City of Renton Sobering Center Pilot: Program Evaluation

Prepared for Emergency Medical Services Division
Public Health - Seattle & King County

By

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Finally, I would like to acknowledge the homeless and other "vulnerable" populations of King County who demonstrate tremendous resilience in the face of systemic adversities.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

The City of Renton Sobering Center Pilot was implemented over nine months, from January – September 2017, to provide an alternative destination for acutely intoxicated individuals in the Cities of Kent and Renton who did not require further medical care in the Emergency Department (ED). The project was a collaboration between Kent and Renton Police Departments, Puget Sound Regional Fire Authority, Renton Regional Fire Authority, St. Vincent de Paul, Pioneer Human Services, Valley Medical Center, Renton Ecumenical Association of Churches (REACH), Tri-Med Ambulance, Valley Cities Behavioral Health Care (Kent and Renton), Kent Human Services, Renton Department of Community Services, Catholic Community Services, Renton Housing Authority, Public Health – Seattle & King County's Emergency Medical Services (EMS) Division, and King County's Department of Community and Human Services (DCHS).

Sobering Center client data were collected by Pioneer Human Services, who operated the facility, and were then analyzed for this evaluation. There were 87 unique Sobering Center clients who collectively visited the Sobering Center 319 times. The Sobering Center Pilot clients were primarily homeless (93%), male (86%), and many self-reported a history of criminal convictions (40%) and concurrent medical issues (33%). Additionally, 47% reported receiving mental health services in the past, indicating the prevalence of mental illness among this population, as well as some existing connections to behavioral health supports. The demographics of Sobering Center users are consistent with national trends and indicate the complex health and social needs of this population.

While First Responders and Valley Medical Center referred eligible clients to the Sobering Center, missed opportunities for Sobering Center referrals resulted in continued transport to hospitals. Most Sobering Center encounters (64%) were self-referrals or walk-ins. This reflects some of the challenges agencies faced in referring clients, including changing behaviors to utilize a harm-reduction service over the ED. The high prevalence of walk-ins also indicates clients' awareness of the Sobering Center and their desire for a secure and safe location to spend the night. **The Pilot diverted up to 87 clients from the ED, including 14 "high users" (with 3+ Sobering Center visits), who tend to be the most complex and costly users of hospital and law enforcement systems.**

After Sobering Center discharge in the morning, clients were transported by Tri-Med Ambulance to receive off-site social services. Since 78% of discharges were self-discharges to the street, most clients likely did not encounter the outreach component of the pilot. However, 11 Sobering Center clients (13%) engaged with Valley Cities Behavioral Health Care after their Sobering Center admission, indicating that some clients were made aware of Valley Cities and were motivated to learn more.

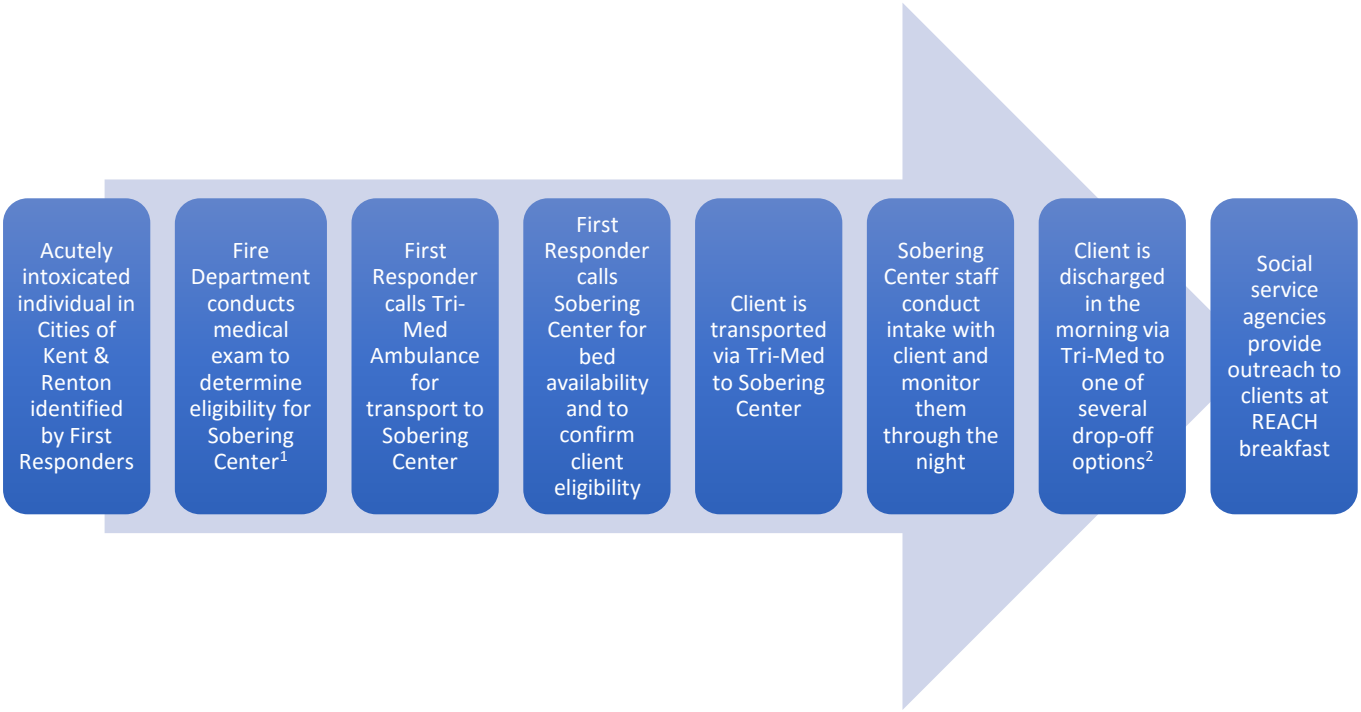
The qualitative data were collected via interviews, site visits, and surveys with 16 key partners and were analyzed for program barriers, strengths, and areas for improvement. Major barriers included challenges in communication between project partners, logistical challenges (hours of the Sobering Center, location, eligibility requirements, and timing of services), difficulties fostering culture change among providers, lack of warm hand-offs, and challenges around the outreach component after discharge. The identified strengths were the collaboration of the partners, city and county support, the monthly planning meetings, and that the pilot provided a needed service in the region. Primary lessons learned included meeting the clients "where they are at," promoting culture change among partners, and fostering strong partner relationships.

Moving forward, the Sobering Center Pilot evaluation findings can inform how decision-makers and community-based organizations garner community support and integrate sobering services with other patient-centered, community-based, and wrap-around services to serve vulnerable populations and address the root causes of substance use, mental illness, and homelessness.

INTRODUCTION

Emergency Medical Technicians (EMTs) and law enforcement officials, together known as "First Responders", regularly respond to 9-1-1 calls for chemically dependent patients who are then brought to a hospital emergency department (ED). The Cities of Kent and Renton, along with King County Emergency Medical Services (EMS) Division and Department of Social and Health Services (DSHS), partnered with community agencies in response to the concern that First Responders do not have an alternative for acutely intoxicated individuals to receive appropriate care outside of the ED. The nine-month pilot project from January – September 2017 established a sobering center to provide an alternative destination for acutely intoxicated patients ages 18 and older in Kent and Renton who required no further medical attention. First Responders from the Cities of Kent and Renton, as well as Valley Medical Center, a public hospital in Renton, referred patients under the influence of alcohol, most whom were homeless, to sleep at the Sobering Center. The facility later accepted walk-ins or self-referrals. The Sobering Center was open from 8pm to 8am 7 days a week, during which clients were monitored by EMTs. In the morning, clients were offered connection to social support services off-site at locations in Kent and Renton, depending on the city who referred them. Clients were steered towards the city from which they originated (Kent or Renton), a prerequisite for city approval of the pilot. Figure 1 outlines the Sobering Center Pilot's continuum of care.

Figure 1: Sobering Center Continuum of Care



[1]Occurs during sobering center operating hours (8pm-8am, 7 days a week)
[2]Discharge locations include Valley Cities Behavioral Health Kent (if the client came from Kent), Renton REACH breakfast (if client came from Renton, only open on weekdays), or Renton Transit Center (If client came from Renton, only on weekends)

This evaluation of the Sobering Center Pilot assesses whether the program achieved its goals to 1) provide a safe and secure location for acutely intoxicated individuals who require no further medical care, 2) connect clients with community behavioral health and social service resources, and 3) relieve local hospitals and First Responders from using costly resources on intoxicated individuals who do not

require further medical attention. The evaluation includes recommendations to inform decision-makers regarding the future of sobering centers and similar services in King County.

