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Examining the Utility of Sobering Centers:

National Survey of Police Departments and Sobering Centers

Final Report

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I. EXECUTIVE SUMMARY

The lack of sufficient behavioral health services across the U.S. has resulted in law enforcement officers serving as first responders to incidents involving persons in crisis. Historically, this has led to officers resorting to using arrest to handle persons in crisis who might be better suited for diversion. In turn, community and policymakers have called for police to reduce the use of arrest and rely on alternatives, particularly as a growing body of research demonstrates the profound impact of net-widening policing tactics on incarceration rates and collateral consequences (Engel et al., 2019; Travis, 2014). One solution for the low-level offense of public intoxication has been the diversion from jail to sobering centers. Sobering centers provide short-term recovery from the effects of acute alcohol or drug intoxication while offering connections to social, health, and behavioral services for their clientele.

Sobering centers offer a unique opportunity to reduce arrests for vulnerable populations while removing a person from a potentially dangerous situation. Despite the long and complex history of their use, little is known systematically about the effectiveness of sobering centers as an alternative to arrest. Only a handful of studies have examined the impacts of sobering centers on the criminal justice system, and these studies typically focus on a single site. To build the evidence on sobering centers, Arnold Ventures funded our research study assessing the utility of sobering centers as an alternative to arrest.

This report is the first in a series detailing our multi-method and multi-site research study, launched in January 2020. In this research study, 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?

This report focuses on the quantitative findings of Phase I, disclosing the results of two national surveys—one for law enforcement agencies and one for sobering center facilities. Survey findings shed light on how police use sobering centers and the perceived benefits and barriers to their use. In turn, the survey findings also provide important insights on how to build effective partnerships and enhance the utility of sobering centers as an alternative to arrest.

A. Methodology

This report is the first of a three-phase research study designed to examine the utility of sobering centers as an alternative to arrest. As part of our research, we engaged in a scan of the field to find sobering centers operating across the country, where we identified 53 sobering centers. We examined patterns in the concentrations of these locations, finding:

- Over half of centers (56.6%) were in the Western region of the U.S.
- Centers were concentrated in both small cities (34% with less than 100,000 residents) and in large cities (28.3% with more than 500,000 residents).
- Approximately 51% of sobering centers were in cities with a $50,000 to $70,000 median household income.
- Most police agencies (64.2%) in the jurisdictions with sobering centers were midsize agencies and most commonly received 100,000 to 499,000 calls for service annually.

Our research team developed two national surveys—one for sobering center facilities ("Sobering Center Survey") and one for police departments ("Police Survey"). Our research team emailed *Qualtrics* survey links to sobering center directors and police officials within the 53 jurisdictions with identified sobering centers between May and September 2021. Of the 53 jurisdictions, only 46 were still operational during survey administration. We gathered responses from 29 police agencies (63.0% response rate) and 18 sobering centers (39.1% response rate). The responding sobering centers and police agencies are listed in in Appendix A.

Due to the lack of existing information on the relationship between law enforcement and sobering centers, the analyses presented within this report are primarily descriptive and based on a cross-sectional research design. The percentages reported below are based on valid survey responses.

B. Police Survey

The Police Survey is organized across four conceptual areas: (1) organizational policies and practices; (2) data collection and use; (3) impact of COVID-19; and (4) utility of sobering centers. The Police Survey includes 44 items based on a mixture of fixed and free response options. Highlighted findings under each survey category are summarized below:

Organizational Policies and Practices

- All police departments reported using sobering centers agency-wide (rather than by a specific unit) for non-violent inebriated individuals with no other criminal charges.
- 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 provide officers with any formal or informal guidance regarding the use of sobering centers.
- Most agencies (80.8%) reported training officers on using sobering centers. The length and format of this training varied but is often less than one hour and roll-call based.

Data Collection and Use

- Most police agencies collect data on officers who drop-off clients to the sobering center and the client themselves.
- Most police agencies (61.5%) reported using these data to adjust police practices on sobering center use and to better understand the areas which require more resources.

- Most respondents agreed there are specific areas where officers are more likely to pick-up individuals for the sobering center, including areas located near large homeless populations, the sobering center, or bars and nightlife entertainment.

Impacts of COVID-19

- The COVID-19 pandemic impacted 69% of police agencies' use of sobering centers.
- These operational impacts included limited capacity at sobering centers (83.3%), as well as changes to transportation (44.4%), policies (27.8%), and informal practices (27.8%).

