



State of Washington
Joint Legislative Audit and Review
Committee

Chronic Public Inebriates Survey Report

Report 97-4

June 27, 1997

*Upon request, this document is available in alternative formats
for persons with disabilities.*



State of Washington
Joint Legislative Audit and Review
Committee

506 16th Ave. S.E., Olympia, WA 98501-2323
(Campus Mail: PO Box 40910), Phone: (360) 786-5171

Chronic Public Inebriates Survey Report

Report 97-4

June 27, 1997

*Upon request, this document is available in alternative formats
for persons with disabilities.*

TABLE OF CONTENTS

Chapter		Page
	SUMMARY	i
	ADDENDUM	iii
1	CHRONIC PUBLIC INEBRIATES IN WASHINGTON	1
	Estimated Prevalence of CPIs in Washington	1
2	OVERVIEW OF SERVICES PROVIDED FOR/USED BY CPIs	5
3	THE PORTLAND PROGRAM	9
4	PROGRAMS IN OTHER METROPOLITAN AREAS	13
5	CONCLUDING DISCUSSION	15
Appendix		
1	Scope and Objectives	17

CHRONIC PUBLIC INEBRIATES

Summary

Despite the expenditure of significant public resources over the years to deal with Chronic Public Inebriates (CPIs), the problems associated with this population have remained intractable—particularly in the downtown Seattle area. It is estimated that in fiscal year 1997 the state of Washington will spend approximately \$9.2 million statewide on direct and indirect services to this population. The total rises considerably when local and private costs are factored in.¹

The primary purpose of this survey has been to identify and review strategies used in other metropolitan areas around the country that are considered to be successful and/or cost-effective in dealing with this population. The program in Portland, Oregon has been of particular interest since it is often pointed to as being a national “model.”

The primary results of our limited survey can be summarized as follows:

- The Portland program provides a broad-based continuum of care, and embodies a coordinated approach to service provision. Major distinguishing features include its organizational structure, including the existence of a primary service coordinating entity, and the comparatively wide availability of alcohol- and drug-free housing for CPIs either in or awaiting treatment.

¹ A 1986 city of Seattle report (see footnote 2) estimated that the CPI population in Seattle used public and private resources valued at \$19 million per year for food, shelter, medical, and other subsistence, and alcohol-related services.

Introduction

Purpose
was to
identify
model
programs

Portland program widely praised

- Although the Portland program is widely praised and appears to be a worthy one, there have been no formal program evaluations or other types of comprehensive, outcome-based research that documents program effectiveness. There certainly are anecdotal claims of effectiveness, however. The executive director of the main coordinating agency reports that the number of CPIs has decreased significantly over the past ten years. Indeed, he estimates that currently there are only 50 CPIs in the Portland area—compared to an estimated 1200 CPIs in Seattle/King County.
- We were unable to identify services or programming in other metropolitan areas that are widely viewed as model programs, either through our review of the literature or through our contacts with national organizations and professionals in the field. This is despite the fact that there have been two rounds of national demonstration projects directed toward this population (although additional data regarding these demonstration projects may become available later this year).

These issues are addressed more fully later in this report. The report begins, however, by first defining the term “chronic public inebriate,” and then by providing brief overviews of both the prevalence of CPIs in Washington and of the types of services provided to them.

ACKNOWLEDGMENTS

This survey was conducted by Robert Krell, Gerry McLaughlin, and Valerie Whitener of the JLARC staff, under the supervision of Ron Perry. We appreciate the assistance of the many individuals who assisted in this effort.

Cheryle A. Broom
Legislative Auditor

On June 27, 1997, this report was approved by the Joint Legislative Audit and Review Committee with committee addendum and its distribution authorized.

Representative Cathy McMorris
Chair

ADDENDUM

Statement of the Joint Legislative Audit and Review Committee

The Joint Legislative Audit and Review Committee acknowledges that the presence of chronic public inebriates in certain urban areas of the state is a recurring problem that deserves attention by both state and local officials.

