The intervention strategies and services necessary to address these issues have become virtually non-existent in recent years, or at least until a few years ago. The resultant gap in social service strategies has had a trickling effect, with these social failures eventually landing on the shoulders of law enforcement to address. Law enforcement should not be the strategy or the first face of government these individuals encounter or rely upon for help; law enforcement should be the last form of government these people encounter, and only when the intervention efforts have failed resulting in a criminal violation of law.

The interrelated problems of mental illness, drug addiction, and homelessness remain a challenge for law enforcement across the country. While these problems are the most complex issues I have faced in my three decade law enforcement career, I believe the creative work being done by my colleagues and I can succeed if provided the right tools and resources.

Today I will specifically speak to what the Orange County Sheriff's Department is doing to address mental illness and provide you with recommendations to further assist these efforts. I must note that we cannot make the mistake of looking at social problems impacting our communities in a silo. As my law enforcement colleagues can attest, those we interact with who are homeless often have drug addiction; those who are drug addicted often have or will develop mental illness; and some of those who are experiencing mental illness are also homeless. These issues cannot be addressed independently; they are interconnected and must be addressed concurrently. Consequently, my recommendations to specifically address mental illness are, and should be, integrated with solutions to address homelessness and drug addiction.

First, a brief overview of the challenges we face in Orange County, which unfortunately is not unique to us. As the Sheriff, I operate the County's largest mental health hospital — the Orange County Jail. On any given day, of the approximately 5,000 inmates entrusted to our care within the Orange County Jail System, up to 2,000 have a daily nexus to mental health treatment. A number of those inmates experiencing mental illness may also have a co-occurring substance abuse issue. The majority of the inmates booked into my jail serve a sentence of 30 days or less than 30 days (75%), and half are in my custody seven days or less. This provides little time to achieve mental stability and/or sobriety.

Exacerbating this issue is the rise in mental health cases over the past five years, which has consistently risen exponentially over this period. In 2015 we had an average of 1,219 daily open mental health cases. In 2019, that number had increased to 1,950 cases (an increase of 60%), resulting in approximately 1 in 5 inmates requiring mental health treatment.

While this is a phenomenon being seen across the nation, it is compounded in California as a result of the public safety realignment of 2011, in which a portion of state prisoners were reclassified to serve their sentences in county jails. State Prison Realignment interjected more criminally sophisticated and complex health challenged inmates into a county jail system designed for low level offenders serving short-term sentences. Many of these prisoners are sentenced to and are serving multi-year sentences. Not surprisingly, assaults on staff and inmates more than doubled, and narcotics trafficking into the jails

increased by 300% in the first two years post-implementation. Needless to say, the challenges law enforcement officers are experiencing at the street level are exacerbated within my and my colleagues' jails.

To meet these challenges, in the last year we have implemented significant reforms in the Orange County Jail system. Reforms include:

- Implementation of a new jail classification system that enhances out-of-cell time with increased access to necessary and critical programming. The result is a 300% increase in dayroom time and program opportunities, and a 20% decrease in assaultive behavior.
- Elimination of late-night releases, thus releasing sentenced inmates beginning at 8:00 am. This policy change enables those being released to connect to services, thus increasing their chance for post-custody success upon re-entry.
- Construction of new mental health housing modules, increasing LPS housing for the severely mentally ill from 5 to 30 beds for males and 0 to 15 beds for females, as well as ADA housing throughout our jail system.
- Increased and enhanced staffing ratios for mental health housing facilities, which includes staff being trained in Critical Intervention Training for personnel assigned to mental health modules.
- Expanded use of Medically Assisted Treatment (MAT) Programs and implementation of Substance Use Disorder (SUD) Step-Down Units to treat the 100-120 people who are detoxing off of alcohol and/or drugs in our care every day.
- Created a Housing Unit for Military Veterans, connecting veterans to services and care with the goal of successful re-integration post-release and elimination of recidivism of this population.

Despite all these efforts, that I believe will remain necessary, we cannot deny the fact that treating mentally ill individuals in jail is not the best option. Jails must always be a place to hold accountable those who purposely and deliberately harm society. It can also be a place to rehabilitate those who seek reform and are willing to rebuild their lives. Incarceration should not serve as the first option for someone with mental illness or battling addiction.

To that end, my department has worked with the County Board of Supervisors to develop the Integrated Service Plan, in which separate county agencies, the private sector, and key stakeholders coordinate our efforts in addressing the at-risk sectors of our population. The ability to see past bureaucratic silos utilizing a spirit of collaboration and cooperation has proven critical to create innovation. For reference, the County of Orange Integrated Services Plan is attached for the record.

My jail reforms will have little success unless there is an integrated system of care to assist in the re-entry of inmates upon leaving custody. This re-entry service is critical to ensuring individuals do not return to jail or prison. This integrated system also works to limit those coming into custody by incorporating intervention strategies and services on the front-end that are necessary to divert the mentally ill into programs and make use of concepts like collaborative courts.

The County of Orange is moving in the right direction, but obstacles continue to exist. The President's Law Enforcement Commission can help remove these obstacles by pursuing the following recommendations:

1) Pre-Custody Intervention Strategies

People experiencing a mental health crisis are often left with little, if any, options for treatment. Crisis Stabilization Units (CSUs) are virtually non-existent. Consequently, when a law enforcement officer encounters an individual experiencing a mental health crises, that person is often transported to a local area hospital for diagnosis. These hospitals are designed for medical triage and care, not mental crisis. The treatment often lacks, not as a result of best efforts of doctors and hospital staff, but because they are not designed for mental health services. If the individual is suspected of committing a crime, the officers takes the individual to jail. There were more than 61,000 booking into the Orange County Jail in 2018. Of those, 9,200 people who were mental ill were repeatedly booked over and over again that same year. 2,200 inmates were designated severely and persistently mentally ill, the highest designation of mental illness. The remaining 7,000 inmates were moderately or mildly mentally ill.