Utility of Sobering Centers

Overall, many police agencies reported experiencing multiple benefits from using a sobering center. The overwhelming majority of representatives agreed sobering centers:

- Save resources from hospitals and other emergency departments (88.5%).
- Connect the individual to additional resources (88.5%).
- Provide a better alternative for an individual than jail (88.4%).
- Save officer time and resources (80.7%).

To generate additional information regarding officer perceptions, respondents were asked to estimate how most officers in their agencies view certain aspects of their local center. Most agencies' respondents agreed:

- Officers viewed sobering centers as a useful approach to public inebriation (73.1%).
- Officers viewed sobering centers as a less stressful approach than arrest (77.0%).
- Officers did not feel overburdened with another alternative to arrest (80.7%).
- Officers did not view centers as a risky alternative with few benefits (84.6%).

Police agencies were asked about potential obstacles preventing officers from using sobering centers. Many potential obstacles did not appear to be problematic.

- The most frequently reported obstacles appeared to be COVID-19 related, with agreement that center-related restrictions (42.3%) and officer-related restrictions (38.5%) are obstacles to sobering center use.
- The next most frequently reported obstacle and concern was non-cooperation by intoxicated individuals (30.8% of respondents).

C. Sobering Center Survey

The Sobering Center Survey is organized across five conceptual areas: (1) organizational details; (2) sobering center services; (3) sobering center data collection; (4) law enforcement partnership; and (5) impact of COVID-19 and includes 65 items based on a mixture of fixed and free response options. Highlighted findings under each survey category are summarized below.

Organizational Details

- Most sobering centers (82.4%) are housed as a part of a non-profit organization—only a few centers reported operating as a stand-alone.

- While most sobering centers (58.8%) followed an inebriate alternative model, 12% followed a medical detoxification model, and 30% followed "other" models, which respondents described as social model detoxification and residential treatment.
- There was wide variation across annual budgets (ranging from $150,000 to $3M), funding sources, funding mandates, and reliance on grant funding.

Sobering Center Services

- Sobering centers were surveyed regarding their services and functions, including staffing, client referrals, admission processes, and capacity. Our research confirms earlier descriptive research that individual sobering centers vary in terms of their treatment model, capacity, budget, and services provided (Warren et al., 2016).
- Almost all sobering centers indicated accepting referrals from more than one source, and the most accepted referral sources were law enforcement (69.2%), emergency departments (61.5%), and walk-in/self-referrals (53.9%).
- There is much variation in capacity across centers, ranging from three beds to 84 beds.

Sobering Center Data

- Sobering centers were asked to provide estimates of clients served along with the ways they collect, report, and use their sobering center data.
- There is wide variation in the estimated number of clients served during 2019 (pre-pandemic) and 2020 (during the pandemic). For example, one sobering center reported serving ten clients, while another reported serving 13,325 clients.

Law Enforcement Partnership

- About two-thirds of sobering centers report having a formal partnership and about 75% have an informal partnership with law enforcement agencies.
- As a part of the formal partnership with law enforcement agencies, sobering centers highlighted regular meetings with law enforcement, memorandums of understanding, protocols to use sobering centers, and providing an alternative to arrest.
- Informally, sobering centers serve as a resource to law enforcement, and law enforcement serves as a referral source for sobering centers.
- Barriers described by sobering center respondents include changing law enforcement culture to embrace the use of alternatives beyond arrests. Relatedly, some sobering center representatives expressed there might be some misunderstanding in law enforcement about the scope and limitations of sobering centers.

Impact of COVID-19

- Most sobering centers decreased capacity due to the COVID-19 pandemic (by an average of 38%), and the number of clients served decreased by an average of 22%.
- Sobering center respondents most commonly reported reducing capacity, adhering to state guidelines, and implementing new safety protocols in response to COVID-19.

D. Conclusions and Recommendations

The findings documented in this report are part of a broader research study designed to examine the utility of sobering centers as an alternative to arrest. The current study builds upon the available literature by including the perspectives of police officials, and 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.

This research is among the first to examine police agency guidance for officer decision-making on this arrest alternative. Officers appear to have significant discretion on whether to drop off inebriated individuals at sobering centers. In light of these findings, we recommend police agencies consider how they guide officer discretion, how frequently they train officers for 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 this arrest alternative to diffuse through police agencies.

