CHRONIC ALCOHOL USE WITH JUSTICE-SYSTEM INVOLVEMENT REPORT

An Evaluation of the Marin County System of Care and Recommendations for Improvement

FEBRUARY 2013

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EXECUTIVE SUMMARY

In Marin County, as in many counties around the country, there is a growing concern with spending on certain high-need people, including those who frequently encounter the criminal justice system as a result of alcohol abuse. These individuals tend to continually cycle through some of the most expensive public service providers, yet do not receive appropriate care to meet their complex needs. As a result, they can exhaust thousands of dollars in public resources, with little or no improvement in their quality of life.

In response to this concern, the Marin County Department of Health and Human Services (HHS) was interested in evaluating the current system of care in Marin, investigating the costs of serving this population, and identifying best practice-based recommendations to better and more cost-effectively serve this population. To accomplish these goals, HHS convened an Advisory Group comprised of representatives from numerous county and city agencies to inform and oversee this report.

CURRENT MARIN COUNTY SYSTEM OF CARE

An examination of the system of care in Marin shows that there are a multitude of services available to assist different populations in the county. However, there are few agencies that specifically serve or have the capacity to target those individuals who cycle through the justice system due to their alcohol use. As a result, many frequently receive the majority of their services from those agencies that should function more as a last resort, and offer the most expensive services with a lack of targeted treatment.

In Marin, law enforcement is one of the most frequent service providers for this population. Police officers are responsible for handling individuals who are drunk in public, and often pick them up in the community for violating California Penal Code §647(f). Once they have someone in custody, the police have limited options to help find them assistance. While there is a detoxification center in Marin, The Vine, limitations in its medical capacity prohibit admission of the many chronic substance abusers in this population. Most often, the police will have no option but to take the individual either to a local emergency department for a medical evaluation or to the jail for custody. As a result, many people enter the criminal justice system and spend time in jail. Once they are released, the majority of people cycle back through this system without ever having their most serious needs met. While there are strong program models throughout the county, particularly in the courts and mental health systems, many individuals in this population either do not qualify or are not a priority for their services.

COSTS TO THE SYSTEM OF CARE

Given the cycle of individuals frequently receiving services through these various high-cost providers, HHS was interested in investigating the true impact of chronic alcohol users on public funds. To facilitate this process, the District Attorney's Office compiled a list of the individuals in the county most frequently arrested for §647(f) violations over the course of one year. That list of 34 individuals became the sample population for which data was collected.

County agencies and service providers from each facet of the current system provided information on how often individuals in the sample population utilized their services, as well as the average cost per service. When the costs are accumulated, Marin spent approximately $2,039,463 on serving these 34 individuals. However, actual costs are most likely much greater, as several large service providers did not report data. Additionally, those that did report were typically conservative with their estimates.

SERVICE GAPS AND RECOMMENDATIONS

Considering how much is spent each year on serving individuals in this population without truly improving their outcomes, it is important to identify the large gaps in service to help recognize where changes can help the county better meet their needs. With this analysis, there are several recommendations from this study, listed in order of feasibility and cost:

- ***Designate the Forensic Multi-Disciplinary Team (FMDT) as the Body to Oversee the Continuing and Coordinated Efforts.*** This recommendation addresses both the concern about disjointed intervention efforts throughout the county, and provides strong and knowledgeable leadership for overseeing completion of the other recommendations.
- ***Expand the Capacity of the FMDT to Conduct Outreach and Follow Up***. To accomplish this recommendation, the FMDT will begin to function more similarly to an Assertive Community Treatment team and provide low-barrier and ongoing support and treatment to this population.
- ***Develop a Jail Diversion Program***. By creating a Treatment In Lieu of Incarceration program in the county, the courts can help divert repeat offenders away from the criminal justice system and into treatment.
- ***Establish Targeted Scattered-Site Permanent Supportive Housing*.** Research demonstrates that housing is an effective method of improving outcomes and quality of life for homeless chronic alcohol abusers. Both the public and those in this population would benefit from the creation of low-barrier housing with wrap-around supportive services.
- ***Create a Viable Medical Detoxification Option.*** After researching the current need, Marin should explore options for providing detox services with medical supervision. This would help divert many intoxicated individuals from the emergency department, potentially saving hundreds of thousands of dollars per year, and provide a more targeted and appropriate level of care.

INTRODUCTION

Across the country, there is a growing awareness of the high cost to public agencies and the complex needs of individuals with chronic alcohol use. Especially when coupled with homelessness, many people with addiction issues cycle through the criminal justice system, emergency health systems and various treatment options. This can lead to a strain on public resources, as the majority of these services for this population are paid with county or other local funds. In response, many localities are beginning to examine the system of care they have in place in an effort to develop, implement and evaluate cross-system strategies to improve the quality of life and reduce public costs among people with these complex unmet needs.

Similarly, in response to a growing concern about poor outcomes for this population in Marin County, the Department of Health and Human Services (HHS) commissioned this report to examine the impact these individuals have on public resources and how the system of care can be improved to meet their needs. Specifically, Marin was concerned about the alcohol-addicted population that continually cycles through the various arms of the criminal justice system. While identifying the gaps in services and costs to the county are important, HHS was particularly interested in exploring ways to implement evidence-based practices to more effectively serve these individuals.

This report is a product of a great deal of collaboration within the county to address these issues. Conversations with the Marin County Sheriff, the Public Defender, the Public Guardian, local hospitals, the City of San Rafael and various treatment providers helped build the momentum and interest in more deeply exploring potential solutions. To oversee the collection of data and inform the direction of this report, HHS convened an Advisory Group made up of experts from various county agencies that serve the target population.[1] It also convened several larger meetings of county policy makers to vet recommended solutions and determine their feasibility.

The following report attempts to provide a comprehensive look at how the current system of care functions, including a detailed look at the costs incurred by the county by serving alcoholic individuals with repeated justice-system involvement. It also identifies those areas where there are gaps in the available services, and poses several solutions to improve the system of care as it relates to these frequent users.

OVERVIEW OF THE MARIN COUNTY SYSTEM OF CARE FOR INDIVIDUALS WITH CHRONIC ALCOHOL USE AND JUSTICE-SYSTEM INVOLVEMENT

The system of care for individuals addicted to alcohol with justice system involvement is comprised of private and public organizations seeking to improve the lives of both individuals in the population and the community as a whole. While each separate component addresses these

1 The Advisory Group includes representatives from the County Administrator's Office, various divisions of Health and Human Services, the Superior Court, the District Attorney's Office, the Public Defender's Office, the Public Guardian's office, the San Rafael Police Department, and the City of San Rafael.

needs with its own expertise and available services, there is concern in Marin that the current system is not as integrated and collaborative as it can be. In order to identify the appropriate interventions for frequent users in Marin, it is important to understand the way the current system works and how individuals move through it.

LAW ENFORCEMENT

Law enforcement, specifically local police departments, plays a significant role in connecting individuals with chronic alcohol use to the available services in the county. If a person is found to be extremely drunk in public or committing a quality of life violation,[2] police officers are typically the first responders to the situation. They are often forced to make decisions about whether to arrest someone or, as an alternative, about the individual's level of need and the appropriate place for them to receive assistance.

If an officer judges that someone is so intoxicated that he cannot be left on his own, the officer has several options for detaining him: The Vine Detoxification Center,[3] local hospital emergency departments or other medical treatment facility, or the county jail. Often, due to the medical license limitations of The Vine Detoxification Center and the jail, the only place that the officer can drop off an individual is the most costly to the county – an emergency department. However, unless the individual presents a clear medical emergency, even the hospitals are typically only able to perform routine checks.

Whatever the location, these individuals are typically allowed to leave within a few hours. Those taken to jail and charged are usually released with a promise to appear at a later set court date. The Vine only requires individuals to stay for at least four to six hours to monitor any symptoms as they detoxify; after that they are free to leave. Similarly, medical centers will discharge someone once they are examined and medically cleared. According to numerous accounts, it is not uncommon for an individual that is quickly released from one of these facilities to be picked back up by law enforcement on the same day. This continuous cycle of officers responding to, transporting, and dropping off intoxicated individuals takes a significant amount of resources and curbs their ability to carry out their other crime prevention duties.

COURT SYSTEM

Once an individual is arrested for being intoxicated in public and taken to jail, he is usually charged with violating §647(f) of the California Penal Code. This charge is a misdemeanor for being intoxicated to a point that the individual is unable to exercise care for his own safety or the safety of others, or interferes with, obstructs or prevents the free use of any street, sidewalk, or other public way.[4] Because this is a misdemeanor, the individual goes before a judge and can face jail time. While chronic alcoholics can be charged with other crimes, the majority of misdemeanor cases against these individuals in Marin County are for drunk-in-public violations.

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2 Quality of life infractions include jaywalking, drinking alcohol from open containers and urinating in public, among others.

3 See below: Alcohol and Other Drugs, page 7-8.

4 CA Penal Code Section 647(f).

Until the beginning of 2013, all §647(f) cases were heard in Courtroom M of the Marin County Superior Court. Since that time, the court has been restructured and misdemeanor cases can be handled alongside felonies in any of the five courtrooms. Judicial staff report that a considerable amount of the court's time is spent handling these types of cases, despite the fact that the group of people commonly arrested for this type of misdemeanor is not that large – around 25 to 50 people at any given time.[5] However, these individuals cycle through the court on a regular basis. In fact, it was reported that it is not uncommon for a person to be arrested and charged with a §647(f) infraction more than once in a 24-hour period. Moreover, one charge can result in numerous court appearances.

The court, under the leadership of Commissioner Wood, has implemented various strategies to try to reduce the impact that these cases have on the court caseload and the individuals involved. One such alternative involves fashioning longer sentences to give the individuals enough time in jail to detoxify from their alcohol addiction and break the cycle of continually being arrested for alcohol-related crimes. Another is to impose less jail time, in an effort to not be overly punitive and disruptive to the individual's life. The court has even tried allowing individuals to enter alcohol treatment rather than go to jail. None of these solutions, as they were implemented in Marin County, have had much of an impact on the recurrence of arrests. Currently, the court imposes the standard sentencing structure for the §647(f) misdemeanors.

Marin has several issue-specific problem-solving courts that occasionally serve chronic alcoholic individuals. Legal Aid of Marin, the St. Vincent de Paul Society and the Superior Court collaborated to develop the Community Court, which helps homeless and precariously housed individuals handle their outstanding infractions and citations without having to go through traditional court procedures. For this population, even small infraction tickets typically carry a fine, and they can get increasingly expensive as they accumulate. Instead of paying a fine for an infraction, for example, the participant may be asked to perform community service or apply for mainstream benefits. While this court has been successful in helping many people, it is not able to handle the §647(f) cases because those are misdemeanors, not infractions.

Marin also has a mental health court, the Support and Treatment After Release (STAR) Court, which handles cases for persons with serious mental illness who are in need of treatment and other services.[6] Participants must agree to have their case handled by the court and are required to follow an individualized treatment plan and sign a contract with the court saying that they will abide by the it. Once an individual has completed the program, he may have his misdemeanor-related case dismissed, jail sentence stayed and/or probation terminated. While §647(f) charges can be handled through this court, many individuals with chronic alcohol use do not qualify because they do not have a serious and persistent mental illness.

Marin also has a specialty court designed to provide structured outpatient treatment for those convicted of drug-related, but non-violent, crimes. Once an individual pleads guilty, they are offered the opportunity to engage in Adult Drug Court. Upon program enrollment, participants are required to complete self-help and drug treatment programs, as well as counseling. They meet with a probation officer on a regular basis and make frequent appearances before the

5 Interview with Commissioner Beverly Wood, Marin County Superior Court, November 19, 2012.

6 For additional information on the STAR program, see below: Mental Health, page 7.

court. Participants are subject to random urine tests to ensure they are not using drugs. The program takes 13 months to complete, and participants move through four phases before they can graduate.[7] At that point, they are eligible to have their case dismissed, sentence stayed, and probation terminated.

While these courts are effective in serving their target populations, no specific court program exists in Marin to deal with the complex needs of chronic alcoholics who are in regular contact with the justice system. As such, the Superior Court is inundated with cases against these individuals, particularly for §647(f) cases, and many end up serving time in jail.

MARIN COUNTY JAIL

Once an individual is sentenced to jail time, the Sheriff's office and the jail offer several services to help intervene and find solutions for the chronic alcoholic population. While serving time, the jail offers programming to help address certain needs, such as drug and alcohol abuse, anger management, and behavior modification courses. In fact, the jail is currently in the process of creating more robust education and treatment-focused opportunities under California Assembly Bill 109.[8]

In addition to internal program opportunities, one entity that serves this cohort is the Marin County Sheriff's Office Reentry Team. This team, which is comprised of members from the Sheriff's Department, the Probation Department, Health and Human Services, and community-based organizations, focuses on helping people housed in the jail make a successful transition to the community and reduce their likelihood of recidivism. Meeting twice per month, the team reviews a list of all inmates scheduled for release within 60 days. They brainstorm ideas on how to address each individual's issues and identify ways to connect them with services that will help them transition into the community – both while still in jail and once they are released. They may recommend that someone partake in one of the jail's course offerings while still in custody, such as behavior modification courses or educational opportunities. In the weeks leading up to the inmate's release, the team works with providers in the community to identify spaces in appropriate programs, such as substance abuse or mental health treatment; identify potential housing; investigate whether they qualify for conservatorship through the Public Guardian's Office; connect them to veteran's services; and refer them to organizations to help them receive necessities, including applying for mainstream benefits.

While the Reentry Team has worked with many chronic alcohol users, it does have some limitations. Because of its structure, it only works with individuals with a known release date. Also, a shortage of staffing prevent them from conducting much follow up, although some accountability is provided through collaboration with probation officers and incorporating Reentry Team strategies into the overall plan for the probationer. The Reentry Team is also investigating the possibility of creating a Daily Reporting Center, which would be a central location for all required probation check-ins, testing and completion of courses. The center

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7 The Adult Drug Court phases are as follows; Phase 1, Treatment and Intensive Supervision (90 days); Phase 2, Integrating Substance Abuse Treatment with Life (60 days); Phase 3, Maintenance and Independent Choices (60 days); Phase 4, Integrating Recovery Needs (180 days).

8 Assembly Bill 109 (AB 109) is a California prison realignment bill that places some of the responsibilities of the state's prison system on the county jails. As a result of AB 109, jails around the state are housing more people for longer periods of time. The bill provides additional funding to counties to help handle this new responsibility, including more funding for programs to address the needs of those in jail.

could provide additional services, treatment, references and education as needed. However, nothing like this currently exists in Marin for the criminal justice-involved population.

FORENSIC MULTI-DISCIPLINARY TEAM

After recognizing some people require additional assistance navigating the current system of care in the county, a former San Rafael Police Department officer, Joel Fay, founded the Forensic Multidisciplinary Team (FMDT).[9] The goal of the FMDT is to monitor individuals who are identified as needing additional assistance with connecting to the services and resources that can help them. This can include referring an individual to mental health or substance abuse treatment, finding housing or being placed on conservatorship under the Public Guardian. The strength of the team comes from its broad membership of various service providers in the county, including representatives from the criminal justice, mental health, substance abuse and homeless services fields, among others. In September 2011, the FMDT came under the direction of a Leadership Team, comprised of representatives from the Public Guardian's Office in partnership with the Probation Department and the San Anselmo Police Department.

