Changing the Care Environment For Acute Intoxication:

Giving Clients an Alternative to the Emergency Department and Jail

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10/23/20

1

2

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THE INTERRUPTORS

- Excuse the potential interruption….
- Penelope la Roux
- Olive LunaBella
- Mushi

2

LEARNING OUTCOMES

- Examine operational and care practices at sobering centers in the U.S. in the care of acute intoxication
- Identify best practices and barriers to providing sobering care as an alternative to the ED and jail
- Discuss the feasibility of establishing sobering centers as an alternate care environment throughout the U.S.

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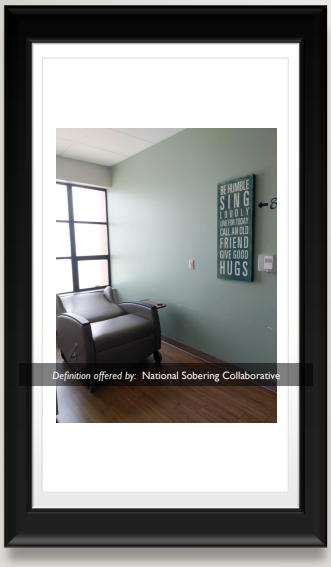
3



WHAT IS A SOBERING CENTER?

- Public facility where individuals with acute intoxication can safely recover from the effects of alcohol and/or drugs
- Over 40 sobering programs nationally
  - Also known as: 'recovery centers' 'sobering-up stations' 'crisis stabilization (if co-located)'
- Goals of sobering care
  - Reduce harms from acute drug and alcohol intoxication
  - Offer alternative to jail/ criminal justice system
  - Relieve emergency departments in the care of acute intoxication
  - Offer targeted interventions informed by evidence-based practice with harm reduction focus

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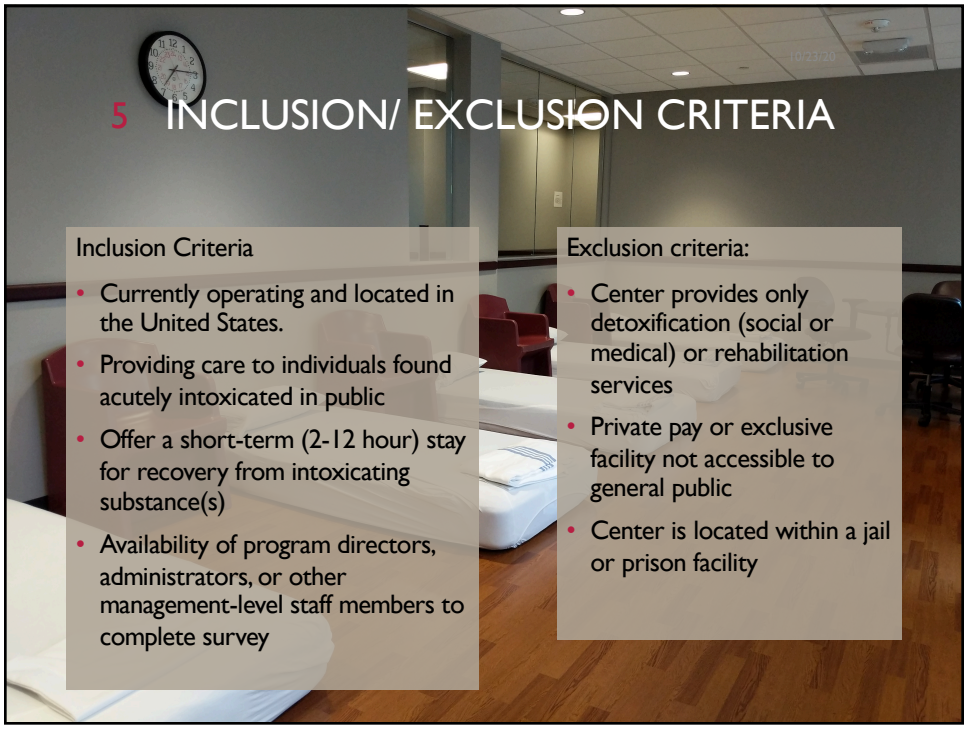
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5 INCLUSION/ EXCLUSION CRITERIA
Inclusion Criteria
• Currently operating and located in the United States.
• Providing care to individuals found acutely intoxicated in public
• Offer a short-term (2-12 hour) stay for recovery from intoxicating substance(s)
• Availability of program directors, administrators, or other management-level staff members to complete survey
Exclusion criteria:
• Center provides only detoxification (social or medical) or rehabilitation services
• Private pay or exclusive facility not accessible to general public
• Center is located within a jail or prison facility

