Frequently Asked Questions - Sobering Centers

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Hello and thank for checking out these Frequently Asked Questions regarding sobering center care!

For those of you who do not know me, I have worked in sobering care since 2007, first spending 10 years with the San Francisco Sobering Center and now conducting related research, consulting, and heading up the 501(c)3 nonprofit National Sobering Collaborative.

Below are questions that I am often asked as communities are looking to develop and implement sobering center care. The answers are informal and not prescriptive. Please note a bit of legalese: *these answers are based on my own professional experience and do not represent all centers nor the views of the National Sobering Collaborative. The goal is to share common questions to help guide the conversation. Not all answers may be appropriate for the needs of your community nor fully adhere to the legal and policy considerations within your region.*

I also recommend you take a look at the National Sobering Collaborative website for additional resources, including the Research page which offers a list of sobering-related literature. Find it here: https://nationalsobering.org/research/

Thank you and reach out once you have had a chance to read through these. I am always willing to talk about sobering centers and help you launch or expand your own program!

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What is a sobering center?

A sobering center is a typically community-based program that provides short-term (4-12 hour) care and monitoring of individuals during acute intoxication, often as an alternative to the emergency department or jail. The essential goal of a sobering center is to reduce the harms associated with acute intoxication, such as injury or poisoning, and help the individual return to a baseline where they can safely care for themselves. It is not a treatment program, though most sobering centers screen for and provide education around substance use disorders and prioritize assisting people to access appropriate stabilizing services such as detoxification and treatment.

Why and when were the first sobering centers created?

Sobering as a concept officially occurred in the early 70's with the passing of the Alcoholism and Intoxication Treatment Act (the "Uniform Act"). These sobering programs were established almost exclusively for law enforcement use as an alternative to jail and offered direct transition to co-located detoxification centers. Primary goals were to offer intoxicated individuals more appropriate care for alcohol use disorders considering the disease model of addiction as an alternative to punitive, criminal justice response.

What is the difference between a "sobering center" and "social detox"?

This is a frequent question and the distinction between 'social detox' and 'sobering center' is something often misunderstood. If anything, sobering care is like "pre-detox". Sobering is short-term, addressing immediate risks and harms of acute intoxication - with a goal to help connect people to resources if there is interest in treatment. Yet abstinence and full detoxification and cessation of substances is not the primary goal of a sobering center. Rather, the focus is on keeping people safe from acute intoxication as an alternative to standard models of care (e.g., jail, emergency departments).

Some facilities have both sobering care and then transition to detox in the same facility, yet the two care models are distinct from one another.

How are sobering centers regulated?

There are no established regulations for or designations of sobering centers nationally. Some states do have emerging guidelines, such as Oregon which requires sobering centers to register with the state.

There had been conversation investigating the use of FQHC (federally qualified health center) licensing for sobering centers. There is only one that I know of has that distinction (San Francisco Sobering Center), and it is primarily because it is co-located to a Medical Respite that has satellite FQHC designation to a primary care clinic. Most sobering centers would not pursue FQHC status as few services provided are billable to insurance, and the common health and wellness monitoring metrics (e.g., HgA1c, mammogram, colonoscopy) are not provided in a sobering care environment. It would be overwhelmingly costly, and likely not practical, to attempt FQHC status without the standard billing benefits.

With this, the National Sobering Collaborative aims to establish recommended standards of sobering care, with a goal to create a national accreditation program for sobering centers. The standards are in draft form and will be undergoing further editing in the summer/ fall 2021.

If we were to regulate, what are potential requirements that could be put in place regarding sobering center care?

There are many promising discussions and thoughts around this. A first consideration is the specific type of care being provided, who the referring parties will be, and how clients will access the sobering center; this will be covered a bit later in the FAQs. Main considerations and some ideas for how to regulate a sobering center include:

Operations:

- All appropriate adults accepted without incurring individual charges and regardless of insurance or ability to pay
- Front line staff and management team with experience of and training in substance use disorders, related evidence-based topics (e.g., trauma informed care, social determinants of health, mental health), and community resources.

