

The Chronic Inebriate Problem in Anchorage
Brief Overview
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TABLE OF CONTENTS

Table of Contents.....	1
Preface	2
The Chronic Inebriate Problem	2
Alaska Statute Title 47	3
The Community Service Patrol	3
The Transfer Station	3
The Cost.....	4
Pathways to Sobriety II.....	4
The Value	5
The Challenges	5
Conclusion.....	6
Enclosure 1: Pathways to Sobriety Abstract.....	8
Enclosure 2: Scope of Work, Pre-Development Contract	9
(Detox & Treatment in Anchorage)	

PREFACE

The intention of this report is to provide a comprehensive “snapshot” of what the Municipality of Anchorage (in particular the Department of Health & Human Services (DHHS) and the Anchorage Fire Department (AFD))¹ is doing to address the core population of chronic inebriates in and around Anchorage. It will address gaps, shortfalls, and general challenges as they apply to service delivery to this population. However, this report does *not* attempt to lay out anything resembling a long range global strategy to end chronic drug and alcohol abuse.

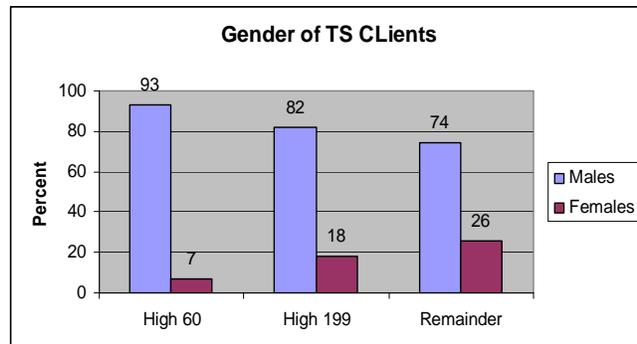
The Community Service Patrol & Transfer Station (CSP-TS) had its beginnings some 20 years ago in Anchorage. It has evolved through a number of operators and benefited from new collateral outreach and treatment programs designed to help individuals escape from the revolving door and enabling aspect of the Transfer Station, or sleep-off center. During this period many working groups, committees, town hall meetings, professional studies, blue ribbon panels, and at least one Mayor’s Task Force have grappled with the issue. To provide clarity and perspective, we include both current and some retrospective information as it applies to the chronic public inebriate problem.

THE CHRONIC INEBRIATE PROBLEM

In 1978, the Kelso Study put the homeless population of Anchorage between 500 and 700 people. It estimated that approximately 100 of these were “chronic public inebriates.” A Blue Ribbon Panel in 1980, appointed by then Mayor Tom Fink, described the problem of public inebriates as “intolerable.” It called for more aggressive law enforcement, and a process to help reduce the visibility of the problem in Anchorage. The panel also recommended that the services provided should be “minimal and humanitarian”, and that treatment opportunities should be available to those who want them.

Current estimates put the serious chronic public inebriate population at 200 to 250 individuals. A UAA/Behavioral Health Research Services (UAA/BHRS) study (August, 2005) reported that “approximately 150 individuals account[ed] for nearly 60 percent of the total number of visits” to the Transfer Station between 1997 and 2005. It is worth noting, based on current Top 10 & Top 50 user lists, that the “serious” number is more like 100 - 150 individuals who account for that 60 percent. While the exact number remains a moving target, the current data makes it clear that this issue follows a classic power law distribution curve as it applies to human behavior. Simply put, a very small portion of the population engages in the behavior a lot while the majority do it infrequently if at all. This small number consumes public resources in an extremely disproportionate manner. It is important to remember that these people are often treatment resistant; they frequently ignore, refuse, or even run away from treatment opportunities that we currently offer.

The UAA report published demographics of CSP-TS clients. Approximately 90 percent are Alaska Native, which is extremely disproportionate relative to the 7 percent of the city’s total population composed of Alaska Natives. Of the top 10 or top 50 users, nearly 100 percent are Alaska Native. Men also account for 70 percent of the clients, and 63 percent are between 35 and 54 years of age.



SERVICE DELIVERY IN ANCHORAGE

The Municipality of Anchorage and their contractor, Purcell Services, operate the CSP-TS under the authority of Alaska Statute Title 47.

