



## MEMORANDUM REPORT

July 17, 2001

TO: County Council

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SUBJECT: **OLO Memorandum Report 2001-5: Issues Related to Establishing a Sobering Center**

This memorandum report by the Office of Legislative Oversight (OLO) examines issues related to establishing a sobering center in Montgomery County. OLO approached this assignment using the following definition:

A Sobering Center is a short-term care facility designed as a safe location for individuals who are under the influence of alcohol or other substances. An individual stays at a sobering center until he/she is sober enough to return to the community. The typical length of stay at a sobering center ranges from four to 12 hours.

**Scope/Purpose of Memorandum Report.** This memorandum report packages what OLO has learned to date about sobering centers in general, the legal framework, current practices in the County, and the operations of sobering centers in other jurisdictions.

The issues OLO identifies are complex and additional staff work is required if the Council wants to further pursue establishing a sobering center. On July 19, 2001, OLO is scheduled to present this initial report to the Public Safety and Health and Human Services Committees. The final chapter outlines the issues that OLO recommends for Council discussion and decision-making.

**Acknowledgements.** OLO appreciates the time taken by agency representatives and community members to share their experiences with and insights into issues related to publicly intoxicated persons. Special thanks are owed to the Montgomery County

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## **DEFINITIONS**

OLO adapted the following definitions from two primary sources: The National Clearinghouse for Alcohol and Drug Information and a report on chronic public inebriates prepared by the Seattle-King County Department of Public Health.

**Publicly intoxicated persons** - persons who are in various stages of intoxication and physically located in a public place, e.g., a sidewalk, park, bus shelter. A publicly intoxicated person may be, but is not necessarily, either an alcoholic and/or homeless.

**Chronic public inebriate** - An individual with a severe alcohol problem who is frequently drunk in public and has repeated encounters with public services, such as police, jail and court services, emergency medical and emergency medical transportation services, public hospital emergency room care, and alcohol detoxification services. For people in this population, alcohol abuse is considered to be their primary problem. Some may also have secondary problem with other drugs or with mental illness. A significant percent is, has been, or will be homeless at some point in time.

**Sobering Center** - a short-term care facility designed as a safe location for individuals who are under the influence of alcohol or other substances. An individual stays at a sobering center until he/she is sober enough to return to the community; the typical length of stay at a sobering center ranges from four to 12 hours.

**Detoxification Facilities** - slightly longer term facilities; typically from 3-7 days designed to control the immediate and psychological complications resulting both from an excess of alcohol or other substances in the bloodstream and the body's response to withdrawal from repeated overdoses. Detoxification services are generally available under a medical model or a social model, and can occur either in an inpatient or an outpatient setting.

**Medical Model** (also called acute) - Medical model programs are directed by a physician and staffed by other health care personnel. A medical model can range from a hospital based inpatient program to a free-standing medically based residential program that is affiliated with a hospital.

**Social Model** (also called sub acute) - Social model programs are staffed primarily by social workers and other non-medical clinicians. The concentration is on providing psychosocial services with an emphasis on nonpharmacological management of withdrawal. If medical emergencies arise, patients are transferred to a hospital for treatment.

## ORGANIZATION OF MEMORANDUM

This memorandum report begins with an overview of why publicly intoxicated persons are a public policy problem. This first chapter (pages 5-14) also outlines the reasons most often cited by other jurisdictions for establishing a sobering center, and reviews what we know (and equally as important, what we don't know) about the number and characteristics of publicly intoxicated persons in the County.

Clearing the streets of publicly intoxicated persons is cited as one of the most important goals of establishing a sobering center. For readers not familiar with "Fixing Broken Windows," Chapter II (pages 15-17) offers a summary explanation of this thesis, which was first published in a March 1982 issue of *The Atlantic Monthly*. The essence of Fixing Broken Windows is that, at the community level, disorder and crime are inextricably linked. Chapter II also presents some more recent empirical research on the validity of the thesis in practice.

Recognizing the many legal issues surrounding the establishment of a sobering center, Chapter III (pages 18-23) reviews the decriminalization of public intoxication in general and outlines the relevant Maryland law. It is particularly important for County officials to know that the legal structure for dealing with public intoxication is established by State (not County) law.

Chapter IV (pages 24-39) presents OLO's findings on current practices in the County. In particular, this chapter summarizes what OLO learned from interviews with management and front-line staff from the different agencies in the County that deal directly with persons who are, or who have been, intoxicated in a public place. The text points out what strategies and resources are currently employed, and the problems with these strategies. Chapter IV also includes a summary of what front-line staff had to say about the desired characteristics of a sobering center.

Figuring out how to effectively deal with publicly intoxicated persons is a challenge that almost all communities face to some degree or another. Chapter V (pages 40-50) provides some comparative perspective by describing sobering centers in nine different places, including Fairfax County, Seattle, and Escondido (outside of San Diego). OLO's research shows that there are different approaches taken to operating a short-term sobering-up facility; centers vary in terms of their population served, staffing, location, and services provided.

Based upon OLO's research to date, the final chapter outlines the issues that OLO recommends at this time for Council discussion and decision-making. In sum, the immediate question for the Council is whether to pursue the idea of establishing a sobering center.

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## **I. OVERVIEW**

### **A. DEFINITION OF THE PROBLEM**

Jurisdictions of all sizes cite a common set of problems associated with individuals who are intoxicated in public places. In particular, publicly intoxicated persons create problems because they can:

- Disrupt businesses;
- Interfere with shoppers;
- Deter users of public parks and other public spaces; and
- Present a real or perceived public safety threat to residents.

Publicly intoxicated persons, and especially chronic public inebriates, often suffer from illnesses or injuries that need medical assistance. Due to their incapacitated state, highly intoxicated persons are also vulnerable to becoming victims of crimes themselves.

Individuals arrested for driving while intoxicated (DWI) represent a subset of publicly intoxicated persons. In Montgomery County, the general practice is for the arresting officer to administer a breathalyzer test and process individuals for DWI at one of the District Stations. Under current law, after processing is completed, there is no authority to detain these individuals despite the fact that they may still be intoxicated and in need of supervision for their own safety or the safety of others.

Publicly intoxicated persons routinely consume the resources of multiple public sector agencies as well as other community members, including:

- Law enforcement officers,
- Health and human service providers,
- Paramedics,
- Hospital emergency room staff,
- Business owners,
- Residents.

In addition, the subset of publicly intoxicated persons who get processed into the criminal justice system are likely to require the time and attention of the Office of the State's Attorney, District Court, Department of Correction and Rehabilitation; Office of the Public Defender; and Division of Parole and Probation.

Dealing with publicly intoxicated persons in the County is an issue that has been around for many years. Through the course of conducting general research, OLO learned that the County has employed a range of strategies and looked into others over the years. In fact, about seven years ago, an internal County task force examined the feasibility of establishing a sobering center. OLO understands that a draft proposal for such a facility was developed but not pursued for fiscal reasons.

## B. REASONS FOR ESTABLISHING A SOBERING CENTER

The chart below lists the five different public policy goals commonly cited as the reason(s) for establishing a sobering center. Although the goals are not mutually exclusive, the potential for goal conflict exists. For example, a strategy of arresting more publicly intoxicated persons for committing minor crimes might successfully clear public spaces of intoxicated persons, but increase the workload in the criminal justice system.<sup>1</sup>

Goal of Establishing a Sobering Center	Summary Description
1. To clear public spaces of intoxicated persons.	This is the "Fixing Broken Windows" goal of improving order maintenance on the streets. <sup>2</sup> The primary result sought is the removal of persons in various stages of intoxication from public places, e.g., sidewalks, bus stops, parks. Clearing the streets of intoxicated persons is also cited as a crime prevention strategy, based upon the logic that prompt intervention may prevent criminal conduct by or against public inebriates.
2. To maintain the safety of publicly intoxicated persons.	This goal is based upon the premise that publicly intoxicated persons left on their own are in danger of being hurt. For example, due to their incapacitated state, an intoxicated person can fall down, walk into traffic, or be robbed or assaulted. An emphasis on this goal places priority on providing emergency care to public inebriates most acutely needing services such as food, shelter, and medical care.
3. To refer publicly intoxicated persons into treatment.	This goal is based upon the belief that the conduct of most publicly intoxicated persons is a manifestation of an underlying illness or set of illnesses. The picking up of public inebriates is seen as the first phase in a continuum of care that results in longer-term substance abuse treatment and rehabilitation of these individuals.
4. To divert publicly intoxicated persons who commit minor offenses (e.g., drinking alcohol on public property, possession of open container of alcohol) out of the criminal justice system.	This goal emphasizes removing "inappropriate" subject matter from the criminal justice system in order to free up the limited time of police officers, prosecutors, public defenders, courts, and other resources for what are considered higher priority law enforcement tasks.
5. To reduce the expenditure of limited emergency medical resources on publicly intoxicated persons who are not in need of emergency medical assistance.	This goal emphasizes reducing the resources of the County's Emergency Medical Services to transport and the resources of hospital emergency rooms to treat publicly intoxicated persons who are not in need of emergency medical assistance.

<sup>1</sup> OLO adapted this list of goals from the research and published work of David Aaronson, Thomas Dienes, and Michael Musheno, authors of The Decriminalization of Public Drunkenness: Tracing the Implementation of a Public Policy, published by the U.S. Department of Justice in January 1982.

<sup>2</sup> See Chapter II for more explanation of the "Fixing Broken Windows" thesis.

### C. WHAT IS KNOWN ABOUT PUBLICLY INTOXICATED PERSONS IN THE COUNTY?

**Currently available data are inadequate for drawing conclusions about the number or characteristics of publicly intoxicated persons in the County. While some relevant data are available from both criminal justice and health and human service agencies in the County, the various pieces of information that do exist do not well quantify or describe the problem of publicly intoxicated persons in the County.**

In sum, OLO identified four sources of data that provide some relevant facts about publicly intoxicated persons in the County: data from the Police Department's Emergency Communications Center on 9-1-1 calls dispatched and verified for "drunken person" (Code 2934); data from the Police Department on the number of arrests for alcohol-related traffic offenses; citation data available through the Criminal Justice Information System (CJIS); and data from the County's annual census of homeless persons.<sup>3</sup>

**Criminal Justice Data.** Summary tables generated from the available Police Department's call data and criminal citation data for 1999 and 2000, and DWI/DUI arrest data 1994-99 are included at the end of this chapter (see pages 11-14). These data show that:

- Each year, the police respond to and verify almost 2,000 calls for service for a "drunken person"; only a handful (less than 10%) of these calls result in a police report, citations, or arrest.
- Dispatches and verified incidents of "drunken person" are unevenly divided among the six Police Districts. Over half of the verified calls occur in the Silver Spring and Wheaton/Glenmont Police Districts.
- Although dispatches for "drunken person" occur every day of the week, the largest number occurs on Saturday and Sunday. Over half of Code 2934 calls occur between 6:00 PM and 2:00 AM.
- The 4,599 DWI/DUI arrests in the County in 1999 represented a 53% increase over the 3,006 arrests in 1994. In 1999, DWI arrests accounted for almost 25% of all arrests in the County.
- Law enforcement officers issue approximately 1,400 criminal citations a year for violations of State laws governing drinking alcohol in public, possessing an open container of alcohol, disorderly intoxication, or trespassing.

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<sup>3</sup> OLO thanks staff from the Police Department's Records Division and Crisis Intervention Team, DHHS' Crisis Center, and the Department of Information Systems and Technology for their assistance in tracking down and compiling available data.

- In general, law enforcement issue a larger number of these citations in the warmer months of the year. Only 10% of the persons cited in 1999-2000 were under 21 years old, and almost half were between 29-45 years old.
- Between January 1, 1999 and December 31, 2000, only 10% of the persons cited for these offenses were "citation repeaters," defined as receiving one or more citations on different days during the time period.

**Health and Human Services Data.** The County's 2001 one-day homeless census reported 1,089 (unduplicated) homeless persons in the County. The literature on homeless persons suggests that most surveys significantly undercount the actual number of homeless persons by as much as one-half. County officials have estimated there could be as many as 3,000 homeless persons in the County.

In the County's most recently homeless census, 1,013 homeless individuals answered questions about their substance abuse and mental illness status. Of those that answered these questions, approximately one-third (33%) self-reported that they had a substance abuse problem; and 29 percent self-reported a problem with mental illness.

**Anecdotal Information Front-line Agency Staff.** OLO's interviews with front-line staff suggest that there are locations in the County where one or more intoxicated persons can be found in a public place on a regular basis. ("Regular basis" here is defined as daily or almost daily.) The places identified consistently by law enforcement officers are the areas in and around the business districts of Longbranch, Takoma/Langley, South Silver Spring, and Wheaton.

In these locations, it is observed that publicly intoxicated persons create a visible public nuisance. In particular, identical to the problems identified in other jurisdictions, publicly intoxicated persons can disrupt businesses, interfere with shoppers, deter users of public parks and other public spaces, and present a threat (real and/or perceived) to residents.

Law enforcement officers also express concern about the subset of persons who are arrested for DWI/DUI and who, after processing, are still in need of supervision for their own safety or for the safety of others. Under current law, there is no authority for the County to detain these individuals after the processing related to the alcohol-impaired driving incident is completed. Although the arrested person often arranges to be picked up by either a family member, friend, or taxicab, there are situations where the next destination of an intoxicated person is not known.

**The Limitations of Available Data.** There are multiple problems with relying upon the available data as an accurate reflection of the "problem" of publicly intoxicated persons. Several of the significant problems are explained below.



The 9-1-1 data on "drunken person" calls provide an incomplete picture of law enforcement's workload with respect to publicly intoxicated persons. These data only include, for example, incidents to which officers are dispatched and do not include interactions with intoxicated persons that occur when officers are out on routine patrol. These data also do not include calls involving publicly intoxicated persons that are cleared as other types of incident, e.g., assault, miscellaneous other. In addition, because so many of these 9-1-1 calls are cleared without a police report or arrest, it is not known how many different persons are behind the 2,000 incidents; for example, it could be the same 200 people each involved in ten incidents during the year.

Data are not maintained explicitly on whether persons who receive citations were publicly intoxicated. As a crude surrogate measure, OLO chose to use the number of citations issued for selected violations where the reasonable assumption can be made that a large percent of the persons receiving the citation were intoxicated in a public place. Even if the surrogate measure is close to being accurate, the number of citations issued for violations such as drinking in public and disorderly intoxication only represent a small subset of the number of publicly intoxicated persons. In practice, we know that the great majority of law enforcement's interactions with publicly intoxicated persons do not result in either a citation or arrest.

As indicated earlier, with respect to the data collected on the County's homeless population, the research tells us that surveys significantly undercount the actual number of homeless persons in a community by as much as one-half. In addition, the research tells us that self-reporting of substance abuse problem is always unreliable.

In addition to the above validity problems, the available data fail to provide answers to the following threshold questions about publicly intoxicated persons in the County:

- What is the total number of intoxicated persons in public places at different times of the day and different days of the week?
- Where are these individuals located?
- What are their ages and other demographic characteristics?
- How many are repeaters vs. non-repeaters?
- How many are homeless street persons vs. persons who have a regular place to sleep?
- How many have other drug problems?
- How many have serious mental health and/or physical health problems?

- What is the criminal history of these individuals?
- What current (or previous) interactions do these individuals have with County services, e.g., emergency shelters, food programs, substance abuse programs?

With respect to the problem of intoxicated persons arrested for DWI/DUI being released while highly intoxicated, we do not know:

- How many of the 4,500-5,000 persons arrested for DWI/DUI each year in the County are still highly intoxicated and in need of supervision after the police complete processing them?
- How often have individuals arrested for DWI/DUI in one evening been re-arrested the same night for another DWI/DUI or other alcohol-related offense?

**If the Council wants to further pursue a sobering center, then OLO recommends investing in a targeted data collection effort so that future discussions and decision-making can be more data driven.** This recommendation is further explained in Chapter VI.