Safety:

- Onsite emergency medical response capability – AED/ defibrillator, oxygen, vital sign assessment and monitoring, first aid, emergency medications (e.g., epinephrine, aspirin)
- Ability to administer naloxone and provide medical care and supervision in response to an overdose
- Minimum level of medical staffing 24/7 (such as EMT-basics or nurses)
- Comprehensive standardized procedures with immediate access to medical back-up (phone minimum)

Providing for vulnerable populations:

- Provide for health and safety including nutrition and for hygiene needs with showers, delousing, clean clothing, rewarming
- Referrals and warm hand-offs to available community programs including detoxification or treatment services
- Ability to refer and arrange transport persons without homeless to appropriate resources

Monitoring and Evaluation:

- Robust data collection within a Sobering Center
- Ability to run reports and evaluate both incident-level and client-level information on sobering clients specifically
- Regularly schedule data review for all negative outcomes (e.g., client injury) such as weekly case reviews
- Immediate response by management in cases of negative outcomes (death, dismemberment, etc.) with - for example - root cause analysis
- Ability to share data amongst parties as needed (sobering, ambulance, ED, police) in case reviews

This is a short list. The National Sobering Collaborative is developing related guides – including a Tool Kit and Standards of Sobering Care to inform a sobering accreditation program – which will further this conversation.

Do sobering centers accept individuals accepted on drugs in addition to or instead of alcohol?

Most to all sobering centers care for persons intoxicated on drugs in addition to or instead of alcohol. Alcohol intoxication is often the most common. Typically, upon intake, staff ask clients what they consumed so there is a better awareness to the potential needs and presentations during their sobering experience. However, if a client were to state alcohol and/or crack-cocaine, MDMA, opioids, marijuana, etc., the individual would almost always still be accepted. Consumption of drugs is often not exclusionary; the intake questioning is to provide the most appropriate care for that individual.

Some centers do exclude certain types of drug intoxication. The most commonly excluded drugs are amphetamine and synthetic cathinone ("bath salts") and phencyclidine (PCP), primarily due to the behavioral difficulties of and challenges de-escalating those intoxicated by these substances.

What about methamphetamine intoxication for a sobering center? Individuals with meth psychosis are filling our psychiatric emergency facilities.

Methamphetamine use has become a complicated and substantial challenge and is a frequent topic for many cities and counties facing an influx of meth and the resulting harms.

Similar to alcohol intoxication, methamphetamine intoxication is not similar across the board. Caring for individuals with either mild to moderate meth intoxication or who are "coming down" after 2-3 days of stimulation may be appropriate for a sobering center. In situations with heavy meth intoxication and co-occurring psychosis, a sobering center may or may not be able to provide appropriate and adequate care. Client and staff safety is paramount. Sobering centers are typically dorm-style, offer verbal de-escalation with trained staff, and are safe spaces - without restraints, without medications to de-escalate individuals, and without heavy security (things that are often found in a psychiatric ED or correctional setting).

If your community has high incidence of both meth psychosis and other behavioral crisis needs, developing a co-located sobering and crisis stabilization center may be the most appropriate choice. These co-located programs often offer on-site access to prescribing providers (NP/MD) to offer a higher level of assessment and medication administration as appropriate. With these stimulants in particular, the care environment ideally can provide an open space allowing for clients to be active and move around.

It seems many sobering centers have not embraced accepting clients intoxicated specifically with opioids. Do you have any insight why this is an exclusion for sobering centers (is it?) or is there a movement towards changing that?

It's a great question. Many programs do not exclude opioid intoxication. One main question is exactly at what stage of opioid intoxication or reversal the individual is at.

With the reduction in oxygen saturation due to decreased respirations, there is the fear of an overdose that is not noticed in time. I know some centers have been ok with clients recently provided naloxone ("Narcan'd") who are brought in for monitoring. Yet there was so much emphasis in the recent past that a person receiving naloxone **must** go to the ED, I think some centers were wary of getting between that. A reason had been that

the effects of naloxone may end before the effects of the drugs consumed; thus an overdose may happen later despite naloxone administration.

If there is active evaluation of someone's respiratory status (aka, visual check that someone is breathing enough times per minute), particularly in the first 30-60mins of someone's stay, I find a sobering center can safely care for an individual with recent opioid use.

A challenge and reality is: there may be fentanyl in just about any drugs now, so respiratory status monitoring is important for any and all admitted clients during early sobering.

