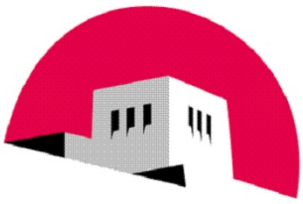

The University of New Mexico

Bernalillo County Department of Substance Abuse: Public Inebriate Intervention Program

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Alexandra Toscova Tonigan, B.A.
Paul Guerin, Ph.D.

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UNIVERSITY OF NEW MEXICO, INSTITUTE FOR SOCIAL RESEARCH

INTRODUCTION

The purpose of the Bernalillo County Department of Substance Abuse Program's (DSAP) Public Inebriate Intervention Program (PIIP) in Bernalillo County, including Albuquerque, New Mexico is to relieve congestion in UNM Hospital's Emergency Department and Psychiatric Emergency Services, as well as other hospital emergency rooms in Bernalillo County (Presbyterian and Lovelace) and to reduce the number of bookings at the Metropolitan Detention Center (MDC). To do this, the Department of Substance Abuse Program (DSAP) has partnered with the Albuquerque Fire Department (AFD) and the Albuquerque Police Department (APD) to "identify inebriates in the community and offer voluntary transportation to the Bernalillo County Metropolitan Assessment Treatment Services (MATS) facility," where individuals have the opportunity to stay up to 12 hours in a stable and safe environment until they sober up (Board of County Commissioners, DSAP). In doing so, the inebriated individuals receive the appropriate treatment and care, crowding within jails and hospitals is alleviated, and a substantial amount of money can be saved.

The program is located at the Bernalillo County Metropolitan Assessment Treatment Services (MATS) facility. This program houses a number of programs including detoxification services, a medical observation and treatment unit, supportive aftercare, residential services, and a hospital for adult/adolescent medical detoxification and rehabilitation. The information presented in this report originates from forms maintained by MATS on individuals who were served by PIIP in April, May and October of 2014.

BACKGROUND

The Problem

For more than 70 years, agencies within the United States have sought out ways to control and prevent public inebriation (Reynolds, 1982). Programs designed to provide prevention and treatment services for alcohol dependence and abuse have been around since the 1940's. Across the United States, community members from both the medical and criminal justice system have become increasingly aware of jail and hospital overcrowding. The decriminalization of public inebriation in many states has helped alleviate jail and hospital over-crowding, however, it has not been a long-term solution—one which reduces the involvement of the criminal justice system and the utilization of medical services, while providing the appropriate services to help public inebriates. Today, communities are exploring ways to achieve this by not only addressing the apparent surface problems, but also the underlying problems. For example, public inebriation is often associated with homelessness and alcohol abuse/dependence (Pate, 2012).

All in all, the problem of public inebriation is that it requires services from a variety of agencies. Unfortunately, many agencies within the community, such as the criminal justice system and the healthcare system, lack the resources to provide a continuum of care for such individuals.

Since the 1980's, research professionals have discussed different ways of approaching the problem. Although slightly outdated, a publication by Reynolds et al. (1980) is still referred to when discussing the fundamental principles surrounding this topic. In it, Reynolds et al. suggests that such services can be categorized by need:

1. Social Control—Services to eliminate the nuisances caused by the "chronic police-case inebriate" and the danger posed to the community by the occasional "non-public inebriate drunk";

2. Caretaking—Services to meet the basic needs of the public inebriates for shelter, food, and other non-alcohol-related services; and
3. Alcoholism and Alcohol Abuse—Education, counseling and treatment services for both the occasional and the chronic inebriates who are willing and able to address their drinking problems.

Today, many individuals maintain that these issues must first be resolved before anything else is addressed (Pate, 2012). Currently, data indicates New Mexico residents use and abuse illegal drugs and alcohol at a higher rate than the national average (National Survey on Drug Use and Health (NSDUH), 2013). Moreover, drug and alcohol-attributable death rates are more than twice that of any other state in the Nation. (Department of Health (DOH), 2013). According to the New Mexico Department of Transportation (NMDOT), there were approximately 2,320 alcohol-involved car crashes. Out of all the counties, Bernalillo County accounted for 681, almost 30%, of the alcohol-involved crashes (NMDOT, 2011).

