Report to
The Vermont Legislature

Public Inebriate and Sober Bed Programming
2023 Report to the Legislature

In Accordance with Act 185 of 2022

Submitted to:	**House Committees on Human Services and Appropriations** **Senate Committees on Health and Welfare and Appropriations**
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Introduction

In accordance with Act 185 (2022), the Department of Health has prepared this report in consultation with the Chief Prevention Officer, Vermont Preferred Provider Network, Vermont Association of Addiction Treatment Providers, Vermont Care Partners, the Vermont Association for Mental Health and Addiction Recovery, and the Vermont Alliance for Recovery Residences. This report examines whether there is excess bed capacity among those programs designated for use by individuals who are incapacitated; reports bed utilization rates; and includes an analysis of the financial sustainability of these programs.

Program Overview

Public Inebriate Program (PIP)

Vermont statute (18 V.S.A. § 4802 (7)) defines an incapacitated person as "a person, as a result of his or her use of alcohol or other drugs, is in a state of intoxication or of mental confusion resulting from withdrawal such that the person: (A) appears to need medical care or supervision by approved substance abuse treatment personnel, as defined in this section, to assure his or her safety; or (B) appears to present a direct active or passive threat to the safety of others." Pursuant to 18 V.S.A. § 4810, Public inebriate programs (PIP) are available 24 hours per day, 7 days per week, 365 days per year to provide screening to individuals who may be incapacitated and refer them for further medical assessment at the hospital, placement within a correctional facility, or placement in a diversion bed (also known as a PIP bed). PIPs are in 10 locations statewide: seven locations have screening and bed capacity, and three locations have screening capacity only (see Table 1 and Appendix A).

PIPs play a critical role in identifying and protecting individuals who are incapacitated. When a person who may be incapacitated is identified by law enforcement, they are transported to a PIP for a screening (see Screening Tool in Appendix B). If the person is found not to be incapacitated, they are able to leave on their own or in the care of a responsible adult. If they are incapacitated, they are transported by law enforcement to one of three locations: 1) If there are substantial medical concerns, the screener will recommend they be taken to the hospital; 2) If there are behavioral concerns, the individual refuses services, or the program is at capacity, they will be taken to a correctional facility; 3) If an individual is appropriate for the PIP and the PIP has capacity, they have the option of staying at the facility to be monitored until they are no longer incapacitated, which is typically less than 24 hours, at which point they will be discharged (see the Decision Tree and Data Dictionary in Appendix C).

PIPs are uniquely positioned to provide intervention and connection to treatment and recovery through their inclusion in the Vermont Department of Health's Division of Substance Use Programs' (DSU) continuum of services. PIPs provide critical intervention to individuals exhibiting high-risk substance use. Once individuals who utilize a PIP bed are no longer incapacitated, PIP staff attempt to engage in a conversation around unmet needs, possible

referrals, and continued treatment. Some individuals may not engage in these discussions or decline referrals.

In addition to providing an important intervention and connection to treatment and recovery, PIPs are intended to divert individuals from utilizing high-cost resources such as emergency departments and Department of Corrections facilities. While some individuals screened by PIPs are appropriate for either the emergency department or the Department of Corrections, approximately half of those screened pre-pandemic utilized a PIP bed. While that percentage decreased with COVID-19, it increased in State fiscal year 2022.

Sobering beds

In order to support individuals who are at risk of losing their place in a recovery home due to a temporary return to substance use, a pilot program has been implemented beginning in March 2021 by a DSU-funded recovery home program, with locations in Chittenden, Lamoille, Franklin, and Caledonia counties. The program has established an emergency location sobering bed for individuals to use due to a return to substance use which allows them to temporarily retain their bed in their recovery home and return to it if they choose. If an individual from the pilot program network returns to substance use, the program will either drive the individual to the emergency location or offer a hotel room and stay with them, so the individual is not alone, for an average of 3-5 days. This program has an average of one person per month who utilizes this emergency location and approximately half of the individuals end up returning to the recovery home. In other recovery homes if a person returns to substance use their bed may not be held for them as there can be waitlists for recovery home beds.

Methodology

The Department's DSU employed several methods to examine bed capacity utilization and analyze financial sustainability of programs designated for use by individuals who are incapacitated. These methods included calculating of bed-days utilized and collecting stakeholder feedback.