The FMDT monitors between 15 and 25 individuals at a time. Referrals come through a variety of agencies, including law enforcement, the Public Guardian's Office, mental health treatment providers, or any of its partner agencies. When taking on a new case, the team will discuss the individual's unique circumstances and challenges, brainstorm ways to help them connect to necessary services, and create an individualized plan to meet any outstanding needs. If an individual is identified prior to release from jail, the team will coordinate a mental health assessment while the person is still in custody. Particularly with the chronic alcoholic population, they will test the individual for alcohol-related dementia, a common consequence of long-term or excessive drinking. The team may also make referrals to community resources, in particular the Ritter Center,[10] prior to release to help connect the individual to medical care, apply for benefits and set up representative payee services.

The FMDT holds a person on its caseload until he has been successfully connected to the necessary services or they determine that they are not able to assist him. However, the team does not bring the individual into the meetings in which he is discussed, nor does it have a staff person to formally monitor or supervise clients. It uses a network of county agencies, including the STAR and Community Alternative Response Team (CARE) teams,[11] the Probation Department and any other agency or nonprofit that has regular contact with the individual to follow up on whether he is adhering to the plan. The group will even try to work with those that refuse help, although capacity issues prevent them from trying to engage these people for extended periods of time.

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9 The current team is comprised of representatives from the Public Guardian's Office, the District Attorney, the Public Defender, the Probation Department, Marin Mental Health and Substance Use Services (including Alcohol and Drug, Jail Mental Health, the STAR and Odyssey teams and Psychiatric Emergency Services), several local police departments (including San Rafael, San Anselmo/Twin Cities, Novato and Sausalito), the Sheriff's Office, Jail Nursing, Adult Protective Services, Mill Street, Ritter Center, Voyager/Carmel, Buckelew Programs, National Alliance on Mental Illness (NAMI), Marin General Hospital, Patients' Rights Advocates, Marin Humane Society, College of Marin, the Marin Housing Authority and the Family Service Agency of Marin.

10 See below: Homeless Services, page 8-9.

11 See below: Mental Health, page 6.

MENTAL HEALTH

There are several services in Marin that focus specifically on those with mental illness and who may also have chronic alcohol abuse issues. Individuals contact these treatment options through many different avenues, including jail, the Sheriff's Reentry Team, the police, homeless service providers, such as the Ritter Center, and family. In addition, the Marin Division of Mental Health and Substance Use Services provides mental health treatment in the county jail. Privately funded community resources for mental health treatment include the Enterprise Resources Center and the Ritter Center.

For those in an acute mental health crisis, Marin offers stabilization care at the Psychiatric Emergency Services (PES) unit. The unit is open 24 hours per day, 7 days per week. People in crisis can be brought in by police, be referred by other Marin County agencies or self-refer. Intoxication does not prevent admission to PES. However, because the unit is not staffed to handle complex medical issues related to detoxification, anyone experiencing such symptoms would be sent to an emergency department for treatment. If someone does not fit the criteria for admission, the staff will work to find a more appropriate placement, such as the The Vine Detoxification Center. Upon admission to PES, the individual is evaluated over a 24-hour period and treated as necessary. Once the individual has stabilized, the PES staff work to refer him to longer-term mental health treatment. They also refer to substance-abuse treatment facilities for those who would benefit from that level of care.

Marin has several roving mental health outreach teams that connect with the seriously mentally ill in the community. The Odyssey Team, a program run by the Mental Health and Substance Abuse Services Division, provides a continuum of treatment options to homeless individuals who are seriously and persistently mentally ill. The team works with 60 individuals at a time and provides outreach, case management, psychiatric treatment, employment assistance and supportive housing services to its clients. The Odyssey Team works closely with the Community Alternative Response Team (CARE) Team, which is run by Community Action Marin. The CARE Team is a homeless mobile outreach team that travels throughout the county to engage with mentally ill homeless individuals five days per week.[12] Once identifying a client, the team continues to follow up with that individual until he is ready to engage in treatment, which can often take months. In addition to linking people with available mental health and substance abuse services, the CARE Team provides basic necessities to those on the streets, such as socks. While both the Odyssey and CARE teams can work with those that have substance abuse issues, all of their clients must primarily present with a serious and persistent mental illness to receive ongoing assistance.

In 2012, Marin's Health and Human Services (HHS) created the Alliance in Recovery (AIR) program to engage and treat individuals with co-occurring substance use disorders and mental illness. Through collaboration with Center Point, a substance abuse treatment provider in Marin County, the program serves up to 20 people at a time and is designed to engage those who have struggled to succeed in more traditional treatment settings. The AIR program provides clients

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12 In addition to the countywide CARE Team, at the end of January, 2013, Community Action Marin piloted a second CARE van to focus exclusively on the homeless population in San Rafael. This team will assist individuals who have a mental illness, substance abuse issue, or both. They will work closely with the San Rafael Police Department and business community to identify and target individuals in need of assistance. The new team will also have a nurse practitioner on staff 20 hours per week to assist with medical screenings and to administer vaccinations.

with case management, individual and group counseling, psychiatric and substance abuse treatment and assistance developing independent living skills.

The Support & Treatment After Release (STAR) program, a collaborative effort between the Marin County Superior Court and Marin County Mental Health, among others, serves mentally ill individuals who are involved with the criminal justice system.[13] The STAR Team, consisting of social workers, mental health care practitioners, local law enforcement, probation officers and employment counselors, carries out the STAR program's work. Many of the program's clients were arrested for minor crimes, often related to symptoms of their mental illness, and can elect to participate in the program as an alternative to traditional supervised probation. Once in the program, each participant receives an individualized treatment plan that includes medication and treatment compliance, case management, life skills education, housing and other support services. The goal of the program is to decrease the participant's interaction with the criminal justice system.

While there are a myriad of mental health treatment options available to those who are homeless, have substance abuse issues and/or have frequent contact with the criminal justice system, restrictive eligibility criteria are a significant barrier to access. One of the most restrictive qualifiers is the requirement that the individual have a serious and persistent mental illness. While many people who chronically use alcohol may have mental health issues such as depression, anxiety or trauma,[14] often those are not considered serious mental illnesses. This leaves a huge gap in available and affordable care options for chronic alcohol-using individuals.

ALCOHOL AND OTHER DRUGS

Marin offers several treatment opportunities for those who chronically abuse alcohol or other substances and are without the means to afford other options. In fact, some programs have designed certain aspects of their program to directly serve the chronic alcoholic population that is the focus of this report.

One of the resources that specifically targets this group in Marin County is The Vine Detoxification Center. The Vine is a non-medical detoxification program that allows individuals a place to safely withdraw from the symptoms of drugs and/or alcohol. Currently, The Vine has contracted 11 beds, with a total capacity of 24. Two of contracted beds are specifically designated for homeless individuals who have chronic alcohol use issues;[15] these beds are typically either at or over capacity.

People can enter The Vine through a variety of entry points. However, many homeless individuals are typically brought to The Vine by police, who pick them up on the streets for being drunk in public. Before someone can be admitted to The Vine, he must be medically cleared; The Vine is not sufficiently medically-staffed to handle any complex medical issues such as a head injury or seizures.[16] Typically, a police officer will call before bringing the individual to The

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13 See above: Court System, page 3.

14 Call with Chris Kughn, Marin County Health and Human Services, Division of Mental Health Services, December 11, 2012.

15 In addition, six beds are for the general public, two serve individuals on probation through AB 109 and one is reserved for perinatal women.

16 The San Rafael Police Department (SRPD), which interacts with individuals with chronic alcohol use on the streets on a regular basis, reported that they almost never refer to The Vine anymore. Due to the lack of appropriately-trained medical staff, The Vine is reluctant to take almost anyone they bring in that is at any risk

Vine to check if there is bed availability. At that time, staff conduct a brief phone screening to ensure that the person is not suffering from any serious medical injury or condition. If he is medically cleared and admitted to the facility, the individual is required to stay between four to six hours so that staff can closely monitor him during the early stages of detoxification. Staff at The Vine have some basic medical training, such as first aid and CPR, and conduct regular vital signs checks on all clients during that time. If the individual is going to stay for longer than four to six hours, however, staff are given the option to take him out for a medical evaluation.[17] These checks can take place at the Ritter Center medical clinic during normal business hours. If Ritter is not open, staff must go to the more expensive option of either Marin General or Novato Community Hospital.

Upon completing a stay at The Vine, staff work to help the individual connect with formal substance abuse treatment programs. One resource that is available is the Safety Net Program, a collaboration between Center Point and Homeward Bound of Marin, a housing provider in Marin County. The program provides intensive outpatient treatment and housing to those who are homeless. As long as an individual is participating in treatment, he is guaranteed a bed at the Mill Street shelter for single adults. Once he completes the first thirty days of the program, he moves to New Beginnings, a longer-term shelter option, to continue his treatment.

There are other substance abuse treatment programs in the county, including inpatient and outpatient programs at Center Point. However, many may not be accessible or feasible for those in this report's target population, particularly for those who are homeless. The programs with no cost to the patient have very limited openings, and other programs can be expensive. Additionally, many treatment programs have very high expectations that make it difficult for some high-needs individuals to succeed. Specifically, some require long days of treatment sessions for extended periods of time. For an individual that may be lower functioning or lack certain life skills, it can be difficult to meet these standards and remain in the program.

HOMELESS SERVICES

There are several service providers that work with individuals who chronically use alcohol and are also homeless or precariously housed. The assistance they provide can range from providing a shower and food to placing someone in permanent housing.

The Ritter Center in San Rafael is a low-barrier services and housing provider that works with individuals to both prevent homelessness and help those who are homeless become housed. It serves as both the "front door and last resort" to many individuals that are homeless in Marin.[18] To accomplish this, the Ritter Center offers many basic necessities, such as food, showers, laundry and mail, in addition to case management, benefits counseling, medical care, and mental health treatment. It also operates the county's only Housing First program,[19] which

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of having a medical complication. According to the SRPD, they are regularly told by staff that they need to get a medical clearance for the individual before they can be admitted to The Vine. Because of the time it takes for an officer to gain such clearance – they have to wait with the individual at the medical clinic or hospital while they are evaluated – the officers do not have the capacity to do this. As such, they avoid taking individuals to The Vine, and take them to either the county jail or the emergency department instead.

17 The average length of stay for this population is around one day.

18 Interview with Diane Linn, Ritter Center, December 12, 2012.

19 The Housing First model allows individuals to move into permanent housing before addressing other issues, such as substance abuse. The philosophy behind the model is that housing is a primary need and must be addressed before an individual is capable of making other life changes.

provides housing accompanied with a range of wrap-around services to the chronically homeless population of Marin. Finally, Ritter runs a comprehensive medical clinic, which became a Federally Qualified Health Center in 2011. The clinic provides primary and urgent care to the homeless and other uninsured patients. It also provides mental health treatment and substance abuse counseling.

Other providers, such as Homeward Bound of Marin and the St. Vincent de Paul Society of Marin County, offer many necessary services that may be used by the chronic alcoholic homeless population. In addition to the New Beginnings and Mill Street shelters mentioned above,[20] Homeward Bound provides transitional and permanent housing for single adults. St. Vincent de Paul provides a dining room, support services, home visits and affordable housing to homeless and low-income individuals. It also runs the Rotating Emergency Shelter Team (REST) program, which provides seasonal shelter for homeless individuals during the winter months. In addition, the Marin Housing Authority offers supportive housing to mentally ill homeless individuals through its legacy Shelter Plus Care program. The Housing Authority works with the Odyssey program to house some of their clients, among others.

CITY OF SAN RAFAEL

The concentration of intoxicated people on the streets of San Rafael has led community groups, local businesses and the police department to take steps to address this populations' needs and decrease its visibility and potential disruptiveness. While not necessarily part of the system of care, the city is currently focused on developing intervention methods and has begun to take steps to address these concerns.

In response to pressure from downtown businesses, the San Rafael Police Department (SPRD) recently began an initiative to more aggressively issue citations for quality of life infractions, such as jaywalking, drinking alcohol from open containers and urinating in public. The policy was intended to target certain types of behavior, not individuals, but nonetheless the majority of individuals given citations were homeless, many of them with chronic alcohol abuse issues.[21] To hold people accountable without large repercussions, the SRPD worked with the homeless service providers in the area, including St. Vincent de Paul Society and the Ritter Center, to develop non-judicial penalties. An example of an alternative sanction used would be to require the individual to sweep St. Vincent de Paul's floors instead of paying a fine.

In addition, the SRPD teamed up with the San Rafael Community Coalition to address the issue of alcohol availability in the city. Under the assumption that the more alcohol is available, the more people will use it, they have approached liquor stores and the downtown Safeway to encourage them to adjust their policies. While they have not had much success with the liquor stores, Safeway made several changes to reduce the availability of alcohol. One example is that Safeway hired a security guard to watch over the liquor aisles of the store. They also placed "food-only" restrictions on gift cards sometimes given to the homeless by service providers.

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20 See above: Alcohol and Other Drugs, page 8.

21 Interview with Lieutenant Ralph Pata, San Rafael Police Department, January 14, 2013.

SUMMARY OF SYSTEMS OVERVIEW

Based on this review of the current system of care, it is clear that Marin County has many services to assist individuals with chronic alcohol abuse issues. While some individuals have made great strides in improving their lives as a result of these services, there are many others that fall through the cracks of the system. One current concern in the county is that many people in that population repeatedly cycle through these various agencies, especially those that are more costly, without success.

COSTS TO THE MARIN COUNTY SYSTEM OF CARE

Based on the vast array of services available to those individuals with alcohol addiction and justice-system involvement in Marin, the Marin County Health and Human Services Agency (HHS) was interested in learning about the financial burden this population places on public resources. Research in other communities and anecdotal evidence in Marin County suggested that the costs to the system could be significant.[22] There is also the concern that the resources currently being used to serve these individuals are not the most effective in addressing their needs, and that they are overburdening the system of care. In order to justify investment in additional services that would better target this population, it is important to understand how much is currently being expended by the county.

DEFINING THE SAMPLE POPULATION

Prior to collecting data, the Advisory Group was assembled to oversee the study and data collection.[23] This group took on the responsibility of defining the study population in a way that allowed for an accurate reflection of the costs to the county, while protecting the privacy of the individuals involved. As the focus of the study evolved to concentrate on those who utilize the most county resources, including the criminal justice system and treatment services, it became most logical to focus on those individuals who were most often arrested for and charged with being drunk in public. As described in the Systems Overview section above, these individuals often cycled through most, if not all, of the available services and would most likely account for a significant burden on county resources.

To develop the list of individuals that best fit this characterization of the issue, the District Attorney's Office used its records to identify all of the individuals who had been referred for prosecution six or more times for §647(f) violations in the county during a one-year period from June 1, 2011 to May 31, 2012.[24] This generated a list of 34 individuals to make up the sample population. Demographically, 32 of the individuals in the cohort were male and the average age

22 For costs in other communities, see: Dunford, James V. et al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals of Emergency Medicin 47.4* (2006):328-36; Larimer ME, Malone DK, Garner MD, et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems." *JAMA 301.13* (2009):1349-1357; Moore, T.L., (2006, June). *Estimated cost savings following enrollment in the Community Engagement Program: findings from a pilot study of homeless dually diagnosed adults.* Portland, OR: Central City Concern; Floyd, CW. Anchorage Department of Health and Human Services. *The Chronic Inebriate Problem in Anchorage: Brief Overview*, 2007.