A random aside: Based on some experience with individuals intoxicated on opiates or heroin, I often saw that these individuals did not like lying in beds - all wanted to sit up in a chair (such as a lazy boy recliner). You may find at least moderately reclining chairs preferable for persons on opioids, and thus could consider having a mix of beds and chairs for client use.

Lastly, a fantastic specialist on caring for active opioid intoxication is Dr. Jessie Gaeta, chief medical officer at Boston's Health Care for the Homeless where she runs the SPOT program (Supportive Place for Observation and Treatment). SPOT focuses only on opioid intoxication and have some amazing stories to tell and years of experience. SPOT is like a sobering center (I consider it one) yet only takes opioid intoxication.

Do you have a sense of what a reasonable staff to client ratio is? How is this decided?

In general, the staffing and make-up are dependent on 1) the population intended for the sobering center, and 2) the main systems which would be referring to the center. Law enforcement-only referrers, and a previously jail-bound population, can often operate successfully with comprehensively trained peer-level staffing, basic medical staffing (EMT-Basics for example), and substance use specialists (harm reduction coaches, recovery or sober coaches, etc).

There are no established staffing ratios just yet. Either in commonality nor in the research, and in my opinion, we do not want overarching (such as state or federally mandated) "required ratios". First, each sobering center is unique in terms of local resources, funding, population, and potential co-location. And as outpatient facilities, it is not necessarily appropriate to follow an inpatient mindset (such as exactly "5 patients per 1 RN") that has an environment with validated acuity measures and established patient presentation.

When considering staffing levels, any center should always have a minimum two staff with ideally a 3rd person available to sit in during breaks. No staff member should be working independently with acutely intoxicated individuals (or really any overnight program that is client-facing).

A coordinated and often budget-friendly safe and appropriate staffing model may also be achievable with co-located programs. For example, one RN and one recovery specialist could successfully care for 10-15 clients in sobering while an additional peer-level staff member holding a radio roaming between sobering and co-located crisis management, medical respite, shelter, or detoxification program (with its own medical and support staff).

If you are considering EMS ambulance drop-offs and/ or accepting more highly-intoxicated individuals (aka, inability to ambulate, lower cognition), nurse level staffing is recommended and may likewise be required (make

sure to check your local and state emergency medical system regulations). A successful and safe staffing pattern may include one or more registered nurses, licensed vocational or practical nurses, and/ or EMT-paramedics with a mix of non-clinical staff including peer-level or recovery specialists, certified AOD counselors, case managers, client safety specialists, etc. More information is provided in the 911-ambulance section below.

If the intended program does not anticipate EMS ambulance referrals or clients with higher-risk intoxication, a staffing mix of EMT-basics with peer-level and certified recovery specialists can work fabulously.

We want to set up a sobering center to take intoxicated clients from 911-ambulances directly. What other considerations should we have?

If you all are looking towards EMS (ambulance) drop-offs in the future or maybe just for peak times, I will answer based on my experience of the work at the San Francisco Sobering Center. Operating since 2003 accepting directly from 911 ambulances, the basics for the San Francisco Sobering Center to receive intoxicated adults referred with EMS/ ambulances:

- Full cooperation and protocol and policy development with local EMS agency and health system
- 24/7 operation with at least one RN available at all times
    - Other options: San Francisco historically staffed with LVNs; Los Angeles CA has LVN/RN mix; Austin TX staffs with paramedics
    - Of note, many health care providers come into a sobering environment pretty taken aback by the acuity, in particular the altered mental status often found with acute intoxication. I recommend training for signs and symptoms of acute intoxication (including what is 'normal' versus a crisis), including a focus on harm reduction, process and timeline of healthy sobering, signs and symptoms of withdrawal, concerns co-intoxication with drugs and alcohol. This will help empower the staff and provide a safe environment for all clients.
- Triage guidelines for EMS ambulances; basic guidelines for police and others
    - There are good examples in the literature today that have been studied. The National Sobering Collaborative website has a Research tab – scroll down to EMS Collaborations for related triage literature.
- Standardized procedures for nurses and paramedics to direct care and response for common healthcare concerns and treatment
- Medical back-up
    - This can be via a program medical director – though this individual may not be able or willing to take 24/7/365 on-call duty.
    - A recommended option is to contract with the public health department or emergency department to utilize the ED attending on duty.
    - A second option is to engage with an existing pool of on-call physicians as back-up in the middle of the night. Similar to acuity training on presentation of acute intoxication, appropriate training to the care within the sobering center is critical to ensure appropriate, effective care is provided. Otherwise, most inquiries to on-call back may result in unnecessary transports to the emergency department. (Though – as you'll see later, err on the side of caution!)
- Emergency equipment on site: oxygen access such as a concentrator, BVM bag-valve-mask, naloxone/ Narcan, epinephrine, comprehensive first aid kit for wounds, AED.