As recommended in the All Sheriffs' Authority 2019 Report on Mental Illness, the use of crisis stabilization centers or law enforcement friendly mental health drop-off centers are critical. Such locations ensure there are viable alternatives to custody for the mentally ill that does not result in the problem festering in the community. Orange County will open the first of three Be Well Centers in Fall 2020 to provide critical services for those experiencing a mental health crises. The other two centers are being planned and may open as early as 2021.

Federal resources to develop these sites, as well as supportive housing and clinically-proven detox treatment centers, would be a significant help in the effort to integrate services. If done correctly, these sites will alleviate (not add to) the negative impacts mental illness, drug addiction, and homelessness can have on the community.

2) In-Custody and Post-Custody Treatment

Responding to the mental health population within the jail system has been a challenge, but also present opportunity. Unfortunately, and not by design, the high risk populations of mentally ill and substance use disorder are in one location: the jail. Increasing our capacity to treat the mentally ill, focused on saturation of services and programs, best prepares these populations for stability upon release. It is essential to have a system of care that provides not only prevention on the front end, but post-custody services upon release. Many of these post-custody supportive services do not currently exist or are not robust enough to meet the demands of these populations. This includes low-barrier shelters and long-term housing for those experiencing homelessness. Absent an intricate system that supports this population, we can expect that many will decline in their mental health or return to drug use and inevitably return to jail (reference County's Integrated Services Plan attached).

3) End Inmate Exclusion Act

Those in our custody with mental illness or a co-occurring substance use disorder have costly medical expenses that place a drain on limited county resources. In Orange County we have employed the use of Medically Assisted Treatment for the drug addicted. While proven to be a success, MAT comes with a high cost. We currently have 535 inmates participating in the program at a cost of $174,000 per month.

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

hinders efforts to prevent individuals from committing new crimes upon release. Ending this exclusion policy, particularly for pre-trial inmates, will enhance efforts to reduce recidivism.

Additionally, collaborative strategies such as vocational training, re-entry focused programming, and post-custody services are essential for sustained success and recidivism reduction. A multi-pronged exit strategy encompassing, connecting the most vulnerable to programs and medical services, is essential to maintain mental health stability and sobriety.

4) End Decriminalization of Drugs

The relationship between drugs and mental illness cannot be ignored. For example, recent studies have linked habitual marijuana use to psychosis. For states and federal legislators who are considering legalization of marijuana, I bring a warning. California's experiment with marijuana and decriminalization of other drugs has resulted in tragic consequences.

In 2018, my department led an effort to address a large homeless encampment on the Santa Ana Riverbed. The encampment approached 1,000 people, many of whom were mentally ill and drug addicted. We worked with a federal court to close and clean up the riverbed within a span of a few months. In remediating the riverbed we collected 13,950 used hypodermic syringes. This staggering number is a direct result of the decriminalization of drugs. In California possession of drugs results in nothing more than a misdemeanor citation. This minimal criminal consequence in the criminal justice system perpetuates addiction, resulting in more dangerous health consequences for the users and the community.

To be clear, I am not advocating for the incarceration of the drug addicted. I do, however, know that crimes committed without consequence invite more crime, negatively impacting the community. Again, the implementation of proven treatment strategies, such as drug courts, pre- and post-custody court-imposed treatment, as well as Medically Assisted Treatment while incarcerated, have proven to change behavior; systems that lack individual accountability exacerbate the problem by encouraging bad behavior.

This Commission should take a strong stance against decriminalization efforts. While no addict should be sentenced to a life behind bars, there must be mechanisms in the law to compel treatment and detour self-destructive behavior.

These social issues are interrelated, complex, and not easy to solve. Law enforcement officers are at the tip of the spear in addressing each of them, focused on service with empathy and compassion. I would be remise if I didn't point out that the Orange County Sheriff's Department has numerous, extensive intervention strategies and programs that complement our efforts, including:

- Homeless Outreach Teams focused on serving those experiencing homelessness;
- Supporting Collaborative Courts, such as Drug Court, Mental Health Court, Homeless Court, and Veterans Court;
- Nationally recognized *Drug Use is Life Abuse* drug prevention education program;
- Drug intervention and interdiction teams to combat DTOs and trafficking of narcotics;
- Human Trafficking Task Force to alleviate those being trafficked for sex or other purposes;
- Investigators addressing Sober Living Homes operating as criminal enterprises;

- Juvenile intervention programs to correct inappropriate and/or criminal behavior in our children before adulthood; and,
- School Mobile Assessment and Resource Team (SMART) that responds to investigates all threats and crimes on school campuses

Thank you for the opportunity to share my testimony and considering these recommendations. These issues are not easy to solve, but collectively, working together as one nation, we will be successful.

Shannon Robinson, MD

Principal, Health Management Associates

Dr. Shannon Robinson is board certified in Psychiatry and Addiction Medicine, a Fellow of American Society of Addiction Medicine, and now working as a Principal for Health Management Associates, a national healthcare consulting firm. She was the Director of the Alcohol and Drug Treatment Program at the San Diego, Veterans Administration (VA) where she initiated Medications for Addiction Treatment, expanded assess to evidenced based psychotherapies, as well as assisted with the development of the VA's national educational materials for Alcohol Use Disorders, Opioid Use Disorders, Pain Management and Treatment of Insomnia.

She served as the Chief of Addiction Service for California Correctional Healthcare Services where she initiated Medications for Addiction Treatment within primary care and assisted with the development of enhanced substance use disorder treatment throughout California Department of Corrections and Rehabilitation. This program will eventually cover screening and assessment of 127,000 inmates with psychosocial treatment and FDA approved medications for Opioid and Alcohol Use Disorders for those in need at California's 35 prisons.

Dr. Robinson has two decades of teaching experience with mental health, primary care, pharmacy and nursing staff, which includes curriculum development, in person presentations and interactive webinars for all healthcare disciplines, nonhealthcare staff, patient, family and lay persons. Dr. Robinson has also provided direct care and supervised Telepsychiatry, TeleMedicine and TeleAddictions programs in the Veterans Administration and California Department of Corrections and Rehabilitation.

