AN INDIANAPOLIS ENGAGEMENT CENTER:

A PROVEN MODEL FOR SAVING AND CHANGING LIVES

The Coalition for Homelessness Intervention and Prevention (CHIP)

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EXECUTIVE SUMMARY | INDIANAPOLIS ENGAGEMENT CENTER

Every day local businesses, community leaders, and visitors to Indianapolis encounter residents in our community that are extremely vulnerable and in need of services that are missing from our community. These residents are people who are experiencing homelessness **and** who are chronically intoxicated as a result of mental illness and addiction. Currently, the only place for shelter and refuge for these individuals while intoxicated are the criminal justice system and public health care system.

According to a 2006 Frequent Users' Cost Study: Public Services Utilization conducted by Eric Wright and Indiana University, Indianapolis spends between **$3 million and $7.8 million annually** from its public safety and public health budgets to respond to the needs of people who are experiencing homelessness, who are chronically intoxicated and who may also suffer from mental illness. These costs do not include the cost to business, tourism and, more importantly, the life and death cost to the individuals suffering from homelessness and chronic intoxication.

While the public and private costs in addressing this issue are high and have had little impact in long-term successful outcomes there is one cost-effective solution that is attainable within the next year: The Indianapolis Engagement Center.

An Engagement Center would serve several purposes including:

- Reduction of unnecessary and costly hospitalizations and incarcerations;
- Provision of shelter for those individuals who are homeless, intoxicated and on the streets;
- Engagement in treatment and other support services; and,
- Linking those who are experiencing chronic homelessness to permanent supportive housing and other housing options.

The original Blueprint to End Homelessness, created in 2002, and Blueprint 2.0, created in 2013, are the community adopted vision for Indianapolis to address and end homelessness. Each of these documents has identified various measurements for community success including reduction of mainstream costs that are incurred through inappropriate hospital emergency medical services, Emergency Room visits, arrests and incarceration, as well as specifically calling out the need for an Engagement Center.

Addressing and ending homelessness through criminal justice tactics alone does not create a high-impact solution nor does it address the needs of those experience homelessness. In fact, this approach often leads communities down the path of criminalizing homelessness. The United States Interagency Council on Homelessness (USICH) published a 2012 USICH report, *Searching out Solutions: Constructive Alternatives to Criminalization* that described the criminalization of

homelessness as "using the criminal justice system to minimize the visibility of people experiencing homelessness. In these instances, formal and informal law enforcement policies are adopted to limit where individuals who experience homelessness can congregate, and punish those who engage in life-sustaining or natural human activities in public spaces." That is why in addition to the production of this business proposal for an Engagement Center, it is critical to continue fostering strong partnerships among health, mental health and addictions providers, law enforcement, street outreach, criminal justice, the City of Indianapolis, local policymakers, and many others.

The Indianapolis Engagement Center, as outlined in this proposal, will build on the strengths of the existing partnerships with law enforcement, health centers, mental health providers, and housing providers to **serve** this population rather utilizing our criminal justice system and public health care system. Individuals that are homeless and intoxicated will be provided a safe environment during their period of intoxication, have the opportunity for engagement with and connection to services, and be offered a place to begin detoxification. The Engagement Center will work closely to enhance successful transition to permanent supportive housing and placement into treatment and long-term rehabilitation when individuals are ready for this step.

With appropriations from the City of Indianapolis and the network of service and mental health providers, we can make the Indianapolis Engagement Center a reality. A Center that provides meaningful solutions, **save lives, save dollars,** and build our system of service for residents of Indianapolis.

PROJECT PURPOSE AND MISSION

According to the 2014 annual Point in Time Count, on a single night in Indianapolis, there are at least 1,897 individuals experiencing homelessness. Approximately, 487 of those individuals reported chronic substance abuse problems. Individuals who experience homelessness often have high barriers and limited opportunity to break cycles of job loss, domestic violence, substance abuse, mental illness, physical disability, chronic illness, or incarceration on their own. Moreover, it is common for an individual that is homeless to be experiencing 3 – 5 of these factors at once and often, many more. To move beyond the hurdle of these circumstances and trauma that can accompany it, these individuals need a wrap-around system that will not only address their housing needs but the barriers that led to their homelessness.

The original Blueprint to End Homelessness, created in 2002, and follow up Blueprint 2.0, created in 2013, are the community adopted strategic plans that outline the vision for Indianapolis to address and end homelessness. Each of these documents has identified various measurements for community success. This proposal focuses on the very specific and critically needed goal of reducing the mainstream costs that are incurred through inappropriately utilizing hospital emergency medical services, Emergency Room visits, arrests and incarceration to address homelessness as well as the need for the Indianapolis Engagement Center.

While the public and private costs in addressing this issue are high and have had little impact in long-term successful outcomes there is one cost-effective solution that is attainable within the next year: The Indianapolis Engagement Center.

The Indianapolis Engagement Center would serve several purposes including:

- Reduction of unnecessary and costly hospitalizations and incarcerations;
- Provision of shelter for those individuals who are homeless, intoxicated and on the streets;
- Engagement in treatment and other support services; and,
- Linking those who are experiencing chronical homelessness to permanent supportive housing and other housing options.

The Engagement Center is intended to safely serve men and women within Marion County who are homeless and too intoxicated to go to a shelter and whose actions do not rise to a criminal offense beyond public intoxication. As discussions have broadened, a link is being made between an Engagement Center and the lodging house model to ensure longer-term housing and shelter options for this population. The Engagement Center approach is one of increasing levels of privacy and support and a low demand approach for those needing emergency shelter and housing due to homelessness and intoxication.