¹ The AFD manages the Community Service Patrol/Transfer Station contract with Purcell Services.

Alaska Statute Title 47

Title 47 authorizes Protective Custody Holds (PCH) for individuals who are a danger to themselves or others as a result of drug or alcohol use. Initial PCHs are generally less than 12 hours and are the first step in the overall process allowed under Title 47. Longer periods of involuntary commitment, up to several months, are also allowed by the statute. However, despite numerous clients who could benefit from extended commitment, the process is seeing very little use in Anchorage because the process is very complex and the resources, both service and economic, to support it are lacking.

The Community Service Patrol: *(Operated on contract by Purcell Services)*

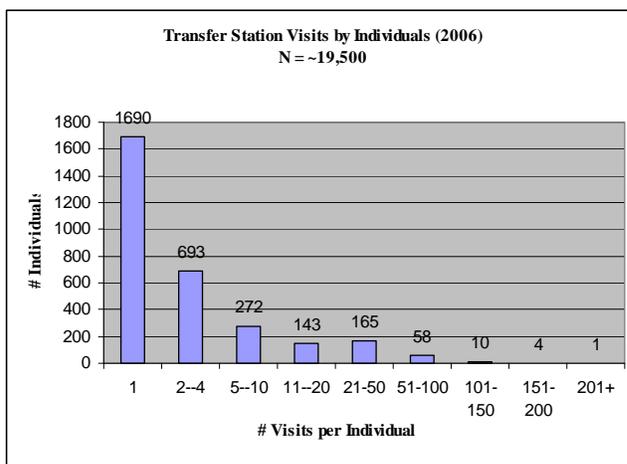


The Community Service Patrol consists of two van shifts daily, staffed by a driver and one EMT. These shifts run from 12:00 PM – 8:00PM and 8:00 PM – 4:00 AM, 7 days a week. During winter months an additional van shift is added to accommodate the significant increase in admissions brought on by the harsh weather conditions. This additional shift runs from 6:00 PM – 2:00 AM from October 1 to March 31. Keep in mind that this additional shift is always “contingent on the availability of funding”. The vans operate in the downtown/midtown area and account for the predominance of all the admissions to the Transfer Station. (Police transports and walk-ins provide other admissions.) The vans are also used, on a limited basis, to deliver clients to

detox and treatment services. This is consistent with the ongoing contractual partnership with the DHHS and Anchorage Community Mental Health.

The Transfer Station: *(Operated on contract by Purcell Services)*

The Transfer Station (TS) is located in the Anchorage Jail Complex and provides a safe and monitored environment for the clients. The TS is open 24 hours a day, 7 days a week, 365 days a year. A minimum of three staff, one of which is an EMT, are on duty at all times. To maintain a staff to client ratio of 10:1, this basic staffing allows for a maximum of 30 clients present at any one time. When that number exceeds 30, additional staff must be added. Clients are checked every 30 minutes to assess their physical condition throughout their stay at the TS.



In 2005 and 2006 there were just over 19,500 admits to the TS. A recent UAA/BHRS study identifies an alarming trend with respect to admits. It projects that, at the current rate of increase, admits may reach 30,000 per year by 2010. Twenty thousand (20,000) admits is an average of 55 per day; 30,000 admits equates to 83 per day! In addition, these numbers were calculated using a 24-hour period, but the reality is that the majority of clients arrive between the hours of 6:00 PM and 6:00 AM, with peak numbers somewhere near the middle of that timeframe.

We are currently seeing peaks of 40+ all too often. With the onset of winter those peaks will go even higher (peaks of 75-80 are not uncommon in the

winter). Current policies and procedures require a staff to client ratio of 10:1. As stated above, there are normally three (3) staff members present during each shift so when more than 30 individuals are present additional staff must be provided. That additional staff all too often comes from pulling the van off the streets and moving those staff into the Transfer Station. Removing the van from the streets exacerbates an already difficult burden on other community resources.

CSP-TS Costs

The current cost for operating the CSP-TS is just over \$1.34M for the contract year April 1, 2007 through March 31, 2008². The Municipal Operating Budget provides approximately 80% of the overall operating budget for the CSP-TS, with the balance coming from various grant sources. This means someone is always chasing additional funds to backfill the grants and avoid a service interruption.