March 11, 2020

To: Dr. Laura Wyckoff
The President's Commission on Law Enforcement and Administration of Justice
Laura.Wyckoff2@usdoj.gov

From: Shannon Robinson, M.D.
Fellow American Society of Addiction Medicine
Principal Consultant
Health Management Associates

Dr. Wyckoff and Commissioners:

I am honored to speak to the workgroup on Social Problems Impacting Public Safety for the President's Commission on Law Enforcement and Administration of Justice.

While working at the University of California and Veterans Administration in San Diego, and California Department of Corrections and Rehabilitation my career has concentrated on research and treatment of mental health (MH) and substance use disorders (SUD), in addition to, research and treatment of MH and SUD within primary and specialty care clinics. Specifically, I participated in research and expanded access to evidence-based psychotherapy and pharmacotherapy for trauma, substance use disorder, co-occurring MH and SUD, along with co-occurring HIV and/or hepatitis C and MH and SUD. My current position is as a principal healthcare consultant working for Health Management Associates, a national healthcare consulting firm, where I predominantly work on increasing evidence-based treatment for substance use disorders within the criminal justice system, across our nation. I will focus my testimony on how government resources (e.g. education and health services) can tackle SUD to reduce crime and improve resource utilization and morale for law enforcement. Although evidence in this testimony focuses on SUD, similar evidence can be presented for MH. I realize there is also a Criminal Justice workgroup, as well as a Re-Entry workgroup and I hope my written and verbal testimony will be shared with these workgroups.

Overview

Trauma, mental illness, substance use disorders and homelessness have bidirectional influences upon each other; collectively MH and SUD are frequently referred to as behavioral health. Increased numbers of childhood adverse events are associated with increased drug use and homelessness (1,2). 80-90% of homeless individuals have a history of trauma (3). 20-50% of homeless individuals have a serious mental illness and 74% of people with an episode of homelessness have a lifetime diagnosis of SUD (4). Adverse childhood events, include having parents who are absent due to incarceration, witnessing or being a victim of violence and experiencing neglect, are more likely when drugs and alcohol play a key role in your formative years. It is easy to see that violence, MH and SUD not only effect the "patient" but are

multigenerational due to the impact on the children and on the older generation often left to care for children whose parents are unable to adequately care for them. This sets up the next generation to be more likely to experience MH and SUD, homelessness and incarceration.

63% of sentenced jail inmates have a drug use disorder, although only 22-28% percent get treatment while incarcerated (5). In the United States, risk and needs assessments have been used to place patients in treatment programs; risk and needs assessments look at criminal history and are designed for law enforcement supervision purposes. It must be kept in mind that risk and needs assessments are not diagnostic tools and should not be used to determine clinical treatment needs. It is imperative that legal, child services and custody partners allow decisions about medication and level of care (outpatient, intensive outpatient, residential) to be determined by the clinical provider with shared decision making from the patient.

71% of deaths within 2 weeks of release from incarceration are due to overdose (6); of those who do not perish, those with SUD are more likely to reoffend than those without a SUD (7). In order to stop this cycle we need to provide evidence based MH and SUD treatment.

We have very clear evidence of what does not work for people with substance use disorder. Over 90% of people with opioid use disorder (OUD), in abstinence-based treatment, fail within one year (8). Historically, forced withdrawal from medications for addiction treatment has occurred upon admission to incarcerated settings; yet patients remaining on methadone while incarcerated were twice as likely to attend a narcotic treatment program (NTP) post release as those who were forced to discontinue medication (9). Similarly, patients who were initiated on methadone while incarcerated were more likely to attend a NTP post release than patients who received counseling or counseling and referral to NTP but no medication (10).

In addition to improved retention in treatment for those continued or initiated on MAT while incarcerated, there are widespread beneficial effects of MAT- such as reductions in illicit opioid use, HIV & hepatitis risk behaviors, criminal behavior (not only while incarcerated but also when not incarcerated), 75% decrease in mortality related to addiction and safer and healthier communities (11-13). When Rhode Island jail and prison systems implemented all three FDA approved medications for OUD there was a 61% decrease in overdose deaths upon release form incarceration and an 12% decrease in the overall overdose death rate in the state (14). In England a 75% decrease in all-cause mortality was seen within the first month post release associated with MAT (13) and in New South Wales, Australia a 74% lower all-cause mortality was seen while on opioid substitution compared to incarcerated persons not on opioid substitution (15). MAT consistently shows a decrease in mortality providing us an opportunity to intervene and rehabilitate individuals during this high-risk time period.

With this information combined with the National Sherriff's Association and the National Commission on Correctional Healthcare's publication of *Jail Based Medication-Assisted Treatment- Promising Practices, Guidelines and Resources for the Field (2018)* along with recent litigation won based on violations of 8th amendment MAT programs are being implemented in some jails and prisons. Recent efforts have focused on increasing access to FDA approved medications for OUD within incarcerated populations, targeting the 15-25% who regularly use heroin (5). Improved outcomes can also be seen with MAT use for alcohol use disorder (AUD); this significantly increases the total population who would benefit from MAT, as not everyone with an AUD also has an OUD. In general, programs are not yet funded to

address the entire incarcerated population with OUD and funding requests to target AUD have generally not started.

Despite recent improvements in MAT access within incarcerated populations with OUD we have much work to do in order to get the entire criminal justice system in sync with evidence-based practices. In some jurisdictions, judges, lawyers and child welfare workers continue to recommend, or mandate, discontinuation of MAT in order to have custody of children.

Operation Relentless Pursuit and the President's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand target gangs and their drug distribution networks, as these jeopardize the safety of our communities. The safety of those incarcerated persons, who would like to take the opportunity they have been given to rehabilitate themselves, is also jeopardized by gangs prohibiting members from accessing MAT. We need to utilize lessons learned from desegregation of housing units (or other prior initiatives) within incarcerated settings to proactively address this issue.

Prior to or upon release from incarceration we need to assure access to MAT by eliminating unnecessary barriers currently present. These include eliminating the 8 to 24 hours of training required to prescribe buprenorphine, restriction on the number of patients that can be treated by each provider and restrictions on telehealth and prescribing MAT. In France where these barriers do not exist, there was a 79% percent decrease in overdose deaths nationally upon implementation of buprenorphine (16). Furthermore, we need to streamline processes for NTP certification in jails and prisons.