Creating a separate shelter for these individuals that are experiencing homelessness and are intoxicated would create access to safe shelter, increase access to services and connection to treatment, as well as connect eligible individuals to opportunities for permanent supportive housing that will effectively end their homelessness. It will also alleviate costs associated with an already over-crowded jail system, free up much-needed space for and unnecessary cost associated with ambulance runs and hospital emergency rooms visits. Such a facility, known as an Engagement Center, fills a critical need in our system and provides a humane and productive alternative temporary refuge for homeless people who cannot be served in the current shelter system due to their intoxication.

The Indianapolis Engagement Center will save millions in local tax dollars.

In addition to providing a vulnerable population with safe shelter during intoxication and connection to treatment, the Indianapolis Engagement Center would save millions of dollars annually in public funding for public safety and health. The Center will significantly reduce public and other costs incurred as a result of police runs, arrests, incarceration, hospital emergency room visits, ambulance runs, inpatient treatment, and other public health expenses. According to a 2006 Frequent Users' Cost Study: Public Services Utilization conducted by Eric Wright and Indiana University, Indianapolis spends between **$3 million and $7.8 million annually** from its public safety and public health budgets to respond to the needs of people who are experiencing homelessness, who are chronically intoxicated and who may also suffer from mental illness.[1] These costs do not include the cost to business, tourism and, more importantly, the life and death cost to the individuals suffering from homelessness and chronic intoxication.

Public safety costs alone are significant. Indianapolis Metropolitan Police Department estimates that the ***typical public intoxication police run and arrest ties up three police officers for approximately one hour each***. Aside from the hourly rate for the time spent by those officers involved, there is an unquantifiable cost of losing those same officers to other law enforcement duties while engaged in that public intoxication arrest. There are also costs associated with processing these individuals through the Arrestee Processing Center (APC).

In addition to the high costs of law enforcement, other public safety costs are implicated. When charges are filed, costs are also incurred in the prosecutor's time to evaluate and present the case, the court clerk's time to process the file, the court and court staff time to preside over the proceedings, the public defender's time to investigate the case and represent the client, the sheriff's

[1] Eric Wright, PhD, and Laura Littlepage, *Frequent Users Cost Study*, The Indiana University Center for Health Policy and School of Public and Environmental Affairs (July 2007)

time to process and house the person if convicted, and other county expenses for costs related to oversight when the person is released back to the community. These costs add up when considering the number of people affected. Many of these arrests and emergency room runs involved the same people, all of who would benefit from the services of an Engagement Center followed by treatment rather than running through an expensive and revolving door in our criminal justice system. Engagement Centers and similar types of shelters have proven to be cost-effective alternatives to utilizing the criminal justice system in numerous communities, including San Diego, CA, Philadelphia, PA, Milwaukee, WI, Portland, OR, Louisville, KY, Columbus, OH, and Memphis, TN.

In addition to saving public safety costs, an Engagement Center would significantly reduce unnecessary and costly emergency room visits, ambulance calls, and inpatient stays. Appropriate intervention with these individuals starting at an Engagement Center would potentially reduce some of the unnecessary expenses. There could also be significant savings for the costly public safety and legal systems within many city and state jurisdictions. Chronically homeless persons living with mental health and/or addiction issues often have the most expensive types of public health care, including frequent emergency medical visits and inpatient hospitalization services. Currently, when an intoxicated and homeless individual is not taken to jail, they are taken to a hospital emergency room. Emergency rooms and hospitals are generally unable to provide effective preventative care or coordination of services for this population. Without an organized effort to coordinate and address an individual's mental health and addiction needs, research suggests that this population will continue to have expensive and disjointed contact with the emergency medical and public health system, and that these contacts will increase and become more intensive as they continue to experience significant mental or physical health crises and as their overall health deteriorates. .

In addition to the benefits stated above, the Indianapolis Engagement Center would also provide for a more adequate response for law enforcement in implementing Crisis Intervention Training (CIT). While CIT is widely viewed as a necessary and effective approach for law enforcement when faced with a crisis situation where someone is suffering from a mental illness or addiction, it is not as effective when there are limited places for an individual in crisis to get help and treatment.

In early 2014, the Indianapolis Department of Public Safety created the Engagement Center Review Team to evaluate the need for the Indianapolis Engagement Center. Over the course of 2014, members of IMPD, the City County Council, Community Court, Wheeler Mission Ministries, Eskenazi Health, Progress House, Horizon House, and CHIP meet monthly to research community data to determine the need for such a center. The findings indicated that in 2013, there were 3,026 records created for a charge of public intoxication only with 2,221 of those cases ending at the Arrestee Processing Center ($72/ per individuals, per arrest) expending precious time and monetary resources.

The Indianapolis Metropolitan Police Department (IMPD) estimates that the typical public intoxication police run ties up three (3) police officers for approximately one hour each. IMPD cites an average cost of $30 per hour, per police officer. For the 2,221 arrests mentioned above, the cost to the City would include:

- 6663 personnel hours;
- Approximately $199,890.00 for the police officers; and,
- Approximately $159,912.00 arrest and processing fees through the APC

For this limited cost analysis of partial resources used, cost for these arrests alone total **$359,802.00.**

The 2014 Department of Public Safety report also found that the daily average of patients brought to Eskenazi Hospital due to public intoxication, with no police involvement, averaged 11. Annualized, we have 4,015 patients a year seeking expensive services for public intoxication that do not produce long-term impact to reduction of over-utilizing public healthcare. In fact, Eskenazi Hospital statistics showed a high incidence of chronic alcoholics with dual diagnosis/co-occurring disorders such as mental health disorders and opiate addictions. These needs and services would be better matched to direct mental health and substance abuse care than emergency room visits.