Pathways to Sobriety II

Pathways to Sobriety (hereafter called *Pathways*) provides outreach and case management services to clients wishing to get clean and sober. An abstract of this program is included with this report (Enclosure 1). *Pathways* presently serves more than 100 clients in various stages of detoxification, treatment, residential, and transitional safe housing. The program also provides for a very comprehensive data tracking system for the clients known as Service Point.

Pathways is directly responsible for many of the increased services at the CSP-TS, as well as numerous other collateral contracts with service providers (some as far away as Wasilla). As the name implies, the program provides a pathway out of the revolving door pattern of life too often found in the sleep-off environment. *Pathways* demonstrates the desire and commitment by DHHS and its partners to improve the CSP-TS to a point where services and alternatives are easily available to the clients ready to begin the long process of recovery.

Furthermore, *Pathways* is responsive to recommendations from the 1980 Mayor's Blue Ribbon Panel, and is quite consistent with several of the recommendations set forth in the August 31, 2005 report from UAA/BHRS.

DISCUSSION

The basic life support aspect of the CSP-TS program is paramount. The service, and Alaska Title 47, both exist to address the fact that this is a very vulnerable and fragile population of people who cannot fend for themselves while they suffer the devastating affects of drug and alcohol addiction. It is also clearly a population which has impacted Anchorage for decades. Absent a well organized, and robust program that contains all the necessary elements of housing, detox, treatment, and cultural awareness, this issue will be around for decades to come. The Alaska Supreme Court was compelled to point out that there is an inherent responsibility by communities to provide for the safety and welfare of this vulnerable population.

2006 Community Costs	
CSP/Transfer Station	\$1,342,738 ³
<i>Pathways to Sobriety</i>	\$651,941 ⁴
Anchorage Police Department	\$424,098 ⁵
Ambulance Services (AFD)	\$267,000 ⁶
Hospitals	\$1,206,643 ⁷
DOC	\$96,186 ⁸
Total	\$3,988,606

Another pragmatic way of looking at the value of the CSP-TS service is purely economic. The Municipality of Anchorage, through its contractor, is providing this service in the most economical way possible. CSP-TS will handle approximately 20,000 admits this contract year (07/08) for a total contract cost of \$1.34M. That results in an overall cost per admit of approximately \$67.

This is a very difficult and often times unpleasant service to provide. And it is not a pretty problem to observe. One recommendation of the 1980 Blue Ribbon Panel was to find ways to lesson the visibility of the problem in downtown Anchorage. We are keeping visibility to a minimum while providing compassionate service to those in need and offering a way out to those desiring to take it.

Sources: 3 & 4 - DHHS; 5 - APD; 6 - AFD for # responses to TS x \$1000 [est. cost per trip]; 7 - # transports to the emergency room by AFD + CSP x \$1811 (the average charge for 26 ER visits by 2 clients to Providence Hospital in 2006); 8 - # releases from TS to jail + DOC # for non-crimis x \$121.60/day.

Note: This (\$1.34M) does not include the money that supports the physical infrastructure, or maintenance (that comes from other municipal funding resources). Nor does it include the additional funding necessary to support collateral programs such as *Pathways to Sobriety* that are provided in and around the CSP-TS

Challenges

The complicating factors facing the CSP-TS are many, and none is more perplexing than the basic problem itself: How do you stop the increasing number of people who are joining the ranks of the chronic public inebriate? And how do you address the well known “core” group who seems to have little desire or motivation to engage in treatment and services and get themselves out of the cycle?

We struggle everyday to simply keep this problem from spilling over into the mainstream services of the community. To that end we have been marginally successful at best. While we do a good job with Basic Life Support (BLS) and we do offer exit strategies for those wishing to seize the opportunity, we see little impact on overall numbers (admits).

The fact is, this issue **IS** spilling over to other basic emergency services, and the costs, while often difficult to compute, are staggering. Serious medical conditions (diabetes, heart disease, infections etc.) and alarmingly high BRAC (Breath Alcohol Content) levels in the clients are increasing, which increases the number of trips to hospital emergency rooms necessary for medical clearances prior to admission to the TS. Emergency room transports are not only time consuming for the drivers, but are extraordinarily expensive for the medical facilities. The chances of their recovering those costs are minimal at best.

