

Public Inebriate Task Force Report 2010

In 2008, Vermont legislators commissioned a diverse group of stakeholders to convene a task force to re-assess Public Inebriate Services in Vermont. This task force charge emerged from the 2007 inebriate summer study found at:

http://healthvermont.gov/admin/legislature/documents/PublicInebriate_LegislativeRpt_011508.pdf

Act 179, Sec. 17. PUBLIC INEBRIATE TASK FORCE

(a) A public inebriates task force is established. The task force shall consist of the following members:

- (1) Two members employed by the office of alcohol and drug abuse programs appointed by the commissioner of the department of health.
- (2) Two substance abuse treatment providers appointed by the substance abuse treatment providers association.
- (3) One member appointed by the department of public safety.
- (4) One member appointed by the Vermont police association.
- (5) One member appointed by the Vermont League of Cities and Towns.
- (6) Two members appointed by the Vermont medical society who shall be hospital emergency department personnel.
- (7) Two members appointed by the Vermont recovery network.
- (8) Two employees of the department of corrections appointed by the commissioner of the department of corrections.
- (9) A representative of the Vermont Association of Hospitals and Health Systems.

(b) The task force shall report to the senate and house committees on judiciary, corrections and institutions, and appropriations no later than January 1, 2010 with a plan to ensure that public inebriates are given appropriate care rather than incarcerated. The plan shall ensure the regional availability of supportive voluntary and secure accommodations for public inebriates by January 1, 2011, and shall include a timetable for providing reimbursement of expenses to programs that house and maintain public inebriates.

In the absence of a lead named as part of the charge, the two members from the division of Alcohol and Drug Abuse Programs of the Department of Health, Peter Lee, Treatment Chief, and Connie Schütz, Policy and Implementation Analyst, facilitated the meetings. The report was written by Connie Schütz, with input from committee members based on their area of expertise and joint review and revisions at the monthly meetings.

These task force members were involved in the deliberations and editing of the report:

Barbara Cimaglio, Deputy Commissioner, Department of Health, Division of Alcohol & Drug Abuse Programs

Connie Schütz, Policy & Implementation Analyst, Department of Health, Division of Alcohol & Drug Abuse Programs

David Yacovone, Director of State Legislative Affairs, Vermont Association of Hospitals and Health Systems

Delores Burroughs-Biron, MD, Medical Director, Department of Corrections

Donald McGee, Board of Directors, Recovery House

Edward Haak, MD, Director, Dept of Emergency Medicine, Northwestern Medical Center, St. Albans, VT

Jill Olson, Vice President of Policy and Operations, Vermont Association of Hospitals and Health Systems

Mark Ames, Vermont Recovery Network

Mary Moulton, Emergency Services, Washington County

Nancy Natvig, RNC, Director of Emergency Department, Copley Hospital

Patricia Singer, MD, Medical Director, Adult Mental Health Services, Department of Mental Health

Paul White, Lt , Vermont State Police

Peter Lee, Treatment Chief, Department of Health, Division of Alcohol and Drug Abuse Programs

Phillip Fernandez, Asst Superintendent, Marble Valley Regional Correctional Facility

Richard Powell, Department of Corrections

Richard Turner, Senior Program Director, Phoenix House

Robert Bick, Director of Mental Health and Substance Abuse Services, HowardCenter

Russell Frank, Office of Vermont Health Access

Thomas Hanley, Chief , Middlebury Police and Chair, Vermont Assn of Chiefs of Police

Todd Mandell, MD, Medical Director, Division of Alcohol and Drug Abuse Programs

Walter Decker, Deputy Chief, Burlington Police Department

William (Butch) Alexander, CEO, Lamoille County Mental Health Services

The following report, then, is submitted by the task force and reflects its findings and recommendations after a year of deliberations at a dozen face-to-face meetings.

