

VERMONT2007

Public Inebriate Report

Report to the Legislature on **Act 65**
January 15, 2008



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Executive Summary

In accordance with **Act 65**

Charge to Committee:

There are questions regarding the continuing relevance and applicability of the existing public inebriate statutes, as well as concerns about the funding, program policies, and availability of services to individuals classified as “public inebriates.” This complex public health issue transcends medical, criminal and public policy arenas and has significant economic impact across several state agencies.

Goals of the Committee:

- Evaluate the current policy and practice on public inebriates and make recommendations for improvements.
- Recommend changes in the statute, program protocols, and resources used to address public inebriate issues.
- By January 15, 2008, the Department of Health shall report on the status of the results of this review to the House and Senate Committees on Appropriations, the House Committee on Human Services and the Senate Committee on Health and Welfare.

The Public Inebriate Study Committee concluded that overall, the inebriate program does not work effectively except in selected areas where staffed shelters exist. Sufficient shelters with staff administering standardized screening tools could help divert a majority of not truly incapacitated persons from correctional facilities.

<http://healthvermont.gov/adap/treatment/PublicInebriate.aspx>

Public Inebriate Program Study Report

Recommendations:

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

- Pilot: small Agency of Human Services task force to develop coordinated care management (Blueprint model) for chronic inebriates known to the system with aim to divert a percentage of them into longer-term solutions in order to reduce cost where this issue seems most pressing.

Background:

In 1978, the Vermont Legislature enacted the Alcohol Services Act.¹ This act decriminalized public intoxication and put in place a program to move public inebriates into treatment rather than into jail, since substance abusers represent a public health and safety problem.² In 2001, the statute was changed to add drugs other than alcohol as incapacitating substances.³

Within two years of its passage, the bill produced results that were contrary to its intent. In 1977, the last full year prior to the legislation, 550 persons were jailed after being charged with public intoxication. By 1980, 572 persons or 47% of those picked up by the police had gone to jail as inebriates without being charged with a crime. In fiscal year 2006, of 4179 persons screened, 2322 (56%) entered protective custody without being charged with a crime; an increase in both total cases and incarcerations.

The intentions of the 1979 change in statutes, to decriminalize public inebriation, have thus not been met. *De facto*, public inebriation is a correctional issue in Vermont, as evidenced by the fact that 56% of public inebriates statewide are remanded to correctional facilities.⁴ A portion of the public inebriates present with medical as well as co-occurring mental health and substance abuse issues. The medical needs for this population cannot be met in correctional settings. Extreme incapacitation due to alcohol or other drugs does present as a medical emergency and significant worries about medical “near misses” exist. A percentage of public inebriates are homeless with no place to go once released. In order to understand and manage both their acute medical problems and their addiction appropriately, the right level of care and services for this population needs to be identified and made available. With respect to underlying or contributing medical or

mental health issues, accurate data has been only sporadically and inconsistently collected, with a substantial amount of anecdotal information available from Chittenden Regional Correctional Facility and Marble Valley Regional Correctional Facility. This underscores the systemic failure vis-à-vis standard screening and data collection protocols.

There is no overall management plan for public inebriates based upon state statutes, hence there is no overall system audit in place. Furthermore, key processes to contain costs are missing and there is no reporting standardization. The financial burden of public inebriates is shared by many state agencies, public and private entities and it is currently impossible to calculate the amount of monies spent, directly and indirectly, on this public health issue. The other issue which could not be treated adequately by this study group is that of inebriate underage persons. Statistical data on underage inebriates is even harder to come by and anecdotal evidence suggests that their disposition is a matter of luck on a case-by-case basis. The following addresses the specific issues encountered by correctional facilities, hospitals, providers, and public safety.

Correctional facilities:

A number of variables frequently found in inebriates in protective custody can lead them to crisis.⁵ Every incapacitated person arriving in a correctional setting should be considered at risk, as national figures show that the suicide rate in county jails is 9 times that of the population at large, with most suicides committed within the first 24 hours.⁶ Correctional facilities have extremely limited space and frequently suffer overcrowding. Overcrowding, especially in holding cells, creates safety issues, such as increased risk for assault, which can be heightened by intoxication. In terms of risk management, this situation is worrisome.

The Chittenden Regional Correctional Facility serves as shelter for 50% of incapacitated persons, while also processing 30% of all men and 40% of all women incarcerated throughout Vermont. The other high-volume correctional facility for inebriates is Marble

Valley in Rutland. With the recent shift of contract to Serenity House, which offers service at all levels from detox to residential to transitional housing, it is hoped that the situation in Rutland will continue to improve.⁷ The experience from shelters that have existed long-term suggests that there will be a significant need for such secure facilities in the future.

