# Safe Sobering: San Francisco's Approach to Chronic Public Inebriation

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*Summary:* Dedicated to the care of alcohol dependent people, the San Francisco Sobering Center cares for intoxicated clients historically treated *via* emergency services. With 29,000 encounters and 8,100 unduplicated clients, the Sobering Center safely and efficiently provides sobering and health care services to some of the City's most vulnerable people.

*Key words:* Sobering Center, chronic inebriate, alcohol dependence, alcohol-dependent person, alcohol intoxication, emergency service utilization, high utilizers, San Francisco, homeless, chronic homelessness.

Providing care to people who are acutely intoxicated is challenging, and working with those commonly labeled *chronic inebriate* can be particularly demanding and costly. Recent studies indicate that alcohol has a substantially negative impact on health in San Francisco.[1,2] Ten of the 17 leading causes of preventable mortality are related to alcohol and up to 10% of premature mortality can be attributed to alcohol. Additionally, a review of San Francisco's 2007–09 indicator for age-adjusted emergency room visits due to acute or chronic alcohol abuse demonstrated a rate of 51.3/10,000 population, far above the goal of 22/10,000 set by San Francisco County. Those between 45–64 years of age had a rate of 88.6/10,000 visits.[3] In one study by the Lewin Group in 2010, the unreimbursed health care costs related to alcohol use was over $18 million in one year.[2] In an effort to improve care and decrease costs associated with chronic alcoholics, San Francisco established a Sobering Center.

**History**. In 2002, over 50 stakeholders throughout San Francisco, including the Department of Public Health, Department of Emergency Management, local community organizations, the Hospital Council of Northern and Central California, and law enforcement agencies, were brought together to evaluate the decade-long trend in emergency department (ED) overcrowding and escalating ambulance diversion rates. Through this investigative collaboration, it was found that homeless alcohol-dependent

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people accounted for more than 20% of all ED visits and stayed nearly twice as long as non-intoxicated people. Additionally, nearly 75% of the high-utilizers of emergency ambulance services—individuals picked up more than four times a month—were chronic public inebriates.[4]

Considering the significant impact of chronic inebriation on both public resources and the individual health of those with alcohol dependence, the San Francisco Department of Public Health worked with nonprofit Community Awareness and Treatment Services (CATS) to design a pilot program addressing the needs of people found intoxicated in public. The McMillan Stabilization Program, now known as the San Francisco Sobering Center, opened in late 2003. The objectives of the program were to provide safe health care while engaging alcohol-dependent clients in order (1) to decrease the number of alcohol-only related admissions to emergency departments, and (2) to decrease the number of alcohol-only related ambulance transports.

**Target population and referral**. The focus of the Sobering Center is the homeless, alcohol-dependent individual; however, anyone found intoxicated in public can use its services. To qualify for admission to the Sobering Center, individuals must have no apparent medical or psychiatric conditions necessitating emergency interventions. Sobering Center accessibility is monitored through a citywide online system, so that emergency providers are able to view real-time sobering bed availability.

First responders throughout the City are trained with specific protocols to triage intoxicated adults for transfer to either an emergency department or the Sobering Center. Specifically, the Sobering Center receives clients from the streets by ambulance, police, and street outreach. Additionally, MAP (Mobile Assistance Patrol, a division of CATS) van services often respond alongside police and ambulance crews, and will take over and transport once a client has been determined to require only sobering services. Aiming to decrease the length of stay of people already in the emergency department, the MAP van also transports clients directly from the ED after preliminary assessments indicate acute intoxication as the only medical need. Walk-in clients are not accepted and are instead referred to an appropriate program or drop-in center for assistance.

**Clinical practice**. All clients are assessed by registered nurses and medical assistants upon intake. The typical client is provided with oral fluids and electrolytes, a meal, shower facilities, and clean clothing. Throughout their stays, clients are monitored closely for any medical or psychiatric complications, using comprehensive nursing protocols developed for the program. If a client's condition is too acute or unstable for the Sobering Center, the nurses coordinate transfer to an ED for further evaluation. Additionally, nurse practitioners and physician's assistants from a co-located Medical Respite program complement clinical services by providing urgent care and detoxification referrals. Once clients have safely sobered up, during a typical stay of 6–8 hours, staff elicit history about acute and chronic medical needs, housing status, and the client's interest in alcohol treatment programs. Staff contact existing case managers, primary care providers, and other community services to assist in coordinating care and disposition. Prior to discharge, clients are offered referrals to medical and social detoxification services, treatment programs and case management.