BACKGROUND

The Public Health Problem

Alcohol use disorders contribute significantly to the global burden of disease and are a risk factor for myriad health and social problems. The World Health Organization causally links alcohol with over 60 medical conditions including certain types of cancer, neuropsychiatric disorders, gastrointestinal disease, violence, and injuries.[1] In the United States, 3.5% of all deaths relate to alcohol intoxication.[2] Furthermore, alcohol is a risk factor for adverse social consequences including work-related problems, family issues, and poverty.[3] These health and social consequences not only affect the drinker, but also their environment and greater society; the high economic costs associated with alcohol, including healthcare, productivity loss, law enforcement, social services, and social harm, amount to more than 1% of the US gross national product (GDP).[4] The burden of alcohol use, often coupled with mental illness, disproportionately affects men, people in poverty, and other marginalized populations including American Indians/Alaska Natives, veterans, and people of low educational attainment.[4,5] Homeless individuals with repeated public intoxication, the target population of sobering centers, disproportionately consume police, fire department, EMS, and hospital resources in a cycle that burdens health and law enforcement systems without sustainably improving the individual's wellbeing.[6]

Alcohol-related ED visits in the United States have increased by over 50% in the last decade.[7] Nationally, 9.7% of all ED visits relate to alcohol consumption. These visits are accompanied by longer hospital stays and increased use of expensive hospital equipment, placing a significant strain on hospital resources.[7] The ED, which is designed and staffed to treat acute illness, is not best suited to manage chronic or recurring conditions like alcohol use disorders. As a result, alcohol-related ED visits often lead to frequent users of hospital resources, indicating that it is not the most effective intervention for alcohol use disorders.[8]

The Sobering Center Model and Pilot Project

The sobering center model has been an effective, harm-reduction intervention for chronically homeless and alcohol dependent individuals across the country, thereby reducing their strain on hospital and law enforcement resources, minimizing their personal risk of violence and injury, and ultimately improving their health outcomes. There are at least two dozen sobering centers in the United States, and more internationally.[9] By providing an alternative destination for intoxicated individuals who do not require further medical attention, sobering centers can relieve local hospitals and First Responders from providing costly resources to those without acute medical needs.[10,2] For example, a sobering center in Houston, Texas saw a net fiscal gain of $2.9 million within the first two years of operation, and the daily operating cost of San Francisco's sobering center, which on average serves 10-14 clients a day, is equivalent to one ambulance ride and ED visit.[11,12] In addition to reducing healthcare costs, sobering centers can provide appropriate care for chronic intoxicants while allowing EDs to focus on other patients with acute needs. The continuity of care coordination, monitoring, and advocacy available at sobering centers provide a needed safety net and point of care for marginalized homeless and alcohol-dependent individuals who are often not effectively connected to services. Acknowledging that those with alcohol-dependence cannot be forced to seek treatment, sobering centers allow individuals to connect with resources on their own accord by first and foremost providing a safe and secure location for intoxicated and housing-insecure people who may not be accepted at traditional shelters.[11] In this

safe and trusted environment, individuals are supported to connect with social services, a critical component of alcohol use disorder treatment.[1]

The City of Renton Sobering Center Pilot seeks to address disparities among people with alcohol dependence in the cities of Kent and Renton under Public Health – Seattle & King County (PHSKC) - EMS's Vulnerable Populations Strategic Initiative (VPSI). The VPSI conducts program evaluations to "assure that EMS provides the best possible care to all King County residents regardless of race, ethnicity, age, socio-economic status, culture, gender or language spoken."[13] King County's EMS system is unique in that it is medically-based, regional, and uses a tiered response. Its regional partners include fire departments, paramedic programs, EMS dispatch centers, and hospitals.[14] As a result, King County EMS is one of the highest regarded in the world.[15] The Sobering Center Pilot aligns with PHSKC - EMS's medical model by integrating health and social services, relying on collaborative decision-making among many community stakeholders, and exemplifying an innovative strategy to increase the efficiency and effectiveness of the EMS system by diverting patients from jails and hospitals when appropriate.[2]

The pilot was designed after community partners identified the formidable need for an alternative destination for intoxicated patients who did not require Emergency Department (ED) services in South King County. EMS baseline data indicate that EMS response to alcohol-related calls in South King County are more than double those in North King County. According to 2008-2012 PHSKC data, alcohol-induced deaths in South King County are similar to the rate in Seattle (10.1 and 10.4 per 10,000 population, respectively), but higher than East (5.7/10,000 population) and North King County (8.3/10,000 population). Sub-regions of Kent and Renton have high alcohol-induced death rates (9.2 and 15.5/10,000 population, respectively). Considering the high prevalence of alcohol-related EMS calls and alcohol-induced deaths, along with the lack of available services in South King County, the Cities of Kent and Renton identified alcohol abuse as a priority issue and agreed to collaborate on the Sobering Center Pilot. After looking at many sites that might be suitable for the facility, St. Vincent de Paul offered a section of its thrift store on the outskirts of Renton. For the purposes of the pilot, referral to the Center was limited to Kent and Renton Police Departments, Puget Sound Regional Fire Authority (Kent Fire), Renton Regional Fire Authority, and Valley Medical Center. While the initial pilot design did not intend for the facility to accept walk-ins, clients self-referred from the beginning. Since there were sufficient beds available, protocols were quickly adjusted and walk-ins via self-referral were permitted throughout the remainder of the pilot.

By primarily serving inebriated and chronically homeless individuals, the Sobering Center is modeled after the Dutch Shisler Service Center, an existing sobering center in Seattle. Like the Sobering Center Pilot, the Dutch is also operated by Pioneer Human Services, a local nonprofit that seeks to rehabilitate those with mental health and substance use disorders. Experienced staff from the Dutch established and operated the Sobering Center Pilot to mirror the Dutch's referral and intake process, but on a smaller scale; the Dutch is a 60-bed facility open 24 hours, 7 days a week, while the pilot facility had 8 beds to accommodate the estimated demand EMS assessed from baseline data. Unlike the pilot, the Dutch is in a central and high-foot traffic area of the city, has on-site social services, and utilizes its own non-emergency vans to transport clients to and from the facility.

METHODS

This mixed methods evaluation of the City of Renton Sobering Center Pilot included both quantitative and qualitative data collection and analysis. The evaluation plan was designed with input from advisors and program stakeholders (*Appendix A*). Pioneer Human Services, who operated the Sobering Center Pilot, collected initial data during the nine-month pilot through intake forms (*Appendix B*), which

contained self-reported data. The demographic data included age, gender, race/ethnicity, and homelessness status. Pioneer also collected Sobering Center admission date, referral source, discharge location, discharge method, self-reported medical conditions, self-reported criminal history, self-reported history of receiving mental health services, self-reported drug use, the client's total number of admissions to the Sobering Center, and pilot clients who also had a history of utilizing Seattle's Dutch sobering center. Through documentation review of Pioneer's records, the quantitative data were aggregated and de-identified into a dataset to protect client confidentiality. User data were confidentially shared with Valley Cities to determine if Sobering Center clients utilized behavioral health services after discharge. The resulting outcome data were again aggregated and de-identified. The data were analyzed for frequency and statistically significant relationships between variables.

Qualitative data were collected through 8 site visits, 8 recorded interviews, and 6 online surveys with a total of 16 key project partners involved in planning and executing the Sobering Center Pilot. Site visits were conducted with as many direct service providers as possible to understand and illuminate First Responders' first-hand experiences with the Sobering Center Pilot. The interview guide (*Appendix C*) was informed by observational data, including site visits and monthly planning meetings with the partners. The survey (*Appendix D*) was designed using Catalyst and contained both open-ended and Likert scale questions that mirrored the interview guide questions. The project partners who provided qualitative feedback represented Kent and Renton First Responders, Pioneer Human Services, Valley Medical Center, Renton Ecumenical Association of Churches (REACH), Tri-Med Ambulance, Valley Cities Behavioral Health Care (Kent and Renton), the City of Renton, King County EMS, and the Department of Community and Human Services. The qualitative data were aggregated, de-identified, and evaluated for trends in perceived strengths, barriers, and recommendations for next steps.

EVALUATION FINDINGS

Sobering Center User Demographics

During the nine-month pilot, Pioneer reported 87 unique users and 319 duplicate encounters to the Sobering Center. User age ranged from 18 to 77 years old, with a mean age of 42 years old. Of the 87 users, the majority (75 or 86%) were male. Users were racially diverse, with 40 (47%) being White, 14 (20%) being Black/African American, and 7-9% representing each of the following racial/ethnic groups: American Indian/Alaska Native, Hispanic/Latino, Other, and Unknown/Not Reported. While not all Sobering Center users were confirmed as being residents of Kent or Renton, these demographics reflect the ethnic and racial diversity of the cities' populations; notably, Black/African American, American Indian/Alaska Native, and Other racial and ethnic groups were over-represented among Sobering Center users compared to the cities' demographics (*Appendix E).*[16,17] Among the self-reported information collected during Sobering Center intake, 81 (93%) of users reported being homeless, 41 (47%) reported receiving mental health services in the past, 35 (40%) of users reported a misdemeanor or felony conviction in the past, 29 (33%) reported having medical conditions including seizures, hypertension, diabetes, or other medical issues, and 40 of 319 (13%) encounters reported other drug use the day of admission. The Sobering Center Pilot users' characteristics are consistent with demographic trends of other sobering centers nationwide; most sobering center clients are men, homeless, and many have concurrent drug abuse or other chronic conditions.[9] Many sobering center users are also the highest users of law enforcement and hospital systems, constituting some of the highest-cost individuals to public systems.[11] The Sobering Center Pilot engaged with the same target population, diverting them from other costly resources while providing a safe and secure location for those with complex health and social needs. Sobering Center staff identified clients as being intoxicated upon intake (either by Blood Alcohol Content or "alcohol on breath" observation),

indicating that the Sobering Center was being properly used as a sobering facility rather than solely as a shelter.