**TABLE 1**  
**911 DISPATCHES FOR CODE 2934 - "DRUNKEN PERSON" - BY DISTRICT**  
**VERIFIED EVENTS ONLY\***  
**1999-2000**

Police District	1999		2000	
	Number	Percent of Total	Number	Percent of Total
1 - Rockville	262	13	260	13
2 - Bethesda	140	7	171	9
3 - Silver Spring	587	30	574	29
4 - Wheaton/Glenmont	463	23	455	23
5 - Germantown	173	9	161	8
6 - Gaithersburg/ Montgomery Village	349	18	334	17
<b>TOTAL</b>	<b>1,974</b>	<b>100%</b>	<b>1,955</b>	<b>99%**</b>

\*Includes incidents handled by Montgomery County, Rockville City, Gaithersburg City, and Town of Chevy Chase Police Departments; does not include incidents handled by Takoma Park Police, M-NCPPC Park Police, Metro Transit Police, or State Police.

\*\*Does not add to 100% due to rounding.

Source: MCPD

**TABLE 2**  
**911 DISPATCHES FOR CODE 2934 - "DRUNKEN PERSON" BY DAY OF THE WEEK**  
**VERIFIED EVENTS ONLY\***  
**1999-2000**

Day of the Week	1999		2000	
	Number	Percent of Total	Number	Percent of Total
Sunday	339	17%	364	19%
Monday	220	11	201	10
Tuesday	254	13	238	11
Wednesday	203	10	217	11
Thursday	258	13	227	12
Friday	292	15	269	14
Saturday	408	21	439	23
<b>Total</b>	<b>1974</b>	<b>100%</b>	<b>1955</b>	<b>100%</b>

\*Includes incidents handled by Montgomery County, Rockville City, Gaithersburg City, and Town of Chevy Chase Police Departments; does not include incidents handled by Takoma Park Police, M-NCPPC Park Police, Metro Transit Police, or State Police.

Source: MCPD

**TABLE 3**  
**911 DISPATCHES FOR CODE 2934 - "DRUNKEN PERSON" BY TIME OF DAY**  
**VERIFIED EVENTS ONLY**  
**1999-2000**

Time of Day	1999		2000	
	Number	Percent of Total	Number	Percent of Total
2:00 am- 6:00 am	279	14	278	14
6:00 am- 10:00 am	85	4	71	4
10:00 am - 2:00 pm	172	9	155	8
2:00 pm - 6:00 pm	315	16	297	15
6:00 pm - 10:00 pm	479	24	525	27
10:00 pm - 2:00 am	644	33	629	32
<b>Total</b>	<b>1,974</b>	<b>100%</b>	<b>1,955</b>	<b>100%</b>

\*Includes incidents handled by Montgomery County, Rockville City, Gaithersburg City, and Town of Chevy Chase Police Departments; does not include incidents handled by Takoma Park Police, M-NCPPC Park Police, Metro Transit Police, or State Police.

Source: MCPD

**TABLE 4**  
**IMPAIRED-DRIVING ARRESTS MADE IN MONTGOMERY COUNTY, 1994-1999**

Year	Number of DWI/DUI Arrests Made By Montgomery County, Rockville City, and Gaithersburg City Police (A)	Number of DWI/DUI Arrests by other Law Enforcement Officers, i.e., State Police, Park Police, Takoma Park Police (B)	Total DWI/DUI Arrests in Montgomery County (A+B)
1994	2,608	398	3,006
1995	2,820	587	3,407
1996	3,350	818	4,168
1997	3,495	352	3,847
1998	3,834	611	4,445
1999	3,901	698	4,599

Source: MCPD, March 2001 and COG Report, December 2000

**TABLE 5  
NUMBER OF CITATIONS ISSUED FOR SELECTED ALCOHOL-RELATED VIOLATIONS  
1999-2000**

<b>Criminal Violation</b>	<b>1999</b>	<b>2000</b>
Drinking Alcohol In Public	490	558
Possession of Alcohol in an Open Container	250	259
Disorderly Intoxication	99	118
Trespass: Private Property	556	464
<b>Total</b>	<b>1,395</b>	<b>1,399</b>

Source: MCPD and DIST

**TABLE 6  
NUMBER OF CITATIONS ISSUED FOR DRINKING ALCOHOL IN PUBLIC, POSSESSION OF ALCOHOL IN AN OPEN  
CONTAINER, DISORDERLY INTOXICATION, AND TRESPASSING  
BY MONTH OF THE YEAR ISSUED  
1999-2000**

<b>Month</b>	<b>1999</b>	<b>2000</b>
January	115	63
February	48	97
March	86	104
April	89	118
May	146	93
June	134	80
July	137	148
August	137	153
September	163	135
October	110	120
November	45	156
December	120	85
<b>Total</b>	<b>1,330</b>	<b>1,352</b>

Source: MCPD and DIST

**TABLE 7**  
**AGE OF INDIVIDUALS CHARGED WITH DRINKING ALCOHOL IN PUBLIC, POSSESSION OF ALCOHOL IN AN OPEN CONTAINER, DISORDERLY INTOXICATION, AND TRESPASSING BETWEEN JANUARY 1999 AND DECEMBER 2000**

<b>Age Range</b>	<b>Number</b>	<b>Percent of Total</b>
<21 years old	211	10
21-28 years old	637	30
29-45 years old	1,020	48
46-60 years old	240	12
<b>Total</b>	<b>2,108</b>	<b>100%</b>

Source: MCPD and DIST

**TABLE 8**  
**NUMBER OF DIFFERENT TIMES THAT INDIVIDUALS WERE CITED FOR DRINKING ALCOHOL IN PUBLIC, POSSESSION OF ALCOHOL IN AN OPEN CONTAINER, DISORDERLY INTOXICATION, AND/OR TRESPASSING BETWEEN JANUARY 1, 1999 - DECEMBER 31, 2000**

<b>Number of Different Times Cited During Time Period*</b>	<b>Number of Persons</b>	<b>Percent of Total Persons Receiving Citations</b>
One	1,980	89
Two	143	6
Three	59	3
Four	18	.8
Five	5	.2
Six	8	.3
Seven	2	.08
Eight	3	.13
Nine	0	0
Ten	5	.2
<b>Total</b>	<b>2,223</b>	<b>100</b>

\*If an individual received one or more citations for the same event, it was counted as one time.  
 Source: MCPD and DIST

## II. THE FIXING BROKEN WINDOWS THESIS

This chapter presents a summary of the now-familiar “fixing broken windows” thesis. Its name derives from an essay written by James Q. Wilson and George L. Kelling published in the March 1982 issue of *The Atlantic Monthly* in March. The essence of “fixing broken windows” is the belief that, at the community level, disorder and crime are inextricably linked. Further, Wilson and Kelling maintain that police attention to order maintenance activities will have an impact on index crimes as well as low-level disorder.

In their original 1982 essay, Wilson and Kelling used the image of broken windows to explain how neighborhoods might decay into disorder and even crime if attention is not paid to their repair. As Wilson and Kelling write:

Social psychologists and police officers tend to agree that if a window in a building is broken and is left unrepaired, all of the rest of the windows will soon be broken. This is as true in nice neighborhoods as in rundown ones. Window-breaking does not necessarily occur on a large scale because some areas are inhabited by determined window-breakers whereas others are populated by window-lovers; rather, one unrepaired broken window is a signal that no one cares and so breaking more windows costs nothing. (“Broken Windows,” *The Atlantic Monthly*, 1982)

Wilson and Kelling argue that once passerbys conclude that “no one cares” or “no one is in charge,” a few will venture to throw rocks and break more windows. Soon, all of the windows are broken and now passerbys conclude that not only is no one in charge of the building, but that no one is in charge of the street. In turn, residents grow reluctant to spend time on the street, which then leads to a decline in what the authors call “community controls.” According to Wilson and Kelling:

We suggest that “untended” behavior also leads to the breakdown of community controls. A stable neighborhood of families who care for their homes, mind each other’s children and confidently frown on unwanted intruders can change, in a few years or even a few months to an inhospitable and frightening jungle. A piece of property is abandoned, weeds grow up, a window is smashed. Adults stop scolding rowdy children; the children, emboldened, become more rowdy. Families move out, unattached adults move in. Teenagers gather in front of the corner store. The merchant asks them to move; they refuse. Fights occur. Litter accumulates. People start drinking in front of the grocery; in time, an inebriate slumps to the sidewalk and is allowed to sleep it off. Pedestrians are approached by panhandlers. (“Broken Windows,” *The Atlantic Monthly*, 1982)

Kelling and Wilson acknowledge that as this process unfolds, it is not inevitable that serious crime will occur on the street. However, the thesis is that many residents will think that crime, especially violent crime, is on the rise, and will change their behavior accordingly. In response to fear, people sometimes call the police. The police respond, an occasional arrest is made, but the disorder remains. It is even possible that citizens begin to perceive the police as ineffective and may stop calling them because “they can’t do anything.”

In 1996, the book, *Fixing Broken Windows: Restoring Order and Reducing Crime in Our Communities* was published. In this book, George Kelling and Catherine Coles further developed the theory presented in 1982. The authors identify the police as holding the key to order maintenance because through their actions, Kelling and Coles argue that the police are in a unique position to reinforce the informal control mechanisms of the community itself. While the police will never have the resources to substitute their presence for that informal community control, the officers’ presence on the street can do a tremendous amount to support it.

The authors identify four elements of the police and the broken windows strategy to explain its link to crime reduction:

- First, dealing with disorder and low-level offenders both informs police about and puts them into contact with those who have committed index crimes (this includes the hard core 6% of youthful offenders).
- Second, the high visibility of police actions and the concentration of police in areas characterized by high levels of disorder protect “good kids” while sending a message to “wannabe” and those guilty of committing marginal crimes that their actions will no longer be tolerated.
- Third, citizens themselves begin to assert control over public spaces by upholding neighborhood standards for behavior and ultimately moving onto center stage in the ongoing processes of maintaining order and preventing crime.
- Fourth, as problems of disorder and crime become the responsibility not merely of the police but of the entire community, including agencies and institutions outside but linked to it, all mobilize to address them in an integrated fashion. (source: *Fixing Broken Windows*, p. 242-243)

#### **UPDATE ON FIXING BROKEN WINDOWS: RECENT EMPIRICAL RESEARCH**

Earlier this year (February 2001), the National Institute of Justice published the results of a research study that assessed the validity of the broken windows thesis. In particular, the study by Robert Sampson and Stephen Raudenbush examined the empirical evidence to support or refute the link between disorder and crime.



In sum, the study suggests that although disorder does not directly promote crime, the two phenomena are related, and that collective efficacy (defined as cohesion among neighborhood residents combined with shared expectations for informal social control of public space) is a significant factor in explaining levels of crime and disorder. The findings imply that disorder may in fact reduce crime, but this is happening indirectly by stabilizing neighborhoods via collective efficacy. The study also found that:

- Disorder and crime alike were found to stem from certain neighborhood structural characteristics, notably concentrated poverty;
- Disorder was directly linked to the level of robbery, but not to the level of homicides; and
- Strong collective efficacy appears to deter disorder, and where it was strong, observed levels of physical and social disorder were low.

### III. LEGAL STRUCTURE

#### A. THE DECRIMINALIZATION OF PUBLIC INTOXICATION

During the 1960's and 1970's, in response to court decisions and recommendations of governmental commissions, significant changes occurred at both the federal and state government levels regarding the treatment of alcoholics and public inebriates.

**Landmark Court Decisions.** In *Easter v. District of Columbia*, (D.C. Circuit 1966) and *Driver v. Hinnant* (4<sup>th</sup> Circuit 1966), the courts held that because alcoholism is an illness, a homeless alcoholic could not avoid being drunk in public and therefore could not be punished for his public intoxication.

In *Powell v. Texas* (1968), the Supreme Court declined to extend this ruling to an alcoholic who has a home and family. However, in this case, a majority of the court held that the punishment of a homeless alcoholic for public intoxication would violate the Eighth Amendment to the U.S. Constitution. (The 8<sup>th</sup> amendment states that excessive bail shall not be required, nor excessive fines imposed, or cruel and unusual punishment inflicted.) In addition, the Supreme Court held that the current facilities, procedures, and the legislative response to the problems of alcoholism had been inadequate.

**Commission Recommendations.** In 1967, three commissions (the US Crime Commission, the D.C. Crime Commission, and the Cooperative Commission on the Study of Alcoholism) concluded that the criminal law was an ineffective, inhumane, and costly device for the prevention and control of alcoholism or public drunkenness. All three commissions recommended that a public health approach be substituted for current criminal procedures.<sup>1</sup>

In 1969, the American Bar Association and American Medical Association supported changes in the attitudes toward and treatment of alcoholism and public intoxication. The organizations released a "Joint Statement of Principles Concerning Alcoholism" which encouraged State governments to adopt new comprehensive legislation that viewed alcoholism as an illness and no longer handled public intoxication as a criminal offense.

**Federal Laws.** In 1968, Congress passed the Alcoholic Rehabilitation Act of 1968 (Public Law 90-574). In this Act, Congress stated that:

The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.

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<sup>1</sup> National Conference of Commissioners on Uniform State Laws, prefatory note, 1971

In 1970, Congress expanded the federal role in the treatment of alcoholism by enacting the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 910616) and establishing the National Institute on Alcohol Abuse and Alcoholism.

**State Laws.** Since the early 1970's, about half of the states have passed legislation that decriminalizes alcoholism and public intoxication. In the remaining states, public intoxication continues to be a criminal or civil offense.

Although specific statutory language to decriminalize public intoxication varies, the general concept is to legislatively preclude the handling of drunkenness by itself as a criminal offense. In practice, law enforcement is then instructed to handle the normal manifestations of intoxication, e.g., staggering, lying down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, etc. as a civil matter.

Maryland was one of the first states to decriminalize public intoxication per se. However, similar to the language found in other states, it remains a criminal offense in Maryland to engage in certain alcohol-related behavior in public, such as: being intoxicated and disorderly, drinking on public property. The following section provides an overview of Maryland law governing public intoxication.

**The Concept of Protective Custody.** OLO's comparative research found that sobering centers appear to be located in states where either: (1) public intoxication remains a criminal offense (e.g., Virginia, California, Texas, Oklahoma); or (2) public intoxication is decriminalized but state law allows law enforcement to take a publicly intoxicated person into "protective custody" for the purpose of protecting the person's health or safety (e.g., Colorado, Nevada, Oregon, Washington).

In states where public intoxication remains a criminal offense and a sobering center exists, law enforcement officers routinely give publicly intoxicated persons a choice. The choice presented is either to be arrested and taken to jail, or to be diverted from the criminal justice system by going to a sobering center. In practice, the jail option continues to serve as an incentive for individuals to abide by the rules and regulations of the sobering center.

In states where public intoxication is decriminalized but the law allows for "protective custody," law enforcement routinely take publicly intoxicated persons into protective custody and transport them (with or without the person's consent) to a sobering center.

For example, the State law in Nevada defines protective custody as "a custodial placement of a person for the purpose of protecting his health or safety. Protective custody does not have any criminal implication."

With respect to intoxicated persons, Nevada law provides that:

A person who is found in any public place under the influence of alcohol, in such a condition that he is unable to exercise care for his own health or safety or the health or safety of others, must be placed under protective custody.

In Nevada, law enforcement officers rely upon the following statutory language as providing their authority to transport publicly intoxicated persons to a sobering center:

A peace officer may use upon such a person the kind and degree of force which would be lawful if he were effecting an arrest for a misdemeanor with a warrant. If a licensed facility for the treatment of persons who abuse alcohol exists in the community where the person is found, he must be delivered to the facility for observation and care. If no such facility for shelter or supervision exists in the community, the person so found may be placed in a county or city jail or detention facility for shelter or supervision for his own health and safety until he is no longer under the influence of alcohol. He may not be required against his will to remain in either a licensed facility, jail, or detention facility longer than 48 hours.

## **B. OVERVIEW OF MARYLAND LAW GOVERNING PUBLIC INTOXICATION**

**Criminal Offenses.** Under Maryland law, public intoxication by itself is not an offense. However, State law prohibits certain alcohol-related activities in public, e.g., disorderly intoxication, drinking alcohol on public property. The maximum penalty for such alcohol-related offenses is generally a fine, but in some cases it can include imprisonment.

Table 9 summarizes the alcohol-related offenses identified in State law that are most relevant to publicly intoxicated persons. As indicated in the table's footnote, State law (Article 2B, Title 19) explicitly preempts the County from adopting legislation that is inconsistent with the State's definition of what constitutes disorderly intoxication in a public place.