The capacity of the CSP-TS is limited by available space and there is no ability to expand at the present location. Peaks of 75 and above during the winter season come seriously close to exceeding capacity, both of physical space and staff.

Client and staff safety continues to be a major priority and concern. We are seeing an alarming upward trend of client-on-staff and client-on-client assaults. Steps have been taken to upgrade our surveillance system and to add barriers between staff and clients wherever possible. Even with these improvements client and staff safety remains a very serious issue.

Staffing levels and van schedules also need revision and expansion. While the Transfer Station itself is open 24/7/365 the CSP vans are not. Essentially, during the summer there is a van on the streets only between 12:00 Noon and 8:00 PM and 8:00 PM to 4:00 AM. If funding permits an additional van and one additional staff person in the TS are added during the winter months. However, even with these additional resources we still face increased client numbers that exceed our staffing ratios. As stated above, the CSP van is then pulled from the streets to provide additional staff in the Transfer Station.

No discussion of challenges would be complete without noting that any program requiring grant funding to meet operating expenses continually faces funding shortfalls and the specter of reduced services. Given that the federal pipeline is slowing down and new funding is increasingly difficult to obtain, it has become a question of ‘when,’ not ‘if’ this happens to CSP-TS.

Finally, we must start thinking “outside the box” with respect to the extremely treatment resistive “core” population of serious chronic public inebriates. Whether we like it or not, the current system is not having any appreciable impact on this group. They continue present their problems in a very visible manner and we continue to have to deal with it. Of course we have both a moral and legal responsibility to help them. But we also have an overwhelming responsibility to find a better, and quite frankly, more economical way to do it.

CONCLUSION

We must continue to look for ways to do more than just keep this problem in check. Numerous communities across the country face this exact problem. Many have elected to venture “outside the box” with their thinking and have moved in directions consistent with the facts that surround this issue. At the very least we must accept these individuals “as is, where is.” These people are chronic inebriates who have, in many cases, been intoxicated 24/7 for years. We have to understand that repeated intermediate failures are part of their long road to success, and continue to provide services and treatment opportunities to them through our programs. The silver lining to keep in mind is by finding a way to remove the top 75 - 100 users from our community mainstream emergency services we could reduce the intake numbers at the CSP-TS by more than 50%.

Minneapolis, MN for example, has established a Housing First facility for late stage chronic inebriates. It's goal is to "minimize the negative consequences of the residents drinking patterns, while providing a stable, and culturally appropriate living environment which encourages a reduction in alcohol consumption." Seattle, WA, also has recently opened a facility of this nature.

The data from Minneapolis indicate that the cost of providing safe, secure, and monitored housing for their core group was still far cheaper than keeping them in the continuous revolving door of mainstream emergency services. The bottom line in Anchorage is that the core group of chronic public inebriates is coming dangerously close to overpowering our key emergency services. Police and Fire are finding themselves burdened by call after call directly related to a chronic public inebriate. Not only are emergency services being impacted but the overall quality of life for our citizens in many areas of the community are suffering.

While great strides have been made and a well defined plan developed to end homelessness in Anchorage, a real comprehensive plan to end the chronic public inebriate problem has remained elusive. The CSP-TS and its collateral programs remains the cornerstone of our efforts within the Municipality of Anchorage.

From a long range perspective the Municipality of Anchorage (DHHS), CITC, and the Alaska Mental Health Trust are currently engaged in a pre-development study designed to clearly define what our system should look like in the years ahead. The study will explore current processes and availabilities, identify gaps and shortfalls, and try to paint a comprehensive picture of what emergency alcohol services within Anchorage should look like. This study is very timely, especially considering that our immediate future will involve a significant loss in services due to the impending closure of Salvation Army's Clitheroe Center. This closure will remove approximately 60 treatment beds from a system that is already operating with marginal resources.