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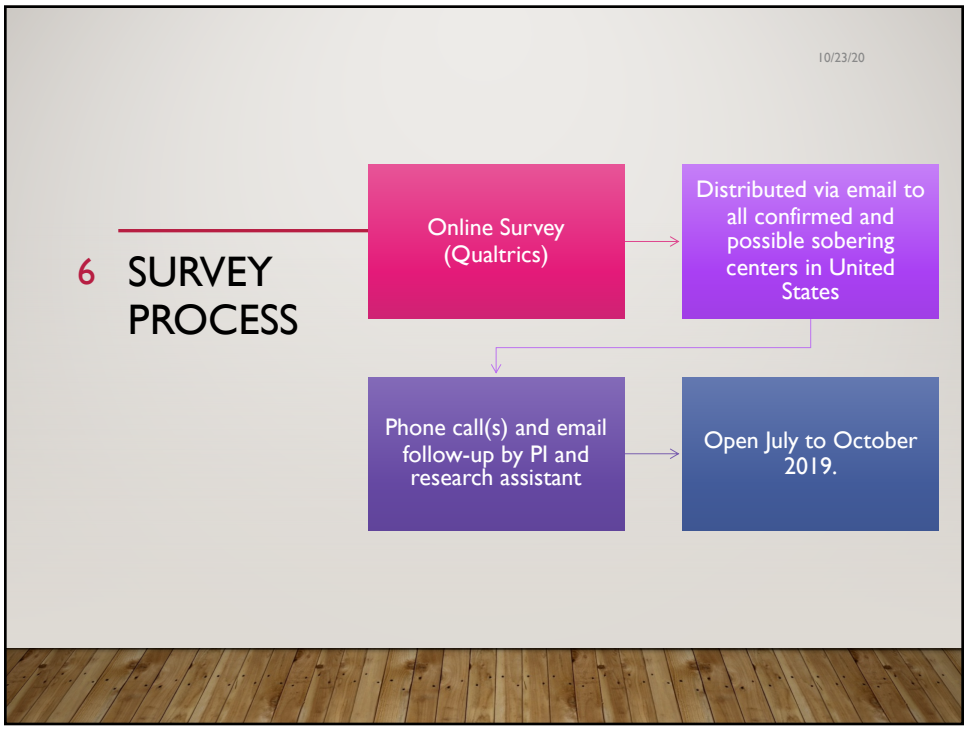
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6 SURVEY PROCESS
Online Survey (Qualtrics)
Distributed via email to all confirmed and possible sobering centers in United States
Phone call(s) and email follow-up by PI and research assistant
Open July to October 2019.

6

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7 RESPONSES

- 53 programs screened – 37 fit inclusion criteria
- 26 Respondees (70% response rate)
- 15 States represented:
  - Alaska, California, Texas, Michigan, Vermont, Maine
  - Oregon, South Carolina, Colorado, Washington, Kansas
  - Maryland, New Mexico, South Dakota, Oklahoma

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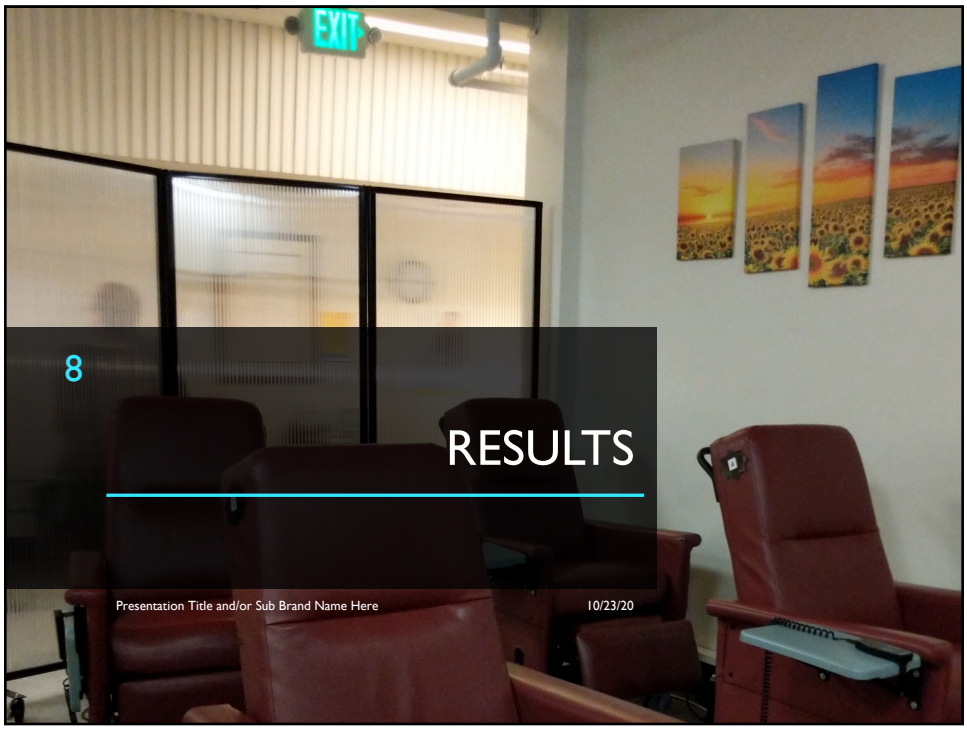