In addition to the offenses outlined in Table 9, State law provides that a person may not drive or attempt to drive any vehicle in Maryland while he/she is so far under the influence of alcohol and/or drugs that he/she cannot drive a vehicle safely. Effective October 1, 2001, the illegal per se limit in Maryland will be a blood alcohol concentration (BAC) of .08. The maximum penalty for a first alcohol-related driving while intoxicated offense is not more than 1 year imprisonment or not more than \$1,000 in fines or both.

**TABLE 9**  
**ALCOHOL-RELATED CRIMINAL VIOLATIONS**

<b>Criminal Violation</b>	<b>State Law Charging Section</b>	<b>Maximum Penalty</b>
Violations that are directly related to drinking alcohol and publicly intoxicated persons		
Disorderly intoxication - intoxicated and endangering the safety of another person/property <sup>2</sup>	Article 2B, Section 19-101(a)(1)	\$100 fine; 90 days imprisonment
Disorderly intoxication - intoxicated or drinking any alcoholic beverage in a public place and causing a public disturbance <sup>1</sup>	Article 2B, Section 19-101(a)(2)	\$100 fine; 90 days imprisonment
Drinking alcohol in public on public property	Article 2B, Section 19-202(a)(1)	\$100 fine
Drinking alcohol in a parking lot of a shopping center	Article 2B, Section 19-202(a)(2)	\$100 fine
Drinking alcohol in a parking lot of a retail store	Article 2B, Section 19-202(a)(3)	\$100 fine
Drinking alcohol in a parked vehicle at any of the above	Article 2B, Section 19-202(a)(4)	\$100 fine
Possession of alcohol in an open container in a shopping center parking lot	Article 2B, Section 19-301(b)(1)	\$100 fine
Possession of alcohol in an open container in a retail parking lot	Article 2B, Section 19-301(b)(1)	\$100 fine
Possession of alcohol in an open container in a parked vehicle at any of the above	Article 2B, Section 19-301(b)(1)	\$100 fine
Other violations that frequently apply to publicly intoxicated persons		
Disturbing the peace - public place or public conveyance	Article 27, Section 121(b)(1)	\$500 fine; 60 days imprisonment
Disturbing the peace - public street/apartment/house, etc.	Article 27, Section 121(b)(2)	\$500 fine; 60 days imprisonment
Disturbing the peace - fail to obey reasonable/lawful order of law enforcement officer	Article 27, Section 121(b)(3)	\$500 fine; 60 days imprisonment
Disturbing the peace - unreasonably loud noise	Article 27, Section 121(b)(3)	\$500 fine; 60 days imprisonment
Trespass- wanton	Article 27, Section 577(a)(2)	\$500 fine; 3 months imprisonment
Trespass on posted property (owner must be summonsed to court)	Article 27, Section 577(a)(1)	\$500 fine; 90 days imprisonment

<sup>2</sup> State law (Article 2B, Title 19-101) explicitly preempts a county, municipality or other political subdivision from adopting local legislation that is inconsistent with this section of State law.

**State law on Disposition of Publicly Intoxicated Individuals.** State law (Health Article, Subtitle 5, Section 8-501) authorizes the police or other authorized personnel to take or send a publicly intoxicated person to certain places under certain conditions. The law reads as follows:

If a publicly intoxicated individual consents or an individual's health is in immediate danger, the police or other authorized personnel may take or send a publicly intoxicated individual to:

- (1) The individual's home;
- (2) A detoxification center; or
- (3) Any other appropriate health care facility as defined in Section 19-114(e) of this article.

The law specifies that an entry of an action under this section may not be made on the arrest or other criminal record of the intoxicated individual. The following section in the law (Health Article, Subtitle 5, Section 8-502, Admission to a facility) sets forth the following conditions for admission to a facility:

After a preliminary evaluation of an individual by the administrator or the designee of the administrator, the individual may be admitted to the facility if it is certified in writing that the individual:

- (1) Has acute symptoms of alcohol or drug intoxication or withdrawal; and
- (2) (i) Appears to be in imminent danger of harming one's self or another individual or the property of another individual; or (ii) is willing to be voluntarily admitted.

The law specifies that an individual admitted under this section may be detained up to 72 hours after admission.

***Note on Current Practice:** Law enforcement officers in the County do, in some situations, transport an intoxicated person home or to a hospital for medical assistance; the medical assistance may or may not include detoxification. In practice, the section of law authorizing the transport of a publicly intoxicated person to a "detoxification center" cannot be used by law enforcement in the County because there is no such "detoxification center" that serves as a police drop-off for intoxicated persons.*

**Release of a Person Arrested for DWI/DUI.** Under current State law, there is no authority to detain a defendant arrested for DWI/DUI after the arresting officer completes the processing of the defendant for the DWI/DUI offense.

The Police Department's directive on this issue states that after the processing is complete for the DWI/DUI offense, the defendant is released in one of the following ways:

- Picked up by a spouse, relative, or friend;
- Picked up by a taxicab;
- Taken home by an officer;
- Released to walk home. (A supervisor must approve the release of an intoxicated defendant to walk home unescorted.)

MCPD's directive makes it clear that the officers are not required to take a DWI defendant home after release.

**State legislation mandating detention of DWIs introduced but defeated.**

During the 2001 session of the General Assembly, legislation (House Bill 69) was introduced that would have required the detention of persons arrested for certain alcohol- and drug-related driving violations (including DWI) for at least 12 hours after the person was arrested. The legislation, sponsored by Delegate Owings, was defeated in the Judiciary Committee.

#### **IV. FINDINGS ON CURRENT PRACTICES IN MONTGOMERY COUNTY**

OLO interviewed management and front-line staff from the different agencies that deal directly with persons who are or have been intoxicated in public places. This chapter summarizes what OLO learned through these interviews.

As expected, there is not a uniform public sector response to individuals who are publicly intoxicated. With the exception of DWI/DUI offenders, whether and how the public sector intervenes with a publicly intoxicated person depends on situational factors such as:

- The location of the publicly intoxicated person, e.g., whether the person is on public or private property, school property, in a business district or a park.
- Time of day and weather conditions, e.g., whether it is during or after business hours, a beautiful sunny day or a dangerously cold night.
- Who from the public sector is on the scene, e.g., law enforcement officer, paramedic, social worker, probation officer.
- The behavior of the intoxicated person, e.g., whether the person is conscious or unconscious, disorderly and belligerent or calm and passive.
- How the publicly intoxicated person came to the attention of the public sector, e.g., whether a resident or business owner called 9-1-1 to report that an intoxicated person was either bothering customers or passed out; whether a patrol officer (while out on routine patrol) sees an intoxicated person sitting down on a park bench.
- Other factors such as: whether the publicly intoxicated person is a known "repeater;" whether the person is homeless; whether the person is under or over 21 years old, and whether the publicly intoxicated person and public sector responder speak the same language.

In comparison to the handling of publicly intoxicated persons in general, law enforcement's approach to an alcohol-impaired driver is more predictable. Officers receive special training in DWI detection and pre-arrest screening. If probable cause exists, the officer places the driver under arrest. There are police directives that govern what to do with the defendant's vehicle and the steps that must be taken to correctly charge a person for DWI/DUI. It is the County's practice to routinely process DWI/DUI offenders at a District Police Station.

After being processed and formally charged, DWI offenders are not detained and do not appear before a District Court Commissioner. As explained in Chapter II, there is no legal authority to detain these individuals after the processing is complete. DWI/DUI



defendants are released in one of the following ways: picked up by a spouse, relative, or friend; picked up by a taxicab; taken home by an officer; or released to walk home. (A supervisor must approve the release of an intoxicated defendant to walk home unescorted.)

Table 10 (page 26-27) lists the public agencies that most often deal with publicly intoxicated persons in the County, and summarizes each agency's primary roles and responsibilities. More detailed observations on current practices are then presented as follows:

Part A contains more detailed findings on the intervention options typically available to police officers for dealing with publicly intoxicated persons. (Note: These options do not apply to situations involving an alcohol-impaired driver, which are governed by standard rules for the pre-arrest screening, arrest, and processing of defendants.)

Part B contains information on the range of County services provided for screening and treatment of substance abuse (including alcohol), and emergency services for persons in crisis.

Part C presents some observations on hospital emergency rooms and publicly intoxicated persons.

**TABLE 10  
OVERVIEW OF AGENCY ROLES AND RESPONSIBILITIES**

<b>Agency</b>	<b>Primary Responsibility for Dealing with Publicly Intoxicated Persons</b>
<p>Police Departments: Montgomery County Police, municipal police (Cities of Rockville, Gaithersburg and Takoma Park, Town of Chevy Chase); M-NCPPC Park Police; Metro Transit Police,</p>	<p>Law enforcement officers are responsible for general enforcement of all alcohol-related laws while on routine patrol. Patrol officers interact routinely with publicly intoxicated persons when they: respond to 9-1-1 calls for drunken person in public place; respond to 9-1-1 calls for other incidents (e.g., domestic violence assault) that often involve intoxicated persons; and conduct traffic stops for suspected situations of Driving While Intoxicated.</p> <p>Depending upon the situation, the police response may include issuance of a citation and/or making an arrest. The police are responsible for guarding an arrestee who needs medical assistance; in cases involving a highly intoxicated person, this may involve guarding the arrestee at the hospital until he/she is medically cleared for processing at the Central Processing Unit.</p>
<p>Department of Fire/Rescue Services</p>	<p>DFRS staff respond to 9-1-1 calls for emergency medical services, which in some cases involves highly intoxicated persons.</p> <p>Whenever Emergency Medical Services (EMS) are dispatched, paramedics provide on-site first aid and make an assessment of the situation. Individuals who are assessed as needing emergency medical assistance are then transported by ambulance to a hospital emergency room.</p>
<p>Department of Correction and Rehabilitation</p>	<p>DOCR operates the County's Central Processing Unit (CPU), which processes persons who have been arrested. CPU staff (in consultation with a nurse from the Detention Center) determine whether someone who has been arrested is too intoxicated to be booked.</p> <p>DOCR operates the County's Detention Center. At any given time, there are individuals who are under DOCR's supervision (pre-trial and after trial) who have alcohol abuse problems. If an inmate under DOCR's supervision is in need of medical care that cannot be provided in DOCR's infirmary, then the inmate is transported to the hospital and placed under hospital guard.</p>

**TABLE 10 CONT.  
OVERVIEW OF AGENCY ROLES AND RESPONSIBILITIES**

<b>Agency</b>	<b>Primary Responsibility for Dealing with Publicly Intoxicated Persons</b>
Department of Health and Human Services	<p>DHHS provides a continuum of emergency food, shelter, and other support services to individuals in crisis, which in some cases, includes publicly intoxicated persons. Certain services are targeted for individuals who are homeless and/or suffering from mental illness, e.g., Mobile Crisis Team, the Assertive Community Treatment teams.</p> <p>DHHS also directs a system of community and correctional based substance abuse screening, assessment, and treatment services. These services include hospital and non-hospital detoxification services.</p>
Office of the State's Attorney	<p>The State's Attorney is responsible for prosecuting persons for alcohol-related criminal and traffic offenses, including driving while intoxicated. The alcohol-related charges most often made against publicly intoxicated persons are disorderly intoxication, drinking in public, open container, disturbing the peace, and trespassing.</p>
District Court	<p>Responsible for adjudicating/sentencing persons for alcohol-related offenses.</p>
Maintenance Functions throughout all agencies, including Parks Maintenance, Urban Districts, DPWT	<p>Responsible for cleaning up debris left by public inebriates, e.g., bottles, cans, public urination/defecation</p>

## **A. OPTIONS FOR POLICE INTERVENTION**

In the great majority of cases, a law enforcement officer is the first public sector representative to arrive on the scene of an incident involving a publicly intoxicated person. Officers interact on a regular basis with publicly intoxicated persons either because a patrol officer is dispatched to a particular incident (in response to a 9-1-1 call), or because an officer observes a publicly intoxicated person while out on routine patrol.

Table 1 (page 11) shows the number of verified calls for the 9-1-1 dispatch of "drunken person" by police district for calendar years 1999 and 2000. The data indicate the police verified almost 2,000 incidents of a drunken person in each of the past two years. These data are only a crude measure of the workload created by publicly intoxicated persons. In particular, these data underestimate the workload because they do not capture the many interactions that officers have with publicly intoxicated persons as a result of other types of calls or while out on routine patrol.

A police officer in Montgomery County has a number of options for dealing with a publicly intoxicated individual. Each option has its advantages and disadvantages, and some options can be combined. While one intervention may solve the immediate problem, it may also create a different set of problems. Consistent with a police officer's general authority to exercise discretion, so long as the person is not a threat to public safety, the officer can decide not to intervene at all. The next six pages summarize the options typically available to police officers:

- Ask the publicly intoxicated person to "move on;"
- Transport the intoxicated person home or to another location that he/she consents to;
- Request that Fire/Rescue Services transport the publicly intoxicated person by ambulance to the hospital emergency room;
- Issue a citation without making a physical arrest;
- Make a physical arrest, take the publicly intoxicated person into custody, and file a statement of charges with the District Court Commissioner.

If the publicly intoxicated person is believed to be suffering from a mental illness crisis, then a representative from the Police Department's new Crisis Intervention Team (CIT) may be called upon to help de-escalate the situation. As of this month, there are 118 law enforcement officers in the County that have been certified as CIT officers. A recently issued Headquarters Memorandum outlining the CIT procedures is attached at © 9.

### **OPTION 1. ASK THE PUBLICLY INTOXICATED PERSON TO "MOVE ON".**

Based upon interviews with patrol officers, asking an intoxicated person to "move on" appears to be the most common police intervention practiced. Depending on the

situation, a cooperative response to an officer's request to "move on" can mean that the intoxicated person relocates him/herself around the block or across the street, or gets a ride (either from a friend or in a taxicab) to another location.

An officer's request to "move on" often solves the immediate problem, e.g., an intoxicated person was bothering customers. It is also common, however, for the "move on" intervention to provide only a very short-term solution. In practice, the same officer (or another officer) is frequently dispatched a short while later to deal with the same intoxicated person in the same or different location.

In some situations, the "move on" strategy does not even work in the short run. It will not work when, for example, the person is too inebriated to understand the officer's request or too incapacitated to physically move him/herself from one place to another. Alternatively, the intoxicated person may not have anyone to call for a ride, may have no money to pay for a taxicab, or may simply refuse to comply with an officer's request.

## **OPTION 2. TRANSPORT THE PUBLICLY INTOXICATED PERSON HOME OR TO ANOTHER LOCATION THAT HE/SHE CONSENTS TO.**

So long as a person provides his/her consent, a police officer may transport the person home or to another location. A practical obstacle with this option is that when someone is highly intoxicated, it is often difficult for an officer to interpret what the person is actually requesting or consenting to. This problem can be exacerbated if the intoxicated person and the police officer do not speak the same language.

Giving an intoxicated person a ride home (or elsewhere) in a police car potentially presents some additional problems for a police officer, such as:

- The desired location may be far away and take the officer out of service for an extended period of time;
- The intoxicated person might get sick or urinate in the officer's car; (this can result in the car being unavailable for several days while it is being cleaned);
- The officer will need to search the person for weapons before placing him/her in the police vehicle; and
- The desired location may create a new set of problems, e.g., the inebriated person may not be welcome where he/she wants to go.

**County Crisis Center and Emergency Shelter Facilities.** Although the County's Crisis Center is staffed on a 24/7 basis to deal with persons who are in psychiatric crisis, it is not currently set up to deal with highly intoxicated persons. If a highly intoxicated person arrives at the Crisis Center (either on his/her own or by police transport), then the Crisis Center's general practice is to call 9-1-1 and request that an ambulance transport the person to the hospital for medical assistance.

Similarly, both the Mobile Crisis Team (part of the Crisis Center staff) and the police department's Crisis Intervention Team were established primarily to deal with persons who are mentally ill. The Mobile Crisis Team and/or CIT officers will respond to calls that involve persons who have co-occurring mental illness and substance abuse problems. However, if a mentally ill person is highly intoxicated, then the Mobile Crisis Team or CIT officer is likely to request that an ambulance transport the person to the emergency room. For additional information on CIT, see © 9.