The committee supports actions at the state level which could provide assistance to local officials in dealing with this problem:

- Modifying the state's Landlord/Tenant Act to establish special provisions for clean and sober housing for recovering substance abusers;
- Monitoring implementation of the State Liquor Control Board's pilot restrictions on the sale of fortified wine in certain locations; and
- Evaluating the state's policies on the General Assistance-Unemployable Program, including issues such as protective payees and alternatives to cash grants.

CHRONIC PUBLIC INEBRIATES IN WASHINGTON

Chapter One

There is no commonly accepted *precise* definition for the term “chronic public inebriate.” We relied upon one that appeared in an appendix of a 1993 report prepared for the Seattle-King County Department of Public Health:

. . . an individual with a severe alcohol problem who is frequently drunk in public and/or has repeated encounters with alcohol detoxification services and other public services, such as police, jail and court services, emergency medical and emergency medical transportation services, public hospital emergency room care and involuntary commitment services.¹

For individuals in this population, alcohol abuse is considered to be their *primary* problem. Some individuals may also have a *secondary* problem with another drug, or with mental illness. A significant percentage of this population is, has been, or will be homeless at some point in time.

ESTIMATED PREVALENCE OF CPIs IN WASHINGTON

Given that there is no commonly accepted definition for the term, it is not surprising that there also is no exact accounting of the number of CPIs in Washington State—or anywhere else for that

Definition
of CPI

No exact
accounting

¹ Clegg and Associates, Inc., and Barbara J. Mauer, *Recommended Array of Services for Chronic Public Inebriates*, Seattle-King County Department of Public Health, February 1993.

matter. Exhibit 1, however, provides estimates for the state’s largest counties. As might be expected, the bulk of CPIs—both in terms of total numbers and on a per capita basis—are located in the immediate Seattle area. The figures for neighboring Pierce and Snohomish counties are significantly less.

Exhibit 1

Estimated Number of Chronic Public Inebriates in Washington Counties with a Population Greater than 200,000			
County	Estimated Number of CPIs ^[1]	1996 Population ^[2]	Number of CPIs Per 100,000
King ^[3]	1200	1,628,800	73.7
Pierce ^[4]	108	665,200	16.3
Snohomish	24	538,100	4.5
Spokane	200	406,500	49.2
Clark ^[5]	27	303,500	8.9
Kitsap	15	224,700	6.7
Yakima	60	207,600	28.9

[1] Unless otherwise noted, based on estimates provided by DSHS Division of Alcohol and Substance Abuse Regional Administrators

[2] Source: Office of Financial Management

[3] Mid-point of estimate provided by King County Regional Administrator

[4] Estimate of 95-100 CPIs in Tacoma’s “downtown area,” provided by Pierce County staff -- increased by 10 percent to reflect county-wide estimates (based on reported estimate of city/county division in King County)

[5] Number of “high utilizers” provided by Clark County detox staff, based on individuals with four or more admissions to detox in 1996

Estimates vary

It must be emphasized that the numbers shown in the table are relatively rough estimates, and come from different sources. The 1,200 figure cited for King County is mid-way between two other relatively recent estimates. The 1993 King County report referenced above stated that an “educated estimate” was that there were 1,000 CPIs countywide, with all but 100 being inside the city. A 1986 city of Seattle report “conservatively estimated” (based on welfare, shelter and other social service data) that there were 1,400 CPIs who were “visible” on Seattle’s downtown streets.²

²Marian Troyer-Merkel, M.P.H., Office of Management and Budget, City of Seattle, *A Comprehensive Review of Treatment and Service Programs Used By Seattle’s Downtown Public Indigent Alcoholics – A Report to the Mayor*, July 1986.

It should also be noted that not all CPIs utilize public services to the same extent. The 1993 King County study stated that only 400 to 600 of the 1,000 total estimated CPIs were “active in the public service system” at any one time. The 1986 city of Seattle report stated that only 500 of the 1,400 total estimated number of CPIs were considered to be “hard core recidivists” who go through detox or treatment programs numerous times every year.