Table 1: Sobering Center Client Characteristics (N=87)

Characteristic	**N (%)**
Unique Encounters	87
Duplicate Encounters	319
Sex	**N=87**
Male	75 (86)
Female	12 (14)
Race/Ethnicity	**N=87**
White	40 (47)
AI/AN[1]	7 (8)
Asian	2 (2)
Hispanic/Latino	6 (7)
Black/African American	17 (20)
Native Hawaiian/Other Pacific Islander	1 (1)
Other	6 (7)
Unknown/Not Reported	8 (9)
Homeless[2]	**N=87**
	81 (93)
Received Mental Health Services[2]	**N=87**
	41 (47)
Criminal History[2]	**N=87**
	35 (40)
Medical Conditions[2,3]	**N=87**
	29 (33)
Other Drug Use[2,4]	**N=319**
Marijuana	30 (9)
Methamphetamine	8 (3)
Heroin	2 (1)
Age, yrs	**N=82**
Mean (SD[5])	42 (13)

[1]American Indian/Alaska Native; [2]Self-reported; [3]Medical conditions include seizure, hypertension, diabetes, or other; [4]Drug use at time of admit; [5]Standard Deviation

Sobering Center Referral and Discharge Data

Among the 319 total admissions to the Sobering Center, the highest prevalence of Sobering Center admissions occurred in March and June (50 and 55 admits, respectively.) Between June and

September, there was a steady decline in admissions (from 55 to 32). The reasons for these trends could not be definitively determined through this evaluation.

Table 2: Sobering Center Usage, Referrals, and Discharges (N=319)

Characteristic	**N (%)**
Median Encounters per Client (IQR)	1 (1, 2)
High users (3+ visits)	14 (16)
Range (visits per client)	[1, 144]
Daily Occupancy (days)	**N=275**
0-1 Clients	178 (65)
2+ Clients	97 (35)
Maximum Daily Clients	5
Average Clients per Night	1.2
Repeat Users from Seattle SC[1]	47 (54)
Referred by	**N=319**
Renton PD	20 (6)
Renton Fire	26 (8)
Kent PD	10 (3)
Kent Fire	21 (7)
Valley Medical	37 (12)
Self-Referral	205 (64)
Discharged to	**N=319**
REACH breakfast	36 (11)
Kent Valley Cities	13 (4)
Valley Medical Center	10 (3)
Renton Transit Center	15 (5)
Street	245 (77)
Discharge Method	**N=319**
Tri-Med	70 (22)
Self/Walk	249 (78)

[1]Seattle Dutch Shisler sobering center

There were 14 clients who used the Sobering Center three or more times (labeled as "high users"). There were no significant associations between high users and demographic variables. High users visited the Sobering Center more times than the median number of visits (1), with one client visiting the Sobering Center 144 times over the nine-month pilot. Readmissions are a common attribute of sobering centers across the country. Compared to single users, repeat users are typically older, more likely to be homeless, have spent more time homeless, suffer from more chronic conditions, have a higher service utilization rate across systems, and have a higher use of ambulances/the ED, along with their related costs.[18,19] High utilization among certain Sobering Center Pilot clients not only diverted a vulnerable population with complex needs from using other systems, but it also allowed for continuity of care and opportunities for brief interventions and referrals. Repeated walk-ins to the Sobering Center Pilot indicate that high users are cognizant of their substance use issue, desire a safe place to

stay, and are aware of some of the resources available to them should they desire to seek treatment services in the future.

Of the 275 nights of operation of the Sobering Center Pilot, 178 nights (65%) had 0-1 clients occupying the facility, and 97 nights (35%) had 2 or more clients. The highest occupancy on a single night was 5 clients. With 8 beds available nightly, the facility was never fully occupied.

Those who also used the Seattle Dutch Shisler sobering center were significantly more likely (OR = 6.5, p=.009) to be high users of the Sobering Center Pilot than those who did not use the Dutch. While no outreach was conducted to Dutch clients to encourage them to use the pilot facility, word-of-mouth and familiarity with the sobering center model likely resulted in duplicate clients, who reportedly preferred the pilot's quiet and intimate nature compared to the larger Dutch facility. The relative proximity of the pilot facility to a transit center also allowed clients to travel between Seattle and Renton.

Of the five referring agencies, including Puget Sound Regional Fire Authority, Renton Regional Fire Authority, Renton Police, Kent Police, and Valley Medical Center, Valley Medical made the most referrals to the Sobering Center (37 or 11.6%). Despite the accessibility issues of the Sobering Center, including geographic remoteness, lack of public transportation, limited walkability, and limited hours, the majority of Sobering Center clients were walk-ins or self-referrals (205 or 64.3%), indicating that the Sobering Center was needed and sought after by those motivated to access it. The consistent low referral numbers reflect the barriers that referring agencies faced in connecting clients to the Sobering Center, which are discussed further in the qualitative findings section of this report. Most discharges in the morning were to the street (245 or 76.8%), though Tri-Med transported clients 70 times (21.9% of discharges). While discharges by Tri-Med transport increased over the first 3 months of the pilot, it then tapered off, as self-referrals and self-discharges increased (*Figures 2 and 3*). There were consistent challenges throughout the pilot facilitating sufficient referrals to fully occupy the Sobering Center. Client-level data are not available to describe demographic trends of clients by referral source or discharge location.

When Tri-Med transported clients during discharge, they most often transported individuals to the nearby REACH breakfast, where outreach services were sometimes available (*Figure 4*). However, there is no mechanism to confirm if those individuals utilized the breakfast or other services available at discharge locations. Tri-Med transportation to the breakfast declined after the first few months of the pilot, as self-referrals and self-discharges increased.

Figure 2: Referrals to the Sobering Center by Month (N=319)

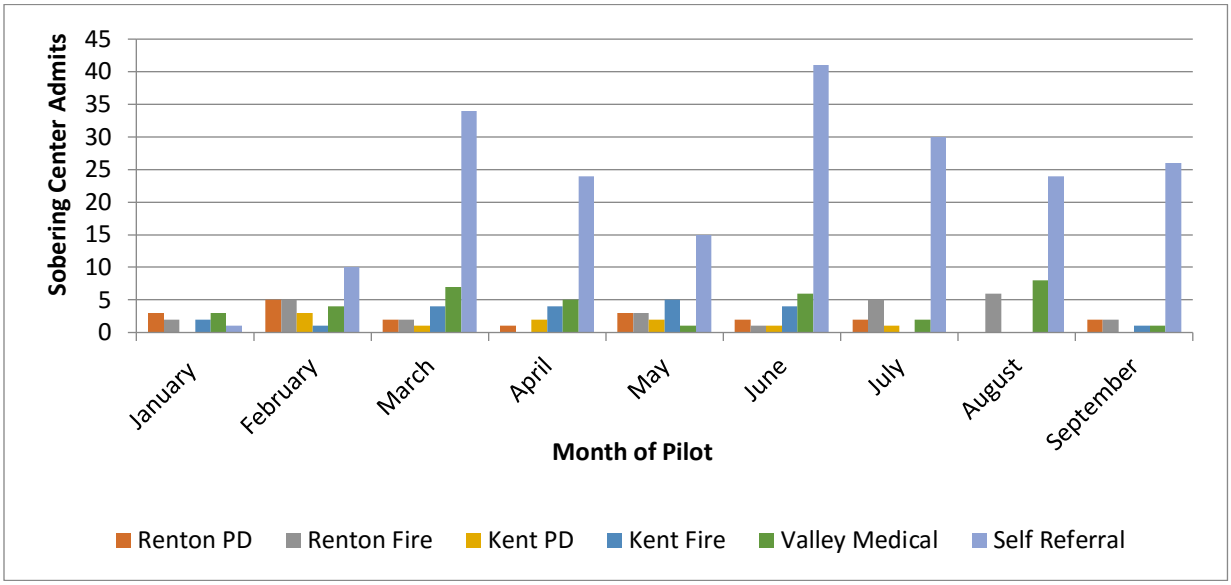


Figure 3: Sobering Center Discharge Method by Month (N=319)