Finally, from a short term perspective our handicap is a basic matter of economics. Data over the past few years points, undeniably, to the fact that the serial inebriate issue in Anchorage is not getting any better and will probably get worse. Despite continued success in programs like Pathways II, the "core" group remains mostly unchanged. In-migration continues to add to the total numbers. This issue continues to spill over onto other core emergency services and, needless to say, is having a negative impact. To deal with this trend in an immediate sense we must find ways to increase our services, and it should come as no surprise that doing so will require additional funds. We will need approximately **\$35,000 per month**, above \$1.34 M that is currently being expended, in order to bring the CSP/TS to a robust 24/7 operation. This additional funding is also necessary if we are to ever consider expanding the regular coverage area beyond downtown and midtown.

We have tried to keep this report factual and to the point. Dealing with this problem is not pretty, it is not fun, and it is not cheap. It is however, necessary and it is our inherent moral and legal responsibility.

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Enclosure 1:

Pathways to Sobriety II Abstract

The Municipality of Anchorage, Department of Health and Human Services, in July 2004, received a three-year grant to address the homeless with chronic alcohol and drug abuse issues. This Bureau of Justice money was used, in part, to fund the Pathways to Sobriety II project. The purpose of the project is to provide a response to illegal drug and alcohol use by homeless individuals, including veterans and those with a dual diagnosis. This project continues the previous Pathways to Sobriety I which has been funded by SAMHSA since 2002.

This project involves a three-pronged strategy that includes: (1) voluntary engagement; (2) Therapeutic Court and alternative sentencing for persons who are dually diagnosed, or who are experiencing alcohol and/or drug abuse; and (3) involuntary commitment for persons who are a danger to themselves or others.

Toward implementing these strategies, Case Managers in the program: (1) identify and assess each individual's need, mental health status and substance use issues, (2) provide outreach and engagement to establish working relationship and meet clients' immediate needs and (3) integrate and link service provision to substance and mental health treatment, social and income support, housing, legal and medical assistance and rehabilitation/employment.

The strategy incorporates case management services at the city's sobering center and approximately 50 homeless persons are served each year. This project also enhances core emergency services to assist chronic public inebriates through outreach services on the streets. In 2005 the program provided 14,552 safe transports, and 19,469 admissions for critical care in the sobering center.

Current intervention is primarily through the city's Emergency Alcohol Service System and Anchorage Police Department. The target population is chronic public inebriates, all of whom have been adjudicated for miscellaneous misdemeanor crimes such as assault, trespassing, and disorderly conduct. In addition, as a preventative measure and secondary focus, persons who have minimal contact with the Emergency Service System will be provided with information, referral, and case management services. It is estimated that one-third of the target population are homeless veterans. This project provides a constellation of services that include.

- ❖ Referral and linkage to Veteran's services
- ❖ Detoxification services
- ❖ Coordination with Therapeutic (drug, alcohol, mental health) Court
- ❖ Access to substance abuse treatment programs
- ❖ Case management services for up to twenty-four months
- ❖ Housing to maintain stability and self-sufficiency

Partners and collaborating agencies for this project include the Municipal Department of Health and Human Services, Anchorage Police Department, Municipal Veterans Affairs Commission and Veteran's services, the Departments of the Army and Air Force, the Alaska Mental Health Trust Authority, Cook Inlet Tribal Council, Inc., South Central Foundation, Anchorage Community Mental Health Services, NANA/Purcell Services, the Alaska Therapeutic Courts, Akeela, Inc., Nugen's Ranch, Salvation Army Clitheroe Center, Alaska Women's Resource Center, SEARHC, Rain Forest Recovery Services, Maniilaq Association, Bean's Café, Brother Frances Shelter, the Department of Corrections, Oxford House and RurAL CAP Homeward Bound.

Enclosure 2:

The following is the Scope of Work (Appendix A) from the Pre-Development contract currently underway. The contractor is presently engaged in meeting with the Stakeholders and collecting preliminary data pertaining to the current state of emergency alcohol services in the Anchorage area.

Appendix A Scope of Work

A municipal facility is scheduled for closure December 31, 2008, due to new federal well water standards and the impending expansion of the Ted Steven's International Airport, resulting in an opportunity to analyze and assess the substance abuse treatment needs of the Anchorage community. As a result, the Municipality of Anchorage, Department of Health and Human Services (DHHS), Cook Inlet Tribal Council (CITC), and the Alaska Mental Health Trust Authority (AMHTA) have recently agreed to work together in pursuit of:

- Planning, funding, and construction of a new facility to house detoxification and treatment services for Anchorage area citizens experiencing alcohol and substance use disorders for whichever service providers successfully compete for future funding; and
- A well-organized campus providing proximity of programs and services for those clients affected by alcohol and substance use disorders through co-location of a cross section of complementary programs and support services designed and built around the well documented value of having these components in the same location.