Executive Summary

Vision: Vermont aims to create an accountable, community-based system of screenings, services and supports that connects public inebriates with needed services. This system will be composed of a continuum of timely, interconnected and coordinated components with multiple entry points and appropriate placement options throughout the state in the form of social detox and shelter beds.

Problem: A cohesive, state-wide system of services and supports for public inebriates does not exist across Vermont. In the absence of adequate resources and infrastructure necessary to address the problem, the correctional system *de facto* constitutes a part of the system of care for a significant percentage of inebriates. This runs counter to the intent of the Alcohol Services Act of 1978,¹ which decriminalized public intoxication, as well as to current Best Practices.

Four particular domains of concern have emerged in the Task Force's analysis of Vermont's Public Inebriate Services:

- Lack of cohesive, state-wide standardized care policies
- Insufficient distinction between four groups of inebriates with divergent needs (see Improvement Domain II for definitions)
- Lack of regionalized placement options for persons in need of services
- The impact of last year's change in Statute, prohibiting public inebriates from being lodged at Department of Corrections facilities after July 1, 2011

Task Force Recommendations:

- Ensure individuals that are incapacitated are appropriately screened at each stage of the process in all areas of the state, leading to appropriate triage for services and community based diversion resources
- Provide adequate training to law enforcement, corrections, emergency department personnel, first responders, public inebriate screeners, and treatment providers to ensure uniform procedures are observed throughout Vermont
- Provide a screening capacity in Addison County, the only county without screeners. This will ensure universal inebriate screening coverage throughout the state
- Allocate sufficient resources to meet the standard of care by screening, social detox and shelter beds, and secure placement beds for the populations as indicated in Domain II. Regionally appropriate capacity for follow-up treatment as needed could be met by nine two-bed public inebriate bed units at an estimated annualized operational cost of \$ 180,000 each
- Amend the previously enacted legislation to restrict use of the correctional facilities to house only those incapacitated persons meeting all of the criteria identified in Improvement Domain II

Introduction

In 1978, the Vermont Legislature enacted the Alcohol Services Act.² This act decriminalized public intoxication and put in place a program to move public inebriates into treatment rather than into jail, since substance abuse can represent a public health and safety problem.³ In 2001, the statute was changed to add drugs other than alcohol as incapacitating substances.⁴

The current report follows the summer study needs assessment that was completed and reported on in January 2008.⁵ The four domains for which improvement is most compelling are presented in detail below, with the improvement goal for each followed by a list of suggested activities intended to help achieve the stated goal.

Improvement Domain I: *Cohesive, standardized care policies*

Problem: Lack of cohesive, state-wide standardized care policies. The current system was developed in a piecemeal fashion in response to local issues and initiatives and thus evidences different policies, procedures, levels of knowledge and collaboration between providers.

Goal: Develop and implement cohesive, standardized care policies for screeners contracted through ADAP. Communicate with Emergency Department Directors to ensure standard emergency department policies and procedures are reflected.

Activities: A system of care framework with guidelines for each covered level of care and support services will be crafted. Policies, procedures and protocols to support this structure and guide its work will be drawn up for the beginning of FY 2011. The task force supports ADAP's efforts at expanding the reach and scope of the existing screening, assessment, and referral protocols for responding to public inebriates as funding permits.

ESTIMATED COST IMPACT: To be incorporated into regular staff duties

Improvement Domain II: *Appropriate triage for services across the state*

Problem: Insufficient distinction between four groups of inebriates with divergent needs.⁶

- Inebriated, but not incapacitated persons: no mandate for services under the statute
- Medically unstable, due to physical or mental health issues, or co-occurring diagnosis: need medical or mental health placement
- Incapacitated, medically stable, and cooperative persons: maintained at supervised public inebriate shelter bed
- Incapacitated, medically stable and also exhibiting aggressive, uncooperative, and/or unpredictable behavior: protective custody should be available as a placement option of last resort

Goal: Screeners in all areas of the state, appropriately trained in state-wide policies in order to triage and offer the right services to each individual needing them

Activities: The universal screening tool will be used by screeners throughout the state beginning in FY 2011. Training will be made available regionally to law enforcement, corrections, emergency department personnel, first responders, public inebriate screeners and treatment providers to ensure basic competencies regarding the use of the tool, available options for treatment and placement in a community, and the process of diversion and protective custody. ADAP, with the assistance of providers, law enforcement and emergency department physicians will develop such a training within fiscal year 2010 and provide no later than the end of the first quarter of FY 2011, as funds and personnel permit.