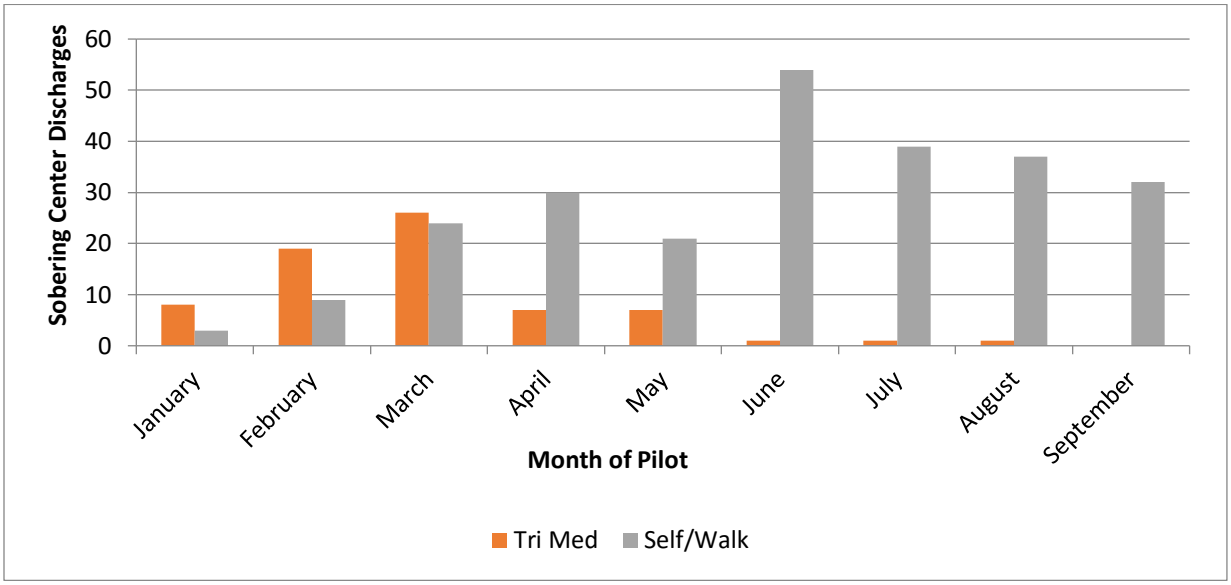
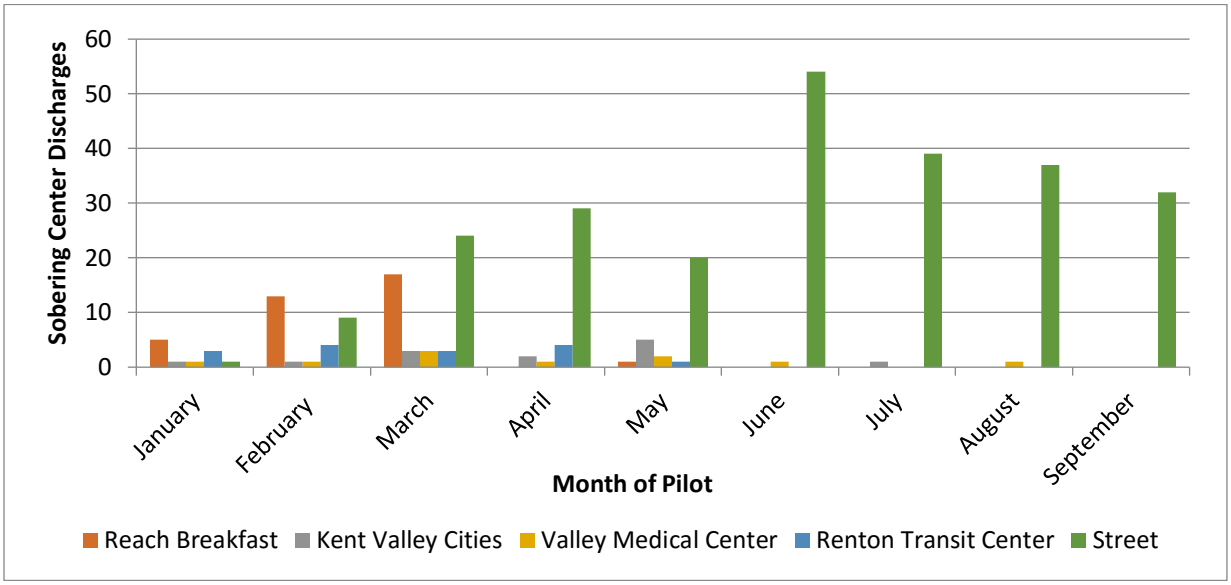


Figure 4: Drop-Off Locations of Sobering Center Discharges by Month (N=319)



Outcome Data: Connection to Social Services

The outcome goal of the pilot was to connect Sobering Center Pilot clients with services at Valley Cities, a community behavioral health system in South King County. Sobering Center clients who originated from Kent had the option of being discharged directly to the Valley Cities Kent location. Several social service agencies, including Renton Housing Authority, Catholic Community Services, St. Vincent de Paul, FD CARES, and Valley Cities Renton provided outreach services at the REACH breakfast, a discharge location option for Sobering Center clients who originated from Renton. Bus tickets were available at the breakfast to facilitate easier transportation to Valley Cities Renton, though it does not appear that the bus tickets were utilized. Table 3 includes outcome data indicating Sobering Center clients who connected with Valley Cities Kent and Renton. The outcome data were aggregated and de-identified to protect patient confidentiality. Consequently, data analyses identifying trends among outcomes and other variables are not available.

Table 3: Valley Cities Outcomes for Sobering Center Clients (N=87)

Outcome	N (%)
No engagement with Valley Cities	68 (78)
Engagement with Valley Cities only before Sobering Center admission	8 (9)
Engagement with Valley Cities after Sobering Center admission	11 (13)
Enrolled in Valley Cities services	5 (7)
Engaged with Valley Cities, but did not enroll in services	6 (9)
Engaged with Valley Cities before and after Sobering Center admission	1 (1)

Of the total 87 unique Sobering Center clients, 68 (78%) had no engagement with Valley Cities before or after their Sobering Center admission. Several clients (8) were already connected with Valley Cities before their Sobering Center admission, but did not utilize those services again after their admission.

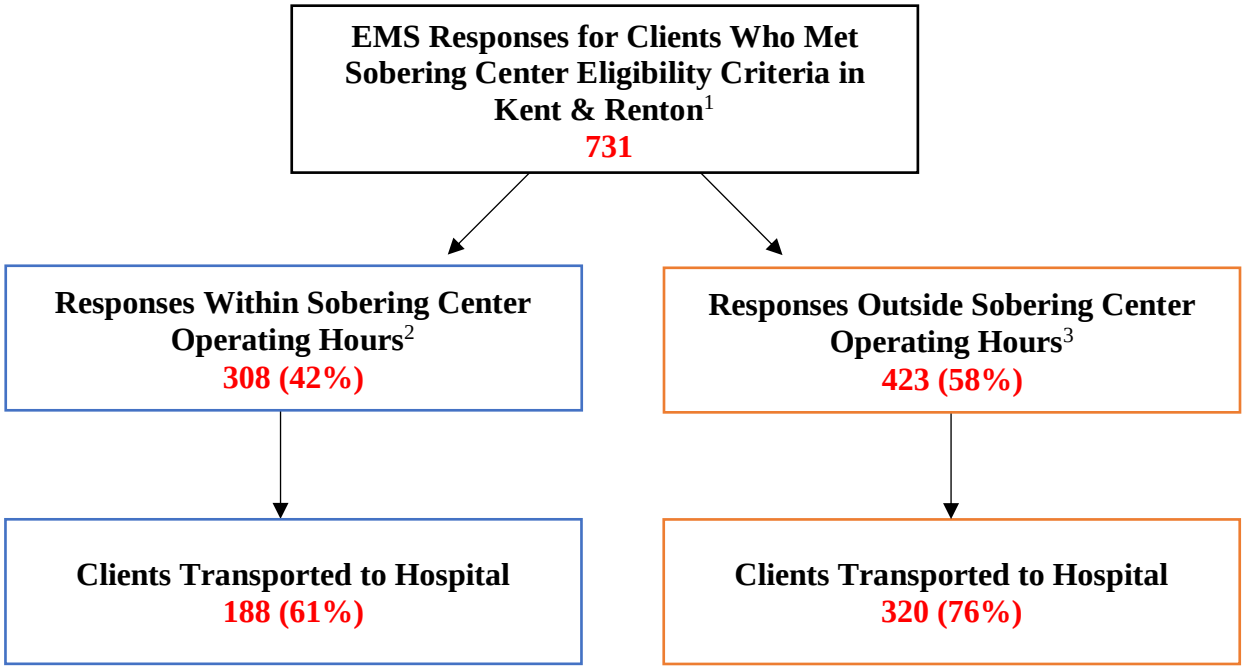
Of the 87 sobering center users, 11 (13%) had some type of engagement with Valley Cities, and 5 of those enrolled in services. The remaining 6 walked in the doors, interacted with staff and/or received information, but did not enroll. Since 47% of Sobering Center clients reported receiving mental health services in the past, some portion of the 68 individuals who never engaged with Valley Cities likely received services from a different behavioral health system. The 11 clients who were motivated to connect with Valley Cities over the nine months, despite all the steps in the continuum of Sobering Center services (*Figure 1*), indicates a notable success of the pilot.

By facilitating referrals from the Sobering Center Pilot to Valley Cities Behavioral Health Care, the pilot project sought to provide integrated services that addressed both psychiatric and substance abuse. Integrated interventions have proven more effective for homeless individuals with mental illness and alcohol dependence than single vertical interventions, like the ED. Integrated services, like sobering centers and counseling services, have led to a reduction in legal problems, increase in social support, and ultimately greater improvement in treating alcohol abuse among homeless and alcohol dependent individuals.[20] Like other sobering centers across the US, the pilot struggled with the availability of case managers and other social service providers to provide outreach and make appropriate referrals.[2] This was further limited by the fact that these services were not available on-site at the Sobering Center, requiring an additional transportation step and providing an opportunity for clients to disengage.