Inebriated individuals and community members don't always receive the healthcare services they require. First, an inebriate may be assessed incorrectly. This results in the inebriated individual not receiving the correct treatment, and also ties up services other community members may need. Second, an inebriate may be assessed correctly, but the service they require might not be provided for a number of reasons including the service is unavailable, there may be a lack of capacity, or the individual maybe directed to the wrong service. Consequently, they are directed elsewhere and don't receive the correct treatment, and also tie up services that other community members may need. Holzer and colleagues (2013) suggest there are distinct differences between patients who utilize ambulance services repeatedly due to intoxication, versus one-time users. Such individuals had different "patterns" of intoxication. Additionally, they were on average, almost 8 years older, less likely to be injured, and more often showed aggression or uncooperative behavior towards paramedics.

From their research, Holzer and colleagues deduced that,

*"The ambulance-service users' generally slight impairment of consciousness and the high proportion of intoxicated patients without any injuries raise the question of how many of these patients could be adequately cared for in a sobering center. Sobering centers might relieve hospital emergency departments of patients not requiring acute emergency care and, in addition, could provide intervention services to prevent relapses "(*Holzer, 2013).

Research suggests that diverting public inebriates from Emergency Departments (ED) can result in significant cost savings. One study comparing the utilization of ED's versus sober shelters found that 399 inebriates accounted for 732 ED visits within a 12 month span. Analysis of the services utilized revealed that the hospital charges ranged from $479.00-$1,241.00 per visit (Mean, $738.00). Of these charges, about 28% were reimbursed primarily by tax-supported payers. The remaining charges (72%) totaled over $388,000 (Williams and Jones, 2010).

The same perpetual domino effect explained for the healthcare system also applies to the criminal justice system. Public inebriation is also time-consuming and costly for the law enforcement. Instead of focusing resources on actual threats to the community, the law enforcement must cite or even book public inebriates because they have nowhere else to go. Jail over-crowding has been a huge and costly problem over the years.

ALTERNATIVE TO EMERGENCY DEPARTMENTS AND JAILS

Sober Centers

Sobering centers are most often described as brief interventions due to their short-term duration (ranging from a few hours to overnight). In many cases, they are the only other legal alternative for individuals booked for public intoxication (Marin County Civil grand Jury, 2013).

Results from a study conducted by a sobering center in Marin County illustrated numerous benefits, including:

- Freed-up needed beds in the EDs of the local hospitals and decreased waiting time for other patients.
- Freed-up needed beds for jail inmates, and generated savings from a decrease in booking fees, officer overtime and other jail related costs.
- Eliminated unnecessary paramedic trips and allowed law enforcement officers to return more quickly to normal patrol duties.
- Provided a safe, clean place for recovery from alcohol intoxication.

Another sober center, known as the Cherry Hill Detox and Safe House, in Alameda County, California, strives to be, "A 'front door' through which chronic inebriates can not only obtain alcoholic rehabilitation services but also receive advice on obtaining more stable living arrangements and information about programs that assist in developing greater self-care" (Marin County Civil Grand Jury, 2013). The center is open 24 hours a day, seven days a week, has a capacity of 50 clients, and offers services to men and women. A cost study conducted in 2010 indicated a cost savings of $280,000 per year (Marin County Civil Grand Jury, 2013).

IMPLEMENTATION

According to *Problem-Oriented Guides for Police, Chronic Public Inebriation*, by Matthew Pate, establishing and adhering to a system of care framework with guidelines for support services is essential. Such guidelines must have consistent assessment scales, which can be used to determine and direct inebriated individuals to the proper level of service and supervision. Complicating matters, it is also essential that the system have sufficient flexibility if it is to effectively address individual circumstances. In other words, such interventions must be tailored to the needs of the inebriated individual, as well as the general community. With both of these conflicting guidelines in mind, each agency must determine the correct balance.