ESTIMATED COST IMPACT: Additional ADAP staff time

Improvement Domain III: *Regionally appropriate placement options*

Problem: Lack of comprehensive, regionalized placement options for all groups in need of services. In areas with placement options (social detox and shelter beds), the diversion rates can be as high as 80%, whereas in areas without such options they linger between 9% and 55%. (See appendix A for statistical data).

Goal: Have a sufficient number of supervised shelter beds available across the state

Activities: The task force came to the conclusion that baseline coverage for services could be achieved by gradually adding nine 2-bed units across the areas of the state that currently have no coverage (see appendix B for current and proposed coverage map). This would significantly reduce the pressures experienced by the correctional facilities under the current system. The annualized operational cost of each of these 2-bed units would be \$180,000.— For purposes of prioritization, population density coupled with active collaborative partnerships between law enforcement, mental health, substance abuse, hospital, corrections, and first responder groups meeting regularly that will assure bed usage might be considered.

ESTIMATED COST IMPACT: \$ 180,000 per 2-bed unit

Improvement Domain IV: *Inebriate Statutes*

Problem: No entity outside of Corrections has been identified as having the statutory authority to establish a secure placement. The percentage of persons entering the system who are actually in need of secure placement is significantly lower than the current number of placements would suggest. This is because law enforcement personnel do not have access to readily available and appropriate placements for public inebriates, which creates tremendous expenses in terms of time and travel (see background section for detail).

Goal: Ensure that only persons meeting all of the following criteria are referred to Corrections:

- Medically appropriate according to uniform ADAP policies and guidelines as developed with community providers and Emergency Department Directors

- Appropriately screened and found to be incapacitated according to uniform ADAP policies and guidelines as developed with community providers
- Exhibit aggressive, uncooperative and/or unpredictable behaviors

Activities: The current statute should be amended to strike the provision that: “A person who has not been charged with a crime shall not be incarcerated in a facility operated by the department of corrections on account of the person’s inebriation.”⁷ The experience at all three active shelters has been that there does exist a percentage of persons who are in need and will continue to be in need of that level of intervention. The increased levels of diversion which will be achieved by implementing the changes suggested above will result in significant reductions in the need for housing inebriates in DOC facilities. This task force unanimously recommends that the legislative language prohibiting access to correctional facilities be amended to restricting use of the correctional facilities to those meeting all of the above identified criteria.

Background Issues:

