HOW LONG WILL THE NEED GO UNFULFILLED? RESIDENTIAL DETOXIFICATION IN SAN LUIS OBISPO COUNTY

SUMMARY

The need for residential detox treatment for persons addicted to drugs and alcohol in San Luis Obispo County is evident every day by the large number of people going through withdrawal in our County's Jail. Addictions to alcohol and drugs are medical illnesses, which can and should be treated. For each dollar invested in substance-abuse treatment, there is a ten-fold savings in health care and criminal justice costs. Comprehensive addiction services, encompassing a full continuum of care, are critical for reaching those in greatest need.

Currently, the County's Drug and Alcohol Services is poised to expand its capabilities by way of a federal waiver to Medicaid (Medi-Cal in California) under provisions of the Affordable Care Act. Though funding is set to improve, providing residential treatment is dependent on both a suitable provider and a cost-effective site location. For the county's lower income residents in particular, the jail remains the de facto detox facility, and it is only available for addicts who end up violating the law. The jail is not designed to deliver treatment. It provides some limited medical assistance to reduce complications from withdrawal but is neither resourced nor organized in ways to provide the supportive environment or services known to lead to better outcomes.

The Grand Jury, based on its investigation of the need for residential detoxification services, has identified several changes within the jail that would enhance delivery of addiction treatment services. These include separating substance abusers from the general population, co-locating service providers, allowing additional medical treatments, initiating psychological and social services for a greater number of inmates, and targeting services to inmates going through detoxification. The Grand Jury also recommends that the County consider a new police-led

diversion program for certain substance abusing arrestees that could help to maximize their treatment involvement. On siting a detox facility, the Grand Jury recommends that the vacated space in the Honor Farm created by the new women's jail be considered for locating a residential treatment facility to serve Medi-Cal insured residents and those in diversion programs.

ORIGIN

The Grand Jury initiated this investigation in response to concerns raised in meetings with county administrative staff and various news reports documenting an epidemic of opioid use, addiction and death.

AUTHORITY

The issuance of this report is authorized under the investigative powers of the Grand Jury pursuant to California Penal Code sections 919, 922 and 925.

METHOD

The Grand Jury used the following sources to develop this report:

- Inspection and review of the San Luis Obispo County Jail (Jail), including interviews with inmates and representative staff from law enforcement, medical care, drug/alcohol services and contracted service providers
- Interviews with County staff responsible for managing and delivering community-based drug and alcohol services
- Interviews with addiction specialists practicing in privately operated detox services
- Written responses from select County staff to questions arising from interviews and the jail visit
- Review of County reports on Addressing Detoxification Needs in San Luis Obispo County (2007 and 2013) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) - Implementation Plan (signed July 5,2016)

- Review of information available through the National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and the recently released Surgeon General's Report on Alcohol, Drugs, and Health ("Facing Addiction in America," November, 2016)

NARRATIVE

This report is organized by first presenting background on the nature of addiction and need for detox services, followed by reviews of current services in the County, and then examination of plans for new services.

Sections on addiction draw heavily from information in the Surgeon General's 2016 report, "Facing Addiction in America," and from the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. The brief history of the County's detox services is taken primarily from information provided in two County reports addressing detox needs. The current state of services derives from Grand Jury interviews, direct observations, and a review of the DMC-ODS[1] implementation plan. The Bibliography provides full citations for these various sources.

NATURE OF ADDICTION

According to the Surgeon General, addictions to drugs and alcohol are chronic brain diseases, medical illnesses, and not moral failings or willful rejections of social norms. These diseases of addiction are life changing and lead to irresponsible and sometimes criminal behavior, as well as death from overdose, accident, suicide, and health complications.