The general practice of the County-supported emergency shelter facilities is not to accept individuals who are intoxicated. In practice, however, between the months of November and April, the Gude Shelter's policy is to offer night shelter to all men (including intoxicated ones) who agree to abide by the facility's basic rules. The rules include orderly behavior and no drinking while on the premises. Shelter staff will call 9-1-1 for an ambulance if a shelter resident appears to be in need of emergency medical care.

**OPTION 3. REQUEST THAT FIRE/RESCUE SERVICES TRANSPORT THE PUBLICLY INTOXICATED PERSON BY AMBULANCE TO THE HOSPITAL EMERGENCY ROOM.**

In some situations, both the police and an ambulance are dispatched to the scene of a publicly intoxicated person. This will typically occur if someone calls 9-1-1 to report that, for example, a person is lying down in a public space and looks unconscious. In the world of public safety communications, this dispatch is referred to as "one down."

Alternatively, if a police officer responds to a situation involving a publicly intoxicated person and believes that the intoxicated person needs emergency medical assistance, then the officer has the option of contacting the Emergency Communications Center and requesting that an ambulance be dispatched.

When Emergency Medical Service (EMS) personnel arrive on the scene, their standard protocol is to examine the intoxicated person and make a field assessment of whether transport to an emergency room is required. Based upon interviews with EMS staff, a person who is unconscious (intoxicated or not) will always be transported to the hospital. If the person can be aroused and passes a field test of general awareness, then depending upon what else the paramedics observe, the person may or may not be transported to the hospital. In all cases, a person has the right to refuse an offer of transport to the hospital.

The police will routinely accompany the ambulance to the hospital if the officer has already taken (or plans to take) the person into legal custody. In addition, EMS staff will ask a police officer to accompany the ambulance to the hospital if the person being transported is belligerent or perceived to be a physical threat.

In almost all cases where EMS decides not to transport the intoxicated person to the hospital or the person refuses the offer of a transport, the responsibility for dealing with the publicly intoxicated person falls to the police officer.

#### **OPTION 4. ISSUE A CITATION WITHOUT MAKING A PHYSICAL ARREST.**

Maryland law designates many of the alcohol-related misdemeanors as violations for which an officer has the option of issuing a criminal citation (similar to a traffic ticket.) With such violations, it is the police officer's discretion to issue a citation with or without actually making a physical arrest and taking the offender into legal custody.

In order to issue a citation, the officer is required to obtain a valid form of identification from the person being cited, including a legal address. (The address is essential because the person receives notification of his/her court date by mail.) Issuing a citation is not a viable option if the person does not have valid identification and/or a legal address. This is especially true with chronic homeless public inebriates.

Although issuing a citation can be an effective law enforcement tool, issuing a citation is not necessarily going to do anything to solve the immediate problem posed by a publicly intoxicated person, i.e., the intoxicated person is being disorderly. Issuing the citation does not automatically remove the intoxicated person from the situation.

Another factor to consider when issuing a citation is the additional criminal justice system resources that are required for the subsequent processing of this action. The process typically includes resources from the Office of the State's Attorney, the District Court, the Public Defender, the Department of Correction and Rehabilitation, as well as more police time. The typical steps are as follows:

- All criminal citations are sent to the Office of the State's Attorney and assigned to a prosecutor on the District Court team. The prosecutor reviews the case, compiles additional information as needed, decides how to proceed, and then prepare the case for trial.
- If a defendant who receives a criminal citation fails to appear in District Court on his/her designated court date, the District Court typically issues a judicial summons to the defendant for his/her failure to appear.
- If the defendant does not respond to the judicial summons, then the District Court typically issues a bench warrant for the individual's arrest. District Court bench warrants are assigned to the County Police Department's fugitive unit for service.

- If/when the defendant is arrested and taken into custody, the District Court Commissioner may decide to hold the person in the Detention Center (pre-trial) until his/her trial date. Depending upon the situation, legal counsel for the defendant may be provided by the Public Defender.

The time commitment from the arresting officer and the prosecutor occur every time the case is scheduled in court. The arresting officer (and any other officers who are serving as witnesses) must always appear even if it is fully expected that the defendant will not appear. Similarly, the prosecutor must always be prepared to take the case to trial every time it is called.

**OPTION 5. MAKE A PHYSICAL ARREST, TAKE THE PERSON INTO CUSTODY, AND FILE A STATEMENT OF CHARGES WITH THE DISTRICT COURT COMMISSIONER.**

If a person commits certain alcohol-related offenses (e.g., disorderly intoxication, drinking on public property), then the law leaves it up to the officer's discretion to decide whether to make a physical arrest or issue a criminal citation. If an intoxicated person commits a more serious offense while interacting with the police officer (e.g., assault on a police officer), then a physical arrest is almost guaranteed to take place.

The scenario that follows a physical arrest of an intoxicated person can vary considerably. What happens will depend upon factors such as:

- Whether the arresting officer determines the arrestee needs medical care before being transported to the Central Processing Unit;
- Whether the Detention Center medical staff determines that the arrestee is in need of medical care before being admitted to the Central Processing Unit;
- If the arrestee is taken to an emergency room for medical assistance, the extent of medical intervention that the hospital determines is necessary; and
- Whether the arrestee signs a form at the hospital that states he/she is refusing medical treatment.

Montgomery County Police Department's Directive. Function Code 811, (effective 10-11-99) sets forth the procedures for the handling, searching, and transporting of prisoners. Medical problems that can result from drinking large quantities of alcohol are considered no different than any other potential medical problem, and MCPD does not have a separate directive for dealing with intoxicated persons.

Function Code 811 requires officers to seek medical attention for their prisoners as soon as possible after they learn of an illness/injury requiring treatment. In situations requiring emergency medical treatment, officers are instructed to request MCFRS to respond. Officers are directed to obtain any needed medical attention before taking a prisoner to the Central Processing Unit (CPU). The directive states that failure to do so may result in the prisoner being refused at CPU.



In practice, what this means is that if an officer arrests a highly intoxicated person and determines that the arrestee is in need of medical care before being taken to CPU, then the officer must accompany the arrestee to the emergency room. During this time (which can be an extended period of time if the hospital admits the person), the arrestee is in legal custody of the MCPD and must remain under police guard. If the hospital guard time extends beyond the arresting officer's shift, then it becomes the responsibility of the arresting officer's district station to continue to guard.<sup>1</sup>

Central Processing Unit Policy. The Department of Correction and Rehabilitation's policy and procedure on the subject of "Accepting Impaired or Injured Prisoners" was most recently updated in August 1995.

A copy of this procedure is at © 9. In sum, the procedure requires that any arrestee brought to the Central Processing Unit who is suspected of being under the influence of alcohol or drugs or suffering from any obvious injury or illness must be screened by Detention Center medical personnel before being accepted by the Central Processing Unit.

- If DOCR's medical personnel (in consultation with the CPU staff) conclude that the medical resources of the Detention Center are sufficient to provide an acceptable level of medical care for the arrestee's injury, illness or level of intoxication, then CPU staff shall accept custody of the arrestee.
- If DOCR's medical personnel (in consultation with the CPU staff) conclude that the arrestee's injuries, illness, or level of intoxication are of such severity that the available medical resources are inadequate, then CPU staff informs the transporting law enforcement officer that CPU is temporarily declining to accept custody.

If custody is declined for medical reasons, then CPU staff advise the transporting officer of the need to take the arrestee to a hospital emergency room. The arrestee will not be accepted at CPU until after he/she has received the appropriate medical clearance documentation from a hospital.

Memorandum of Understanding between the Police Department and Sheriff's Office concerning the hospital guarding of inmates. As described above, before an arrestee is committed to the Detention Center, the arresting law enforcement agency is responsible for guarding the arrestee. Once an arrestee has been committed to the Detention Center, then he/she becomes an inmate. Under current practices, the Sheriff's Office is responsible for guarding the first inmate admitted to a hospital. The Department of Police is responsible for guarding the second and subsequent inmate at the hospital.

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<sup>1</sup> MCPD's directive governing the hospital guarding of prisoners (Function Code 812) states that: "Whenever the police must assume a hospital guard detail, the responsibility for staffing the detail belongs to the district where the original event occurred."

## **WHAT DO ALL OF THESE RULES MEAN IN TERMS OF ARRESTING AND PROCESSING INTOXICATED PERSONS?**

In practice, this means that a patrol officer who makes a physical arrest of a highly intoxicated person with the intent of processing him/her at CPU, may potentially end up being out-of-service for an extended (and indefinite) period of time on hospital guard duty. This depends on the nature of the incident and the medical condition of the arrestee.

OLO's interviews with patrol officers and DOCR staff indicate that, most officers have learned through experience which individuals will be assessed as "too intoxicated" to be accepted at CPU. OLO understands that an intoxicated arrestee will generally be accepted at CPU so long as he/she can walk without assistance and appears capable of understanding the booking process.

**Note:** DOCR's rules governing whether or not to accept intoxicated persons do not affect the arresting or processing of intoxicated persons for alcohol-related driving offenses. This is because under County policy, almost all DWIs are processed entirely at the District Stations. Once the processing of a DWI arrestee is complete, the County has no authority to continue to detain him/her. In some situations, these individuals are still highly intoxicated and officers express concern about simply releasing them, where they may continue to be a public safety risk (either to themselves or others).

## **FEEDBACK ON DESIRED CHARACTERISTICS OF SOBERING CENTER**

Throughout the course of conducting research for this project, OLO asked front-line staff the following open-ended question: "What characteristics would a sobering center need to have in order to make you more effective in your job?"

There was a high degree of consistency in the responses offered by law enforcement officers. Most of the comments dealt with the officers' desire to deal with a problem at hand (i.e., a publicly intoxicated person who was in an unsafe place or causing a public nuisance) and to get back in service promptly.

A majority of the officers interviewed felt that in order to provide police officers with a tool for clearing the streets of publicly intoxicated persons, officers need the clear legal authority to transport persons to a sobering center with or without the person's consent. In other words, a process that requires the intoxicated person to consent up-front to be transported to the sobering center would be inadequate. In practice, it is not the so-called "cooperative drunks" that are law enforcement's biggest headache.

In terms of the logistics of a sobering center, officers consistently identified convenience and certainty:

**Convenient location.** The sobering center needs to be located such that an officer could transport a person there and be back in service within a relatively short period of time;

**Certainty of admittance.** The officers need to be able to count on the intoxicated person being accepted at the sobering center, i.e., it would not work well if intoxicated persons were routinely refused admittance because the center was filled to capacity.

**Minimal paperwork.** The officers need to be able to comply with any paperwork requirements quickly and easily.

Many officers endorsed the idea of being able to use a sobering center for chronic public inebriates and for individuals who have been arrested and processed for DWI. In addition, officers almost universally endorsed the idea of a van service for transporting publicly intoxicated persons to a sobering center. For example, in Denver, Seattle, Louisville, and Fairfax County, officers can call a civilian-driven van that comes and picks up intoxicated persons and transport them to the sobering center.

A recurring comment offered by representatives of the County's Fire/Rescue Services is that a sobering center would need to have sufficient medical presence to ensure that the medical needs of the intoxicated individuals delivered there would be taken care of. Both EMS staff and emergency room staff emphasized that a person's intoxication may mask more serious underlying health problems, and that in some cases, a person who is highly intoxicated does require a high level of medical supervision.

## **B. OVERVIEW OF TREATMENT SERVICES AND EMERGENCY/CRISIS INTERVENTION SERVICES PROVIDED BY DHHS**

The County's Department of Health and Human Services provides an impressive continuum of substance abuse screening, assessment and treatment services and crisis intervention services, including emergency shelter and other support services for homeless individuals. The Department tracks who receives what services and how often individuals are receiving services. However, when a police officer is dispatched to the scene of a publicly intoxicated person, the officer has no way of independently knowing whether the person has been or is currently a recipient of DHHS' services.

## **ADULT ADDICTION SERVICES**

The County's Department of Health and Human Services plans, implements, and directs a system of community and correctional based substance abuse screening, assessment and treatment services. In FY 01, the County screened more than 2,500 persons for substance abuse problems. The Department describes the system of adult addiction services as follows:

The adult addiction services are organized as a managed care system with access for institutional and individual customers as a system priority, with standardized screening, assessment and patient placement criteria. Treatment services are organized into five levels of care. Modified American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC) are used to match clients to the most appropriate level of care. (Source: FY 99 Grant Narrative, DHHS)

DHHS reports that approximately half of the adult addiction clients are from the criminal justice system, about 30% from the social service programs in DHHS (child welfare, emergency services, homeless services, income maintenance) and the remainder from the DHHS public health services.

No one is refused treatment through the County's system because of an inability to pay. The various system components each use a sliding scale fee scale to determine a client's ability to pay.

**Residential Services.** Hospital and non-hospital detoxification services are considered part of the County's residential treatment subsystem. The County provides gatekeeping, utilization review, care management, and on site contract and program monitoring for these services. Table 11 summarizes the major components of the County's residential treatment subsystem. The Department expects that the percent of clients successfully discharged from treatment in FY 02 will reach approximately 30%.

**TABLE 11  
MAJOR COMPONENTS OF RESIDENTIAL TREATMENT SUBSYSTEM**

<b>Facility</b>	<b>Services</b>
Montgomery General Hospital	Hospital detoxification services
Avery Road Treatment Center	14 non-hospital detoxification beds (expandable to 20 beds); 40 intermediate care beds
Avery House	20 halfway house beds for women and their young children (10 adults, 10 children)
Lawrence Court	20 beds (14 male, 6 female)
Phoenix	14 therapeutic community beds
Chase Partnership House	36 beds for homeless males in intensive outpatient treatment
14701 Avery Road	25 – 40 bed program for individuals with co-occurring psychiatric and substance disorders (facility to be renovated for use in FY 02)

Source: DHHS, Adult Addiction Services

### **THE CRISIS CENTER**

The Crisis Center provides telephone and walk-in crisis stabilization services to persons experiencing situational, emotional, or mental health crises. The Crisis Center, located on the ground floor of the DHHS' office building on Piccard Drive in Rockville, is open 24 hours a day, seven days a week. The Crisis Center also operates a Mobile Crisis Team that services persons experiencing emotional or mental health crises.

The Crisis Center responds to more than 10,000 requests for service each year. The Crisis Center routinely deals with individuals who have co-occurring mental illness and substance abuse problems. Situations in which substance abuse is the primary presenting problem accounts for a relatively small percent (less than 5%) of the Crisis Center's business.

The Crisis Center is not currently set up to deal with highly intoxicated persons. If a highly intoxicated person arrives at the Crisis Center (either on his/her own or by police transport), then the Crisis Center's general practice is to call 9-1-1 and request that an ambulance transport the person to the hospital for medical assistance.

Similarly, the Mobile Crisis Team was established primarily to deal with persons who are mentally ill. Effective December 2000, the Mobile Crisis Team's hours were expanded from noon to midnight, seven days a week. The Team does respond to calls that involve persons who have co-occurring mental illness and substance abuse problems. However, if a mentally ill person is highly intoxicated, then the Mobile Crisis Team is likely to request that an ambulance transport the person to the emergency room.

## **HOMELESS ASSISTANCE SERVICES**

The Department of Health and Human Services, in partnership with nonprofit agencies, provides a system of care that seeks to prevent homelessness and to intervene to return persons who are homeless to residential stability, independence, and self-sufficiency. The system includes components for outreach, intake and assessment, prevention, emergency shelter, transitional housing, permanent supportive housing, and supportive services.

The Outreach/Assessment component includes street outreach to street-dwelling and other hard-to-reach homeless persons, including those with substance abuse and chronic mental illness. A description of the Assertive Community Treatment Team (from the Department's web site) is attached at © 15.

The County's Emergency Shelter component includes the operation of four adult emergency shelters that provide safe, temporary accommodations focused on stabilizing client's immediate crisis. Clients are referred to one of the shelters following an assessment of their needs at the Crisis Center.

The general practice of the County-supported emergency shelter facilities is not to accept individuals who are intoxicated. In practice, however, between the months of November and April, the Gude Shelter's policy is to offer night shelter to all men (including intoxicated ones) who agree to abide by the facility's basic rules. The rules include orderly behavior and no drinking while on the premises. Shelter staff will call 9-1-1 for an ambulance if a shelter resident appears to be in need of emergency medical care.

