



Sobering Centers Explained: An Environmental Scan in California

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About the Author

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About the Foundation

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Introduction

Sobering centers offer an alternative to the emergency department (ED) and jail for people who are acutely intoxicated in public. A person with acute intoxication in public can suffer numerous harms, including injury from falls, poisoning, exposure to the elements, or victimization. Typically, the intoxicated person is brought either to jail or the ED until they have sobered sufficiently to no longer be a danger to themselves.

Informed by interviews with leaders in the field and stakeholders, this report describes the range of sobering center models in California and documents commonalities, differences, collective challenges, and best practices. This report is intended to provide background for health care leaders and policymakers in California when planning for, developing, and enhancing the use of sobering centers for acute intoxication.

Background

One-quarter of the nation's known sobering centers are in California. Multiple centers have been developed in the last five years with support from California's Whole Person Care Pilot,¹ made available through the state's Section 1115 Medicaid Waiver, and Proposition 47 grants.² As programs have developed in California, there has been considerable discussion regarding the use of sobering centers as an alternative destination to the emergency department for ambulance personnel. California Emergency Medical Services Authority has an ongoing pilot evaluating ambulance transports to alternate destinations, including sobering centers and mental health facilities.³ Three sobering centers participate — the San Francisco Sobering Center, the David L. Murphy Sobering Center in Los Angeles, and the Mission Street Sobering Center in Santa Clara County.

There has likewise been ongoing legislative action, including four bills proposed since 2018, aiming to update statewide emergency medical services (EMS) policy to permit ambulance transport directly to destinations other than the ED. Three of the four bills

did not advance. They include AB 1795 (Gipson and Ting, 2018, "Emergency Medical Services: Behavioral Health Facilities and Sobering Centers"); SB 944 (Hertzberg, 2018, "Community Paramedicine Act of 2018"), and AB 3115 (Gipson, Bonta, Hertzberg, 2018, "Community Paramedicine or Triage to Alternate Destination Act").

Most recently, California legislators passed AB 1544 (Gipson and Gloria), the Community Paramedicine or Triage to Alternate Destination Act, which was subsequently signed into law on September 25, 2020.⁴ This bill allows for the expansion of local emergency service agencies to establish alternative destinations for triage and transport by paramedics. Sobering centers are included as a potential alternative destination for the care of acute intoxication.

History of Sobering Centers

Sobering centers, also referred to as stabilization or recovery programs, diversion centers, or sobering stations, were initially piloted in the United States 50 years ago. Originating with the inception of the Uniform Alcoholism and Intoxication Treatment Act of 1971, community-based strategies were developed to provide supportive care sites for adults acutely intoxicated on alcohol.⁵ This act was designed to provide states with the legal framework within which to approach care for alcoholism and public intoxication from a health standpoint.

Before sobering centers were established, the traditional response to public intoxication was detainment of intoxicated people in jail cells specifically designated for this purpose — colloquially referred to as "drunk tanks." As an alternative to this approach, which was generating increasingly negative outcomes including deaths from underlying injuries, illness, or suicide, sobering facilities arose with the primary purpose of monitoring, stabilizing, and coordinating provision of care for clients acutely intoxicated on alcohol. These original programs from the early 1970s initially intended to support people during

acute intoxication (“sobering”) and then throughout the alcohol withdrawal and early treatment (“detoxification”) phases. The target population was primarily those with chronic public intoxication, many without homes and with frequent contact with the criminal justice system.

The Need for Sobering Services

Alcohol use disorder is the most prevalent substance use disorder in California⁶ and in the country,⁷ and accounted for more nonfatal emergency department visits in California than all other drug diagnoses combined.⁸ Acute alcohol intoxication may be classified as complicated or uncomplicated. Cases are classified as complicated acute alcohol intoxication if they result from direct deleterious effects of heavy or long-term drinking (e.g., respiratory depression requiring intubation, liver failure) or by other conditions masked by acute intoxication (e.g., intracranial hemorrhage, hypo or hyperglycemia, or cardiac events), all of which would necessitate ED care.⁹

Uncomplicated alcohol intoxication does not require ED-level care. When a person with uncomplicated alcohol intoxication is brought to the ED, care is generally supportive (i.e., requiring observation only). These patients are typically not admitted to the hospital. Moreover, a prolonged ED stay can lead to alcohol withdrawal, a potentially dangerous condition resulting from sudden cessation of alcohol intake and manifested by seizures, severe hyperthermia, unconsciousness, or even death.¹⁰ Studies have shown that for patients assessed with uncomplicated alcohol intoxication in the emergency department, less than 1% required medical care during their stay.¹¹ It is possible to screen for uncomplicated acute alcohol intoxication in out-of-hospital settings (e.g., via ambulance triage) using indicators such as vital signs, glucose levels, and the absence of evidence of injury.¹²

Drug intoxication can likewise impair individuals resulting in a need for evaluation and oversight. Many sobering centers accommodate individuals acutely intoxicated from drugs, in addition to alcohol. Harmful

effects resulting from acute drug intoxication, including risk to the user and to those around them, varies based on the specific drugs consumed. Examples include respiratory depression or death from opioid overdose or the co-ingestion of opioids, alcohol, or benzodiazepines; unintentional ingestion of fentanyl; or behavioral manifestations of psychosis or hallucinations from methamphetamines or phencyclidine (PCP).

Sobering Centers Today

The primary purpose of a sobering center today is the short-term (<24 hours) sobering of adults with acute intoxication who don’t need hospital-based care.¹³ There are an estimated 40 sobering centers in the US, with dozens more in development, offering around-the-clock services. Sobering centers offer a safe place for patients to wait for the effects of alcohol or drug intoxication to wane while being monitored for underlying medical conditions or injury and then connected to treatment and services. Typically, sobering centers provide screening for substance use disorders, brief interventions including motivational interviewing, and direct referrals and transfer to substance use treatment, shelter, or other stabilizing services.

Many sobering programs focus on relieving both the criminal justice system and the emergency medical system by diverting intoxicated adults from jail and emergency departments, respectively. Depending on factors including staffing, funding source, state or local laws, and organizational mission, sobering centers may accept intoxicated people referred by ambulances, law enforcement, emergency departments, clinics, other community programs, or via self-referral.¹⁴ In response to the changing drug use trends across the US, some programs have developed flexible approaches that incorporate the ability to stabilize adults intoxicated on other drugs (such as opioids, methamphetamines, or crack cocaine) in addition to or distinct from alcohol. Although supportive services and referral capacity may be available on-site, the sobering care model is not intended to be a treatment facility nor provide rehabilitation for substance use disorders.

Distinguishing Sobering Care from Other Services

Two other substance use–related interventions are often confused with the sobering care model. First is detoxification, typically referred to as medical or social detox.¹⁵ The goal of detoxification is to safely facilitate complete cessation of alcohol intake often by slowly reducing the amount ingested over a period of days. This can be done with or without medication assistance, depending on the patient and in consultation with a medical provider. Medication is offered when the person is at risk for dangerous alcohol withdrawal syndrome, which can be lethal.

Distinct from detoxification, sobering centers are not intended to result in full cessation or abstinence of a substance. As the name implies, sobering centers aim to sober clients from the unstable and possibly dangerous acute intoxication without then having to manage alcohol withdrawal or treatment services. Sobering is sometimes referred to as “pre-detox,” where the care is aimed primarily at the risk of acute intoxication before signs or symptoms of withdrawal. Referral from sobering to detoxification services can often be facilitated when treatment is desired.

The second model commonly confused with sobering center care is care received in sober living houses. Sober living houses provide a group residential setting for participants in recovery who are abstinent from all drugs and alcohol.¹⁶ A person may reside in a sober living house for many months, often as a final transition from substance use treatment back to home. Typically, substance use of any sort is not tolerated in a sober living facility.