- I. The Contractor will provide consultation, facilitation, documentation, analysis, and technical writing services to support the Stakeholders in a series of activities required to:
 - A. assess the level and nature of need for social and medical detoxification and treatment of persons experiencing substance use disorders in Anchorage;
 - B. assess the service capacity of the existing program and facility providing detoxification and treatment services in terms of ability to meet existing and future community needs;
 - C. identify, document, and evaluate alternatives for replacing the existing facility and the potential interest in and feasibility of co-locating complementary and related services and facilities on-site with a new detoxification and treatment facility; and
 - D. develop a strategy to help facilitate the acquisition and funding of a new detoxification and treatment facility. This includes identifying co-location of complementary programs and services and other related actions with potential for improving coordination and effectiveness of the associated service system.
- II. Contract work will be performed in three phases as outlined below:
 - A. Phase I – Work Plan Development and Community Organization Engagement
 - i. Within 10 days following execution of the contract (subject to availability of representatives of the Stakeholders), the Contractor will meet with Stakeholders to:
 - a. confirm and document as necessary their desired roles in and contributions to the project; and
 - b. define an initial work plan generally outlining processes, actions and schedules for accomplishing the work of the contract and goals of the Stakeholders.
 - ii. Within 10 working days following the initial meeting with Stakeholders, the Contractor will submit a proposed work plan documenting the agreements reached at the initial project meeting and outlining processes, actions, and schedules for accomplishing the work of the project.
 - iii. Upon acceptance of the work plan by the Stakeholders, the Contractor will, on the schedule defined in the work plan and in conjunction with Stakeholders, begin implementing work plan actions required to inform, engage, and mobilize community organizations and interests whose involvement is essential to completing the project.
 - iv. The Contractor will, in conjunction with the Stakeholders, schedule and convene an initial meeting of Stakeholders and other community organizations and interests to define the nature and extent of involvement of other organizations in the project as well as the actions and information required of community organizations to complete the project; the Contractor will facilitate and document the meeting directed toward defining essential information and necessary actions required of community organizations to complete the project as well as identifying other potential contributions.

- v. The Contractor will coordinate and document monthly meetings of the Stakeholders to facilitate project-related decisions and monitor implementation of project activities, challenges and accomplishments.
- vi. The Contractor will coordinate, facilitate, and document meetings of Stakeholders and other organizations as required by the work plan.
- vii. The Contractor will provide consultation to Stakeholders, recommend and facilitate alterations to the work plan, Stakeholders agreements, and other actions needed to adapt to changing or unforeseen circumstances or events affecting the project or overall goals of the Stakeholders outlined in this contract.

B. Phase II – Assessment of Service Capacity and Need

- i. Within 90 days of execution of the contract, the Contractor will review and document the existing programs, services, and facility requirements of the current service providers and information provided to the Contractor by, DHHS and other relevant entities.
- ii. Within 120 days of execution of the contract, the Contractor will analyze and document, within limits of data made available by current service providers, DHSS, and other relevant entities, the:
 - a. historical and current trends in detoxification and treatment service capacity of current service providers;
 - b. the historical and current need for such services within the Anchorage area;
 - c. the trend and current status in the balance of service capacity and service need;
 - d. demographic, service need, and other relevant characteristics of persons served at the existing service providers;
 - e. a projection of the number, nature, and relative capacities of differing types of detoxification and treatment services required to meet the future detoxification needs of the Anchorage area including:
 - 1. medical and social detoxification capacities, including a determination of what proportion of detoxification beds should be social and what proportion medical detox,
 - 2. inpatient and outpatient treatment capacities, and
 - 3. capacities required for specialized treatment of persons with co-occurring disorders and for other identified special needs populations;
 - f. factors relating to facility, service capacity, or service components historically and/or currently impeding effective use of involuntary commitment under AS 47.37 in the Anchorage area; and
 - g. special considerations of capacity or design required in a new facility to facilitate safe and effective use of involuntary commitment under AS 47.37.