Available Data on the Number of Homeless Persons with a Substance Abuse Problem. The County's 2001 one-day homeless census reported 1,089 (unduplicated) homeless persons in the County. The literature on homeless persons suggests that most surveys significantly undercount the actual number of homeless persons in a community by as much as one-half. County officials have estimated there could be as many as 3,000 homeless persons in the County.

Of the 1,013 individuals who answered questions about substance abuse and mental illness status in the County's 2001 homeless census:

- Approximately one-third (33%) self-reported that they had a substance abuse problem; and
- 29% self-report a problem with mental illness.

Of the homeless individuals surveyed, 37% reported being homeless for greater than one year, 15% for a period of six months to a year, and 24% for between one and six months.

### **C. EMERGENCY ROOMS AND INTOXICATED PERSONS**

The emergency rooms at the County's five hospitals routinely deal with highly intoxicated persons, who arrive by different means. Some are transported by an ambulance or by the police; others are transported by family or friends; and still others arrive at the hospital on their own. From the hospital's perspective, whether someone was publicly intoxicated or not makes no difference.

OLO's interviews with hospital personnel indicate that the medical care provided to highly intoxicated persons varies significantly and will depend upon what problems are detected during an initial medical examination. In some cases, an intoxicated person will be assessed, stabilized, and released within several hours. In other cases, a highly intoxicated person will be admitted to the hospital for an extended stay. This is particularly apt to occur with chronic public inebriates, who often have serious long-term health problems underlying their intoxicated state.

## V. COMPARATIVE INFORMATION

Figuring out how to effectively deal with publicly intoxicated persons is a challenge that almost all communities face to some degree or another. OLO's research found that some jurisdictions have established a short-term sobering-up facility as part of their strategy for dealing with publicly intoxicated persons. This chapter describes key characteristics of ten short-term sobering-up facilities located in eight different states (two are in Virginia):

- Escondido Community Sobering Services, Escondido, California;
- Denver CARES, City and County of Denver, Colorado;
- Healing Place Detoxification Center, Louisville, Kentucky;
- Westcare Detoxification Center, Las Vegas Metropolitan Area, Nevada;
- Public Inebriate Alternative Program, Tulsa Oklahoma<sup>1</sup>;
- Hooper Inebriate Emergency Response Center, Portland, Oregon
- Public Inebriate Program, Dallas, Texas;
- Police Diversion Program, Alexandria, Virginia;
- Fairfax Detoxification Center, Fairfax County, Virginia; and
- Dutch Shisler Sobering Support Center, Seattle, Washington.

**Overview.** OLO's research found no single model of sobering center. Although there are some similarities among the facilities examined, they vary in terms of their primary goals, population served, staffing, and location. Specific policies and procedures employed at the centers and physical characteristics also vary. Table 12 (page 50) summarizes information about the ten facilities.

The most common goals cited for establishing the sobering centers studied are:

- To divert individuals from the criminal justice system;
- To promote public safety;
- To respond to complaints from the business community; and
- To refer substance abusers to treatment.

Law enforcement officers can refer clients to the sobering centers in all ten of the jurisdictions. In some cases, hospitals and emergency medical technicians can also refer to the center. Most of the centers also accept self referred individuals. All of the jurisdictions used laws governing public intoxication or civil protective custody to authorize law enforcement officers or civilian-driven vehicles to transport individuals to the sobering center.

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<sup>1</sup> The sobering center in Tulsa is scheduled to open in late summer 2001.



Local governments directly operate five of the ten facilities. Private non-profit organizations operate three and a for-profit organization operates one of the facilities. The local hospital authority operates the Denver facility. In terms of funding, four jurisdictions rely on local funds and five others use a combination of local, state, and federal funds. Private donations fund the center in Louisville.<sup>2</sup>

Nine of the ten jurisdictions operate the sobering center program in conjunction with and in the same location as other related services. Specifically:

- Five of the sobering centers are co-located with a detoxification program;
- One sobering center is co-located with multiple substance abuse treatment services;
- One sobering center is co-located with a facility that houses people waiting for a space in a residential substance abuse program; and
- Two sobering centers are part of a detention facility for other misdemeanor offenders and special offender populations.<sup>3</sup>

The level of coordination among the co-located programs varies across jurisdictions. For example, in some cases the co-located programs share staff, or the clients in the two programs participate in programming together. Unlike the other jurisdictions, Seattle operates a facility strictly for monitoring public intoxicated individuals.

All ten of the facilities operate 24 hours a day, 7 days a week. The capacity of the sobering centers ranges from eight to 100 clients. Most employ counselors, case managers, and/or social workers. Six of the ten centers examined also employ medical personnel. Staff in all of the centers monitor each client's medical condition and call 9-1-1 if there is a problem.

The rest of the chapter provides more details on the ten sobering-up facilities in terms of their: legal framework, goals, populations served, management and staffing, capacity, length of stay, location, transportation, medical and treatment services provided, and funding source and cost.

## **A. LEGAL FRAMEWORK**

Four of the centers studied are located in states where (similar to Maryland), being publicly intoxicated in public has been decriminalized. In these states (Colorado, Nevada, Portland, and Washington), law enforcement officers cannot cite or arrest a person for public intoxication per se. However, these four states each have some version of a civil protective custody law, which authorizes law enforcement officers to take an

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<sup>2</sup> This report includes information about the cost of operating the programs. Since most of the programs are co-located and coordinated with other similar programs, OLO is unable, in most cases, to report accurate cost data for the sobering center components individually.

<sup>3</sup> Special offender populations refer to elderly and pregnant inmates.

individual who is a danger to themselves or others into protective custody. It is the civil protective custody law in these three states that provides law enforcement with the authority to take intoxicated individuals to a sobering center.

The other six centers studied are located in states where public intoxication continues to be a crime. In these states (Virginia, Texas, California, Kentucky, and Oklahoma), law enforcement officers can cite or arrest an individual for public intoxication, which is a misdemeanor crime. It is left to the discretion of law enforcement officers to decide whether to offer the individual who is publicly intoxicated the option of going to the sobering center, instead of being cited or arrested.

## **B. PURPOSE OR GOAL OF ESTABLISHING A SOBERING CENTER**

Through interviews with local officials, OLO learned that the sobering centers studied were established for a combination of purposes. The most common goals or purposes cited are: to divert individuals from the criminal justice system, promote public safety, respond to complaints from the business community, and refer more substance abusers into treatment.

Where public intoxication is a crime, including Escondido, Tulsa, and Fairfax County, the primary goal is to divert the offenders out of the criminal justice system. Staff in Tulsa specifically noted the need to save money by diverting offenders out of the jail and court system. Staff in Fairfax reported that prior to establishing this diversion option, large numbers of individuals were being processed through the criminal justice system for public intoxication. The offenders rarely paid the fines, often failed to appear in court, and frequently had multiple public intoxication offenses. One of Fairfax County's primary goals for establishing their sobering center was to divert these offenders and reduce the associated workload being placed on the criminal justice system.

All of the jurisdictions except Dallas noted the goal of referring individuals to substance abuse treatment. Staff in Alexandria, Dallas, Denver, and Seattle reported that the primary purpose of establishing sobering center programs was to keep the public and the publicly intoxicated people safe. Staff in Escondido and Las Vegas reported developing the sobering centers to promote public safety and respond to complaints from the business community.

## **C. POPULATION SERVED**

Depending on the facility, sobering centers accept clients from law enforcement officers, emergency medical services, and hospitals. Most of the centers also accept self-referrals. Eligibility criteria relate to the person's medical condition, mental status, and/or behavior.

Characteristics of sobering center clients vary. Clients are often homeless and/or mentally ill. In many cases the clients have abused substances for a long time and have multiple medical problems. They are often repeat offenders and/or use the center frequently.

Source of Clients. Law enforcement and self-referrals are the most common sources of sobering center clients in the nine jurisdictions studied. All of the centers except Dallas' also accept self-referrals.

All ten of the sobering centers accept clients from law enforcement officers. The paperwork associated with referring clients to the sobering centers is minimal to allow the officers to return to their beat quickly. In Denver, officers can take drunk driving offenders (after processing) as well as public inebriates to the sobering center.

The sobering centers in Las Vegas and Fairfax County get their clients from all four possible sources including: law enforcement, emergency medical services, hospitals, and self-referrals. Only Seattle and Escondido also accept clients referred by hospitals. Louisville also accepts referrals from emergency medical service personnel.

Eligibility Criteria. The jurisdictions studied use limited eligibility criteria for accepting clients at the sobering centers. None of the centers limit the number of visits to the center. In fact, staff reported that the same chronic substance abusers are brought to the center multiple times. All of the centers, except Las Vegas, accepted only adults. All of the centers, however, required that clients have alcohol in their system at entry to the program. Only the Louisville center is limited to men.

None of the sobering centers will accept individuals who are still in legal custody for committing a criminal offense. In Dallas, other Class C Misdemeanor offenders are housed in the same detention center but in separate facilities as individuals in the public inebriate program. Alexandria, Escondido, and Fairfax County staff report that individuals who are or have a history of violent, uncooperative or other behavioral problems are not accepted at the center.

Sobering center staff do not accept individuals whose medical condition requires hospital care. In Fairfax County, for example, counselors assess an individual's medical condition before they enter the program. The counselors send anyone with a BAC level of 4.0 or higher or an Intoxication Withdrawal Assessment<sup>4</sup> of 19 or higher to the hospital.

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<sup>4</sup> The Intoxication Withdrawal Assessment assesses the individual's risk for medical complications during withdrawal based on BAC level, vital signs, visual disturbances, auditory disturbances, nausea, thought disturbances, and other conditions.

Characteristics of Clients. Many sobering center clients are chronic alcoholics. Other typical characteristics include homelessness, unemployment, and mental illness. Staff in Seattle and Louisville indicate that almost all of the sobering center clients are homeless. Escondido staff estimate that 80% of the clients are homeless and Dallas and Fairfax County estimate that at least 50% of the clients are homeless.

Fairfax County staff estimate that 85% of their clients suffer from substance abuse and mental illness. Approximately 80% of the Seattle Sobering Center clients are male and a disproportionate number are Native American. The City of Alexandria also reports that the majority of their clients are male and unemployed.

The jurisdictions also report that many of the clients are repeat visitors. Fairfax County estimates that 75% of their clients are repeat users. Escondido, Denver, and Louisville sobering center staff estimate that approximately 50% of their clients are repeat users.

#### **D. CENTER OPERATOR AND STAFFING**

Of the places studied, Denver and Las Vegas have operated their centers the longest, with Denver's established approximately 20 years ago and Las Vegas' 15 years ago. Alexandria, Dallas, Escondido, and Louisville established sobering centers between five and ten years ago. The Fairfax County center and current Seattle center have only been in place for several years. Tulsa's center will open at the end of this summer.

The local governments in Alexandria, Dallas, Seattle, and Fairfax County operate the centers. Private non-profit organizations operate the centers located in Portland, Louisville, Las Vegas, and Escondido. A private for-profit organization will run the sobering center in Tulsa. Denver Health, the local hospital authority, operates the sobering center in Denver.

In general, counselors or social workers, and nurses and/or emergency medical technicians staff the sobering centers. The centers in Escondido and Las Vegas also have recovering addicts on staff. Only the Dallas and Denver facilities operate "locked" facilities. Detention officers and deputy marshals staff the Dallas center because it also houses misdemeanor offenders. The Denver facility, which also houses drunk driving offenders, includes security guards.

It is common in centers that are co-located with related services to share staff between the sobering center and the other service(s). Staff in Fairfax County, Las Vegas, and Louisville noted that they share counselor and medical staff between the sobering program and the detoxification program.

## **E. CENTER CAPACITY**

All ten centers operate on a 24/7 basis. The capacity of the centers varies from eight clients to 120 clients. On the high end, the centers in Dallas and Denver hold 120 and 100 clients, respectively.<sup>5</sup> On the low end, Fairfax and Alexandria have space for 8 clients, and Escondido holds 10 clients. Louisville and Las Vegas currently hold 25 clients. Las Vegas plans to expand to accommodate 50 clients. Portland's center holds 75 clients, Seattle's center holds 60 clients, and Tulsa's center will have the capacity to hold 40 clients.<sup>6</sup>

## **F. LENGTH OF STAY**

Sobering centers are intended to provide short-term services, so most implement a maximum length of stay of approximately 24 hours. Individuals requiring additional service are referred to longer-term detoxification or other substance abuse programs. In some jurisdictions, the law establishes minimum lengths of stay at the center. The minimum length of stay may be a set number of hours, may be based on a person's blood alcohol concentration (BAC) level, or left up to the staff's judgement as to the individual's sobriety.

The civil protective custody laws in Oregon, Washington, Nevada, and Colorado authorize law enforcement officers to take into custody people who appear to be a danger to themselves or others. In Nevada, the law does not authorize the center to keep clients against their will. Although clients can leave at any time, staff from the Las Vegas center report that most clients stay approximately 24 hours. In Colorado, the law requires that individuals brought to a sobering center through civil protective custody stay at a sobering center for 24 hours or until they are sober. In Portland, clients must stay a minimum of one hour and a maximum of 48 hours.

Staff at the center in Seattle also have the authority to keep clients, but report that they rarely force individuals to stay because it jeopardizes the client's trust and cooperation with the center. Clients typically stay at Seattle's center for between six to eight hours.

Public intoxication is a crime in the other five jurisdictions. In Dallas and Tulsa, clients must remain at the center until staff determines that they are sober (minimum six hours in Dallas). In Fairfax County they must stay until their BAC level is "0". The time varies significantly depending on the individual. In Alexandria, clients stay at the center a minimum of eight hours and a maximum of 24 hours. In Escondido, clients stay a

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<sup>5</sup> The 100 spaces in Denver's sobering center include some offenders charged with driving under the influence that are housed with first-time public intoxication offenders.

<sup>6</sup> The beds in Las Vegas, Louisville, and Portland accommodate sobering center clients and the co-located detoxification clients.

minimum of four hours and a maximum of 23 hours. Clients at the Louisville center can leave at any time, but if they stay less than 24 hours they cannot return to the center for at least two days.

## **G. LOCATION OF THE CENTER**

It appears common to co-locate sobering centers with another related facility. The centers in Alexandria, Las Vegas, Louisville, Portland and Fairfax County are co-located with a detoxification facility<sup>7</sup>. The Las Vegas and Denver centers are also co-located with substance abuse treatment programs or facilities. The sobering center in Escondido is co-located with a transitional housing facility for people waiting for spaces in residential substance abuse treatment programs. The centers in Dallas and Tulsa are co-located with detention facilities for Class C misdemeanor offenders and special offender populations, respectively. Mental health services are available at the same location as the sobering center in Seattle, but there is little overlap or coordination between the two services.

While it is common for sobering centers to co-locate with other related facilities, it was difficult through telephone interviews to assess the degree of cooperation and coordination between co-located services. OLO visited the center in Fairfax County and found that the detoxification program and the sobering program are very closely coordinated. Sobering clients sleep in a separate area from the detoxification clients, but they share common areas. Sobering clients also participate in all of the detoxification center programming. Staff indicated that the clients interact during their stays and that detoxification clients can be a positive influence on the other clients, encouraging them to seek help for their substance abuse problem.

The sobering centers in Louisville, Las Vegas, Tulsa, Denver, Seattle, and Dallas are located in the downtown or just outside the downtown area. In comparison, Escondido's center is located in an industrial area. OLO's research also found that most of the centers are located near a police station, hospital, jail, courthouse, or substance abuse treatment center.

## **H. TRANSPORTATION**

Some sobering center programs include transportation services. In other cases, law enforcement officers or other official must provide transportation to the center.

In Dallas, Alexandria, Tulsa, Escondido, and Las Vegas<sup>8</sup> law enforcement officers transport the client to the center themselves. In Portland, Denver, Louisville, Seattle, and Fairfax County, law enforcement officers and hospitals call for van pick up when they identify a person that they want to refer to the center.