23 For a list of agencies represented on the Advisory Group, see page 1.

24 This year coincides with the year immediately prior to the beginning of the study.

was 47 years old. At least 31 of the 34 individuals were determined to be homeless,[25] 25 of whom had been homeless for over one year. Since the study began, two of the individuals in the sample population have passed away.

DATA COLLECTION EFFORTS

In an effort to acquire data as quickly as possible, the Advisory Group agreed that it would be best to collect existing data, rather than to start collecting prospective data. This approach did come with some limitations, including accounting for the variety of ways agencies and service providers gather and categorize their data. However, collecting data as quickly as possible was a priority, and data requests were drafted to address the concern.[26]

A collective effort by the Advisory Group resulted in a list of the largest providers in the county from which data should be collected. These included area hospitals, law enforcement agencies, criminal justice system agencies, mental health and substance abuse treatment agencies, and homeless service providers.[27] The list was designed to capture the current crisis and emergency resource utilization by the target population. However, it was not possible to identify and collect data from every organization in Marin County that provides assistance to chronic alcohol users. As such, the costs reported in this report are not fully representative of the costs Marin County expended to serve all frequent users.

Each agency from which data was solicited received both a data request and a list of names of the 34 individuals in the sample population. Prior to the request, HomeBase staff conducted a brief interview to identify those services the individuals in the sample population would most likely utilize. For each of the services identified during that phone call, the agency was asked to provide information about 1) the aggregate number of encounters for people in the study sample between June 1, 2011 and May 31, 2012; and 2) an estimate of the average cost per encounter. They were also instructed to keep the list of names confidential and informed that the list would not be used in connection with any version of this report. To protect the privacy of the individuals in the sample, data was de-identified.

The results of the data collection efforts are described below. While this data is the most accurate and representative of the costs to the system given the time restrictions and client confidentiality concerns, it does have some limitations. As mentioned, it does not capture all of the costs to the community. There are other service providers who interact with these frequent users that are not included in this report. In addition, not all interactions between service providers and the sample population have a direct correlation to their chronic alcohol use. It is also important to note that if utilization were reduced, the cost savings to these agencies would not necessarily be available for reinvestment elsewhere on a dollar-to-dollar basis. However, in

25 Based on data in Marin's Homeless Management Information System, 31 individuals were confirmed homeless, two were confirmed housed, and one individual had an "unknown" housing status.

26 See Appendix for sample data request.

27 Data was successfully collected from the following agencies: Marin General Hospital, Marin County Emergency Medical Services, the Superior Court, the District Attorney's Office, the Public Defender's Office, the Marin County Jail, the San Rafael Police Department, the Marin Probation Department, Marin Health and Human Services Mental Health and Substance Use Services, Center Point, and Homeward Bound. Despite efforts to do so, we were unable to collect data from Kaiser Permanente San Rafael Medical Center, the Novato Community Hospital, and Ritter Center.

many cases, it would reduce the burden on a strained system and allow agencies to refocus and prioritize the use of their resources.

HOSPITAL AND MEDICAL EMERGENCY COSTS

As expected, the largest costs to the system were accrued through visits to the emergency department and admissions at Marin General Hospital.[28] For the one-year period, the study cohort accumulated a total of $977,544 in hospital charges.[29] Overall, 24 of the 34 individuals went to the emergency department at least once. This group accrued a total of 90 hospital visits and/or admissions, or an average of 3.75 visits per person. The highest number of visits for an individual was 15 visits in the year. Of the 90 total visits to the hospital by this population, 33 of those resulted in a discharge to the Marin County Jail.

Due to the clear medical needs of this population, Emergency Medical Services (EMS) providers were often involved in responding to medical emergencies in the community and transporting individuals to the hospital.[30] Twenty-eight individuals in the study cohort had an EMS contact over the course of the study year. EMS provides three types of contacts: 1) basic life support (BLS) transport; 2) advanced life support (ALS) transport; and 3) no transport, which occurs when EMS responds but the individual refuses transportation. For the sample population, 12 individuals received BLS transports, for a total of 26 such transports; 23 individuals received a total of 80 ALS transports over the course of the year; and four individuals refused transport, which resulted in no transport.[31] With an average cost of $522 per encounter, these 110 EMS contacts resulted in a total cost of $57,420.

COURT-RELATED COSTS

All of the individuals in this study appeared in court for §647(f) charges at least once between June 1, 2011 and May 31, 2012. This resulted in a total of 1,587 appearances during the year, for an average of 47 appearances per person per year.[32] However, many individuals were in the court far more often than that, including one who had 187 court appearances during the year. These 1,587 appearances led to a total cost for the court of $145,972. These costs accounted for the proportional salaries of the courtroom clerks, court reporters, bailiffs and judges handling these appearances.[33]

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28 As mentioned above, data was not successfully collected from Kaiser Permanente in San Rafael or Novato Community Hospital. We expect both have large associated costs, as both routinely provide medical clearances and evaluations for individuals in this population.

29 These are based on billing costs, not actual costs, incurred by the hospital.

30 EMS transports typically consist of a paramedic ambulance and one fire department engine.

31 Despite not transporting the individual, a "no transport" still requires significant time on behalf of the EMS team and so is considered to have the same costs as a transport for purposes of this report.

32 While there were 1,587 appearances, only 197 charges were filed against members of this population (as described below). This discrepancy is a result of individuals being required to make numerous appearances for each case filed. For example, for one misdemeanor, a person who is regularly intoxicated may be charged 10 times for violations of their probation. For each violation, that person might make five or more appearances. Also, if a person had multiple cases, and all were called at the same time, their appearance in court would count for all cases in the courts records. For example, if they had 4 cases, this singular time in court would count as four appearances. These were not de-duplicated by the court in its analysis.

33 The costs were further broken down into "court costs" ands "state costs." The court costs accounted for the courtroom clerk ($13.55 per hour), court reporter ($20.15 per hour), and CPS III ($12.25 per hour) for a total of $45.95 per hour and a total of $72,923 for all appearances. The state costs accounted for the judge ($31.00 per hour) and bailiff ($15.03 per hour) for a total of $46.03 and a total of $73,049 for all appearances.

In addition to the costs of the court, the District Attorney (DA) and the Public Defender (PD) Offices provide legal representation that accounts for additional spending. The DA reported a total of 357 referrals for §647(f) cases during the year, which resulted in 197 filings, either in new cases or new sets of petitions to revoke.[34] Similar to the court's cost, the DA's costs are fixed, and so are based on proportional salaries for the individuals who handle the cases. For the 357 referrals, the DA reported a total cost of $6,667, with an average cost of about $18.68 per referral.[35] The total cost for the 197 filings was $4,738, with an average cost per case of $24.05.[36] Therefore, the DA's total costs for handling §647(f) cases for this population was $11,405.

The PD had similar costs, although only for those cases that were filed by the DA. For those 197 cases, the PD reported a total of $9,646. Just as for the DA, they included the proportional salaries for those involved in handling each case. Staff included a legal processing assistant, a Deputy Public Defender II and a Deputy Public Defender IV.[37]

JAIL COSTS

All but two of the individuals in the sample population spent time in the Marin County Jail during the study year. Between the 32 individuals that were held in custody, there were a total of 314 arrests and 3,256 days spent in the jail during that time. While it appears that some people only spent time in jail when they were arrested – for example, one individual had three arrests and three total days in jail – many in the sample population spent significant additional time in the jail for each arrest. The longest jail stay was 204 days by one individual who had 19 arrests over the course of the year.

The cost of housing these 32 individuals for the cumulative 3,256 days can be broken down into two categories – custody costs and medical-care costs. Custody costs account for the staff, meals and other general expenses it takes to house someone in jail. During the study period, it cost a total of $465,819 to hold these 32 individuals in the jail, with an average of $143 per person per day. In addition, there were significant medical costs. When including all of the various medical evaluations and treatments this group received during their time in jail, the county spent a total of $201,657 during the year.[38] All 32 individuals who were held in jail received some form of medical care.

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34 The DA's Office noted that the majority of sample population had other offenses other than §647(f) violations during this time period. These were not included in these figures, but may be related to their alcohol use.

35 These costs were composed of proportional salaries of a filing deputy (with a salary of $74.87 per hour and an estimated 10 minutes per referral, for a total of $4,455) and a legal processing assistant (with a salary of $24.78 and an estimated 15 minutes per referral, for a total of $2,212).

36 These costs were composed of the proportional salaries of a expediter or settling attorney (with a salary of $53.57 per hour and an estimated 20 minutes settlement time for review, negotiation and plea, for a total of $3,518) and legal processing assistant (with salary of $24.78 and an estimated 15 minutes for processing of a filing, for a total of $1,220).

37 The cost break down is as follows: legal processing assistant (salary of $24.78 per hour and estimated 30 minutes to locate, open and assemble files for each filing, for total of $2,441); Deputy Public Defender II (salary of $53.57 per hour and estimated 10 minutes for file review and 10 minutes for jail visit, for total of $3,518); and Deputy Public Defender IV, with salary of $74.87 per hour and estimated 5 minutes per settlement and 10 minutes per appearance, for total of $3,687).

38 The cost break down is as follows: $677.48 in medication for 8 individuals (does not include the basic medication that is available to everyone); $27,113 for 581 nurse sick calls; $11,648 for 96 family nurse practitioner visits; $937 for 15 doctor visits; $121,040 for 9,079 nurse contacts (by far the biggest expense; some individuals had over 1,000 contacts each per year); $10,320 for 3 individuals to receive care for their diabetes (including blood sugar finger sticks, insulin, and/or

OTHER LAW ENFORCEMENT COSTS

The nature of the sample population, especially the qualification that all were arrested for drunk-in-public offenses, requires that they had some interaction with local police departments. Due to the fact that the vast majority of people were located in San Rafael, this study focuses on data from that police department. However, because most police departments will have some costs related to this those in the study population, the police-interaction figures listed below are not comprehensive of the entire cost to the county.

The San Rafael Police Department had contact with 30 out of the 34 individuals in the study cohort. All but one individual had multiple contacts, including several with over 20 contacts during the study year. Overall the individuals in the sample were contacted a total of 337 times over the course of the year, which accounted for a total cost of $18,693. These costs were calculated by assuming one officer made each contact and the contact lasted for one hour.[39] However, as mentioned above, many §647(f) contacts take much longer than one hour and more than one officer is involved. As such, this is a very conservative estimate of the costs associated with police time in San Rafael.

As a result of their justice system involvement, a number of the individuals were also under the supervision of the Marin County Probation Department. There are several types of supervision, including Diversion, High Risk, Medium Risk, Adult Offender Work Program, and Community Service Work. The cost for each type of supervision is based on the proportional cost of the supervisor's salary. When accounting for all five categories of supervision, the Probation Department supervised a total of 13 individuals. This lead an overall cost of $10,930.[40]

SUBSTANCE ABUSE TREATMENT COSTS

Due to the definition of the study population, every individual has issues related to abuse of alcohol. As a result, many have cycled through various substance abuse treatment options available in the county. The most highly utilized service was the detoxification center, The Vine. During the study period, the individuals in the sample population accounted for 96 bed days at The Vine. This resulted in a total cost of $15,360, or $160 per person per day.

In addition to the detoxification at The Vine, several individuals participated in substance abuse treatment programs throughout the county. In total, $8,045 was spent on outpatient treatment. The majority of these costs were incurred by Center Point, one of the county's largest treatment providers for this population. Three individuals attended a total of 85 outpatient treatment groups at Center Point during the year. With an average cost of $75 per group, this accounts for $6,375 spent on this population in outpatient care.[41] The county spent an additional $2,755 in

oral medications); $6,880 for 215 mental health visits; $1,266 for 10 dental visits; $1,650 for 11 x-rays; $660 for 33 tuberculosis tests; $160 for 2 HIV tests; and $19,306 for 181 medical exams at booking.

39 Assumes an officer salary of $55.47 per hour.

40 The cost break down is as follows: $486 for Diversion (5 out of 481 supervisees, with annual salary of $46,738); $8,757 for High Risk (5 out of 45, with annual salary of $78,811); $918 for Medium Risk (1 out of 80 supervisees, with annual salary of $73,445); $679 for Adult Offender Work Program (1 out of 100 supervisees, with annual salary of $67,977); and $90 for Community Service Work (1 out of 625 supervisees, with an annual salary of $56,394).

41 This figure does not account for the more administrative costs associated with enrolling someone in outpatient treatment. For example, all candidates are assessed for eligibility before being accepted into the program. Certified counselors conduct the interviews and licensed professionals conduct the assessments.

residential treatment services. This includes one person who spent 15 days in Center Point's residential treatment program for a cost of $1,425.[42]

MENTAL HEALTH CARE COSTS

In addition to having problems with substance abuse, a portion of the individuals in the study sample had a dually-diagnosed mental illness for which they received treatment. The most highly utilized mental health treatment service was the Psychiatric Emergency Services (PES). During the study year, 13 individuals were seen for a total of 29 admissions. Services at the unit cost $137 per hour, and the average visit is 17 hours. As such, for these 29 admissions the county expended a total of $67,541. In addition, two individuals were assessed by the PES team, but not deemed in a psychiatric crisis and were not admitted. This is not included in the costs.

Another large cost in the mental health system results when an individual has a mental health crisis while in jail and must receive inpatient psychiatric care. Because Marin County does not have the capacity for this type of care, the county contracts with Santa Clara County to provide this service. One individual in the study sample experienced this level of crisis during the year and was sent to the Santa Clara County Jail Psychiatric Inpatient Unit for 24 days. At a cost of $1,500 per day, this treatment option cost the county a total of $36,000.

HOMELESS SERVICES COSTS

The majority of the individuals in the sample population were homeless during the time of the study, and many of them made use of the homeless services available in the county. One of the largest providers, Homeward Bound, offers shelter to homeless individuals in the community. Ten of the 34 individuals stayed in one of Homeward Bound's facilities during the sample year, for a total of 314 shelter days.[43] The average cost per person per day in shelter is $34, which includes 24-hour staffing, case management, a bed, a locker, and meals. The total cost for this population in shelter was $10,676.

SUMMARY OF COSTS

When the costs that were collected as part of this study are accumulated, Marin spent approximately $2,039,463 on serving 34 individuals classified as chronic alcohol users with justice-system involvement between June 1, 2011 and May 31, 2012. This is equal to nearly $60,000 per person per year. However, while the sample population was designed to capture those believed to have the highest need and most interaction with services in the county, it does not encapsulate all individuals in the county that are cycling through the provider agencies. As previously mentioned, it also does not capture data from some of the larger service providers, including two of the emergency departments in the county. Reported costs for some agencies may also be very conservative. Consequently, the costs incurred by the system may actually be much greater.

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42 The recommended residential treatment service stay is six months.

43 While only 10 of the individuals stayed in the shelter during the study year, it was estimated that almost everyone in the sample population has at one time stayed at a Homeward Bound shelter. Homeward Bound offers several shelter options, including Mill Street, New Beginnings and medical beds.