The Surgeon General indicates that both genetic and developmental factors contribute to onset of addiction. Neurobiologically, addiction derives from disruptions to specific brain circuits in three areas of the brain. These disrupted circuits lead to increased importance of substances, reduced sensitivity to pleasure, heighten stress responses, and reduced executive control, particularly in decision making, emotional expression and impulse regulation. These changes heighten the

[1] Drug Medi-Cal Organized Delivery System (DMC-ODS), 2016.

three-stage cycle of abuse: binging/intoxication, withdrawal/negative affect, and preoccupation/anticipation. Adolescence is the most "at risk period" for developing addiction because it is the time when the brain is still undergoing significant change and is more susceptible to psycho-active substances.

Over time, with greater use and increasing tolerance, changes in brain circuitry make it more and more difficult for a person to manage his or her abuse behavior. Life becomes dominated by acquiring and using the abused substance, while important social, family, occupational and leisure behaviors deteriorate. For addicts, the brain disruptions can persist for months after discontinuing substance use. Current research is unclear as to how long or whether some changes in the brain are ever fully reversed.

Diseases of addiction are known as substance use disorders and include designations of symptom severity and substance of abuse, e.g., Amphetamine Use Disorder or Opioid Use Disorder. Severity is assigned as either "mild," "moderate" or "severe." About 8.5% of the U.S. population is in need of substance-use treatment based on National Institute on Drug Abuse nationwide trend data, while only 0.9% of the total population is receiving some form of care. This would mean 24,000 county residents likely need substance abuse treatment.

ADDICTION TREATMENT

Scientific evidence shows that substance use disorders (SUD) can be treated. In fact, approximately 50% of persons who once met criteria for a SUD are currently in stable remission. Yet at any point in time, only about 10% of people with active SUDs are receiving some type of specialty treatment and only a third of them receive treatment that meets standards of care. The Surgeon General report asserts that one reason for this low treatment participation is the poor integration of drug/alcohol services within the broader health care system. It also notes that for every dollar spent on substance abuse treatment it saves four dollars in health care and seven dollars in criminal justice costs.

Drug and alcohol treatment often includes periods of relapse and remission. Relapse rates can be as high as 60% in the first year of treatment and it can take eight to nine years after first seeking

treatment for a severely addicted person to achieve a state of sustained recovery. Recurrence rates for treated addictions are similar to those of other chronic illnesses like asthma, diabetes, and hypertension.

Treatment of SUDs requires a chronic-illness-management approach. The severity of the SUD dictates the level of care. Becoming and staying engaged in treatment is the critical variable in recovery and to a large part this is dependent on receiving the appropriate treatment at the right time. No single treatment pathway to recovery works for all addicts; cultural and social factors often determine what will work for a particular person, at a particular time. The lack of available and affordable treatment is given by about 50% of those not engaged in treatment as their reason for not seeking help. As such, it is essential to have a continuum of care that includes inpatient, residential, intensive outpatient, medication assisted treatment, outpatient, and social recovery services.

The first step always begins with detoxification. By itself detoxification is rarely sufficient and almost all who only go through physical detox will resume substance use within a short time. The standard of care for treating those with severe addictions starts with medically supervised detoxification for three to seven days that is fully integrated within one to three months of residential stabilization. This is followed by several months of intensive outpatient treatment and five to six months of regular outpatient sessions. For most, ongoing social-recovery supports (e.g., 12-step mutual aid groups and peer recovery coaches) are then needed to sustain the recovery. Because relapse is common, the treatment course typically includes several starts and stops, often taking several years to complete. A full continuum of care must have elements to cover all of these steps.

Currently, San Luis Obispo County does not make that full continuum of care available to all its residents.

DETOX SERVICES IN SAN LUIS OBISPO COUNTY

This section provides a brief overview of the history of local detox services and recent additions to the offerings.

History of San Luis Obispo County Detox Services

In San Luis Obispo County, the availability of residential detoxification services has been an issue since the 1982 closure of the 16-bed non-medical detox unit at the now-closed, county's General Hospital. Aside from a brief period in the mid-1990's when French Hospital had an inpatient detox unit, the County relied on outpatient detox services operating from the former General Hospital facilities from 1982-2003, then following a 10-year break and beginning in 2013 operating out of the County's Drug and Alcohol Services (DAS) clinics.