- In 1977, the last full year prior to the legislation, 550 persons were jailed after being charged with public intoxication. At the time, the state had more beds and more regional lock-ups available than it does now. In fiscal year 2009, 4180 persons were screened.⁸ Of these, 2175 were served in the community by existing resources. 2005 persons (52%) entered protective custody without being charged with a crime. This represents an increase in both total cases and percentage of persons incarcerated. *De facto*, public inebriation remains a correctional issue in Vermont. By contrast, diversion rates in some communities with existing resources can be as high as 80%.
- Inebriates are at times incarcerated when no other diversion resource is available. The contacting police officer has no way to know whether the BAC is going up or down, or whether there are any other substance issues involved. Rather than turning such a person out, the officer will elect to “incap” the person rather than risk harm later. Appendix C is a flow-chart that shows the layers of decisions involved in determining public inebriate placement.
- Whether in communities with public inebriate beds or not, there is no special funding attached to managing this population for police, either for transport or for time spent in supervision of an individual throughout the assessment period. Medical examination at a hospital might be sought depending on the individual’s medical condition and supervision of that person, therefore, may tie up a police officer for hours. In Washington County, it is estimated that one individual who requires transport from a police barracks to a hospital for medical examination, utilizing police, ambulance, emergency room and screener staff time, followed by transport to an inebriate bed or a jail, costs the system of care \$2,000-\$3,000/person, depending upon the number of hours personnel are involved in the response.
- The Emergency Department at Northwestern Medical Center in St Albans estimates conservatively that it costs about \$ 1000 per patient for a 12 hour observation and testing of Blood Alcohol Levels. With an average of 16 clients/month occupying the diversion beds, that would amount to an annual cost savings of \$ 192,000.
- When the person is sober and ready to leave a facility, a follow-up screener from a community treatment agency under contract with ADAP may provide follow-up screening, offer services and/or transportation to the individual. Again, there is no funding available for this transportation, and transportation and follow up connections with treatment and recovery

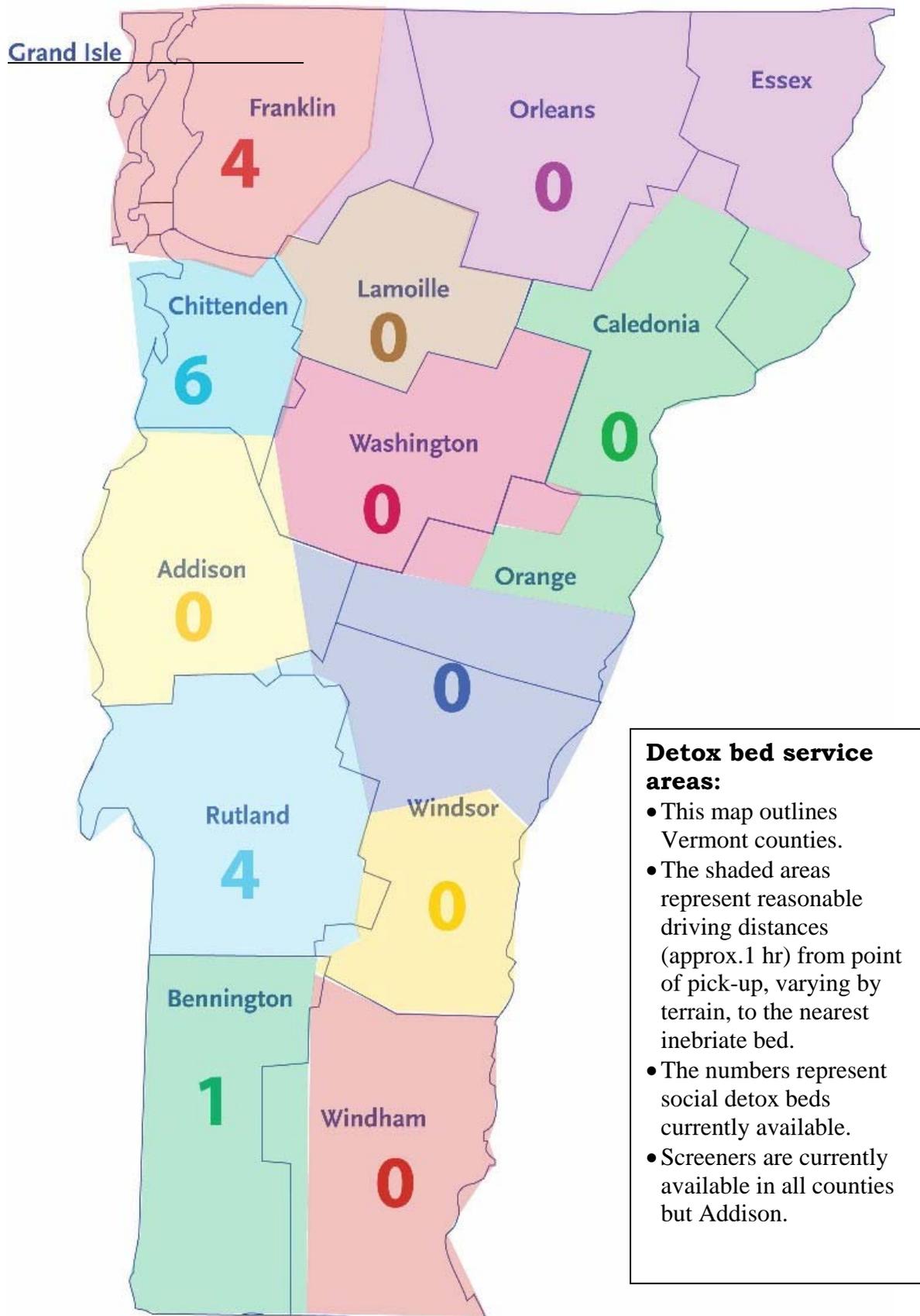
are not consistently provided throughout the state. The individual in protective custody is always encouraged to seek his/her own transportation, but may have no one to contact. If there is no transportation, the individual makes his/her way on foot.