***An Engagement Center will save lives and return people to productive lifestyles*.**

People experiencing homelessness and who are living on the street or in conditions otherwise unfit for habitation are more likely to drink alcohol frequently and are at higher risk for illness and fatalities. The report "The Struggle to Stay Housed", written and published in 2005 by CHIP, indicates that nearly half of the people experiencing homelessness and living on the street had used alcohol seven or more times in the previous 30 days, a rate nearly eight times higher than those living in shelters.[2] When incarcerated, on the street or in a traditional emergency shelter, assuming they can get into a traditional shelter, a homeless person who is intoxicated does not have access to treatment. The Indianapolis Engagement Center would provide temporary refuge for people who are intoxicated and experiencing homelessness and would not be admitted for service in shelters due to their intoxication.

It is estimated that on any day in the City of Indianapolis, there is a need for as many as fifty beds to serve the needs of intoxicated (alcohol and other drugs) men and women who cannot be served through the existing shelter system. Creating the Indianapolis Engagement Center for these individuals would increase their connection and access to treatment and also free up the jail system and hospital emergency rooms. Officials in Columbus, Ohio, offer startling results in utilizing an Engagement Center to support this vulnerable population. In that community, similar to Indianapolis in size and demographics, the local government-funded Engagement Center has been effective in

[2] The Coalition for Homelessness Intervention and Prevention *The Struggle to Stay Housed* (2005)

linking people with treatment services, ultimately reducing the homeless population, reporting that two-thirds of the people that come through the Engagement Center go into treatment and move on to employment and housing.

High impact solutions are key to success.

A growing body of research has focused on the high cost associated with criminalizing homelessness, "using the criminal justice system to minimize the visibility of people experiencing homelessness. In these instances, formal and informal law enforcement policies are adopted to limit where individuals who experience homelessness can congregate, and punish those who engage in life-sustaining or natural human activities in public spaces."[3]

In October 2014, HUD released an article entitled: The Case Against Laws that Criminalize Homelessness. The articles author, Ann Oliva states:

> …Criminalization measures do not prevent or end homelessness; they only exacerbate existing problems. After people experiencing homelessness are arrested, they are returned to their communities, still with nowhere to live and now laden with financial obligations, such as court fees, that they cannot pay. Moreover, criminal convictions – even for minor crimes – can create barriers to obtaining critical public benefits, employment, or housing, thus making homelessness more difficult to escape…

In April 2012, the United States Interagency Council on Homelessness (USICH), in partnership with Department of Justice and HUD, published *Searching out Solutions: Constructive Alternatives to Criminalization*, which outlines "alternatives for communities who implement local measures that criminalize 'acts of living'". *Searching Out Solutions* emphasizes a human rights approach to ending homelessness and points out that criminalization measures are not aligned with this approach.

USICH Executive Director Barbara Poppe stated, "In today's economic climate, it is important for state, county, and local entities to invest in programs that work rather than spend money on activities that are unlikely to achieve the desired result." *Searching Out Solutions* identifies three solutions, examples of specific strategies and interventions, and their successful implementation in communities across the country.

- The creation of comprehensive and seamless systems of care. In an effort to address gaps in service delivery, many local organizations partner with other service providers and government programs to combine housing and services that are supported by

[3] United States Interagency Council on Homelessness (USICH), U.S. Department of Justice and U.S. Department of Housing and Urban Development *Searching out Solutions: Constructive Alternatives to Criminalization* (April 2012)

communitywide planning. These systems of care enable long-term reductions in street homelessness and connect individuals with benefits and services that improve stability.

- Collaboration among law enforcement and behavioral health and social service providers. Collaboration between service providers and law enforcement regarding outreach to individuals and specialized crisis intervention training can limit the number of arrests for non-violent offenses. This partnership can also help link individuals experiencing street homelessness with supportive housing and services to help move individuals off the street permanently.

- Alternative justice system strategies. Strategies that provide alternatives to prosecution and incarceration and that offer reentry planning for individuals who are returning to the community after interaction with the criminal justice system, have shown an increase in the likelihood that an individual experiencing homelessness will look for permanent housing and seek employment. This solution includes use of specialty courts, citation dismissal programs, holistic public defenders offices, and reentry programs.

The cost of homelessness including the cost of criminal justice involvement is a far more expensive and inhumane then utilizing alternative solutions. That is why in addition to the production of this business proposal for an Engagement Center, it is critical to continue fostering strong partnerships among health, mental health and addictions providers, law enforcement, street outreach, criminal justice, the City of Indianapolis, local policymakers, and many others.

With appropriations from the City of Indianapolis and the network of service and mental health providers, we can make the Indianapolis Engagement Center a reality. A Center that provides meaningful solutions, **save lives, save dollars,** and build our system of service for residents of Indianapolis.

The Center will focus on serving street homeless men and women located within Marion County who are eighteen (18) years and older and are unable, due to substance abuse, to access emergency shelters. In addition, the Center will screen for mental illness. Many studies have shown that those with a chronic addiction often also suffer from an underlying and/or undiagnosed mental health issue. This dual diagnosis of substance abuse and mental illness, according to best practices, should be treated simultaneously.

Individuals in need of services may be referred to the Center by law enforcement, a health care provider, mental health and addiction providers, community street outreach and case management providers. In addition, the Center will have a van that will aid outreach in transporting individuals they find who are in need of services provided by the Center.

In this program description, we define the detoxification process as such; to rid the body of a toxic substance. When dealing with addiction, the toxic substances are the drugs of choice. In general there are two types of detox: non-medical and medical. The Center will provide access to onsite non-medical detoxification. Non-medical detoxification refers to the fact that the body will rid itself of drugs (including alcohol) IF no more toxic substances are introduced. Sometimes this is referred to as going cold turkey. The Center will not offer medical detoxification. If a person requires immediate medical services, mental health or medical detoxification for safe withdrawal, an appropriate referral and transport are completed. A strong partnership with a medical facility is important for fast and appropriate response. Individuals can return to the Center when he/she is no longer in need of emergency services.