Figure 1: Total Agency Costs for June 1, 2011 – May 31, 2012

Type of Service	N	Total Encounters	Average Cost*	Total Cost
Medical Emergency Costs				
Hospital Costs (ED visits and admissions)	24	90 visits/admissions	$10,862 per visit	$977,544
Emergency Medical Services response	28	110 contacts	$522 per contact	$57,420
Court-related Costs				
Superior Court	34	1,587 appearances	$92 per appearance	$145,972
District Attorney (pre-filing costs)	34	357 referrals	$19 per referral	$6,667
District Attorney (post-filing costs)	34	197 filings	$24 per filing	$4,738
Public Defender time	34	197 filings	$49 per filing	$9,646
Jail Costs				
Custody	32	3,256 days	$143 per person per day	$465,819
Medical (including mental health and medications)	32	10,481 contacts	$6,302 per person	$201,657
Other Law Enforcement Costs				
Police contact (San Rafael)	30	337 contacts	$55 per contact	$18,693
Probation oversight	13	13 supervisees	$841 per person	$10,930
Substance Abuse Treatment Costs				
Detoxification services		96 bed days	$160 per person per day	$15,360
Outpatient substance abuse treatment				$8,045
Residential substance abuse treatment				$2,755
Mental Health Care Costs				
Psychiatric Emergency Services	13	29 admissions	$2,329 per admission	$67,541
Inpatient jail mental health care (out of county)	1	24 days	$1,500 per person per day	$36,000
Homeless Services Costs				
Shelter	10	314 days	$34 per day	$10,676
TOTAL			**$59,984 per person**	**$2,039,463**

*Costs are rounded to the nearest dollar

GAPS IN THE CURRENT SYSTEM OF CARE

Based on the amount of money being spent and the frequency of encounters with some providers, such as the county jail and hospitals, there must be more efficient and effective ways to meet the needs of the individuals in this population. While Marin County has a considerable number of programs and has made recent efforts to specifically address concerns around frequent users, there continue to be some significant gaps in services.

DISCONNECTED INTERVENTION EFFORTS

While there are currently many efforts in Marin focused on individuals with chronic public alcohol use in the county, these endeavors are neither coordinated nor integrated. Numerous non-profits, county agencies and community organizations are in the process of strategizing ways to address the major needs of this population. While these diverse stakeholders are motivated by different concerns, ultimately all have the same goal: to find a way to help safely move these individuals off of the streets and connect them to appropriate services. By duplicating the efforts in so many arenas, Marin runs the risk of diluting the resources and generating a less effective solution.

SHORTAGE OF LOW-BARRIER TREATMENT OPPORTUNITIES

Marin has several programs that target homeless individuals with a serious and persistent mental illness. Due to medical billing requirements and capacity, the programs are designed to handle only the most seriously mentally ill individuals in the county. However, it is very common for people who abuse alcohol to have other mental health disorders that are not considered "serious and persistent," such as depression or anxiety. While some resources in the community, such as those provided by the Ritter Center, can treat them, those programs do not have the same mobile and/or outreach aspect as some of the programs designed specifically for the seriously mentally ill. It can be difficult to engage a significant portion of the population of chronic alcohol users with treatment in the traditional setting.

Additionally, there are several agencies that provide a variety of substance abuse treatment options. However, many individuals with chronic alcohol abuse problems, especially those that are homeless and maybe lacking in some life skills, are not able to conform to the intensive schedules and high expectations of some of these programs. Programs that do accommodate the special needs of this group are limited and often full.

LIMITED ALTERNATIVE SENTENCING OPTIONS

If a person is picked up for being drunk in public and ultimately charged with a §647(f) misdemeanor, he goes before the court, which determines the disposition of the case. While judges have some discretion to try to address each individual's unique circumstances and needs, they must work within certain parameters. Currently, Marin has very limited alternative sentencing options in place for §647(f) cases. All people who are sentenced to 29 days or more in jail do have the option of applying "parole" instead of serving the sentence, which they may be able to spend in a residential treatment program or on electronic monitoring.[44] However, many choose to just take the time in jail, as half-time credit rules allow the time served to be even shorter. Also, while the court has worked with homeless service providers to create the Community Court process, at this time there is not a similar process through which a judge can handle a misdemeanor case. As a result, many who are frequently intoxicated in public spend a significant amount of time in jail.

LACK OF PERMANENT SUPPORTIVE HOUSING

One of the biggest deficits that exists in Marin is the lack of affordable supportive housing for the homeless. Marin is one of the most affluent counties in the state, and many people in the community are averse to developing housing for the homeless in their neighborhoods. While the housing providers do as much as they can with their funding, the demand for this type of housing far exceeds the supply. In addition, Marin traditionally has not provided much housing under the harm-reduction model, which allows individuals to receive housing while still abusing substances. This makes it very difficult to house individuals who have persistent alcohol abuse concerns that are not ready to enter treatment.

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44 Treatment under this option is not entirely paid by participants; it is typically based on a sliding scale according to income. Additionally, in some instances the Probation Department provides funding for treatment through Center Point at no cost to the client.

ABSENCE OF A MEDICAL DETOXIFICATION OPTION

While The Vine plays an important role in providing many people under the influence of alcohol with a safe place for withdrawal from their symptoms, they cannot admit anyone with potential medical complications. This is a particular concern because many chronic alcoholics tend to have such issues due to their prolonged substance use. Because of liability issues surrounding the lack of trained medical staff, The Vine is frequently unable to admit people in this population.[45] As a result, police officers, a frequent referral source for The Vine, must find an alternative appropriate placement for the individual. Especially after regular business hours or on the weekends, they have no option but to take an intoxicated individual in their custody to the more costly options of either the emergency department or county jail.

RECOMMENDATIONS TO IMPROVE THE MARIN COUNTY SYSTEM OF CARE

Marin County has committed to making changes to its system of care for the alcohol-addicted population that continually cycles through the criminal justice system. The concerns about the cost to the county and the visibility of these people have prompted a significant amount of effort to develop new interventions to address both the needs of the community and the individuals in the target population.

In planning sessions with the Advisory Group, made up of representatives from county and city agencies, a set of outcomes was identified to measure the success of new efforts made in the county. They were intended to respond to the largest inefficiencies identified through the cost study portion of this report and, in part, the gaps analysis. The outcomes include the following nine measures:

- Reduction in the number of contacts with the local police departments
- Reduction in the number of arrests county-wide
- Reduction in the number of days in jail
- Reduction in court appearances
- Reduction in frequency of detox visits
- Reduction in costs to local emergency departments
- Increase in the number of people who are housed
- Increase in the number of people engaged in treatment
- Reduction in overall costs to the county

Each of these recommendations should help in accomplishing several of these goals. The recommendations are interrelated and intended to work together to build the most complete system of care possible. While implementing these recommendations individually should advance these goals, the greatest impact would come from them all working in conjunction with one another.

The recommendations in this report are all based on best practices that other communities have used to improve the way their alcohol-addicted, and often homeless, frequent users interact

45 Interview with Lieutenant Ralph Pata, San Rafael Police Depatment, January 14, 2013.

with the criminal justice system and receive services. While some funding is available to support these efforts in Marin, a few of the recommendations may be costly or take additional time to research and plan. Marin does not have the same dense population or urban environment as other communities and may not have the capacity to build as robust or expensive programs as its larger counterparts.

Keeping funding and capacity issues in mind, the recommendations below are described in order of feasibility and expense, the first recommendation being the most feasible and least expensive. This report is intended to be a draft timeline for the county to begin its work to address the target population's needs. The first few recommendations should be considered first, as they will take less planning and funding to put into place. The later recommendations are the more robust, costly options, but could dramatically reduce the long-term costs to the county once implemented. While they may have significant impact, they will take additional resources and planning efforts to complete.

DESIGNATE THE FMDT AS THE BODY TO OVERSEE THE CONTINUING AND COORDINATED EFFORTS

In order to carry out the recommendations in this report, it is important to identify a group or task force that can take on the responsibility of making decisions, coordinating with the necessary providers, identifying funding and tracking outcomes. To be effective, the group should have a diverse membership, including all of the potential stakeholders who are affected by the problem and want to be involved in the solution. Ideally, it would include representatives from behavioral health and substance abuse treatment agencies, the legal system, law enforcement, hospitals and homeless services providers. This is particularly important when there are so many coordinated efforts around the city to address concerns about the chronically inebriated population.

The idea of creating a team to continue the important work of implementing interventions that both reduce the financial impact on the county and address the service needs of the population was discussed at a policy-makers meeting leading up to this report. Creating a new group to tackle this problem raised many concerns, mostly due to the fact that there is already such a disjointed effort in Marin when it comes to problem solving for this group. Adding another work group or task force seemed to be both inefficient and unnecessary.

Instead, the consensus was to increase the scope of an already existing group to assume this responsibility. Because it includes so many county agencies and non-profit organizations working with the target population,[46] the Forensic Multi-Disciplinary Team (FMDT) is the logical choice to assume this role. With its knowledge of the current service availabilities within the county and familiarity with the issues this population often faces, it should be the most effective group to carry out these recommendations.

If adopted, this recommendation will expand the current scope of the group, as it has historically not taken on this type of planning role. In doing so, the group should consider its capacity and whether it should expand to include additional organizations. It should also think about whether it should select a smaller subset of the team, other than the current Leadership

46 See description of the FMDT above at page 5 for list of representative team members.

Team, to spearhead the effort and how it can coordinate with the planning divisions of Marin County Health and Human Services. Once sources of funding have been identified, the group will need to develop a concrete timeline to implement the appropriate recommendations and identify outcomes to track in an effort to measure success.

EXPAND THE CAPACITY OF THE FMDT TO CONDUCT OUTREACH AND FOLLOW UP

One of the identified gaps in Marin County is the lack of low-barrier treatment options for individuals who are in contact with the justice system due to their alcohol abuse, especially for those who are not seriously mentally ill. Many people may slip through the cracks of the currently available services, and the only way they receive any assistance is through the criminal justice system. Groups like the FMDT were developed in part to address this service gap. While the FMDT is an effective model for developing individualized plans, it is unable to provide the follow up and outreach aspects of care that can help in working with this population.

In response to the difficulty of serving some chronic alcohol users who are homeless, other communities have created Assertive Community Treatment (ACT) teams to engage these individuals out in the streets where they live. These multi-disciplinary teams provide a range of behavioral health and support services to clients out in the community, rather than in traditional settings. These services are designed to address the client's specific issues, including intensive treatment, rehabilitation, and case management.

Although the ACT model was initially developed to serve the mentally ill, at least one program has specifically targeted chronically homeless individuals with addiction disorders. The Community Engagement Program (CEP) in Portland, Oregon, uses a mobile team comprised of case managers, mental health treatment providers and peers to engage with potential clients on the street to encourage them to enter the program.[47] Once a client is enrolled, CEP staff help the individual obtain safe housing. They also begin providing services, and the teams meet clients wherever they feel most comfortable, whether that is the street, a provider's office or the individual's new home. Case managers and program staff check in regularly with each client and provide individualized continuity of care.

While building such an expansive program in Marin may not be feasible, it should be possible to expand the capacity of the FMDT to take on some of these roles. The team already does similar work, such as developing an individualized plan based on the client's needs and attempting to connect him with appropriate services. However, the team currently lacks the important direct engagement, outreach and follow-up components to most effectively serve this population. Adding new case management staff to take on this role could be a cost-effective way of increasing the success of the team. In fact, the team has already expressed interested in hiring a full-time staff person to follow up with individuals in between meetings. This person would essentially act as a central liaison between all of the various services that the client receives and would make sure they are following through on each part of the individualized plan. The county currently has a strong model for this type of case management in the form of Recovery Coaches

47 Moore, T.L., (2006, June). *Estimated cost savings following enrollment in the Community Engagement Program: findings from a pilot study of homeless dually diagnosed adults.* Portland, OR: Central City Concern; *Community Engagement Program*. Central City Concern, 2011, available at: http://www.centralcityconcern.org/changing-lives/community-engagement-program.html; Interview with Sarah Goforth, Central City Concern, October 18, 2012.

and Care Managers.[48] By adopting a similar model within the FMDT, the county can provide the intensive case management and outreach that would benefit many in this group.

While the CEP program in Portland has a sizeable budget to carry out its work, it is a much broader program than is envisioned for Marin. The current CEP has a budget of about $500,000 to cover the team of five individuals and all associated costs (i.e. transportation, cell phones). It also provides services to around 100 people per year, which is a much larger target population. It is primarily funded through federal grants from SAMHSA and some health-care billing. By building the ACT model into the current FMDT and hiring less staff than required by Portland's program, Marin should be able to implement a similar structure with a much smaller budget.

DEVELOP A JAIL DIVERSION TREATMENT PROGRAM

Some of the biggest inefficiencies created by this alcohol-addicted population are with the county courts and jails. Individuals are constantly cycling through both arms of the criminal justice system, yet the system is often left without ways to divert them.

A way to lessen the burden that public drunkenness places on these agencies is to intervene with substance abuse treatment so individuals end their cycle of alcohol abuse. Although treatment options may be repeatedly offered to individuals with chronic alcohol-related issues, it may be difficult to get them to voluntarily enroll and complete a program. The Treatment in Lieu of Incarceration model capitalizes on the leverage courts gain over individuals that are repeatedly arrested and charged with alcohol-related offenses by offering them treatment as a way to avoid jail time. The program can be designed with this specific population in mind and holistically address not only their substance abuse, but other issues as well.

For example, in San Diego County, a Serial Inebriate Program (SIP) was established to place chronic alcohol users with justice-system involvement into treatment rather than through the revolving door of law enforcement and custody.[49] In reaction to the realization that many of the same people were being booked into jail for alcohol-related offenses and then released 4 to 24 hours later without criminal charges, the local police department proposed a program to divert this population to treatment. In collaboration with the prosecutor's office, local courts and treatment providers, the court now has the option to offer a six-month alcohol treatment program in lieu of jail to individuals who have been in regular contact with law enforcement and sobering services. In addition to substance abuse treatment, participants are provided medical and mental health treatment, intensive case management and transitional housing. A cost study of the SIP found that the program, which serves six people at a time, reduced the county's average monthly costs by $73,352.[50] In addition, they reported a 50% decline in the use of

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48 Currently, HHS employs 2.5 full time Recovery Coach/Care Managers. These case managers currently work with individuals involved in the Adult Drug Court as well as medium- and high-risk probationers in the community through SB678 and AB109. The purpose of this position is to help provide support and link them to necessary support services, such as benefits, employment, treatment and housing.

49 Dunford, James V. et al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals of Emergency Medicine 47.4* (2006): 328-36; Castillo, Edward, et al. Institute for Public Health. *An Evaluation of the Impact of San Diego's Serial Inebriate Program*. San Diego, CA, 2005; Interview with Deni McLagan, Mental Health Systems, Inc., October 12, 2012.

50 Dunford, James V. et al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals of Emergency Medicine 47.4* (2006): 328-36. The costs savings were broken down as: $5,662 for EMS transports, $12,006 for Emergency Department visits, and $55,684 for inpatient hospital admissions.

ambulance services and hospital admissions, and a 58% reduction in arrests among program participants. Following the successes in San Diego County, the SIP has been replicated in communities around the country, including Santa Cruz and Sacramento.[51]

This type of model could be implemented in Marin to address the needs of some individuals who are in regular contact with the justice system as a result of their alcohol abuse. Although there are some who may not choose treatment (the SIP model does not require treatment, but offers it as an alternative to jail), for those ready it can be an excellent opportunity to take the next step and enter a program. The Superior Court has already confirmed that it would be a willing partner in such an effort.