Finally, our research is the first to assess the national-level impacts of the COVID-19 pandemic on the operations of sobering centers. Representatives from both types of agencies reported COVID-19 reduced admission capacity in most sobering centers and resulted in changes to policies. Indeed, the most frequently reported barriers to police use of sobering centers were related to COVID-19.

Based on the findings in this report, we offer a series of recommendations for police agencies and sobering centers:

- Police agencies should explicitly adopt formal policies about sobering center use.
- Police agencies should continue to train and reinforce officer use of sobering center diversions for publicly intoxicated individuals.
- Police agencies and sobering centers should collect and use data that demonstrates police resources saved.
- Sobering centers should proactively enhance their partnerships with local police agencies.

Additionally, we offer several suggestions for future research, such as using additional research designs and assessing the long-term impacts of COVID-19. Many of the limitations of this research study phase will be examined during the remaining phases of this work. For example, Phase II of the current research study includes an in-depth examination of five case study sites, using data provided by both the law enforcement agency and the sobering center. The quantitative data from these agencies is supplemented with focus groups with patrol officers in each jurisdiction to better understand what factors influence decisions to use sobering centers. Taken together, the insights provided by the national surveys, along with the additional work from Phase II and Phase III, help us to shed light on the patterns and decision-making for police use of sobering centers, how this may help to reduce arrests within these jurisdictions, and identify the best practices for law enforcement-sobering center collaboration.

II. INTRODUCTION

Community and policymaker calls to reduce police use of arrest in lieu of other alternatives have grown tremendously in recent years, particularly as a growing body of research demonstrates the profound impact of net-widening policing tactics on incarceration rates and unsustainable financial burdens (Engel et al., 2019; Travis, 2014). Furthermore, there is little empirical evidence to support the notion that increases in the arrest of minor crimes result in reductions in serious crime problems (Greenburg, 2014). Taken together, this evidence lends itself to a growing chorus of voices from inside and outside of law enforcement recommending the prioritization of alternative, non-arrest responses to a small number of minor violations that are voluminous in nature (IACP, 2016).

While several forms of police encounters with the public might result in police diversion, this report focuses on using sobering centers as an alternative to arrest for publicly intoxicated individuals. In this report, we refer to "sobering centers" as those facilities that provide short-term recovery, detoxification, and recuperation from the effects of acute alcohol or drug intoxication, providing an alternative to jail (for public intoxication arrest) or emergency departments. These facilities may be referred to as detoxification centers or public inebriate alternatives in some jurisdictions.

Despite the long and complex history of using sobering centers, little is known systematically about the effectiveness of sobering centers as an alternative to arrest. Thacher (2018) demonstrated three key findings in his historical review of sobering centers. First, sobering centers rarely (if ever) operate as a panacea. Resource constraints and practical limitations often undermine the utility of sobering centers. Second, for individuals sent to sobering centers, there is little doubt the treatment received there is of higher quality (e.g., treatment of withdrawal symptoms) than of traditional jails. Third, the use of sobering centers alone does not likely lend to a change in the trajectory of those who receive services – mainly when the options were arrest versus sobering centers (i.e., coerced submission). Although this demonstrates a blurred picture regarding the benefits versus problems associated with this alternative to arrest, sobering centers offer a unique opportunity to reduce the use of arrests for vulnerable populations while removing a person from a disturbance call or potentially dangerous situation.

To date, only a handful of studies have examined the impacts of sobering centers on criminal justice system outcome measures, such as arrests, jail admissions, and incarceration rates, and these studies typically focus on a single site (Jarvis, 2019; Turner, 2015). Similarly, the available research lacks systematic information about the types of partnerships between police and sobering facilities and evidence on how to best develop effective partnerships. The current research study aims to enhance knowledge on using sobering centers as an alternative to arrest, obstacles to their use, and strategies to overcome such obstacles. This is the first research study we are aware of that assesses the use and best practices associated with *both* police departments and sobering centers.

This report is the first in a series detailing our multi-method and multi-site research study assessing the utility of sobering centers as an alternative to arrest. 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?

This three-phase research study was launched in January 2020. Phase I includes a scan of the field to identify operational sobering centers and uses interviews and surveys to understand patterns of policies and practices for police and sobering centers across the United States. 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 includes a feasibility assessment to promote the further use of sobering centers and enhance research on the effectiveness of sobering centers.