EMS Pilot Data

While the Sobering Center served 87 unique individuals with 319 total encounters, data indicate that this was only a small percentage of total clients in the region that could have benefited from the Sobering Center. According to EMS data collected during the Sobering Center Pilot (*Figure 5*), Fire Departments in Kent and Renton responded to 731 alcohol-related calls for clients that met the eligibility criteria for the Sobering Center. Of those calls, 308 (42%) occurred during Sobering Center operating hours, and over 60% of those calls resulted in transport to a local hospital. During the pilot, Kent and Renton Fire referred 47 admits to the Sobering Center, accounting for just 15% of Sobering Center-eligible EMS calls. These data indicate the need for expanded Sobering Center hours as well as the missed opportunities for Sobering Center referrals to divert patients from costly hospital resources. There are several limitations of the EMS data; location type of each response could not be discerned, and therefore the dataset includes non-street and highway responses, one of the eligibility criteria for Sobering Center referrals. The data also do not reflect interventions provided by EMS First Responders, which would deem a client ineligible for the Sobering Center.

Figure 5: Sobering Center-Eligible EMS Responses, Kent & Renton (Jan. – Sept. 2017)



[1]Eligibility criteria include primary diagnosis codes related to alcohol use without health needs requiring the ED, and those ages 18 or older

[2]Although the Sobering Center closed at 8:00, operating hours were regarded as 20:00 to 5:00, when the Sobering Center stopped accepting new clients

[3]Hours outside of Sobering Center operation were 5:01 to 19:59

Qualitative Data: Findings from Interviews, Site Visits, and Surveys

The 16 sources who were interviewed and/or surveyed were comprised of direct service providers, including First Responders and social service outreach staff, and leadership from the pilot project partner agencies. Those involved in referring clients to the Sobering Center, including First Responders, tended to find the pilot more burdensome than those involved in other aspects of the pilot primarily due to difficulties remembering and navigating the many nuances of eligibility, particularly among agencies that work 24/7 across multiple jurisdictions. Agencies internally promoted and communicated information about the pilot to their staff through online and in-person memos/emails, in-person briefings/trainings, and physical reminders (e.g. signs and resource cards). Half of the respondents (8/16) reported conducting or receiving repeated in-person reminders, which they found more effective than emails or memos. All the First Responders visited through site visits also reported that physical reminders, including resource cards or "cheat sheets" with simple referral instructions, were useful tools to facilitate their referrals to the Sobering Center.

The qualitative data, pulled from interviews, site visits, and surveys, exposed barriers and facilitators for the Sobering Center Pilot, and can be used to inform future similar projects (*Appendix F*). The weighted averages of the Likert scale survey questions regarding respondents' level of satisfaction with various project components mirrored the overall qualitative results.

The major barriers identified by the project partners were:

Challenges in communication between project partners (13/16 or 81%)
Site visits and interviews exposed that there was a lack of coordinated communication between the many partners of the Sobering Center Pilot. There were instances where direct service providers did not receive all updates and feedback discussed at monthly meetings. There were also changes in staffing for several agencies during the pilot, which posed communication challenges when that person was the agency's primary liaison to the pilot. Some partners felt that there was insufficient communication before the pilot started to adequately prepare for the pilot. Partners also commented on the lack of coordinated communication between partners involved in different components of the pilot. These communication lapses prevented warm hand-offs and opportunities to troubleshoot issues, while also resulting in some confusion around each partner's role in the pilot. The communication challenges also reflect the challenges of collaborative projects when agencies are accustomed to working in silos.

Design limitations, including hours, location, eligibility requirements, and timing of services (16/16 or 100%)
Nearly all respondents indicated that the hours of the pilot were a barrier for clients and staff alike. The limited hours of the pilot did not align with First Responders, who respond to calls 24/7. Although the hours of the Sobering Center were selected to maximize the facility's availability, the EMS data indicate the need for more extended hours to meet the demand of acute intoxication calls, the majority of which occur between the hours of 12pm and 3am. Some partners found the location of the Sobering Center Pilot challenging, as it was isolated, hard to access by foot or public transport, and was not close to the city center where the target population and other social services are located. Some First Responders believed that the pilot facility, which was co-located with a St. Vincent de Paul thrift store, was not well-suited or inviting for the target population. Those in leadership positions generally found the location and facility to be appropriate and essential to getting city buy-in, as the cities preferred that the pilot be less centralized and visible for city residents. First Responders also expressed lack of clarity around standardized eligibility protocols; this was particularly challenging for agencies that worked across Kent or Renton city limits, who had to remember where they were while determining if a client was eligible for the Sobering Center.

Time lapses between the continuum of pilot services were a challenge to maintain client engagement; clients were discharged from the Sobering Center and transported by Tri-Med to their drop-off location earlier than outreach services (REACH breakfast and Valley Cities Kent) opened. This resulted in lack of warm hand-offs between Tri-Med and service providers, who infrequently encountered each other. Consequently, the only way to identify clients as coming from the Sobering Center was if they self-identified themselves, which rarely occurred. Partners speculate that many clients did not wait around for services to open, and even if they were transported to a location in the morning, they walked away before accessing services.

Difficulties fostering culture change among providers (6/16 or 38%)
First Responders and their management expressed difficulties remembering the Sobering Center as an option when they encountered acutely intoxicated clients, as they are habitually accustomed to sending those clients to the ED. This was confirmed by the EMS pilot data, which identified 308 Sobering Center-eligible EMS calls that occurred during the facility's operating hours, with most of those calls resulting in transport to a hospital. First Responders who worked at multiple sites, some of which were not within the pilot's jurisdictions, often did not know about the pilot or understand it well.

Respondents also commented that the Sobering Center Pilot lacked standardized direct outreach to educate providers, including before the pilot started. The onus was on agencies to educate their providers, resulting in inconsistencies across partners.

Lack of warm hand-offs and opportunities for clients to disengage (9/16 or 56%)
Lack of coordinated communication between service providers, as well as time lapses between Sobering Center discharge and outreach services, resulted in lack of warm hand-offs to keep clients engaged throughout the continuum of care. The complex continuum of care (*Figure 1*) indicates many nuances for staff and clients to navigate, resulting in opportunities for clients and referring agencies to disengage somewhere in the process.

Challenges specific to outreach after discharge (8/16 or 50%)
Sobering Center clients had the opportunity to connect with social service agencies at the REACH breakfast, or had the option of being directly transported to Valley Cities Kent upon discharge, depending on the client's original location. Outreach was not provided on-site at the Sobering Center. Therefore, exposure to social services required extra transport steps, and excluded clients who did not go to the REACH breakfast. Some respondents felt that there were insufficient strategies to operationalize the pilot's outreach goals, as the pilot's priority remained building up the Sobering Center client base. Without accurate and standardized methods for data collection and sharing information across outreach providers, it was challenging to identify Sobering Center clients or refer them to other agencies. Ultimately, outreach agencies lacked the capacity to send their staff to the REACH breakfast when they could not verify whether they were reaching Sobering Center clients, resulting in inconsistent availability of outreach services.

The major facilitators identified by the project partners were:

The collaboration and commitment of the partner agencies (12/16 or 75%)
There was a successful collaboration of community-based agencies who planned and facilitated the Sobering Center Pilot. The agencies' missions closely aligned with the pilot, resulting in strong buy-in, political will, and commitment of the partners to the pilot. Several agencies had existing relationships with each other, further facilitating a strong collaborative effort. All the partners were willing to adapt to overcome challenges as they arose, stayed committed to the pilot despite challenges, and supported one another to play their respective roles to make the pilot work. As exemplified through this pilot, bringing local partners together reduces duplication of services and leverages each agency's existing strengths to serve populations with health disparities.

City and County support for the pilot (7/16 or 44%)
The Cities of Kent and Renton, as well as King County EMS and DCHS, were strong advocates for planning and executing the pilot. They provided their resources, expertise, leadership, and community connections to support the partners in serving a vulnerable population in South King County.

Offering a needed service to a vulnerable population (9/16 or 56%)
The Sobering Center Pilot is a needed resource in South King County, a historically high-need and under-resourced area of the county.[21] The project partners indicated that an alternative destination for acutely intoxicated and homeless patients is necessary for diversion from other costly systems, like the ED. Furthermore, providing a safe location for sobering through this harm-reduction model has proven successful elsewhere, including in Seattle.

The monthly planning meetings (7/16 or 44%)
The monthly planning meetings allowed partners to gather, share experiences, troubleshoot issues as they arose, and make collective decisions to improve the pilot. The meetings were a consistent opportunity for agencies involved in different aspects of the pilot to understand the project as a whole. The meetings also facilitated relationship building among agencies, an asset to this project that can also be leveraged in future projects.