Pate also provides a sample triage plan, in which individuals are organized by four general behavioral/need classifications; suggesting that first responders should ascertain whether:

1. Subject is inebriated, but not incapacitated.
2. Subject is medically unstable due to a physical or mental health issues.
3. Subject is incapacitated, medically stable, and cooperative.
4. Subject is incapacitated, medically stable, but exhibits aggressive, uncooperative, unpredictable, or violent behavior

Other well established projects emphasize the importance of a few core elements. The elements should be prioritized and tailored based on the specific needs of the community. The first element addresses the ways in which public inebriates are "recruited" into the programs. There are numerous programs across the United States that successfully "recruit" individuals all in different ways. This appears to be attributed to the purpose of the program and what the outcome is driven by, specifically:

- Does the program intend to use arrest as a deterrent for individuals opting out of treatment?
- Does the program intend on providing long term treatment options, or referrals to such treatment programs?
- Is the intention of the program to reduce visibility of public inebriates (and potentially homelessness)?
- In regards to recruitment, do programs only accept referrals, or are walk-in's allowed?

San Diego's Serial Inebriate Program (SIP) was developed in January 2000 through the partnering of the law enforcement, the courts, hospitals, and emergency medical services. SIP serves chronic homeless inebriates by providing treatment in lieu of custody. SIP's continuum of care includes intensive case management, treatment and recovery services, housing support and services, and additional supportive services such as mental health, medical home, transportation, education, employment and job training (Mental Health Systems, Inc.)

When an individual is placed in custody for the crime of Public Intoxication, they are assessed for SIP eligibility. Eligibility is based on being identified as a "chronic" inebriate, meaning the individual has accumulated five transports to the Inebriate Reception Center (IRC) within thirty days. Once identified as a chronic inebriate, the San Diego Department Liaison officer is responsible for notifying the SIP case manager. While all SIP patients are unique and have different needs, according to there are some trending characteristics which include the following:

- 95% male
- Age ranging from 23-71 years old, with a mean of 50 years old
- 70% abuse other substances in addition to alcohol
- Approximately 90% have additional mental illnesses, beyond that of mixed substance abuse and dependence
- A little more than 38% have psychosis
- 53% were identified as having one of more infectious disease

While *"SIP continues to be recognized across the nation as a best practice with the chronic homeless alcoholic,"* (San Diego Annual Report) Mangano acknowledges that the San Diego model *"may not be for every city because it calls for the police to make arrests for public drunkenness, something that is seen as inappropriate in some cities*," (Greene, 2007).

In contrast, "Dunford's research indicates that the threat of jail is an important inducement for treatment. Only about half of those who enter the system choose treatment, but they choose it more often when the jail term they face is longer. Treatment was accepted by 20% of those who faced a sentence of 30 days or fewer but by 63 percent of those looking at 150 days or more in jail," (Greene, 2007).

THE COSTS

Emergency Care Systems

The following reports cost savings through the analysis of DSAP-PIIP data in Albuquerque, New Mexico. Data collected from 2013 (April, May, June, July, August, September, October and November) for jail diversions, and 2014 (April, May and October) for ER diversions suggest the program diverts individuals from local emergency rooms and the local jail thereby producing cost savings.

APRIL and MAY

Data entry beginning in June 2014 through July 2014 consisted of information maintained by MATS from April 2014 and May 2014 intake forms. A total of 966 intake forms were collected and entered into a database for analysis. The MATS Public Inebriate Intervention Program intake form is designed to briefly screen individuals who arrive at PIIP. The form includes the individual's name, the date and time the form was completed, date of birth, ethnicity, age, gender, and a space for two blood alcohol content measures and the time of each measure. The form also collects information on how the client arrived at MATS, if they were referred from a hospital the referring hospital, the client's hospital of choice, type of insurance, and whether the client has any thoughts of suicide or a plan. Finally, the form has an informed consent for services section, a pledge of confidentiality section, and spaces for client and staff signatures. This form is completed before the individual is accepted for services. Important for this study is the information on how the client arrived at MATS and the referring hospital.