This report documents the quantitative outcomes of Phase I, focusing on the results of two national surveys—one for law enforcement agencies and one for sobering center facilities. The purpose of the surveys was to understand the practices of sobering centers and police departments across the United States. For example, the surveys queried the types of policies in the cities where the sobering centers are located that govern admissions, length of stay, treatment refusal, and follow-up care practices. The surveys assessed the collection and use of data by police and sobering centers regarding admissions. Surveys also questioned respondents regarding the centers' associated costs and funding. Additionally, the surveys measured the impacts of COVID-19 on police use of sobering centers and sobering center operations.

Ultimately, the survey findings shed light on how police use sobering centers and the perceived benefits and barriers to their use. In turn, the survey findings also provide important insights into how sobering centers partner with law enforcement and their perceived benefits and barriers to an effective partnership. Collectively, this report provides the first national-level assessment of the collaboration between sobering centers and police departments.

Section II of this report reviews the existing literature assessing the utility of sobering centers. Section III follows with a discussion of the methodology, including the survey instruments and analyses presented. Section IV discusses the survey results from police department representatives. Section V discusses the survey results from sobering center representatives. Finally, Section VI provides implications of the findings, limitations, and recommendations for future research based on the survey findings.

III. LITERATURE REVIEW

Alcohol abuse and addiction have long been one of the leading causes of preventable deaths in America, with more than 140,000 people dying from excessive alcohol use each year (CDC, n.d.). For much of history, the traditional response to public intoxication was arrest or detainment in jail (Smith-Bernardin, 2021). In fact, of the six million arrests reported to the FBI Uniform Crime Report in 1966, one-third of those arrests were for public drunkenness (President's Commission on Law Enforcement and Administration of Justice, 1967; Thacher, 2018). However, arresting these individuals did little to nothing to stop them from committing the same offenses repeatedly (Thacher, 2018). Negative impacts of alcohol and the handling of intoxicated persons are demonstrated in overburdening both the healthcare system (Cornwall et al., 2012; Flower et al., 2011) and the criminal justice system, where there were still nearly 250,000 arrests made for drunkenness in the United States in 2019 (FBI, 2021).

A solution posed to reduce the problems associated with alcohol abuse is sobering centers, which are locations where acutely intoxicated individuals can have a safe place to recover and potentially seek treatment. What we now know as sobering centers first appeared in Eastern Europe and Russia in the early 1900s (Moore, Sivarajasingam, & Heikkinen, 2013). Sobering centers eventually began to appear in the United States in the late 1960s (Nimmer, 1970). Sobering centers were introduced with the goals of preventing acutely intoxicated individuals from being labeled as criminals, providing safe and humane places to stay other than jail, providing medical attention to acutely intoxicated and often homeless individuals, and reducing the burden of public intoxication on emergency departments and the criminal justice system (Nimmer, 1970; Smith-Bernardin, 2016; Thacher, 2018; Warren et al., 2016). This role of serving as a diversion from jail or the emergency room is perhaps the most vital aspect of sobering centers.

However, law enforcement officials did not always agree with this approach, with anecdotes from officials believing traditional enforcement tactics like arrests were the best route for rehabilitating intoxicated individuals. Further, these officials thought it was not their job to ensure these individuals received treatment options (Nimmer, 1970; Aaronson et al., 1977, 1978). After an initial period of success following the creation of sobering centers in the late 1960s, the amount of research attention and favorable publicity towards sobering centers in the United States began to fade (Nimmer, 1971; Smith-Bernardin, 2016). This was largely due to law enforcement officials becoming dissatisfied with the services centers provided, issues with centers not being able to secure stable funding, and a lack of communication and cooperation between law enforcement and the centers (Goldstein, 1977; Aaronson et al., 1978). The last decade, however, has demonstrated a resurgence of sobering centers in the United States. Notably, this reemergence was juxtaposed with a limited evidence base regarding the impact of sobering centers. Smith-Bernardin (2021, p. 678) wrote, "despite a scarcity of evidence about the efficacy of sobering centers, the number of centers has more than doubled in less than ten years."