LESSONS LEARNED

The primary lessons learned and recommendations suggested by the project partners were:

Meet the target population "where they are at" (10/16 or 63%)
Respondents expressed the importance of prioritizing the convenience and accessibility for clients by expanding service hours to be 24/7, broadening the service area to meet the needs of more individuals, providing social services on-site, and putting the facility in a highly visible and accessible location for clients. Knowing that this target population is a difficult population to motivate towards behavior change, project partners suggested streamlining the continuum of services to include more warm hand-offs and reduce opportunities for clients to disengage. For example, utilizing non-emergency vans, following the Dutch's model, can reduce barriers for First Responders and clients in accessing the Sobering Center.

Promote culture change among providers (8/16 or 50%)
Changing provider behaviors to utilize an alternative service model like sobering centers takes time, repeated information delivery, and comprehensive training to increase provider buy-in. Project partners suggested beginning provider training before a pilot begins, through resources like referral instruction "cheat sheets." When the Dutch Shisler sobering center began in Seattle, Pioneer staff provided direct outreach and education to referring agencies, a component that may have benefitted this pilot. First Responders must also be supported to utilize a service like a sobering center; with the EMS pilot data indicating 731 alcohol-related calls for clients that met the eligibility criteria for the Sobering Center, providers must have adequate resources and support to appropriately refer and triage those clients for non-hospital transport when appropriate. Some respondents requested additional training for First Responders that includes information about substance use and mental health disorders, while supporting the reframing of emergency response "success" away from quick interventions and towards providing wrap-around services. Considering that sobering centers' harm-reduction approach does not parallel traditional First Responder training, and behavior change to facilitate referrals takes time, nine months was likely not long enough to foster a culture change. Many partners hoped that a similar service would become permanent in the future, allowing time for it to become more integrated in the community's service delivery landscape, like Seattle's Dutch Shisler Center.

Facilitate strong relationships between project partners (8/16 or 50%)
While the partners were a clear asset to this project, there were also many communication challenges between partners. Cultivating strong and trusting relationships among all partners, including those in leadership positions and direct service providers, can improve communication and increase warm hand-offs, critical components of harm-reduction interventions. The collaboration between partners should also build shared understanding around defining and operationalizing goals, specifying how partners will work together, and establishing how data will be tracked and shared between partners.

The partners' recommendations are supported by best practices gathered from a cross-sectional study of 11 sobering centers across the US. Lessons learned from other sobering centers include:[22]

- A streamlined referral and intake process for First Responders and other personnel
- A location that is highly visible and accessible, ideally 24 hours a day
- Enhancing collaboration and mutual understanding between all key players to familiarize each partner with one another's roles, foster collaboration, and ultimately facilitate warmer hand-offs between partners.
- A strong referral process, including case managers and healthy relationships between service providers, to link clients to existing community services.

HOPES FOR THE FUTURE

In addition to the recommendations of the partners and best practices gathered from other sobering centers, this evaluation highlighted several other lessons learned to inform future projects of this kind in King County.

Community Response and Buy-in

Community acceptance is paramount to the success of harm-reduction interventions. The Sobering Center Pilot was successful in garnering buy-in from the City of Renton to approve the facility. This approval was contingent on the Sobering Center being outside the city center and minimally visible to city residents. It also relied on clients returning to their city of origin upon discharge so as not to displace one city's homeless population into another. As a result, the Sobering Center was not located in a highly visible and accessible location for clients and service providers. On the other hand, the location was relatively close to transit and the city center to facilitate some walk-in clients. The conflict over the most suitable Sobering Center location reflects the differing needs and concerns of providers, clients, and community members.

This experience is not unique; harm-reduction interventions for homeless, substance-dependent populations are often politicized by decision-makers.[23] Local residents may hold commonly negative perceptions of homeless individuals, including their social and economic burden on communities. This may invoke fear and stigma that harm-reduction services will increase or perpetuate homelessness in their communities.[24] This fear never materialized in the Sobering Center Pilot. Both Valley Cities Behavioral Health Care and Valley Medical Center reported no negative repercussions from serving Sobering Center clients. Similarly, the Commander of the Kent Police Department expressed that the Sobering Center was "all positives with no real negatives," with no increased criminal activity due to the Sobering Center. In fact, St. Vincent de Paul staff reported that vandalism at the Sobering Center site decreased while the Sobering Center was in operation and increased again after the pilot ended. This demonstrates the resulting problems for the community when services are lacking and people are on the street without a safe place to go.

Moving forward, decision-makers should draw on the evidence of this pilot to alleviate community fear and advocate for social services to be more centralized and easily accessible to prioritize the needs of the target population. In serving homeless populations, stakeholders should also be committed to reducing stigma and trauma associated with homelessness and including the target population in designing the intervention to best serve their needs. Finally, transparent, honest, and research-driven information should be disseminated to educate the public about the intervention and its impact on their communities.[23,24,25]

Informing Strategic Initiatives

Lessons learned from the Sobering Center Pilot can also inform broader county-wide strategic initiatives. King County is currently embarking on its Familiar Faces strategic vision, which seeks to create a system of patient-centered, integrated, and community-based services for frequent jail utilizers with complex mental health and substance use needs.[26] Over the next five years, Washington state's Medicaid Transformation project will seek to integrate physical and behavioral health systems while improving health equity.[27] The sobering center model aligns with these strategic visions. Moving forward, the barriers, facilitators, and recommendations revealed by this Sobering Center Pilot can inform how decision-makers and community-based organizations integrate sobering services with other wrap-around services. Partners might investigate opportunities to co-locate a sobering center with other resources that serve populations with complex health and social needs in South King County. A "one-stop shop" for populations with complex needs, containing centralized, low-barrier, and easily navigable services for the target population, has the potential to disrupt the cycle of substance abuse and homelessness, reduce stigma in communities, and ultimately address the root causes of health disparities.

LIMITATIONS

There were several limitations of this evaluation. One of the primary goals of the Sobering Center Pilot was to relieve local hospitals and First Responders from using resources on intoxicated individuals by diverting them from the ED and saving costs. There was no cost analysis included in this evaluation, though established sobering centers have resulted in net fiscal gains by diverting patients from costly hospital and law enforcement systems.[11,12] Determining to what extent the Sobering Center relieved the burden on local hospitals was also limited by the pilot's small sample size and lack of hospital-level data. There were several additional limitations of the Sobering Center user data. To protect client confidentiality, data were aggregated and de-identified, restricting data analyses from assessing for significant associations between some variables. Some data were self-reported by clients, which could result in information bias and affect data validity. Differing data collection methods between the various partner agencies also presented challenges for comparing data and measuring outcomes. Pioneer intended to collect additional demographic variables, including tribal and veteran status, which have been disproportionately represented in other sobering center users.[4,5] However, these data were not consistently collected, so this evaluation was unable to assess their prevalence. Qualitative data sources did not include the Sobering Center users or target population, another limitation of this evaluation.

CONCLUSION

The City of Renton Sobering Center Pilot provided a needed service to acutely intoxicated and homeless individuals in the Cities of Kent and Renton. This evaluation assesses to what extent the pilot achieved its three goals:

1) Provide a safe and secure location for acutely intoxicated individuals with no further medical needs

Examining the demographics of the pilot users, the Sobering Center successfully provided a safe and secure location to 87 individuals within the target population, comprised of homeless, alcohol-dependent individuals with complex health and social issues who did not require hospital care. The 205 self-referrals and 14 "high users" of the Sobering Center indicate that clients sought out the facility as a safe and secure location.

2) Connect clients with social service resources

The pilot connected some clients with behavioral health services. Of the 87 unique clients, 11 (13%) engaged with Valley Cities Behavioral Health Care after their Sobering Center admission. Many Sobering Center clients (41 or 47%) also reported already being connected with mental health services. However, the post-discharge outreach component of the pilot faced many challenges in engaging with clients and tracking client outcomes.

3) Relieve systems from using costly resources on acutely intoxicated individuals

With the available data, small sample size, and lack of cost analysis, it is challenging to assess to what extent the pilot met its goal of diverting acutely intoxicated individuals from other costly systems. The EMS pilot data indicate many missed opportunities for Sobering Center referrals compared to eligible alcohol-related EMS calls, with the majority of those calls resulting in transport to the ED. However, the 14 "high users" of the Sobering Center Pilot utilized the Sobering Center rather than the ED, potentially avoiding many hospital visits. While this pilot did not include a cost analysis, other established sobering centers have proven to be cost-effective over time by diverting patients from ED.[11]

While sobering centers offer an acute solution by providing a safe and secure location for individuals to spend the night, this harm-reduction model should be viewed within a comprehensive, integrated approach to address the root causes of substance use, mental illness, and homelessness. Social services that address homelessness, along with accompanying health and social issues, are disproportionately utilized by people of color, low-income individuals, those with complex health issues, and those with criminal histories.[28] These racial, social, and health disparities indicate underlying societal issues that are perpetuated by institutional factors, including racism and discrimination, the criminal justice and mental health systems, as well as livable wages and affordable housing.[28] The County's Familiar Faces strategic initiative is a promising cultural shift to address systemic disparities in King County by providing comprehensive, community-based services to address King County's growing inequities, including those faced by acutely intoxicated individuals in South King County.