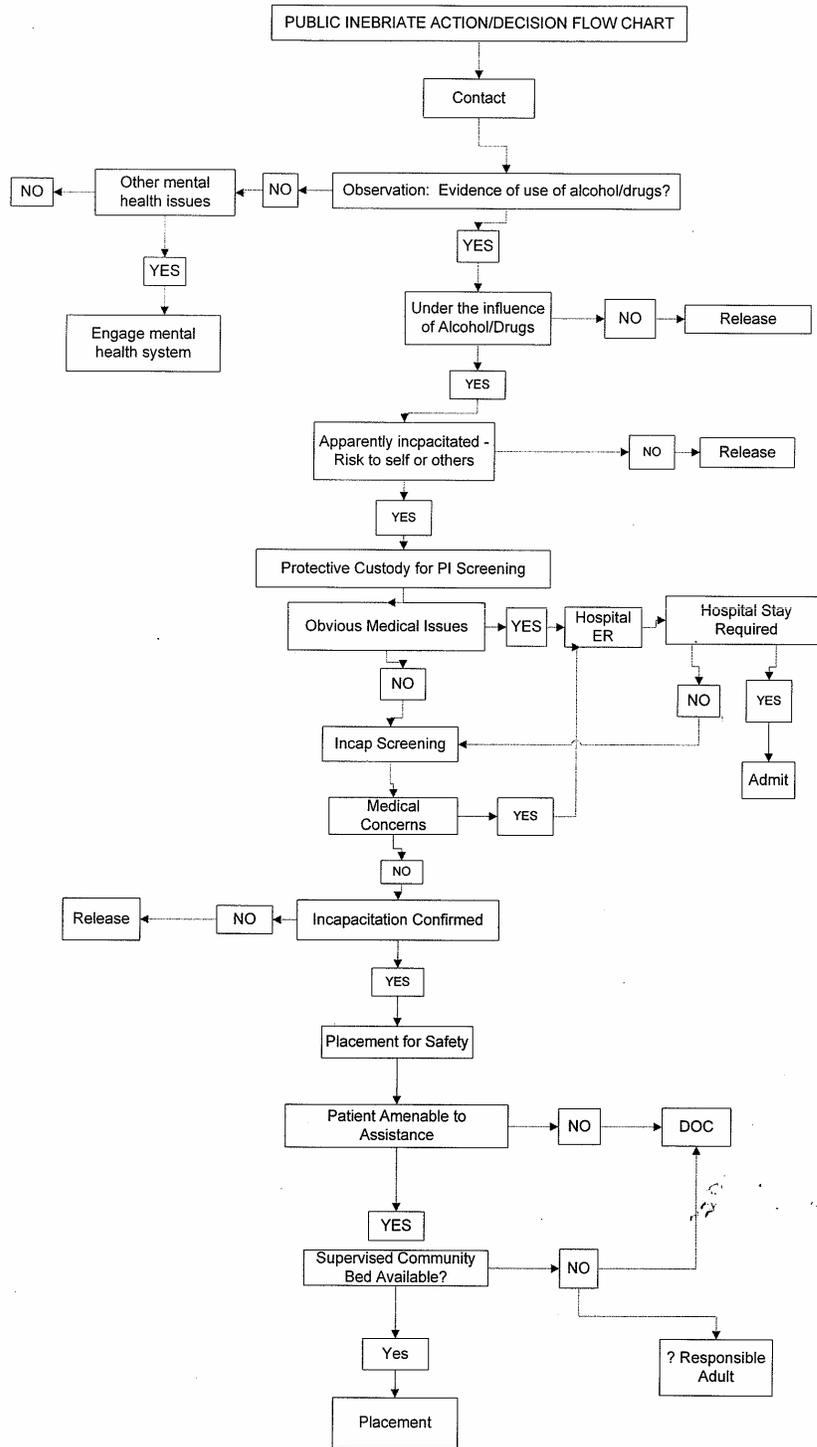
- The majority of individuals enter the public inebriate program only one time; however, those who repeat several times/year are can be extremely costly to the system of care. Additionally, a subset of the public inebriates served present with medical as well as co-occurring mental health issues. A percentage of public inebriates are homeless with no place to go once released.