In 2007, the DAS issued its first comprehensive report on addressing detoxification needs, which indicated a need for six or seven residential treatment beds to meet the County's needs. This was determined by analyzing bed-to-population ratios in comparable counties which had residential detox services. By 2008, the DAS identified several private entities that were looking to open residential detox services in the County, including the homeless shelter. Reportedly due to high costs, problems in site location, limited local expertise, and questions about revenue stream, none of these materialized. As a result, out-of-county detox services were contracted to provide services to those with the severest need. These contracted services were rarely used.

By 2013 the most recent DAS report on detox needs proposed the creation of a mobile, outpatient detox team to better address the residential deficits as well as the increase in opioid abuse. With this team, features of a residential detox service could be approximated, at least in part, for those addicted persons able to relocate to a sober living home with the mobile team providing the medications and limited counseling services needed to move through detoxification. The hope was that this would lessen the residential-treatment need until private providers could be found or sober living houses could be converted to residential treatment facilities. This team was put into operation in 2014.

Finally in 2016 a private, high-end medically oriented residential treatment service has opened in south County to meet some of the County's need.

County's Outpatient Detox Team

As noted, the County's outpatient detox team has been operating since 2014 and is intended to serve 150 clients a year. It is composed of a part-time nurse practitioner, a psychiatric technician or licensed vocational nurse, and a case manager. This team is designed to be "mobile and available for consultation and detox visits in the field or homes as needed."[2] Included services are ongoing medication monitoring and as-needed or as-willing treatment groups, individual counseling, and/or case management assistance. According to American Society of Addiction Medicine, such outpatient services are suitable for persons with SUDs of mild to moderate severity.

Information from the 2015-16 fiscal year indicates that 141 people received services, 16 for alcoholism and 125 for opioid addiction (95% of which were slowly detoxed using Medication Assisted Treatments or MAT). For those receiving more than just MAT, the average length of treatment was about 4.7 months. Twelve clients were noted to be repeats. Individual counseling was provided to only 30 of the 141 participants. In its review of 60 discharged cases who received two or more services, 27 (45%) were considered "successful." When interviewed, staff reported that the team was most effective delivering services to opioid-addicted persons. They also noted that residential treatment would be used more often if available locally and they identified a particular need for residential detox to serve persons with alcohol addiction.

The Haven

This new private 18-bed residential treatment program began serving County and out-of-county residents in June, 2016. The Haven is composed of three separate six-bed houses, one for men, a second for women and a third for detoxification. Staffing for the medically-managed detox unit is superior to that found in less costly clinically-managed services. Like other residential treatment services, the Haven utilizes drug and alcohol trained staff to deliver group and individual counseling, and activity-based treatments. Medications are provided by two physicians—an addiction specialist and a practicing psychiatrist—each providing their services on a part-time basis. Although detox treatment is designed to last 30 days, insurance companies

[2]Report for Addressing Detoxification Needs for Substance Use Disorders in San Luis Obispo County," September 2013

are covering less time, generally from 3 to 14 days only. Following detox, the Haven is designed to provide additional residential treatment at its other houses and then outpatient services following discharge.

Clientele is reported to be 80% alcohol and only 20% drug involved. Cost of care is upwards of $30,000 per month. Neither Medi-Cal nor Medicare is accepted in payment. County residents are expected to make up 50% to 60% of the Haven's clientele.

When interviewed, Haven staff reported that they have been receiving upwards of five calls a day inquiring about residential treatment for addicted persons on Medi-Cal or Medicare. When asked about need for additional residential detox services in the county, staff acknowledged the deficit and significant need for at least 12 beds to serve those with few financial resources, no insurance, on Medi-Cal, or on Medicare.