The Center will provide a place to sleep off intoxication and an opportunity to engage in resource referral. If an individual seeks non-medical detoxification, those services will be available on site with a link to a Recovery Coach. Individuals will be referred to facilities currently established within the community that offer medical detoxification services and other services as needs are assessed.

Individuals will also be linked to a Resource Coordinator who will serve as the lead contact and working with the Recovery Coach to utilize best practice strategies. These strategies will include motivational enhancement and brief therapy interventions in order to meet the resource and referral needs of the individual and assess motivation for change using the Stages of Readiness for Change (Prochaska and DiClemente) best practice model. This model states that behavior change usually occurs gradually as the person moves through five developmental stages of motivational readiness or intention to change.[4] Progress is not always in a direct linear fashion as a person may

[4] Prochaska, J.O., Norcross, J.C., Diclemente, C.C. (1994). *Changing for Good.* New York: Avon Books.

revert to an earlier stage before entering the next stage. It suggests that environmental support for the change is very important. Sustaining behavioral change is very difficult if the environment provides cues that trigger the old behavior (Prochaska and DiClemente). In addition to removing the cues and triggers in this model, the Center will utilize strengths-based, culturally competent services that are also recognized as best practice approaches.

The Engagement Center will have the requirement of inebriation and homeless status, as defined by U.S. Department of Housing and Urban Development, for admission in order to provide and safety without creating barriers to shelter and services. Individuals must be respectful of others and their belongings. Individuals will not be allowed to be in possession of any weapons while seeking shelter at the Center. The individual cannot use any drugs or alcohol while inside the Center building, but can enter under the influence. The Center will be accessible 24/7. The individual will be requested to stay at the shelter for a minimum of four hours to ensure safety upon exiting the center or until blood alcohol levels have reduced to an appropriate level that no longer puts them at risk for arrest for public intoxication. If an individual leaves prior to this time and is a risk to self or others, law enforcement will be called to assist in the situation.

Outreach providers would work with the Center to help bring individuals in from the streets. Outreach providers could be located within the Center to respond to needs for transport and pick up using the Center's van. In addition, due to their established relationships with some individuals, outreach workers can help urge the individuals to seek refuge at the Center. Strong partnerships with law enforcement are important in order to aid in any possible emergency situations to help ensure safety.

The Center would have a total of 50 beds available, 32 beds dedicated for daily drop-in and 18 beds for short-term non-medical detoxification. The beds will be set up in such a manner as to ensure privacy. The need for male beds is anticipated at thirty-eight (40) and women at ten (10). The units for men and women would be separated.

PROGRAM DESCRIPTIONS

The program would be designed to meet the needs of the client base. The suggested program design would differentiate program/ service in the following stages:

- 0-12 Hours (four-hour minimum stay requested with reduced intoxication)
- 24 Hours (four-hour minimum stay requested and willingness to complete screening)
- 72 Hour – 120 Hour Recovery Engagement Program

Short-Stay 4-12 Hours Services (four hour minimum stay requested):

- Provide a safe shelter alternative to reduce intoxication
- Initial link with Resource Coordinator to offer services

The goal of services for up to twelve (12) hours is to provide individuals, with no alternative to a safe shelter, a safe environment to reduce their state of intoxication to a level that no longer puts them at risk for arrest for public intoxication. Individuals would be requested to stay in the shelter for at least four hours or until blood alcohol levels are such to ensure safety upon exiting the center and that they are no longer at risk for arrest for public intoxication. Individuals will be able to access this level of service as many times as needed with the acknowledgement that there may be limitations for admission due to safety and capacity issues.

The individual admitted will have access to a bed and personal hygiene items. The individual will be made comfortable by being provided with clean dry clothes if wet, and the opportunity for a shower if desired. The Center will provide basic personal hygiene support, nutritional support and information and service referral assistance.

Short-Stay Up to 24 Hour Services:

- Provide a safe shelter alternative to reduce intoxication
- Initial link with Resource Coordinator to offer services
- Individual will have a willingness to complete a screening process

The individual would meet with their Resource Coordinator one-on-one to complete a screening process that includes their physical health, mental health and addiction needs as well as housing, food, clothing and other personal needs in order to begin to develop together a plan of care. The individual will have access to a bed. The Center will provide basic personal hygiene support, nutritional support and information and service referral assistance.

As part of the care plan, individuals may also choose to engage in non-medical detoxification and at this point transition to the Recovery Engagement Center program that offers 30 day non-

medical detox for those that wish to stabilize their sobriety.

Recovery Engagement Program 30 day Services:

- Provide a safe shelter alternative to reduce intoxication
- Provide a safe non-medical detox environment to begin steps towards sobriety
- Initial link with Resource Coordinator and Recovery Coach to offer services and motivational coaching through the process of sobriety.
- Individual will have a willingness to complete a screening process
- Individual will commit to engage in continuing services through referrals
- Individual will work with a recovery coach through the process of sobriety

Recovery Engagement Program

This 18-bed detoxification program is based upon non-medical social setting models. The population served by this program includes indigent individuals experiencing physical symptoms of drug or alcohol dependency. The program is structured as an entry-level access point for individuals seeking a supervised option for physical withdrawal from drugs or alcohol. The 18 beds are divided by 2 separate programs, which include a 13-bed men's and 5-bed women's program.

The goal of services for up to 30 days is to provide an individual an option for non-medical detoxification and connection to continuing long-term recovery services through referrals. The individual would meet one-on-one with their Recovery Coach to complete an assessment of needs and then develop an action plan for service(s) referral. The individual would make a commitment to continued contact with their Recovery Coach during drop-in day hours to receive incentives for follow through on plan of care.