To calculate the percent of bed-days per year a public inebriate program bed was occupied, by fiscal year, the number of beds were multiplied by the number of days in a year to calculate the bed-days available, then the total number of days a bed was utilized was divided by the bed-days available.

Capacity

Several factors contribute to program capacity including physical space, number of beds, staffing, staffing patterns, utilization, and funding. Public inebriate program bed capacity has not substantially changed since 2011, except for periodic decreases in capacity due to the COVID-19 pandemic. Programs maintain their capacity to provide legislatively mandated services regardless of utilization. Hiring and retaining staff has been a challenge across public inebriate programs (as with the organizations more broadly). Most programs report operating below their optimal staffing levels, with some programs needing to limit services and bed capacity due to inadequate staffing.

Table 1: PIP Bed Capacity

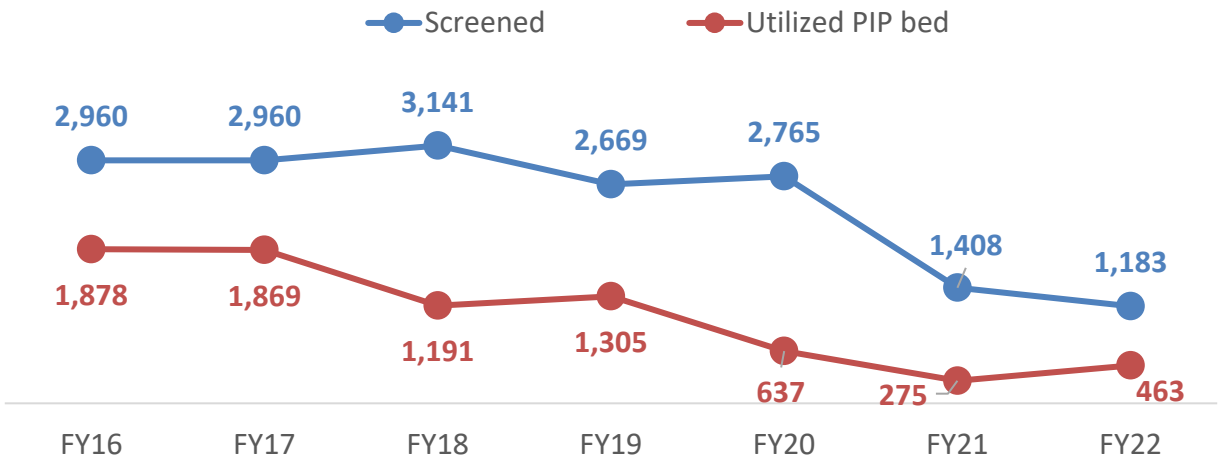
Program Name	Location	Beds
Washington County Mental Health Services / Central Vermont Substance Abuse Services	Berlin, Washington County	1
Clara Martin Center	Randolph, Orange County	0*
Health Care and Rehabilitation Services	Springfield, Windsor County	0*
Howard Center ACT 1	Burlington, Chittenden County	6
Howard Center	St. Albans, Franklin County	4
Lamoille County Mental Health Services	Morrisville, Lamoille County	1
Northeast Kingdom Human Services	Newport, Orleans County	0*
Northeast Kingdom Human Services	St. Johnsbury, Caledonia County	1
Recovery House	Wallingford, Rutland County	5
United Counseling Services	Bennington, Bennington County	1

* screening services provided without PIP bed.

Utilization

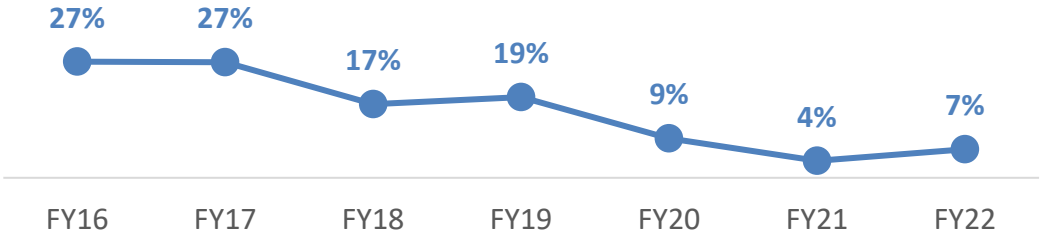
Utilization of public inebriate programs (PIP) has historically varied. PIPs saw a sharp decrease in the number of screenings conducted and beds utilized at the onset of the COVID-19 pandemic. Screenings and PIP bed utilization remain lower than pre-pandemic (Figure 1).

