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Examining the Utility of Sobering Centers: Project Summary and Recommendations for the Future

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INTRODUCTION

Police are increasingly looking for effective alternatives for the use of arrest when handling vulnerable populations. Sobering centers, facilities that provide inebriated individuals the time and resources to recover from acute intoxication, are a beneficial alternative to public intoxication arrests. Before the research findings summarized in this study, little was known systematically about their use and effectiveness as an alternative to arrest. ***Results from this study lend credible support to the efficacy of sobering centers in reducing police use of arrest, thereby saving valuable time and resources for police and reducing collateral consequences for those arrested solely for public intoxication.***

With support from Arnold Ventures, this study assesses the utility of sobering centers as an alternative to arrest. This summary is the third and final report in a series detailing our multi-method and multi-site research study. In this research, we examine four primary research questions:

1. What are the patterns of policies and practices for police use of sobering centers as an alternative to arrest? What guides this decision-making?
2. What are the situational factors police use *in practice* to determine whether or not to use sobering centers as an alternative to arrest?
3. How do police balance and overcome policy and legal inconsistencies guiding the transport to and use of sobering centers?
4. When individuals are sent to sobering centers in lieu of arrest, does it alter their relative risk of recidivism or future contact with police?

Launched in January 2020, this study includes three phases. Phase I consists of a scan of the field to identify operational sobering centers. It uses interviews and surveys to understand the policies and practices relevant to both police and sobering centers across the US. Phase II includes site-specific analyses of five case study jurisdictions—Austin, TX; Houston, TX; Oklahoma City, OK; Tulsa, OK; and Wichita, KS—based on police and sobering center data in each site. Finally, Phase III assesses the available evidence to promote further use of sobering centers and research on their effectiveness.

This project summary aims to tie together findings across the various phases of this research, highlighting the major findings, gaps in knowledge, directions for future research, and considerations for police and sobering center officials.

PHASE I: SEMI-STRUCTURED INTERVIEWS AND NATIONAL SURVEYS

Before the launch of this study, we identified two case study partner jurisdictions in Oklahoma: Tulsa and Oklahoma City, and we conducted site visits in March 2020 with both locations. To find the remaining two case study partners and launch Phase I, we conducted an exhaustive search to identify sobering centers.[1] We identified 53 operational sobering centers across the United States. We identified some patterns in the concentrations of these locations, such as:

- Over half of the centers (57%) were in the Western region of the US.
- Centers were concentrated in both small cities (34% with less than 100,000 residents) and large cities (28% with more than 500,000 residents).
- Approximately 51% of sobering centers are in cities with a $50,000-$70,000 median household income; it is unnecessary for a city to be affluent to establish and maintain a sobering facility.
- A majority (64%) of the police agencies in the jurisdictions with sobering centers were midsize agencies and most commonly received 100,000 to 499,000 calls for service each year.

After the COVID-19 pandemic began, we adjusted our work plan due to concerns about facility closures. Throughout July 2020, the research team contacted all identified sobering centers to determine their operating status (closed, open, open at partial capacity, etc.) due to the impacts of COVID-19. After determining that 48 of the 53 identified sobering centers were still operating, we resumed the next step of Phase I: in-depth interviews. We conducted the interviews from August through October 2020 and spoke with leaders from five sobering centers and seven police departments across seven cities. We chose these locations to represent a stratified sample of centers across different geographic regions, lengths of operation, and facility sizes. The cities included:

- San Francisco, CA
- Seattle, WA
- Houston, TX
- Wichita, KS
- Indianapolis, IN

[1] Sobering centers were identified using the following key terms: sobering center, engagement center, detoxification center, and diversion from emergency departments. Searches were conducted using Google, Google Scholar, news articles and an online university database of scholarly articles. Additionally, a list provided by the *National Sobering Collaborative* (http://www.nationalsobering.org/) was used to identify centers.

- Cambridge, MA
- New Orleans, LA

During these conversations, we identified our remaining two case study locations: Houston and Wichita.[2] Building off these discussions and previous work measuring sobering center operations, we developed two national surveys: one for sobering center facilities ("Sobering Center Survey") and one for police departments ("Police Survey"). These electronic surveys were sent to sobering center directors and police officials between May and September 2021, resulting in responses from 29 police agencies (63% response rate) and 18 sobering centers (39% response rate).[3] Both surveys queried respondents about organizational policies and practices, data collection and use, the impact of COVID-19 on sobering center operation/use, and views on the partnership between police and sobering centers.