Approach

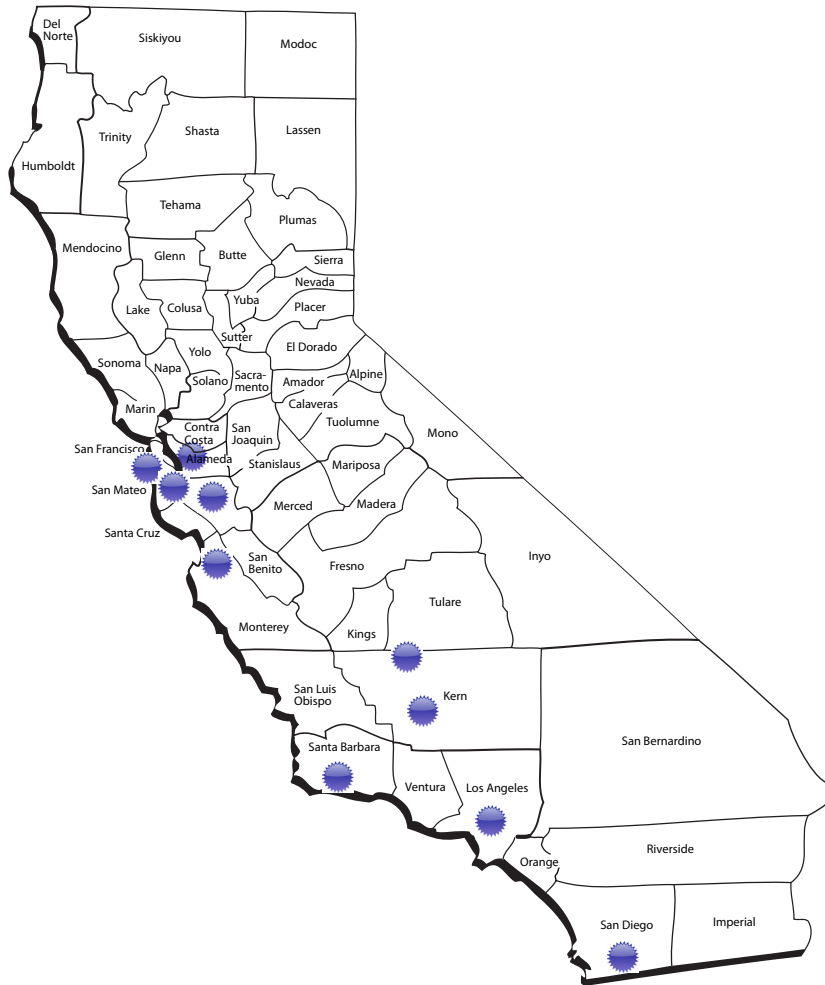
The key question for this project was, What role do sobering centers in California play in the care of those with acute alcohol and drug intoxication? This report is based on three primary sources. First, semi-structured interviews were conducted with two dozen key stakeholders involved in the design, implementation, and/or operation of sobering centers throughout California. Second, programmatic documents and related files of these centers were reviewed to infer common practices and operational components, including policies and procedures, mission statement, guidelines for referring parties (such as triage criteria for emergency medical system providers), intake assessment and monitoring guidelines, and proposed or established evaluation metrics. Last, site visits were conducted for many programs; due to COVID-19 shelter-in-place restrictions, not all centers were visited during 2020.

Findings

As of November 2020, 10 sobering centers are currently in operation in California, with another six to eight additional programs being considered or implemented (Figure 1, page 6; Table 1, page 7). Two centers ceased operation during 2020, one directly related to COVID-19 restrictions and the second likely related to budget fluctuations and reprioritization due to the regional impact of COVID-19 (Table 2, page 7). Leadership and key stakeholders from 9 of the 10 currently open sobering centers participated in interviews for this environmental scan. Additionally, interviews were conducted with staff and stakeholders from one of the recently closed centers and a sobering center currently in development.

There was notable variety in the sobering centers throughout California, including the staffing configuration, facility layout, funding sources, and services provided. Yet commonalities, including harm reduction focus, client-centered care approach, operations, and the principal role of sobering as part of the substance use continuum of care, were prominent.

Figure 1. Sobering Centers in Operation in California, as of November 2020



- Bakersfield Recovery Station**
Bakersfield
Kern County
- Cherry Hill Sobering Center**
San Leandro
Alameda County
- CREDO 47 Stabilization Center**
Santa Barbara
Santa Barbara County
- David L. Murphy Sobering Center**
Los Angeles — Skid Row
Los Angeles County
- Delano Recovery Station**
Delano
Kern County
- First Chance Sobering Center**
Burlingame
San Mateo County
- McAlister Sobering Center**
San Diego
San Diego County
- Mission Street Sobering Center**
San Jose
Santa Clara County
- San Francisco Sobering Center**
San Francisco
San Francisco County
- Sun Street Sobering Center**
Salinas
Monterey County

Note: See the appendix for profiles on each of the ten sobering centers.
 Source: Qualitative research conducted by Shannon Smith-Bernardin, PhD, RN, 2020.

Table 1. Planned or Potential Sobering Centers in California, as of November 2020

COUNTY	CITY	STATUS OF PROJECT	ANTICIPATED OPENING DATE
Contra Costa	TBD	Initially approved for funding in 2016. Location not approved, and project on hold until location identified. Last update summer 2020.	TBD
Los Angeles	Los Angeles	Downtown Safe Haven. Construction delayed due to COVID-19.	Early 2021
Los Angeles	Long Beach	Pending; continued discussions in Long Beach as of mid-2018.	TBD
Los Angeles	Willowbrook	Pending location at MLK Campus — in discussion mid-2018.	TBD
Mendocino	Ukiah	Part of a larger Safe Haven Clinic Initiative colocated with street medicine, medical respite, outpatient pharmacy.	TBD
Orange	TBD	In active planning stages throughout 2020.	TBD
Sacramento	Sacramento	Sobering center aimed at methamphetamine intoxication announced in summer 2020.	TBD
San Diego	Oceanside	Expected opening fall 2020.	Fall 2020
Shasta	Redding	Conversation with sheriff January 2020 indicates still in planning stages.	TBD

Table 2. Sobering Centers in California That Permanently Closed in 2020

COUNTY	CITY	CENTER NAME	DATES OF OPERATION
Santa Barbara	Santa Barbara	Santa Barbara Community Sobering Center	Opened: 1994; closed: March 2020
Santa Cruz	Santa Cruz	Janus Sobering Center	Opened: 2015; closed: July 2020

TABLES 2 AND 3:

Note: *TBD* is to be determined.

Source: Qualitative research conducted by Shannon Smith-Bernardin, PhD, RN, 2020.

Commonalities

Sobering centers in California serve adults age 18 years and older, and all but one program is currently open 24 hours a day, 7 days a week, 365 days a year. The average length of stay ranges from 7 to 12 hours, while the maximum length of stay for many centers was 23 hours and 59 minutes due primarily to behavioral health or shelter funding, or licensing regulations restricting care to under 24 hours. Three centers stipulate a minimum four-hour stay. Length of stay was flexible based on individual client needs; for example, preventing alcohol withdrawal (i.e., shortening the stay) or transitioning clients to after-care resources (lengthening the stay) such as detox bed availability, case management, or an urgent care clinic.

Key Differences

Staffing. Staffing patterns were considerably diverse among the sobering centers. Allied medical personnel, such as medical assistants or emergency medical technicians, were staffed at most but not all the centers. Half the sobering centers employ licensed vocational or registered nurses, with two offering registered nurse support 24 hours a day. Other centers employ nonclinical personnel to complete intake and ongoing assessments throughout the client stay, following specific criteria and guidelines. The presence of security likewise varied, with half the centers featuring staff in a security role.

Referrals. All centers currently accept intoxicated people originating from the criminal justice system; additional referral sources differed by center. As noted in the appendix, common referral sources included emergency departments, outreach teams, and ambulances. The ability to accept walk-ins or self-referrals contrasted by community. Certain centers indicate that they were restricted from accepting walk-ins based on agreements instituted during center implementation, while other programs reserve walk-in ability to those well known to the centers, with active engagement and care management plans.

Location. Facility layout, general location, and colocation varied. Approximately half the programs were stand-alone, while others were colocated with medical respite, detoxification, behavioral health services, or reentry services. Sobering dorms were segregated by gender, with two facilities offering limited individual rooms in addition to the often-larger dorms. Three facilities indicated they offer crates if the person intoxicated has a dog or cat, to safely accommodate even those companion animals not certified as service animals.

Funding

There is considerable diversity in the funding of sobering centers. A number of California sobering centers were initiated through state or local funding streams focused on diversion from the emergency department and jail, criminal justice reform, or improved mental health care access. As will be discussed later, many centers indicated that the procurement and sustainability of funding streams was a significant challenge.

These featured state-level grants offer support for sobering centers:

- ▶ **Whole Person Care Program, the Medi-Cal Waiver Initiative.** Three counties (Contra Costa, Los Angeles, Santa Clara) were awarded five-year Whole Person Care grants in the July 2016 application phase; two successfully initiated services (David L. Murphy in Los Angeles and Mission Street Sobering Center in San Jose), while one county redistributed the funds to a related project after an unsuccessful attempt to find a location suitable to the program and community (Contra Costa County).
- ▶ **Proposition 47, “No Zip Code Left Behind.”** Approved by California voters in November 2014, in part it reduced a number of low-level drug offenses from felonies to misdemeanors. The provided funding can support public agencies in providing mental health services, substance use disorder treatment, or jail diversion. Both Sunstreet Sobering (Salinas, Monterey County) and CREDO47 (Santa Barbara County) receive Proposition 47 funding.