Figure 1. Number of screenings and Public Inebriate Program (PIP) beds utilized, by state fiscal year (FY)



Between State fiscal years 2016-2017, approximately 27% of bed-days were utilized per year (see Methodology for calculation details). The percent of bed-days utilized declined to 17% in State fiscal year 2018 and declined further to a low of 4% during the pandemic. In State fiscal year 2022 there was an increase in utilization (Figure 2), however it is too soon to discern whether this is an upward trend.

Figure 2. The percent of bed-days per year a public inebriate program bed was occupied, by fiscal year.



Stakeholder Feedback

A series of webinars, meetings, and a survey were sent to the stakeholders identified in Act 185 (2022) to gather feedback: the Chief Prevention Officer, Vermont Preferred Provider Network, Vermont Association of Addiction Treatment Professionals (VAATP), Vermont Care Partners, the Vermont Association for Mental Health and Addiction Recovery, and the Vermont Alliance for Recovery Residences, as well as law enforcement and the Department of Corrections. Survey responses were received from organizations located in the counties of Addison, Caledonia, Chittenden, Essex, Franklin, Grand Isle, Lamoille, Orange, Orleans, Rutland, Washington, Windham, and Windsor. Respondents to the survey included public inebriate program providers, Vermont Preferred Provider Network, Vermont Association of Addiction Treatment Providers (VAATP), Vermont Alliance for Recovery Residences (VTARR), VT Care Partners, Vermont Foundation for Recovery (VFOR), and Vermont Association of Hospitals and Health Systems (VAHHS).

Key themes that emerged from the stakeholder feedback related to utilization of public inebriate program were the difficulties in predicting capacity, staffing, and funding:

- "It is hard to predict necessary capacity - utilization has been low but then when we need it we don't always have a bed available. The unpredictable 'surge' is hard to staff/plan for and if we had added capacity we would be able to serve more direct admissions from the hospital for sure."
- "There are physical beds available, but not always staff capacity or sufficient funding to pay staff."
- We are asked to run a 24/7/365 program, and that is what we provide. We attempt to do this in the economical manner as we can, and still operate at a loss. So, while there are beds open (we are not used all day, every day) I would not describe this as excess."
- "Regardless of volume we need to be staffed and prepared for 24/7 - so the cost is what the cost is regardless."

As a result of stakeholder engagement, the following barriers to utilization of the public inebriate program were identified:

- Workforce constraints across law enforcement and public inebriate programs;
- Law enforcement capacity to identify and transport individuals for a screening;
- Emergency housing program capacity;
- Social distancing needs and PIP bed configuration related to COVID-19;
- Bars and restaurants closing for in-person business; and
- An increase in acuity and mental health needs among those being screened.

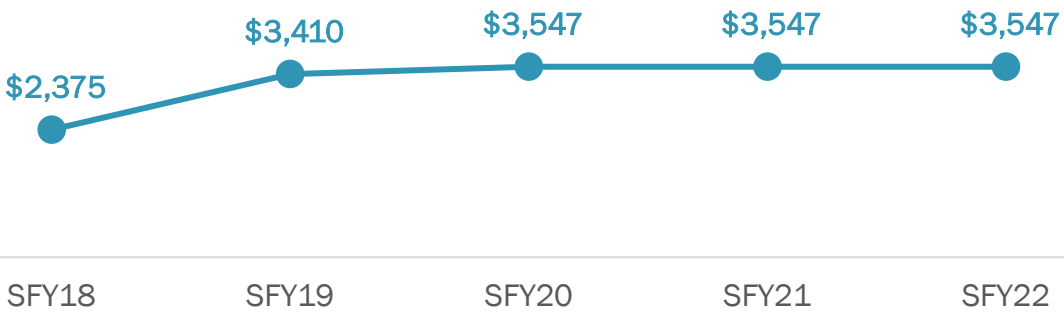
One respondent summarized a fundamental challenge in the following way: "[PIPs] serve the community for the service they were intended for. [In] recent years, the needs of communities have changed far beyond what the PIP is currently used for."