We need to ensure education for healthcare providers who are in training and mandate education for providers who are already licensed. Currently it is not required for all doctors to learn about substance use disorders, only psychiatrists. In order to successfully curtail the SUD epidemic in the United States, treatment cannot be relegated to specialists and must be tackled by all healthcare and mental health care providers. Addiction education could be mandated for medical schools, residencies, nurse, social work, psychology, pharmacy and other training programs. Moreover, a comprehensive strategic workforce development plan will include an increase in community health workers, substance use disorder navigators, and peer recovery coaches.

In addition to all healthcare providers receiving education, our law enforcement colleagues need to be educated about the neurobiology of SUD, evidenced based treatments (both psychosocial and pharmacological treatments) and that treatment for these chronic brain diseases is a decision between the patient and the provider. Legislation should not mandate which FDA approved medications for addiction treatment are available for person involved in the criminal justice system; we do not legislate which medication for other disorders will be available in jails. Nor should a child welfare worker be able to remove a child solely because someone is on MAT. Stable brain chemistry is good and is more likely to result in good parenting. Instability, resulting from a decrease or discontinuation of medication, is NOT good for parenting and may lead to relapse and death, leaving a child to be brought up in the foster care system.

In our nation, jails and prisons are our largest behavioral health treatment facilities. Treatment of MH and SUD result in safer communities and therefore a long-term decrease in costs to the state and federal government (17). During incarceration, there are no food scarcity concerns or transportation barriers interfering with treatment, making this an ideal time to intervene.

While building addiction education into existing training programs and mandating continuing education on addiction to health care, mental health care providers, correctional, legal and child services workers it is imperative that we assure this education, and ultimately treatment, is not directed solely at OUD, but all substance use disorders. The federal government has recently expanded the focus of Comprehensive Opioid Abuse Program to Comprehensive Opioid, Stimulant and Substance Abuse Program, which hopefully will guarantee that alcohol use disorders are addressed as alcohol continues to kill more people than opioids or amphetamines; alcohol just kills more slowly. As there are no medications which are FDA approved for substances other than opioids and alcohol, it is critically important that evidence-based psychotherapies also be available. Adequate training in and access to evidence-based psychotherapies including motivational interviewing, cognitive behavior therapy, and trauma informed person centered medical and behavioral healthcare will lead to improved outcomes and decreased recidivism.

In line with the focus on evidence-based treatments for SUD, the president has an initiative to stop opioid abuse that includes ensuring at least half of all federally employed healthcare providers adopt best practices for opioid prescribing within two years, with all of them doing so within five years. Starting with federal employees is an excellent first step; however, most healthcare providers do not work for the federal government. Consideration should be given to ensuring all federally and state funded MH and SUD care is evidence based. Many providers and programs are delivering care that is not well grounded in science, which is a waste of resources and leaves providers, patients, family and law enforcement disillusioned with lack of progress and success, negatively impacting morale. Programs not utilizing evidence-based psychotherapy and pharmacotherapy should not be eligible for federal or state funding. Another funding issue that could improve outcomes for persons involved in the criminal justice system is allowing utilization of federal dollars during the last month of incarceration. This would incentivize in reach from post release providers of physical, MH and SUD care, which has shown to increase retention in treatment post release.

In summary trauma, mental illness, substance use disorders and homelessness have bidirectional influences upon each other. Although evidence presented in the above testimony focused on SUD, similar evidence can be found for MH disorders. To stop the multi-generational effects of these issues and ever-increasing resource utilization we can treat MH and SUDs with evidence-based treatments including motivational interviewing, cognitive behavioral therapy, contingency management and MAT; an opportune time to do this is while persons are involved in the criminal justice system. We need to allow medication and level of care of treatment decisions to be made by clinical providers with shared decision making from patients, provide education for all medical and behavioral healthcare staff, along with custody, judicial and child service staff, address gangs preventing access to MH and/or SUD services, eliminate unnecessary barriers to MAT, stop federal, state and local funding of care which is not evidence based and incentivize in reach to prepare for smooth transitions to the community. These steps will improve outcomes, including decreases in recidivism, and improve morale of providers, patients, family and law enforcement, and ultimately decrease costs to our federal, state and local governments.

For additional information: Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings. HHS Publication No. PEP19-MATUSECJS Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2019.

Sincerely,

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Sheriff Paul Penzone

Phoenix Police Department

Sheriff Paul Penzone has a combined 30 years of law enforcement and public safety experience. His resume includes a distinguished 21-year career with the Phoenix Police Department, with seven years dedicated to the department's nationally-recognized Silent Witness program, which focuses on solving cold cases and apprehending dangerous fugitives. After retiring from Phoenix PD, Sheriff Penzone spent time as Vice President with Childhelp, a 60-year-old nonprofit dedicated to the treatment and prevention of child abuse. He also owned and operated a successful private security firm that focused on issues such as school and workplace safety, threat mitigation, internal investigations and comprehensive security. The Maricopa County Sheriff's Office operates in an area nearly the size of Vermont and is the primary or supporting law enforcement agency for a population of more than four million residents. MCSO's jails process and house all felony and most misdemeanor inmates for the County, in excess of 100,000 intakes annually. The Sheriff is a member of the Arizona Sheriff's Association, the Major Counties Sheriff's Association, IACP, and the Department of Homeland Security Regional Advisory Council.

Paul Penzone
Sheriff
Maricopa County Sheriff's Office

The Issue:

Mental illness is a complicated issue that disrupts the quality of life for valued members of our society. The impact of this challenge extends beyond the individual, affecting the health and stability of those directly and/or indirectly connected to the suffering community member. Additionally, the impact results in collateral damage for community members incapable, unwilling or unprepared to understand and appropriately manage the behavior, environment and circumstances. Beyond the personal or relational impact there are collateral elements which undermine our ability to establish a harmonious stability promoting safety, functionality and strong community relationships. The financial impact, demand on social and medical services, impact on criminal behavior and substance abuse contribute to violence and instability in our communities. Law enforcement has inadvertently become the primary respondent to these complex issues, responsible for de-escalating, mitigating, resolving, restraining, investigating, and providing ongoing care for the ill, unhealthy and unwell members of our society while in custody. The demands have long ago exceeded law enforcement abilities, resources and its core mission. It is time to evaluate all factors and establish a sustainable enforcement and justice system where we recognize unique aspects of this illness and it's social issues as well as construct a system that is solution oriented while still adhering to the core purpose of the justice system and the interests for victims of crime.

