National Sobering Collaborative's National Sobering Summit in Washington DC:
Filling the Gap in Substance Use Care
October 5-6, 2023
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General Summary:

The National Sobering Collaborative was founded in 2015 to serve people with harmful substance use outside traditional criminal and emergency systems. They have continued to grow since then and their current mission is to "support the expansion of and advance the best practices for sobering care services to provide short-term, easy-to-access, and safe environments for recovery from intoxication."

The conference started with an overview of sobering centers and where they fit in the context of a recovery- and safety-based continuum of services. Then a number of providers from across the country described their programs. The conference ended with an interactive panel of leaders from SAMHSA who discussed aspects of sobering and behavioral health care.

At the conference, individuals from across the country shared their models, their challenges, and their successes around sobering centers. Attendees included behavioral health and public health officials, representatives of the peer workforce, first responders, emergency department personnel, law enforcement, and community service providers.

Despite differences in individual programs, there was clear consensus around the need for a sobering center as an essential part of any substance use continuum.

Clearing up confusion - "sobering" vs. "detox":
One of the most important issues elevated at the summit was the need for a shared understanding of terminology. This includes not only "sobering" vs. "detox", but extends to other seemingly common words such as "crisis," "stabilization," and "emergency."

The attached article - Sobering Centers Explained: An Innovative Solution for Acute Intoxication - does a great job differentiating between sobering and detox. I've briefly summarized the differences below:

- **Sobering:**
  This basically refers to coming down off whatever substance you may be on. In the old days Sobering Centers were "drunk tanks" - places where people could be relatively safe while they slept off their alcohol intoxication and left after a few hours.

  The underlying concept remains the same today, but the substances people use can be more dangerous, take longer to sober from, and have more complicated withdrawal syndromes than in the past. Therefore, even though they ***largely function in the realm***

of public safety, Sobering Centers currently require more monitoring, medical oversight and safety precautions than their historical counterparts.

Acute intoxication generally does NOT constitute a medical emergency. Sobering Centers are **alternatives to ERs** for this very reason.

- **Detox:**
  Detox goes beyond sobering, and refers to the process by which people fully clear substances from their bodies.

  Because people become physically dependent on substances they are addicted to, with a variety of associated physiologic changes, detoxifying from the substance has physical manifestations. Many of these are extremely unpleasant but not dangerous (diarrhea, extreme anxiety, sweats, brief seizures).

  But some of the physical manifestations can be true medical emergencies.

  Detox Centers provide significant medical oversight, monitoring, education and medications to ensure that people do not become medically unstable as they withdraw. Detox is more recently referred to as "withdrawal management."

  The detoxification process can take days to weeks or even months. As with sobering, managed detox is not a medical emergency.

Some quotes from conference presenters and attendees:

- "Sobering is NOT a place for detox, but it can be a LINK to detox."
- "Sobering may happen over a few hours, and people generally leave when they're ready. Detox requires medical monitoring and oversight."
- "Sobering doesn't require medical stability at the level of an ER, it just requires that people be 'stable enough' to be safe."
- "Sobering centers open the door to care and recovery, and set standards of safety for the community."
- "The sobering center is the gateway to care."
- "'Return to use' is part of the process! At each transition there's the potential for people to move forward, or to relapse. But we stick with them no matter what."

<u>Major considerations around Sobering Centers</u>:

A number of jurisdictions at different stages of implementation presented on their sobering programs. Themes that emerged included the following:

- **The "use case" for Sobering Centers - necessary for public safety and for avoidance of unnecessary use of crisis services:**
    - There is a huge personal toll on individuals using various substances.
    - Public intoxication places a huge strain on communities' public safety and health systems, including EMS, Fire Dept, law enforcement, jails, courts, public defenders, prosecutors.
    - Sobering Centers offer alternatives to ERs and jails, providing safety for intoxicated individuals and also the public, without utilizing costly, stretched, and unnecessary crisis care resources.
    - Sobering Centers are more related to public safety than to behavioral health. However, there is a clear intersection with healthcare, EMS, homeless services, and behavioral health.
    - Health systems are often the biggest financial beneficiaries of Sobering Centers due to diversion from ERs.
- **Methods of identifying potential clients:**
    - Referral
        - Hospitals
        - Jails
        - Friends/family
        - Shelters
    - Walk-in
    - Assertive and proactive outreach teams
- **Goals:**
    - Individual safety: "To improve people's quality of life and keep them safe."
    - Public safety.
    - Decrease crisis system utilization, divert from jails and ERs. "We want to divert everyone with a behavioral health issue from EDs and law enforcement, so long as they will be safe!"
- **Criteria for acceptance to the Center - variable, with some common themes:**
    - Stable vs. unstable vs. "stable enough". Not needing an emergency level of care.

    - Must be under the influence of drugs and/or alcohol, but not TOO intoxicated.
    - Can't be in active withdrawal or TOO at risk from withdrawal.
    - Must be directable.
    - Can't have suicidal intent or homicidal intent or intent to harm people.
    - Can't be dangerously violent.
    - Can't have significant trauma (laceration, head injury, broken bone)
    - Must agree to be there.
    - Need to be able to get into and out of a cot.

- **Options for transportation to the Center - variable:**
    - Van with transport team (not necessarily medical personnel)
    - LYFT
    - EMS (although in some places the goal is to completely divert from EMS because EMS by definition constitutes a higher level of care)
    - Law enforcement
    - Private vehicle

- **Law enforcement perspective:**
    - The vast majority of officers got into the profession to serve.
    - Staffing is a huge challenge - St. Louis (a county of 350,000 residents) needs about 1200 police officers but has about 930. There is tremendous strain on the individual officers and on the police force as a whole.
    - "Police officers hate the way things are, but also hate change" □
    - Things that can help them in their mission of service will be embraced, but it will take work to bring them in due to histories of exclusion, mistrust, misperceptions.
    - Building relationships, supporting department champions, including in officer education - all are crucial.
    - Make the process efficient and simple.

- **Types of substances:**
    - Some limit the substances people can be on coming to the Center, such as no K2, PCP.
    - Others do not worry about the substances, the key is the behavior.
    - All acknowledge that alcohol is still the major contributor!

- **Types of services:**
    - Activity rooms: Helpful for people intoxicated on meth.
    - Private rooms: Helpful for people coming off meth.
    - Cots - low to ground, with emphasis on safety.
    - Recliners
    - Trauma-informed
    - Some offer case management or other connections to different programs/shelters/etc.

- **Staffing - high variability:**
    - Nurse-driven?
    - LVN-driven?
    - Peer driven?
    - In ALL cases there is oversight by expert administrative staff.
    - Medical provider
    - Medical assistants
    - Nurses
    - LCSWs
    - Peers

- **Length of stay:**
    - Typically hours.
    - Can be up to weeks, but these are outliers. The center should be built around the most typical use case, but must be flexible enough to understand there will be outliers and account for that.
    - “Repeat utilization is NOT a failure!”

- **Discharge and Linkages:**
    - Recognize that **most people are discharged without referral.** His ties to the primary goals of public safety, individual safety, and diversion from crisis systems.
    - Referral on discharge can potentially be made to:
        - Withdrawal management
        - Respite/shelter
        - Same day meds

- **Funding and billing is complicated, siloed and uncoordinated, and often requires a layered approach:**
    - Many places rely on county levies.
    - Blended and layered funding.
    - California is doing an innovative program called CalAim that allows for Medicaid reimbursement for sobering coverage. Goal is to improve mental health outcomes and overall wellbeing of Medicaid enrollees.1 in 3 California residents are on Medicaid.
    - Note that for Medicaid, even if reimbursed, the day rate is very low, so there must be additional funding. Can layer on additional reimbursable services such as care coordination.
    - State appropriations from ARPA
    - SAMHSA grants

<u>Some interesting innovations</u>:

- “High touch care coordinators”
- Deemed by the Homelessness Continuum of Care to be an entry point into housing.