The Phase I results are discussed in the *Examining the Utility of Sobering Centers: National Survey of Police Departments and Sobering Centers Final Report* (Isaza, Engel, & Cherkauskas, 2022).[4] Importantly, this work is the first to assess law enforcement views on the utility of sobering centers as an alternative to arrest. The findings suggest police agencies hold overwhelmingly positive views on the utility of sobering centers, primarily through saving officer time/resources and providing a better alternative for intoxicated individuals than jail. These findings lend support to policymakers and police officials in other jurisdictions who are looking for effective alternatives to arrest.

Additional key findings from police department respondents include:

- Approximately 65% of agencies leave the decision to use sobering centers to officers' discretion and use formal written policies and informal practices to provide guidance. Notably, nearly 20% of responding police agencies do not give the officers formal or informal guidance regarding using sobering centers.
- Most respondents agreed there are specific areas where officers are more likely to pick up individuals for the sobering center, including areas near large unhoused populations, the sobering center, or bars and nightlife entertainment.
- Nearly 20% of agencies do not train officers on how they should use sobering centers. Of those who do train, the vast majority of agencies only train once after the policy/practice is implemented, and while this training varied, it was usually less than one hour and roll call format.
- When presented with potential obstacles that might prevent officers from using sobering centers, most were not viewed as problematic. The most frequently

[2] Note that a fifth case study site, Austin, Texas, was added in early 2021 due to their strong interest in participating in the study.
[3] Of the 53 jurisdictions originally identified in the scan of the field, only 46 were still operational during survey administration.
[4] Available at https://www.policinginstitute.org/publications/.

reported obstacles were restrictions due to COVID-19, followed by the lack of cooperation from intoxicated individuals.

Highlighted findings from sobering center respondents include:

- Almost all sobering centers indicated accepting referrals from more than one source, and the most accepted referral sources were law enforcement (69%), emergency departments (62%), and walk-in/self-referrals (54%).
- The most common reasons sobering centers deny admissions are due to violence, unresponsiveness, and blood alcohol content levels that are too high.
- About two-thirds of sobering centers report having a formal partnership, and about three-quarters have an informal partnership with law enforcement agencies.
- Barriers described by sobering center respondents include changing law enforcement culture to embrace alternatives beyond arrests. Relatedly, some sobering center representatives expressed that there might be some misunderstanding in law enforcement about the scope and limitations of sobering centers.

Given these findings, we recommend that police agencies consider how they guide (informally vs. formally) officer discretion, how frequently they train officers about sobering center use, and how they use collected data to adjust agency practices and track officer time saved. Our findings suggest there are opportunities to enhance training and supervision for officer use and embracement of this arrest alternative. We also recommend that sobering centers proactively strengthen their partnerships with local law enforcement. The survey demonstrated that a quarter to one-third of sobering enters reported no relationship with law enforcement. Those with existing partnerships would benefit from enhancing relationships as this will increase collaboration and reduce barriers in the future.

Despite these valuable findings, there are limitations to the Phase I work that should be acknowledged and research questions that remain unanswered. First, it is possible that during our scan of the field, we missed operating sobering centers or identified sobering centers that may be misidentified. We cannot rule out these possibilities, though we did our best to reduce these risks. Second, surveys from police department representatives revealed that policy and training likely guide much of officer discretion in bringing individuals to sobering centers rather than arrest for a public intoxication charge. However, we cannot tell from the survey whether situational factors impact officer decision-making during encounters or if officers believe there are inconsistencies in guidance from their agency. Further qualitative research methods are needed to delve into these factors, which is part of our Phase II work.

Third, the national surveys revealed important insights into the variation of operations of sobering centers across the US but could not demonstrate the distinct impacts of those

centers on the cities where they operate. Our survey indicated that police officials see value in sobering centers by saving officer time and resources and serving as a better alternative to jail. There are likely other positive impacts from sobering centers and their services that we cannot measure in a survey. Instead, these benefits could be measured by changes in admissions to jails (for public intoxication arrests), in emergency departments (for intoxication admissions), and successful referrals to other service providers given by sobering centers.