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<sup>7</sup> Alexandria's center is co-located with a 30-bed detoxification facility, and Fairfax with a 27-bed facility. The Louisville facility is a 25-bed detoxification facility that also accepts publicly intoxicated people that law enforcement and EMS bring to sober up.

<sup>8</sup> Van services will be available in the near future in Las Vegas.

Portland staff deputized by the Sheriff's office provide van service on Thursday, Friday and Saturday. Denver uses one van staffed with two emergency medical technicians to transport individuals 24 hours per day. Seattle's Emergency Service Patrol has three vans that are in service 24 hours per day. Fairfax County has two vans in operation between Wednesday and Saturday from 4 pm to 1 am. One van responds to calls in the northern part of the County and the other transports individuals from the southern part of the County. The Community Assistance Program in Louisville provides van service to the sobering center from 10 am to 2 am daily. Law enforcement and other officials transport clients when the van services are not operating.

## **I. MEDICAL AND TREATMENT SERVICES PROVIDED**

Treatment and Social Services. Nine of the ten sobering centers studied refer clients to detoxification, substance abuse treatment services, and other related social services. The center in Dallas does not provide referrals to other services.

In some cases, clients can attend counseling sessions or other programs while at the sobering center. In Fairfax County, for example, the clients attend all of the scheduled programming provided through the detoxification center. This also provides the opportunity to interact with individuals who have taken the step to enroll in a detoxification program.

Medical Services. The sobering centers studied typically assess a potential client's medical condition immediately upon arrival, and will send individuals to the hospital if it is deemed necessary.<sup>9</sup> Centers also monitor the health condition of the clients on site, such as checking vital signs and blood alcohol concentration (BAC) levels, and observing for any indications of a serious medical problem.

In some cases, non-medical staff are trained to conduct this monitoring. In other cases, the staff includes medical personnel such as registered nurses, nurse practitioners, or doctors. In all cases, staff calls 9-1-1 to request ambulance transport to a hospital if a problem arises that appears to require more medical assistance than the center can provide. In Tulsa, Louisville, and Escondido, non-medical staff are trained to take vital signs and identify potential medical problems. In Dallas, staff observe clients for medical problems, but do not check vital signs or BAC levels.

The sobering centers in Las Vegas, Denver, Alexandria, Seattle, Portland, and Fairfax County employ medical personnel to monitor client health. Medical care for sobering center clients is still limited to taking vital signs and monitoring for health problems. The Las Vegas, Portland, and Seattle sobering center staffs include emergency medical technicians. The Alexandria and Denver centers employ nurses and the Fairfax

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<sup>9</sup> In Escondido, sobering center staff do not take vital signs at entry to the center. They rely on the law enforcement officer's judgement of a potential client's medical stability.

County center shares registered nurses, nurse practitioners and a medical doctor with the co-located detoxification facility. The centers in Denver, Tulsa and Las Vegas also report that they have access to psychiatrists or mental health crisis teams for mental health emergencies. Fairfax County sobering center staff also have mental health care training.

## **J. FUNDING SOURCE AND COST**

Funding Source. The ten sobering centers that OLO studied receive funds from a variety of sources. Nine of the ten rely on public funds. Louisville's Healing Place is funded solely with private donations. The centers in Escondido, Dallas, Portland, and Tulsa rely solely on local funds. Tulsa uses funds from a dedicated sales tax to operate their Public Inebriate Program.

Seattle funds its sobering center with a federal Department of Housing and Urban Development grant. Fairfax County uses a state criminal justice grant. Alexandria uses a combination of federal, state, and local funds to operate the sobering center. Las Vegas relies on a combination of federal, state, county and city funds, including federal grants, state legislative funds, and state liquor tax revenues. Primarily local, and some state dollars, fund the Denver CARES program.

Cost. Staff from the nine sobering centers researched reported annual operating costs ranging from \$217,000 to \$3.6 million. The broad range is explained in part by the different capacities and service offerings of the different centers. In addition, some of the jurisdictions could not separate the cost of the sobering center from the cost of other co-located services, such as detoxification. For example, the center in Las Vegas houses the sobering program and detoxification. The cost of either component separately is not available. The sobering and detoxification programs together cost approximately \$1.5 million annually.

Similarly, staff in Denver report that the total cost of the Denver CARES program is \$3.6 million annually. That includes a sobering center for public inebriates, a residential substance abuse treatment center, and a holding facility for DUI offenders. The Public Inebriate Program in Dallas is co-located with a detention center. One portion of the facility houses public inebriates and another section houses other misdemeanor offenders. The total cost of the facility is approximately \$1.35 million annually.

Fairfax County receives a \$316K grant from the state to operate their program. The grant funds staff and operating costs, but does not cover the cost of the facility and some staff that is shared with the County's detoxification program. Seattle uses a \$2 million federal grant to operate the city's sobering center. The annual operating cost of the center totals \$1.6 million and the cost of the transportation component of the program totals approximately \$500,000 annually.



The Tulsa County Criminal Justice Authority contracts with a private organization called Avalon to run the Public Inebriate Alternative program. The Authority will pay Avalon \$26 per day per bed or approximately \$440,000 annually. The City of Escondido contracts with a non-profit called Interfaith Community Services to operate Community Sobering Services for \$217,000 annually. Information about the operating cost of the centers in Alexandria, Portland, and Louisville was not available.

**TABLE 12  
SUMMARY OF COMPARATIVE INFORMATION**

	<b>Crime?</b>	<b>Purpose or goal?</b>	<b>Referrals?</b>	<b>Operator?</b>	<b>Capacity?</b>	<b>Co-location?</b>	<b>Transport?</b>	<b>Staff?</b>	<b>Funding?</b>
Alexandria, VA	Yes	Public safety; Refer to treatment	Police; Self referral	Local government	8	Detox	No	Counselors, social workers, nurses	Federal, state and local funds
Dallas, TX	Yes	Public safety	Police	Local government	120	Detention Facility	No	Detention officers	Local funds
Denver, CO	No	Public safety; Refer to treatment	Police; Self referral	Hospital authority	100	Substance abuse treatment; DUI holding center	Yes	Counselors, nurses, security guards	State and local funds
Escondido, CA	Yes	Public safety; Crime prevention; Diversion; Treatment; Respond to business complaints	Police; Self referral; Hospitals	Private non-profit	10	Transitional housing	No	Case managers, recovering addicts	Local funds
Fairfax County, VA	Yes	Diversion; Refer to treatment	Police; Self referral; EMS; Hospitals	Local government	8	Detox;	Yes	Counselors, nurses	State funds
Las Vegas, NV	No	Public safety, Respond to business complaints; Refer to treatment	Police; Self referral; EMS; Hospitals	Private non-profit	25	Detox; Substance abuse treatment	No	Counselors, EMTs, recovering addicts	Federal and state
Louisville, KY	Yes	Refer to treatment	Police; Self referral; EMS	Private non-profit	25	Detox	Yes	Case workers	Private donations
Seattle, WA	No	Public safety; Refer to treatment	Police; Self referral; Hospitals	Local government	60	Mental health services	Yes	Case managers, EMTs	Federal funds
Portland, OR	No	Public safety	Police	Private non-profit	75	Detox	Yes	Case workers, EMTs	County funds
Tulsa, OK	Yes	Diversion; Refer to treatment	Police; Self referral	Private for-profit	40	Detention Center	No	Counselors	Local funds

## **VI. ISSUES FOR COUNCIL DISCUSSION AND DECISION-MAKING**

### **A. DOES THE COUNCIL WANT TO PURSUE THE IDEA OF ESTABLISHING A SOBERING CENTER IN THE COUNTY?**

The immediate question for the Council is whether to pursue the idea of establishing a sobering center. To assist the Council in its discussion of this question, arguments on both sides are set forth below.

#### **ARGUMENTS IN FAVOR OF PURSUING A SOBERING CENTER.**

1. There are locations in the County where intoxicated persons can be found in public places on a regular basis. The places identified most often by law enforcement officers and Fire/Rescue staff are in and around the business districts of Longbranch, Takoma/Langley, South Silver Spring, and Wheaton. In these locations, publicly intoxicated persons create a visible public nuisance to the extent they disrupt businesses, interfere with shoppers, deter users of public parks and other public spaces, and present a threat (real and/or perceived) to residents.
2. The "fixing broken windows" thesis cites the presence of publicly intoxicated persons in public spaces as one component of neighborhood disorder, and argues for placing high priority on order-maintenance activities, such as the removal of public inebriates. As George Kelling and Catherine Coles write:

Both disorder and the fear it generates are serious problems that warrant attention in and of themselves. Disorder demoralizes communities, undermines commerce, leads to the abandonment of public spaces, and undermines public confidence in the ability of government to solve problems; fear drives citizens further from each other and paralyzes their normal, order sustaining responses, compounding the impact of disorder. Restoring order is key to revitalizing our cities, and to preventing the downward spiral into urban decay that threatens neighborhoods teetering on the brink of decline, regardless of whether a reduction in crime results. (Fixing Broken Windows: Restoring Order and Reducing Crime in Our Communities, 1996, p.242)

3. OLO's initial research identified shortcomings with the County's current approaches to dealing with intoxicated persons who are causing a problem in a public place, e.g., sidewalk, street, bus stop, park. In practice, the responsibility for responding to the problem most often falls to a police officer. While the County provides an impressive array of emergency shelter services and substance abuse treatment services, these services are not now designed to deal with highly intoxicated persons on a regular basis.

4. As reviewed in Chapter IV, an officer faces difficult choices when asked to intervene with a publicly intoxicated person. For example:
  - In order to remove a disorderly drunk from a public place, should a police officer arrest the individual if the likely result is that the officer will spend the remainder of his/her shift guarding the arrestee in the hospital until he/she is sober enough to be booked at the Central Processing Unit?
  - Alternatively, should a police officer intervene by simply encouraging a highly intoxicated person to move on, knowing that the person might wander into the street and be hit by a car?

Another set of issues is created when a publicly intoxicated person is transported by the County's Emergency Medical Services (EMS) to a hospital's emergency room. In some cases, the person is in need of emergency medical assistance and the use of a County ambulance and emergency room destination is appropriate. In other cases, however, the publicly intoxicated person does not need emergency medical assistance, but ends up consuming EMS resources and occupying a trauma bed in an emergency room because there is not an alternative place for him/her to be taken.

5. There are times when an intoxicated person is arrested for DWI/DUI and (after processing) remains highly intoxicated and in need of supervision for his/her own safety or for the safety of others. Under current law and practice, the County has no authority to detain DWI/DUI defendants after processing is completed, and no place where they can be taken to sober up in a supervised environment.
6. OLO's comparative research found that other jurisdictions have established sobering centers for one or more of the following purposes:
  - To clean up the streets for the benefits of citizens and businesses;
  - To maintain the physical safety of publicly intoxicated persons;
  - To divert chronic public inebriates out of jail and the criminal justice system;
  - To reduce the volume of publicly intoxicated persons treated in emergency rooms; and
  - To refer more persons into substance abuse treatment.<sup>1</sup>

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<sup>1</sup> There is a lack of formal program evaluation or outcome-based research that document the extent to which sobering centers have actually accomplished these goals. See argument #5 on the next page against pursuing a sobering center.

## **ARGUMENTS AGAINST PURSUING A SOBERING CENTER AT THIS TIME.**

1. The available evidence does not suggest that Montgomery County currently faces a Countywide “crisis” of neighborhood disorder caused by publicly intoxicated persons. It appears to be a problem that, at least for the present, is concentrated in a limited number of specific geographic areas in the County.
2. Although there are gaps and shortcomings in the County’s current approach to dealing with publicly intoxicated persons, in many cases, the available options do (albeit imperfectly) resolve the immediate problem. For example:
  - A police officer’s request to a disorderly drunk to “move on” will often, at least temporarily, relieve the business owner and customers from being bothered;
  - A publicly intoxicated person who is transported to the emergency room in a County ambulance will remain physically safe and out of harm's way; and
  - Issuing a publicly intoxicated person a citation for drinking on public property may (in some cases) deter the person from repeating the behavior.
3. Improving the tools available to front-line staff to deal with publicly intoxicated persons will inevitably cost additional public resources. The experience of other jurisdictions suggests that establishing a sobering center may reduce the expenditure of criminal justice and emergency medical service resources on intoxicated persons, but will simultaneously increase costs in the human services area. Given the County’s current fiscal situation, now may not be the appropriate time to launch a new, potentially costly initiative that will have to compete with alternative public safety, health and human services, and other community needs.
4. It would likely be a multi-year research and planning effort to move the concept of a sobering center to reality. As outlined in the following section, data need to be collected and analyzed, the County will likely need one or more changes in State law, and staff from multiple agencies would have to be involved in the design of a sobering center proposal.
5. As indicated above, although some of the sobering center programs found across the country are widely praised and appear to be worthwhile, there is little in the way of formal program evaluations or outcome-based research that documents anecdotal claims of overall effectiveness

**B. IF THE COUNCIL DECIDES TO PURSUE A SOBERING CENTER, THEN WHAT ACTIONS SHOULD THE COUNCIL TAKE?**

If the Council decides to pursue a sobering center, then OLO recommends a three-step action plan:

1. Rank the desired goals of a sobering center, and collect data so that future decisions can be more "data driven."
2. Formally request a County Attorney's opinion on the interpretation of State law. If deemed necessary, seek changes in State law that would allow law enforcement officers to transport publicly intoxicated persons with or without their consent to a sobering-up facility.
3. Convene an interagency group to design the details of a sobering center proposal.

The sequence of these action steps and built-in decision points are further explained below.

**Action Step 1: Rank the desired results in order of priority, and collect data so that future decision-making can be focused and "data driven."**

To ensure that future decision-making about a sobering center is focused and data driven, OLO recommends the Council's first step should be to rank the desired results in order of priority and invest in a targeted data collection effort,

**Rank the desired results.** There are five different public policy goals that are commonly cited as the reason(s) for establishing a sobering center. Because the potential for conflict exists among these goals, it important for any future staff time spent on a sobering center to be focused on accomplishing the highest priority results that are desired.

**OLO recommends that Councilmembers review the five goals (listed below) and select the highest priority result that the Council seeks to accomplish.** If more than one result is selected, then OLO recommends that the Council place them in priority order. Knowing, for example, whether the primary public policy goal is to "clear the streets," divert publicly intoxicated persons out of the criminal justice system, or to refer additional persons into substance abuse treatment, will effect what data to collect and the potential design of a sobering-up facility.

	<b>Potential Goal for Establishing a Sobering Center</b>
A.	To clear public spaces of intoxicated persons.
B.	To maintain the safety of publicly intoxicated persons.
C.	To refer publicly intoxicated persons into treatment.
D.	To divert publicly intoxicated persons who commit minor alcohol-related offenses (e.g., drinking on public property, open container) out of the criminal justice system.
E.	To reduce the expenditure of limited emergency medical resources on publicly intoxicated persons who are not in need of emergency medical assistance.

**Invest in a targeted data collection.** Available data do not provide adequate information on the number and characteristics of publicly intoxicated persons. In order for a solution to be data driven, OLO recommends the Council support a cost-effective effort to collect data on publicly intoxicated persons in 3-4 geographic areas of the County over a three-month period. OLO estimates that an outside research organization could be hired to design and conduct this type of data collection for \$15-20,000.

The final list of data elements and geographic boundaries for data collection should be developed by the researcher in consultation with representatives from the criminal justice and health and human services system. Examples of the data to be collected are answers to the following questions:

- What is the total number of intoxicated persons in public places at different times of the day and different days of the week?
- Where are these individuals located?
- What are their ages and other demographic characteristics?
- How many are repeaters vs. non-repeaters?
- How many are homeless street persons vs persons who have a regular place to sleep?
- How many have other drug problems?
- How many have serious mental health and/or physical health problems?
- What is the criminal history of these individuals?
- What current (or previous) interactions do these individuals have with County services, e.g., emergency shelters, food programs, substance abuse programs?

In addition to data on publicly intoxicated persons, data should be collected on the number of persons arrested for DWI/DUI who, after processing, are assessed by the arresting police officer as being "too intoxicated" to be released unsupervised. It would also be useful to know:

- How many DWI/DUI defendants are not able to arrange to be picked up by a friend, family members, or taxicab?
- How often are DWI/DUI defendants re-arrested within 12 hours after being released from the District Police Station?