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9 UTILIZATION DATA

- Capacity range: 3 to 84 clients (all but one open 24/7)
- 5,560 – Average number of Encounters in 2018 (n=20)
  - Median 4,680, range 300-22,000
  - 106,000 total encounters in 2018
- 2000: Average number of unduplicated clients (n=21 programs)
  - Total 36,300 clients in 2018
- 7.7 Hours: Average Length of Stay (typical range 4-28 hours)

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10 FUNDING & SUSTAINABILITY

BUDGETS

Range in annual budget (n=20 responses):

- $202,000 up to $4.8 million
  - $200,000 to <$1M: 9 program
  - $1M – $1.9M: 6 programs
  - >$2M or more: 5 programs
- Median budget = $1.165 million

Co-location common

- Including social detox, medical respite, homeless shelter, residential treatment, re-entry services, outpt services, MH crisis stabilization, methadone clinic, homeless outreach team offices

FUNDING SOURCES

13 programs with single funding source:

- City (n=4) or County (n=4)
- State (n=2)
- One each: Grant; Consolidated city-county; Sheriff Department

Combinations! Many… city, county, and state combined.

- Hospitals partially fund 3 different programs

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10

11


Figure II: Types of Paid Staff Working in Sobering Centers
Medical assistant
Psychiatrist
Paramedic
Nurse Practitioner/ Physician Assistant
Housing coordinators
Nursing assistant/ CNA
Social worker (MSW, MFT, LCSW)
Case manager
LVN/ LPN
Security/ law enforcement
Registered Nurse
Certified drug & alcohol counselors
Recovery coaches
EMT-Basic
0 1 2 3 4 5 6 7 8 9 10
Number of Programs with Select Staffing
11
STAFFING
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11

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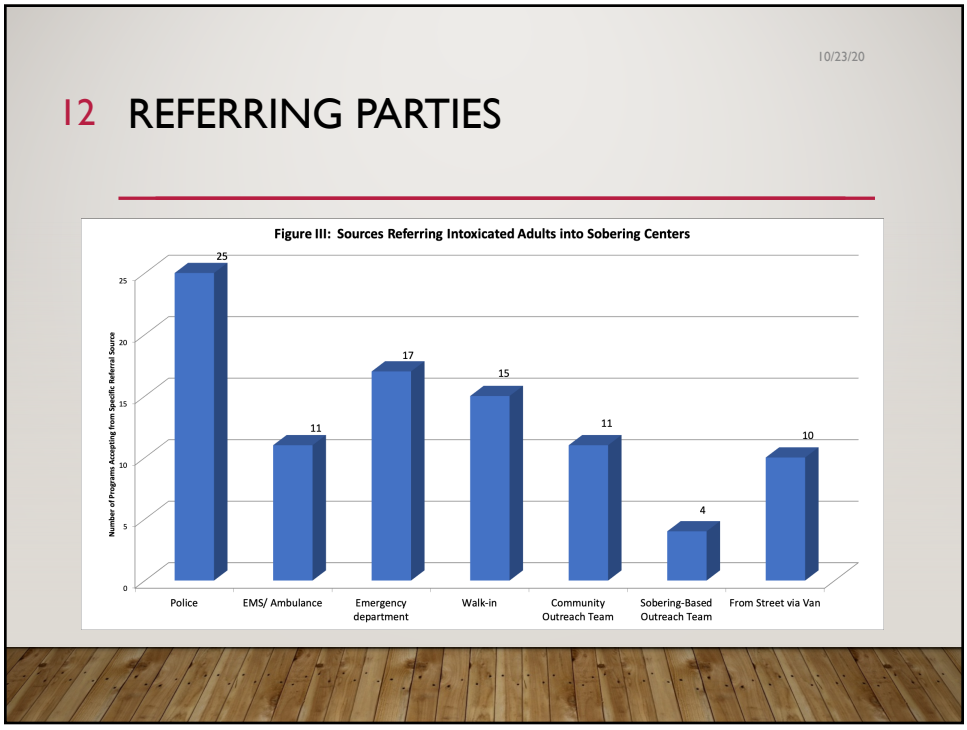
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12 REFERRING PARTIES
Figure III: Sources Referring Intoxicated Adults into Sobering Centers
Number of Programs Accepting from Specific Referral Source
0 5 10 15 20 25
25
11
17
15
11
4
10
Police
EMS/ Ambulance
Emergency department
Walk-in
Community Outreach Team
Sobering-Based Outreach Team
From Street via Van