Individuals who are a part of the detoxification program stay for approximately 30 days, dependent upon the severity of withdrawal symptoms experienced. During this time, staff monitors utilize various assessment measures in order to determine the severity of withdrawal symptoms. For the first several days, individual assessments are conducted every 4 hours to measure changes in physical condition. Based upon similar models, approximately 15% of individuals that go through the social setting detox program will need more intense care and will be transferred to a local hospital. A referral agreement with a local healthcare provider will need to be in place in order to create an efficient process.

While an individual is a part of the detoxification program, they will remain on-site and will be monitored 24 hours a day. Individuals will be allowed to take any non-addictive medications that were prescribed to them prior to admission. Over the counter medications will also be allowed to help with symptoms of withdrawal, but individuals will not be placed upon detox medication tapers while connected to the program.

Clients connected with the detoxification program will meet with a Recovery Coach who will assess the basic needs of each individual. The Recovery Coach will work to get individuals connected to community resources that will help to support them in their recovery in order to reduce the chance of relapse. Individuals will also be linked to partner agencies that offer long-term programs to aid in the stability of their recovery and develop a long-term recovery plan to increase their success.

BUDGET NARRATIVE

As the primary advocate in the City of Indianapolis for the Indianapolis Engagement Center, the Coalition for Homelessness Intervention and Prevention (CHIP) secured a capital grant of $750,000 from the Sara Reuben Revocable Trust in 2011. Based on a 2011 Cripe Report [5] that suggests a building site of 1-1.5 acres of land and building footprint of approximately 10,000 SF., total capital costs are estimated at $2.25M. The Coalition for Homelessness Intervention and Prevention (CHIP) will seek additional funders and partners to secure the remaining capital funds needs for investment. However, the original grant from the Reuben Trust is set to expire in 2015 without secured operational dollars.

Potential Facility Locations

Currently, Progress House owns parcel 201 South Shelby. Although this parcel is approximately 60% occupied by parking and the current Progress House main facility, there is an area of land south of the Progress House facility that is currently undeveloped. For the purposes of the Recovery Engagement Center, parcels 1110, 1106, and 1104 Bates would need to be purchased.

An alternative location for the Recovery Engagement Center could involve parcels 1032, 1030, 1022, 1018, 1014, 1010, 1006, 1002, and 960 Bates Street. The location at 1032 is currently for sale and Progress House administration has been approached about the purchase of this property. Of the remaining parcels, only 1002 and 1006 appear to be currently occupied. 1030, 1022, 1018, and 960 are currently undeveloped parcels of land.

[5] Cripe Architects and Engineers *CHIP Engagement Center: Site and Facility Location Analysis* (October 2011)

In review of best practice models, the following program budget is submitted based on the need in Indianapolis. If the Engagement Center were to serve a total of 1,460 unduplicated clients through the Short-Stay Program and Recovery Engagement Program with 18,250 bed days available (50 x 365 days), the cost per client day would be $82.94.

The budget includes 31.0 full and part-time employees. The staffing structure for this program will include one detox monitor per every eight clients. Both the men's and women's program will provide 24 hour services and will need to be staffed three shifts per day, 365 days per year to access for basic medical needs. There will be one Resource Coordinator per every eight clients that will span three shifts 365 days per year to oversee basic needs of clients, including safety, comfort, and basic service engagement. The Center will have one front desk person to handle phone, walk-ins and reception functions, and a program coordinator to ensure staffing, operations and business functions of the program. There will be a driver that will pick up individuals at designated areas throughout Indianapolis. Pickups will be made during first and second shift, 7 days per week. The average salary and benefit cost for both full and part-time employees is estimated to be $23,572.77

The operations costs include Building Expenses- Utilities (phone, water, electric, gas, etc.), Maintenance & Repairs (Equipment Contracts, Facility Cleaning, Facility Supplies- light bulbs, toilet paper, paper towels, etc.) and replacement needs. Additional operating expenses include facility and professional liability insurances, nutritional support at approximately $1.65 per offering and miscellaneous expenses involving physical/medical support and transportation expenses.

The cost for evaluation is built into the program model design and implementation. Outcome evaluation is necessary in order to provide evidence of cost- savings in order to demonstrate program efficiency and effectiveness.

Budget Assumptions:

Operations	$402,880.00
General Expense	$82,235.00
Program Services	$135,000.00
Utilities	$44,550.00
Insurance	$39,243.00
Miscellaneous	$39,000.00
Professional Fees	$3,150.00
Staffing & Benefits	$1,110,808.00
	$1,513,688.00

Initial startup cost estimated at $150,000.00 as a onetime expense to outfit the facility with initial furnishings. This money has been committed by the Lilly Endowment, Inc. and secured by the United Way of Central Indiana.

PARTNERSHIP LIST

Throughout this proposal we reference the need to focus on key partnerships and working with multiple sectors to make a meaningful impact with the Indianapolis Engagement Center. That is why it is important to identify those partnerships early on that will need intentional connection through all stages of bringing this Center to fruition.

In addition to the support of local City leadership such as the Mayor of Indianapolis and City County Council, below is a list of partnerships critical to the success and outcomes of the Center.

Criminal Justice
Arrestee Processing Center
City of Indianapolis Public Safety
Community Corrections
Courts- Community, Drug Treatment
Indianapolis Metropolitan Police Department
Marion County Justice Agency
Marion County Sheriff's Department
Parole
Probation

Physical Healthcare
Eskenazi Hospital/Health & Hospital Corporation of Marion County
Homeless Initiative Program
Marion County Health Department
Pedigo Health Clinic/ Horizon House
Regenstrief Institute

Mental Health and Addiction Treatment, Resource Coordination, and Advocacy
Adult & Child Center
Centerstone
Dove House
Drug Free Marion County
Fairbanks
Gallahue Mental Health Center/Community Hospitals of Indiana, Indianapolis
Intecare, Inc.
Marion County Mental Health Association
Midtown Mental Health Center/Health & Hospital Corporation of Marion County

National Alliance for the Mentally Ill (NAMI)
Partners in Housing
Pathways to Recovery
Progress House