**Action Step #2: Formally request a County Attorney's opinion on the interpretation of State law. If deemed necessary, seek changes in State law that would allow law enforcement officers to transport publicly intoxicated persons with or without their consent to a sobering-up facility.**

OLO recommends the County not establish a sobering-up facility until there is clear legal authority for a law enforcement officer to transport publicly intoxicated persons to such a facility with or without the person's consent when either:

- The law enforcement officer determines it would be in the best interest of the publicly intoxicated person's health or safety; or
- The law enforcement officer finds the publicly intoxicated person is being a public nuisance.

OLO's comparative research found that sobering-up facilities appear to be located in States that have a legal structure that is different from Maryland's in one of two ways. In particular, all of the sobering centers that OLO located are found either in states where public intoxication remains a criminal offense (e.g., Virginia, California, Texas), or in states where public intoxication is decriminalized but state law allows law enforcement to take a publicly intoxicated person into "protective custody" for the purpose of protecting the person's health or safety (e.g., Nevada, Oregon, Washington).

Before further pursuing a sobering center, OLO recommends the Council formally request a County Attorney's opinion on what authority law enforcement officers have, under current State law, to transport a publicly intoxicated person with or without their consent to a sobering-up facility. State law (Health Article, Subtitle 5, Section 8-501) already provides some authority for the police to take or send a publicly intoxicated person to certain locations, and the interpretation of how this section of law can be used is an important first step. Depending upon what the County Attorney's opinion says, the Council may need seek a change in State law before proceeding any further.



**Action Step #3. Convene an inter-agency group to develop a specific proposal for a sobering-up facility, including recommendations for changes in protocols and resources needed to accomplish the desired results.**

OLO recommends the Council postpone this step until there is certainty that the legal structure to make a sobering-up facility work is in place. Then and only then should the Council ask staff to develop a specific facility proposal.

As noted throughout this report, dealing with publicly intoxicated persons directly affects the workload and resources of multiple agencies. Recognizing the inter-agency nature of this problem, the process of designing a sobering center needs to involve representatives from each of the agencies that have a major role.

If the pursuit of a sobering center gets this far, then OLO recommends that Council request the following agencies to designate one or more representatives to participate in the development of a specific proposal:

- County Government: Police Department, Fire/Rescue Services, Health and Human Services, Correction and Rehabilitation, Office of the County Attorney;
- Other law enforcement agencies in the County: M-NCPPC Park Police, municipal police, Metro Transit Police;
- Office of the State's Attorney; and
- District Court.

*Subtitle 5. Alcohol and Drug Abuse — Publicly Intoxicated Individuals,  
Court Ordered Evaluations, and Voluntary Treatment.*

**§ 8-501. Disposition of publicly intoxicated individuals.**

(a) *Authorized personnel.* — (1) In cooperation with State and local police, the Administration may adopt regulations under which personnel other than the police are authorized to exercise the powers under this section whenever feasible so that the exercise of those powers by the police are reduced to a minimum.

(2) The police and other authorized personnel who act under this section are acting within the scope of their official duty.

(b) *Disposition of individuals.* — If a publicly intoxicated individual consents or an individual's health is in immediate danger, the police or other authorized personnel may take or send a publicly intoxicated individual to:

(1) The individual's home;

(2) A detoxification center; or

(3) Any other appropriate health care facility as defined in § 19-114 (e) of this article.

(c) *Record.* — Unless a criminal charge is filed, an entry of an action under this section may not be made on the arrest or other criminal record of the intoxicated individual.

(d) *Admittance.* — An individual taken or sent to a detoxification center or a health care facility under subsection (b) of this section may be admitted to the facility with the consent of the director of the facility or the designee of the director. (An. Code 1957, art. 2C, § 303; 1982, ch. 21, § 2; 1983, ch. 583, § 2; 1988, ch. 758, § 2; 1989, ch. 782, § 1; 1990, ch. 6, § 2; 1995, ch. 3, § 22; 1999, ch. 702, § 5.)

**Editor's note.** — Section 5, ch. 702, Acts 1999, effective Oct. 1, 1999, provides that:

"(a) The publishers of the Annotated Code of Maryland, subject to the approval of the Department of Legislative Services, shall propose the correction of any agency names and titles throughout the Code that are rendered incorrect by this Act; and

(b) Subject to the approval of the Director of the Department of Legislative Services, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act." Pursuant to § 5 of ch. 702, appropriate changes have been made in (b) (3).

**§ 8-502. Admission to a facility.**

(a) *Conditions for admission.* — After a preliminary evaluation of an individual by the administrator or the designee of the administrator, the individual may be admitted to the facility if it is certified in writing that the individual:

(1) Has acute symptoms of alcohol or drug intoxication or withdrawal; and

(2) (i) Appears to be in imminent danger of harming one's self, or another individual, or the property of another individual; or

(ii) Is willing to be voluntarily admitted.

(b) *Length of detention.* — An individual admitted under this section may be detained up to 72 hours after admission.

(c) *Notice of right to leave.* — An individual detained under this section shall be informed in writing at the time of admission of the right of the individual to leave the facility after 72 hours.

(d) *Admission not required.* — This section does not require a facility to admit an individual when:

- (1) Space is not available;
- (2) A patient demonstrates medical and psychiatric conditions beyond the certified capabilities of the program staff; or
- (3) As a result of an evaluation of an individual, the individual is determined to be an inappropriate admission to the facility. (1989, ch. 782, § 1.)

**Editor's note.** — Section 1, ch. 782, Acts of 1989, redesignated former § 8-502 of this article to be § 8-503 of this article and enacted present § 8-502 of this article.

### § 8-502.1. Admission of minors to inpatient facilities.

(a) *Application of parent or guardian.* — A parent or guardian of the person of a minor may apply, on behalf of the minor, for admission of the minor to a certified inpatient alcohol and drug abuse program or facility under this section.

(b) *Conditions for admission.* — A program or facility may not admit an individual under this section unless the program or facility has determined that:

- (1) The individual has an alcohol or other drug dependency that necessitates the level of care provided by the program or facility;
- (2) The individual would benefit from treatment;
- (3) The parent or guardian making application for admission of the individual understands the nature of the request for admission and the nature of the treatment provided by the program or facility; and
- (4) Assent to the admission has been given by the Director or the Director's designee of the program or facility.

(c) *Conditions for retention.* — In order for an individual to be retained for treatment under this section:

- (1) The parent or guardian who applied for admission of the individual shall have the right to be actively involved in treatment; and
- (2) The facility must note on the application for admission whether or not the minor was admitted in accordance with the provisions of § 20-102 (c-1) of this article.

(d) *Discharge.* — A facility has the right to discharge an individual admitted for treatment under this section if the individual is not complying with the treatment program or the facility's policies and procedures. (1992, chs. 494, 495; 1994, ch. 175.)

**§ 8-503. Disposition of arrested individuals.**

(a) *In general.* — If, after the police arrest an intoxicated individual for a criminal offense, the individual seems to require emergency medical treatment, the police immediately shall take the individual to a detoxification center or other appropriate health care facility as defined in § 19-114 (e) of this article.

(b) *Detoxification facility.* — (1) If necessary, after medical treatment, the police shall transport the individual to a detoxification facility.

(2) The individual may be admitted to the detoxification facility in accordance with the provisions of § 8-501 (d) of this subtitle. (An. Code 1957, art. 2C, § 303; 1982, ch. 21, § 2; 1988, ch. 758, § 2; 1989, ch. 782, § 1; 1995, ch. 3, § 22; 1999, ch. 702, § 5.)

**Editor's note.** — Section 1, ch. 782, Acts 1989, effective Jan. 1, 1990, redesignated former § 8-502 of this article to be present § 8-503 of this article and redesignated former § 8-503 of this article to be present § 8-504 of this article.

Section 5, ch. 702, Acts 1999, effective Oct. 1, 1999, provides that:

(a) The publishers of the Annotated Code of Maryland, subject to the approval of the Department of Legislative Services, shall propose

the correction of any agency names and titles throughout the Code that are rendered incorrect by this Act; and

(b) Subject to the approval of the Director of the Department of Legislative Services, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act." Pursuant to § 5 of ch. 702, appropriate changes have been made in (a).

**§ 8-504. Police responsibility.**

In carrying out §§ 8-501, 8-502, and 8-503 of this subtitle, the police or other authorized personnel shall make every reasonable effort to protect the health and safety of the intoxicated individual. (An. Code 1957, art. 2C, § 303; 1982, ch. 21, § 2; 1988, ch. 758, § 2; 1989, ch. 782, § 3.)

**Editor's note.** — Section 1, ch. 782, Acts 1989, effective Jan. 1, 1990, redesignated former § 8-503 of this article to be present § 8-504 of this article.

Section 2 of ch. 782 repealed former § 8-504 of this article.

**§ 8-505. Evaluation of criminal defendants.**

(a) *In general.* — (1) Before or during a criminal trial or prior to sentencing, the court may order the Department to evaluate a defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment if:

(i) It appears to the court that the defendant has an alcohol or drug abuse problem; or

(ii) The defendant alleges an alcohol or drug dependency.

(2) The court shall set and may change the conditions under which the examination is to be conducted.

(b) *Outpatient examinations.* — Except in a capital case, on consideration of the nature of the charge, the court:

(1) May require or permit an examination to be conducted on an outpatient basis; and

(2) If an outpatient examination is authorized, shall set bail for the defendant or authorize the release of the defendant on personal recognizance.

(c) *Custodial examinations; detention and examination; habeas corpus.* —

(1) If a defendant is to be held in custody for examination under this section:

(i) The defendant may be confined in a detention facility until the Department is able to conduct the examination; or

(ii) The court may order confinement of the defendant in a medical wing or other isolated and secure unit of a detention facility, if the court finds it appropriate for the health or safety of the defendant.

(2) (i) If the court finds that, because of the apparent severity of the alcohol or drug dependency or other medical or psychiatric complications, a defendant in custody would be endangered by confinement in a jail, the court may order the Department to either:

1. Place the defendant, pending examination, in a health care facility that the Department designates as appropriate; or

2. Have local health department staff, or other qualified personnel who the Department finds appropriate, immediately conduct an evaluation of the defendant.

(ii) Unless the Department retains a defendant, the defendant shall be promptly returned to the court after an examination.

(iii) A defendant who is detained for an examination under this section may question at any time the legality of the detention by a petition for a writ of habeas corpus.

(d) *Duties of evaluator.* — (1) If a court orders an evaluation under this section, the evaluator shall:

(i) Conduct an evaluation of the defendant; and

(ii) Submit a complete report of the evaluation within 7 days to the:

1. Court;

2. Administration; and

3. Defendant or the defendant's attorney.

(2) On good cause shown, the court may extend the time for an evaluation. (1989, ch. 782, § 3.)

### § 8-506. Commitment for evaluation.

(a) *Prerequisites.* — (1) A court may commit a defendant to the Department if:

(i) The court finds it is not clinically appropriate for the defendant to be evaluated in a detention facility or an appropriate outpatient facility; or

(ii) After an evaluation in a detention facility or an outpatient facility, the Department recommends a comprehensive inpatient evaluation of the defendant.

(2) Before a court commits a defendant to the Department for evaluation, the court shall consult with the Administration.

(b) *Services.* — The Department shall provide the services required by this section.

§ 8-101

ANNOTATED CODE OF MARYLAND

Subtitle 7. Prohibited Acts; Penalties.

Subtitle 8. Short Title.

- Sec. 8-701. Unlawful or improper adjudication as drug or alcohol abuser or dependent.
- 8-702. Operation of program a violation of title.
- 8-703. Discrimination.

- Sec. 8-801. Short title.

Subtitle 9. Prohibited Acts; Penalties.

- 8-901. [Repealed].

Subtitle 1. Definitions.

§ 8-101. Definition.

(a) *In general.* — In this title the following words have the meanings indicated.

(b) *Administration.* — “Administration” means the Alcohol and Drug Abuse Administration.

(c) *Administrator.* — “Administrator” means the program director or the clinical director of an alcohol or drug abuse treatment facility or a health care facility.

(d) *Alcohol misuse.* — “Alcohol misuse” means:

- (1) Unlawful use of alcohol;
- (2) Alcohol abuse; or
- (3) Alcohol dependence.

(e) *Alcohol abuse.* — “Alcohol abuse” means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

(f) *Alcohol dependence.* — “Alcohol dependence” means a disease characterized by:

- (1) Alcohol abuse; and
- (2) Physical symptoms of withdrawal or tolerance.

(g) *Detoxification facility.* — “Detoxification facility” means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social, and emotional needs of the individual by:

- (1) Monitoring the amount of alcohol and other toxic agents in the body of the individual;
- (2) Managing withdrawal symptoms; and
- (3) Motivating the individual to participate in the appropriate addictions treatment programs for alcohol or drug abuse.

(h) *Director.* — “Director” means the Director of the Administration.

(i) *Drug.* — “Drug” means:

- (1) A controlled dangerous substance that is regulated under the Maryland Controlled Dangerous Substances Act;
- (2) A prescription medication; or
- (3) A chemical substance when used for unintended and harmful purposes.

(j) *Drug misuse.* — “Drug misuse” means:

- (1) Unlawful use of a drug;
- (2) Drug abuse; or

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(3) Drug dependence.

(k) *Drug abuse*. — “Drug abuse” means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

(l) *Drug dependence*. — “Drug dependence” means a disease characterized by:

- (1) Drug abuse; and
- (2) Physical symptoms of withdrawal or tolerance.

(m) *State Advisory Council*. — Repealed by Acts 2000, ch. 61, § 1, approved Apr. 25, 2000, and effective from date of enactment. (1988, ch. 714, § 2; ch. 758, § 2; 1989, ch. 782, § 1; 2000, ch. 61, § 1; ch. 593.)

**Effect of amendments.** — Chapter 61, Acts 2000, approved Apr. 25, 2000, and effective from date of enactment, repealed (m).

Chapter 593, Acts 2000, effective Oct. 1, 2000, reenacted (a) and (b) without change.

**Editor’s note.** — Section 5, ch. 61, Acts 2000, approved Apr. 25, 2000, and effective from date of enactment, provides that “the provisions of this Act are intended solely to

correct technical errors in the law and that there is no intent to revive or otherwise affect law that is the subject of other acts, whether those acts were signed by the Governor prior to or after the signing of this Act.”

**Cited in** *Clark v. State*, 115 Md. App. 208, 692 A.2d 949 (1997), *aff’d*, 348 Md. 722, 705 A.2d 1164 (1998).

## § 8-102.

Reserved.

### *Subtitle 2. Alcohol and Drug Abuse Administration.*

## § 8-201. Established.

There is an Alcohol and Drug Abuse Administration in the Department. (1988, ch. 758, § 2.)

## § 8-202. Director.

(a) *Appointment*. — The head of the Administration is the Director, who shall be appointed by the Secretary.

(b) *Tenure*. — The Director serves at the pleasure of the Secretary.

(c) *Qualifications*. — The Director shall:

(1) Have at least:

- (i) A baccalaureate degree; and
- (ii) Experience in health administration; and

(2) Be knowledgeable about the functions and programs of the Administration.

(d) *Salary*. — The Director is entitled to the salary provided in the State budget. (1988, ch. 758, § 2.)

by the General Assembly. The Michie Company shall adequately describe any such correction in an editor's note following the section affect-

ed." Pursuant to § 9 of chs. 635 and 636, appropriate changes have been made in this section.

*Subtitle 2. Dorchester County Transition.*

**§ 18-201. Continuation of Dorchester County Dispensary System.**

The Dorchester County Dispensary system shall remain in operation until such time as the General Assembly enacts a comprehensive plan of legislation that creates a rational system of alcoholic beverages licenses for the county. (1995, ch. 523.)

**Editor's note.** — Section 2, ch. 523, Acts 1995, provides that "on October 1, 1996, subject to the provisions of Title 18, Subtitle 2, the dispensary system shall terminate and all stock shall be liquidated in a manner prescribed by the Liquor Control Board. Any profits from the sale of the stock, after payment of expenses and debts, shall be distributed as follows:

- (a) 50% to the Dorchester County government; and
- (b) 50% to the Dorchester County General Hospital."

