Sobering Center Care in the United States:

An alternative to hospital-based and police-based holding policies

The National Sobering Collaborative

**Table of Contents**

Introduction 3

Preliminary Data 4

Proposal 9

Budget 13

Personnel 14

Table 15

Bibliography 16

**Introduction:**

Acute alcohol intoxication and its treatment significantly affect the efficient operations and finances of hospitals, Emergency Departments (EDs), Emergency Medical Services (EMS), and municipalities. An estimated 9.7% of all ED visits are related to alcohol intoxication1. Outside the hospital, municipal police, EMS, and homeless and social support service agencies devote significant resources to the ramifications of alcohol abuse in the community2–7. Additionally, studies defining and characterizing frequent users of emergency services find high rates of alcohol abuse and intoxication in this population8–13.

To address potentially avoidable health care utilization among intoxicated individuals without co-morbid illness or injury, hospitals, municipalities and community services have developed “sobering centers” where intoxicated individuals are observed in a safe setting. The existing medical literature on programs addressing chronic alcohol addiction describe individual centers2,14, triage protocols15–18, cost analysis14, and effectiveness of case management/housing services19,20. While the emergency department is able to treat acute medical conditions in intoxicated patients, the quality of care for the underlying cause of presentation, alcohol addiction, is often sub-optimal21,22. This is particularly true for the population that sobering centers target- namely homeless alcoholics who use emergency medical services frequently.

While not explicit in their mission statements, sobering centers attempt to fill an important void of value-based care of the serially acutely intoxicated individual. To our knowledge, existing literature and policy has focused only on individual sobering centers and has not evaluated sobering care as a national alternative model to current Emergency Department or police-based safety holding practices for intoxicated individuals.

**Preliminary Data:**

We recently formed an organization- The National Sobering Collaborative, to study this practice on a national level. We identified and surveyed many centers across the country that provide “sobering care” to acutely intoxicated individuals. A summary of our findings are presented in the table below.

Our data suggest that sobering centers are operating across the country without uniform or standardized practices, including triage protocols and outcomes assessment. We also found that administrative oversight and funding for these centers come from a wide variety of sources.

No center identified bills insurance or individuals for these sobering services, including billing of state-run Medicaid services. This is surprising given the potential healthcare savings these centers provide to Centers for Medicare and Medicaid Services (CMS) or private insurance companies. One study found significant decrease in healthcare dollars after initiation of a police diversion program14, but to our knowledge, no study has performed a cost-benefit analysis on sobering centers specifically.

In general we found that sobering centers tend to focus on one of three main programmatic purposes: 1. Police diversion, 2. Emergency Department diversion and 3. Homeless/Social welfare practices. This distinction is based upon how the programs began, what their overall goals are and how each program is funded. Many centers surveyed have components of each of these three priorities in providing sobering care.

*Jail Diversion*

There is no federal law that applies to public intoxication. In 1968, the US Supreme Court in Powell vs. Texas upheld that state’s laws prohibiting public intoxication did not violate the 4th Amendment against illegal search and seizure. Public intoxication is a misdemeanor offense in many states and not an offense in other states. For instance, in California, individuals found to be under the influence of alcohol and who pose a danger to themselves or others, are in violation of California penal code 647 f- a misdemeanor offence23. By contrast Rhode Island law section23-1.10-10, specifically states that if an individual is taken into protective custody for “incapacitation by alcohol” that “no entry or other record shall be made to indicate that the person has been arrested or charged with a crime.”24 Most states have laws regarding “Drunk and Disorderly Conduct” or “Disturbing the Peace” which gives police jurisdiction to cite and to press charges against intoxicated individuals who have otherwise not committed another offense. While states may create the legislation, different municipalities within the same state may enforce the laws differently.

Toward this end, police departments are often charged with addressing the issue of the serially intoxicated, and often homeless, population. This can create a large burden on police departments, and has put financial and operational pressure on police departments to create alternatives to protective police custody. Sobering centers funded by police departments or municipal budgets are one solution. As an example in San Diego, CA, the Serial Inebriate Program offers rehabilitation services as an alternative to jail time to individuals who are habitually arrested for public intoxication. While not a sobering center itself, the SIP is associated with a sobering center run by the Volunteers of America14. All centers we surveyed accept police transport to the sobering center. Houston, TX and San Diego, CA are based solely on police referrals, while other centers, such as San Francisco, CA, Portland OR and Seattle, WA accept other referral sources as well.

*Emergency Department/EMS Diversion*

Of the sobering centers surveyed, most had a stated a goal of reducing the burden of caring for the serially intoxicated patient from EDs and EMS. Seven of the centers surveyed reported that clients are referred directly to the sobering center from the ED after a medical evaluation. While not true ED diversion, this practice does relieve the ED by opening beds for other individuals requiring emergency level care. This ability to transfer intoxicated individuals to dedicated sobering services allows the emergency department to focus on other high-need individuals. True ED diversion, where EMS or a non-medical staffed van transports clients directly to a sobering center, bypassing the emergency department, is done at three of the centers surveyed. State and local laws dictate EMS procedures and protocols, and have been amended in some jurisdictions to allow direct EMS to transport individuals to a non-ED setting. While many of the components of the triage process are similar, each triage and screening protocol was developed locally. These screening exams and checklists are performed either pre-hospital or at the sobering center or both.

*Homeless and Social Welfare Sobering Centers*

While all sobering centers surveyed provide care for homeless clients, some centers arose directly from homeless shelters or are closely affiliated with homeless services. For instance, CASPAR in Cambridge, MA offers drop-in homeless services and operates an emergency shelter that is part of the sobering center. While this center does take police drop-offs of intoxicated clients, most clients are walk-ins such that intoxicated clients and non-intoxicated clients sleep in the same room. In Portland, OR the sobering center is part of a larger, centralized center for homeless services. Other centers report affiliation with medical respite groups for homeless clients, as well as housing services.