In conversations with members of the Superior Court, it has become clear that it may not be feasible to create an additional problem-solving court or build this work into the existing Community Court. At this time, neither the District Attorney's Office nor the Public Defender has the staff to take on these additional responsibilities. However, the program can easily be built into the Court's current schedule. In San Diego, for example, those identified as fitting the criteria for the program are brought before the court just as they would be if charged with a §647(f). Upon determination that they qualify for the program, their file is marked as such. They are not released from jail, as they would be normally under a misdemeanor charge. Instead, they are held in custody until they can go before a judge, which is typically within 48 hours, to ensure they appear before the court. At that point, the judge has the option to offer treatment in lieu of the applicable jail sentence.

As for the treatment options, it may be possible to build this program into the Safety Net Program held at Mill Street and New Beginnings. Another option would be to develop a parallel program, in conjunction with county service providers, at another facility. It will be important to bring in additional wraparound services to address the population's other needs, such as mental health care, medical care and life skills training. Additionally, programs in other jurisdictions often offer some form of housing for the duration of the program.

In implementing a Treatment in Lieu of Incarceration program in Marin, there are several key decisions to be made. Eligibility criteria must be established. For example, San Diego allows someone to qualify for admission to the program if police transport him to the sobering center more than four times within 30 days. In a smaller community, such as Santa Cruz, a person qualifies upon his fifth arrest for a §647(f) offense within 60 days. For Marin, this criterion may be more appropriate due to the size of the population, and is more consistent with the matrix used by the District Attorney in generating the list for the study cohort. In developing the criterion, it is also important to take into consideration the expected capacity of the program. The smaller the capacity, the narrower the criterion should be. This would help ensure that everyone who qualifies has the opportunity to enroll.

A costlier and more difficult decision is whether to provide housing and, if so, what type. As mentioned above, it may be possible to build the program into current substance abuse treatment programs for the homeless. However, if that is not the case, additional housing could be identified. This may prove to be a challenge in Marin, due to the limited amount of shelter

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51 Mental Health Systems, one of the organizations integrally involved with managing the SIP in San Diego, currently offers in-person presentations and consultation for communities starting their own Serial Inebriate Program. .

and transitional housing, but this option should be explored. Providing a stable, sober living environment is key to helping participants succeed in their treatment.[52] For example, the San Diego SIP program provides transitional housing in clustered shared-housing apartments. An alternative is the Sacramento model, which houses participants at an alcohol treatment center.

Other considerations when developing the program include the length of the treatment program, whether criminal backgrounds will prevent acceptance into the program,[53] the style and frequency of case management and how to handle individuals that relapse. They should all be developed with Marin's unique circumstances in mind, including the size of the target population and the capacity of service providers.

In terms of cost, the San Diego SIP historically cost the county approximately $200,000 per year: $120,000 for substance abuse treatment services and case management and $80,000 for housing all of its clients. It recently added a significant mental health aspect to the program, for an additional $100,000 per year. The cost in Marin would depend on the scope and size of the program and type of housing provided (if any).

ESTABLISH TARGETED SCATTERED-SITE PERMANENT SUPPORTIVE HOUSING UNITS

The lack of affordable housing in Marin County is a major challenge in improving the outcomes for chronic alcoholics experiencing homelessness. Not only is Marin an incredibly expensive place to rent or buy existing housing, community resistance and restrictive zoning laws prevent the creation of new housing. While several housing providers have worked hard to do as much as they can with available funding to create housing options for the homeless, demand continues to exceed capacity. However, as mentioned above, housing is a key component to helping people stabilize and improve their health. Permanent supportive housing, which provides services along with housing, is used in many communities to meet the needs of people who are homeless with ongoing addiction issues.

One example of this is the Housing for Homeless Addicted to Alcohol (HHAA) program in Santa Clara County.[54] This program provides permanent housing, supportive services and access to substance abuse counseling for chronically homeless people addicted to alcohol. It uses a housing-first model in which clients are moved directly from the streets into housing under a harm-reduction approach. This philosophy recognizes that some people will engage in dangerous behaviors and thus seeks to mitigate the potential dangers and health risks associated with these behaviors. As such, there are no "zero tolerance policies," and maintaining housing is not contingent upon abstinence. There are only two requirements for participation in the HHAA program: 1) clients must allow periodic apartment reviews/inspections by a case manager; and 2) they must participate in a money management system, either through a representative payee or regular budget meetings with a case manager.

The HHAA program uses a scattered-site model with five to 15 units at each housing complex. The purpose of the scattered-site approach is to help the program find ways to "mainstream"

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52 Interview with Deni McLagan, Mental Health Systems, Inc., October 12, 2012

53 The San Diego SIP, for example, does not accept those with histories of violent crime, arson, or child abuse because of the limitations of group living.

54 "EHC LifeBuilders Off the Streets for Homeless Addicted to Alcohol HUD application." EHC LifeBuilders, Santa Clara County, California, 2005; interview with Robert Dolci, Santa Clara Mental Health Department, October 17, 2012.

participants into the community. By having more than one unit at each location, the participants still have support and a sense of camaraderie to help them succeed. Case managers visit individuals in their home to conduct their routine check-ins. Participants are offered a variety of services, although they are not required to engage in them. These range from food, transportation and basic living skills training to benefits advocacy, substance abuse treatment and case management. To provide this assistance, the program collaborates with a number of county agencies and homeless service providers.

Developing more of this type of housing, and targeting it at the chronic alcohol using population, could be very effective in Marin. While community feedback tells us that a project-based program, in which all participants would live in one building, would not be politically feasible in Marin, the scattered-site model has already been used successfully by housing providers in the county.

Funding is always a large concern when implementing this type of housing program, especially in areas as expensive as Marin. For example, the HHAA program had an annual budget of about $1 million with a program capacity of 42 individuals during its first two years. $500,00 per year was funded by a grant from the U.S. Department of Housing and Urban Development (HUD), but they received additional funding from numerous non-profit organizations, county and city agencies, and private funders from around the county. Fortunately, there are various sources that offer grant funding for this type of project. HUD provides funding for this type of program through various sources, most notably its Continuum of Care (CoC) Program. Historically, Marin has been eligible to apply for new funding through this program every year.[55] In addition, HUD occasionally provides grants to house special populations – Santa Clara County initially funded its HHAA program through such an opportunity. Other federal agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) may also provide funding to support the services aspect of the housing. It may also be possible to solicit support from local agencies. For example, the HHAA program received leveraged funds from government agencies, such as the police departments and district court, because of the reduction they expected to see in their costs. Several homeless service providers and the county alcohol and drugs and mental health departments matched the funding with services.

In addition to identifying funding sources, there are many decisions to be made when designing a permanent housing program for this population. While partly determined by the funding available, determining the nature of the housing and the size of the program are important first steps. These decisions should be made keeping in mind that the majority of clients will need extensive services in conjunction with their housing in order to remain successfully housed. It is important to identify the potential service providers and consider their capacity during this initial phase of the planning.

Additional decisions include where to locate the housing. In some respects, placing housing in more urban areas, such as San Rafael, makes it easier to find existing units to repurpose and allows greater access to services and amenities. However, due to the resistance of some

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55 In 2012, Marin County was eligible to apply for $28,588 in Permanent Housing Bonus funds through the CoC Program. This funding must be used for permanent supportive housing for chronically homeless individuals. To qualify as chronically homeless, the individual must have 1) either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years; and 2) a disabling condition (which can include a substance use disorder).

communities to housing homeless individuals, rural areas may provide a less politically difficult alternative. If units are placed in less urban areas, the program must account for accessibility issues and build solutions into the program model. Other options include placing individual units throughout the county, so the population is more spread out, or clustering several units together in one area, such as in the HHAA program. The advantage to clustering apartments, especially for Marin, would be increasing the efficiency of delivering in-home services.

Whether to adopt the harm-reduction housing philosophy, which allows housing people without a sobriety requirement, is another key decision. Evidence-based practices show that the harm-reduction model is an effective way to help an addicted population move into permanent housing.[56] For many, simply being housed reduces stress and symptoms related to substance abuse disorders. Studies that examined the use of the harm-reduction model for frequent users at a program in Seattle found that it reduced public costs by $2,449 per person per month.[57] In addition, residents cut their heavy drinking by 35% and everyday drinking by about 50% during their first two years of housing. Whether providing that type of housing or not, the program must deliver services. Determining what level of assistance to provide, at what frequency, and how they will be administered is a large part of the program design for this type of intervention.

CREATE A VIABLE OPTION FOR DETOXIFICATION WITH MEDICAL SUPERVISION

While Marin County has a very valuable service provided by The Vine, the program's lack of capacity to admit individuals with potential medical concerns creates a large gap in its ability to serve the target chronic alcoholic population. A medically-equipped sobering center would bridge this gap by providing effective alternatives for individuals who would otherwise typically be taken to the emergency department while intoxicated. As such, medical sobering centers not only free up critical emergency department resources, but also provide individuals a more targeted and appropriate level of care.

One example of a medial sobering center is the San Francisco Sobering Center, which provides 24-hour care for intoxicated clients historically treated via emergency services.[58] The 12-bed Sobering Center is co-located with San Francisco's Medical Respite Program, which includes approximately 60 respite beds and temporary housing for homeless persons leaving San Francisco General Hospital or other neighboring clinics. The Department of Public Health provides all of the medical care while the non-profit Community Awareness and Treatment Services (CATS) provides supportive services for the clients and staff, including case management, client transportation, social and educational activities.

56 Tsemberis S, Gulcur L, Nakae M. "Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis." *Am. J. Public Health 94.4* (2004): 651–56.

57 Larimer ME. et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems." *JAMA*. (2009): 1349-1357; Collins, Susan E. et al. "Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories." *American Journal of Public Health 23* (2012): 511-519.

58 City and County of San Francisco. San Francisco Department of Public Health. *McMillan Stabilization Pilot Project, 6-Month Interim Draft Report, August 2003 – January 2004*. San Francisco, CA, 2004; Smith-Bernardin, S., Schneidermann, M. "Safe Sobering: San Francisco's Approach to Chronic Public Inebriation." *Journal of Health Care for Pool and Underserved 23* (2012): 265-270.

The concern about increasing The Vine's capacity to include a medical license is the cost; it is estimated that it would be hundreds of thousands of dollars to build that capacity.[59] For example, the San Francisco Sobering Center, which serves between 10 and 14 clients per day, has an annual budget of around $1 million dollars. For the population size of Marin County, it does not seem practical to invest such a large amount of money to create such an extensive program. However, there may be other options to address the inefficiency of using the emergency departments to get medical clearance.

Before exploring the options of expanding The Vine to take on medical capacity, it would be beneficial to examine the level of medical need of the current clients of the facility. This may be increasingly important as federal health care reform continues to change the medical field and the county completes its restructuring to create the Community Health Division. Anecdotal accounts show that the level of need for medical detoxification services is rising, as The Vine continues to serve an aging and increasingly complex population, including those with prescription drug abuse concerns. Conducting an evaluation of those accessing these services would help determine the scale and level of care required when expanding to include more medical supervision.

Once an evaluation is complete and there is a stronger sense of community need, one strategy could be to combine developing a detoxification program with a medical respite center, such as in San Francisco. Unfortunately, there does not seem to be a medical respite center currently in existence that would be able to handle that capacity.[60] However, there is a medical center in Marin that is focused on serving the homeless population – the clinic at the Ritter Center. It may be worth exploring that facility's capacity to build upon existing services to house several medical detoxification beds. To fully meet the need of the population, however, medical care should be available 24 hours per day. Not surprisingly, detoxification service needs are more frequent at night or on the weekend.[61] Currently, Ritter only operates during normal business hours.

Other options to consider for developing medical detox capacity include the potential to contract with a 24-hour on-call physician to perform medical clearances. Other communities have considered this strategy,[62] although more research needs to be conducted into the feasibility of this option. Another potential would be to partner with neighboring communities, such as San Francisco, and deliver medically vulnerable, intoxicated individuals to their sobering centers for the appropriate level of care. However, in exploring these options, it is important to consider the impact they would have on other aspects of the system of care, such as police officer transport availability, to ensure they do not create more of a burden.

59 DJ Pierce, November 6, 2012 Advisory Group meeting.

60 Homeward Bound runs a Transition to Wellness program, housed next to New Beginnings, which provides six medical respite beds for homeless people leaving the hospital after serious illness or injury. All clients are referred directly from hospital discharge planners. Homeward Bound provides support staff and shares a medical social worker with the Ritter Center. Ritter's Federally Qualified Health Center provides medical oversight. However, there is not 24 hour per day medical supervision at the facility.

61 Interview with Lieutenant Ralph Pata, San Rafael Police Department, January 14, 2013; Interview with DJ Pierce, Health and Human Services, Alcohol and Other Drugs Division, January 29, 2013.

62 Robert Jeffries. Travis County Criminal Justice Planning Department Memorandum. *Re: Consider and Take Appropriate Action on Application for Travis County to be Selected as a Justice Reinvestment Initiative Phase II Site by the Bureau of Justice Assistance, which, if Selected, will Provide Funding and Technical Assistance for a Sobriety Center, Attachment 1*. January 18, 2011.

CONCLUSION

Marin County has a robust system of care currently in place for individuals in regular contact with the justice system due to their chronic alcohol use. However, many individuals continue to fall through the cracks of these services and end up costing the county millions of dollars per year in court, law enforcement, medical, treatment and homeless services. The recommendations in this report aim to address some of the gaps in current services and more appropriately addressing this population's needs. With the leadership and expertise of the FMDT and Health and Human Services Department in implementing these recommendations, the county should be able to both reduce the strain on public resources and improve the outcomes for these individuals.

REQUEST FOR DATA: [AGENCY NAME]

HomeBase, a nationally-recognized homelessness technical assistance firm, is working in collaboration with the Marin County Department of Health and Human Services to conduct a study examining the impact that individuals with chronic alcohol abuse issues and justice-system involvement have on public services in Marin County. The ultimate goal of the study is to propose cost-effective solutions to both help reduce the impact on these services and improve outcomes for the population. **[Agency Name]** was identified as one of the agencies that serves this population, and we would like to include your data in the study.

The District Attorney's Office compiled a list of the individuals who most frequently enter its system for alcohol-related infractions. This list of 34 individuals will serve as the sample population for the study. ***This list is strictly confidential and no personal identifying information will be referenced in any version of the report about the study.*** We also ask that you only share this information with those individuals within your agency who are necessary to assist in collecting the requested data.

In prior conversations with your agency, we identified the following services as those that the individuals in this population most likely frequently utilize:

1) _____
2) _____
3) _____

For each of the above services, we are requesting that you submit to us: 1) the aggregate number of encounters for people in the study sample ***between June 1, 2011 and May 31, 2012***; and 2) an estimate of the average cost per encounter. It would also be helpful if you provide any other information that describes the inefficiencies this population creates for your agency that are not captured by actual accrued costs.

If possible, please submit this information by email to Alissa Weber by **________ __, 2012**. If you have any questions or concerns about this request, please feel free to contact Alissa Weber at HomeBase by phone or email at any time.

Marin Health and Human Services 20 North San Pedro Road #2004 San Rafael, CA 94903 Julie Van Winkle, MPH, Policy Analyst jvanwinkle@marincounty.org 415.473.6873	**HomeBase /The Center for Common Concerns** 870 Market Street, Suite 1228 San Francisco, CA 94102 www.homebaseccc.org Alissa Weber, Staff Attorney alissa@homebaseccc.org 415.788.7961 Ext. 302

An Overview of Program Alternatives for Serving Persons with Chronic Alcohol Use and Justice-System Involvement

Section I provides an overview of common steps or phases for communities working to initiate programs to address the needs of people who have chronic alcohol use and justice system involvement. It also includes a listing of key characteristics of effective programs. Section II provides an overview of program examples implemented by communities, organized into four program types.