Shelters
Dayspring Family Shelter
Holy Family Shelter
Ruth Lilly Salvation Army Women and Children's Center
Salvation Army Adult Rehabilitation Center (ARC)
Wheeler Mission Ministries for Men
Wheeler Mission Ministries for Women and Children

Street Outreach Teams/ Case Management
Adult and Child
The Damien Center
Eskenazi Health
Homeless Initiative Program
Hoosier Veterans Assistance Program (HVAF)
Horizon House/Street Outreach Rapid Response Team (SORRT)
Humane Society
Indianapolis EMS/MESH
IMPD Homeless Unit
Midtown Community Mental Health
Marion County Probation
Outreach Inc.
Parole District 3
The Pourhouse
Roudebush VA Medical Center
Ruth Lilly Salvation Army Women and Children's Center
Tear Down the Walls Ministry
Wheeler Mission Center for Women and Children
Wheeler Mission for Men

Business
Indianapolis Downtown Inc.

OTHER NATIONAL MODELS: OVERVIEW OF MODEL PROGRAMS THROUGHOUT THE U.S.

ENGAGEMENT CENTER MODELS

The Engagement Center programs described below are three examples of best practice examples that the Indianapolis Engagement Center is modeled after. These models have informed the structure of our program, particularly the Engagement Center at Maryhaven, and demonstrate savings in public costs as well as effective client outcomes.

Engagement Center at Maryhaven - Columbus, Ohio was established in October of 1999, born out of a collaboration between city, county, the Alcohol and Drug and Mental Health Board (ADAMH)* and the Community Shelter Board (CSB). The Engagement Center is only for intoxicated homeless individuals. The Engagement Center is a homeless shelter, not a treatment program; however the reason for the success of the Engagement Center is the connection with the oldest alcohol and drug provider in Columbus.

The Engagement Center's leverages existing resources by partnering with community organizations to provide services to Center clients. Usually the average length of stay is 3 days for detoxification only, however if a resident engages in referral services (detoxification and treatment) the stay can be extended depending on the needs of the resident. Although the Engagement Center does not specifically treat those with mental illness or a dual diagnosis, The Engagement Center's goal is to refer to outside agencies for services, for example, Netcare for mental health evaluation for a resident. Maryhaven's programs have resulted in savings for law enforcement, jails, and ER costs. In its first year, it cost $62 per bed, per night versus a bed in the emergency room which cost $250 per day and a bed in jail cost $200.

Genesis Detoxification Center - Milwaukee, WI is viewed by many clients as a crisis intervention center and the gateway for alcohol and other drug abuse (AODA) treatment. Genesis is open and accepts admissions 24 hours a day, 365 days a year. The Center is the first point of contact in the treatment of substance abuse for many of the clients served. Most of the clients have limited resources available to them and often view public detoxification as the primary access point into a continuum of treatment. The primary role of Genesis is to manage withdrawal in a safe and humane manner and to motivate clients to recognize and address their AODA problem. The target population served is adults who primarily present with substance abuse or a dual diagnosis of mental illness with substance abuse.

Genesis has been coordinating and providing acute alcohol detoxification services in Milwaukee County since July of 1988 for those who are indigent or have no alternative resource to address their need for detoxification services. They are the first provider to coordinate the detoxification program for Milwaukee County with a sober-up component. This component is important in determining the

various levels of client needs and corresponding cost-effective treatment. The average length of stay is 8-12 hours. If the determination is made to admit the client, physician orders are obtained. Admission to the Sober Up component includes inventorying and securing client's property, escorting the client to the unit, and making the client comfortable (i.e. provide clean, dry clothes if client is wet; provide shower facilities if the client is excessively dirty, etc.).

Hooper Sobering Program-Portland, Oregon was created as an alternative to the use of the City Jail for publicly intoxicated individuals and was envisioned as a more humane and cost effective approach to managing urban problems related to public intoxication. It was also designed to function as an entry point into the treatment system.

There are three distinct operational units of the Hooper Center (opened in 1971). Those include the Central City Concern Hooper Inebriate Response Service (CHIERS). The second component is the Sobering Program, which was designed to provide a medically monitored, safe environment in which to sober up. The third component is the detox center; which is a 54 bed sub-acute medical detox program in which individuals can stay for four to seven days while they receive counseling, treatment for withdrawal symptoms and other recovery services.

Transportation and Admission to the Program is 69% police; 29% CHIERS (van/outreach program with staff trained as EMTs); 2% other. The van staff are "deputized" by Multnomah County and given the limited authority to place people who are incapacitated as a result of drug or alcohol use on civil holds. If a person is combative or violent, then the CHIERS staff will have a police officer dispatched to the scene to transport the person to the Sobering Program. A police officer has the option of taking the person home or taking them to the Sobering Program. If a person has also committed a crime, they may also receive a citation. When the police find someone who is inebriated, they can dispatch the CHIERS staff and they do that through the Bureau of Emergency Communications. http://www.centralcityconcern.org/hooper_center.htm

TREATMENT PROGRAM MODELS

These programs also demonstrate the best practices and cost savings associated with inebriate and mental health intervention and treatment as opposed to solely relying on criminal justice or emergency department usage. These programs differ from the Indianapolis Engagement Center model in that our program does not include long-term treatment in the Engagement Center. However, our Engagement Center model will be closely tied with such programs and will be an entry point for connection to more intense or medical interventions.