Financial Sustainability

The cost of operation for these programs, which must always remain open, increases year-over-year due to factors outside of provider control such as inflation and staffing shortages. Low program staff pay was identified as a reason for staffing shortages. In addition, many programs operate an on-call staffing model or share staff with other similar or co-located programs within an organization. PIPs report challenges in finding staff willing to work the on-call model because, unless there is an individual to screen and provide care for, they are paid at an on-call rate as opposed to the higher rate they receive when providing care to an individual in the PIP bed. Thus, staff are not guaranteed a higher rate of pay for the time they work. This has been identified as another potential contributor to high staff vacancy rates.

The Department's DSU is the primary funding source for public inebriate programs. While costs associated with these programs have increased, DSU funding has remained relatively unchanged for the past four fiscal years. In State fiscal year 2022, DSU paid approximately $3,550 per day for capacity across 10 programs (19 beds total). However, the dollars granted to organizations by DSU to operate their public inebriate programs may not cover all the organizational costs associated with the PIP. Five out of eight agencies report their public inebriate program operates at a deficit ranging from approximately $15,000 to $365,000 per year ($40-$1,000 per day) (Figure 3).

Figure 3. Amount budgeted for the public inebriate program per day has remained relatively constant over the past four years.



Source: Public Inebriate Program funding through Division of Substance Use Programs grants.

Stakeholder Feedback

Stakeholder feedback related to fiscal suitability included:

- "Our current program is running in the red more and more each year; not sustainable as it currently exists, and we are likely to be unable to provide this service beyond this fiscal year."
- "PIP beds are a critical service to help ease already burdened PDs [Police Departments] and the hospital ER and are a better approach to care for the recipients than the PD or ED

alternatives. The reimbursement rates are woefully inadequate to cover costs of the programming potentially jeopardizing the viability of this programming and/or expansion."

- "The PIP programs are a critical support in the community. Often the interaction with this program helps individuals to progress on to treatment for a substance abuse problem. In every admission, we save vital and seriously limited Police department and Emergency Room, capacity to attend to other priorities. This program saves people's lives."
- "PIP beds have been great to keep people out of jail when intoxicated on alcohol. The need has changed over the years. We need stabilization locations or a safety net to provide respite for those in various transitions."
- "I do not think that police will travel far as transportation is a barrier for them and takes much needed resources, so if there was a bed closely linked to hospital or other 24/7 programming this is ideal. I would like to see an alternative transport that is safe and secure created by the state for incapacitated individuals. …"