Section 3, ch. 523, Acts 1995, as amended by ch. 366, Acts 1996, effective Oct. 1, 1996, provides that "the Liquor Control Board shall terminate on October 1, 1996, and the Board of License Commissioners shall conduct the sale of all assets, the liquidation of all stock, the payment of all debt, and the distribution of all profits of the Liquor Control Board."

Section 4, ch. 523, Acts 1995, provides that the act shall take effect Oct. 1, 1996.

TITLE 19. DISORDERLY INTOXICATION.

*Subtitle 1. In General.*

**§ 19-101. Prohibited acts; supplemental ordinances or resolutions.**

(a) *Prohibited acts.* — A person may not:

- (1) Be intoxicated and endanger the safety of another person or property; or
- (2) Be intoxicated or drink any alcoholic beverage in a public place and cause a public disturbance.

(b) *Supplemental ordinances or resolutions.* — A county, municipality, or other political subdivision of this State may not adopt ordinances or resolutions identical or supplemental to this section, and any existing ordinance, resolution, or other legislation inconsistent with this section is repealed. (1978, ch. 603, § 2; 1981, chs. 401, 450; 1985, ch. 267; 1989, ch. 5, § 15.)

**Maryland Law Review.** — For article, "Survey of Developments in Maryland Law, 1984-85," see 45 Md. L. Rev. 634 (1986).

**Causal connection between elements in paragraph (a) (2) not required.** — There is no need for causal connection between the two elements in paragraph (a) (2), prohibiting a person from being intoxicated or drinking alcohol in a public place, alternatively and causing

a public disturbance. *Curtin v. State*, 60 Md. App. 338, 483 A.2d 81 (1984), cert. denied, 302 Md. 409, 488 A.2d 500 (1985).

**Parking lot of apartment complex is "public place"** within the meaning of paragraph (a) (2). *Curtin v. State*, 60 Md. App. 338, 483 A.2d 81 (1984), cert. denied, 302 Md. 409, 488 A.2d 500 (1985).



Art. 2B, § 19-102 ANNOTATED CODE OF MARYLAND

Quoted in *Simpler v. State*, 318 Md. 311, 568 A.2d 22 (1990).

§ 19-102. **Penalty.**

Any person who violates the provisions of this subheading is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$100 or imprisonment not exceeding 90 days, or both. (1978, ch. 603, § 2; ch. 724; 1981, chs. 401, 450; 1982, ch. 770, § 4; 1989, ch. 5, § 15; 1993, ch. 5, § 1.)

§ 19-103. **Ordinances or resolutions in certain counties and Baltimore City; subheading inapplicable in Kent and Queen Anne's Counties; regulation of possession or consumption of alcoholic beverages in City of Annapolis.**

(a) *Ordinances or resolutions in certain counties and Baltimore City.* — The subdivisions enumerated in this subsection may adopt ordinances or resolutions supplementing this subheading. This includes the authority to regulate possession or consumption of any alcoholic beverage on any public property, property used by the public in general, or on any highway:

- (1) Anne Arundel County;
- (2) Baltimore City;
- (3) Baltimore County;
- (4) Harford County;
- (5) Prince George's County;
- (6) St. Mary's County;
- (7) Cecil County;
- (8) Garrett County; and
- (9) Frederick County.

(b) *Subheading inapplicable in Kent and Queen Anne's Counties.* — This subheading does not apply in the following subdivisions:

- (1) Kent County; and
- (2) Queen Anne's County.

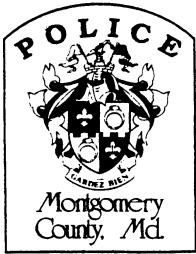
(c) *Regulation of possession or consumption of alcoholic beverages in City of Annapolis.* — In the City of Annapolis and the City of Frederick, the Mayor and Aldermen may regulate within the City limits the possession or consumption of any alcoholic beverages on any public property owned by the City or on any public highway. (1978, ch. 603, § 2; 1979, ch. 7; 1981, chs. 401, 450; 1983, ch. 183; 1984, ch. 255; 1985, ch. 267; 1989, ch. 5, § 15.)

*Subtitle 2. Drinking in Certain Places.*

§ 19-201. **Definitions; application of subheading.**

(a) *Definitions.* — (1) In this subheading the following word has the meaning indicated.

(2) "Public property" includes any building, ground, park, street, highway, alley, sidewalk, station, terminal or other structure, road or parking area



## HEADQUARTERS MEMORANDUM 01-09

File With: FC 921

Distribution: All

Date: 06-15-01

### Subject: Crisis Intervention Team (CIT) Program

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The Crisis Intervention Team (CIT) has been established to identify volunteer officers willing to receive training on handling the mentally ill consumer. A consumer is an individual (or parent of a minor child) who received mental health services from the Maryland Public Mental Health System.

The volunteer officers will receive a 40 hour block of instruction on mental illness and techniques used to effectively de-escalate crisis incidents involving mentally ill consumers. Examples of this type of incident may include a disoriented or mentally ill person yelling at passing motorists, family trouble calls involving a mentally ill consumer, or consumers exhibiting severe depression without suicidal comments or actions.

Upon completion of the 40 hours of training, the officers will become certified as CIT members. The CIT officer will be identified in the CAD with a code so they can be dispatched when requested to handle complicated mental illness calls for service.

The CIT officers will be awarded a CIT insignia to be worn above their nametags. These insignias make the CIT officers readily identifiable to other officers and mentally ill consumers who have had contact with the CIT officers on multiple occasions.

The Communications Division will include a "capability code" within the dispatch system to identify qualified CIT officers. The CIT officer will respond to the scene when requested by the beat officer or officer assigned to the call. If there are no trained CIT officers available in a specific district, an adjoining district CIT officer and that officer's supervisor will be notified of the need for the CIT officer to respond.

Once the CIT officer is on the scene of a mental illness call, the CIT officer becomes the primary officer. This does not relieve the first officer on the scene of a hostage, barricade, or life threatening situation from activation of the Emergency Response Team as directed in FC 950, "Emergency Response to Hostage, Barricade, and All Life-Threatening Situations," if such activation is tactically necessary.

The CIT officer will determine:

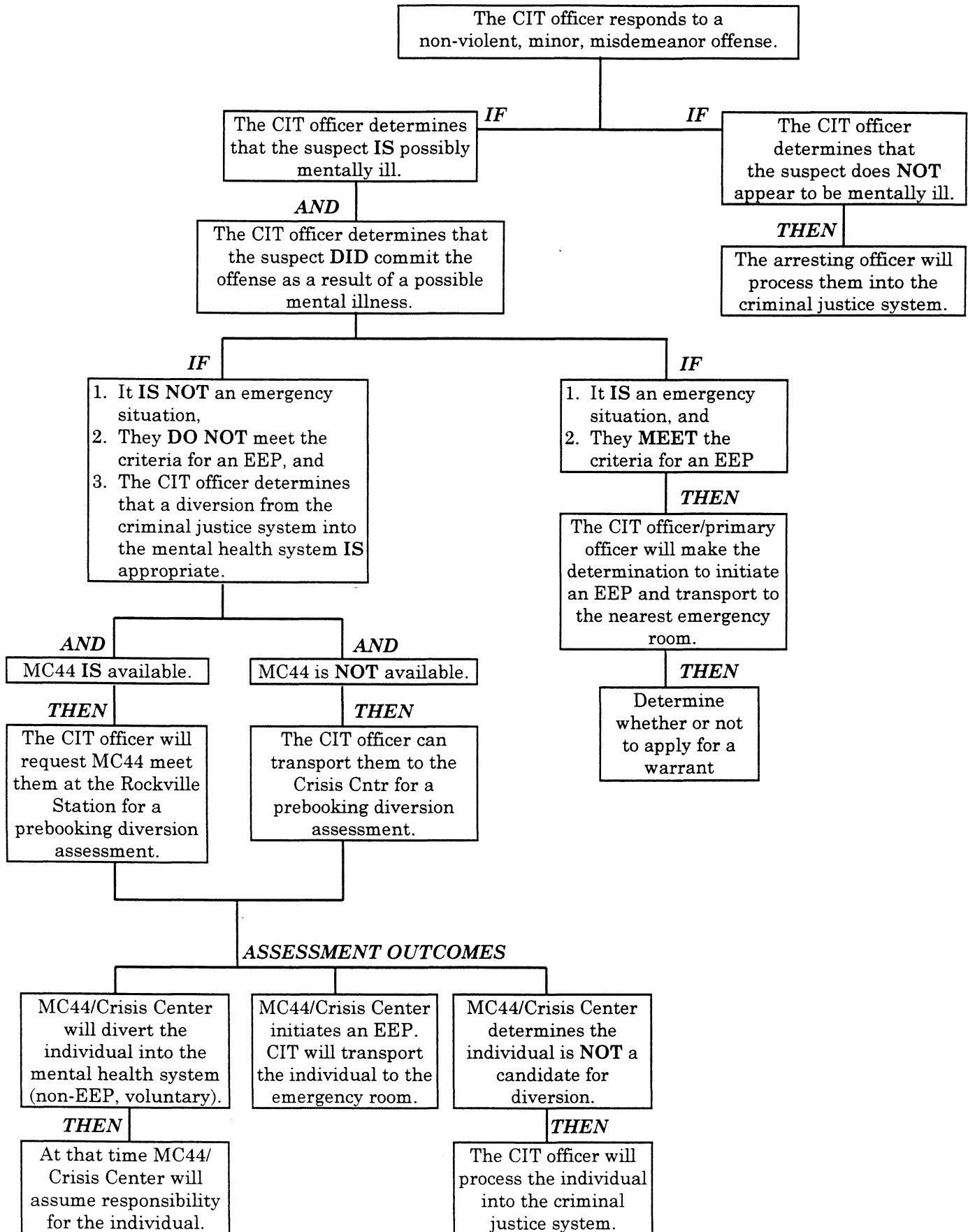
1. If the mentally ill consumer is in need of a petition for emergency evaluation.
2. If the Mobile Crisis Team needs to respond to assist.
3. If the mentally ill consumer needs to be charged criminally or diverted to mental health services.
4. If the mentally ill consumer does not require immediate medical or mental health attention and can be referred to resources available during normal business hours.

The CIT officer will receive additional training in the preparation of the MCP 922, "Crisis Intervention Team Report," and participate in after-action critiques of recent CIT incidents. A CIT newsletter and advanced training will also be available to CIT officers.

The goal of the CIT program is to train one CIT officer per shift in each district. This program is designed for the patrol officer to enhance their safety and assessment skills and ensure that they can better serve the mentally ill consumers in our county.

The CIT program will offer training to local and outside police agencies, Montgomery County Sheriff's, county school representatives, and the correctional staff of the Montgomery County Detention Center. Applications for CIT training are subject to the approval of the Director, Strategic Planning Division.

# CRISIS INTERVENTION TEAM (CIT) Pre-Booking Diversion



MONTGOMERY COUNTY DEPARTMENT OF CORRECTION AND REHABILITATION  
DETENTION DIVISION POLICY AND PROCEDURE MANUAL

Policy and Procedure: 200-16  
Subject: Accepting Impaired or Injured Prisoners

Approved By: *Jon Galley, Devon [Signature]*

Distribution: B & L

Effective Date: August 15, 1995  
Replaces: April 20, 1991

POLICY: The Detention Center shall accept for commitment and housing only those prisoners who have been medically screened and approved in accordance with the following guidelines. These procedures are necessary to safeguard the well-being of the prisoner, as well as to protect both the County and the Detention Center staff from potential civil liability actions.

I. PROCEDURES:

- A. The R&D Officer shall immediately notify both the Unit Manager/Assistant Unit Manager and Medical personnel of the arrival of any prisoner brought to the Detention Center who is suspected of being under the influence of alcohol or drugs or who appears to be suffering from any obvious injuries or illnesses. Upon being so notified, both the Unit Manager/Assistant Unit Manager and Medical personnel shall respond to the Police Entrance sally port to assess the condition of the prisoner before he/she is admitted into the facility.
- B. The prisoner shall then be screened by Medical personnel to assess his/her present physical condition, extent of injury, level of intoxication or impairment, medical fitness for housing within the institution, etc. An evaluation shall also be made at this time to determine if the prisoner poses a potential danger to him/herself or others if he/she is not immediately treated or admitted to a hospital. This screening process shall be conducted prior to accepting the prisoner into the facility.
- C. Whenever a question arises about accepting a prisoner with medical problems into the Detention Center, the Unit Manager/Assistant Unit Manager and Medical personnel shall confer about the matter. The Unit Manager/Assistant Unit Manager shall be responsible for making the final decision on accepting the prisoner, after receiving appropriate advice from Medical personnel.
  1. If the results of the preliminary medical examination are such that the Medical personnel conclude that the immediately available medical resources of the Detention Center are sufficient to provide an acceptable level of medical care/maintenance for the prisoner's injuries, illness, or level of intoxication, the Unit Manager/Assistant Unit Manager shall accept custody of the prisoner from the transporting law enforcement officer.

# INJURED ARRESTEE REPORT

\_\_\_\_\_  
Arrestee Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time Medical Staff was called

\_\_\_\_\_  
Name of Medical Staff contacted

The above arrestee was brought into the CPU with the following injuries/medical complaints:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The arrestee was \_\_\_\_ was not \_\_\_\_ treated at a hospital and released.

After being seen by MCDC Medical Staff, the arrestee was:

Accepted \_\_\_\_\_

Not Accepted \_\_\_\_\_

\_\_\_\_\_  
Print Name of Medical Staff

\_\_\_\_\_  
Signature of Medical Staff

\_\_\_\_\_  
Date and time

\_\_\_\_\_  
Signature of CPU Senior Officer

\_\_\_\_\_  
Date and time

Nurse's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 1 copy for Arrestee's CPU folder
- 1 copy faxed to Medical Section
- 1 copy to Shift Supervisor



*Helping county residents achieve and maintain healthy, safe, and self-sufficient lives*

## **Assertive Community Treatment (ACT) Team**

The Assertive Community Treatment (ACT) Team utilizes a service-delivery model that provides comprehensive treatment to people with serious and chronic mental illness. The ACT team may be contacted by calling (240) 777-4835.

ACT is comprised of a multi-disciplinary mental health staff, whose primary functions are to provide treatment, case management, and support services to clients to assist them in successful community living. ACT will work with those clients who have not successfully responded to traditional treatment provided by community mental health clinics because of inability to keep scheduled office-based appointments and failure to comply with prescribed medication. ACT interventions (i.e. treatment and rehabilitative services) takes place in community locations. This includes the client's residence, neighborhood, place of employment or recreation, and at times, shelters, jails, and hospitals.

### Who Benefits From ACT?

- Montgomery County residents who are 18 years or older who have a severe and persistent mental illness causing symptoms and impairments which produce distress and major disabilities in adult functioning (i.e. employment, self-care, and social and interpersonal relationships).
- ACT clients are adults with bipolar disorder, schizophrenia or other psychotic disorders or those who experience significant disability from other mental illnesses.
- People who have difficulty getting to appointments on their own as in the traditional model of case management, or who have not successfully been able to access the mental health system, or who have limited understanding of their need for help.

### Primary Goals of ACT:

- To lessen or eliminate the debilitating symptoms of mental illness each

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client experiences and to minimize or prevent acute episodes of the illness through support and education.

- To enhance the quality of life.
- To enhance an individual's ability to live independently in his or her community.
- To improve functioning in adult social role or employment role.
- To lessen the family's or significant other's burden of providing care by providing support, education, and skill teaching.

#### The Difference Between ACT and Traditional Care:

The ACT multidisciplinary staff work as a team. The ACT team works collaboratively to deliver the majority of treatment, rehabilitation, and support services required by each client to live in the community. The individual is the consumer of the team, not the individual staff member. This team has the capacity to do whatever is required to help clients access and participate in their care.

For additional information, see the [ACT team web site](#).

*Together We Can!*

#### Home

Montgomery County  
Department of Health and Human Services  
401 Hungerford Drive  
Rockville, Maryland 20850  
Phone: 240-777-1245  
TTY: 240-777-1245  
Fax: 240-777-1494  
E-mail: [hhsmail@co.mo.md.us](mailto:hhsmail@co.mo.md.us)

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