- ▶ **Proposition 63, Mental Health Services Act Innovations.** The grant, administered by the California Department of Health Care Services, is designed to expand and transform California's behavioral health system to better serve those with or at risk of serious mental health issues. The Kern County sobering programs (Bakersfield and Delano) each receive MHSA Innovations funding.
- ▶ **Edward Byrne Memorial Justice Assistance Grant.** This primary block grant funding stream is available to state and local criminal justice agencies and the courts. It has been used previously by sobering care efforts in Escondido (San Diego County); these sobering services are no longer in operation.

Some financing was initiated through county funding streams:

- ▶ **Alameda County's Measure A "Essential Health Care Services Tax Ordinance,"** approved in 2004 to allocate a half-percent sales tax toward a number of public health interventions
- ▶ **San Diego County Behavioral Health Services** provides funds to McAlister Institute, the organization that runs the San Diego sobering center¹⁷
- ▶ Santa Cruz County Sheriff's Department
- ▶ City and County of San Francisco general fund

To augment support and to provide additional services to sobering center clients, many centers have pursued smaller funding streams, including these:

- ▶ **Medication-Assisted Treatment (MAT) Expansion Project,** aimed at increasing the number of MAT access points in California.
- ▶ **Prosecution and Law Enforcement Assisted Diversion Services (PLEADS)** is a pilot model program accepting a specific target population under the influence of substances other than alcohol, primarily methamphetamines and heroin. PLEADS is a collaboration in San Diego County between County Behavioral Health Services, the city attorney's office, and the police department.

- ▶ **Medi-Cal Administrative Activities Recorders,** which provides a small per diem rate when eligible people are screened for and referred to expedited county services such as Medi-Cal.

Additional funding options identified as potentially viable but that have not yet been obtained include:

- ▶ Gaining certification as a Drug Medi-Cal site to increase availability of substance use-related interventions
- ▶ Statham funding (PC 1463.16), originating from court fines related to "drinking driver" convictions, can be used toward the development of privately operated programs at the local county level in alcohol-related interventions

No sobering centers are currently directly billing those served nor are they billing insurance companies.

Best Practices

California sobering centers share a number of promising practices that sustain and support their work. Four primary themes emerged from the key informant interviews: (1) using a low-barrier, compassionate service model; (2) providing clear protocols and streamlined services; (3) playing a central role in coordinating client care between city- and countywide agencies; and (4) being flexible with programming.

Low-Barrier, Compassionate Service Model

Key informants discussed their ability to operate as a very low-barrier facility while treating clients humanely with respect and dignity. Low-barrier services promote an easily accessible and user-friendly environment, minimizing barriers such as paperwork, eligibility requirements, and complex intake processes. Key informants expressed their goals to "meet people where they are at" and create a welcoming environment that is trauma informed, nonjudgmental, safe, with a harm reduction focus. Key informants expressed the importance of initially enlisting a leadership team (administrators and managers) who understand and support low-barrier, easy access, and harm reduction efforts who then hire frontline staff dedicated to

the same mission. This initial focus on recruiting the right team — from leadership to frontline staff — was expressed as critical to developing and implementing a successful service model.

An example of this best practice is that programs make considerable effort to accommodate people despite disagreeable behavior, only rarely permanently restricting them from returning for services. For example, those with a violent or threatening episode would be either provided a short-term restriction from sobering services (typically a few weeks) or would be assessed at each visit to determine risk of violence. Some programs utilize a safety committee of frontline and managerial staff who regularly review behavioral incidents. A second reason for permanent restriction, as will be discussed further in the “Challenges” section, involves those with severe alcohol use disorder suffering from significant health and cognitive decline. Particularly for centers that have been in operation a few years, some regular sobering services participants were eventually restricted due to chronic decline in health requiring substantially higher care, such as skilled nursing or one-to-one client-to-staff ratios.

“Everybody is treated with a high level of respect and dignity, and more often than not, it’s just people who made a poor decision. They’re not bad people out doing bad things. They’re not criminals. So we do a lot of education the short time that they’re here with us, so hopefully they don’t find themselves in this predicament again.”

— Program director

Centers that monitor a restriction-of-service list indicated between three to six people would be on the list at any one time.

Staff training is critical to successfully developing this culture. Training topics noted to be of particular value included risks and complications of acute intoxication, de-escalation, substance use disorders, mental health conditions, motivational interviewing, trauma-informed care, and harm reduction practice. Many interviewees emphasized incorporating staff with lived experience (in substance use disorders, mental health, and/ or homelessness) for direct client care, engagement, and guidance. It was noted this staff need to be in a position to have a pivotal role with the intoxicated person during their sobering stay, rather than relegated to indirect roles such as janitorial, kitchen, or outside security.

Clear Protocols and Streamlined Service Provision

Key informants stated their goal is to admit and retain people for successful sobering from intoxication, and the intake process is as streamlined and easy as possible. They indicated that clear eligibility criteria and field screening tools, admission and assessment guidelines, and a streamlined admission process were critical to their success. They recommended limiting or eliminating any intake paperwork required of the intoxicated client, citing a priority to reduce unnecessary agitation of the client while intoxicated. Referring parties likewise benefit from the rapid intake process, allowing first responders to seamlessly complete the transfer and quickly return to the field. For law enforcement, the intake process is typically under 10 minutes compared to 60- to 120-minutes at jails.

While offering a fast referral process, the intake must assess all incoming clients for higher-level medical or psychiatric needs. Those requiring such care are referred to the appropriate resources.

Central Role in Care Coordination

Key informants noted that their centers function as a hub in the continuum of care for people with substance use disorders, navigating between multiple agencies including health care, behavioral health, criminal justice and probation services, and homeless services. Factors that facilitate effective coordination include around-the-clock staffing, the ability to hold and engage clients for enough time to support direct transitions into stabilizing services including treatment, staff specialized in substance use disorders, and extensive community partnerships. Operating 24 hours a day, 7 days a week allows for immediate response to those in crisis, timely communication with other service providers, and the ability to keep people on-site until other services are open for direct linkages.

Staff specialized in substance use disorders and knowledgeable about available resources were critical to these efforts, recognizing when a patient is ready for the next step and providing referrals to detoxification or other treatment services. Common services provided to aid in care coordination include screening for substance use disorders, assistance with prescriptions, intensive case management or care navigation, vulnerability assessments, and referrals to housing and benefits.

Effective care coordination approaches can position sobering programs to be a key player in promoting systems integration. First, many sobering centers offer comprehensive coordination for frequent users of community systems, including emergency services and EDs, psychiatric emergency services, and community paramedicine teams. In particular, key informants discussed the ability to engage with people who are homeless, provide on-site hygiene and support services, and assist in navigating community resources such as shelter services, entitlements, or health access. Additionally, sobering center leadership reported participating in weekly or monthly case conferencing meetings with service providers from community- and hospital-based organizations.

“One of the biggest positive things that comes out of a sobering center that runs 24/7 and that’s staffed with recovery specialists and people who are educated or have a background in SUD is that . . . no matter what time of day you call, whatever time of day it is, you’re going to get somebody on the phone who can direct you. Who can help you.”

— Program director

“One of my favorite stories. . . . There was a lady that came in, kind of a frequent flyer, homeless, just a sad, sad state of affairs. The staff are cutting and peeling the socks off of her feet, and if you could just picture these two young women. Gently washing her feet and talking to her and saying, ‘Honey, you don’t have to live like this.’ Just the kind of care and compassion that she received in the sobering center rather than going to jail was heartwarming and just powerful. Those are the unseen social connections and caring. . . .

When I talked with staff about it, they said, ‘That’s somebody’s mom. What if it was my mom, and my mom was somewhere else and needed help.’ They really treated her just as they would want their own mother treated had she been in the similar situation.”

— Program director

“It’s a multi-institutional organization of which the sobering center is at the epicenter.”

— Medical director

Second, within the behavioral health continuum of care, sobering centers can augment the mental health system, providing care coordination and support in the care of intoxicated adults with mental health needs. Programs indicated up to 60% to 70% of those served report co-occurring mental health diagnoses. By providing short-term sobering for clients with dual diagnoses, programs can re-refer clients directly to the mental health care system, which can engage more successfully.

Care coordination is supported in some centers by comprehensive access to electronic records within the sobering center, with the ability to view community data on the clients (health records, case management, to assess document readiness for housing, etc.). However, community-level data were not implemented at every center, and for many the access was read-only, so the sobering staff was unable to provide updates or longitudinal information regarding services provided.

“I just think flexibility, learning to roll with the punches, and if you have to change the model that you designed originally or that you started with . . . to reach a greater number of people to help, just be willing to roll with those punches and don’t sit there and wait for census when there’s things you can do to get out and create census.”