San Diego- Serial Inebriate Program (SIP) is overseen by the City of San Diego's Police Department. SIP began in 2000 involving the City and County of San Diego, the Police and Sheriff's Departments, as well as partnerships with the Superior Court system, County Health and Human Services, and

Mental Health Systems. SIP began as a problem-solving effort to reduce the use of jails, detox centers, and ER visits by those who are chronically homeless and suffer from a chemical addiction. The program offers treatment rather than custody time that is obtained from a guilty verdict for public intoxication. Clients are provided with wraparound services designed to help their recovery from alcoholism and begin moving them toward re-entering society as a sober community member. Clients are sentenced to 179 days with treatment in lieu of custody time and our clients are strictly criminal justice referrals. The 179 days, one day short of 6 months, allows for the client to also be sentenced to probation (Deni McLagan, Mid Coast Program Manager). SIP candidates are closely screened and must express a sincere desire to enter treatment.

A study of 548 individuals who met the definition of a (Serial Inebriate Program) SIP client between Jan.1, 2000 and March 2, 2004 showed the following results:

Impact of SIP on Utilization of Healthcare Resources:

- EMS/ED use decreased by 50% for those who accepted the SIP program versus no change in use among chronic inebriates not accepting SIP (average per person per month)

- For the 443 inebriates who used EMS and ED services, there was a combined average decrease of $18,120 per month in charges for these types of services after accepting SIP.

- For the 83 inebriates who required hospitalization, there was a combined average decrease of $180,223 per month in charges for these types of services after accepting SIP. (62% reduction in average rate of monthly hospitalization after acceptance of SIP).

Conclusions: Chronic inebriates place disproportionately large, under-compensated service demands on EMS and hospital resources. Comprehensive, community-based strategies such as SIP may offer an opportunity to reduce episodic care costs and use of public safety resources. The duration of incarceration is clearly associated with the probability of acceptance of services. (ISP Proposal, Impact of a Multi-Disciplinary Serial Inebriate Program (SIP) on Emergency Care Services in San Diego, June 5, 2001, retrieved November 30, 2004).

Another one of the program's outcomes was to reduce the chronic inebriates' drain on public services (e.g. hospital visits, paramedic services, and jail time.) The SDPD confirmed that for program participants, 32 percent were successful in treatment, ambulance contacts were reduced by 88 percent, emergency room visits were down 92 percent, and arrests were reduced by 58 percent

(San Diego Housing Commission Report, Mental Health Systems Serial Inebriate Program Transition Housing Grant, June, 2004). http://cpac.berkeley.edu/documents/castillo_findings.pdf

The Healing Place-Louisville, Kentucky and in Wake County, North Carolina is a non-profit rescue and rehabilitation facility that offers a free, long-term, peer-run, 12-step-based residential recovery program for homeless adult men with alcohol and drug addictions. Their stays range from one night to graduation from the program after several months. Modeled after a nationally recognized rehabilitation facility, the program offers addicted, homeless men a number of programs: Emergency Shelter which offers overnight refuge to homeless men, even if intoxicated; provides food, shelter, and clothing; provides a bed; ensures safety through security provided by residents committed to the program.

The Sobering-up Center operates 24 hours a day, 7 days a week, with trained caseworkers who monitor vital signs and provide support and motivation for recovery; coordinates with law enforcement to get homeless alcoholics and addicts off the streets; serves up to 22 clients with a variable length of stay, according to severity of withdrawal.

Off-the-Street Program provides a guaranteed bed each night; offers a place to store personal belongings in exchange for attending Recovery Dynamics classes; encourages advancement upon attendance at 12-Step meetings; fosters cooperation and team building as residents become responsible for maintaining our facility; accommodates 40 residents.

Peer-to-Peer Recovery provides a phased, mutual-help program with men in recovery who serve as teachers and mentors; offers residential and transitional programs; develops residents' marketable skills so that they can become self-sufficient independent and productive citizens; accommodates 46 residents who serve as role models for others in the program. http://www.hpowc.org

OUTREACH MODELS

Indianapolis has an effective model of outreach through the Professional Blended Street Outreach Teams, comprised of health care professionals, social workers, mental health professionals, homeless service providers and Indianapolis Metropolitan Police officers who work as a single entity to provide outreach, referrals and services to those on the streets. This cooperative effort and referral mechanism is an essential element of a successful Engagement Center.

San Diego-The Homeless Outreach Team (HOT) combines the resources and efforts of the San Diego Police Department, the Psychiatric Emergency Response Team and the County of San Diego in providing a humanistic approach towards improving the quality of life for homeless individuals. The team is assigned to work the Police Department's Central, Northern and Western Divisions. The goal of HOT is to assist the chronic homeless to become productive members of society thereby reducing the financial and public health and safety burdens on our community. Among the services provided to the homeless are field assessments for eligibility to public entitlements, crisis intervention, referrals, comprehensive case management, drug/alcohol rehabilitation placement, and

psychiatric/medical treatment and placement. The team also does a collection and analysis of homeless demographical data, but just as important is the building of relationships with clients and community organizations.

The University of California and the San Diego City Police Department conducted a before/after cohort study on 15 randomly selected homeless alcoholic clients (all with >10 visits/yr. to detoxification centers) enrolled during the initial phase of the HOT program in the downtown region of the city. Conclusions: The initiation of a multi-disciplinary HOT program in their community was associated with a decrease in ED visits by a cohort of homeless alcoholics receiving frequent ED care. http://www.sandiego.gov/homeless-services/programs/hot.shtml

Crisis Intervention Team (CIT)-Memphis, Tennessee: In 1988, the Memphis Police Department joined in partnership with the Memphis Chapter of the Alliance for the Mentally Ill (AMI), mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialized unit. This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events. This community effort was the genesis of the Memphis Police Department's Crisis Intervention Team. The CIT is made up of volunteer officers from each Uniform Patrol Precinct. CIT officers are called upon to respond to crisis calls that present officers face- to-face with complex issues relating to mental illness. CIT officers also perform their regular duty assignment as patrol officers. The Memphis Police Department has approximately 225 CIT officers who participate in specialized training under the instructional supervision of mental health providers, family advocates, and mental health consumer groups. Due to the training, CIT officers can, with confidence, offer a more humane and calm approach. These officers maintain a 24 hour, seven day per week coverage. http://www.memphistn.gov/Government/PoliceServices/CrisisInterventionTeam.aspx

COMMON CLINICAL DEFINITIONS

Addiction: Addiction is the compulsive need for habit-forming substances like tobacco, drugs or alcohol. Addiction is both physical (physiological) and mental (psychological). An individual suffering from an addiction, also known as an addict, is driven by both physical and mental needs to continue using the addictive substance, regardless of the consequences.