Law Enforcement Factors:

As I am not a mental health professional, I will speak to the factors within the scope of my expertise, law enforcement. There are many contributors to the challenge law enforcement professionals face as it relates to mental illness. As part of the law enforcement mission, professionals respond to crime, civil disputes, violence, domestic conflict and erratic behaviors by individuals. As first responders, they are expected to conduct evaluations, restore stability and investigate potential criminal behavior.

Historically, law enforcement was summoned in circumstances when lives were endangered, or a crime had occurred. With strides in technology, communities established the 9-1-1 system with specific intentions to create an outlet to expedite police response for urgent circumstances. Prior to this transition the non-emergency number for police was familiar and utilized when appropriate. This is no longer true.

Over time, 9-1-1 became the most widely used and only familiar number to request police assistance. Due to the convenience, it became more common place to call the police for all social conflicts or civil disagreements. As families became more dependent on police support to resolve personal conflict the demand on police expanded exponentially. Now, law enforcement professionals assume a heightened level of liability, greater responsibility and more complex social challenges.

Drug and alcohol impairment, anxiety, emotional instability, special needs and disorders, mental illness and other factors are often present during law enforcement interactions. The volume of calls complicated by the percentage of the population affected by the previously described factors has led to an unmanageable problem.

It is unfair to expect law enforcement professionals to be mental health experts capable of ascertaining the cause of the erratic behavior, establishing public safety and resolving a mental health episode while de-escalating the threat of violence. Yet, we demand these outcomes without considering the impact these experiences have on the mental health and wellness of the very professionals responsible for delivering public safety.

Once in custody, the responsibility becomes even more complex. Inside the jail system all detainees are affected by the loss of freedom, threat of violence, confinement and anxiety of the unknown. Those with mental illness more so. Our detention officers, in partnership with mental health and medical professionals, work to restore unstable and mentally ill individuals, who are often capable of unpredictable acts of violence, to a state of normalcy and mental stability. An inmate's stay in custody can be short term or years in length. Over the course of this time frame the staffing model is expected to provide a high level of care while protecting the inmate and others from violence.

Sworn law enforcement and detention personnel will receive 16-24 weeks of training to become versed in a variety of topics, including legal issues, investigations and use of force, among others. They will receive a minimal amount of training related to mental illness and impairment. It is impossible to provide adequate training in an academy to prepare new officers for the wide range of mental health behaviors they will encounter.

<u>The Maricopa County Jail System:</u>
Maricopa County is the fourth largest county in the nation, encompassing over 9,000 square miles with over 4.5 million residents. It is the fastest growing county in the nation, with an estimated 200 new residents moving to the county every day.

Our jail system incarcerates over 100,000 detainees annually with an average daily population ranging from 7,300-8,300. We serve the custody needs for approximately 25 law enforcement agencies in the region. Within our jail system we incorporate federal partners, courts, medical professionals, mental health and addiction experts and other service providers.

Every detainee goes through a comprehensive evaluation upon entering our custody. On average, between 3,000-3,500 detainees will have a comprehensive mental health evaluation. Approximately 28% of those evaluated will be classified as have some level of mental illness. Additionally, 8-10% will be designated as Seriously Mentally Ill (SMI). Of the SMI population, 28% will report some level of homelessness or home instability. An estimated 34% of SMI self-report some degree of substance abuse as an additional factor complicating the behaviors and threat to safety.

Our process and protocols are designed to manage these factors and determine best practices to restore detainees to some form of stabilization for their mental illness and/or substance abuse problems. We provide constant observation for those deemed to be at a high risk for self-harm. We separate the population affected by these factors from the general population to ensure we can consolidate the trained professionals to spaces where they can more efficiently access the population in most need.

When possible, we create a plan for care and stabilization for those willing to participate in their own recovery. The plan includes clinical services and counseling, and when appropriate and under the direction of clinicians, chemical prescriptions to support the needs of the detainee/patient.

Our process is complex and consistent, focusing on stabilizing the mental health of the detainee. When releasing from detention, we attempt to connect them with similar service by providers in the public domain. It is our intent to see the individual receive ongoing support with the hope that stable housing, appropriate care and a supportive environment will lead to a successful future. The societal benefit would be a productive and constructive member of society with less likelihood of recidivism.

<u>The Impact:</u>
It is unrealistic to expect that we can eliminate or separate the criminal population so precisely that our population would no longer include those with mental illness or drug addiction. If we are truly invested in identifying and addressing the contributors to crime, we must acknowledge mental illness can lead to criminal behavior and violence and drug addiction is a considerable contributor to mental illness.

As jail systems cannot and do not set costs in an "a la carte" formula, we set daily fees based off of all services provided to the inmate population broken down to average cost per inmate. In Maricopa County our fees for incarceration are broken into two costs. The first fee is at booking as the initial services are most comprehensive and costly. The booking fee for a newly accepted detainee is approximately $340. The daily rate once booked into the jail is $125 per day. The reason these fees are so high is due to all the complex medical and mental health services and supplies needed to provide care for inmates. Because of liability, case law and institutional history the inmate services directly contributing to these fees is mandated and outside of the control of the Sheriff to adjust. To provide some perspective on the investment into the inmate population, it is my understanding we invest $8-$10 per day to educate our children and provide for their care in public institutions.

<u>Suggestions for Consideration:</u>

Create and centralize a national study center for law enforcement focusing on.