DE FACTO DETOX SERVICES AT THE JAIL

County administrators, law enforcement personnel, and health services staff readily acknowledge that the County Jail serves as the de facto detox facility and no one interviewed believed this is a good situation. Persons arrested in the County show high incidences of SUDs. Among the approximately 1,000 arrestees booked each month, jail staff estimates that over 50% are substance abusers; this is in line with national estimates indicating 65% of all prisoners meet SUD criteria. In the last half of 2016, the jail reported an average monthly intake of 985 persons, of which 265 (27%) were identified as under the influence of opiates, benzodiazepines or alcohol. Jail staff acknowledges that this number is likely an underestimation because they see substance-involved inmates who have gone undetected at intake.

Detox Process

A standard process occurs at the jail for inmates who might be substance abusers. Custody and nursing staffs do brief screenings of every arrestee's mental and physical status, during which the level of intoxication is assessed. Signs of severe physical complications from substance use, such as delirium or seizures that can be life threatening, are evaluated. As a result, some arrestees, deemed to be medically unsuitable or questionable for jail placement, are turned away. And the

arresting officers are required to take the person to a hospital emergency room for evaluation of need for hospital care. No summary data were available on how often this occurs, but staff estimated that, on average, it happened about once a day.

Following booking, the substance-involved arrestee is placed in a sobering cell located in the Intake and Release Center. These cells have padded floors, toilet, glass fronts for easy monitoring, and no furniture, beds or seating. The cells are gender separated, supervised by custody staff and always lighted. There are also several non-custody personnel working in the area who provide incidental monitoring. The substance-involved arrestees can be held in these cells for a maximum of 12 hours before either being released from jail or transferred to one of the jail's dorm, double-cell or single-cell units pursuant to the jail's inmate-classification procedures. Custody staff report that signs and symptoms of severe intoxication as well as painful withdrawal are often evident with inmates in these sobering cells, and staff have observed some very sick, disoriented, scared, and tormented people sometimes squirming on the floor in the throes of withdrawal.

For those inmates identified as experiencing severe alcohol or opioid withdrawal, the jail's medical service provides both medications to lessen symptoms and daily checks to assure physical complications are identified early. The intake nurse is responsible to initiate withdrawal protocols when indicated. Custody personnel can also make referrals for medical evaluation based on their direct observation of an inmate's behavior or an inmate's request for medical help with substance withdrawal. When medical services receive a referral, according to current written protocols, a registered nurse is required to assess the inmate within 8 hours in the case of alcohol use and 16 hours for opiates. Response times, however, are reported to be much shorter, and these protocols are under revision to reflect this quicker response. On assessment, the nurse determines whether a withdrawal protocol is to be started and for what duration. In rare cases, the nurse may recommend hospital evaluation and transfer. Data on frequency of such hospital transfers of inmates for substance-induced symptoms is not available, but several staff estimated that it occurs about once a month.

The approved withdrawal protocols for mild to moderate symptoms entail a short course of medications and monitoring for either three or five days. Specific medications target symptoms of restlessness, nausea, diarrhea, anxiety, depression, and confusion. These protocols are reported by staff to be similar to what is commonly done under medical supervision in residential detox programs.

Scope of This Process

Data collected over the last six months of 2016 indicate a significant number of inmates underwent this limited medical detox at the jail. On average, 43 inmates per month were placed on opiate and 14 on alcohol withdrawal protocols. This resulted in an average of 57 people per month receiving detox treatments to ease the suffering of withdrawal. This translates to more than 680 people per year going through medically-supervised detox at the jail.