— Program director

Programmatic Flexibility

Last, key informants noted the importance of programmatic flexibility and the ability to meet the needs of the clients and the community at large. Individual-level flexibility was reflected by centers offering longer stays on a case-by-case basis, accepting people altered from multiple substances in addition to alcohol, providing overnight shelter to people released from jail during inhospitable weather, or assisting in the care of those of high need or high risk who may not meet standard eligibility criteria (e.g., an unintoxicated adult experiencing homelessness with a housing interview the following morning).

On a larger community level, one program director noted that their center created a sobering-based outreach team to better serve the local community, locate more people at greater risk of harm related to their public intoxication, and increase census. Another collaborated with rehabilitation centers to receive those who had relapsed in treatment. The sobering center would provide short-term sobering, access to showers and laundry, and then return the person to their treatment program within one day.

Program leadership did note that flexibility, however, was strongly influenced by whether the funding stream allowed the center to be nimble in its service provision.

Additional Strengths and Advantages of the Sobering Care Model

Throughout the interviews, leadership noted additional strengths and advantages of the sobering care model and some notable successes. First, all the programs noted low rates of those served in a sobering center requiring transfer to the emergency department — generally less than 5% of discharges, which was credited to strong admission criteria, comprehensive staff training, and specific medical protocols for intake and monitoring.

Many programs noted moderate to high rates of recidivism by those with chronic alcohol use as a sign of strength, reflecting positively on the program having earned the trust of both a disenfranchised population

and the parties who refer these clients to their care. Additionally, the sobering model lends well to facility colocation with other community services: mental health crisis stabilization, homeless health care (such as medical respite), or detoxification.

Last, most sobering centers are operated by nonprofit organizations well established in either the mental health or substance use continuum of care. These centers note a streamlined access to services, such as detoxification, psychiatric urgent care, and substance use treatment including access to medication-assisted therapies and psychiatric medications.

Challenges

Key informants noted that the success and sustainability of sobering centers were met with core challenges, including: (1) securing long-term funding, (2) stigma and lack of community acceptance, (3) the disjointed nature of the behavioral health system, (4) misunderstanding of the sobering care model, (5) difficulty achieving buy-in of referring parties, and (6) providing care to a population with increasing care needs.

Funding

Sobering centers are not intended to be profitable. They generally provide cost avoidance from higher-priced services (such as those provided in EDs) or by saving first responder time (including decreased “wall time” [ambulance patient off-load time]¹⁸ for paramedics or the previously mentioned reduction in law enforcement time for transfer of intoxicated people). Despite the potential benefits to a community from operation of a sobering center, securing and maintaining funding of sobering care services was identified as a significant challenge by numerous centers, including dependency on grant or static funding.

A critical funding challenge often noted by key informants is a disconnect between the entities that benefit from sobering centers and the entities that fund sobering centers. This disconnect impacts sustainability, as cost benefit analysis may indicate multiple parties

benefit and thus funding could theoretically be leveraged from various sources. Yet many parties that benefit from the care of intoxicated people do not have obvious moneys to contribute (such as universities for care of intoxicated students), or shared memorandums of funding streams are unable to be negotiated.

Much of grant funding secured is short-term, imposing precariousness to the implementation and sustainability of sobering services. Many funding streams that offer support for sobering services were noted to be limited to a specific use and often do not permit integration between substance use, mental health, medical care, or criminal justice services.

Despite the use of emergency departments for uncomplicated acute intoxication, an ED may successfully bill certain insurance providers for this care and obtain payment higher than cost. In this scenario, a profit is realized. Thus, the hospital may be financially disincentivized to partner with a sobering center to reduce their census of acutely intoxicated patients.

Stigma and Lack of Community Acceptance

Securing a facility to operate a sobering center in was identified as a significant challenge by all newer centers (in operation less than four years). Key informants noted that substantial time and effort was required to identify, achieve community approval for, and build out locations provide sobering services in. They also suggested that behind these difficulties lay stigma about alcohol use and discrimination toward intoxicated people, including and especially toward those with co-occurring homelessness, mental illness, or histories of incarceration. Community pushback in the form of “NIMBYism” (not in my backyard) was often exposed during the design and implementation phases of establishing a sobering center and was generally expressed as fear that a site will lead to unwelcome populations being attracted to or abandoned in the respective community. In some cases, this pushback led to substantial postponements in operation launch, with upward of two- to three-year delays, and some

even led to the full cancellation of the centers despite securing funding.

“They [some community members] get upset over the way their city looks, but they’re not willing to put in the effort, or just the voice to what works. . . . They just get stuck on this idea that it’s an eyesore, or that it’s going to bring in a bad population. They don’t read the tape all the way through to see what the nice endings look like. And so that’s the frustrating part, to me.”

— County administrator

Certain centers noted that when finally located, they were placed in neighborhoods that were more dangerous, undesirable, or far from resources and after-care options.

Disjointed Behavioral Health “System”

Within the systems of care, providers struggle with the largely distinct treatment and care environments for mental health versus substance use. Key stakeholders indicated difficulty in engaging with mental health providers and programs that did not have the capacity to provide care to those with both a mental health diagnosis and active substance use. As noted by one director, “The world of alcohol and drugs . . . there’s still a blood and guts kind of street world that is getting more and more sophisticated, but it’s still not really integrated with mental health enough.”

Yet many expressed that care coordination — including colocation of sobering services and behavioral health crisis management — can directly decrease provider stigma, improve management of co-occurring conditions, and improve individual care.

“We have to look at the ubiquity of complex problems. We have to look at substance use disorder as not being something apart from mental health. We really do have to deal with that, and it’s difficult because we have laws and regulations to segregate things, and we do.”

— Program director

Sobering Care Model Misunderstood

Many centers indicated that community members and stakeholders do not understand the activities and benefits of a sobering center, and that the concept of sobering centers in general is too abstract and ill-defined. Despite sobering centers often functioning within a community’s continuum of behavioral health care, many do not recognize or understand its value.

“I still think the world in general is very unclear on what the sobering model is exactly. I know that’s always the first question that someone asks us when they come visit, or they come on a fact-finding mission. Exactly what is the sobering model, because it’s very easy to mix up with residential detox or detox, and people just don’t truly understand the sobering concept.”

— Program director

Leadership expressed a need to outreach to community members and key partners, as the changing political climate, gentrification of neighborhoods, or funding mechanisms required constant engagement. Despite this outreach, requests to reduce or alter sobering services to assist in unrelated projects

or populations were frequent. Particularly for centers with a greater demand than capacity, sobering center leadership indicated a need to constantly balance the ongoing requests while staying true to their mission and not decreasing care for their intended populations.

Achieving Buy-In with Referring Parties

While some centers indicated they had space limitations and were often exceeding capacity, newer programs (open less than one year to five years) indicated a slow start-up, with lower than anticipated utilization and ongoing need to obtain buy-in from referring parties.

Newer programs indicated at least 12 to 24 months of full-time operation before anticipated census numbers were reached. Sobering leadership stated resistance and difficulty changing preexisting beliefs of referring parties. Specific to law enforcement, achieving buy-in often requires a considerable cultural change to the mindset that “a person behaving badly deserves to go to jail” for which a sobering center visit is not punishment enough.

Efforts have been made to reduce hours to be more cost-efficient. However, this is confusing for both the referring parties seeking services on off days and for continuity of care.

“It’s the outreach with the law enforcement agencies, educating them, talking to them. And from my standpoint, what I’ve seen is . . . officers that are longer-time officers maybe would have been a little more hesitant . . . resistant in bringing the young ones in. And I think once they touch it, see it, feel it, they’re in there. They’re seeing how we are on intake. I can’t tell you the number of times I’ve had officers just look at me with this very soft face all of a sudden, and they just go, ‘You’re an amazing person to do this.’ It’s really interesting to me, the feedback we get from them, because they see them [the intoxicated people] in a different light, in a different way. They have a different outcome if they do take them to jail versus bringing them, and they see what we do.”

— Nurse coordinator

“I think our sobering center is seeing people who are being failed at every level of our system and our society and are often difficult. They’re difficult people to be with a lot of the time, and I think there is a desperate need for advocacy. When I say bearing witness, I don’t just mean bearing witness to the client who is going through this, but I think also bearing witness to the system. That this is the way our system is failing people, who are so profoundly vulnerable.

I think that’s tremendously important work, because these are human beings and they are literally about as vulnerable as anyone in this country ever, ever, ever, ever is, and no one deserves to die on the street like that.”

— Medical provider

Population with Increasing Care Needs

Leadership and medical providers noted the mounting challenges to serving a medically fragile population in declining health that faces increasingly greater needs — yet is not able to access appropriate care. Functionally, many in this population transition between homelessness, the sobering center, and emergency services without long-term stabilization.

Staff struggle with the question of what the options are for someone unable to be stabilized within the current system of care. Key informants indicated a lack of appropriate facilities to help arrest the decline of those at high risk of hospitalization, incarceration, trauma, or death. Many are unplaceable in traditional settings (e.g., board-and-care or skilled nursing facilities), yet are too impaired to live in independent housing.