- Services: oral rehydration, hygiene (showers, toilets), snacks/ sandwiches/ ramen

Is it possible to create a sobering center without nurses or medical staff? Have you seen that done before?
I do know of some programs without health care professionals on site and know of some that started that way yet are adding health professionals now into the staffing mix. Some primary considerations as you consider the most appropriate staffing model:

- Who exactly is referring clients? If anyone but police and street outreach teams, I'd strongly consider at minimum an EMT as part of the staff mix.
- Who is the primary population(s) you think will be referred? If binge drinkers who are not chronic consumers, yes please have medical staffing - alcohol poisoning is an incredible, frequent risk. Persons who have been homeless on the streets for many years with very long-term alcohol consumption – the risks are different, such as with alcohol withdrawal, and not insignificant (and yes, nonmedical persons may be successfully trained to assess for signs and symptoms of withdrawal). These clients may benefit from some regular medical care; a full-time RN either early in the AM or later in the evenings could offer a lot to these folks on a longer-term trajectory.
- What is the staffing at the current alternatives? How necessary/ obsolete is that model of staffing for the clients you think will arrive and what are the challenges regarding that staffing model? For example, does the jail space for these clients currently have a medical team or RN that rotates regularly and sees clients for higher needs on a regular basis? Or does the jail technically have an RN on staff down the hall and is only called ~2% of the time for issues? Some solid protocols for monitoring and emergency response may offer a similar or even higher level of safety.
- If the concern is primarily budgetary (essentially that health care personnel would be too costly), investigate where and how you anticipate your sobering center may provide cost savings. There may be considerable cost-avoidance in diverting persons from jail (e.g., no jail stay, shorter hand-off by law enforcement, fewer incidences of withdrawal or negative outcomes) or the ED (e.g., ED staff can focus on traumas or other billable cases, many clients may not be billable for the ED care due to lack of insurance, or the insurance of repeat clients may not be billed as frequently as they come to the ED). Make the case that client safety can be ensured with cost-effective budgeting.

EMT-basics are typically well trained and economical. And they have the fabulous skills to take vital signs, respond to a higher capacity in cases of emergency, and have a medical conversation with medical back-up (say, a nurse or provider in the ED).

Regardless of the staffing model your program chooses – **always err on the side of caution**. Sobering centers are intended to be a safe space for uncomplicated intoxication. They are not intended to be emergency medical or psychiatric facilities and not every case of intoxication will be appropriate for a community-based level of care. Even with well-known, frequent clients whom your sobering center may serve regularly – some visits may not be appropriate, and that individual may have to be sent elsewhere for that moment. And client presentation and health status can change during the stay – that is why consistent and frequent oversight and monitoring is critical. As the saying goes, “When in doubt, send the client out”.

How quickly will we hit capacity? My funders want to show cost-savings within three-to-six months.

To start, the uptick in use is **slow** when a sobering center opens. Regardless of how enthusiastic the community or referring providers are prior to opening, the initial utilization is often far lower than anticipated. Almost every sobering center starts so much slower than anticipated. Many administrators and funders underestimate the cultural change that must happen for both referring parties and clients. Establishing trust that 1) the sobering staff will actually accept almost all referrals, and 2) that it is a safe space can take many weeks or even months.

From what I have seen at newer programs, it can be about 12-18 months before consistent utilization occurs. Whatever goals the region sets for intakes - for example, "500 admissions a month" - just assume you will not actually hit that until at least a few months into operation. It's worth the wait! And, I can almost guarantee it will be a wait.

Yet **there are things you can do to help move the needle towards increasing appropriate utilization**. A critical component to reaching and sustaining capacity goals is **community engagement** both before and after opening. Get out there and meet your partners and your clients.