Challenges of This Process

Several staff at the jail mentioned that evidenced-based medication assisted treatments for either opioid or alcohol are not allowed to be initiated for those beginning detoxification. Continuation of these treatments is allowed in a few situations. If a new inmate is on Buprenorphine, a medicine often used for opioid addiction, it may be administered in the jail as long as the outside prescription can be verified. For someone on Methadone Maintenance Therapy, administration is also possible but more difficult in the jail since this therapy requires an approved community methadone clinic to both authorize and supply the medicine for an inmate who is actively enrolled in the clinic's program. So, for practical purposes, medication assisted treatment is not an option for detoxing inmates with severe addictions at the jail.

Also, as noted earlier, detox alone is not proven to be sufficient in changing the course of addiction. The jail is simply unable to offer the psychological and social services (e.g., SUD counseling and education) that should be provided during and following physical detoxification. These services are essential to prepare the person for the next step in managing his or her illness. The jail has two DAS counselors and one case manager who serve only inmates covered by the AB 109 law (the prison realignment statute that downgraded certain felony crimes, resulting in sentences being served in county jails rather than prison). These counselors provide group and

individual services to these long-term inmates, who account for only a small percentage of those going through detoxification. Counselors are intended to serve a caseload of no more than 30. One counselor is assigned to male inmates and the other to the females. With these limited resources, it means that the majority of inmates actually going through jail detox receive none of the critical psycho-social treatments that are integral to the efficacy of residential treatment programs.

DAS counselors report little collaboration with staff from medical services, in part due to offices being located in different parts of the jail. Counselors indicate that they rarely receive direct referrals from medical or, for that matter, psychiatric services. In turn, when asked by the Grand Jury about DAS services, several medical staff members were unable to say how many DAS counselors were on staff or describe the services. On this apparent separateness, several experts interviewed stated specifically that this was an issue, and they felt that a fuller integration of these separate services would help support rehabilitation.

Finally, staff and service providers report a host of additional institutional challenges in delivering group treatments in the jail setting not suitably designed or equipped for such. These include the following:

- Limitations on available treatment space
- Need to conduct groups in open areas where uninvolved inmates can listen or disrupt
- Low group attendance due to pressure from other inmates who dislike being locked in their cells during group time
- Few participants in groups on some units and no way to allow cross unit participation
- Too much time spent in transit from unit to unit
- Scheduling challenges for custody staff
- Skeptical comments from other staff about the helpfulness of treatment
- Inmate complaints of being pressured to drop out of treatment

Possible Remedies

Staff and others familiar with the jail offered their thoughts about remedies to meet some of these challenges, which included:

- Housing inmates motivated for drug and alcohol treatment in one part of the jail
- Creating an area of the jail for primary substance abusers that approximates a treatment center
- Increasing training for custody staff to help overcome some of the misconceptions about addiction and its treatment, to enhance understanding and compassion

During the Grand Jury's visit, many of these logistical challenges were evident: groups were held in open areas or in small rooms, older units appeared to lack space, and inmate movement from unit to unit was disallowed. It was also noted that, with the opening of the new women's jail, female honor-farm participants had been moved from the communal housing at the honor farm back to the jail, leaving the 57 beds and buildings in the honor farm unoccupied.

Additionally, several staff members would like to see something done to help inmates who detox and are then released to the community only to resume using. They note that the month after release is the most difficult for addicts and alcoholics and it is a time that the chance for overdosing peaks. One of their recommendations is to allow medical staff to initiate Medication Assisted Treatments, i.e., Buprenorphine for opioid addiction and perhaps Naltrexone for both opioid addiction and alcoholism. Both medicines are being used by community addiction specialists and are proven to be helpful in stabilizing the addict and reducing substance use. Initiating the use of such medications with incarcerated persons is being done in other states, such as Maine, Rhode Island and Maryland, which are providing these medications for select jail populations to prevent overdose on release and increase the likelihood of transitioning to community recovery programs.

JAIL DIVERSION

When addiction experts were asked about alternatives to jail placement for lower-level, substance-abusing arrestees, several agreed that finding alternatives to the criminal justice system would be beneficial, especially for some young adults who are not so criminally minded. Several experts interviewed spoke highly of the County's Adult Drug Court, but also liked the idea of exploring ways to divert arrestees before entering the criminal justice system.