This leads to sobering care that is often split between two populations with very different needs. The first are the “high-need” clients — those with chronic intoxication, cognitive impairment, or co-occurring homelessness who are severely disorganized. The second population is more functional — they may be housed or homeless, yet they can function independently. They only require a safe space to metabolize alcohol and do not need intense services. Thus holding beds nightly for those with no other residential option takes up beds also needed for those who may only require a few hours of sobering.

Leadership expressed a critical need for very low-barrier residential facilities to accommodate the high-need sobering clients, including palliative care, medical respite, and managed alcohol programs.

Areas for Improvement/Expansion

A number of areas for improvement or enhancement were shared by key informants.

Staffing

Key stakeholders expressed interest in enhancing staffing with medical personnel, such as nurses or paramedics. Yet many centers with basic or no on-site

medical staffing found current funding streams were not enough to expand substantially into a medically enhanced model.

Lack of After-Care Services

Finally, there was consensus around a lack of resources available to offer clients interested in stabilization, including detoxification, residential treatment, housing, and long-term care. Without adequate detoxification beds, emergency shelters, or residential facilities, sobering centers do not have many options to assist in on-site long-term stabilization. This may result in some clients rotating in and out of short-term services, sometimes for years.

Effect of the COVID-19 Pandemic on Sobering Centers

Sobering centers function in a congregate setting, and all sobering centers modified or restricted service in response to the COVID-19 pandemic and resulting health and shelter-in-place recommendations. The response to COVID-19 has primarily affected capacity, with reductions to accommodate social distancing. Additionally, some centers indicated a change in population. One center at the time of this report continues to provide services exclusively as a COVID-19 isolation and quarantine site for those with suspected or confirmed coronavirus; all sobering care services have temporarily ceased.

Challenges specific to operations include an interruption of the traditional lines of communication, reducing the ability for sobering leadership to engage with referring parties for education, training, and care coordination meetings. Funding is anticipated to be more precarious, as budgets throughout the state have taken a substantial hit due to COVID-19. Additionally, for nonprofit organizations operating sobering centers, general organizational funding may be reduced as community members who would typically donate to nonprofits do not have the capacity this year.

On a positive note, one center shared incredible progress serving their most frequent clients through the creation of a targeted managed alcohol program colocated with their sobering center.¹⁹ Initiated to support shelter-in-place by those with chronic alcohol consumption, high-use sobering clientele who participated in the managed alcohol program were noted to achieve levels of stabilization not previously seen, including reduced interaction with the emergency medical system, adherence to medication management, decreased levels of intoxication, and increased nights sheltered.

Further Developing the Role of Sobering Centers Throughout California

Sobering center leadership, in particular those in newer programs, outlined a number of critical aspects to successful design and implementation of new sobering centers.

Visiting Sobering Centers

First, connecting with and visiting existing sobering centers — both in California and more broadly within the United States — was critical to choosing an appropriate model, identifying potential challenges, and assessing recommended practices for local implementation. Each sobering center operates differently than others. Key informants indicate this ability to deep dive into the distinct models was essential to the successful development of their centers.

Current sobering centers can offer example paperwork and information on medical protocols and data collection. For example, many centers referenced the medical protocols originally created at the San Francisco Sobering Center, which were distributed to numerous other programs both in California and nationwide to be modified by their respective communities.

Center Design and Development

Up-front building investments can be substantial and must be included in initial budgeting, including facility build-out and safety and code improvements.

In part for budgetary reasons and previously noted community resistance, some communities opted to pursue a county-owned building in which to house a sobering center. Locating it on county property has benefits, yet a few core challenges were expressed. These include the inability to use 911 or police response for on-site emergencies, as county properties are within the sheriff's catchment, which may offer less rapid nonemergency response. An arrangement that indicates county employees must be used for staffing needs may impact both staffing budget and the ability to contract with an established community organization. Last, many stakeholders voiced ongoing tensions between county and city organizations, leading to disagreements on which organizations would be permitted to refer people to the sobering center if located on county property.

Community Engagement

Some stakeholders likewise stressed the importance of the support of the community in the early stages of development and throughout the process of initiating operations. This community engagement is recommended regardless of funding stream, contracted partners, or mission. The most effective engagement practices include proactively pursuing face-to-face meetings to offer education about the goals and anticipated impact of a sobering center, identifying needs, and addressing concerns of community members. This includes outreach and engagement with community leaders, county and city leadership, business associations, the county board of supervisors, criminal justice stakeholders (city, county, and state law enforcement agencies, district attorney, and public defender), broader mental health and substance use treatment services, and neighborhood organizations.

Messaging

Many key stakeholders noted a need for increased messaging about the role of sobering centers in the continuum of care. Much of this work requires continued efforts to “step up” the reputation of sobering centers both in California and in the United States.

They recommend a coordinated information campaign detailing the specific activities within a sobering center, role in the system of care, distinction between sobering and related care models, and how each center supports its clients and the community at large. Additional content ideas included details on safety of the sobering center for those served, types of enhanced care compared to alternate services (jail, ED), and specifically how the center is positively impacting the community.

As indicated, there is an ongoing, frequent need to educate referring parties and the community about the work and goals of a sobering center. Notably, this was expressed as both a best practice and a challenge; as stated by one program director, the “job is never done.”

Monitoring and Oversight

There are currently no certification or accreditation programs for sobering services specifically. Many organizations who run sobering centers do have accreditation for some or all of their nonsobering programs, such as detoxification, rehabilitation, or behavioral health interventions. The primary goal of accreditation is to gauge a health care facility’s ability to live up to predetermined industry standards set by veritable bodies within their field. Accreditation is awarded by entities, organizations, or associations not affiliated with any government.

If the center is associated with a well-developed community organization with additional clinical services that performs billing within the health care system, such as a primary care or urgent care clinic, pursuing status as a satellite of the existing Federally Qualified Health Center (FQHC) may be feasible. If the sobering

center is the primary clinical program, then it is unlikely to be eligible for FQHC status.

Efforts toward accreditation or licensing may be more critical for sobering centers intending to take intoxicated people directly from the 911 ambulance system as an alternative destination to the ED. Sobering centers receiving clients exclusively from law enforcement, the ED, and street and homeless outreach teams may not require additional oversight than currently provided. AB 1544, the “Community Paramedicine and Alternate Destination Act,”²⁰ legislatively paves the way for many communities to consider ambulance referrals, while the Centers for Medicare & Medicaid’s ET3 (Emergency Triage, Treat, & Transport) Pilot offers billing capability for transports to non-ED destinations.²¹ These options may allow a sobering center to be designed with EMS referrals in mind, while not opening to all other referring parties until accreditation or appropriate licensing can be achieved.

Recommendations to Promote Adoption of Sobering Care Model in California

A number of components are recommended to promote the successful implementation and expansion of sobering centers in California.

Lower Barriers to Make Services Accessible

All efforts must support a fully accessible, low-barrier model of the sobering center. A critical aspect of sobering care is the ability to broadly serve adults who may be intoxicated in public: insured and uninsured, documented citizen or not, housed or homeless. In addition to supporting equitable access, this ensures frontline responders can triage intoxicated people based on actual need and refer to the most appropriate level of care.

Sobering should be welcoming and engaging, not punitive. Due to stigma, those with long-standing substance use — particularly those with co-occurring homelessness — are often dehumanized. They face incredible stigma both overt and subtle. The sobering environment is often the only setting where people with chronic public intoxication are consistently accepted as they are and treated with compassion. This culture will impact the person's willingness to engage and consider options to change harmful behaviors.

That said, although increased connection to the substance use system is a goal, many clients do not initially accept direct transfer to treatment. Most intoxicated people referred to a sobering center are not actively seeking care — they are brought in while in a symptomatic phase of their condition. A majority will utilize the sobering service, safely recover from acute intoxication, and return to their communities. For many, the active engagement of staff through motivational interviewing and a compassionate approach will encourage behavior change.

Improve Partnerships with Referring Entities

During the design and preparation phases of opening a sobering center, key stakeholders should actively engage with the frontline responders expected to refer intoxicated people. Ideally occurring early in the process, this engagement can take the form of ride-alongs with field paramedics and law enforcement, observation of emergency department staff and operations, focus groups, and key informant interviews. This targeted exploration will provide the opportunity to promote buy-in by establishing trust, identify unmet needs of referring parties and their clients in use of a sobering center, and work to resolve any needs and concerns of referring parties.

Increasing the focus of sobering centers in the diversion of emergency services is supported by published research.²² Even so, it is not recommended to restrict sobering care access only to emergency services. In

partnership with law enforcement via jail diversion, a sobering center can reduce contact with the criminal justice system and provide more direct access to substance use services for those with harmful substance use.