Persons with repeat public inebriate admissions are more likely to have a prior criminal record. During the last 16 years, 75% of people were only admitted as incapacitated once. The remaining 25% of inebriates make up 45% of the lodgings for inebriation.⁸ Incapacitated persons, because they are neither sentenced nor charged with a crime, cannot receive any medical care of any kind in correctional facilities in Vermont. If any medical problems are suspected, the person is sent back to the emergency room via ambulance. There is no clear avenue for follow-up once incapacitated persons are released from a correctional facility, so they are essentially warehoused and their chances for receiving treatment are not increased. This is in no way due to lack of effort on behalf of correctional staff or PIP staff, but rather lies in the way our system is structured. The correctional system gets stretched in ways that are not immediately apparent.⁹

Hospitals:

The stigma of addiction seems to persist in dealing with public inebriates in some hospitals. Inebriation and the potential associated incapacitation are not only public health, but also medical issues. Per Dr. Phil Brown, emergency room director at Central Vermont Medical Center, inebriated persons are the largest group presenting to his Emergency Room that does not receive adequate treatment. Other patients, even without insurance, could get excellent cardiac or mental health care. The patient with chest pain will probably be admitted, have a stress test or be transferred from CVMC to another facility for a cardiac catheterization, an end point in care. The inebriated patients are rarely offered detox/rehab or medical treatment options, which are also considered endpoint of care. These options are not available at Dr. Brown's facility.

All of the hospitals visited recently on behalf of the Futures project reported increased acuity and behavioral disruption from inebriated patients, some of whom are more impaired than the Emergency Department is set up to manage. Consultation is also reported as being difficult to obtain. Concerns exist about whether other patients seeking more “routine” care feel safe in the environment. ‘Drug-seeking’ individuals with pain management issues have an increased presence in ED’s in recent years. While pain management clinics may help to alleviate this, emergency management is still a challenge.

Mental health dispositions are time-consuming, with limited placement options available. Mental health patients are not usually admitted to hospitals unless sober, as mental status is hard to assess when someone is intoxicated, and such persons can present considerable behavior management problems. Substance abuse dispositions are also difficult, due to lack of appropriate resources; i.e., housing, long term treatment or short term detox, and again intoxication precludes intakes at mental health facilities. Public inebriates end up being discharged to the street when their level of inebriation (Blood Alcohol Level) has dropped sufficiently. This creates a dissonance for clinicians, as a potential for follow-up is lost at that point. This is especially true if incarcerated at a distance from home, as local providers are not present to engage individuals in follow-up treatment in their community.

Screeners:

The decision to include drugs other than alcohol in the definition of inebriation was of concern to screeners, because it occurred without additional training and necessary changes in policies and program protocols. Medical clearance is defined differently by different communities, an issue that presents challenges nationwide. Availability of screeners and hospitals differs by county.

Providers:

Getting crisis beds up and running takes considerable effort, as the payments do not cover the true costs. Attaching such beds to existing shelters, such as recently accomplished in Rutland at Serenity House, might be a feasible solution where such centers are available. For non-violent persons, alternatives to correctional settings should include transportation and a place to stay.

Public safety resources:

Providing transport to and from correctional facilities and emergency rooms is an inefficient use of time, personnel and resources. Less police coverage for the towns in their jurisdiction is available during that period of time that staff use to provide transportation for a public inebriate.

Current Capacity for Public Inebriates:

Northwest Hospital/ Champlain Drug & Alcohol Services St. Albans	4 beds
Champlain Drug & Alcohol Services Burlington	9 beds
Rutland Grace House (depending on gender mix)	4 or 5 beds
Bennington United Counseling Services	1 bed
Northeast Kingdom Mental Health	1 bed

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

² *Ibid.*, §708: “(d) A person judged by a law enforcement officer to be incapacitated, and who has not been charged with a crime, may be lodged in protective custody in a lockup or community correctional center for up to 24 hours or until judged by the person in charge of the facility to be no longer incapacitated, if and only if: (1) The person refuses to be transported to an appropriate facility for treatment, or if once there, refuses treatment or leaves the facility before he or she is considered by the responsible staff of that facility to be no longer incapacitated; or (2) No approved substance abuse treatment program with detoxification capabilities and no staff physician or other medical professional at the nearest licensed general hospital can be found who will accept the person for treatment. (e) No person shall be lodged in a lockup or community correctional center under subsection (d) of this section without first being evaluated by a substance abuse crisis team, a designated substance abuse counselor, a clinical staff person of an approved substance abuse treatment program with detoxification capabilities or a professional medical staff person at a licensed general hospital emergency room and found to be indeed incapacitated. (f) No lockup or community correctional center shall refuse to admit an incapacitated person in protective custody whose admission is requested by a law enforcement officer, in compliance with the conditions of this section.”

