Chronic Public Intoxication: Considerations for implementing and running a sobering center

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Agenda

- What is a “sobering center”?
- Programs in the US
- San Francisco Sobering Center
- Developing a sobering center
- Data & evaluation
- Next steps
What is a “sobering center”?

- Public facility where individuals acutely intoxicated on alcohol can safely recover from acute intoxication.
- Often utilized as alternative to jail and emergency departments.
- Excludes:
  - longer-term (>2 nights) housing, medical detoxification and residential substance abuse treatment centers
  - private-pay centers unless affiliated with a sobering center

*Definition offered by: Sobering Center Collaborative*

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Sobering: programs nationally
Sobering Center Surveys

- Three surveys conducted in 2013 by different parties

Goals:
- Confirm existing sobering programs
- Start dialogue regarding common language, goals
- Investigate best practices
- Begin dialogue regarding standards of care and evaluation, including data collection

Confirmed Sobering Centers

- Dutch Shisler, Seattle WA
- Central City Concern, Portland OR
- San Francisco Sobering Center, CA
- Cherry Hill Sobering Center, Alameda County
- Santa Barbara Community Sobering Center, CA
- Yukon Kuskokwin Sobering Center, Bethel AK
- VOA Sobering Center, San Diego CA
- CASPAR, Cambridge MA
- Public Safety Unit, San Antonio TX
- Houston Recovery Center, TX
Sobering Centers

Similarities between confirmed sobering centers:

- Most financed by local government (city or county)
  - Bethel AK (state-funded)
  - Santa Barbara (police department/local hospital)
- No security on site
  - Houston TX the exception
- Care for adults aged 18 and older
- All centers take clients from police
Typical Referral Sources

- Police
- Ambulance/ Emergency medical services
- Emergency departments
- Outreach vans – including emergency medical response vans and homeless outreach services
- Walk-in/ self-referral

Referral Sources

<table>
<thead>
<tr>
<th>Police referrals ONLY</th>
<th>Jail &amp; ED Diversion/ Relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteers of America Sobering Center (San Diego)</td>
<td>Via EDs or EMS-Response Vans</td>
</tr>
<tr>
<td>Collaborates with Serial Inebriate Program (SIP)</td>
<td>Dutch Shisler Service Center (Seattle WA)</td>
</tr>
<tr>
<td>Houston Center for Sobriety (TX)</td>
<td>Cherry Hill Sobering Center (Alameda CA)</td>
</tr>
<tr>
<td>Santa Barbara Community Sobering Center (CA)</td>
<td>CASPAR Emergency Services Center (Cambridge MA)</td>
</tr>
</tbody>
</table>

- Yukon Kuskokwim (Bethel AK)
- Central City Concern (Portland OR)
- San Francisco Sobering Center (CA)*
  - "Direct from ambulance also"
San Francisco Sobering Center

San Francisco Sobering Center: History

Why a Sobering Center in SF?

- **ED diversion** rates increase 10-fold
- Individuals with chronic public intoxication >20% of all ED visits
- **One-third ambulance** transports for homeless alcoholics.

July 2003: Sobering Center Pilot Project

"McMillan Stabilization" established by Department of Public Health in collaboration with non-profit Community Awareness & Treatment Services (CATS)

Goals of SF Sobering Center

Mission Statement

- The mission of the San Francisco Sobering Center is to provide safe, short-term sobering and care coordination for acutely intoxicated adults in San Francisco.

Main focuses of the SF Sobering Center:

- Reduce inappropriate use of emergency department resources.
- Decrease use of ambulance transports for acutely intoxicated individuals.
- Increase care coordination for chronic inebriates.
Surge Services

Surge Services
Developing a Sobering Center

Some initial considerations:

- **Focus:** ED, jail, homeless health, public health?
- **Clients:** High utilizers/chronic versus Binge drinkers?
- **Substance:** Alcohol-only versus Other drugs?
- **Stakeholders and collaborating partners?**
- **Budget:** Financing options
Focus of sobering program

Where’s the relief or help needed?
- Municipal jail/ police department
- Emergency department(s)
- Public health/Safety (i.e. exposure, assaults, trauma)
- Shelters (i.e. Overcrowding, lack of safe oversight, no 24/7 access)
- Homeless healthcare services
- Connection to substance abuse services

....All the above goes directly into staffing and programmatic configuration.

Focus: Staffing

Staffing models vary:
- Local, specifically trained staff (front-line staff certification or licenses not necessarily required)
- EMT-only or EMT/Paramedic
- Registered Nurses or Licensed Vocational (Practical) Nurse

Additional staff may include:
- Substance abuse specialists; medical assistants; nursing assistants; community health workers; peer level staffing
- Volunteer staff of all levels
- Security
Staffing: SF Sobering Center

- Started with LVN-only
- Converted to RN/MEA staffing model
- Ambulance diversion
- Ability to provide medication management
- Advanced wound care
- 24/7 response to Medical Respite emergencies

LVN: Licensed vocational nurse; RN: Registered Nurse; MEA: Medical assistant

Target Clientele

- Individuals with chronic public intoxication and/or alcohol dependence
- Periodic binge drinkers

Considerations for different populations:
- Connection to services - detox or shelter access options
- Alcohol poisoning versus chronic medical disorders
- Tendency towards violence/ inappropriate behavior
- Comorbid mental illness
Substances

- Alcohol-only
- Alcohol+
- Other drugs – which ones?