A broader range of agreements may offer greater care coordination capability and enhance services provided (e.g., reserved patient slots at urgent care, shelter beds, or medication-assisted therapy intake appointments for sobering clients).

Last, any sobering center must allow for some flexibility in the specific design, implementation, and ongoing modification of services offered and populations served. It is important to establish a sufficient catchment area with ample referring parties to both capture the populations requiring sobering care and to achieve capacity. Set appropriate expectations that buy-in takes time; experience by sobering centers statewide indicate that initial utilization is typically lower than anticipated and that the anticipated census may be achieved over a 12- to 24-month period.

“We ultimately are providing them a safe place where they know people care. That’s a lot of the feedback we do get from our participants. . . . They can come in intoxicated and in crisis. And to just have feedback from actual individual participants to our staff of, ‘Wow, we need more people like you because I feel like a human being. I feel like you’re talking to me like a person.’ And they don’t always get that when they’re homeless and having addiction issues.”

— Charge nurse

Ensure Sustainability

A promising option for financing is billing through the In Lieu of Services mechanism within California’s Medi-Cal reform proposal — CalAIM (California Advancing and Innovating Medi-Cal). In Lieu of Services (ILOS) are flexible wraparound services aimed to address medical or social determinants of health needs, instead of (in lieu of) more expensive emergency room stays or preventable hospital stays.²³ Sobering centers are one of 14 ILOS approved by the state.

As a population health strategy, sobering centers function to decrease reliance on the more costly alternatives of care (e.g., ED visits for acute intoxication) while introducing more targeted services based on population need. ILOS has the potential to address many of the sustainability challenges faced by sobering centers. Managed care plans will likely receive incentive payments to help build capacity for ILOS. These dollars could help to support facility build-out, staffing, and operations. Sobering centers would then need to create infrastructure to bill for encounters and report data to their contracted managed care plans.

“We have too many square holes for our round pegs, and so advocacy and bearing witness to the system that says, ‘This is wrong to let people suffer in this way.’ If you can’t see that it’s wrong, at least see that it’s expensive for your system and it overburdens your system in places that it doesn’t have to be overburdened. If sobering centers can help advocate up to city, state governments to say, ‘This is what we see, this is what we need. How can we get these things?’”

— Medical provider

Evaluate Sobering Center Impact

Sobering centers can function well as part of continuum of care, yet they are not anticipated to be profitable. Evaluations ought to consider outcomes such as cost avoidance (e.g., unreimbursed ambulance transports or ED visits, jail encounters), staff time efficiencies (e.g., reduced hand-off at sobering center vs. other destination), individual-level outcomes (e.g., reduction in ED visits for high-need clients), and related factors (e.g., staff satisfaction, reduction in injuries).

Likewise, process evaluations can gauge how a sobering center augments and enhances service provision in the continuum of care. Most notably, linkages to after-care and stabilizing services should be assessed. Examples of this includes connection to case management services, initiation of medication-assisted therapies or injectable antipsychotics, or the provision of primary care and wellness services for the higher-use clients.

Establish Data Management Systems

There was substantial variation reported in data collection and charting capabilities. Many sobering centers are collecting data either on paper or on local electronic spreadsheets and remain electronically disconnected from the larger system. Many key informants indicated a need to implement a robust yet functional database, though they did not have the resources to develop their own system.

Larger electronic health records used by hospital systems could offer charting capability, though some may be too complicated or not specific enough to capture and report sobering-level data, such as referring parties, disposition, or screening and referral outcomes. Ideally, sobering centers would obtain access to a system that offers community-level charting and navigation for care coordination yet is specific enough for internal reporting of client outcomes, feedback to referring parties, and program evaluation.

To better coordinate sobering services across the continuum of care, to bill Medi-Cal managed care plans, and to enhance quality improvement and quality assurance efforts, the development of more comprehensive data management tools is necessary. Considering the needs of sobering centers, as well as regional and statewide interests, this data management may benefit from the following features:

- ▶ Customizable permissions to control what users can access at a granular level (this would allow users, based on their scope and role, access to some forms and fields but not others, and could also be used to limit their access to a specific sobering center or to grant access to several centers).
- ▶ Shared standardized and templated forms, with the ability to customize on the front end so local sites can edit or create additional forms to meet their local needs.
- ▶ A cloud-based system aggregating data from multiple sobering centers would allow for statewide assessment of care provided, the populations served, and — importantly — an ability to monitor drug use trends throughout the state.
- ▶ Visual dashboards and custom reports that include de-identified aggregate data from many sites (statewide, regions like Southern California, etc.). Individual sobering centers could make changes to their reports, or create additional reports, at the local level to support regional funders and community partners.
- ▶ Modern security features like multifactor authentication, password expirations, user activity logs for auditing purposes.
- ▶ A mix of technical support options including dedicated project management, in-app chat support for users, and reporting assistance like writing custom database queries.

Depending on funding streams and the broader expansion of sobering centers, local participation in a statewide data dashboard for the sobering care provided may be possible.

Raise Awareness Among Policymakers About Sobering Services

Finally, it is critical that state policymakers and decisionmakers leading efforts for (or interested in) the expansion of sobering centers in California enhance their direct knowledge of sobering care. There would be great value in visiting a variety of sobering centers, both within California and across the country. These visits allow for in-depth discussion with management and frontline staff providing sobering care, a visualization of how the center operates within the surrounding community, and the opportunity for conversation with related stakeholders including homeless health care, hospital, law enforcement, and emergency services leadership. Additionally, the National Sobering Collaborative offers resources for communities exploring sobering care including a targeted Community Needs Assessment, Tool Kit for Sobering Center Development, list of sobering-related research, and a National Directory of Sobering Programs.

Recommended Collaborations/ Colocations for Sobering Centers

Depending on community and population needs, collaborations or colocation of sobering services may offer substantial benefits.

Homeless-Related Services

Homelessness is common among people with acute intoxication, and centers providing sobering care should include services for people who are homeless. Alcohol use disorders cross all socioeconomic categories, yet research indicates higher rates of ED use and recidivism for those with co-occurring homelessness and alcohol use disorders.²⁴ It is estimated that 38% of people experiencing homelessness suffer from severe alcohol use disorders, with over 80% of those

chronically homeless experiencing an alcohol or drug use disorder during their lifetime.²⁵ This co-occurrence of homelessness with an alcohol use disorder negatively impacts health²⁶ and results in elevated mortality.²⁷ This is important, because although EDs offer comprehensive medical care, most EDs do not have the resources, time, or expertise to offer targeted longer-term interventions for patients with co-occurring substance use disorders and homelessness.

“We see people sometimes in some of their periods of their greatest suffering. You also then can see clients have the opportunity to thrive and do things differently and [sobering staff] can really play a role in someone having an improved quality of life. Even in their worst moments, you know that you are contributing to their well-being in a meaningful way. So those are things that staff reflect back . . . being able to sit with them in some of that suffering.”

— Nurse coordinator

The role of a sobering center in caring for those with comorbid homelessness and substance use cannot be overstated. One-third of sobering centers nationwide indicated a focus on the person who is both homeless and frequently intoxicated in public, and it is likely other centers are serving similar clients. Practical on-site interventions to improve quality of life can include shower and hygiene facilities, clean clothing, delousing care and medication, laundry, food, and oral rehydration. Care coordination services may include peer navigation, case management, and referrals to shelter or housing. Centers with access to licensed health care providers may offer wound care and chronic disease medication management, or provide for urgent care or primary care needs.

Suggested partnerships: Medical respite / recuperative care, street medicine or street health teams, homeless outreach, case management, transitional housing providers, palliative care.

Behavioral Health

Mental health care. The colocation and coordination with mental health crisis stabilization and sobering centers have brought notable successes. In addition to the new Santa Barbara County sobering center located alongside crisis services, three cities — Kansas City, Kansas; Kansas City, Missouri; and Baltimore, Maryland — have colocated sobering centers with crisis stabilization. This placement allows for a full range of conditions, from mild intoxication through psychosis (both behaviorally based and drug-induced). Particularly for communities faced with a high number of methamphetamine-related psychosis, this placement helps to limit the number of decisions a frontline provider needs to make in deciding where to transport an altered person. It provides for an environment that can accommodate both more-acute clients requiring medication assistance for stabilization and those only requiring rest and monitoring — providing flexibility for changes in individual presentation or emerging care needs.

Substance use services. Partnerships may be with both abstinence-based and harm reduction-focused services. For example, colocation with a medical detoxification program or an arrangement for direct transfer will decrease access barriers and increase treatment-oriented discharges for interested clients. Centers with prescribing providers may establish buprenorphine starts and follow-up connection to ongoing medication-assisted treatment.

Suggested partnerships. Medical or social detoxification, residential rehabilitation, addiction medicine and nursing specialists, medication-assisted therapy providers, outpatient pharmacy.