12

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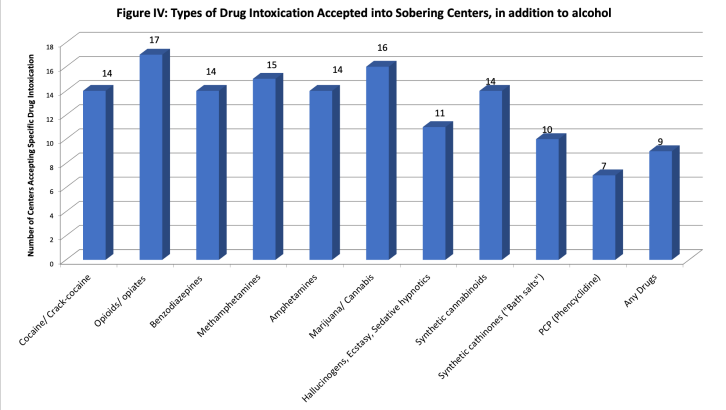
13 DRUG INTOXICATION



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DISCHARGE OUTCOMES TO HIGHER LEVELS OF CARE

- Medical-based discharge to Emergency Department
  - 0-1% = 25% of programs (n=5)
  - 2-4% = 45% (n=9)
  - 5-7% = 20% (n=4)
  - 8-10% = 10% (n=2)
- Behavior-based discharge to psychiatric facility or police custody
  - 0-1% = 40% of programs (n=8)
  - 2-4% = 35% (n=7)
  - 5-7% = 10% (n=2)
  - 8-10% = 15% (n=3)
- *Note: 20 programs provided utilization and outcome data out of 26 respondents*

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15 CARE & SERVICES PROVIDED

Health & Monitoring	% Centers
Vital Signs	50-75%
Alcohol Level via breathalyzer	
Medication Management	36%
Wound Care	~25%
Withdrawal management medication	
Anti-emetics/ anti-nausea	
Medication Assisted Therapy (arrange or provide onsite)	18%

*See *Challenges re: limited options*

Social & Connecting Services	% Centers
Substance use treatment referrals	All*
Shelter, housing referrals	50-75%
Motivational interviewing	
Substance use screening, education	
Individual counseling	33-50%
Follow-up calls post-discharge	
Transportation via van service, bus passes	
Health insurance enrollment	~25%
Appt accompaniment	
Case management	

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16 BEST PRACTICES

- Partnerships and communication with community partners
  - providing education and outreach to community members
  - establishing inter-organizational communication
  - establishing a continuum of care for clients
- Offering a compassionate, respectful environment with caring and committed staff who are "*willing to accept clients that other programs have turned away*", and who "*never give up on anyone*".

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17 BEST PRACTICES

- Establishing protocols and specific criteria for care and services provided, with frequent QI/ data evaluation
- Support a "*growth and improvement mindset*"
  - Motivational interviewing
  - Medication assisted therapy
  - Early intervention
  - Trauma informed care
  - *"Working outside the box to assist clients"*

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18 BARRIERS/ CHALLENGES

- Funding & Sustainability
  - Many dependent on grant or static funding
  - Lack of space to expand services, capacity
- Lack of awareness or inaccurate knowledge of the program/ SUD by local community and stakeholders
- Increase in severity of co-morbid mental illness
- Lack of after-care services (detox, treatment, housing)
- Newer programs (<1-5yrs open) indicated a slow start-up and on-going need to obtain buy-in from referring parties

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"Only a crisis—actual or perceived—produces real change. When that crisis occurs, the actions that are taken depend on the ideas that are lying around.

That, I believe, is our basic function: to develop alternatives to existing policies, to keep them alive and available until the politically impossible becomes the politically inevitable."

— *Milton Friedman*

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19

20

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21

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22