**Utilization**. Utilization of the Sobering Center has been substantial. Since opening in 2003, the Sobering Center has provided services to over 8,100 individual clients with

over 29,000 total encounters (see Table 1). Nearly 80% of these clients have had no more than one or two encounters during the eight years since the program has been in operation. At last count, fewer than 200 individuals (less than 2% of the unduplicated clients) account for nearly 70% of total visits (see Table 1). Significantly, nearly 90% of all Sobering Center clients have a history of homelessness.

Over 40% of client encounters are referred *via* ambulance, with an additional 35–40% from the street *via* MAP van (see Table 2). These are clients who would otherwise go to a nearby emergency department. Over 2,000 encounters—approximately 7%—have transferred from EDs to the Sobering Center. Police, clinics, case management programs and street outreach refer 10% of total client encounters. A majority of clients (nearly 90%) safely sober up and discharge either to self-care or a substance abuse facility. Annually, fewer than 3% of clients referred from EMS or ED bounce back to the emergency department. In eight years, there have been two deaths in the facility. Given the acuity of the clients, this is far fewer than expected.

**Outcomes**. The impact of the Sobering Center can be seen in both the short and long-term. In the short term, up to 29,000 inappropriate encounters with emergency services may have been avoided by diverting chronic inebriate care away from the ED to the Sobering Center. Decreasing inappropriate visits helps decrease ED overcrowding and allows the ED to operate more effectively for critical services. Additionally, the MAP van services that provide transportation directly from police or ambulance crew hand-off and directly from the ED to Sobering Center, allows emergency services and emergency department beds to be available sooner to receive new calls and clients. The Sobering Center operating costs (including staffing) are approximately $1 million dollars annually coming from Department of Public Health general funds. The daily operating costs for this 24/7 operation is less than $2,700, which makes it comparable to the cost of a single ambulance ride and emergency department visit (which combined ranges from $1,850 to $3,800). With an average census of 10 to 14 clients a day, the cost avoidance to the City is substantial.

## Table 1.

### UTILIZATION FROM 2009–11[a]

| | 2011 | 2010 | 2009 |
|---|---|---|---|
| Total Encounters | 5175 | 3254 | 2588 |
| Unduplicated Clients | 1682 | 1248 | 1080 |
| Annual visits per unduplicated client | | | |
| >75 visits | 6 clients | 1 client | 0 clients |
| 21–74 visits | 41 | 19 | 15 |
| 11–20 visits | 43 | 23 | 25 |
| 3–10 visits | 235 | 190 | 149 |
| 1–2 visits | 1357 | 1015 | 891 |

[a]All data obtained through San Francisco Coordinated Case Management System.

## Table 2.

### ENCOUNTERS BY REFERRING PARTIES[a]

| | 2011 | 2010 | 2009 |
|---|---|---|---|
| Ambulance | 1878 (36.3%) | 1448 (44.5%) | 1128 (43.5%) |
| Mobile Assistance Patrol (MAP) | 1991 (38.5%) | 1227 (37.7%) | 1033 (40.4%) |
| Police | 393 (7.6%) | 286 (8.8%) | 167 (6.5%) |
| Transfer from Emergency Department via MAP | 599 (11.6%) | 116 (3.6%) | 71 (2.7%) |
| Referred by Other | 314 (6%) | 177 (5.4%) | 189 (7%) |

[a]All data obtained through San Francisco Coordinated Case Management System.

Longer-term outcomes, such as improved health of chronic alcoholics, are more difficult to evaluate and demonstrate. That said, the Sobering Center is a vital partner in engaging complex, marginalized, high-cost individuals. Up to 70% of the highest-utilizers of multiple systems (referred to as *HUMS clients* in San Francisco) come through the Sobering Center. Individualized plans for those with complicated medical, psycho-social, or forensic issues are created for these clients and include coordination with ambulance personnel, case management and primary care services, mental health and recovery services, and when necessary, the Public Guardian's office (which operates under the authority and direction of the California Probate Code and the San Francisco Superior Court to provide conservatorship of persons and estates). Detailed progress notes on all clients are entered into a citywide database (the Coordinated Case Management System), accessible to numerous other community programs and health care personnel.

As many chronic alcoholics are not effectively connected to primary care, family or friends, subtle changes or declines in functional and cognitive status often go unrecorded. The ongoing relationship with Sobering Center staff provides continuity for many otherwise unmonitored individuals. For example, the Center's highest utilizer this year—a homeless man with over 140 visits—suffered a months-long decline in his cognitive and self-care abilities that could not be assessed or addressed effectively in the emergency department. As a result of the Sobering Center's detailed clinical documentation, advocacy, and coordination with the patient's case manager and the Public Guardian's office, he is now receiving care in a long-term facility. This type of care coordination is difficult to implement in other sectors of the health system and can be another benefit of a Sobering Center, especially one that has worked successfully with other safety-net providers.