In order to determine the cost savings for ER diversions, it was necessary to understand how many diversions had taken place during the study time period. Determination of whether a client was diverted from an ER to MATS was based on how the client arrived at MATS and the referring hospital. In conversations with DSAP staff this method was discussed, vetted, and agreed upon. In general clients were considered to be diverted from an ER to MATS if a referring hospital was listed or if the client arrived from a source that typically would have resulted in an ER visit if MATS did not exist. This included APD/AFD transports, transports by MATS, ambulance transports and transports from any hospital. Diversions do not include individuals who are listed as a "walk-in" and for whom there is no referring hospital information. It is likely some of these individuals would become ER diversions and if whether or not the client was truly a "walk-in" was verified and if a referring hospital were listed. We have been told that sometimes individuals who "walk-in" may have been an APD transport or some other type of arrival and either staff did not clarify the type of arrival or the client did not clearly provide the information. MATS staff is working to better collect this information.

Table 1 reports the method of arrival and the referring hospital if known.

Table 1. Method of Arrival at PIIP

Arrival Method	Hospital Known	Hospital Not Known
Unknown	Yes	No
Ambulance	Yes	Yes
AFD/APD Transport	Yes	Yes
Cab	Yes	No
Presbyterian	Yes	Yes
MATS Transport	Yes	Yes
UNM Transport	Yes	Yes
UNMH	Yes	Yes
VA	Yes	Yes
Walk-in	No	No

Response options were then narrowed down to either, "Yes" and No" based upon discussions with MATS staff. Following the model above, we determined that approximately 462 of the 974 were diversions. The remaining 512 cases could not be definitively categorized as a diversion. Of the 512 non-diversions, over 90% were listed as "walk-ins." As described earlier, it is unclear how many walk-in's may have actually been a diversion, and how many were simply walk-in's.

Table 2 reports the number of diversions and non-diversions and their methods of arrival.

Table 2. Diversion from Emergency Department Scale

Method of Arrival	Diverted		Total
	No	YES	
Unknown	30	4	34
AFD	0	2	2
Ambulance	0	34	34
APD Transport	0	294	294
Cab	4	33	37
MATS Transport	0	62	62
Presbyterian DT	0	10	10
UNM Transport	0	22	22
VA	0	1	1
Walk-in	472	0	472
Other	6	0	5
TOTAL	512	462	974

Diversions were also categorized by month (April or May) and hospital or facility, which includes the following, Lovelace, Presbyterian, UNMH, VA, MOTU, and "Unknown".

Table 3. Hospital Diversions by Month and Total

Month	Lovelace		MOTU		Presbyterian		UNMH		VA		Unknown		Total
		%		%		%		%		%		%	
April	5	1.08%	2	0.43%	19	4.11%	41	8.87%	2	0.43%	172	37.22%	241
May	3	0.65%	0	0.00%	10	2.16%	37	8.01%	1	0.22%	170	36.80%	221
Total	8	1.73%	2	0.43%	29	6.28%	78	16.88%	3	0.65%	342	74.02%	462

Of the 462 diversions, approximately 52.1% took place in April, and almost 48% took place in May of 2014. Additionally, of the 462, 120 (25.9%) could be matched to a particular hospital. Of these, UNMH accounted for the majority (16.9%) of identifiable diversions.

Lastly, costs were calculated for the diversions. The average cost per ER visit was calculated using $1,873.62 as the amount. This average cost per diversion is based on a set of data we have from another study (Guerin and Tonigan, 2013). This housing study of formerly homeless individuals included actual hospital costs for study group members from Lovelace, PHS, and UNMH. Costs were NOT calculated for non-diversions, or walk-in's. Because of this, estimated costs are very conservative. For April and May 2014, there was a total cost savings of $865,612.44. Excluding the Unknown, UNMH accounted for the most cost savings ($146,142.36).