- Mental illness and chemical impairment to ensure we are current, timely and relative for the evolving challenge to public safety,

    - A national standard curriculum for recognition, mitigation and de-escalation of individuals with mental illness and special needs. (i.e. Autism)
    - A national study to determine a demand scale of "Calls for Service" for today's law enforcement professionals. Identify the demand on officers/deputies to better comprehend their core responsibilities and the allocation of their time during the course of duty
    - A standardized training program, based on the data from the national study previously described, whereas the curriculum is aligned with operational demand for today's law enforcement professionals.
- Fund the expansion and specialization of facilities who can specialize in care and custody of inmates with moderate to severe mental illness. Facilitate the creation of independent detention facilities for the major jail systems whereas the ratio of clinical care providers is adequate to meet the needs of the population. The detention staff would then return to their area of expertise providing safety and security to the population.
- Enhance and fund support services for "At Risk" populations in the community, thereby reducing recidivism and violence by providing care prior to incarceration.
- Provide funding for transportation of the vulnerable populations to and from health service appointments, court appearances, and clinical reviews.
- Increase affordable housing options for individuals with mental illness
- Legislate diversion programs so that upon clinical review and recommendation, non-violent offenders may be diverted to appropriate treatment facilities opposed to incarceration.
- Invest in more effective drug education prevention programs for youth to curb the behavior thereby reducing chemically induced mental illness.
- Conduct a study to determine best practices for a comprehensive system to track successes and failures of existing mental health programs across the country. Thereby promoting best practices on a macro scale.
- Encourage private and public health insurance providers to evaluate inmates prior to release for ongoing services upon re-entry.
- To approach mental health, homelessness and substance abuse in a holistic manner as they are so intertwined

Thursday, March 26, 2020

Dr. Keith Humphreys

Professor and Section Director for Mental Health Policy in the Department of Psychiatry and Behavioral Sciences, Stanford University

Keith Humphreys is a Professor and the Section Director for Mental Health Policy in the Department of Psychiatry and Behavioral Sciences at Stanford University. He is also a Senior Research Career Scientist at the VA Health Services Research Center in Palo Alto and an Honorary Professor of Psychiatry at the Institute of Psychiatry, King's College, London. His research addresses the prevention and treatment of addictive disorders, the formation of public policy and the extent to which subjects in medical research differ from patients seen in everyday clinical practice. For his work in the multinational humanitarian effort to rebuild the psychiatric care system of Iraq and in the national redesign of the VA health system's mental health services for Iraq war veterans, he won the 2009 American Psychological Association Award for Distinguished Contribution to the Public Interest. Dr. Humphreys has been extensively involved in the formation of public policy, having served as a member of the White House Commission on Drug Free Communities, the VA National Mental Health Task Force, and the National Advisory Council of the U.S. Substance Abuse and Mental Health Services Administration.

24/7 Sobriety and Alcoholics Anonymous Within The Criminal Justice System

Presidential Commission on Law Enforcement and the Administration of Justice
March 26, 2020

Keith Humphreys

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Senior Research Career Scientist, Veterans Health Admin.
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The Stanford Stumper

Alcohol and Crime are Linked

- Alcohol is the number one drug in terms of arrests, violence, and incarceration
- A plurality of homicides and assaults occur when offender, victim, or both, are intoxicated
- In many correctional facilities, the majority of inmates meet diagnostic criteria for substance use disorders

Focus on Two of Many Possible Approaches

- Taxing and licensing laws
- Advertising Regulations
- Screening and Brief Intervention in Primary Care
- Medications
- Specialty Alcohol Treatment Programs
- *24/7 Sobriety*
- *Alcoholics Anonymous*

24/7 Sobriety

Common Characteristics of Alcohol-Involved Offenders

- Low impulse control, present time orientation
- Low education, some non-native speaker
- Negative history with CJS fostering distrust and anger
- Need clear, transparent, consistent rules with frequent feedback over short intervals

If you don't clean up your room right now there is a 40% chance that a month from now, I will ground you for two years!

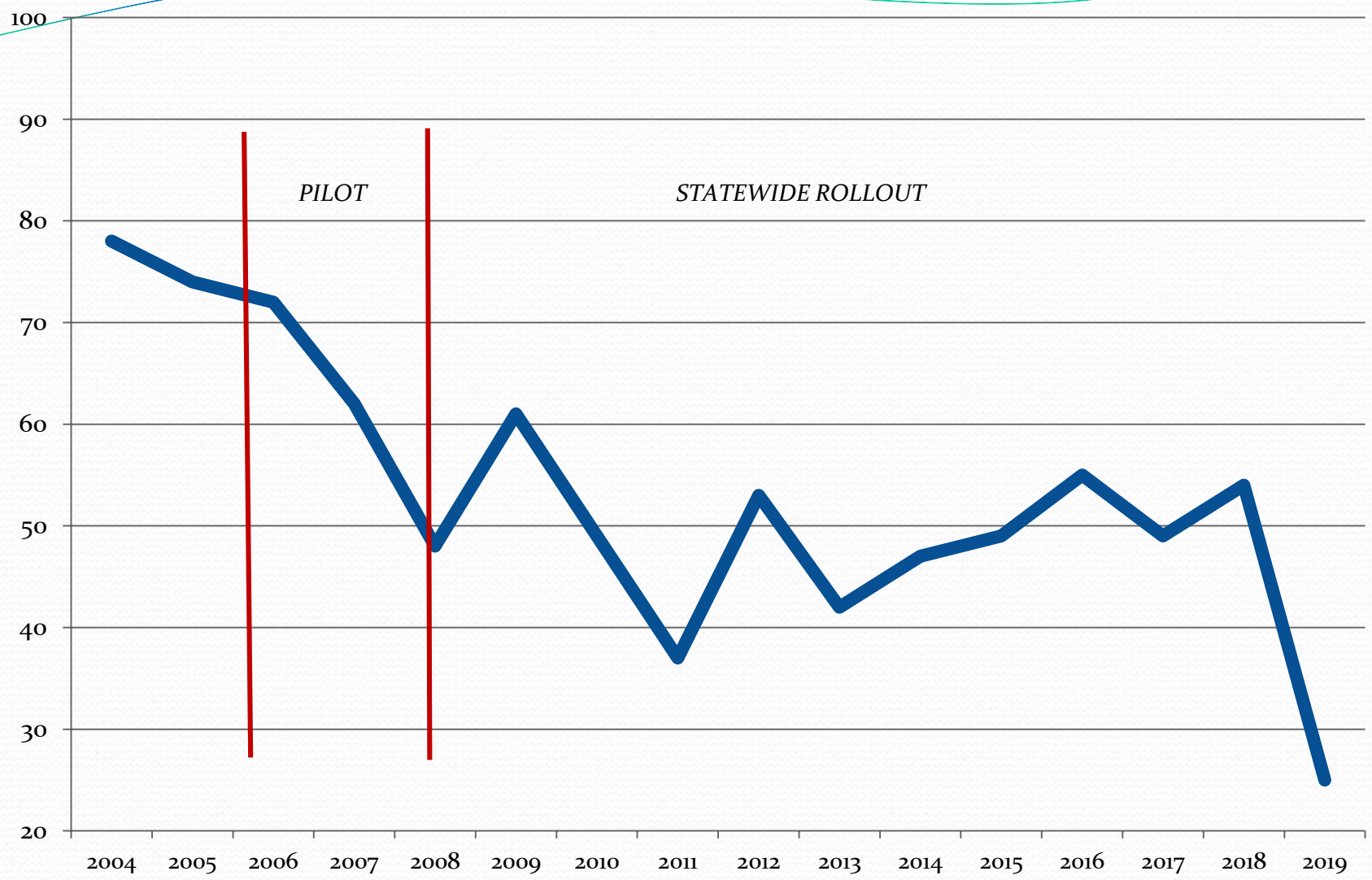
Criminologist James Q. Wilson's analogy for how we respond to criminal offenders