Appendix A: Percentage of Public Inebriate Clients Diverted from Protective Custody by State Fiscal Year

Location	2006	2007	2008	2009
Behavioral Health & Wellness (Copley)	37%	17%	29%	18%
Central VT Substance Abuse Services	10%	5%	21%	9%
Clara Martin Center - Randolph	36%	30%	26%	13%
HCRS - Bellows Falls	27%	29%	25%	36%
HCRS - Springfield				35%
Howard - Act One/Bridge	56%	57%	57%	55%
Howard - CDAS/St. Albans	63%	63%	75%	80%
Recovery - Grace House			63%	72%
RMH - Evergreen Center	5%	9%		
TriCounty - Newport (NKHS)	34%	13%	17%	16%
TriCounty - St. J (NKHS)	9%	10%	12%	15%
UCS - Bennington	55%	30%	44%	51%

Appendix B: Detox bed coverage for Vermont





Appendix D: Transport of Inebriates in Police Vehicles:

Below is a photograph of an average size male in the rear of a police car. This particular car has special low profile molded plastic transport seats. Note the lack of leg room and the barrier, which creates a sense of claustrophobia. In some areas of the state, inebriates might be transported for 45 minutes to an hour in this condition. Many of them roll over on their sides and are unable to manipulate themselves to sit back up. It is difficult under good conditions getting people in and out, and if the cruiser has the standard rear passenger seat, the leg and head room is further reduced. There is a danger of positional asphyxia, along with the potential to aggravate a pre-existing medical or behavioral health issue.



¹Vermont State Statutes Title 33, chapter 7, § 701: “It is the policy of the State of Vermont that alcoholism and alcohol abuse are correctly perceived as health and social problems rather than criminal transgressions against the welfare and morals of the public. The general assembly therefore declares that: (1) alcoholics and alcohol abusers shall no longer be subjected to criminal prosecution solely because of their consumption of alcoholic beverages or other behavior related to consumption which is not directly injurious to the welfare or property of the public; (2) alcoholics and alcohol abusers shall be treated as sick persons and shall be provided adequate and appropriate medical and other humane rehabilitative services congruent with their needs. (Added 1977, No 208 (Adj. Sess.), § 1.)”