To that end, the Grand Jury learned of a new, pre-booking program called the Law Enforcement Assisted Diversion program (LEAD) which has been operating in Seattle, Washington since 2011 (*New York Times*, October 25, 2016) and more recently implemented in other cities across the country. This police-led diversion program enables the arresting officer to divert the drug-offending arrestee into the care of a case manager, drug treatment service, residential substance abuse program, or other social service. Studies have found that LEAD participants were 58% less likely to be rearrested than non-participants. This sort of diversion is seen to enhance motivation, change circumstances, and perhaps alter a life's course. And it keeps a lifetime blemish off the person's record, an arrest record that can significantly reduce employment and training options in the person's future. Implementation of LEAD pilot programs in California has been approved (June 2016) and codified in the Penal Code (Sections 1001.85-1001.88), with grants administered through the Board of State and Community Corrections[3]. The decision to implement this type of program rests with the law enforcement agency (city police or county sheriff) and its governing body (city council or board of supervisors).

HOMELESS SHELTER

For the past decade, the DAS has reported on the Homeless Shelter's intention to develop two or three detox beds. The Grand Jury inquired into the status of this and learned that there would be space available in the new Homeless Services Center (HSC) when completed next year for two detox beds. The HSC Board representative, however, indicated that the HSC does not anticipate having the resources to actually administer such beds and would need a treatment provider to deliver the requisite detox services. This creates numerous challenges including the high staffing costs for only two detox treatment beds if the HSC is unable to provide some or most of the 24/7 coverage required of a licensed residential treatment service. The Grand Jury learned of another option available to the County, one which is currently being used at the Good Samaritan Shelter's drug and alcohol detox program in Santa Maria. This program utilizes what appear to be on-site outpatient service providers to deliver the treatment detox services for program participants residing in the facility's "acute care" detox beds.

[3] Note: Applications for LEAD pilot program grants authorized by this legislation were due by February 1, 2017.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

The County is planning to make a significant improvement in this area with a program called the Drug Medi-Cal Organized Delivery System (DMC-ODS). Its implementation plan drafted in July 2016 and approved by the County Board of Supervisors in August 2016, lays out a very ambitious and comprehensive delivery system to expand county drug and alcohol services and better meet the increasing need for substance abuse treatment. Consistent with national standards, this plan describes a managed care approach and targets those receiving Medicaid under the Affordable Care Act. In fact, the funding that underlies the plan derives from a federal waiver granted to California on its implementation of Medicaid (i.e., Medi-Cal) services. Obviously in these political times, both the waiver and allocation of Medicaid dollars are at risk for reduction.

Final approvals for the County's implementation plan by the Federal Centers for Medicaid and Medicare Services and the California Department of Health Care Services were received in March 2017. Partial roll out has begun but absent confirmation of its Fiscal Plan and final approval by the Board of Supervisors (expected by July 2017), the hiring of new clinicians and support staff for full activation has been delayed. When this plan is fully implemented, there will be a significant change in how County drug and alcohol services are funded. Previously, 60% of service participants had been on sliding fee and 40% on Medi-Cal; with implementation, over 85% will be Medi-Cal and less than 15% sliding fee. The plan's target population is the estimated 4,100 to 5,600 Medi-Cal recipients in the County who suffer from substance-use disorders.

Treatment services are required to increase significantly under this plan. Services must include withdrawal management/detox, residential services, intensive outpatient, outpatient, opioid treatment, recovery services, case management, and physician consultation, plus a toll-free 24/7 access phone line. Optional services encompass medication assisted treatment, recovery residences, and telehealth (video-mediated service provision). Without the federal waiver, Medi-Cal reimburses for only three services: outpatient, opioid treatment, and residential treatment for pregnant women and their children. Though the Grand Jury has not seen a copy of the Fiscal Plan which sets fees for each service, it assumes that activating the plan will allow the County to

receive fee-for-service reimbursements for the eight required services and perhaps some of the optional ones. With these added billable services, the County's fiscal resources in support of drug and alcohol treatment will improve substantially.