Traditional Approach	New Paradigm
	Simple and transparent Rules
Unpredictable consequences	Certain consequences
Harsh consequences that feel unfair	Modest consequences that feel fair

24/7 Sobriety in South Dakota

- All offenders get careful orientation to program rules
- Twice-daily breath testing OR alcohol-sensing bracelet
- Alcohol use or no show results in *prompt* arrest and *certain, modest* punishment (1 night in jail)
- Treatment and/or Alcoholics Anonymous not required but available to those who need it to abstain

Annual Alcohol-Related Road Fatalities, South Dakota



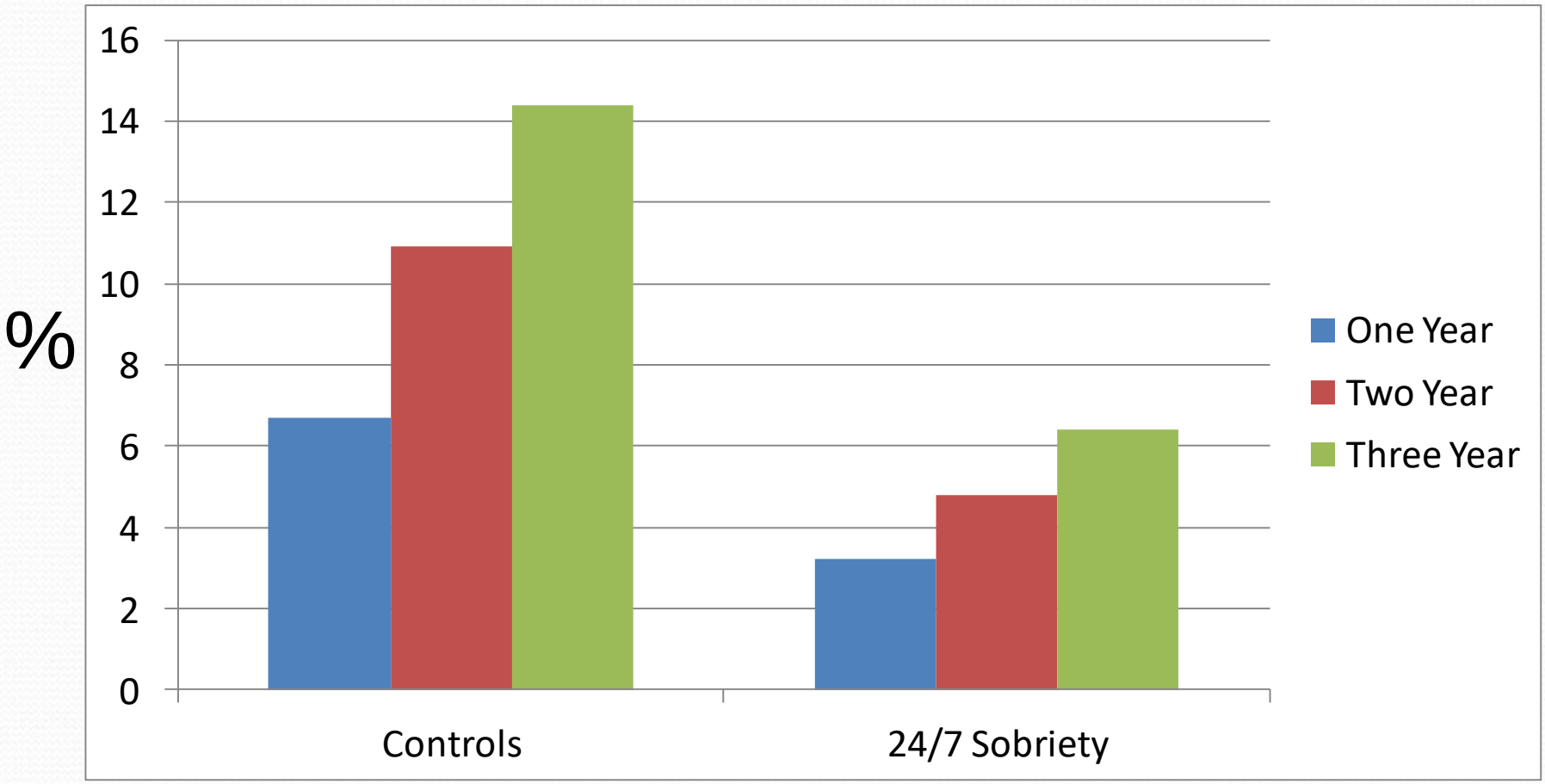
Source: South Dakota Department of Transportation
N.B. State population grew 14.3% 2004-2019