APRIL 2022 FORUM DISCUSSION

Midway through this project (April 7, 2022), the International Association of Chiefs of Police (IACP) hosted a convening of police executives, researchers, and sobering center executives to discuss sobering centers. Four members from the research team, three representatives from IACP, five police representatives, and five sobering center representatives from each of the five sites participating in this study[5] traveled to IACP headquarters in Alexandria, VA, to discuss the best practices in police-sobering center collaboration. The forum was framed by preliminary findings from Phase I of the research study, emphasizing the findings on general operations and police-sobering center partnerships. During the eight-hour meeting, each site discussed its operations in detail, discussed partnerships between the sobering center and law enforcement, and highlighted ways they have overcome obstacles in their partnerships and operations. The IACP will develop resources for the field based on the discussions during the forum and the findings from this research project, but we emphasize some key findings here.

First, much of the conversation surrounded demonstrating the value of sobering centers to city officials, police, and the community. Several sites highlighted this challenge, particularly for maintaining funding and receiving community buy-in about the need for these facilities. Discussants identified the importance of framing sobering centers as tools for cost avoidance and investing in helping people instead of being profitable facilities. One of the greatest values of sobering centers is diverting individuals from resource-intensive admissions to emergency departments or jails. Police agencies benefit from diverting individuals from jail because this requires significantly less time and resources on the officers' behalf. Additionally, individuals benefit from diversion by preventing the costs of involvement in the criminal justice system, particularly chronic users of emergency services. Conveying these messages, coupled with any data on sobering center admissions compared to changes in the use of emergency services, is vital to gaining community and governmental support. Some sobering centers have partnerships with

[5] Austin, TX; Houston, TX; Oklahoma City, OK; Tulsa, OK; and Wichita, KS.

police and other emergency service providers who can give them access to these data to demonstrate the impact of their facility.[6]

The second key takeaway from discussions was the importance of written policies for internal guidance and partnerships between sobering centers and police departments. Police agency policies should provide officer guidance on when it is best to leave a publicly intoxicated person in the custody of a responsible guardian (i.e., family or friends), to divert to a sobering center, to take for an in-custody arrest, or to transport/refer to emergency medical services. Formal written policies between police and sobering centers also help delineate the criteria for officers to divert to sobering centers and when these individuals need to be transported elsewhere.

Forum discussants also identified several recommendations for jurisdictions wanting to establish a sobering center. First, the discussants agreed that assessing community needs and available resources is necessary and should help guide the placement of sobering centers. This will help determine the most efficient services to combine into a single facility, which likely varies across communities. Discussants also emphasized that the center's location is critical and recommend placing these facilities near the primary jail so that travel time does not discourage officers from using this arrest alternative. Police agencies identified the importance of having a "champion" of the sobering center within a department, advocating for the use of sobering centers to increase officer perceptions about the benefits of this alternative. Altogether, the forum resulted in thoughtful conversation, meaningful ideas for future work, and optimism about improving collaboration between police and sobering centers.

PHASE II: ANALYSES OF FIVE JURISDICTIONS

During Phase II, we conducted comprehensive examinations of the opening of sobering center facilities in five jurisdictions: Oklahoma City, OK; Tulsa, OK; Wichita, KS; Austin, TX; and Houston, TX. Using admission data from the five sobering centers, we examined the individuals diverted from jail and emergency services to the sobering center. The analyses explored the admission patterns that emerged and the factors which predict repeat clients compared to single-admission clients, time to re-admission, and receiving a referral at discharge. Using police records for each site, we examined the impact of the sobering center on official intoxication-related arrests over time and assessed if certain arrest charges were reduced more than others. The findings of Phase II and Phase III are

[6] For example, the Houston Recovery Center.

available in the *Examining the Utility of Sobering Centers: Analyses of Police and Sobering Centers Across Five Jurisdictions.*[7]

We traveled to each sobering center and police department to meet with sobering and police executives to gain first-hand knowledge of operations and partnerships at each site. From August to September 2022, we conducted focus groups with sworn law enforcement (primarily patrol officers) at four of the five police departments, directly gathering officer views on sobering centers. At the police department where we did not employ focus groups (Wichita), we met with the Homeless Outreach Team, the primary police unit that diverts individuals to the sobering center in Wichita.

