



Sobering Centers Explained: An Innovative Solution for Care of Acute Intoxication

Sobering centers present an intriguing, cost-effective alternative for providing care to persons with acute intoxication whose public alcohol or drug use puts themselves or others at risk. New interest in the decades-old approach has been sparked by California Advancing and Innovating Medi-Cal (CalAIM), which is a multiyear process led by the California Department of Health Care Services to improve the health outcomes and quality of life experienced by Medi-Cal patients. CalAIM will designate sobering centers as one of 14 reimbursable, nontraditional services available to augment or supplant medical care. The reforms are designed to foster greater integration between physical health, mental health, and social services for all Medi-Cal enrollees.

Recent legislation aimed at easing emergency department (ED) overcrowding in California (California Assembly Bill 1544 — Community Paramedicine or Triage to Alternate Destination Act, Chapter 138, Statutes of 2020) also has focused new attention on sobering programs. AB 1544 authorizes local emergency management services (EMS) agencies to develop triage programs that allow for the transport of nonemergent patients with mental health conditions and substance use disorders to alternative care destinations.

The following insights have been gleaned from a field report on California sobering programs produced by Shannon Smith-Bernardin PhD, RN, CNL, an assistant professor in the School of Nursing at the University of California, San Francisco. Smith-Bernardin is president and co-founder of the [National Sobering Collaborative](#) and a leading expert in the field. Her full report will be published by the California Health Care Foundation later in 2021.

What is a sobering center?

A sobering center is a short-term care facility designed to allow an individual who is intoxicated and nonviolent to safely recover from the debilitating effects of alcohol and, more recently, drugs. The centers typically operate 24 hours a day, seven days a week, and have lengths of stay ranging from four to just under 24 hours. They are also known as stabilization programs, recovery programs, diversion centers, and sobering stations. Sobering centers are separate and distinct from two other kinds of alcohol-related care facilities: detoxification centers, which support individuals in the gradual and complete cessation of alcohol consumption over a period of days, and sober living houses, which provide a group residential setting for those in recovery and abstinent from drugs and alcohol.

What kinds of services do they provide?

Safety is paramount. Clients are monitored regularly for negative effects of intoxication, including alcohol poisoning and drug overdose. A primary goal of sobering centers is to help connect clients to other community services providing care for substance use, mental health, or stabilization.

In addition to providing a secure environment to recover from intoxication, sobering centers typically offer screenings for substance use disorders, acute medical and mental health conditions, injuries, and health care services eligibility, as well as brief interventions, including motivational interviewing. Direct referrals are provided to substance use treatment, shelter, and other services. Many programs stabilize adults intoxicated from drugs, such as opioids, methamphetamines, and crack cocaine, in addition to addressing alcohol inebriation.

What is their history?

The sobering center concept was initially proposed 50 years ago as part of the federal *Uniform Alcoholism and Intoxication Treatment Act*. The legislation reflected growing societal recognition that alcoholism was a disease and treating public intoxication as a criminal offense consequently represented an “ineffective, inhumane, and costly” approach to the problem. The law provided states with the legal framework for creating a range of treatment solutions, including voluntary, short-term care centers that could provide monitoring, stabilization, and coordination of care for clients acutely intoxicated on alcohol.

The first sobering center programs in the early 1970s were designed to support individuals during acute intoxication (sobering) and throughout the alcohol withdrawal and early treatment phases (detoxification). Target populations were and often remain those who frequently become intoxicated in public settings, many of whom are without homes and in frequent contact with the criminal justice system. Some centers focus primarily on young binge drinkers. Today, an estimated 40 sobering centers operate across the US, with dozens more under development.

According to a 2019 survey of 20 centers nationwide, annual patient census can range from a few hundred to more than 20,000, depending on the size of the community, bed capacity, and other factors. In 2018, more than 105,000 intoxicated adults were provided care.¹

Before the advent of sobering centers, the most common response to public intoxication was to detain individuals in jail cells — colloquially known as drunk tanks — and charge them with a drunk and disorderly or public intoxication offense. These cells were typically unmonitored, and intoxicated individuals frequently suffered complications, including preventable death from overdose, suicide, or an unidentified medical condition (e.g., head trauma).

What advantages does the sobering care model offer?