OVERVIEW OF SERVICES PROVIDED FOR/USED BY CPIs

Chapter Two

Exhibit 2 provides an overview of the types and extent of basic services that are directed primarily to CPIs in Washington’s largest counties. The types of services included, aside from direct treatment, are as follows:

- **Van Service:** For picking up “downed” CPIs.
- **Sobering Units:** A short-term care facility (typically from 4 to no more than 12 hours) designed for persons who need to “sleep off” the effects of alcohol.
- **Detoxification Facilities** (“detox”): Slightly longer-term facilities—typically from 1 to 7 days, designed to control the immediate medical and psychological complications resulting both from an excess of alcohol in the bloodstream and the body’s response to withdrawal from repeated overdoses of alcohol. Generally, there are considered to be two basic types or models of detox—although in practice, there may often be some degree of overlap between them:

* Medical (also called “acute”) - In this model, the inebriate is considered to have a potentially serious physical problem that requires immediate and expert medical attention. Facilities often have full- or part-time physician coverage, and full-time nursing supervision.

* Social (also called “sub-acute”) - In this model, facilities are staffed primarily with non-medical personnel who

Types of services used

are trained to care for intoxicated alcoholics with little or no medicine. If medical emergencies arise, patients are transferred to a hospital for treatment.

- **Case Management:** Outreach services designed to link CPIs with treatment and other services, including housing and financial assistance.
- **Alcohol/Drug-Free Housing:** Low-cost housing, typically “single room occupancy” (SRO), requiring abstinence from alcohol and drugs as a condition of occupancy, designed for those who are in or are awaiting treatment programs.

Other services accessed by CPIs, but not reflected in Figure 2, include shelters (that provide overnight housing and up to two meals per day), medic one-type units, law enforcement, fire departments, and hospital emergency rooms.

Exhibit 2

County	Van Service [yes/no]	Sobering Units [capacity]	Social/Sub Acute Detox [capacity]	Medical/ Acute Detox [capacity]	Case Mgt. Services [yes/no]	Alcohol/Drug Free Housing [capacity]
King	yes	35	25	15	yes	461
Pierce	no	0	16	0	no	unk
Snohomish	yes	0	15	0	no	10
Spokane	yes	12	14	0	yes	25
Clark	no	0	6	0	no	20
Kitsap	no	0	6	0	yes	30
Yakima	no	0	14	0	no	0

Source: DASA and/or county staff
Unk = Unknown

Services available in WA

Services for CPIs are developed and coordinated at the local level. There is no statewide program in Washington that is primarily focused on this population. In 1987, the legislature enacted the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) which initially *was* focused on the CPI population; with its primary purpose being to get indigent alcoholics/addicts into treatment. Legislative priorities for the program changed in 1988, however.

Currently it is directed primarily towards chemically-dependent pregnant and parenting women, and parents with children. Although CPIs now have comparatively little involvement with the ADATSA program, staff of the state's Division of Alcohol and Substance Abuse report that a fairly sizable number of them eventually get into the program over time. Still, those that do represent only a small proportion of the total CPI population.

THE PORTLAND PROGRAM

Chapter Three

The program in Portland, Oregon has been pointed to by several sources as being a national model for dealing with chronic public inebriates. It is one that can generally be characterized as providing a broad-based continuum of care, and embodying a coordinated approach to service provision.

The key player in the Portland program, and the primary coordinating entity, is a private non-profit organization called Central City Concern (CCC). This organization, which was established in the late 1970s, provides/operates:

- Over 1,000 units of low-income housing, including over 400 units of “alcohol- and drug- free community” (ADFC) housing;
- Chemical dependency intervention services through what is known as the Hooper Center. These include van, sobering and medical detox services;
- The Portland Addictions Acupuncture Center (PAAC), which is one of Portland’s five primary chemical dependence outpatient treatment programs for homeless and low-income individuals; and
- Job training for homeless individuals.