Particular considerations:
- Meth/PCP: higher propensity for violence; inability to stay in communal environment
- Opiates/ Heroin: overdose, decreased respirations

Stakeholders

- Emergency medical services
- Municipal jail
- Police/Sheriff departments
- Hospitals
- Homeless healthcare and service providers
- Case management services
- Community: residents, businesses
- City/County administrators
- Supervisors
- Clients themselves
Stakeholders: EMS/ED

- San Francisco: In 2003, little known regarding EMS/ambulance triage to sobering programs
- EMS Diversion Pilot: one-year starting October 2003
  - Developed and evaluated decision tree for triage
  - Evaluated feasibility and safety of ambulance triage directly to sobering versus ED
  - EMS administrators work to alter state-level policy
- Sobering established as Ambulance Destination in August 2005
- Today: Five studies (US and international) published in 2012-2014 regarding ambulance triage to sobering center destination

Stakeholders: Criminal Justice

- To criminalize or no?
- Can you have a sobering center that is non-punitive in a system which criminalizes public intoxication?

San Francisco:
- Public intoxication report: 647-f P.C., misdemeanor
  - Individuals may be cited by officers for public intoxication prior to arriving at sobering. This is separate from the sobering program and does not affect individual stay.
- Citation **not** required for sobering. Most are not cited.
Budgetary Considerations

Are there any billing options for your services?

Any other 24/7 programs with which you can share space/expenses?

Possible funding streams:

- General Fund of city/county/state
- Department of public health
- Police department
- Grants
- County measures/bonds via vote
- Private entities (hospitals, foundations)

Budgetary Considerations

<table>
<thead>
<tr>
<th>Expense Categories</th>
<th>Rent, insurance, utilities, maintenance, janitorial, permits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building</td>
<td>Salaries, benefits, training, security</td>
</tr>
<tr>
<td>Staffing</td>
<td>Vital sign machines, desks, computers, phones, fax</td>
</tr>
<tr>
<td>Equipment</td>
<td>Medical supplies, bedding, nutrition, electrolytes, medications, laundry</td>
</tr>
<tr>
<td>Patient Care</td>
<td>Brochures, office supplies, staff perks, bathroom and kitchen supplies</td>
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</table>
Budgetary Considerations: SF

San Francisco initiated program with one-time grants from:

- Northern & Central California Hospital Council: $400,000
- Private hospitals in SF: ~$400,000 combined
- City & County of SF General Fund

Current:

- Ongoing funding as line item in General Fund budget
- 2013: Received FQHC* status with Medical Respite as satellite to primary care clinic. Billing only NP/PA hours

*FQHC: Federally-qualified health center

Data Collection & Evaluation
Evaluation

Purpose of evaluation
- Service improvement, including expansion
- Continued funding
- New funding streams including grants
- Comparative analysis between sobering programs
- Comparison to alternative (ED/Jail) services

Data to collect:
- Distinct clients: recidivism, visit history
- Demographics: gender, housing status, age, ethnicity
- Admission: referring party, time, day of week
- Health measures: level of intoxication, hypothermia, ambulatory status, cognition
- Incidents: emergencies, injuries, behavior
- Outcome: disposition, referrals made, services provided, length of stay
Measures of Success

PreSobering Identification
- Ability of referring parties to identify appropriate clients
- Referring parties
- Adherence to mission/goals

Admission
- Safe triage process
- Resources for immediate needs
- Protocols
- Appropriate versus inappropriate clients

During Stay
- Identification of medical/psychiatric emergencies
- Services provided
  - Medical care
  - Nutrition
  - Counseling
  - Lice treatment
  - Laundry
  - Warming
  - Clothing donations

Discharge
- Sober versus not sober
- Referrals to services
- Recidivism and high utilization

Measures of Success

No standardized measures between programs at this time

Evaluation of program ability to accomplish:
- Raw numbers of individual clients and encounters
- “Safe sobering”
- Recognition of and treatment provided for higher medical or psychiatric needs
- No new injuries sustained during sobering
- Equivalent or lower cost compared to traditional services

How to measure impact on traditional services after sobering program created?
Best Practices

And barriers from Sobering Programs across the country

Barriers

- “Lack of access to substance abuse services”
- “Not enough supportive housing”
- “Different views [by various community stakeholders] of exactly what is addiction and substance abuse, and how it should be managed”
- “Serving high-risk population without medical staff”
- “Getting word out to community and referring parties about what we can and cannot do”
- “Finding staff willing to work with intoxicated clients”
Best Practices

- **Strong collaborations** with: community support services; case management programs; high-utilizer efforts; referring parties
- **Peer-to-peer** recovery support services
- Introduction of **Serial Inebriate Program** (with police department)
- **Staff training:** motivational interviewing; SBIRT; harm reduction; substance abuse and addiction; trauma informed care
- **Volunteer** program for healthcare providers
- Option for **private/isolation rooms**
- Medications for **withdrawal management** to bridge to detox

Next steps: what is the future for sobering centers?
Sobering Center Collaborative

Group of individuals nationwide interested in furthering the discussion of sobering programs.

Goals include:

- Confirm existing programs
- Determine best practices
- Standards of care
- Data collection recommendations
- Define measures of success for ongoing evaluation
- Evaluate cost-benefit and cost-effectiveness of sobering programs as compared to traditional alternatives
- Explore programmatic connections: Detoxification, respite, shelter, wet housing

Contact Information

For information on sobering centers, or to join our national Sobering Center Collaborative, contact:

- Shannon.smith-bernardin@sfdph.org
- 415-734-4209

Check out our new SF Sobering Center website:

- http://www.sfsoberingcenter.com