Table 4. Diversion Savings by Facility

Hospital	Count	% of Diversions	Cost Savings of Diversions
UNMH	78	16.9%	$ 146,142.36
Presbyterian	29	6.3%	$ 54,334.98
Lovelace	8	1.7%	$ 14,988.96
MOTU	2	0.4%	$ 3,747.24
Unknown	109	23.6%	$ 204,224.58
Other/NA	233	50.4%	$ 436,553.46
VA	3	0.6%	$ 5,620.86
Total	462	100.0%	$ 865,612.44

Demographics

Some of the personal information collected from diverted individuals, such as social security numbers and birthdates, were determined to be unreliable sources of data. Data on client gender and ethnicity was more complete and reliable. The following tables reports available demographic information for the 974 individuals.

Of the 974 individuals, 72 did not indicate a gender—this is indicated below (Table 4). Of the remaining 902, 10% were identified as female, and 90% were identified as male.

Table 5. Gender

Gender	Count	Percent
Female	91	10%
Male	811	90%
TOTAL	902	100%

Missing 72

Of the 974 individuals, over 70% did not indicate an ethnicity. Of the remaining 30% (286) individuals, the majority of the clients identified as Hispanic (51.4%).

Table 6. Race/Ethnicity

Race/Ethnicity	Count	Percent
Asian	1	0.4%
Black	15	5.2%
Hispanic	147	51.4%
Native American	53	18.5%
White	70	24.5%
TOTAL	286	100%

Missing 688

OCTOBER

For the month of October, a total of 388 intake forms were completed. Like the months of April and May, determination of whether a diversion occurred took into account the method of arrival and whether or not the referring hospital was known. It remains difficult to determine whether or not walk-in's are true diversions. For this reason, all walk-in's have been categorized as non-diversions.

Table 7 reports the method of arrival and the referring hospital if known.

Table 7. Method of Arrival at PIIP

Arrival Method	Hospital Known	Hospital Not Known
Unknown	Yes	No
Ambulance	Yes	Yes
APD Transport	Yes	Yes
Cab	Yes	No
Shelter	No	No
Family	No	No
MATS Transport	Yes	Yes
Presbyterian	Yes	Yes
UNM Transport	Yes	Yes
UNMH	Yes	Yes
VA	Yes	Yes
Walk-in	No	No

Using the model above, it was determined that a total of 172 individuals (44%) were diversions and 216 individuals (56%) were non-diversions. The majority of non-diversions were categorized as walk-ins (99%), with only two other instances being an external agency, such as a shelter, and family.

Table 8 reports the number of diversions and non-diversions and their methods of arrival.

Table 8. Diversion from Emergency Department Scale

Method of Arrival	Diverted		Total
	No	YES	
Ambulance	0	24	24
APD Transport	0	78	78
Cab	0	24	24
MATS Transport	0	27	27
Presbyterian DT	0	11	11
UNM Transport	0	8	8
VA	0	0	0
Walk-in	214	0	214
Other	2	0	2
TOTAL	216	172	388

Diversions were also categorized by hospital or facility, which included UNMH, Presbyterian, Lovelace, VA, and "unknown". UNMH and Presbyterian account for almost 90% of the diversions, with 101 (59%) from UNMH and 48 (28%) from Presbyterian.

Table 9. Diversion Savings by Facility

Hospital	Count	% of Diversions	Cost Savings of Diversions
UNMH	101	59%	$ 189,235.62
Presbyterian	48	28%	$ 89,933.76
Lovelace	7	4%	$ 13,115.34
VA	10	6%	$ 18,736.20
Unknown	6	3%	$ 11,241.72
Total	172	100%	$ 22,262.64

Lastly, costs were calculated for the diversions using the same method described above for the months of April and May 2014. For the month of October, there was a total cost savings of $322,262.64. In contrast to the months of April and May, UNMH accounted for $189,235.62 of the cost savings and only 3% of diversions that took place in October could not be categorized by hospital or facility.