CCC also provided the organizing impetus for another entity which is a key feature of the Portland system: the Homeless Alcohol and Drug Intervention Network, known as HADIN. This network consists of 22 alcohol and drug treatment agencies that serve homeless and low-income individuals. It is organized in such a way

Program
overview

Structural
issues

that member agencies are allowed to share confidential client information with each other. Representatives of the member agencies meet weekly to develop network-wide treatment plans and to work out any problems in the service referral system.

In addition to its basic organizational structure, other stand-out features of the Portland program are as follows:

Alcohol/drug-free housing is cornerstone of program

Alcohol and Drug Free Community (ADFC) Housing: In an interview, the executive director of CCC indicated that the existence of this type of “clean and sober” housing was perhaps the cornerstone of its program. Included are two types of housing: *transitional*, which serves both those coming directly out of detox and who are waiting to enter into a treatment program, and those coming out of residential care who are awaiting permanent ADFC housing; and *permanent*, which serves those who are either in treatment or in post-treatment recovery programs. By providing a round-the-clock, stable residence, this type of housing fills the gaps shelters leave open. In describing the symbiotic relationship between ADFC housing and treatment programs, a CCC publication notes that: “Without this housing, treatment would have failed with all but a handful of lucky individuals. Without treatment, it is unlikely that any would be sober, rather most would be dead or caught in the revolving door of addictions, the streets, jail, hospitals, and social and welfare services.”¹

May require special legislation

CCC’s executive director emphasized that for this type of housing to be successful, there needs to be a “zero-tolerance” policy with respect to residents drinking or using drugs, with violations resulting in *immediate* eviction—something which is typically not permitted under standard landlord-tenant laws. The Oregon Legislature has enacted legislation which exempts alcohol- and drug-free housing programs from such requirements.

Fortified Wine/Other Alcohol Restrictions: The city of Portland has imposed restrictions on the sale of fortified wine since 1986 and on large-size containers of malt beverages since 1993. Although the restrictions have reportedly resulted in

¹ Richard Harris, Central City Concern, *Alcohol- and Drug-Free Community Housing Proposals Providing Supportive Housing For Homeless and Low Income*, March 1997.

some dispersal of the problem (i.e., to other areas), the program manager of the City's Liquor Licenses and Regulatory Permits division said they have reduced the incidence of alcohol-related problems within certain problem areas. (In Washington, the Liquor Control Board has negotiated restrictions with individual retailers in the Pioneer Square Area.)

Financial Assistance: Supplemental income programs, such as Supplemental Security Income (SSI) or General Assistance (GA), are essentially unavailable in Oregon for this population. A CCC publication notes that: "Providing SSI income to addicts and alcoholics will not only fail to provide food and shelter, but will actively contribute to the addiction process. This is literally a solution that kills . . . [such programs] may be appropriate for some populations but are irresponsible programs for addicts and alcoholics."²

Downtown Association: Merchants and property owners in the central area have formed an organization called the Association for Portland Progress. A self-imposed assessment fee is used to hire workers who have quasi-police powers with respect to dealing with CPIs. These workers provide security services, identify and/or assist downed CPIs, including calling the van to pick them up, and also help to keep up the physical appearance of the central area through activities such as picking up litter and painting over graffiti. These activities cost approximately \$2.2 million annually.

Exhibit 3 provides a summary overview of the features and services of the Portland program, and compares them to what exists in the Seattle area.

The executive director of CCC estimates there are only 50 CPIs in the Portland area; a significant reduction from past years. Further, he described them as generally being younger and having been addicted to alcohol for less time than the CPIs one currently sees in the Seattle area. He attributes this to the success of their program, and states that the very long-term CPIs have either died, been rehabilitated, or moved away. The director of CCC's Hooper Center echoed a similar assessment when he said that the streets of Seattle or San Francisco today look like the streets of Portland ten years ago.