In all five sites, the sobering center was available 24 hours a day, seven days a week. Across sobering center facilities, the clientele was primarily male, White, with an average age between 35 and 43. For Oklahoma City and Tulsa, most clients admitted were unhoused, while about one-third in Austin and two-fifths in Houston and Wichita were unhoused. The impact of COVID-19 varied by site, with admissions in Austin, Houston, and Wichita significantly reduced during parts of the pandemic, while admissions in Tulsa and Oklahoma City remained relatively stable.

In examining the factors which predict repeat admissions, we found the probability of a client being a repeat is greatest when an individual is unhoused, older, male, and admitted for using a single substance. When we examined the association between admission characteristics and length of stay, we found that unhoused clients in all sites but Wichita had a longer average stay at the sobering center. In Austin and Houston, older clients had a longer stay, on average, than younger clients. In all sites but Houston, the average stay in the sobering center was longer for clients admitted during the day. These findings underscore the importance of housing status driving the likelihood of being a repeat client, the number of sobering center admissions, the amount of time to re-admission, and the length of stay at sobering centers. Further, the findings demonstrate the critical role that sobering centers play in diverting unhoused members of the public away from the criminal justice system for minor offenses.

We examined arrest data from each police agency within our case study sites, using different types of analysis to assess how the availability of a sobering center impacted arrests. We also used qualitative methods to examine officer decision-making to divert to sobering centers instead of arrest. We found that all five police departments guide officer decision-making regarding diversion to sobering centers for a public intoxication arrest through departmental policy. These policies require officers to use the sobering center for eligible individuals upon the voluntary approval of the intoxicated person and the sobering center. In Austin and Houston, officers must obtain supervisory approval to take a publicly intoxicated person eligible for the sobering center to jail instead. In Tulsa,

[7] Available at https://www.policinginstitute.org/publications/.

supplemental data is collected for individuals arrested for public intoxication as a sole charge—this data illustrates that the most cited reason was for aggressive or violent behavior.

Given that sobering centers are used as an alternative to arrest in the agencies included in this study, we anticipated a reduction in total arrests and intoxication-related arrests following the opening of each jurisdiction's sobering center. We examined the direct impact of sobering center openings (pre/post analysis) in Tulsa, Wichita, and Austin. Overall, the bivariate and multivariate time series analyses indicated a pattern of findings supporting the hypothesis that opening a sobering center would significantly reduce specific arrests. There was, however, some variation across sites. In Tulsa and Austin, public intoxication arrests declined by 20% and 24%, respectively, above and beyond any changes in total arrests and net of time-varying controls. By contrast, once other factors were controlled for in Wichita, overall arrests did not change at the time of the sobering center opening, nor did arrests for public intoxication. We attribute this to the unique setting of Wichita, where public intoxication in and of itself is not an arrestable offense as a sole charge. Relative to the other sites, public intoxication arrests in Wichita were more akin to proxy arrests (i.e., transportation of alcohol in a public space, possession of narcotics/under control, and consumption of liquor by a minor). Finally, most WPD officers do not directly use the local sobering center.

While our case study analyses showed that sobering centers have the potential to reduce arrests related to public intoxication, the establishment of a sobering center will not eliminate arrests for public intoxication violations. Indeed, across the five case study sites, the percentage of arrests for intoxicate-related charges varied between 15% to 30%, with most sites ranging between 20% to 25% post-implementation of a sobering center.

While this study provides critical insights through examining police data and multi-site comparisons, an important research question identified at the onset of this project could not be examined. Due to data limitations, we could not address whether diverting individuals to sobering centers in lieu of arrest alters their relative risk of recidivism or future contact with police. Data available to our team did not include any specific identifiers (i.e., name of the person arrested), nor did any sobering center provide us any unique identifying information based on Health Insurance Portability and Accountability Act (HIPAA) requirements. Future research would need matched identifiers (name, date of birth, SSN, etc.) across the data sources to measure individual-level trajectories.

PHASE III: FEASIBILITY ASSESSMENT

Our analysis of data collection efforts across sites found considerable variability in the type and quality of data collected. In our second report, we laid out recommendations for collecting and analyzing sobering center data to promote robust research. Sobering centers will need to carefully consider what information they are interested in collecting

and consider how to ensure data are collected efficiently and accurately. Recommendations include how to define and collect uniform, consistent measures that will assist in comparisons of sobering centers across jurisdictions. We recommend ancillary measures such as the source of referral to the sobering center, location information, and additional details on client background information such as arrest/incarceration history, mental health issues, veteran status, and student status. Sobering centers may then measure trends in their admissions, characteristics of their clientele, and even a rigorous examination of what factors predict clients who are chronic users or accept referral services.