Assessment: The ongoing process of determining an individual's strengths and needs.

Barriers to Housing Stability – the Blueprint has prioritized specific target populations. In general, it is expected that Blueprint projects serve one or more of these targeted populations and identify the specific barriers, which they are prepared to assist affected persons in overcoming. Among the barriers recognized by the Blueprint are:

A. Chronic and/or persistent mental illness:

- A major mental illness (i.e., schizophrenia, bi-polar, or major depression) or co-existing condition (mental illness and substance abuse), and
- A recent or extensive history of psychiatric hospitalization; or
- An extensive history of receiving community based treatment and supportive services; or
- Significant life functioning limitations (i.e., social, self-care vocational skills).

B. Chronic alcohol and/or substance abuse: The person has a substantial history of at least one year of dependence upon mood-altering chemicals, with or without prior treatment episodes, and evidence of substantial life losses to the extent that it interferes significantly with social, economic and/or physical functioning, inclusive of suitable living arrangements, as a result of substance abuse

Detoxification: To rid the body of a toxic substance. When dealing with addiction, the toxic substances are the drugs of choice. In general there are two types of detox: non- medical and medical.

Dual diagnosis: Dual diagnosis refers to people who have been diagnosed with a major mental illness along with addiction. The problem is that substance abuse, which has components of mental illness, often masks and/or aggravates other psychological symptoms. Conversely, those with psychological symptoms may self-medicate with drugs and alcohol. The result can be confusion over the needed treatment resulting in relapse and other major problems.

As a general rule, treatment for mental illness is close to impossible if the mentally ill addict is still

abusing the drug of choice. On the other hand, the addict may find it extremely difficult to actually stop using until at least some of the psychiatric symptoms are relieved. Ideally, both conditions are recognized and treated together. In practice one problem is often recognized before (sometimes long before) the other.

Engagement Center: Provides the same service as a wet shelter or sober up center; however may have an added component where individuals are provided with some information on services that could be available to them, should they want to engage in them.

Inpatient Treatment: Inpatient rehab generally consists of actually staying in a hospital or residential treatment center for a number of days, weeks or months. A stay of 28 or 30 days is probably the most typical. Most inpatient programs start with either medical or non-medical detoxification. Many inpatient treatment centers draw on the 12 Step model and include in-house 12 Step meetings as well as group therapy and individual counseling. Some provide education and/or meetings for families during the addicts stay. If the treatment center is near a metropolitan area, addicts may be bussed to outside 12 Step or other recovery meetings as part of the program.

Medical Detoxification: Medical detox refers to a wide variety of detoxification techniques used by the medical profession; these techniques range from simple observation by professionals while an individual detoxifies naturally to medical intervention, which may include tranquilizers or other drugs that reduce the symptoms caused by the withdrawal from the addictive drug. The precise medical detox procedure depends on many factors, including the type of addictive drug (alcohol, opiate, etc.), the severity of the addiction and the philosophy of the treatment provider. Terms used include: medical detox, rapid detox, etc. The most successful detox programs deal with both the mental and the physical symptoms of withdrawal.

Non-medical Detoxification: Non-medical detox refers to the fact that the body will rid itself of drugs (including alcohol) IF no more toxic substances are introduced. Sometimes this is referred to as going cold turkey.

Outpatient treatment: Typically outpatient treatment consists of a series of meetings at the treatment center. If the treatment is intensive, there are probably four or five meetings each week. Less intensive programs meet less often, but usually at least once or twice a week. How many weeks involved depends on the program. Outpatient meetings are generally a combination of education and group therapy facilitated by a professional with experience and/or certification in addiction counseling. Drug testing may be a requirement of outpatient treatment. The outpatient program may use at least part of the 12 Step model or it may use a different model.

Public Intoxication: Any person who is found in any public place under the influence of intoxicating

liquor, any drug, controlled substance, toluene (inhalant), or any combination of any intoxicating liquor, drug, controlled substance, or toluene, in such a condition that he or she is unable to exercise care for his or her own safety or the safety of others, or by reason of his or her being under the influence of intoxicating liquor, any drug, controlled substance, toluene, or any combination of any intoxicating liquor, drug, or toluene, interferes with or obstructs or prevents the free use of any street, sidewalk, or other public way.

Sober up center/shelter: Provides a safe place for an individual to sleep while recovering from intoxication.

Treatment: The term treatment, or rehab, usually refers to a professional and/or medical center that detoxifies the addict and begins the education process to help them live a life free of their drug(s) of choice. Treatment may be on an outpatient or inpatient basis, or a combination of the two.

Wet Shelter: Provides immediate safety, a night on a bed and possibly a morning shower for individuals who are intoxicated and cannot go into another shelter.

Withdrawal: This is a clearly defined set of physical reactions that are measurable as a result of cessation or decrease in the drug/chemical substance that was previously used. Withdrawal is often difficult to define in exact medical terms. The effects are different for the different categories of drugs. Some symptoms are body aches, vomiting, muscle tremors, insomnia, perspiration, hot flashes, diarrhea, cramps, dehydration, dizziness, visual distortion and a sudden drop in blood pressure. Some symptoms may be short- lived, while others may last several weeks or longer. This is also called the abstinence syndrome.

http://www.soberrecovery.com/Glossary/Treatment.html