² Ibid

³ Ibid., § 708: “(d) A person judged by a law enforcement officer to be incapacitated, and who has not been charged with a crime, may be lodged in protective custody in a lockup or community correctional center for up to 24 hours or until judged by the person in charge of the facility to be no longer incapacitated, if and only if: (1) The person refuses to be transported to an appropriate facility for treatment, or if once there, refuses treatment or leaves the facility before he or she is considered by the responsible staff of that facility to be no longer incapacitated; or (2) No

approved substance abuse treatment program with detoxification capabilities and no staff physician or other medical professional at the nearest licensed general hospital can be found who will accept the person for treatment. (e) No person shall be lodged in a lockup or community correctional center under subsection (d) of this section without first being evaluated by a substance abuse crisis team, a designated substance abuse counselor, a clinical staff person of an approved substance abuse treatment program with detoxification capabilities or a professional medical staff person at a licensed general hospital emergency room and found to be indeed incapacitated. (f) No lockup or community correctional center shall refuse to admit an incapacitated person in protective custody whose admission is requested by a law enforcement officer, in compliance with the conditions of this section.”

⁴Ibid.,: (9) ‘Incapacitated’ means that a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication, or mental confusion resulting from withdrawal, such that the person: (A) appears to need medical care or supervision by approved substance abuse treatment personnel, as defined in this section, to assure his or her safety; or (B) appears to present a direct active or passive threat to the safety of others. (10) “Intoxicated” means a condition in which the mental or physical functioning of an individual is substantially impaired as a result of the presence of alcohol or other drugs in his or her system. Vermont State Statutes Title 33, chapter 7.

⁵ These were the recommendations made to the legislature in the January 2008 report:

- Develop a system and protocols that allow for the 1977 statutes to be put into practice statewide.
- Develop shelters strategically placed where there is no current placement for inebriate diversion.
- Standardize state-wide public inebriate screening by designated providers through the use of an agreed-upon tool and adequately hire and train staff to administer it.
- Explore innovative methods or services providing secure management of an incapacitated person while they are in the agitated stage of intoxication, with the goal that once beyond this stage the inebriated person will be more amenable to accept a non-correctional option for placement.
- Assess whether screeners’ liability for outcomes can be limited, as long as quality standardized screenings are used as directed.
- Assess possibilities for transportation and investigate whether existing programs can be leveraged to facilitate.
- Offer regular emergency management training for police officers, state troopers, correctional personnel, and clinicians that publicizes established beds and the limits of medical care for inebriates in correctional facilities.
- Each year, report to the legislature the status of barriers that continue to exist regarding implementation of the statute on public inebriates, such as the number of diversion beds or insufficient interagency collaboration.
- Prioritize resource allocation and bring components in line with utilization.
- Conduct an analysis to develop recommendations on the sustainability of existing programs, as well as investigating what resources will be necessary to fund the needed expansion.
- Assess the possibility of requiring Medicaid recipients with caseworkers to check in with their caseworkers to see what additional assistance is needed for them.
- Pilot: small Agency of Human Services task force to develop coordinated care management (Blueprint model) for chronic inebriates known to the system with aim to divert a percentage of them into longer-term solutions in order to reduce cost where this issue seems most pressing.

⁶ The definitions in the statutes are as follows: (9) ‘Incapacitated’ means that a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication, or mental confusion resulting from withdrawal, such that the person: (A) appears to need medical care or supervision by approved substance abuse treatment personnel, as defined in this section, to assure his or her safety; or (B) appears to present a direct active or passive threat to the safety of others. (10) “Intoxicated” means a condition in which the mental or physical functioning of an individual is substantially impaired as a result of the presence of alcohol or other drugs in his or her system. Vermont State Statutes Title 33, chapter 7.

⁷ Sec.12. 33 V.S.A. § 708a. Sec.22. (a) Effective Dates specifies:” Secs. 11 and 12 of this act shall take effect on July 1, 2011.”

⁸ See Appendix A for statistical data for 2009.