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APPENDICES

Appendix A: Evaluation Project Logic Model

Inputs	Activities	Outputs	Outcomes
Sobering Center space (St. Vincent de Paul) Funding/agreement from King County EMS and Cities of Kent/Renton SC staff (EMTs), First Responders who refer, outreach workers SC Protocols/supplies (Pioneer) Data tracking tools and systems	Identifying eligible SC clients on scene Referrals from PD, Fire, Valley Med, self-referrals Transport from scene to SC Intake interview Medical assessment and monitoring by EMTs at SC Discharge Transport upon discharge (if requested) Outreach at REACH breakfast Monthly meetings of key stakeholders (for planning and implementation)	<u>A safe and secure location for the target population:</u> • Number of people served at SC and their demographics • Duplicate clients and their demographics • # referrals to SC from each partner • compare to EMS baseline data (# SC-eligible clients) <u>Access to wrap-around services:</u> • Number of people from SC exposed to support services at breakfast • Discharge method and destination	<u>Connecting clients to wrap-around services:</u> • # SC clients seen at Valley Cities Behavioral Health Care <u>Diversion of ED/jail resources</u> • Comparing cost of SC versus ED (**not part of this evaluation)** • Hospital data: Change in # encounters for intoxication at ED (**not part of this evaluation:** sample size too small) • EMS data: Transport destination of EMS encounters with SC-eligible clients

Appendix B: Sobering Center Intake Form

PIONEER HUMAN SERVICES

Sobering Center
1930 Boren Avenue – Seattle, WA 98101
Telephone: (206) 205-1092
ADMISSION/INTAKE ASSESSMENT

Client Name: _____ DOB/Age: _____

Pickup Location: _____

Current Complaints: _____

Received Mental Health Services(Y/N)____ Convicted of a Crime(Y/N):____ Misdemeanor or Felony(M/F):____

Current Medications: _____

Drugs Used Today: ☐ Alcohol (Time Alcohol Last Used: _____ ☐ Cocaine ☐ Heroin

☐ Marijuana ☐ Methamphetamine ☐ Other: _____

Medical History: Seizure: ☐ Yes ☐ No Hypertension: ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No ☐ Other/Disabilities_____

Presentation: Slurred Speech: ☐ Yes ☐ No Unsteady Gait: ☐ Yes ☐ No

Orientation: Person: ☐ Yes ☐ No Place: ☐ Yes ☐ No Time: ☐ Yes ☐ No

Pupils: Normal : ☐ Abnormal: ☐ Size: L: _____ R: _____

Behavior: ☐ Verbal Aggression ☐ Physical Aggression ☐ Cooperative ☐ Uncooperative

	Date	Time	B/P	Pulse	Resp.	Temp.	Bal.	N/V/Trem	Mat	Code	Initial
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											

Wake-up Time: _____ Client leaves facility early (prior to transport) ☐ Yes

Property that went into Client's Bag: ☐ Jacket ☐ Hat ☐ Shoes ☐ Backpack/Bag ☐ Wallet/Purse
☐ Cell phone ☐ Money ($ _____) ☐ Other: _____

- I have taken possession of all my belongings: ☐
- I understand that I will be responsible for any property I choose to keep with me.
- I also agree to obey the rules during my stay.
- Pioneer Human Services is not responsible for lost or stolen property.

Signatures

_____ ADMISSION
Date & Time of Admission: _____

_____ DISCHARGE
Date & Time of Discharge: _____

Appendix C: Interview Guide

1. What was your organization's role in the Sobering Center pilot? What was your role specifically?
2. How does your organization generally serve publicly intoxicated individuals? How did the Sobering Center pilot integrate into your existing processes?
3. How did your organization communicate support for the pilot and disseminate information to inform staff of its existence and how to use it?
4. How did you work/collaborate with the other partners involved in the pilot?
5. From your point of view, what were the strengths of the pilot? What worked well?
6. What challenges did you/your organization face during the Sobering Center pilot?
7. What do you see as the lessons learned from the pilot to inform successful future projects of this kind? What are your suggestions for future programs of this kind based on what you learned from the pilot?
8. What are your hopes for the future of similar projects that serve homeless and acutely intoxicated individuals?
9. Do you have any final comments that you'd like to share with me?
10. For partners involved in planning/community buy-in: Please explain the process of getting community buy-in to approve the pilot. What were the challenges? What was successful?

Appendix D: Survey

Question 1.

Organization Name

Question 2.

What was your organization's role in the Sobering Center Pilot? (select all the apply)

☐ Pre-pilot planning
☐ Identifying eligible clients for the Sobering Center
☐ Referring eligible clients to the Sobering Center
☐ Caring for clients while at the Sobering Center
☐ Administrative support
☐ Providing outreach and/or social services for Sobering Center clients after discharge
☐ Providing transportation to/from the Sobering Center
☐ Attending monthly Sobering Center meetings during the pilot
☐ Other:

Question 3.

What was **your** role specifically in the Sobering Center pilot?

Question 4.

How did you/your organization communicate support for this program to your providers? (select all that apply)

☐ One-time in-person briefing/training
☐ One-time email/memo
☐ Repeated in-person reminders
☐ Repeated email/memo reminders
☐ Physical reminders (i.e. signs)
☐ We did not disseminate information
☐ I'm not sure or N/A
☐ Other:

Question 5.

The Sobering Center pilot easily integrated into my organization's existing work (choose one)

☐Strongly agree
☐Agree
☐Neutral
☐Disagree
☐Strongly disagree

Question 6.

Please provide your suggestions for reducing the burden on staff in integrating programs like the Sobering Center pilot into your existing work.

Question 7.

In your opinion, what about the Sobering Center pilot worked well?

Question 8.

The following organizational and communication aspects of the Sobering Center pilot worked well:

Collaboration between partners to plan/execute the pilot (choose one)

☐Strongly Agree
☐Agree
☐Neutral
☐Disagree
☐Strongly Disagree
☐N/A

Internal Communication with your organization regarding the pilot (choose one)

☐Strongly Agree
☐Agree
☐Neutral
☐Disagree
☐Strongly Disagree
☐N/A

Pre-pilot planning meetings (choose one)

☐Strongly Agree
☐Agree
☐Neutral
☐Disagree
☐Strongly Disagree
☐N/A

Monthly meetings during the pilot (choose one)

☐Strongly Agree
☐Agree
☐Neutral
☐Disagree
☐Strongly Disagree
☐N/A

City/county support to plan and execute the pilot (choose one)

☐Strongly Agree
☐Agree
☐Neutral
☐Disagree
☐Strongly Disagree
☐N/A

Question 9.

Please provide any additional feedback on organizational and communication aspects of the pilot (see Question #8).

Question 10.

In your opinion, what about the Sobering Center pilot did **NOT** work well?

Question 11.

What, if any, **logistical** challenges did you/your organization face during the Sobering Center pilot? (e.g. hours, location, eligibility requirements, jurisdiction, etc.)

Question 12.

What, if any, **interpersonal** challenges did you/your organization face during the Sobering Center pilot? (e.g. working with your staff, clients, and partners)

Question 13.

What, if any, **process-related** challenges did you/your organization face during the Sobering Center pilot? (e.g. changes to your existing assessment/referral procedures, hand-off processes, etc.)

Question 14.

What are your suggestions for future programs of this kind based on what you learned from the Sobering Center pilot?

Question 15.

What are your hopes for the future of similar projects that serve acutely intoxicated and homeless individuals in South King County?

Question 16.

Additional comments:

Appendix E: Population Demographics of Kent and Renton by Race/Ethnicity (2015)

Figure 6: Renton Demographics by Race/Ethnicity, 2015[16]