- Do ride-alongs with the referring parties to see how their work happens and discern potential barriers to transfer to the sobering center. Attend law enforcement huddles. Attend emergency department staff meetings. Do this before and for the first few months after opening, and then on a regular basis (such as every six months). Some of these can be quick engagements – 10min at the ED staff nurse meeting to answer questions and trouble-shoot issues.
- Also remember – your referring parties are hiring new staff all the time who must learn about your services. Even after 10 years at the San Francisco Sobering Center and tens of thousands of admissions, I would often talk with paramedics, physicians, or nurses that had never heard of our program. Keep the conversation going.
- Visit detox and talk with the clients. Engage with potential consumers to educate them on the program.
- Proactively educate the community. Why do you have a sobering center? Tell people how you are helping the community, what your goals are, and how the community members can support your work (e.g., donations of clothing, shoes, annual gifts for nonprofit partners). Social media can be very beneficial and helpful here!
- Perform weekly or monthly reviews of admissions and – as able – those who were not admitted. Why did the jail still see dozens of those with acute intoxication this past weekend when sobering had plenty of beds? Be curious and collaborative involving your partners and stakeholders in evaluating the process and the population. Put together monthly or quarterly reports or updates – a quick one-pager – and send it to the leadership throughout the community.
- Remember the goal is to provide safe, appropriate care. The numbers will follow. You will not have to sacrifice care or safety.

What is the average length of stay?

- Typical length of stay is 4-8 hours. Depending on the program, folks may stay up to 10-16 hours if they are more frail, need more sleep, are less likely to go into withdrawal, etc. Some sobering centers have a minimum stay of 4 hours; most do not have a maximum perse (if it is, it is 23hrs and 59min due to community-based behavioral health regulations).

How frequently are individuals brought to a sobering center who should have gone someplace else?
Transferring to a higher level of care (medical or psych ED) does happen - based on the research and feedback from programs nationally, this is typically <5% of the time.

Do sobering centers typically provide medications for detoxification?
Not typically – yet we can! "Sobering care" is not detoxification, and yet it can offer an opportunity to connect individuals to other services. Many programs are looking to bridge folks over while they are waiting on a detox bed, or initiate medication assisted therapy (e.g., buprenorphine or naltrexone) to support stabilization and reduce harms of use.

Again, looking at the San Francisco Sobering Center, we initiated a Withdrawal Management pilot back in January 2013 to help the transition of clients from a sobering stay into medical detox. Without medication support, intoxicated clients who wanted to stop drinking were going to withdrawal in the middle of the night, while awaiting their scheduled detox bed in the morning. They would either eventually require emergency department support or leaving in the middle of the night to get a drink. In either case, the reserved detox bed was often lost and the referral process had to start again. We found great success and have had hundreds of individuals utilize this withdrawal management service. Please reach out to discuss more and to receive a copy of the withdrawal management protocols.

What protocols or practices are most important in a sobering center?
I will focus on both safety and engagement when considering this question. For safety, the client encounter has three primary considerations:

- **Screening and intake**
  - Specific, comprehensive guidelines should be provided to both referring providers and staff managing the intake. Examples of basic parameters: adult aged 18 and older, no obvious trauma, no acute medical complaints, appears intoxicated based on presentation or blood alcohol level (via breathalyzer).
  - A screening can be completed in the field by referring parties and then an intake done upon client entering sobering. The screening is often less intense perse than the actual intake which may have additional questions or process.
  - Importantly, a quick reminder goals of the intake including ensuring the client is appropriate **and** to be as accessible and low-barrier as possible. A priority is to make the client comfortable. For example, if the intoxicated individual is refusing your standard vital signs – such as blood pressure check. Yet they are talking, moving all their limbs, and not complaining of any cardiac related issues – consider delaying a BP check until the individual is more willing (unless there is legitimate concern of an imminent health related crisis of course!).
  - Additionally, both referring party and client-facing paperwork ideally is kept to a minimum. As the client sobers, they are often more willing and able to engage in additional questions.