DIRECTIONS FOR THE FUTURE

Based on the cumulative findings across this research study, we offer the following recommendations:

1. **Expand the use of sobering centers as an alternative to arrest.** The current study provides strong evidence that sobering centers reduce arrests, primarily through the reduction of public intoxication charges. Further, these facilities are well received by police—from command staff to line-level officers. They serve as a no-cost facility to clients that can reduce the collateral costs of criminal arrest and connect clients with necessary service providers while saving police time and resources. We recommend the expansion of the use of these facilities across the United States.

2. **Conduct a needs assessment.** Jurisdictions that do not already have a sobering center should conduct a needs assessment to measure community needs and available resources. This will help determine the most efficient services to combine into a single facility, which likely varies across communities. This will also help identify whether a sobering center would be useful. Additionally, policymakers should consider the center's placement. We recommend Fthese facilities be located where the following two factors converge: 1) where large proportions of public intoxication arrests occur, and 2) near the primary jail so that travel time does not discourage officers from using this arrest alternative (i.e., utility).

3. **Strategically plan the implementation of a sobering center.** There are many things to consider when opening a sobering center that should be detailed in policy and procedures. Specific topics to consider include funding, location, staffing, the potential need for on-site security, intake criteria, and acceptable referral sources (and whether walk-ins are permitted). Many of the most common best practices can be found in our *National Survey Report* and on the website for the National Sobering Collaborative.

4. **Document the use and effectiveness of sobering centers.** Findings from our national survey and focus groups demonstrated that most police and sobering center staff perceived sobering centers to save police time and resources. However, we found that few police departments track officer time saved. We recommend that agencies develop a method to document sobering center use and analyze these data to adjust agency practices and measure resources saved. Phase III of the current study also highlights multiple clientele metrics that sobering centers should collect to assess success and utility better and to identify recidivism or reuse risks.

5. **Police agencies should adopt formal policies about sobering center use.** We recommend that all police agencies develop a formal, written policy describing the circumstances under which officers should and should not divert intoxicated individuals to their local sobering center. We also recommend that this policy is developed in collaboration with representatives from the local sobering center to ensure the guidance is appropriate for their facility. Police agencies should also specifically train and reinforce the use of this arrest alternative to their officers. Finally, agencies could consider identifying a "champion" of the sobering center within a department who could serve as an important advocate for the internal use of sobering centers to increase officer perceptions about the benefits of this tool.

6. **Sobering centers should enhance their partnerships with local law enforcement.** Our research demonstrated most centers have a formal or informal relationship with the police and/or sheriffs in their jurisdiction. However, the strength of this relationship varied by site. We recommend that sobering centers identify ways to develop or enhance their partnerships, as this will likely increase collaboration and reduce barriers in the future. For example, in Austin, the sobering center occasionally hosts cross-training with local law enforcement and quarterly gratitude events where food and drinks are shared with local police to build rapport. Sobering centers with advisory boards should ensure a member of their local law enforcement has a seat to represent their views and build effective partnerships.

7. **Emphasize the utility of sobering centers as an alternative to arrest.** Most previous studies focus on using sobering centers as a diversion from hospital emergency departments. This study is the first to illustrate and highlight the utility of sobering centers as an arrest diversion. Given the promising findings of this research, more emphasis should be placed on how sobering centers can divert the costs associated with a criminal record while still providing a solution to handling a publicly inebriated person. Based upon previous research and the current study's findings that show disparate risk for those that are unhoused and public intoxication arrests by race and ethnicity, an emphasis on reducing arrest disparities for non-violent,

public order arrests may reduce racial and ethnic disparities exacerbated by police contacts.

8. **Future research should examine costs versus benefits and the impact on individual-level recidivism.** There are several avenues for future exploration of the effectiveness of sobering centers. For example, the research could conduct cost-benefit analyses across jurisdictions to better understand where and how sobering centers might save financial resources for cities. Due to data limitations, we could not address whether diverting individuals to sobering centers instead of arrest alters their relative risk of recidivism or future contact with police or the success of referrals to other service providers given by sobering centers. Future research would need matched identifiers across the data sources to measure individual-level trajectories; however, this research would provide important insights to enhance the knowledge base on sobering centers.