Coordinated services under this plan are provided according to the client's assessed level of care, based on criteria established by the American Society of Addiction Medicine (ASAM). Four levels are described. Detox services are required at each level as shown in the chart below.

ASAM Levels of Care for Withdrawal Management (Detox)

Level	Withdrawal Management	Description
1 – Outpatient[4]	Ambulatory detox without extended on-site monitoring	Mild withdrawal with daily or less outpatient supervision
2 - Intensive Outpatient[5]	Ambulatory detox with extended on-site monitoring	Moderate withdrawal with daily support and supervision
3 - Residential Treatment	3.2 Clinically managed residential detox 3.7 Medically monitored inpatient detox	Moderate withdrawal but needs 24 hour support Severe withdrawal, needs 24 hour nursing visits
4 – Inpatient	Medically managed intensive inpatient detox	Severe and unstable withdrawal, needs hospital care with daily physician contact

The plan commits the County to providing only outpatient detox under Level 1, with the other detox levels being provided through as-needed contracts. Residential detox treatment services are to be provided through out-of-county providers. Within three years, the plan indicates a decision will be made on whether local residential treatment services are necessary and must be developed within the County.

CONCLUSIONS

The Grand Jury completed an extensive investigation into the history, need, and future plans for residential detox services in San Luis Obispo County. This need has been apparent since 1982

[4] Outpatient—less than nine hours of service per week for adults, less than six for youth
[5] Intensive Outpatient—nine or more hours of service per week for adults, more than six for youth

when the detox unit at General Hospital closed its doors. The addition of the Haven last year reduces the need for those who can afford or have private insurance to cover the high costs. For those less fortunate, the county jail remains as a de facto detox facility and it is not an option for most residents in need. Addicts admitted to the jail experience services that are less than optimal. Jail staff and service providers have identified areas for improvement. Though medicines are used for short-term withdrawal management, the standard medication assisted treatments for opioid addiction are rarely employed at the jail. And, some substance-abusing inmates are considered as simply misplaced in the jail setting. As an alternative, a police-led, pre-booking diversion program (LEAD) was identified as a way to better serve some lower-level drug and alcohol offenders, including residential treatment when needed. Coincidentally, space for alternative programs or repurposing has become available on the grounds of the jail with the relocation of female honor-farm participants to the new women's jail. For the County's homeless whose addiction rates run very high, the long-planned detox beds at the soon-to-be-completed Homeless Services Center remain possible but appear to lack a clear plan. And lastly, the Grand Jury notes the likely positive impact that the County's DMC-ODC Implementation Plan will have on detoxification services, if that plan comes to fruition.

FINDINGS

F1. Available and affordable residential detox services are necessary for delivering comprehensive substance abuse treatment in San Luis Obispo County.

F2. The opening of the Haven provides needed detox services for County residents who are privately insured or can afford the high costs.

F3. There are no residential detox services available in the County for those with limited financial resources or insurance through Medi-Cal or Medicare.

F4. The County Jail provides physical detox to newly admitted inmates but fails to provide the additional psychological and social treatments and supportive environment essential for the first phase of addiction treatment: detox-stabilization.

F5. There are some arrestees currently booked in the County Jail who would be more effectively served by a diversion program, like Law Enforcement Assisted Diversion, and/or receiving treatment in a residential substance-abuse facility.

F6. There is a lack of integration in how medical and drug/alcohol services are provided at the County Jail.

F7. The use of medication-assisted approaches for detox and addiction treatment at the County Jail is limited while other jurisdictions have been able to provide such treatments.