A notable aspect of modern sobering centers is the variation in the structure and the service models offered by unique facilities. For instance, two studies have surveyed sobering centers across the United States—Warren and colleagues (2016) surveyed nine sobering centers, and Smith-Bernardin (2021) surveyed 26 sobering centers—both studies came to similar conclusions regarding the substantial variation in centers' budgets, service models, referral sources, and client capacity. Overall, there is very little empirical evidence on which delivery model is most effective for treating publicly intoxicated individuals (Smith-Bernardin, 2021; Pennay et al., 2021).

A major proposed benefit of sobering centers is the economic relief they could supply to the criminal justice system and emergency departments, as they can be a less costly option for intoxicated individuals (Marshall et al., 2021). Several studies have found sobering centers can result in significant economic benefits for the criminal justice system and emergency health care providers (Dunford et al., 2006; Fischer, 2017; Jarvis et al., 2019; McClure et al., 2009; OKC Metro Alliance, Inc., 2017; Smith-Bernardin, 2016, 2021; Weltge et al., 2016).

Previous evaluations of sobering centers have also found the use of sobering centers may help to reduce the usage of emergency services by chronically intoxicated individuals (Castillo et al., 2005; Dunford et al., 2006; Liu, 2004; Smith-Bernardin, 2016). This reduction in chronic users is critical because a common criticism of sobering centers is they may become a "revolving door" for "frequent flyers," or the repeat clients who are repeatedly coming in and out of centers (Annis & Smart, 1978; Brady et al., 2006; Sputore et al., 1998). For example, some studies found 17% and 23% of sobering center clients are those that have been admitted three or more times over one year (Jarvis et al., 2019; Weltge et al., 2016). Similarly, Smith-Bernardin and colleagues (2017) found approximately 51% of San Francisco admissions at a sobering center were attributed to clients with six or more visits to the sobering center in one year. Reducing chronic users in emergency departments or jail facilities would have a profound impact on the strain within those systems.

In addition to providing a safe place for acutely intoxicated individuals to sober up, sobering centers may also help connect clients to treatment or emergency health services. Jarvis and colleagues (2019) found that upon discharge from a sobering center, 48% of clients accepted a referral to services, requested housing assistance, or enrolled in a treatment program. Furthermore, repeat clients are much more likely to 1) utilize medical detoxication services than single-time clients, 2) frequently utilize healthcare services, and 3) require emergency department visits more than non-repeat clients (Smith-Bernardin et al., 2017). To combat this disproportionally high rate of emergency service use and subsequent strain, some scholars argue sobering centers should expand to "a hub for services, engaging with individuals who are likewise utilizing other services throughout an urban environment" and can "target individuals who are higher users of these [health] services to offer interventions aimed at increasing health and decreasing service use" (Smith-Bernardin et al., 2017, pgs. 1067-1068).

Recent studies investigating the impacts of sobering centers on criminal justice system outcome measures, such as arrests and incarceration rates, are less common than other outcome measures.

The limited available evidence for this topic supports a reduction in public intoxication arrests in cities where sobering centers are opened (Jarvis et al., 2019; Turner, 2015; Weltge et al., 2016). For example, Jarvis and colleagues (2019) examined the impacts of a sobering center on jail admissions in Houston, TX. Houston drafted a policy in 2010 calling for publicly intoxicated persons to be diverted away from jails and into a newly created sobering center to combat issues related to jail overcrowding and strains on emergency services. Jail admissions for public intoxication in Houston decreased by 95%, from 20,508 in 2010 to 835 in 2017, demonstrating the significant impact sobering centers and policies can have on arrests and jail admissions. This reduction in jail admissions also freed up valuable police resources and reduced operational costs, which could be re-invested into other community health and safety strategies (Dunford et al., 2006; Jarvis et al., 2019; Smith-Bernardin, 2021). While this site-specific information is helpful, *no* studies have yet examined police perspectives on using sobering centers, nor have they discussed the partnership between sobering centers and police. Further, there is no research examining the situational, policy, or legal guidelines for police use of sobering centers.

Overall, the evidence base regarding the impacts of sobering centers is meager, leaving significant gaps in the literature (Pennay et al., 2021). Many "evaluations" which exist are not methodologically or statistically rigorous. Instead, they are retrospective, exploratory, or descriptive studies primarily describing the functions and best practices of sobering centers without any form of control group or randomization to investigate the specific impacts of sobering centers (Fischer, 2017; Fischer et al., 2020; Smith-Bernardin, 2016, 2021; Warren et al., 2016). Furthermore, many evaluations of sobering centers do not allow for examinations into any potential long-term effects of sobering centers (Smith-Bernardin, 2021), as these evaluations typically utilize a follow-up period of less than one year (see Dunford et al., 2016; McClure et al., 2009).