Sobering programs provide safe environments and critical access to a range of community health services for at-risk populations. Equally important, they relieve pressure on both the emergency medical system and law

enforcement by diverting rapidly growing numbers of intoxicated adults from emergency rooms and jail.

ED visits for alcohol intoxication in the US jumped by 51.5% between 2006 and 2014, to 2.7 million visits annually.² Alcohol-related diseases, including acute intoxication, now account for 8% of all ED visits, and the total annual cost of these encounters is estimated at \$9 billion.³ Alcohol use disorder is the most prevalent use disorder in California⁴ and nationwide,⁵ accounting for more nonfatal ED visits in the state than all other drug diagnoses combined.⁶

While acute alcohol intoxication can require emergency medical intervention due to potential complications, such as respiratory depression or liver failure, studies have shown that fewer than 1% of individuals assessed with uncomplicated alcohol intoxication need emergent services.⁷ Studies further suggest that if sobering centers were implemented in all major urban areas nationwide, annual savings to the health care system could reach \$2.1 billion.⁸ Most EDs simply do not have the resources, time, or expertise to provide targeted interventions for individuals with substance use disorders and frequently co-occurring homelessness.

For the law enforcement community, the sobering center model allows officers to return to the field more quickly to contend with other issues. Studies estimate that a law enforcement officer can drop an intoxicated person off at a sobering center in as few as seven minutes,⁹ whereas the time required to book someone into jail for public intoxication can range from 45 minutes to several hours. And because individuals incarcerated for public intoxication are not always subject to visual monitoring, sobering centers help reduce the risk of injury during incarceration or co-occurring medical conditions that could result in hospitalization or death.

Forgoing incarceration also saves municipalities money: An evaluation of a sobering center that opened in Houston, Texas in 2013, calculated the daily cost of a sobering center admission at \$127, which is 55% less than the \$286-cost-per-day of a jail admission.¹⁰

What role do they play in California?

As of November 2020, 10 sobering centers — a quarter of the nation's total — were operating in California, with six to eight more programs under consideration or in the process of implementation. Two centers ceased operations in 2020, one due to COVID-19 restrictions and the other likely due to budget fluctuations associated with the pandemic. All centers serve adults 18 and older, and all but one is open 24 hours a day, 7 days a week, 365 days a year. Average lengths of stay range from seven to 12 hours, with three centers stipulating a minimum four-hour stay. In 2019, an estimated 30,000 encounters occurred at all operational centers statewide.

How are sobering centers staffed?

Allied medical personnel, such as medical assistants or emergency medical technicians, staff most of the centers in the state. Approximately half the centers are staffed with licensed vocational or registered nurses, with two offering registered nurse support 24 hours a day. Others rely on nonclinical personnel to complete intake, provide peer-level support or motivational interviewing, and conduct guideline-driven assessments throughout the client stay. About half the centers include staff in a security role.

How are individuals referred to them?

Depending on factors such as staffing, funding sources, local laws, and organizational mission, sobering centers may accept intoxicated persons referred by paramedics, law enforcement, EDs, clinics, other community programs, or via self-referral and walk-in.

How are the centers funded?

As is the case with many community health facilities, funding sources for sobering centers vary widely and are often of limited duration. This can make sustaining funding a significant challenge. A number of centers have been established through state or local funding streams by variously targeting diversion from the ED or jail, criminal justice reform, or improved mental health access. No sobering centers currently bill individuals served or commercial payers.

Key state-level grant funding for sobering centers includes:

- ▶ Whole Person Care Program, Medi-Cal Waiver Initiative
- ▶ Proposition 47, No Zip Code Left Behind
- ▶ Proposition 63, Mental Health Services Act Innovations Funding
- ▶ Edward Byrne Memorial Justice Assistance Grant

Financing initiated through local and county funding streams includes:

- ▶ Alameda County Measure A — Essential Health Care Services Tax Ordinance
- ▶ San Diego Behavioral Health
- ▶ Santa Cruz County Sheriff's Office
- ▶ City and County of San Francisco General Fund

Many centers have pursued smaller funding streams to provide additional client services. These sources include:

- ▶ Medication-Assisted Treatment (MAT) Expansion Project, which is designed to increase the number of MAT access points in the state
- ▶ Prosecution and Law Enforcement Assisted Diversion Services, a pilot program targeting individuals under the influence of substances other than alcohol
- ▶ Medi-Cal Administrative Activities Recorders, which provides a small per diem rate when eligible individuals are screened for and referred to expedited county services

What are the primary funding challenges?