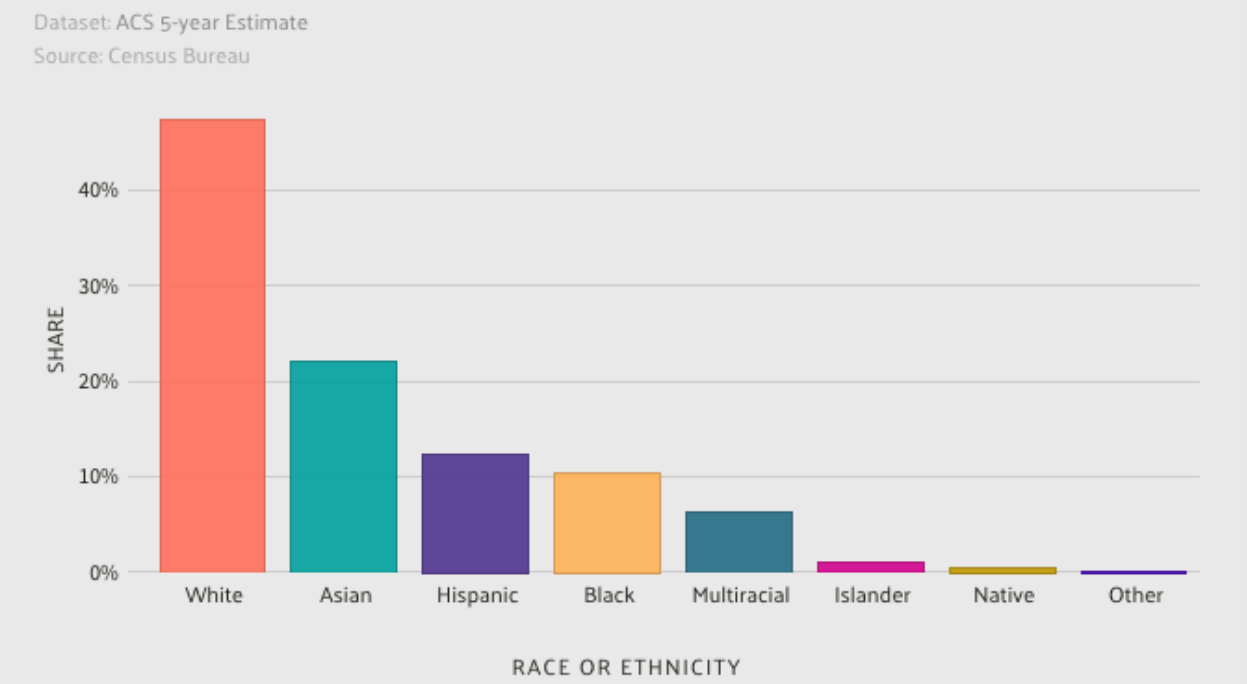
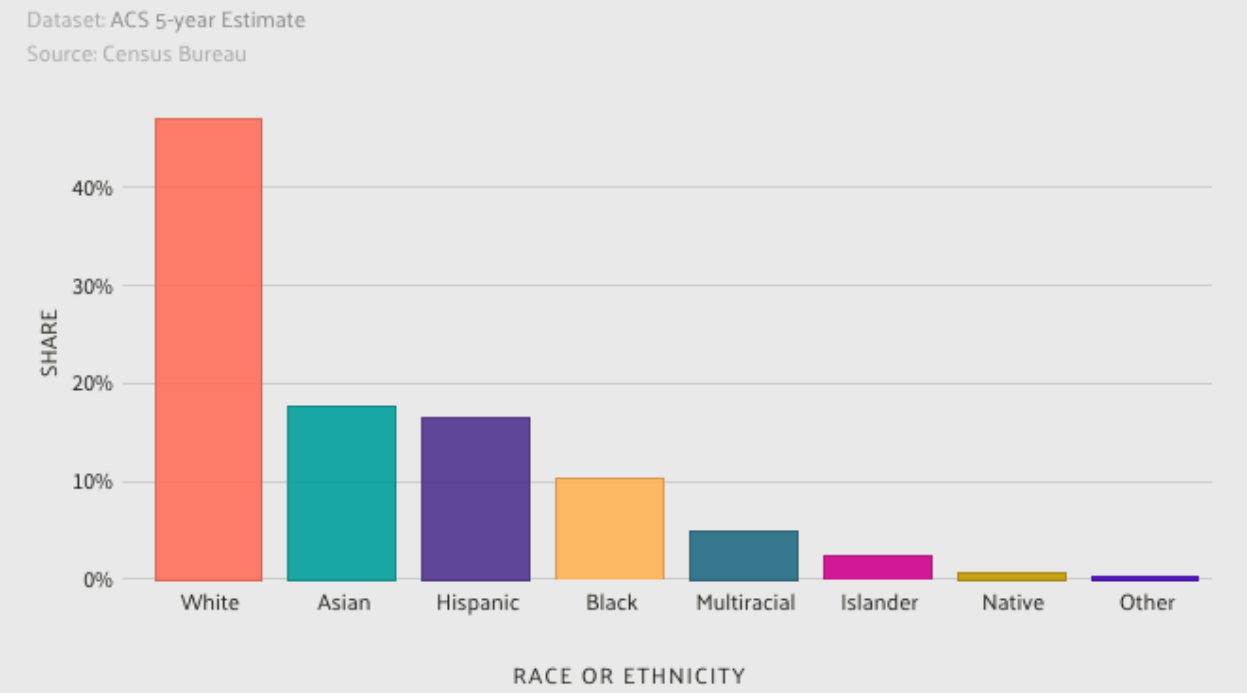


Figure 7: Kent Demographics by Race/Ethnicity, 2015[17]



Appendix F: Aggregate Qualitative Data Results

Question 2: Level of Burden Integrating Pilot

Job Role	Level of Burden (count)
Direct Service Provider - First Responder	Easy: 2 Neutral/Difficult: 2
Leadership (Involved in Referral Process)	Easy: 0 Neutral/Difficult: 4
Leadership (other)	Easy: 8 Neutral/difficult: 2

Response (count)
Minimal/easy (6) -replication of a successful model in Seattle (4) -fit into existing services/mission/scope of work (5) -resource card to facilitate easy referrals (1)
Neutral (3) -difficulty reminding staff to use it (1)
Difficult (3) -lack of staff understanding of when/how to use it/remembering to use it (1) -hours were major barrier to easy integration (2) -jurisdiction limitations (1) -limited staff capacity to take on pilot (2)

Question 3: Internal Communication About Pilot

Response (count)
information from monthly meetings did not trickle down from management to on-site providers (2)
on-time email/memo (1)
one-time in-person briefing/training (2)
repeated in-person reminders (8) -were more effective than emails/memos (1) -difficult when staff move around to other sites that don't use SC (1)
repeated email/memo reminders (5)
physical reminders (signs, resource cards) (3) -were effective to remind staff to refer to SC (3)

changes in staffing/late onboarding into pilot resulted in communication/information lapses (2)

Question 4: Collaboration with Partners

Response (count)
lack of direct communication between SC partners (6) -SC staff with outreach agencies (4) -SC staff with referral agencies (2) -between outreach agencies (3) -Tri-Med and destination agency (1)
Primarily happened at monthly meetings (5)
Lack of communication to partners prior to pilot starting (1)
Good collaboration among partners with existing relationships (8)
Confusion re: each partner's role in SC pilot (3)

Question 5: Strengths of Pilot

A. Planning

Response (count)
Location; Jurisdiction limitations necessary for buy-in (3)
Collaboration of partners committed to the pilot (12)
Monthly meetings (7)
City/county support (7)
Offering a needed resource (SC) (6)

B. Implementation

Response (count)
Replication of a successful harm-reduction model (3) -Pioneer is experienced, replication of that model
Having support/outreach services integrated into pilot (3)
Eligibility guidelines were clear (2)
Tri-Med (3)
Resource cards/sign reminders (2)

Streamlined internal processes developed for pilot (2)

Question 6: Challenges of Pilot

A. Logistics

Response (count)
Location -isolated (5)
Transportation (5) -no vans for easy transport -only 1 ride offered after discharge
Timing laps → no warm hand-offs (9) -Discharge to breakfast/VC
Hours (12) -not 24/7
Physical SC space (2) -not well-suited for SC
Inconsistent attendance at monthly meetings (3)
Unclear eligibility requirements (5)
Inability to track SC clients after discharge and share PHI/data (6)
No on-site outreach (5) -breakfast only opportunity to connect with resources
Too many steps (3)
Jurisdiction limitations (9) -political tension between cities -Awareness of SC among staff who work at multiple sites (2)

B. Communication

Response (count)
Lack of communication between managers and on-site providers to share info from monthly meetings (1)
Lack of direct communication between partners (9) -confusion around partners' roles (2)
Limited staff capacity to take on pilot (4)

Staff changes during pilot (6)
No standardized outreach tools (4)
Not enough info for partners prior to pilot starting (2)
Lack of shared understanding re: outcome goals and infrastructure to meet them (4)
Limited communication with Valley Medical (4)

C. Process

Response (count)
SC clients discharged to street - limited opportunity to engage and track (4) -lack of controlled discharge
Changing behaviors/culture to make referrals (6) -remembers SC is an option -educating/training providers to use SC (4)
Allowing walk-ups (1) Allowing high utilizers (1)
Allocating resources to fund SC (1)

Question 7: Lessons Learned

Response (count)
Use Dutch's transportation model (vans) (1)
Expand hours to 24/7 (6)
Improve communication/relationships among community-based orgs/partners (4)
Better promotion/training among providers (6) -buy-in is critical -start before pilot
Expand service area (1) -to match that of providers
Takes time to change behavior/culture change (2) -9 months not long enough
Meet patients where they're at (e.g. on-site outreach services) (2)
Clearly define goals and strategize how to operationalize them from the beginning (2) -Establish way to share information despite HIPAA (1)

-emphasize importance of outreach (2)
We can have a larger impact together than separately (1)
Streamline the process to include warm hand-offs and reduce opportunities for clients to disengage (2)
How this pilot fits into larger county strategic plan to integrate wrap-around local services (1)

Question 8: Hopes for the Future

Response (count)
It's a needed service - would like to see it exist in the future (9) -should be accessible to the population, meet them where they're at (3)
Need for expanded hours (3)
Coordination of community-based organizations, working together (2)
Need to address root of problem to disrupt cycle of substance abuse/homelessness (2)
Foster community buy-in (4) -to reduce stigma towards the target population -so partners understand pilot
One-stop shop for vulnerable populations (4) -Integrate this model into an existing service -centralized -easy to navigate -low-barrier -addresses complex wellness needs