Much remains unanswered as it relates to the research questions posed in this study. No literature examines what guides officer decision-making in using sobering centers. A few site-specific studies indicate sobering centers reduce jail admissions. Still, these studies do not directly assess individual or aggregate patterns of sobering center client re-contact with the criminal justice system. This leaves researchers and practitioners with many remaining questions regarding best practices, the long-term impacts on public health outcomes, and the benefits of criminal justice system diversion. This is only compounded by the variation in public intoxication laws between and within states, leading to “fragmented care” for a vulnerable population and a lack of evidence-based answers with which law enforcement, health care providers, and sobering center officials can address the problem of public intoxication (Warren, 2016, p. 2140). This highlights the critical need for continued research into sobering centers, including studies with more rigorous methodologies. Our research seeks to fill the void in some of these gaps by examining how police use and collaborate with sobering centers nationally and seeks to identify implementation challenges and lessons learned. The dissemination of this knowledge will be critical for any jurisdiction considering the implementation of a sobering center as an alternative to public intoxication arrest.

IV. METHODOLOGY

As previously noted, this report is the first of a three-phase research study designed to examine the utility of sobering centers as an alternative to arrest. Across the various phases of the study, we explore different aspects of sobering centers using both qualitative and quantitative techniques at the local and national levels.

Launched in January 2020, this research study began with site visits to sobering centers and police departments in Tulsa and Oklahoma City, Oklahoma, to discuss project goals, assess available data, and visit facilities. In Spring 2020, our research team conducted a comprehensive search for operating sobering centers, including gathering contact information for both sobering facilities and police departments. The research team searched using Google, Google Scholar, news articles, and an online university database of scholarly articles. Sobering centers were identified using the following key terms: sobering center, engagement center, detoxification center, and diversion from emergency departments. Additionally, a list provided by the National Sobering Collaborative (http://www.nationalsobering.org/) was used to identify centers. This search resulted in a list of 53 jurisdictions in the U.S. with sobering centers. Throughout July 2020, research staff contacted all sobering centers to determine their operating status (e.g., closed, open, open at partial capacity, etc.) due to the impacts of COVID-19. After determining most facilities remained operational, we resumed the next step of Phase 1: in-depth interviews with police departments and sobering center representatives from five to seven cities.

Based on our scan of the field, we identified seven cities in different geographic regions to participate in semi-structured interviews: Cambridge, MA; Houston, TX; Indianapolis, IN; New Orleans, LA; San Francisco, CA; Seattle, WA; and Wichita, KS. We requested separate virtual interviews with sobering center directors and police officials from each jurisdiction that lasted approximately 30 – 45 minutes. These in-depth interviews were conducted from August through October 2020 with representatives from five sobering centers and seven police departments. The semi-structured interview instrument asked a series of questions of agency officials, including general practices and policies around sobering centers, intake/exit procedures, perceptions of outcomes for clients who use sobering centers, and the impacts of COVID-19 on facility operations. Conceptual themes and questions were gathered based on a review of interview notes and were used to develop questions for the national surveys which are focus of this report.

A. Survey Administration

Two national surveys were developed—one for sobering center facilities ("Sobering Center Survey") and one for police departments ("Police Survey")—based on prior surveys of sobering centers (National Sobering Collaborative, n.d.; Warren et al., 2016) as well as the semi-structured interviews described above. The primary goals of the surveys are to better understand the relationship between law enforcement and sobering centers on a national level and identify implementation challenges and lessons learned. In contrast to existing surveys, we expanded the sobering center instrument with questions about their partnerships and barriers to working with

law enforcement and assessed the impact of COVID-19 on their operations. This is the first national survey to assess how law enforcement agencies use and partner with sobering centers.

The surveys were administered electronically between May and September 2021. To administer the surveys, our team emailed *Qualtrics* survey links to sobering center directors and police officials within the 53 jurisdictions with identified sobering centers. Of the 53 jurisdictions, only 46 were still operational during survey administration (May–Sep 2021). While the surveys were emailed to sobering center directors and police agency leaders, the surveys asked each organization to have one representative knowledgeable about the use of sobering centers complete the survey on the organization's behalf. Based on this approach, survey responses may reflect the perceptions of the responding individual and not necessarily reflect the thoughts and opinions of others within the organization. To reduce this concern regarding generalizability, respondents were instructed to complete items based on their experiences along with their perceptions of other officers or staff members' viewpoints within their organizations.