SECTION I: OVERVIEW OF COMMON STEPS IN GETTING PROGRAMS OFF THE GROUND

While the political, economic and social context may vary from community to community, places that have successfully initiated programs for people who have chronic alcohol use and justice-system involvement report a similar trajectory to their process. The following is a generalized overview of the typical steps or phases for communities that have established programs.

1. Recognition of a Problem: This recognition may be based on hard data, anecdotal accounts, or may be the result of a high-profile trigger event, but it is something that has grown to be recognized by different stakeholder groups along with a desire for action to address the problem. The problem may be defined in a number of ways, including poor client outcomes, unmet client needs, overburdened public systems, the need to control costs and/or a recognition of shared responsibility across agencies and systems for individual and community outcomes.[1] An example is the recognition by emergency departments, police officers and courts that significant resources are being used on a distinct group of individuals who repeatedly cycle thorough their systems, without achieving any improvement in their situation.
2. Initiation of a Work Group or Task Force to Investigate The Problem and Propose Solutions: This Work Group or Task Force must have legitimacy, which ultimate means it has the authority to implement any recommendations. It should have a diverse membership, involving all the potential stakeholders who are affected by the problem and/or should be involved in the solution, including representatives from hospitals, behavioral health agencies, law enforcement, business community and homeless services providers. Strong leadership, by an individual with vision and the power and connections to help keep the process moving forward, is important. Finally, it should work within a concrete timeline to produce a report providing more information on the problem along with suggested solutions. Typically, these reports include cross-system data that documents the size of the problem and illustrates the potential cost-savings from action.
3. Building Support for Implementation of the Proposed Solution: Once a proposed solution is identified, especially if the solution is controversial, it needs a champion to promote it and united support from all the key stakeholders. It is also important to have a concrete plan to solicit the support of decision makers (Mayors, City Councils, Board of Supervisors, agency heads, hospital CEOs, etc.). This should include a media plan to build public support.
4. Planning and Implementation Group Continues Work: Once the Board of Supervisors or City Council accepts the report along with its proposed solution, often a Planning and Implementation Group will be established to move forward with design of the program. This may be the same as the initial work group/task force or it may be different. It may begin gathering information to guide program design, visit similar programs in other communities, and ultimately develop operational protocols, suggest staffing plans and identify budget and funding sources. Participants should be high-level members of the agencies who will be involved in the solution, who have the capacity to make agreements, commit resources, etc. Many communities also suggest that it is important to have a NIMBY (Not In My Back Yard) strategy if the solution involves siting a program in a neighborhood that may oppose it.

[1] Corporation for Supportive Housing. "Frequent Users of Public Services: Ending the Institutional Circuit". Report of the National Frequent Users Forum in Chicago, Illinois, October, 2008. pp. 3-7. Available at: http://documents.csh.org/documents/pubs/FUFReportFINAL1209.pdf.

5. Commitment of Funds for a Pilot: These programs often begin with agreement to commit funds for a one-year pilot project, with the caveat that the program will be evaluated and future funding will depend on proof of its effectiveness. Effectiveness is typically defined as demonstrating that clients are stabilized and their use of public systems diminishes. Pilot funding may come from multiple sources, including general fund dollars, foundation grants and/or allocations from stakeholders, such as private hospitals.
6. Oversight and Evaluation: Typically a group is established (it likely is the same planning and implementation group) to oversee implementation, address problems that arise, and ensure data is gathered and an evaluation conducted. This group is usually charged with reporting back to the Board of Supervisors or other government body on a periodic basis on the implementation process and ultimately on the outcomes documented by the evaluation.
7. Additional Funding: With data from the evaluation documenting its effectiveness, funding for the program is typically compiled from a number of public and private sources.

KEY CHARACTERISTICS OF EFFECTIVE PROGRAMS

- Have mechanisms to target/identify the population be served, including street outreach, in-reach to institutions, use of cross-system data analysis, etc.
- Are multi-disciplinary, involving all of the systems and agencies needed to provide comprehensive care to clients.
- Provide integrated medical, mental health and substance abuse services with coordination of care among providers.
- Address clients' housing needs, through Housing First and other low-threshold approaches.
- Provide intensive case management, at least until client stabilizes and basic needs are met.
- Incorporate trauma-informed care and harm reduction approaches.
- Have a diverse funding base, including federal, state and local dollars as well as private sources of funding including foundations, business and other fundraising.
- Include a solid data-gathering and evaluation component to enable continuous program improvement as well as to document effectiveness to political leaders, the public and funders.

SECTION II: OVERVIEW OF PROGRAM EXAMPLES

I. ASSERTIVE COMMUNITY TREATMENT TEAMS/INTENSIVE CASE MANAGEMENT THROUGH MULTI-DISCIPLINARY TEAM

Assertive Community Treatment (ACT) Teams are multi-disciplinary teams that provide a range of behavioral health and support services to clients with severe mental illnesses while they are in the community (as opposed to institution). Using an intensive case management approach, ACT teams provide a range of services designed to address the client's full range of needs, including intensive treatment, rehabilitation, and support services.

COMMUNITY ENGAGEMENT PROGRAM[2]
PORTLAND, OREGON

The Community Engagement Program (CEP), run by Central City Concern, is a multidisciplinary recovery model designed to comprehensively meet the needs of chronically homeless individuals with co-occurring mental health,

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[2] Moore, T.L., (2006, June). *Estimated cost savings following enrollment in the Community Engagement Program: findings from a pilot study of homeless dually diagnosed adults.* Portland, OR: Central City Concern; *Community Engagement Program*. Central City Concern, 2011, available at: http://www.centralcityconcern.org/changing-lives/community-engagement-program.html; Interview with Sarah Goforth, Central City Concern, October 18, 2012.

addiction disorders and/or physical concerns. The CEP teams initially meet with clients out in the streets until they are ready to engage more fully in the program. Once a client is enrolled, teams still meet clients in areas wherever they feel most comfortable. The staff-participant ratio is 1-15.

Typical Client Profile

- Primarily Caucasian and most (80%) are male.
- Average age is 42.2 years; average length of homelessness over past five years was 3.7 years.

Overview of Program Operation

1. A mobile team comprised of case managers, mental health service providers, and peers engage with potential clients on the street to encourage them to enter the program.
2. Once they agree to enrollment, CEP staff helps the individual obtain safe housing. Participants are placed in scattered-site housing paid for with HUD Shelter + Care funds. Individuals are not clustered in one building; instead they choose where they want to live. Several housing specialists assist them in finding a housing option that works for their needs.
3. After finding a place to live, staff work with clients to take the necessary steps toward stability and/or recovery. CEP staff partner with physicians, mental health practitioners, social workers and vocational counselors to create a plan for each participant.
4. Case managers and program staff check in regularly with each client and provide individualized continuity of care. The only program requirement is that the participants allow program staff to enter their apartments for this contact once per week. Case managers continue to stay active with individual's housing needs, connecting them to housing that is treatment oriented and eventually to secure independent permanent housing.
5. Clients graduate when they have the means to sustain themselves, either through benefits or employment. Whether an individual is ready to graduate is determined on a case-by-case basis; however most participants are actively enrolled in the program for at least one year. After graduating, clients can still access many of the program's services, but no longer receive financial assistance.
6. If a client relapses or is no longer self-sufficient after they graduate, they are able to reenroll with the program.

Cost

The Community Engagement Program (CEP) has a budget of about $500,000 to cover the team of 5 individuals and all associated costs (i.e. transportation, cell phones). The services component of the program is primarily funded through federal grants from SAMHSA and some health-care billing. Members of the team include the team lead, social workers, and a substance abuse treatment provider. They provide intensive services to around 100 individuals a year, and other less-intensive wraparound services to another 80 clients. About $1 million in HUD Shelter Plus Care funding provide housing vouchers for 180 program participants per year. Funding and services are matched by non-profit organizations in the community.

Collaboration

Central City Concern, which runs CEP in Portland, partnered with the following agencies in creating its ACT team:

- Police
- Parole
- Probation
- Housing Authority
- District Attorney
- County Mental Health & Addiction
- Housing Bureau
- Homeless Service Providers

Outcomes

For more than 200 people in this program, 99% remain in housing one year after enrollment at an overall program cost that is 36% lower than services typically associated with this population

- $42,075 estimated pre-enrollment annual cost/person (health and behavioral health crisis care and incarceration)
- $24,876 (59%) reduction in service costs post-enrollment/person/year
- $15,006 annual cost savings/person after 1st year of enrollment in CEP

II. TREATMENT IN LIEU OF INCARCERATION

Although treatment options may be repeatedly offered to individuals with chronic alcohol-related issues, it may be difficult to get them to voluntarily enroll and complete the program. The treatment in lieu of incarceration model capitalizes on the leverage that courts gain over individuals that are repeatedly arrested and charged with alcohol-related offenses to offer engaging in treatment as a way to avoid jail time. This strategy is in place in several California Counties, including Santa Cruz, Sacramento and San Diego, and in Travis County, Texas.

SERIAL INEBRIATES PROGRAM (SIP)[1]
SAN DIEGO, CALIFORNIA

The Serial Inebriates Program (SIP) is an intervention and treatment program that offers people the option of treatment in lieu of jail time when convicted for public intoxication. Once in treatment, they are provided with wraparound services designed to help recovery from alcoholism and assist them in moving toward re-entering society as a sober community member. SIP's goal is to reduce the number of people cycling through detoxification centers, county jail, local emergency rooms and treatment.

How SIP Was Initiated:

1. *Desire for Change:* There was broad recognition of the problem and frustration with the status quo by those interacting with the population of chronic inebriates, including law enforcement, treatment providers, etc.
2. *Data Gathered to Document Problem*: A study was done documenting the medical costs incurred by 15 individuals over 18 months at two hospitals. This documented the magnitude of the problem and the opportunity for significant cost-savings by better addressing their needs.
3. *Support from Policy Makers and Other Stakeholders Obtained:* Officers at the San Diego Police Department offered to lead the efforts. Agreement was developed on a program model and the roles and responsibilities of each of the partner agencies. The County Board of Supervisors allocated resources to support a pilot.
4. *Pilot launched*. SIP was initiated in 2000. Data on program outcomes was gathered to document success.
5. *Collaboration*. The program was rolled out and overseen by a steering committee made up of many county, city and nonprofit stakeholders. The purpose of the committee was to set goals for the program, define which roles each agency would play, develop procedures and strategies, discuss areas of concern, adjust systems and monitor progress. When the program first launched, the committee met monthly for the first 6 months. Now that the program is well established, the group meets on an as-needed basis.

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[1] Dunford, James V. et al. "Impact of the San Diego Serial Inebriate Program on Use of Emergency Medical Resources." *Annals of Emergency Medicine 47.4* (2006): 328-36; Castillo, Edward, et al. Institute for Public Health. *An Evaluation of the Impact of San Diego's Serial Inebriate Program*. San Diego, CA, 2005; Interview with Deni McLagan, Mental Health Systems, Inc., October 12, 2012.

The stakeholders on the committee included:

- County Board of Supervisors
- San Diego Alcohol and Drug Services
- San Diego Housing Commission
- San Diego Superior Court
- San Diego Police Department
- Office of the San Diego City Attorney
- San Diego District Public Defender
- San Diego District Attorney
- San Diego Sheriff's Department
- Medical Services Enterprise (paramedics)
- UCSD Medical Center
- San Diego Mental Health Systems

Budget: The Board of Supervisors designated $400,000 from a tobacco settlement to cover the program's costs for the first few years. The program has since been sustained with an annual budget of $200,000: $120,000 from the County of San Diego through a contract with Mental Health Systems, Inc. for treatment services and $80,000 from the City of San Diego Housing Commission, paid for with fees collected through the Inclusionary Housing Ordinance. In 2012, the program increased its budget by $100,000 (total of $300,000) by adding a full-time therapist to treat participants' mental health needs.

Target Population: Individuals who have been sent to 4-hour sobering services following arrest more than four times in a 12-month period

Typical SIP participants have spent 5-16 years living on the street, and have had as many as 30 intakes/month at the City's Inebriate Reception Center run by Volunteers of America. Their primary drug of choice is alcohol, followed by methamphetamine and marijuana. They have multiple, intertwined health care needs, including:

- 70% abuse other substances in addition to alcohol
- Approximately 90% have an additional mental illnesses
- 53% were identified as having one or more infectious diseases

Program Capacity: 15-20 clients at a time

Overview of Program Operation

1. Individuals found to be drunk in public are arrested (under section 647(f) of the California Penal Code) and transported to Detox. If records indicate chronic use of the facility, the individual is booked into jail; otherwise Detox accepts them.
2. The Police Department changed its booking procedures so that individuals would no longer be released after 4 hours; instead, they remain in jail until arraignment.
3. All in-custody arrest reports are sent to the City Attorney with SIP stamped on the front for special handling. The City Attorney brings all of these cases to trial.
4. After a guilty verdict is rendered and mandatory custody time imposed, the court offers an option of a 6-month alcohol and drug treatment program in lieu of jail. The individual must volunteer to be assessed to determine eligibility.
5. An abbreviated assessment determines whether an individual is eligible and willing to enter treatment. If determined eligible, the Court releases the client to treatment. If the individual refuses the treatment program or is determined ineligible, s/he remains in jail and ordered to attend an in-custody alcohol treatment program.
6. If the client accepts treatment, a San Diego Police Department Officer transports them to St. Vincent de Paul Village Family Health Center for their medical and psychiatric evaluation. They are given

medicine for any health conditions and informed that that SVDP is their new "medical home", thus replacing hospital Emergency Departments. They are then taken to Mental Health Systems, Inc. for their treatment intake process.

7. The program rents three apartments to use as housing for program participants. They remained housed in these apartments for the duration of the 6-month program. During the program, clients also receive treatment, case management, and other services to support treatment and recovery. In 2012, the SIP added a full-time therapist to provide mental health treatment to clients. Case managers also assist clients in putting housing and other supports in place for after they finish the treatment program.
8. Treatment does not always work on the first try. Individuals are not removed from the program if they relapse, but the SIP staff may work with them to see if they can get them into a residential treatment program. Similarly, if participants "graduate" from the program and are later arrested for being drunk in public, they are always allowed to reenter SIP.

Outcomes

From 2000-2003:

- $17.7 million in health care charges (emergency medical services (EMS), emergency department (ED) visits, & inpatient services) by 529 individuals
- Most of this was uncompensated care – payments for only 18.6% of charges were received

For those who chose treatment:

- 50% decline in use of EMS, ED and inpatient services
- $73,352 decrease in average total monthly charges, including $5,662 (EMS), $12,006 (ED) & $55,684 (inpatient services) – average of $5,642/person/year
- No change in service usage among those that did not accept treatment

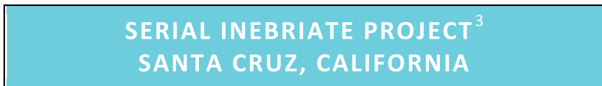
Additionally the San Diego Police Department reports:

- 58% reduction in arrests among this population

The percentage of treatment acceptance increases with the threat of longer sentences. While treatment acceptance is only 20% among those with sentences of 0-30 days, it is 63% for those with sentences longer than 150 days.