F8. Logistical and environmental challenges at the County Jail make delivery of drug and alcohol treatment services difficult and inefficient due to placement of inmates with substance use disorders.

F9. With the opening of the women's jail, there is unused space in the honor farm which presents an opportunity for alternative program development.

F10. The homeless shelter has no clear plan as to how it will provide its long-anticipated detox beds/service.

RECOMMENDATIONS

R1. The County Health Agency's Drug and Alcohol Services should resume its concentrated efforts to develop a residential detox service in the County to serve its Medi-Cal and less financially able citizens.

R2. The Board of Supervisors should direct the Sheriff and the Health Agency to evaluate the feasibility of and approach to repurposing vacated buildings within the County Jail's honor farm as a residential detox service. A final report on the feasibility and if indicated the specific steps

required to convert this housing to a substance-abuse residential and/or treatment facility should be completed by June 2018.

R3. The County Health Agency's Drug and Alcohol Services should expand its County Jail programs, including individual and group counseling, to cover inmates who go through withdrawal protocols regardless of AB 109 status.

R4. The County Jail should revise inmate classification and cell assignment to take into account the inmate's substance abuse treatment needs and interest in such when determining cell placement.

R5. The County Jail should house inmates interested and/or involved in drug and alcohol services in such a way as to create groups of addiction-treatment participants (e.g., units or pods) that allow for efficient delivery of treatment services; this includes separation from other inmates who interfere or disrupt treatment participation.

R6. The County Health Agency and Sheriff should integrate the functions of the jail's medical and drug and alcohol service providers by locating their offices in close proximity and requiring coordinated care for inmates with substance use disorders.

R7. The County Health Agency should pilot the usage of medication-assisted treatments, i.e., Buprenorphine and Naltrexone, with a select population of opioid and alcohol addicts at the County Jail.

R8. The Board of Supervisors should evaluate the Law Enforcement Assisted Diversion program or a similar pre-booking substance abuse diversion for County implementation as a means of motivating and engaging young adult arrestees who are assessed to be primarily substance abusers and not criminally oriented. A written evaluation by the County Administrative Officer should be reviewed at a meeting of Board of Supervisors by June 2018.

R9. The San Luis Obispo City Council should evaluate the Law Enforcement Assisted Diversion program or a similar pre-booking substance abuse diversion for City implementation as a means of motivating and engaging young adult arrestees who are assessed to be primarily substance abusers and not criminally oriented. A written evaluation by the City Manager should be reviewed at a meeting of the San Luis Obispo City Council, by June 2018.

R10. The County Health Agency should direct its Drug and Alcohol Services to work with the board of the homeless shelter to develop a plan for operationalizing two detox beds in the yet-to-be-built Homeless Services Center, which could entail the DAS providing onsite outpatient detox services if other treatment options are not viable. This plan is to be developed prior to the opening of the center or by June 2018.

REQUIRED RESPONSES

The County Health Agency's Drug and Alcohol Services is required to respond to Findings F1, F2, F3, F4, F5, F6, F8, and F10.

The County Health Agency's Health Care Services Division is required to respond to Findings F5, F6, and F7

The County Health Agency is required to respond to Recommendations R1, R3, R6, R7, and R10.

The Sheriff is required to respond to Findings F4, F8, and F9 and Recommendations R4, R5, and R6.

The Board of Supervisors is required to respond to Recommendations R2 and R8.

The San Luis Obispo City Council is required to respond to Recommendation R9.

The responses shall be submitted to the Presiding Judge of the San Luis Obispo County Superior Court. Please provide a paper copy and an electronic version of all responses to the Grand Jury.

Presiding Judge	Grand Jury
Presiding Judge Barry T. LaBarbera Superior Court of California 1035 Palm Street Room 355 San Luis Obispo, CA 93408	San Luis Obispo County Grand Jury P.O. Box 4910 San Luis Obispo, CA 93403

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