*Medical Care and Triage Processes*

Given the wide range of staffing models across the centers surveyed, the amount of medical care and evaluation is varied. In centers where there is no medically trained staff, there is no formal medical evaluation. These centers report an informal evaluation process where EMS services are called for clients who “don’t look good” or cannot walk safely. Other centers with EMT staffing are able to perform basic medical services such as taking vital signs and providing basic wound care. San Francisco reports the ability to perform venipuncture for lab assessment and provide oral medication with their RN staff. Cambridge, MA is affiliated with a clinic operated by a homeless health care service and clients can make appointments during business hours. Other centers report affiliations with detox centers with medical alcohol detox including medication and nursing and physician supervision. These are separate from the sobering center proper.

Four studies to date have determined the sensitivity and specificity of sobering center triage checklists. The largest, by Ross et al, describes a 22-point checklist. They found high sensitivity and low specificity in a prospective study15. Other smaller studies have found similar results16–18. Each study used a different checklist; however each had exclusions based upon observed or suspected acute illness or injury, ability to ambulate with minimal assistance and abnormal vital signs.

The triage process and triage protocols used are dependent on the medical capabilities of the receiving center. To date no study has compared different triage protocols, or compared performance of triage protocols to assessments by non-medical people without assessment of vital signs as is the case at some centers. A multicenter study with derivation and validation of triage protocols is a potential area of future research.

While sobering centers are necessarily unique at the local level, national sobering center data is needed. As we strive for value in healthcare and in social services, sobering centers will continue to be an important extension of a city’s health safety net. Future studies should focus on pooling outcome data related to triage protocols, staffing guidelines, cost-benefit analysis. This data can help guide national and federal policies on sobering centers and create billing structures for these services.

**Proposal**

Our initial research has identified a clear need for prospective data that is standardized across many centers. To do this, a national collaboration must be organized with standardized data collection instruments, and analysis of outcomes and cost. This proposal addresses these needs.

*Specific Aims:*

1. *Development of database*
2. *Creation of website*
3. *Promotion of database and website with data sharing*
4. *Cost-benefit analysis*

*Aim 1:* Development of Database

Integral to this project is the development of a database that can be standardized across many centers. Currently, sobering centers collect data on a heterogeneous number of factors. These data points include demographic data, housing data, physical exam and vital sign findings. Most centers do not track substance abuse outcome data such as referral to treatment, recidivism, or use of emergency services for substance abuse.

This program will develop a database that is adaptable and universal as well as comprehensive. Given the heterogeneity of these centers across the country it is not feasible to standardize a single data collection sheet that will work for all centers- at least initially. A web -based reporting database such as REDCap will be used in the initial development phase. This program allows for flexibility on both the development and the reporting to the database.

This project will focus on key areas of data collection:

1. Demographic data
2. Intake assessment
   1. Physical assessment
   2. Vital Signs
   3. Medical triage
3. Housing Data
4. Substance Use
5. Health care utilization
   1. Emergency Department Usage
   2. Primary Care Access
6. Outcomes/disposition
   1. Referral to treatment
   2. Recidivism
   3. Need for emergency services (under-triage)
7. Budgetary data

*Aim 2: Development of a Website*

There is currently no centralized resource for sobering center communication, data sharing and client resources. One of the main goals of this project will be to develop a website that will serve as a resource for sobering centers. It will feature blog components as well as serving as a promotional tool for the database to encourage sobering centers to participate in the Sobering Center Collaborative. It will also have a “tool-kit” for communities looking to start a sobering center.

*Aim 3: Promotion of The National Sobering Collaborative*

One of the biggest hurdles to this project is to encourage current sobering centers to collaborate on this project. Currently sobering centers are a heterogeneous group of organizations with local goals and local funding. With a few exceptions, most sobering centers do not have vested interest in sharing their data or collecting the data this project aims to generate.

We found that encouraging collaboration was a difficult task when performing the pilot survey listed in the Table. Many centers we attempted to contact did not have specific data that we were interested in, or had no incentive to share their data.

A key piece of this project is the promotion of a national organization that will advocate for common goals. The website will be a key promotional tool, and we aim to create incentives for joining the National Sobering Collaborative and pooling data into the national database. The ultimate incentive will be the creation of billing structures through a comprehensive cost-benefit analysis that pooled data will make possible.

*Aim 4: Cost Benefit Analysis*

It is our belief that sobering centers are a superior alternative to emergency department and jail-based holding practices. It is our belief that these centers are better equipped to address the underlying substance abuse and homelessness issues that plague this population. It is also our belief that these centers offer a more cost efficient solution to this nation-wide problem.

However, there has been no cost-benefit analysis of sobering centers that we know of. San Diego, CA has done a cost benefit analysis of a jail diversion policy but not of the sobering center directly14. Other programs have shown reduction in health care costs with intensive case management programs targeting high utililyzers19,20 of emergency services.

Performing a cost-benefit analysis on national sobering center data will require reliable budgetary and outcome data as developed in the database. By comparing this data with Medicaid expenses, police and ambulance services as well as county jail expenses we hope to approximate comparative costs of sobering centers versus traditional policies.

It is our belief that sobering centers will be shown to offer more value than alternative policies. Our goal with this proposal is to prove this value and convince more communities and Medicaid to develop sobering centers.

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**Table: Sobering Center Survey Summary Findings**

Can also be found at: http://www.acep.org/Clinical---Practice-Management/Sobering-Centers/

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