- **Client monitoring**

- Intoxicated individuals often require frequent visual assessments and ideally the facility is designed so that every client is always visible to staff
    - Some common risks requiring ongoing monitoring: increasing intoxication or overdose due to drug/ alcohol consumption immediately before admission; falls including client rolling out of bed; seizures; mental status that either decreases or does not improve indicating a possible neurological condition such as acute brain trauma; agitation due to unmet needs.
    - Some current sobering centers have every-15-minute walkthroughs, which are documented for every individual, to ensure client is in a safe position (recovery position, sitting up if in chairs), breathing adequately, not in apparently distress.
    - Regular vital sign assessment and monitoring is recommended, at minimum between every 2-4 hours. My personal practice, in addition to the above monitoring, was to encourage clients to use the bathroom at about four hours of their admission. This was a good way to assess sobering progress, signs of withdrawal, and start to do a higher level of conversation and engagement for disposition planning.

- **Emergency response capability**
    - Though the vast majority of clients with intoxication will recover without incident, staff should be ready to respond to emergency.
    - As noted in sections above, an emergency kit with supplies is critical
    - Staff need to feel adequately trained and empowered to respond in case of emergency. **All** staff should understand and be able to initiate emergency response, including CPR, first aid, naloxone administration, and how to contact emergency services and provide a report - not only medical or nursing providers.
    - Especially early in your sobering center operation, conduct reviews of all client encounters that result in individual who is sent out to a higher level of care (such as the emergency department) or who have a negative outcome such as an injury on site. Spend time at front-line staff meetings discussing some of these situations to gather feedback on ways to improve the care model, etc.

For engagement including **disposition planning**, my vision is that all sobering centers provide a comprehensive, appropriate level of care and engagement aimed at their substance use and related needs (e.g., homelessness, poverty, health access), care that is better coordinated than that they currently receive in alternative sources. The goal is to safely provide a space to sober and to receive education, support and encouragement, and referrals to decrease the harms of their substance use.

Related practices can include:

1. Established direct referrals to community-based programs such as detoxification, shelters, health system-based addiction treatment services (i.e., Kaiser's chemical dependency referral program)
2. Time to engage with peer-level staffing throughout the client stay, for education and encouragement
3. Screening for substance use disorders (such as the SBIRT protocol or CAGE survey) and mental health conditions. Which screening tools you use will also depend on the populations you serve.
4. Ongoing coordination for individuals who visit the sobering center more than one time.

Are there particular risks we should be aware of when working with intoxicated individuals?
This is a big question!, and one that is not easily answered in this format. Alcohol and drug intoxication can bring many risks: from direct harms (e.g., overdose, poisoning), indirect effects (e.g., injuries from falls or assault, head trauma, other injuries or illnesses masked by intoxication), to acute behavioral risks (e.g., suicide attempts, depression, anxiety). I recommend consulting with a medical professional familiar with your community and resources before launching any program to ensure protocols and safeguards are in place.

With that, some familiar health scenarios I have seen:

- Respiratory conditions, such as pneumonia – the cough is often masked due to intoxication and the fever masked due to hypothermia from being outside in the cold or underdressed.
- Fractures which are not apparent initially due to the diminished pain masked with intoxication
- Suicide ideation and/ or attempts prior to arrival
- Subdural hemorrhage
- Alcohol poisoning in the individual who may have consumed a substantial and unusual amount of alcohol ("binge drinking")
- Alcohol withdrawal in the individual with chronic consumption, that may occur within minutes to 2-4 hours after their last drink.

In all these scenarios above which I have witnessed as a nurse in sobering care, a low-barrier yet comprehensive intake process, frequent monitoring practice, and emergency protocols provided safe and effective response.

When will my sobering center start to turn a profit?
It will not – but that is ok. Profitability is not an intended nor realistic goal for sobering care. The financial impact in sobering comes largely from providing high-value care with cost-avoidance and cost-savings. Common ways a sobering center benefits the local community and related agencies:

- Faster drop-off times by law enforcement into sobering (average 5-8 minutes) as compared to booking in jail or waiting at the ED (which can be hours). This allows law enforcement back into the community tremendously faster.
- Faster drop-off times by ambulance personnel into sobering as compared to the ED. If ambulance personnel often face "wall-time" at the ED (awaiting a gurney to transfer the patient), the reduction can be in hours.
- Less costly beds within the sobering center as compared to the ED in which a client may wait for transfer to another program (e.g., detox) or to be connected with after-care services (e.g., shelter, case manager, family).
- Direct access and transfer with warm-handoffs into detox or treatment services, versus only providing clients a phone number to call in the morning
- High-value care within the sobering center with client ability to interface with substance use specialists from admission throughout their stay

What question did I miss? Please email!