² Ibid.

Other program features

Few CPIs in Portland

Exhibit 3

Primary Features of Portland's Program For Chronic Public Inebriates And Comparison to Seattle/King County

Feature	Portland/Multnomah County	Seattle/King County
Estimated # of CPIs ^[1]	50 (8.0 per 100,000 population) ^[2]	1,200 (73.7 per 100,000 population) ^[3]
Organizational Structure	Central City Concern [®] (CCC), a private nonprofit organization, serves as the primary coordinating entity. Treatment services are provided and coordinated through 22 member agencies of the Homeless Alcohol and Drug Intervention Network (HADIN), which is organized in such a way as to enable the sharing of confidential client information.	No comparable private organization, though state and local agencies are attempting to fill the coordinating role. A treatment provider network is in the process of being formed, and attempts are being made to "work out the legalities" that currently prohibit the sharing of client information.
Services/Resources		
Van Service (for picking up "downed" CPIs)	Available 18 hours per day. No problems reported in coordinating pick-ups between van staff and police.	Available 24 hours per day. Coordination issues reported to be in "need of attention."
Sobering Unit ^[3]	50 slots (approx.) (8.0 per 100,000 population)	35 slots (2.1 per 100,000 population) 25 more planned for opening in 1998. (for total of 3.7 per 100,000 population)
Social Detox ^[3]	Not available	25 slots (1.5 per 100,000 population)
Medical Detox ^[3]	54 slots (8.6 per 100,000 population)	15 slots (0.9 per 100,000 population)
Case Management	Available	Available
Outpatient Treatment	Available	Available
Alcohol/Drug Free Housing	426 units (68.0 per 100,000 population). Programs are statutorily exempted from certain landlord-tenant laws.	461 units (28.3 per 100,000 population). Units are not effectively linked into a system.
Job Training (w/Housing)	62 slots (9.9 per 100,000 population)	Few slots directed specifically towards the CPI population.
Other System Features		
Fortified Wine Sales	Restrictions imposed in designated "impact areas."	Restrictions negotiated with selected retailers in Pioneer Square area.
GA-U Financial Assistance	Essentially unavailable for this population since alcohol/drug dependency cannot be a contributing factor to the disability.	Limited availability for this population. Alcohol/drug dependency can be a secondary disability. DSHS does not track secondary disabilities.
Downtown Association	Self-imposed assessment fee funds workers to help "police" CPIs, and to keep downtown area clean.	Necessary organization reported to be "coming together," but funding provisions are not yet in place.

[1] For Portland, estimate provided by CCC Director. For Seattle/King County, mid-point of estimate provided by King County DASA Regional Administrator.

[2] Based on 1995 estimated population for Multnomah County of 626,600, and 1996 estimate for King County of 1,628,800.

[3] Definitions are not precise. Some overlap may exist.

Portland/
Seattle
comparison

Unfortunately, no formal evaluations have been conducted of the Portland program. We were further unable to identify any other comprehensive outcome-based research which could be used to help document claims of program effectiveness.

Planning
underway
in Seattle

It should be noted that a major planning effort directed towards the problems of chronic public inebriacy has been underway in the Seattle/King County area for the past year. This effort, which was originally initiated by the current King County Executive, is being spearheaded by a group called the CPI Systems Solutions Committee. This committee is very familiar with the Portland program, and has examined various facets of its operations. It has formed sub-committees devoted to the following issue areas: Employment and Vocation, Housing Resources, Social and Human Services, Systems Financing and Legislation, and Public Safety and Community Livability.

PROGRAMS IN OTHER METROPOLITAN AREAS

Chapter Four

We were unable to identify services or programming in other metropolitan areas that are widely viewed as model programs, either through our review of the literature or through our contacts with national organizations and professionals in the field.