C. Phase III – New Facility and Campus Development

- i. Within 180 days of execution of the contract, the Contractor will, within limitations of cooperation and information provided by the Stakeholders, current service providers, and other community organizations:
 - a. define and document the programmatic functions which must be supported by a new detoxification/treatment facility or campus of facilities;
 - b. define the programmatic requirements with respect to the physical infrastructure which must be met to support these functions;
 - c. identify and document service system changes necessitated as a result of developing the new facility or campus of facilities;
 - d. identify and document opportunities for synergies and service system improvements possible by co-locating adjunct and complementary programs and services on a campus with the new detoxification and treatment facility;
 - e. identify and document other opportunities for collaboration and service system improvements related to development of the new detoxification/treatment facility and campus;
 - f. analyze and document the potential benefits of co-location and other identified system improvements;
 - g. provide an analysis of the level of interest of community organizations and actions required to realize potential benefits of co-location and other identified service improvements; and

- h. define and analyze imperatives of, and potential advantages, benefits, disadvantages, limitations, and feasibility of alternatives for ownership, governance, and operation of the new detoxification/treatment facility and other programs or services potentially co-located on the same campus.
- ii. Within 180 days of execution of the contract, the Contractor will identify a minimum of three (3) potential sources of funding for a new detoxification and treatment facility and actions required to pursue funding from these sources.

III. Deliverables

A. Phase I – Work Plan

- i. Work Plan – within 10 working days following the initial meeting with Stakeholders the Contractor will submit a proposed work plan documenting the agreements reached at the initial project meeting and outlining processes, actions, and schedules for accomplishing the work of the project. The work plan will be provided in an electronic format agreed to by the Stakeholders and the Contractor and delivered via e-mail.
- ii. Meeting Summaries – within 5 working days following a regular monthly meeting of the Stakeholders or a meeting of Stakeholders and other community organizations defined in the work plan, the Contractor will provide participants with a summary of the meeting identifying participants, discussion and action agenda, discussion and action summary. Meeting summaries will be provided in an electronic format agreed upon by Stakeholders and the Contractor and delivered electronically via e-mail.

B. Phase II – Assessment of Service Capacity and Need

- i. Needs Assessment and Service Capacity Report – within 120 days of execution of the contract, the Contractor will submit a report containing information outlined in Appendix A, Section II. B. The report will be provided in an agreed upon electronic format along with 4 hard copies.

C. Phase III – New Facility and Campus Development

- i. Comprehensive Strategy Report – within 180 days of execution of the contract, the Contractor will provide a Final Strategy Report summarizing information developed in and required by all three project phases as outlined in Appendix A sections I.-III. The report will be provided in an agreed upon electronic format along with 4 hard copies. The Comprehensive Strategy Report will concisely explain:
 - a. historical, current and projected service capacities and needs;
 - b. detoxification/treatment facility(ies) required to meet future needs;
 - c. potential synergies and service improvements possible through development of a new detoxification/treatment facility and co-locating or otherwise improving coordination of complementary and related services;
 - d. actions required to pursue development of new facilities and service improvements, including potential funding sources; and
 - e. alternatives for facility and service ownership, governance, and operation.

IV. Alterations in Scheduling of Work and Deliverables

- A. Completion of the project within the schedule outlined in this contract is dependent on the involvement and cooperation of not only the Stakeholders and the Contractor, but other community organizations.
- B. Adjustments in the schedule of work and deliverables may be necessitated by lack of information, lack of timely cooperation, or lack of availability of community organizations.
- C. Neither the Contractor nor the Stakeholders shall be liable for delays or necessary adjustments in work schedule or deliverables necessitated by action or inaction of community organizations or interest groups which are beyond the control of the Contractor and the Stakeholders.

- D. Both Stakeholders and the Contractor agree to timely inform each other of problems obtaining cooperation, information or participation of community organizations and interest groups which may affect the schedule of work or deliverables.
- E. Stakeholders and the Contractor will negotiate alterations in schedule of work and deliverables as necessary based on factors beyond their control.

Source: DHHS/CSP-TS data base.