**Challenges**. Staff members strive to keep the individual in a safe, supportive environment, off the streets, and out of the emergency department. However, the lack of sufficient discharge options negatively influences the ability to create long-term plans for clients. For those seeking sobriety, the wait for a residential rehabilitation bed can be weeks, taking longer than the maximum 21 days allowed at medical detoxification.

Thus, clients are discharged from detoxification to shelters rather than transitioning directly to rehabilitation; the sobriety achieved at detox often ends soon after. To reduce homelessness, San Francisco offers permanent supportive housing options through the Direct Access to Housing program. However, many of our most vulnerable clients are unable to achieve sufficient sobriety and organization to complete the applications and interview required, despite community-based intensive case management services. With this, a majority of our clients are discharged directly to the street without adequate access to transitional or permanent housing.

Due to capacity limitations, the Sobering Center is unable to accommodate walk-in clients. This is an obvious limitation as there are many clients, not acute enough to be brought in by first responders, who would benefit from sobering services. Currently, people who walk into the sobering center are referred to a local drop-in center or shelter. Unfortunately, the shelters do not accept people at all times of the day and night, seven days a week. We have found that a small number of clients are using the 911 system to request a ride to the Sobering Center, simply because they cannot get into a shelter bed in the middle of the day or late into the evening. We have no internal mechanism for tracking these data yet; however, there is continuing collaboration with the shelter health programs to discuss ongoing needs.

Additionally, the work is challenging. Many clients are subject to assaults or trauma and often show the physical and emotional scars of surviving on the streets. A significant challenge to staff is witnessing this scenario repeated weekly (sometimes daily) in some clients who have lost the will or ability to change their situation. Furthermore, most clients brought into the Sobering Center are not interested in decreasing their alcohol use; the reality is that clients are brought in because they are intoxicated, not because they are reaching out for assistance. That said, staff have learned that, no matter how frustrating or how unhealthy it is for the individual, every person must come to his or her own decisions, at his or her own time. In some cases, this constant, positive presence that the staff provides can work. One of our facility's most frequent users, coming regularly for nearly five years but never once accepting a referral to any service, finally this year asked for help. He successfully completed detoxification and is now living in a residential rehabilitation facility.

**Next steps**. Through extensive data review and feedback from both clients and staff, the Sobering Center has continued to refine its services. For example, when we reviewed our data of the number of successful referrals to medical detoxification, our numbers were lower than expected—with less than 20% of interested clients obtaining a detox bed. A root-cause analysis demonstrated that the wait-time for a detoxification bed was often longer than 24 hours, far longer than many clients can wait before experiencing alcohol withdrawal. Clients would either become unstable necessitating transfer to an emergency department or leave to begin drinking and become lost to follow-up. To address this problem, the Sobering Center initiated a withdrawal management pilot project in January 2012. In order to safely bridge the time between admission to the Sobering Center and transition to residential medical detoxification, clients are assessed with the revised Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale and, when indicated, provided medications for withdrawal management for up to 24 hours until a detox bed becomes available. Though longer-term data are not yet available,

we anticipate an increase in the numbers of clients safely transitioning to detox, with a reduction in the number of clients who are sent to emergency departments due to withdrawal or who leave independently unable to tolerate the wait for a bed. Of 18 clients treated in the pilot so far, 15 have successfully moved to medical detoxification.

**Conclusion**. The San Francisco Sobering Center offers a refuge from the streets and a safe place for chronic public alcoholics to sober. The center also demonstrates an innovative approach to diverting non-acute patients away from overcrowded emergency departments, resulting in significant cost avoidance. Because so many frequent users access the Sobering Center, it has also become a place where safety net services and coordinated care plans can be implemented for high cost patients. Finally, the Sobering Center is sometimes the only point of care for extremely marginalized homeless alcoholics. Clients arrive at the Sobering Center in a vulnerable state: intoxicated, wet, hungry, often unable to provide self-care. Harm reduction is the principle that guides the care at the Sobering Center. Every effort is made by staff to demonstrate acceptance and compassion. Specialized and dedicated staff can build trust and engagement, resulting at times in decreased alcohol use or abstinence. Work is ongoing to develop solutions for public inebriation and chronic alcoholism; until then, the Sobering Center will continue to provide an alternative to emergency care for some of the City's most vulnerable and marginalized people.

## Notes

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