- Coalitions serving as oversight organizations.
- Mobile integrated health teams following all Narcan reversals.
- Geospatial mapping of where intoxicated people are picked up, identifying hot spots.
- One Mayor's office has a team of scientists from a variety of fields studying the science of civic interventions!

Some impacts being seen so far:

- Substantial decrease in public intoxication and law enforcement interaction with intoxicated individuals.
- In one program (Houston) there have been massive cost savings for stabilization housing and outreach ($120,000/person/year) as compared with hospital stays ($1.2 million +)

Other considerations:

- EMTALA: Sobering Centers do NOT fall under EMTALA.
- Licensing - i.e., in SF, their center is licensed as "primary care".
- Credentialing
- Malpractice
- Contracting with managed care

Some challenges:

- Need for a place where people can be held over while they await detox or next level of care.
- People need an average of 18 months to see a significant decrease in "return to use."
- There needs to be something to link it all together. Ensure that each piece of the puzzle fits into the bigger picture.
- "Too many cooks in the kitchen" - need to have coalition, but it needs the right people and there needs to be leadership.
- Defining what success looks like.
- Inadequate emergency housing for homeless.
- Transportation.
- Timelines for design and build-out.
- Capacity of long term SUD treatment beds.

- Funding, particularly restrictions on funding, such as with opioid settlement money.

Jurisdictions represented:

- Kern County, CA - Bakersfield Recovery Station
- Los Angeles, CA - Exodus Recovery
- Houston, TX - Houston Recovery Center + Harris Health Sobering Center
- San Francisco, CA - SOMA Rise; Sobering Center and Managed Alcohol Program
- St. Louis, MO - Preferred Family Healthcare + Metropolitan Police Department
- Washington, DC - DC Stabilization Center
- Calgary
- SAMHSA
- San Leandro, CA
- Baltimore, MD
- Marion County, OR
- Washington County, OR

A case study: Houston Recovery Center plus Harris Heath Sobering Center's Multi Visit Patient (MVP) program - a partnership to reduce ED overutilization.

- Started with the recognition that crisis systems are bearing the cost of those not entering the system in the right place and not getting the right care (through no fault of their own). EDs, EMS, jails, law enforcement.

- 9900 unique unsheltered clients, 21,700 hospital admissions by a small percentage.

- 11,000 clients generated 56,000 EMS transports to 65 hospitals in the Houston area.

- Triad - SUD, housing instability, BH barriers

- Got a coalition together - the Greater Houston Collaborative. With 1115 waiver, partnered with health dept and city to design a recovery program for people cycling through EDs.

- Focus is on Care Pathways. The population drives the program delivery.
    - Recognizes some people might not be ready now (if ever) to fully abstain. So they have created a "Reduced Use Pathway" - a non abstinence pathway for people to begin their journey, hopefully leading to recovery.

- Started a street outreach initiative with a public intoxication team and a van that picks people up, takes them straight to the Sobering Center.

- Set up a simple hotline - made it easy for anyone to refer with a basic phone screening.

- Assertive identification.

- Consistent messaging.

- Proactive!!!

- The money follows the CLIENT, regardless of what path they follow. “It can’t be about billing, it has to be about focusing on the individuals with a goal of having them have a better life! The fact that it happens to be much less expensive is a secondary benefit.”

- There has been an evolution from sobering centers to community hubs with dedicated recovery pathways.

- The system “humanely treats people the way they deserve to be treated.”

Some final takeaways:

- Hospitals need to be in the room because they bear the highest cost burden.

- There are multiple economies that hold the status quo in place. That’s why the process needs to be externalized. Example - the Greater Houston Collaborative.

- Funding must follow the client. “Stop slicing and dicing people!”

- Must be open 24/7, accept people easily, in a safe environment.

- Provide a place where people can be safe, acknowledging that they will come back and this doesn’t constitute failure. BUT also provide linkages to the next level to the extent possible.

- Relationships are essential! “Find out what each person is good at and hook them into the process!” but also “Sometimes you’ll need to mix oil and water and that’s okay!”

“Prevention, intervention and treatment work! Recovery is possible for everyone!”