CRIMINAL JUSTICE SYSTEM

In order to determine the cost savings of each jail diversion, collected data first needed to be re-sorted and cleaned. During this process, we found approximately 142 transported individuals, or 13%, of the cases examined were missing too much information for us to determine whether they were diverted from the

MDC. In other words, the entry contained such incomplete information, that it could not be used for data analysis. As a result, only 954 cases out of the 1096 were utilized for data analysis. Based on information received from the County regarding jail costs the average jail cost per day was determined to be $67.52. Costs were only calculated for valid data, in which a case was determined to be a diversion. It was determined that the average length of stay (ALOS) was 3.5 days. The total cost savings was calculated by multiplying $67.52 by 3.5 days per diversion.

Data was then organized by month, for the following months: April, May, June, July, August, September, October and November for the year 2013.

Table 10. MDC Diversions

Month	Diverted	% of Valid Data	Diverted Days	Cost Savings
April 2013	55	28%	192.5	$12,997.60
May 2013	12	29%	42	$2,835.84
June 2013	67	30%	234.5	$15,833.44
July 2013	43	43%	150.5	$10,161.76
August 2013	30	18%	105	$7,089.60
September 2013	17	20%	59.5	$4,017.44
October 2013	8	10%	28	$1,890.56
November 2013	9	16%	31.5	$2,126.88
Total Cases	**241**	**100%**	**843.5**	**$56,953.12**

Of the 954 valid cases, 241(25%) were identified as diversions, amounting to a total cost savings of $56,953.12. Findings suggest that the majority (28%) of jail diversions took place in June, while the least (less than 1%) took place in October. After accounting for the ALOS, it was determined that the 241 diverted individuals accounted for over 843 days in the MDC. Further analysis of the data is necessary in order to determine the number of beds freed-up, and any other significant factors.

CONCLUSION

In conclusion, public inebriation has several negative consequences for the individual, as well as the community. Public Inebriation Programs (PIP), also sometimes referred to as Serial Inebriation Programs (SIP), offer alternatives to some of these consequences, such as expensive emergency hospital visits and overcrowded jails.

Such diversion interventions often occur in lieu of incarceration or unnecessary hospitalization, thus aligning the criminal justice system and the social service and therapeutic communities' interests. Moreover, transporting inebriated individuals to safe and secure facilities, such as PIIP, removes any perceived threat, either towards the community or to the inebriated individual. Aside from alleviating overcrowding in hospitals and jail, which as a result reduces the expensive costs to the community, inebriated individuals have the opportunity to pursue treatment if desired. Because the benefits appear to impact a broad array of issues and affect a diverse range of community members, it has been suggested

that public inebriate programs offer both short-term and long-term solutions for the community as a whole.

According to Matthew Pate, *"When chronically inebriated individuals disruptively or persistently violate community standards by being intoxicated or passing out in places not "approved" for such behaviors, the police may be called to intervene. As is also the case in dealing with mentally ill and homeless populations, it is important to recognize that chronic public inebriation is not, in and of itself, solely a police problem. It is also a medical and social services problem. That said, a number of the problems caused by, associated with, or resulting from chronically inebriated individuals often manifest themselves as police problems, such as disorderly conduct, threats, public urination and defecation, passing out in public, thefts, and assaults,"* (Pate, 2012).

The program should develop a method to more completely collect the method of arrival and the referring hospital. This would allow the program to more completely report diversions from hospital ERs that currently might be listed as "walk-ins". Further, if in fact, APD transports to MATS would have resulted in transports to hospital ERs if MATS did not exist, it would be useful to document the hospital from which they were diverted.

Existing literature supports positive findings however it is community specific and therefor incomprehensive. There still remain unanswered questions and further research is necessary. Further exploration may include:

1. What are the primary types of incidents related to chronic public inebriation (e.g., disorderly conduct, medical distress, panhandling, etc.) that generate calls for police service?
2. Are there situational or background characteristics common to frequent or recurrent offenders (e.g., homelessness, mental illness, veterans' status)?
3. How much prior contacts have individual inebriates had with police? What has been the nature of that contact (e.g., as victim, serious crime offender, petty crime offender, nuisance offender)?
4. Do complaints and incidents tend to cluster around particular places, or around particular seasons, days or times of day?

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