³ *Ibid.*, “Incapacitated” means that a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication, or mental confusion resulting from withdrawal. Amended 2001, No. 146 (Adj. Sess.), § 5, eff. June 21, 2002.)

⁴ “The reality is that no system was ever established to satisfy the mandate of this policy. For the most part, there is no ‘appropriate medical and other rehabilitative service’ provided unless done at the inebriate’s own choosing.” Tom Hanley, Commentary for the Vermont Association of Chiefs of Police, August 2007, p.1

⁵ “... certain factors often found in inmates facing a crisis situation could predispose them to suicide: recent excessive drinking and/or use of drugs, recent loss of stabilizing resources, severe guilt or shame about the alleged offense, and current mental illness and/or prior history of suicidal behavior. These factors become exacerbated during the first 24 hours of incarceration, when the majority of jail suicides occur. Inmates attempting suicide are often under the influence of alcohol and/or drugs and placed in isolation. In addition, many jail suicide victims are young and generally have been arrested for non-violent, alcohol-related offenses.” Prison Suicide: An Overview and Guide to Prevention. U.S. Department of Justice, National Institute of Corrections

<http://www.nicic.org/pubs/1995/012475.pdf>

⁶ “... over 88% of victims under the influence of alcohol and/or drugs at the time of incarceration committed suicide within the first 48 hours of confinement, with over half of these victims being found dead within the first three hours of confinement. In addition, 68% of the victims placed in isolation committed suicide within the first 48 hours of incarceration, with over 30% of these victims dying within the first three hours of confinement.” Training Manual for Suicide Prevention, pp. 3-1–3-4. <http://www.nicic.org/pubs/1995/012559.pdf>

⁷ Prior to the contract change to Serenity House, a total of 209 incapacitated persons were housed at Marble Valley Correctional, for a daily average of 1.124. Since the contract change on 07/01/07, 68 persons have been lodged, for a daily average of 0.701, a 38% decrease in numbers for Marble Valley since the change of contract. Without this option, Marble Valley would be at 375, or 1.325 per day. (numbers as per Phil Fernandez, Asst. Superintendent, Marble Valley Regional Correctional Facility)

⁸ An example of a high utilizer is a person who was housed at Chittenden as incapacitated 18 times in March 2007, with a further 7 nights as a detainee for trespassing. He spent 32 nights at Chittenden during the course of 6 months.

⁹ Here is an example of what happens to an INCAP in the correctional system: Once an INCAP is lodged by law enforcement, steps are taken to ensure safety and security for the facility. All INCAPs are patted down for contraband or any other items that could pose problems for staff. Rarely, an INCAP will be strip searched based upon information from the lodging authority that the INCAP could be in possession of dangerous items in a manner that a pat down would not discover. During the search process, the shift supervisor will go over all the paperwork delivered with the INCAP to ensure its thoroughness. If the INCAP has been seen at a hospital, we need to make sure the person is appropriate for placement in the facility. Generally the INCAP has been screened by a substance abuse screener.

The next step is inventorying all property that cannot be in the INCAP's possession while lodged. This includes all money and/or wallet contents, shoes, belts, jewelry, any clothing that could be used in suicide attempts, and any other objects that could be used to injure one self or others. Then the shift supervisor needs to decide which area of the facility is most appropriate for the INCAP to spend their time until sober. Usually this is in the general holding cell, but in certain instances the INCAP will be placed in segregation due to their behavior or risk of suicide. Female INCAPs present an additional issue in male facilities. Females are never housed with males, so separate spaces need to be created. Depending on the level of overcrowding, this can truly result in creative means to meet all goals.

Next is a base level screening by the on-duty nurse. Any issues detected during this screening can result in an ambulance call as correctional facilities do not provide any medical care to INCAPs. Medical care is a contracted service and the contract does not allow for care to be given to anyone who is not under the custody of the Commissioner of Corrections. Once situated, the INCAP will be placed on documented checks that occur no more than fifteen minutes apart. The observing officer will note the condition of the INCAP on the check sheet. Any issues that arise during the stay will be immediately brought to the supervisor's attention. Any unusual incidents are required to be noted on an electronic form that is sent to Central Office for their notification.

If all goes well, the INCAP is screened by a substance abuse screener prior to release from the facility. At that point the screener will make appropriate referrals, but there is no mandatory follow up by the INCAP. Sometimes the screener will arrange transportation for the released INCAP to be brought home or to another safe place. All property is returned to the released INCAP and this is documented by staff.

Workgroup Participants:

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Chief Bill Jennings, Berlin Police Department

Chief Tom Hanley, Middlebury Police Department

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Ed Haak, Northwest Medical Center

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