Positive Impact in South Dakota Large Even at County Level

- Repeat Drink Driving arrests down 12%
- Domestic Violence arrests down 9%
- Statewide all-cause mortality down 4%

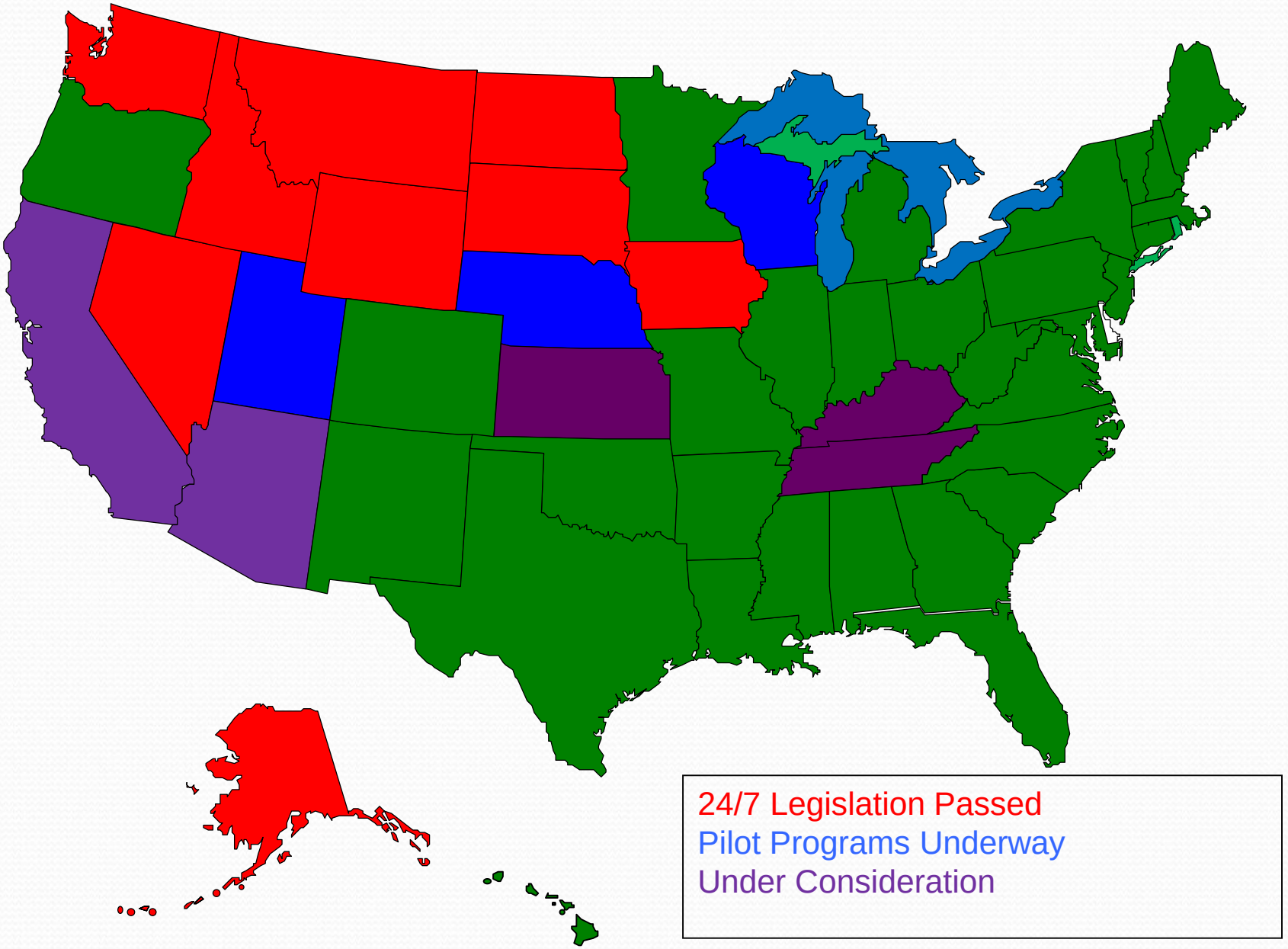
Source: Kilmer, B. et al (2013). American Journal of Public Health, 103, no. 1 (2013): e37-e43; and Nicosia, N., et al. (2016). Lancet Psychiatry, 3, 226-232.

Recidivism Among Two-Time Drink Drivers is Lower for Years After 24/7 Sobriety Program



Source: South Dakota Attorney General's Office

24/7 Sobriety in the United States



What the Commission Could Do

- Recommend that every state that hasn't passed enabling legislation do so.

- Recommend that every state not accessing federal highway funds for 24/7 Sobriety do so

Alcoholics Anonymous

Background on Alcoholics Anonymous

- Founded in Midwestern U.S. in 1935
- Sole purpose: To help “alcoholics” become sober
- Offers meetings, sponsorship, literature, 12 steps
- Free of charge, no paperwork
- Most widely sought source of help for alcohol

Cochrane Collaboration Review

- Multi-year review by international team released on March 11, 2020
- Integrated studied from 145 scientist in 67 institutions across 5 countries
- Restricted to rigorous studies

Three Key Findings

- Very large advantage over other treatments for abstinence
- As good for other outcomes, *including reducing drinking*
- Reduces health care costs significantly

What the Commission Could Do

- Recommend that every correctional facility make space and means available for onsite meetings.
- Include AA on list of options in community sentences, parole and probation (within Constitutional bounds)

Summary

- 24/7 Sobriety has evidence of reducing alcohol consumption and alcohol-related injury and violence.
- Alcoholics Anonymous has evidence of reducing drinking and health care costs
- The criminal justice system should be supporting both options throughout the country.

For More Information

Stanford Network on Addiction Policy
https://addictionpolicy.stanford.edu/