Sobering centers are not intended to be profitable. Instead, they prevent use of higher-priced services, most notably ED care, while saving time and resources for first responders. Despite these important community benefits, securing and sustaining funding is often an ongoing problem. Part of the challenge, according to stakeholders, is the disconnect that frequently exists between entities that benefit from sobering centers and the centers' funding realities.

Hospitals typically have not earmarked monies to contribute to centers nor entered into any shared memorandums of funding to help support them. Many hospitals, in fact, may be disincentivized from cooperating with sobering centers, given that uncomplicated acute intoxication care can be billed to some insurance companies at rates that exceed the cost of service.

At the same time, the relatively short-term nature of many available grants contributes to uncertainty about developing sustainable, local funding once the grant period expires. Finally, many of the funding streams that support sobering centers contain restrictions that do not allow organizations to use the money to help support improved integration among substance use, mental health, medical care, and criminal justice services.

What other strategic or operational hurdles exist?

Stakeholders report that securing a facility in which to operate a sobering center can be problematic. Considerable time and effort is often required to identify an appropriate location and achieve community approval. Complicating this process is the stigma typically attached to alcohol use and chronically intoxicated individuals, particularly when many are experiencing homelessness, are experiencing co-occurring mental illness, or have histories of incarceration.

Local resistance to sobering centers often focuses on fears that undesirable populations will be attracted to, or abandoned in, the community. In some cases, local opposition has led to substantial delays in opening the facilities and even outright cancellation of already-funded centers. In other instances, centers have been relocated to areas considered more dangerous, undesirable, or distant from other resources and aftercare options.

Newer programs can also face resistance in changing the preexisting beliefs of referring parties. Achieving buy-in from law enforcement, for example, can require shifting the traditional mindset that “a person behaving badly deserves to go to jail” and that a sobering center visit may not constitute adequate punishment.

Do they coordinate with other services?

Yes, many centers function as referral hubs for services directed toward individuals with substance use disorders, including health care, behavioral health, criminal justice and probation services, and homeless services. Having staff with expertise in substance use disorders and knowledge about available community resources is important in helping recognize when an individual is ready to move ahead with additional treatment services and where they may be referred.

Partners include EDs, psychiatric emergency services, community paramedicine teams, and homeless service providers. Sobering centers also can provide care coordination for intoxicated adults who have mental health needs, with many programs indicating that between 60% to 70% of individuals served have co-occurring mental health diagnoses. By providing short-term sobering for dual-diagnosed individuals, sobering centers are able to refer patients to mental health facilities to engage more successfully than otherwise may have been possible.

Are sobering centers part of the behavioral health care continuum?

While sobering centers clearly focus on a key element of behavioral health and frequently refer to mental health facilities, many nonetheless operate largely apart from the traditional behavioral health continuum. This may be due in part to the stigma associated with substance use as well as a lack of capacity by mental health providers to provide care for individuals with both a mental health diagnosis and active substance use. An additional complication for successful coordination includes the often-present belief within the behavioral health system that abstinence from alcohol and drugs is the only acceptable goal for substance users. Though sobering centers may support an individual’s desire to be abstinent, the primary focus is on reducing harm. Mandated complete cessation may restrict the options available for those seeking mental health care.

Considerable confusion also exists about the activities and benefits of sobering centers among not only mental health providers but also community leaders and other potential partners. That said, stakeholders indicated that coordinating care by collocating sobering services with

crisis management or other behavioral health facilities could decrease stigma, improve care integration, and strengthen individual care.

Do sobering center clients have unique or higher-level clinical needs?

Sobering center clients typically fall into one of two populations, each with substantially different care needs, according to stakeholders. The first group includes persons who may be housed or experiencing homelessness and who are capable of functioning independently, requiring only a safe space and time to metabolize alcohol or drugs.