Conclusion

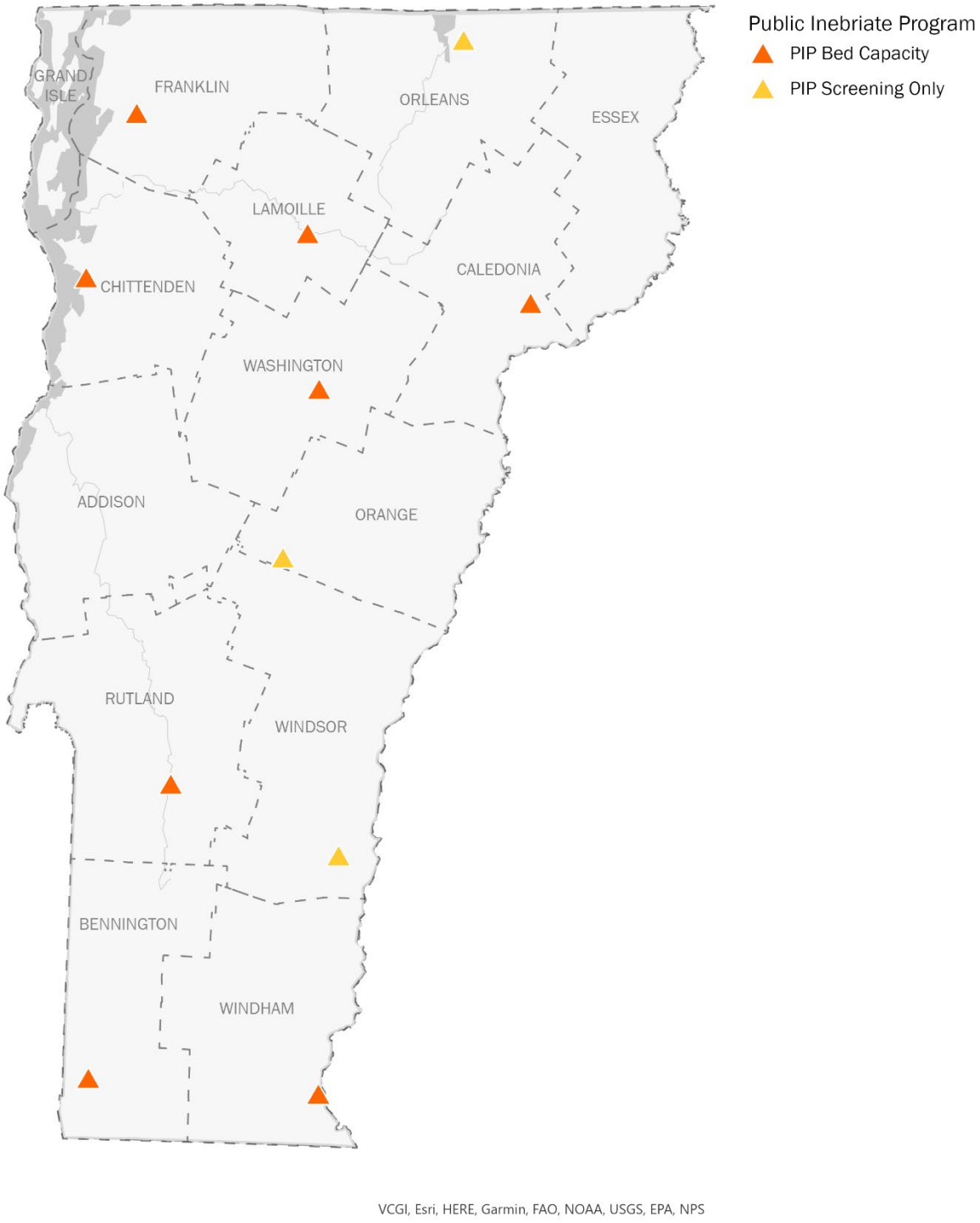
Public inebriate program capacity has been largely consistent for the past decade, with the last significant change in capacity in 2011. Historically, PIP utilization was approximately 25% of bed-days utilized per fiscal year, which began to trend downward in State fiscal year 2018. The pandemic accelerated that downward shift in utilization, and while State fiscal year 2022 did not show continued utilization decline, it is too soon to tell whether utilization will rebound.

However, despite this relatively low average utilization rate, the unpredictability of utilization needs means that there is not always capacity at a given PIP, and planning for alternative uses for these beds could result in even fewer beds being available for incapacitated individuals in need. This challenge is compounded by overextended operating costs and staffing deficiencies faced by PIPs in Vermont that may lead to fewer PIP beds being available in the future.

Additionally, the increased mental health needs among those being screened indicate the PIP could benefit from having the capacity to provide co-occurring screening, co-occurring intervention, and connection to mental health services. These additions would help overcome some of the barriers to the utilization of the PIP and align with the Agency of Human Services' work to expand co-occurring services across the health care system and the Agency, including the Department of Corrections.

The impact of such an expansion on workforce challenges and operating costs to programs needs further investigation. In order to assess the feasibility of the PIP adding these services, it is recommended that DSU, in coordination with the Department of Mental Health, determine whether there is a cost neutral manner to establish a pilot or pilots that better accomplishes this integration of care and if there is, to move toward implementation.