In FY2007-08, 24% completed the 6-month treatment program. At discharge, all were in permanent housing and all were employed, involved in employment preparation activities, or permanently disabled.

A new study is currently underway to evaluate the outcomes for the original 500 clients to evaluate their outcomes over the long term. The program hopes to have the results of that study by the beginning of 2013.[2]



SERIAL INEBRIATE PROJECT[3] SANTA CRUZ, CALIFORNIA

The Santa Cruz Serial Inebriate Program began in 2004 but was halted in 2008 because of recession-induced public budget shortages. It was reestablished in 2010 after a study demonstrated the cost burden this population placed on hospitals, due to the revolving door use of emergency departments.

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[2] Source: phone call with Denette McLagan, Program Manager of Mid-Coast SIP, October 12, 2012.

[3] Catholic Health World, "For alcoholics, a bed to sleep it off, or a shove toward treatment, sobriety." November 15, 2011, available at: http://www.chausa.org/For_alcoholics_a_bed_to_sleep_it_off.aspx; Santa Cruz County, "Mental Health Board Meeting Minutes, April 15, 2010," available at: http://www.santacruzhealth.org/cmhs/MHBoard/pdf/Minutes%202010%2004.pdf

Leadership was provided from the Board of Supervisors as well as from the partner agencies to identify funding to reinitiate the project.

Partners: County of Santa Cruz Health Services Agency, City of Santa Cruz, Dominican and Sutter Hospitals, Central California Alliance for Health, the Courts, District Attorney, the Public Defender, the County Sheriff, EMS providers.

Program Operation: For a person's first four arrests within six months, he or she is processed at the jail and released within a few hours. On the fifth arrest, the person remains in jail until he or she can go before a judge, who then offers the choice of 30 days in jail or treatment. If the individual takes the treatment and violates the terms or is drunk in public, they are returned to jail and the term is increased to 90 days. The program contracts with local private agencies to provide the treatment. The program budget pays for the treatment and a caseworker to arrange for and monitor it. When the individual is doing well in residence, he/she can be transferred to an outpatient treatment facility.

Funding: Funding comes from the City and County of Santa Cruz and from the private hospitals.

Outcomes: A review of 31 chronic alcoholics in 2006 showed that the Serial Inebriate Project reduced emergency department visits by 41% and arrests by 10%. It saved all project sponsors about $1.50 for every $1 spent on the program.

SERIAL INEBRIATE PROGRAM[4] SACRAMENTO, CALIFORNIA

Sacramento's Serial Inebriate Program offers 90-day treatment followed by ongoing services and housing as an alternative to incarceration for individuals who have cycled through short-term detoxification multiple times within a twelve-month period. Ten beds in The Comprehensive Alcohol Treatment Center (CATC) are reserved for the Serial Inebriate Program. CATC is an 80-bed Detoxification Center and the primary receiving center for inebriates referred by law enforcement agencies in Sacramento County.

Partners: The District Attorney, the Downtown Sacramento Partnership, Sacramento Police Department, and the Volunteers of America.

Target Population: Individuals who were admitted to the Sacramento County Jail or the CATC at least 25 times within the previous twelve months, and who pose a danger to themselves or others due to excessive alcohol consumption.

How Program Was Initiated: The Serial Inebriate Program was initiated as an expansion of the County's contract for The Comprehensive Alcohol Treatment Center (CATC), operated by Volunteers of America (VOA). Persons arrested for public intoxication are brought to CATC and placed in a 72-hour civil protection hold. CATC also includes a 32-bed, 60-day Recovery program, which is available to people after their detox. However, a significant number of the CATC's most chronic users of the 72-hour hold program do not opt to participate in the 60-day Recovery portion, despite persistent efforts and outreach by CATC staff.

Data was collected showing that a small number of clients repeatedly cycled through the program, using a disproportionate amount of resources. In response, the Public Safety Committee, City and County law

[4] City of Sacramento City Council, "Memorandum of Understanding to Fund Operations at the Comprehensive Alcohol Treatment Center," December 13, 2011, available at: http://sacramento.granicus.com/MetaViewer.php?view_id=8&clip_id=2856&meta_id=377099

enforcement, the District Attorney, the Public Defender, the Sacramento Downtown Partnership, Sacramento County and Cities Board on Homelessness (SC&CBoH), and the Director of the Department of Human Assistance (DHA) the Department of Human Assistance (DHA) requested the Board of Supervisor's authorization to amend the existing contract to allow for the provision of a court-ordered 90-day treatment program to serial inebriates within the existing CATC (Detox/Recovery) program.

The Serial Inebriate Program was initiated as a pilot targeting individuals found intoxicated within the downtown area. There was an agreement to collected data over a 6-month period to allow evaluation of its effectiveness. If proven effective, The Department of Human Assistance would continue and expand the program to serve the entire County.

Program Operation: After an arrest has been made and a report taken that documents the indication of intoxication, the individual is transported to the Jail and booked into custody. At arraignment, which takes place within 48 hours of booking, the Deputy District Attorney offers the defendant the choice of serving 120 days in jail or 90 days in the CATC in return for a guilty plea.

If the individual chooses treatment, the Sacramento Police Department transports the person from jail to the CATC. The individual must participate in and complete the 90-day Serial Inebriate Program for alcohol addiction, or they will be subject to re-arrest for non-compliance. At the end of the treatment program, the Deputy District Attorney and the Assistant Public Defender calendar a court date for the defendant to clear any outstanding warrants or other de minimis offenses that may be pending. These offenses, with certain exceptions, will be dismissed in light of the successful completion of the Serial Inebriate Program. After successful completion of the SIP, the individuals transition into other mainstream programs in the Continuum of Care for housing and services to assist them further in becoming self-sufficient.

PROJECT RECOVERY[5]
AUSTIN/TRAVIS COUNTY, TEXAS

Project Recovery is a therapeutic program relying on court collaboration and referrals for defendants with a long history of public intoxication arrests. Participants have criminal charges pending until dismissal at the successful completion of the regimen or sentencing if unsuccessful. The program began providing services in November 2006.

Partners: This program is a collaborative effort between the City of Austin, Travis County and Austin Travis County Integral Care (ATCIC).

Program Overview: The program is a 180-day (6 months) treatment model consisting of intensive treatment and case management, providing a holistic healthcare approach to recovery, obtaining employment and working to reintegrate individuals to community living.

The program begins with 90-days of residential and transitional treatment followed by an additional 90 days of intensive case management, individual counseling, community support, on-going skill building and chemical dependency interventions to motivate change in daily living. After hours, professional staff provide on-call crisis support. Individuals are encouraged to continue treatment with recovery support groups and other fellowship opportunities after completing the program.

[5] Project Recovery, Austin Travis County Integral Care, available at: http://www.integralcare.org/?nd=bh_projectrecovery.

Program Capacity & Eligibility: The program is limited to 15 adult men with a history of chronic inebriation referred by Travis County Court and who have been incarcerated for enhanced (Class B) public intoxication. Clients may have dual diagnoses of mental illness and alcohol dependence.

Outcomes: The program has consistently reduced recidivism by 45 to 50% generating savings for the Austin Police Department and Travis County.[6]

III. PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing is used in many communities to meet the needs of people who are chronically homeless with severe and ongoing disabilities.

HOUSING FOR HOMELESS ADDICTED TO ALCOHOL (HHAA)[7] SANTA CLARA COUNTY, CA

Housing for Homeless Addicted to Alcohol (HHAA) provides scattered-site permanent housing, supportive services and access to substance abuse counseling for chronically homeless people addicted to alcohol. This program is operated by Santa Clara County Mental Health Department and was initiated in 2005.

HHAA is a housing-first model in which clients are moved directly from the streets into permanent, scattered-site affordable housing, and are provided with intensive support services and case management. It uses a harm-reduction approach, which seeks to assist individuals in reducing harmful behavior that may lead to crisis. The harm-reduction approach recognizes that some people will engage in behaviors that carry risks and thus seeks to mitigate the potential dangers and health risks associated with these behaviors. As such, there are no "zero tolerance policies" and maintaining housing is not linked with abstinence.

Target Population: Chronically homeless individuals with long-term alcohol addictions

How HHAA was initiated:

- EHC LifeBuilders, a housing and supportive services provider in Santa Clara County, responded to a HUD solicitation for proposals to develop demonstration projects focused on housing homeless individuals who are addicted to alcohol.
- At the time, EHC LifeBuilders was part of a 20-organization collaborative called the Navigator Project, which provided case management and wrap around services for chronically homeless people with substance abuse and/or mental illness. It leveraged those connections in its application to HUD. It developed a collaboration for this project that included: Santa Clara Superior Court, various police departments, the Santa Clara County Department of Alcohol and Drug Services (DADS), Santa Clara Mental Health Department (MHD), and Emergency Departments at five hospitals, the faith-based community, and other housing and homeless service providers.

[6] This data is from a 2009 report and has not been confirmed with the program.

[7] Sources: http://www.ehclifebuilders.org/our-programs/housing-homeless-addicted-to-alcohol; EHC LifeBuilders Off the Streets for Homeless Addicted to Alcohol Application to HUD, 2005; interview with Robert Dolci, Homeless Concerns Coordinator, Santa Clara Mental Health Department, October 17, 2012.

- Funding was leveraged by nonprofits and government agencies, including police departments, the district court, and the Office of Affordable Housing. Several homeless service providers and the County Alcohol & Drugs and Mental Health Departments provided service matches.

Program Eligibility & Entry: Entry into the HHAA program is by referral only. A network of 6 or 7 housing service providers meets monthly and discuss potential participants. The opportunity to place a person in the program rotates through the participating service providers as openings become available. Program participants are selected based on the following criteria:

- Program participants must be chronically homeless individuals who are addicted to alcohol They may also have mental health issues.[8]
  - Have been living on the streets for at least 365 days over the past 5 years or have 4 episodes (a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter) in the last 3 years; AND
- Have no history of living in transitional or permanent housing over the last 5 years; (Short-term stays in emergency shelter, jail, or detox programs do not disqualify clients) AND
- Come from the streets at the time of initial contact with the program, and not from transitional housing or from long-term residential substance abuse treatment.
- Capacity to live independently, maturely, and cooperatively
- Ability to pay monthly rent on time. The program pays the client's rent to his or her apartment complex and s/he is responsible for paying 30% of his or her income to EHC LifeBuilders.

If the individual is accepted into the program, the HHAA Program Manager assigns them a case manager.

Because of HHAA's harm reduction approach, there are no zero-tolerance policies or a laundry list of program rules that must be followed to remain in the program. There are only two requirements for participation: 1) clients must allow periodic apartment reviews/inspections by a services coordinator, and 2) they must participate in a money management system, either through a representative payee or regular budget meetings with a services coordinator.

Housing: Program participants are placed in scattered-site units throughout the county, with 5 to 15 units at each housing complex. The purpose of the scattered-site approach was to help the program find ways to "mainstream" program participants into the community. Yet, by having more than one unit at each location, the participants would still have support and a sense of camaraderie to help them succeed.

Participants are placed one per unit in SROs and studio apartments (and occasionally one bedroom apartments).

Services Offered: Clients are offered a variety of services, although they are not required to participate in them. Services provided include:

- Assistance meeting immediate needs, such as food and shelter
- Housing and rental subsidies
- Case management and goal planning
- Benefits advocacy
- Education on basic living skills
- Health care

[8] In 2012, the program submitted a grant amendment to HUD to require program participants to have co-occurring mental health and substance use issues. This resulted from the Mental Health Department taking over administration of the grant a few years ago.

- Access to substance abuse counseling and referral to substance abuse/mental health treatment.
- Clinical therapy
- Transportation assistance

1811 EASTLAKE AVENUE[9] SEATTLE, WASHINGTON

1811 Eastlake Avenue is a permanent supportive housing facility that opened in 2005 and is operated by the Downtown Emergency Service Center (DESC) in Seattle, Washington. The program serves formerly homeless individuals with chronic alcohol addiction.

Target Population & Capacity: 75 men and women who are formerly homeless and have chronic alcohol addiction.

The tenant profile is predominately male with an average age of 48. The average resident was homeless 31 of 36 months prior to moving in. They are often disabled with chronic health conditions and over 40% have co-occurring severe mental illnesses.

Program Objectives

- Help tenants achieve housing stability
- Reduce alcohol consumption and its harmful effects
- Reduce tenants' use of the community's crisis response system
- Reduce public nuisances

Program Costs & Funding Sources

Total Project Development Costs -- $11.4 million

- $1.1 million for the land and 10.3 million to construct a new building
- Funding Sources: Seattle Housing Levy, King County Housing Opportunity Fund, Washington State Housing Trust Fund & Low Income Housing Tax Credit Program

Total Annual Operational Costs -- $900,000

- 75% of operational costs are staff expense, 25% are non-personnel
- Funding Sources: McKinney Supported Housing Program, Section 8 Rent Subsidies, Clinical Treatment Subsidy &Tenant Rent Portion

Per person costs for housing and services averages $1120/month or $13,440/year

The Building: 1811 Eastlake is a single building that contains 49 furnished studio apartments on its upper floors and 26 furnished, semi-private cubicles on the ground floor. The ground floor also includes a community dining room area, kitchen, offices for DESC staff, and private spaces for services. A roof top deck provides an outdoor area for tenants.

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[9] Sources: 1811 Eastlake, United States Interagency Council on Homelessness, http://www.usich.gov/solutions/1811_eastlake/**;** Bob Hobson, 1811 Eastlake, available at: http://www.apainc.org/html/1811%20Guide.pdf; Larimer ME. et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems." *JAMA*. 2009;301(13):1349-1357; and Collins, Susan E. et al. "Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories." *American Journal of Public Health*: March 2012, Vol. 102, No. 3, pp. 511-519.

Overview of Program Development Process and Timeline:

1. *Recognition of the Problem & Establishment of a Workgroup to Propose Solutions:* In December 1997, the Mayor of Seattle and the County Executive held a press conference calling the public's attention to the public costs of late-stage chronic alcoholics. They established the Chronic Public Inebriate Systems Solutions Workgroup, composed of key representatives from law enforcement, public health, downtown businesses, and service providers, to identify solutions. In January 1999, the Workgroup presented its "Housing Plan for Persons who are Chronically Publicly Inebriated" to both the City and County. This Plan included a recommendation for housing, which would not require sobriety but would offer services and treatment to residents.
2. *Developing the Project & Building Support:* DESC took the lead in developing a housing program as described in the Workgroup's Plan, and then along with other key stakeholders (the business community, law enforcement and hospital emergency departments) worked to gain support from state and local government.
3. *Assembling Financing:* It took 2 years to assemble financing for the capital development and to underwrite the project's annual operational costs. Nearly the all money came from public sources.
4. *Site Selection & NIMBY Challenge:* By late 2001, a non-residential site on the edge of downtown was purchased and construction was set to begin. A series of lawsuits were initiated by a nearby commercial property owner. The lawsuits were rejected by the courts, though the process took 28 months to resolve.
5. *Tenants Identified & Project Initiated:* DESC partnered with county officials to identify the most expensive consumers of crisis services, including the community's major hospital, the sobering center, and the County's detox facility and jails. Eligible individuals were contacted and offered tenancy in the project. 1811 Eastlake opened its doors in 2005.

Program Structure & Philosophy: Permanent affordable housing and wraparound services are delivered at the same site, by the same agency. The program operates with a "housing first" approach that offers immediate access to housing and does not require that clients access services and treatment, or that they maintain sobriety. However, on-site case mangers work to engage residents and encourage use of treatment and services.