There were certain metropolitan areas, however, that were referenced more often in the literature as having a history of providing a range of services for this population. We contacted the responsible service providers and coordinators in eight of those metropolitan areas: Phoenix, San Diego, Denver, Minneapolis, St. Louis, Cincinnati, Philadelphia, and Washington, DC. None of the current programming provided by the areas had undergone any type of formal evaluation, nor was any comprehensive cost, outcome, or usage data available regarding their operations.

There have been two rounds of “national demonstration” programs directed towards “effective and replicable approaches to the treatment of homeless persons with alcohol and other drug problems.”¹ Although the first round, which included nine sites, did result in a number of general “lessons learned,” information concerning program effectiveness was limited and generally inconclusive. There were also significant data limitations.²

¹ Administered by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), with funding provided through the Stewart B. McKinney Homeless Assistance Act of 1987, and subsequent amendments.

² National Institute of Health, National Institute on Alcohol Abuse and Alcoholism, *Community Demonstration Grant Projects For Alcohol and Drug Abuse Treatment of Homeless Individuals – Executive Summary*.

Unable to
identify
other model
programs . . .

. . . despite
national
demonstration
programs

Additional
data may
become
available
later

According to NIAAA staff, the final results of “Round 2” of the national demonstration projects—which is focused on rigorous evaluation of program results at 14 sites—will likely not be ready for publication until the fall of 1997. We were able, however, to review a summary of the results of ten of the programs. They generally could be characterized as ambiguous. One of the major conclusions, for example, was that clients in the experimental groups improved significantly by treatment’s end—but those in the control groups, however, improved just as much. Further, the improvements that were noted immediately after treatment seemed to diminish over time.³

It should be noted that one of the Round 2 demonstration projects was conducted in Seattle. The objective of the project/study was to determine if intensive case management intervention is effective in three areas: 1) reducing alcohol use among CPIs; 2) improving the financial status of CPI clients; and 3) improving the residential stability of CPI clients. Although the preliminary study results showed statistically significant differences favoring the case managed group over the control group in all three targeted areas, the differences were “not large.”

³ Gerald J. Stahler, *The Effectiveness of Social Interventions for Homeless Substance Abusers*, *Journal of Addictive Diseases*, 1995.

CONCLUDING DISCUSSION

Chapter Five

A major purpose of this survey was to identify effective programs and strategies from around the country for dealing with the CPI population and to at least consider their potential for possible replication in Washington State. Importantly, however, we also sought objective evidence of program effectiveness.

Other than the Portland program, we were unable to identify any programs that are viewed as potential models. Unfortunately, although that program appears to be a worthy one, there is no comprehensive outcome-based research that documents program effectiveness.

Nonetheless, the anecdotal claims of effectiveness for the Portland program are impressive. Therefore, it may be worthwhile for the appropriate governmental officials to further examine and consider those features of the program that have been reported to be instrumental to its success, including:

- An organizational structure that provides for overall system coordination;
- A wide availability of alcohol- and drug-free housing for CPIs either in or awaiting treatment (along with exemptions from standard landlord/tenant laws that allow for the immediate eviction of those residents who fail to abide by the housing's abstinence requirements);

May be
worthwhile
to further
examine
Portland
program

- Restrictions on the sales of fortified wine and other alcoholic beverages in identified problem areas;
- Elimination of direct governmental financial assistance for individuals with alcohol and drug dependencies, and;
- A downtown association, with its own funding base, to provide security services related to the CPI population.

SCOPE AND OBJECTIVES

Appendix 1

SCOPE

This study will entail a limited survey of programs and/or strategies used in various metropolitan areas around the country that are viewed as being particularly effective in dealing with chronic public inebriates.

OBJECTIVES

- To identify and review selected programs that are considered to be models for dealing with chronic public inebriates.
- To assess the availability and/or applicability of research concerning the effectiveness and/or outcomes of such programs.
- To compare characteristics of Portland, Oregon's program for chronic public inebriates to what exists in the Seattle/King County area.