Appendix A. Map of Vermont Public Inebriate Programs



Appendix B. Screening Tool

Click to reset form

Personal Information

Name (last, first): | DOB: | Age: | SSN:
Address:
Race: American Indian or Alaskan Native | Asian | Black or African American | White | Native Hawaiian or other Pacific Islander
Gender: Male | Female | Transgender | Non-binary | Other | Refused
Ethnicity: Hispanic or Latino | Not Hispanic or Latino
Lives: Alone | W/others | Homeless
Phone #:
College Student: UVM | St Mike's | Champlain | Other: | NA

Contact Information

Date: | Time (24hr): :
Agency: | Screener:
Referred by: Police | Self | Hospital | Family | Other:
Officer's Name:
Doctor's Name:

Screening Information

Substance(s) used: Alcohol | Opiates | Benzos | Crack/Cocaine | Other:
Time last used: : | Amount used: | Route:
BAC 1: | BAC 2: | Refused

Are you having thoughts of harming yourself?	Y N	Oriented x 3?	Y N
Is this person a danger to self?	Y N	Impaired speech?	Y N
Are you having thoughts of harming others?	Y N	Can client walk without assistance?	Y N
Is this person a danger to others?	Y N	Is client taking any medications?	Y N
Impaired judgment/decision making?	Y N	Immediate medical concerns?	Y N
Psychiatric/crisis screening required?	Y N	Were they screening in the ED?	Y N

Non-Admit Reasons

Not incapacitated	No beds available	Medical concerns Mental health Physical health Drug use/interaction	Behavioral concerns Rule non-compliant Uncooperative Refused BAC Threatening, offensive or violent Flight risk Overuse of services

Disposition Information

PIP program | Self | Family | Hospital | Correctional Facility
Other:
Screener's signature:

Discharge Information

D/c date: / / | D/c time (24hr): : | Left APA | Police notified | Time: :
BAC @ D/c:
Subsequent contact? Y | N | Referrals made:
Staff signature:

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Appendix C. Decision Tree and Data Dictionary

Decision Tree

Not incapacitated ➡ **Released to self/family/responsible adult**

Incapacitated ➡ No beds available ➡ **Transported to corrections**

Incapacitated Beds available
↓
Medical concerns such as bleeding, drug interaction ➡ **Transported to medical services**
↓
Once medically cleared by hospital, return to PIP if appropriate

Incapacitated ➡ Beds available
↓
No medical concerns
↓
Individual refuses services, refuses to follow rules, refuses breathalyzer, etc. ➡ **Transported to corrections**

Incapacitated Beds available
↓
No medical concerns
↓
Individual agrees to comply with PIP rules
↓
Served in PIP bed

Non-Admit code definitions:

☐**Not incapacitated** – Individual is either below legal BAC parameters, or does not meet criteria for incapacitation as defined in 18 V.S.A. § 4802. (Programs should have a policy around releasing these individuals to self, family, or responsible adults).
☐**No beds available** – Program has no available beds, or does not have adequate staffing to safely care for the incapacitated individual.
☐**Medical concerns** – Concerns about the individual's safety due to physical or mental health reasons, see below:

- ☐**Mental health** – individual is presenting with suicidal or homicidal ideation with a plan or intent, or is presenting in a way that raises concern for the safety of the individual or others in the program.
- ☐**Physical health** – individual presents with a physical ailment, such as but not limited to a possible concussion or fall that involves head trauma, bleeding, or chest pain, or

other ailment that raises concerns for the safety of the individual or program staff; or an individual is needing a prescription medication to be administered.

☐**Drug use/interaction** – concern that the individual has taken drug(s) that in combination with alcohol pose a concern for the safety of the individual; BAC is above threshold for program; individual has a known history of detox symptoms that require medical management. *(Programs should have a policy around BAC threshold).*

☐**Behavioral concerns** – Individual has verbally or through their actions refused to stay in a PIP program.

☐**Rule non-compliant** – Individual does not agree to follow rules of program.

☐**Uncooperative** – individual is not complying with screening or is unable to complete the screening.

☐**Refused breathalyzer** – Individual refused to give BAC.

☐**Threatening, offensive or violent behavior** – individual has verbally or physically threatened staff or other individuals in the program, or has a history of violent behavior when previously kept in the program; or individual is making derogatory or otherwise inappropriate or offensive remarks, uses hate speech or uses other speech that violates the rules of your program. *(Programs should have a policy that defines and prohibits this behavior)*

☐**Flight risk** – individual has a history of fleeing the program, or is threatening they will flee during screening.

☐**Overuse of services** – individual exceeds the written programmatic rules regarding use of services in a set period of time. *(Programs must have a policy in place that defines what constitutes overuse of services when checking this box).*