- DESC owns and manages the housing and is also the primary service provider. This blended approach facilitates good communication and partnership between service and housing staff. Daily team meetings and collaborative case planning further enhance coordination.
- The on-site service team consists of a registered nurse and five clinical social workers. In addition, there are also 2-3 Residential Counselors on duty at any one time. They carry out functions related to security, rule enforcement, crisis intervention, and counseling.
- Individualized support services are available for all residents, including comprehensive mental health services, chemical dependency counseling, nursing support, medication assistance, and help with independent living skills, such as money management and housekeeping. Meals are also offered on site.
- Alcohol consumption in public areas both in and outside the building is prohibited; however tenants may drink in their rooms. Visitors may not come into the building and drink. Alcohol is not provided to tenants; tenants must purchase their own alcohol. However, about half of the tenants voluntarily participate in a managed alcohol distribution program through which staff members dispense to the tenant upon request the alcohol that the tenant has purchased. On-site staff continually support and encourage tenants to reduce alcohol consumption and enforce appropriate behavior.

Outcomes

- In the year prior to entering the program, 95 residents incurred $ 8,175,922 in service costs (jail, sobering center, ED, inpatient and outpatient services, Emergency Medical Services, shelter, detox & inpatient substance abuse treatment) -- this is a median cost of $4,066/person/month.
- After one year in the program, total system costs/person were reduced $42,964 (88%). Cost savings averaged $2,449/person/month above their housing costs.
- Residents cut heavy drinking by 35% and everyday drinking by about 50% during their first two years in the building.
- Length of time in housing was significantly related to reductions in alcohol use and cost of services, with those housed for the longest period of time experiencing the greatest reductions.
- Adjusting for deaths (6), 74% of tenants remained housed for at least one year.

KARLUK MANOR[10]
ANCHORAGE, ALASKA

Karluk Manor is a housing residence for chronic alcoholics located in downtown Anchorage, operated by Rural Alaska Community Action Program (RurAL CAP). It opened in December 2011 and is the first Housing First facility in Anchorage. It does not require that residents maintain sobriety.

Program Development Process: The mayor championed and devoted staff resources to address the problem of chronically homeless public inebriates. The impetus for this was some deaths on the streets of public inebriates and acts of violence against this population as well as ongoing concerns about the costliness of this population for the City and health and safety concerns for the public at large. Support for the project was built by documenting the high costs to the city of each chronic homeless alcoholic and showing how those costs could be reduced through supportive housing. This evidence was derived from local experience with the Anchorage Homeward Bound Supportive Housing Program and national research on the effectiveness of housing first models for this population. However, there was extensive opposition to the site chosen for the program, resulting in the formation of the Fairview Business Association, which continued to lobby for a different location even after the program opened.

Target Population & Eligibility: People eligible to reside at Karluk Manor must be identified as a beneficiary of the Alaska Mental Health Trust Authority, homeless according to the standards of the United States Department of Housing and Urban Development (HUD), known to be affected by chronic alcoholism, and have an income below 30% of the area median income for a single person.

The initial residents of Karluk Manor were selected from 150 applicants and are some of the neediest and most vulnerable chronic homeless alcoholics in Anchorage. They were selected based on criteria including Community Service Patrol pickups, incarcerations and emergency room visits.

Building Structure: Karluk Manor includes 46 furnished efficiency units. Each unit is approximately 220 ft^2 and includes one bathroom. The first building is a two-story structure with 10 units. The building has a

[10] Sources: Rural CAP, Karluk Manor Overview, available at: http://www.ruralcap.com/index.php?option=com_content&view=article&id=572&Itemid=354; Theriault Boots, Michelle. "Success of Karluk Manor depends on who you ask," Anchorage Daily News, May 28, 2012, available at: http://www.adn.com/2012/05/28/2483192/success-of-karluk-manor-depends.html; Chronic Public Inebriates and Related Issues of Homelessness: The Mayor's Strategic Plan, available at: http://www.muni.org/Departments/health/Documents/MayorsStrategicActionPlan.pdf

main entrance/lobby area, an office, a laundry facility, and a storage room. The second building includes 36 units and is an elevated two-story structure with parking underneath.

Services Provided: RurAL CAP provides on-site staffing through Residential Services Specialists (RSS) who are responsible for: coordination between social service providers and residents; facilitating the establishment of a healthy tenant community; fostering strong buy-in by all residents to agreed-upon community standards and reinforcing the consequences of continued violation of these standards (i.e. eviction); and coordinating the service hours each resident is expected to contribute. In addition, the following onsite services are provided:

- Assistance to access services: medical, mental health, financial, legal, employment
- Life skills training
- Crisis intervention and safety planning
- Community engagement activities
- Chore and housekeeping services twice a month
- Ensuring that those who qualify for low-income bus passes have access
- Providing meals delivered onsite 7 days per week

Tenant Requirements:

- Must pay rent based on sliding fee scale ($50 to $700)
- May not panhandle or loiter on the premises or in surrounding areas
- Expected to contribute four hours a month to the project
- Must follow visitor policies and all guests must sign in and out of the building
- No smoking in rooms
- No drinking in common areas or outside

Costs and Funding Sources: The nonprofit RurAL CAP spends $23,000 annually to house people who were each costing the public $60,600 a year in services. Karluk Manor is funded with a mix of federal and state grant money and rent contributions from residents.

Outcomes: There is no data to report yet but researchers from UAA's Institute for Circumpolar Health Studies, the Alaska Housing Finance Corporation and Alaska Mental Health Trust Authority are monitoring Karluk Manor to track residents' health and use of social services.

IV. SOBERING CENTERS

Sobering Centers can be effective ways to divert individuals that would typically be taken to the emergency department to a more appropriate and less costly place for them to receive the treatment they need while intoxicated. Below are several examples of how several cities have adopted this model in their community.

SAN FRANCISCO SOBERING CENTER[11]
SAN FRANCISCO, CALIFORNIA

The San Francisco Sobering Center cares for intoxicated clients historically treated via emergency services. It operates on a 24-hour, 7-day/week basis.

The 12-bed Sobering Center is co-located with SF's Medical Respite Program, forming The Medical Respite and Sobering Center, a partnership between the non-profit Community Awareness & Treatment Services (CATS) and the San Francisco Department of Public Health (DPH). The Medical Respite Center includes approximately 60 respite beds and temporary housing with medically oriented support services for medically frail, homeless persons leaving San Francisco General Hospital or other neighboring clinics. DPH provides all of the medical services and CATS provides supportive services for the clients and staff, including case management, client transportation, social and educational activities and janitorial services.

Overview of Program Development Process and Timeline:

1. *ED Crisis Catalyzes Establishment of a Task Force:* In response to rapidly rising diversion rates from SF Emergency Departments (EDs), the Board of Supervisors established an Emergency Room Diversion Task Force.
2. *Task Force Identifies Problem and Proposes Solution:* In November 2002, integrating input from stakeholders that included more than 50 representatives from City departments, community-based agencies, private hospitals and healthcare providers, the Task Force presented a report identifying the key issues and making policy recommendations to address this problem. One main finding of this investigation was that homeless alcohol-dependent individuals accounted for more than 20% of all ED visits and stayed nearly twice as long as non-intoxicated people. Additionally, nearly 75% of the high-utilizers of emergency ambulance services – individuals picked up more than four times a month – were chronic public inebriates. As a result, the Task Force recommended establishment of a pilot Stabilization Project to provide onsite medically supported sobering services, intensive case management and linkages to a continuum of services for homeless alcohol-dependent persons.
3. *Advisory and Planning Committees Established to Design and Implement Pilot:* In early 2003, a Medical Advisory Committee and a Project Oversight Committee were convened to continue the work of the Task Force and undertake the planning to design and implement the pilot program. Key to the success of this effort was the active involvement of a diverse array of public and private stakeholders, including programs of the Hospital Council of Northern and Central California, San Francisco Department of Public Health (SFDPH), the San Francisco Fire Department (SFFD), Citywide Emergency Department physicians, community-based providers, community advocates, and representatives from the Board of Supervisors and the Mayor's Office. These stakeholders reached consensus on the program design and operational protocols.
4. *Pilot Initiated & Oversight Group Established:* The San Francisco Department of Public Health implemented the McMillan Stabilization Pilot Project in July 2003. An SFDPH internal Organizational Development Workgroup and a Project Oversight Committee, comprised of the

[11] Sources: San Francisco Department of Public Health, McMillan Stabilization Pilot Project, 6-Month Interim Draft Report, August 2003 – January 2004. Available at: http://www.hospitalcouncil.net/sites/main/files/file-attachments/mcmillan_sfdh_report_report040804_0.pdf; http://catsinc.org/Medical_Respite.html; Shannon Smith-Bernardin, RN, MSN, CNL and Michelle Schneidermann, MD , "Safe Sobering: San Francisco's Approach to Chronic Public Inebriation," Journal of Health Care for Pool and Underserved 23 (2012): 265-270. http://www.sfgate.com/health/article/Funds-for-sobering-center-S-F-hospitals-2672227.php

primary stakeholders who participated in the planning process, provided ongoing oversight of the McMillan Stabilization Pilot Project, continued to develop service protocols and program policy, and helped identify and address systemic barriers, gaps in communications, and tracking and evaluation needs.

5. *Pilot Evaluated and Project Continued:* Based on a 6-month evaluation report, the project was funded again for a second year, and has continued to be funded. Support at the highest levels of SFDPH and by the Mayor was key to the project's success.

Project Partners:

- SFDPH
- CATS
- SFFD, whose paramedics triage chronic public inebriates on the street
- Emergency Communications Department (ECD) which provides communications support between the EDs and the Sobering Center;
- Hospital Council of Northern and Central California, a nonprofit hospital and health system trade association representing more than 200 hospitals.
- Baker Places, a community-based substance abuse and mental health service provider; which operates the medical detoxification programs.
- Homeless Advocacy Project of the Volunteer Legal Services Program, a program providing benefits advocacy and legal assistance to homeless individuals.

Target Population: The target project population is homeless alcohol-dependent persons in San Francisco. Alcohol abuse is considered the primary problem, though many have secondary problems with other drugs, mental illness and/or multiple medical problems. Almost all of this population is homeless or marginally housed and uninsured.

Cost: The operating costs, including staffing, are approximately $1 million per year, which is provided by the SFDPH general funds. The daily operating costs for the 24/7 center is less than $2,700 per day, which is around the same cost as just one ambulance ride and emergency department visit in San Francisco.

Program Operation: Patients are transported to The Sobering Center by ambulance, the police, or by the CATS Mobile Assistance Patrol (MAP) van. Clients may not self-refer to the program. Paramedics follow a detailed set of medical protocols to triage homeless alcohol-dependent persons to the Sobering Center rather than to an ED.

Following comprehensive protocols, clients are assessed by registered nurses and medical assistants upon intake and monitored throughout their stays for any medical and psychiatric complications. Nurse practitioners and physician assistants from the Medical Respite program complement clinical services by providing urgent care and detoxification referrals. If a client is too acute for sobering services, the nurses will coordinate transfer to an ED for further evaluation.

Throughout the client's stay, which is typically 6-8 hours, staff attempts to engage the client in discussion regarding their health and well being, focusing on alcohol use, housing status, and acute medical needs. For those clients with complicated medical, psycho-social, or forensic issues, individualized plans are developed in coordination with ambulance personnel, case management and primary care services, mental health and recovery services, and when necessary, the Public Guardian's office. Prior to discharge, clients are offered referrals to detox services, treatment programs and case management.

Program Impact Data:

- Annually, the program serves 900-1,600 clients with more than 3,000 total encounters.

- Nearly 80% of clients have had 1-2 encounters during 8 years of operation. Fewer than 200 individuals (less than 2% of unduplicated clients) account for nearly 70% of the total visits. Nearly 90% of the clients have a history of homelessness.
- Over 40% of client encounters are referred by ambulance, diverting Emergency Department admissions, with another 7% transferred from EDs. 35-40% come from the street by the MAP van and 10% come by referral from the police, clinics, case management programs and street outreach.
- 90% of clients, once sober, discharge to self-care or a substance abuse facility. Only 4% of clients have needed referrals to medical of psychiatric emergency departments for a higher level of care. There have been only 2 deaths out of 26,000 total encounters in8 years. Clients referred by Emergency Medical Services or the Emergency Room bounce back to the emergency room at a rate of less than 3% annually.

SOBERING CENTER[12]
SANTA CLARA COUNTY, CALIFORNIA

Santa Clara County is now in the process of developing Sobering Center, based on the San Francisco model and experience.

Overview of Program Development Process and Timeline:

- *Identification of Problem and Request for Additional Information:* In November 2011, a County Supervisor requested that the EMS Agency provide a preliminary evaluation of the need for an inebriate center. The impetus for this evaluation was numerous anecdotal comments from stakeholders identifying a large volume of inebriate patients intensively using EMS and hospital services. The core group of stakeholders involved in this preliminary analysis included the Public Health Department, Valley Medical Center, Valley Homeless Health Program, the Mental Health Department, Department of Alcohol and Drug Services, Jail Health Services and Destination Home.

- *Report Presented and Investigation into Inebriate Center Continued:* In February 2012, the preliminary evaluation of the need for an inebriate center report was presented to the Health & Hospital Committee (HHC). The Committee requested that the Public Health Department and the EMS Agency continue their efforts and provide a status update in approximately six months.

- *Continued Analysis of Inebriates With the County EMS and Hospital Systems and Preliminary Program Design:* The Santa Clara Valley Health & Hospital System (SCVHHS) departments listed above continued to analyze the characteristics of inebriates within their system, including a review of one year of ambulance-based data which identified a significant number of clients who were only or primarily inebriated; engaged and garnered support from additional stakeholders, such as county and municipal law enforcement agencies and hospitals; and sent a group of county and SCVHHS leaders to visit the San Francisco sobering center. They have also continued to design a possible Sobering System for the County which would consist of three components: 1) the pre-hospital care component, by which patients identified as being only inebriated would be transported from the field setting or the hospital emergency department by sobering van to the

[12] Source: County of Santa Clara Santa Clara Valley Health & Hospital System Public Health Department, Memo to Health and Hospital Committee, September 12, 2012 on an Inebriate care System. Available at: http://www.sccgov.org/sites/ems/Documents/EMSCo%20Meeting%20October%204,%202012.pdf, page 12.

sobering center; 2) the sobering center, which is staffed by medical personnel, and provides clinically-appropriate, dignified care to inebriates; and 3) integration into longer-term care services, such as drug and alcohol treatment, mental health services, or social support services. An EMS pre-hospital clinical screening protocol, has been developed based on the San Francisco inebriate screening protocol. Access to longer-term services, such as drug and alcohol treatment, mental health services, and social support, has been identified as starting in Phase 2 of the sobering system development, which would occur soon after the center has been opened.

- In September 2012, a status report was presented to the Committee and planning work continues. The SCVHHS departments and stakeholder groups are analyzing call volume and payer mix, developing staffing projections and completing clinical protocols. Consensus is developing on a center of between 16 and 20 beds. The location, leadership, financial projections, revenue sources, and operations of the sobering center are still in discussion. There is some discussion regarding hiring a contract project manager to manage this project from the current analysis and planning stage through the implementation phase. Preliminary timelines suggest that a sobering system could be implemented by March 31, 2013.