Emergency Medical System

A most promising collaboration in California is the expansion of sobering services to accommodate referrals from the 911 ambulance system. The Emergency Medical Services Authority has seen continued success in the aforementioned alternative destinations pilot program. Looking at creating or modifying sobering centers to receive referrals from paramedics, EMS providers may need assurance that the care provided is safe and that there are robust protocols both in the field and within the sobering center for individual assessment and monitoring. Clear, comprehensive screening tools and protocols are critical to the implementation and ongoing success in providing sobering care to intoxicated people.

There are three key stages during the transition of an intoxicated person to a sobering center that offer the opportunity to perform screening to ensure safety and appropriateness for care in a sobering center. First, clear eligibility and exclusionary criteria for potential transfer to a sobering center. Second, thorough intake assessment performed at the sobering center before admission. And third, guidelines for the ongoing monitoring of intoxicated clients during their sobering stay including assessments for withdrawal, decompensation due to polysubstance use, and protocols in case of emergency.

In sobering center development, certain steps to promote safety are recommended. First, sobering and EMS leadership should coordinate on developing triage and monitoring guidelines that are evidence-based and specific to local resources. Research on triage guidelines²⁸ should be reviewed, including triage and monitoring guidelines currently used by existing sobering centers who accept patients from ambulances. This could include protocols from the San Francisco Sobering Center, Austin Sobering Center in Texas, and the Los Angeles Fire Department SOBER Unit, which transports to the David L. Murphy Sobering Center. Second, centers accepting from EMS should establish regular reviews of client encounters that arrive via EMS and are later sent to the ED due to a medical need.

“We have had such success in our collaboration with the emergency medical system and the community paramedics. For so many years, I felt like we were still siloed, and we still are in many ways. But now, especially with our collaboration with the community paramedics. . . .

I feel like we really just bridged that gap where everybody kind of sees the bigger picture. We’re trying to do right by the system, but we’re also trying to help these clients. And the community paramedics have really contributed to that. The collaboration with the emergency medical system has been so key. In not just the relationship and not in the department, but the outcomes for the clients are so much greater than they were before because we can do so much more. We can connect longer-term rather than just the short term, which is what we focus on.”

— Charge nurse

Last, support from EMS leadership and transparent communication will be key. Paramedics may be wary of using sobering centers if they perceive a risk of negative patient outcome or concern a triage error may lead to loss of their license. As noted by an emergency medical director during the interviews, “We know there’s a finite error rate [in triage decision-making] because humans are humans. It’s just going to happen. . . . We don’t get 100% of people going to the right places the first time. It’s just a matter of training, oversight, quality improvement. That would be no different than any other component of the

health care system in terms of where people go and then get moved up the food chain if they need to.” Communication will need to offer both reassurance and training, while soliciting ongoing feedback from paramedics and leadership throughout the respective counties.

Conclusion

Nine of the 10 functioning sobering centers of California were reviewed, representing 25% of such centers nationwide, through interviews with two dozen key stakeholders, programmatic document reviews, and site visits. While program details vary, almost all offer services to adults 18 and over, and all but one are open 24 hours a day, 7 days a week, 365 days a year.

Four primary areas of promising practice were identified by the interviewees:

- ▶ Operation as a low-barrier, compassionate service model
- ▶ Development of clear protocols and streamlined service provision
- ▶ Successful, centralized role in care coordination
- ▶ Programmatic flexibility

Significant core challenges to successful center establishment and operation were identified:

- ▶ Procurement of initial and ongoing funding
- ▶ Stigma and community acceptance
- ▶ Disjointed behavioral health system
- ▶ Misunderstanding of sobering care model
- ▶ Underutilization by referring parties
- ▶ Provision of care to a population with increasing needs requiring higher levels of service

To succeed in the expanded adoption of the sobering model of care in California, focused attention should be given to:

- ▶ Creating low-barrier, accessible services through streamlined processes and protocols
- ▶ Being responsive to community needs through active engagement with frontline responders
- ▶ Establishing data management systems for consistent, secure collection of client information and evaluation
- ▶ Collaborating and colocating with related systems and facilities

There is great variation in the operation, size, and models of sobering centers in California, similar to sobering centers nationally. Yet many of the centers have achieved a significant role in serving their communities, featuring integrated, well-functioning, and accessible programs for those with acute and chronic intoxication.

Sobering centers are a last resort for many people, becoming a waystation for those suffering from effects of long-term substance use, related comorbidities, and co-occurring homelessness who have nowhere else to go. At its best, a sobering center can serve a critical role in individual patient engagement and care, identifying the broad needs of a population at risk of alcohol- or drug-related harms and providing advocacy for high-quality and integrated care and services within the system.

Appendix. Sobering Center Profiles

Bakersfield Recovery Station

Bakersfield, Kern County

Operating organizations	Telecare Inc. partnering with Kern Behavioral Health and Recovery Services
Year opened	2020
Operational components	<i>Capacity:</i> 10 people <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 312 Kentucky Street, Bakersfield 93305
Funding mechanism	Mental Health Services Act (MHSA) Innovation Funding
Oversight	Mental Health Services Oversight & Accountability Commission
Mission / Target population	The goal of the Bakersfield Recovery Station is to provide a law enforcement diversion for persons who are acutely intoxicated and have a co-occurring mental illness where, instead of being arrested, they are presented with an opportunity for peer engagement, assessment, brief clinical interventions, and linkage with community-based services.
Admission criteria	Intoxication from alcohol and/or any drugs
Referring parties	Law enforcement, Mobile Evaluation Team (MET), behavioral health treatment providers, homeless providers No walk-ins or self-referrals
Staffing model	Peer staff trained in mental health and substance use disorder, substance use counselors, project manager, licensed clinician in role as administrator
Services provided	Mental health screening, assessment, and referrals for care (depression, anxiety, posttraumatic stress disorder); substance use screening; counseling, motivational interviewing; referrals to substance use treatment
Proportion of clients served experiencing homelessness	To be determined

Cherry Hill Sobering Center
San Leandro, Alameda County

Operating organization	Horizon Services
Year opened	2010
Operational components	Capacity: 35–40 people; 17 with social distancing protocols Hours: 24 hours a day, 7 days a week Location: 2035 Fairmont Drive, San Leandro 94578
Funding mechanism	Measure A “Essential Health Care Services Initiative,” approved in March 2004
Oversight	Alameda County Behavioral Health Care Services
Mission	To deter incarcerating individuals found to be under the influence in the community with the goal of servicing 520–600 clients/month
Target population	Intoxicated adults throughout Alameda County
Admission criteria	Intoxication from alcohol and/or any drugs Age 18 and older
Referring parties	Law enforcement, mental health facilities, emergency department, community organizations, clinics. Walk-ins and self-referrals accepted.
Staffing model	Registered or certified substance use counselors (intake); certified emergency medical technicians (health technicians); sobering specialists; licensed vocational nurses (weekdays); van driver. Medical direction: On call physician
Services provided	Food (meals, snacks), oral rehydration, hygiene; direct referral and transfer to medical detoxification. Assist with medication refills.
Proportion of clients served experiencing homelessness	Specific data not available for report. Currently serving a large number of individuals who are homeless and have high rates of recidivism.

CREDO 47 Stabilization Center

Santa Barbara, Santa Barbara County

Operating organization	Good Samaritan Shelter
Year opened	2020
Operational components	<i>Capacity:</i> 10 people; 7 with social distancing protocols <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 427 Camino del Remedio, Santa Barbara 93110
Funding mechanism	Proposition 47
Oversight	County of Santa Barbara Crisis Services
Mission	To divert incarceration for substance abuse and connect with treatment opportunities
Target population	People with substance use disorders
Admission criteria	Intoxication from alcohol and/or any drugs
Referring parties	Cottage Hospital, Santa Barbara County Jail, police, sheriff, probation, parole, public defender, child welfare services (adults), family members, walk-ins, crisis services
Staffing model	EMT paired with sober coaches each shift; certified drug and alcohol counselors, one part-time RN directing medical services, program manager
Services provided	Food, shelter, medical monitoring, medication management as prescribed, COVID clearances, TB screening. Referrals to mental health and substance abuse services, including medically assisted treatment, housing, and transportation. Legal services and social services.
Proportion of clients served experiencing homelessness	Initial utilization data shows 64% of individuals served do not have permanent address.