The second group includes individuals often experiencing homelessness while managing chronic intoxication, cognitive impairment, and other health issues. Because sobering centers are not equipped to help arrest the decline of these most sick and vulnerable individuals, this population requires additional care options. Yet most of these individuals are unplaceable in traditional settings (board and care or skilled nursing facilities) and too impaired to live independently.

Stakeholders consequently see a critical, ongoing need for low-barrier residential facilities that can accommodate high-need sobering clients with services such as palliative care, medical respite, and managed alcohol programs.

What role do sobering centers play in addressing homelessness?

An estimated 38% of individuals who are homeless have severe alcohol use disorders, and 80% of the individuals who are chronically homeless experience an alcohol or drug use disorder in their lifetime. The role of a sobering center in helping provide care for those with comorbid homelessness and substance use, therefore, cannot be overstated.

Practical, onsite 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 that employ licensed health care providers also may offer chronic disease medication

management, wound care, or provision for other unmet urgent or primary care needs.

Are sobering centers accredited or subject to monitoring and oversight?

Specific certification or accreditation programs currently do not exist for sobering services, although many organizations that run sobering centers do have accreditation for some or all of their nonsobering programs, such as detoxification, rehabilitation, or behavioral health interventions.

If the center is associated with a community health center that provides additional, billable clinical services, such as primary or urgent care, pursuing satellite status to the existing Federally Qualified Health Center (FQHC) may be feasible. But if the sobering center is the primary clinical program, FQHC status is likely unachievable.

What do best practices look like?

Most California sobering centers share several key best practices that sustain and support their work:

- ▶ **Low-barrier, compassionate, streamlined service model.** Low-barrier services promote an easily accessible and user-friendly environment in which barriers such as paperwork, eligibility requirements, and complex intake processes are minimized. Clear eligibility criteria and field screening tools, admission and assessment guidelines, and a streamlined admission process are vital to success.
- ▶ **Central role in care coordination.** Around-the-clock staffing and services allow sobering centers to provide an immediate response to individuals in crisis while facilitating timely communication with other service and referral partners. By functioning as a referral hub, sobering centers help at-risk individuals access services they might otherwise forego.
- ▶ **Programmatic flexibility.** The ability to pivot to meet the specific needs of individuals as well as the community at large has been cited as important for sobering centers. This flexibility can take the form of offering longer stays on a case-by-case basis, providing overnight shelter to individuals released from jail during inclement weather, or assisting in the care of

a high-need individual who may not meet standard eligibility criteria. On a community level, program flexibility could include creating an outreach team to locate vulnerable individuals and bring them to the facility.

No entity presently exists to disseminate California-specific program guidance or support best practices uptake. However, the National Sobering Collaborative does provide a clearinghouse for national sobering center research, best practices, and policy initiatives.

Will sobering centers ultimately emerge as an integral part of the community health continuum?

Time will tell. Despite the range of benefits sobering centers offer, health system stakeholders still have a rudimentary understanding of their value. Even though sobering services are one of the 14 In Lieu of Services approved by the Department of Health Care Services, there is currently no evidence suggesting managed care plans intend to contract with programs in the state in January 2022. No models for collaboration between health plan and sobering center have yet emerged, nor is there any guidance about what billing Medi-Cal for sobering services could look like. With the numerous sobering centers currently in operation in California and more in development, it is possible that pilots may surface, and with them, promising practices.

Without the involvement of health plan partners, sobering centers may be available only in jurisdictions with county-operated or financed EDs and/or EMS systems. Given these realities, the Community Paramedicine or Triage to Alternate Destination Act (AB 1544) may prove a more effective catalyst in stimulating sobering center capacity and scale than the CalAIM reforms. Assuming paramedicine programs grow and spread following AB 1544's implementation, communities may be inclined to expand the range of alternative drop-off sites to include sobering centers. This, in turn, should present opportunities for stakeholders to convene, learn, measure, and eventually pilot new relationships involving payer and delivery system partners. Aligned with the passage of AB 1544 is the federal Emergency Triage, Treat, and Transport (ET3)

Model recently launched in January 2021 by the Centers for Medicare and Medicaid Services. The ET3 pilot is a voluntary, five-year payment model that offers additional flexibility and payments to ambulance companies transporting Medicare beneficiaries to alternate destinations, including sobering centers.¹¹

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About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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