David L. Murphy Sobering Center

Los Angeles, Los Angeles County

Operating organization	Exodus Recovery, Inc.
Year opened	2017
Operational components	<i>Capacity:</i> 50 people <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 640 Maple Avenue, Los Angeles 90014
Funding mechanisms	Combination including Whole Person Care; Office of Diversion and Re-Entry; Measure H
Oversight	Los Angeles Department of Health Services, Housing for Health
Mission / Target population	Divert chronically inebriated vulnerable adults living on or adjacent to Skid Row away from hospitals and institutions including incarceration
Admission criteria	Intoxication from alcohol and/or any drugs
Referring parties	Law enforcement, Department of Health Services Outreach Teams, emergency departments, Exodus Outreach, Los Angeles Fire Department SOBER Unit
Staffing model	Registered nurses, licensed vocational nurses, sober coaches, security officers, recovery supervisor, intake coordinator, program director
Services provided	Vital sign monitoring, minor wound care, urgent care needs; manage ADLs, hygiene needs, delousing; nutrition and oral fluids; case management for high-use clients; referrals to shelter and detoxification needs; housing and entitlement referrals
Proportion of clients served experiencing homelessness	85% of individuals currently homeless

Delano Recovery Station

Delano, Kern County

Operating organizations	Telecare Inc. partnering with Kern Behavioral Health and Recovery Services
Year opened	2020
Operational components	<i>Capacity:</i> 6 people <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 629 Main Street, Delano 93215
Funding mechanism	Mental Health Services Act (MHSA) Innovation Funding
Oversight	Mental Health Services Oversight & Accountability Commission
Mission / Target population	The goal of the Delano Recovery Station is to provide a law enforcement diversion for persons who are acutely intoxicated and have a co-occurring mental illness where, instead of being arrested, they are presented with an opportunity for peer engagement, assessment, brief clinical interventions, and linkage with community-based services.
Admission criteria	Intoxication from alcohol and/or any drugs
Referring parties	Law enforcement, Mobile Evaluation Team (MET), behavioral health treatment providers, homeless providers. No walk-ins or self-referrals.
Staffing model	Peer staff trained in mental health and substance use disorder, substance use counselors, project manager, licensed clinician in role as administrator
Services provided	Mental health screening, assessment, and referrals for care (depression, anxiety, posttraumatic stress disorder); substance use screening; counseling, motivational interviewing; referrals to substance use treatment
Proportion of clients served experiencing homelessness	To be determined

First Chance Sobering Station

Burlingame, San Mateo County

Operating organization	StarVista
Year opened	1991
Operational components	<i>Capacity:</i> 14 people <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 826 Mahler Road, Burlingame 94010
Funding mechanisms	Combination of police departments and county health department
Oversight	County of Santa Barbara Crisis Services
Mission	An alternative to jail for those arrested for public intoxication or driving under the influence of alcohol and/or drugs
Target population	Adults intoxicated in public or under arrest for DUI
Admission criteria	Intoxication from alcohol and/or any drugs
Referring parties	Law enforcement, designated hospitals, addiction treatment providers. Walk-ins are not accepted.
Staffing model	Registered or certified addiction counselors
Services provided	Oral rehydration and snacks; clean clothing; assessments, case management, coping strategies; referrals to treatment services
Proportion of clients served experiencing homelessness	Specific data not available for report.

Note: Interviews were not conducted with leadership or key stakeholders of the First Chance Sobering Station. Details included in this table were obtained via electronic sources through an online search conducted in October/November 2020.

McAlister Institute Sobering Services Center

San Diego, San Diego County

Operating organization	McAlister Institute (since 2015)
Year opened	1984
Operational components	<i>Capacity:</i> 60 people; 15 with social distancing protocols <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 3511 India Street, San Diego 92103
Funding mechanisms	County of San Diego and City of San Diego Do not bill. Will accept donation (recommended: \$35) from participants or family members willing and able to contribute.
Oversight	San Diego County administrators; McAlister Quality Assurance team
Mission	Provide county-wide diversion, non-residential, non-medical, sobering services in a drug- and alcohol-free environment for public inebriates and intoxicated individuals dropped off by health, safety, and law enforcement agencies.
Target population	Adults aged 18 and older contacted by law enforcement under the influence
Admission criteria	Sobering Services Center: Intoxication related to alcohol and marijuana PLEADS (Prosecution and Law Enforcement Assisted Diversion Services) Pilot program: Intoxication from other drugs including opioids and methamphetamines
Referring parties	Law enforcement agencies in San Diego county
Staffing model	Service navigators, substance use disorder counselors, registered alcohol and drug technicians; registered nurses (12 hours/ day specific for PLEADS pilot program), program director, medical director (administrative)
Services provided	Laundry, bathroom, clean clothing, storage of personal belongings (up to 72 hours), minor wound care, light food and oral rehydration. Counseling, resource information, and referrals to stabilizing services including treatment, shelter, and housing resources. Community collaborations provide Medically Assisted Treatment (MAT) and short-term psychiatric care.
Proportion of clients served experiencing homelessness	10% unduplicated clients are chronically homeless

Mission Street Sobering Center

San Jose, Santa Clara County

Operating organization	Horizon Services, Inc.
Year opened	2017
Operational components	<i>Capacity:</i> 20 people total (10 Sobering, 10 Mental Health Drug Triage pilot project); 10 with social distancing protocols <i>Hours:</i> 24 hours a day, 7 days a week <i>Location:</i> 151 W Mission Street, San Jose 95110
Funding mechanism	Whole Person Care
Oversight	Whole Person Care administrators; leadership within County of Santa Clara including from ReEntry Resource Center, EMS Agency, Substance Use Treatment Services
Mission / Target population	Reduce the use of hospital emergency rooms and jails in the care of acute intoxication
Admission criteria	Sobering: Alcohol only Mental Health Drug Triage pilot: Methamphetamines, marijuana
Referring parties	All Santa Clara County law enforcement agencies; Santa Clara County operated EDs (Valley Medical, O'Connor, and Saint Louise); and county community organizations who provide substance use and mental health treatment services
Staffing model	Licensed vocational nurses, EMTs, sobering specialists
Services provided	Crisis Intervention, medical and mental health assessment, motivational interviewing, HMIS – VISPDAT assessments for housing, Medi-Cal applications, care coordination with Whole Person Care and case managers, clothing, showers, light stacks, referrals, transportation to and from providers.
Proportion of clients served experiencing homelessness	41% clients currently homeless

San Francisco Sobering Center

San Francisco City and County

Operating organizations	SF Department of Public Health partnering with Community Forward SF
Year opened	2003
Operational components	<p><i>Capacity:</i> 12 people; 5–6 with social distancing protocols</p> <p><i>Hours:</i> 24 hours a day, 7 days a week</p> <p><i>Location:</i> 1185 Mission Street, San Francisco 94103</p>
Funding mechanisms	City and County of San Francisco General Fund
Oversight	Department of Public Health, City and County of San Francisco
Mission	Providing safe, short-term sobering and care coordination for actively intoxicated adults as an alternative to the emergency department and jail
Target population	Individuals with co-occurring homelessness and alcohol use disorder
Admission criteria	Primary focus: alcohol intoxication. Other drug intoxication accepted based on individual behavior to ensure safety for clients and staff.
Referring parties	Field paramedics, police, sheriff, emergency departments, community paramedics, physical and mental health clinics, community agencies. Walk-ins on limited basis for case managed clients.
Staffing model	Registered nurse (24 hours a day), personal care assistants/ certified nursing assistants, peer navigator, social worker, part-time nurse practitioner, charge nurse, program director
Services provided	Vital sign monitoring, minor wound care, urgent care needs; manage ADLs, hygiene needs, delousing; nutrition and oral fluids; case management for high-use clients; referrals to shelter and detoxification needs; withdrawal management to bridge to detoxification services; medication management
Proportion of clients served experiencing homelessness	<p>60–70% of unduplicated individuals served are currently homeless.</p> <p>>95% of returning clients have current or former history of homelessness.</p>

Sun Street Centers Sobering Center

Salinas, Monterey County

Operating organizations	Sun Street Centers partnered with Monterey County Behavioral Health Department
Year opened	2017
Operational components	<i>Capacity:</i> 10 people <i>Hours:</i> Thursday at 3pm through Monday at 3:30pm <i>Location:</i> 119 Capital Street, Salinas 93901
Funding mechanisms	Proposition 47 Grant with Monterey County Behavioral Health Department Monthly "Whole Person Care" billing
Oversight	Monterey County Behavioral Health Department
Mission	Preventing alcohol and drug addiction by offering education, prevention, treatment and recovery to individuals and families regardless of income level.
Target population	All individuals 18 years and older with public intoxication (penal code 647F) or driving under the influence (DUI)
Admission criteria	Accept drug intoxication if alcohol is also present. Additional assessments completed on individuals under influence of opiates or methamphetamines to ensure safe for sobering environment.
Referring parties	Law enforcement including but not limited to police, sheriff, and California Highway Patrol
Staffing model	Recovery specialists, medical assistants, program manager, data entry person
Services provided	Assess and monitor BAC via breathalyzer. Vital signs, assess for withdrawal, provision of light food and oral rehydration. Referrals to physical, mental health, and substance use services. Transportation provided upon discharge.
Proportion of clients served experiencing homelessness	Specific data not available for report.

Endnotes

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