B. Respondents

After multiple follow-up emails and phone calls, this process resulted in responses from 29 police agencies (63.0% response rate) and 18 sobering centers (39.1% response rate). The locations of the respondents are displayed in Figure 1 below. Additionally, lists of all responding agencies can be found in Appendix A. Compared to sobering centers, the higher survey response rate from police agencies is likely due to police agencies' increased staffing capacity, familiarity and comfort with participating in research studies, and routine public reporting of activities.

Figure 1. Locations of Responding Police Agencies and Sobering Centers

Table 1 compares the 53 known jurisdictions with sobering centers to the 29 responding police agencies and 18 responding sobering centers. We consider differences in responding and non-

responding agencies across various measures, including Census region, 2020 Census population, Census median household income, sworn police size, and annual police calls for service (CFS) received.[1] This provides comparison information to determine the representativeness of our responding police agencies and sobering centers.

In terms of geographic concentration, Table 1 demonstrates the majority of jurisdictions with sobering centers are concentrated in the West (56.6%), followed by the South (22.6%), the Midwest (11.3%), and the Northeast (9.4%). As shown, compared to the 53 jurisdictions with sobering centers, police agency respondents overrepresent agencies from the Midwest (24.1% of respondents vs. 11.3% overall) and underrepresent agencies from the West (44.8% of respondents vs. 58.5% overall); sobering centers respondents also underrepresent the West and slightly overrepresent the Midwest, South, and Northeast.

Although there is a fair amount of dispersion in the cities based on population size, the greatest concentration of jurisdictions with sobering centers are found in cities with less than 100,000 residents (34.0%), followed by cities with more than 500,000 residents (28.3%). The responding police agencies also overrepresent agencies serving 500,000 or more residents compared to the total 53 jurisdictions with sobering centers (44.8% of respondents vs. 28.3% overall) and responding sobering centers underrepresent midsize cities, and slightly overrepresent cities with 500,000 or more residents.

There appears to be a wide distribution of median household incomes in jurisdictions with sobering centers, according to the 2020 Census. More than half (n=30) of the jurisdictions identified with sobering centers are in cities with a median household income lower than the average median household income in the United States of $64,9994 in 2020. The remaining sites (n=23) are in jurisdictions with higher household incomes than the national average. Categorized median household income statistics demonstrate the largest concentration of sobering centers (50.9%) are in cities with a $50,000 to $70,000 median income, meaning it is not necessary for a city to be affluent to establish and maintain a sobering facility. Responding police and sobering centers also have the largest concentrations in cities with a $50,000 to $70,000 median income.

In terms of annual calls for service received, the greatest concentration in sobering centers are in jurisdictions with 100,000 to 499,000 calls, and responding police agencies appear to slightly underrepresent these types of agencies (34.6% of respondents vs. 40.5% overall) and overrepresent agencies with half-a-million or more calls for service each year (46.1% of respondents vs. 35.1% overall). Finally, the 53 jurisdictions with sobering centers are most commonly concentrated with midsize city police departments (64.2%). Responding police agencies appear to slightly overrepresent large police agencies and slightly underrepresent midsize police agencies.

[1] Region information is derived from the 2020 census data, while agency characteristics came from the 2016 LEMAS survey.

Table 1. Comparisons of Identified Jurisdictions with Sobering Centers to Responding Law Enforcement Agencies and Sobering Centers

	Jurisdictions with Sobering Centers (n=53)		**Law Enforcement Respondents (N=29)**		**Sobering Center Respondents (N=18)**	
Census Region	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
West	56.6%	30	44.8%	13	38.9%	7
Midwest	11.3%	6	24.1%	7	16.7%	3
Northeast	9.4%	5	10.3%	3	16.7%	3
South	22.6%	12	20.7%	6	27.7%	5
Total	100.0%	53	100.0%	29	100%	18
Census Population	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
0-99,999	34.0%	18	20.7%	6	33.3%	6
100,000-249,999	26.4%	14	20.7%	6	16.7%	3
250,000-499,999	11.3%	6	13.8%	4	11.1%	2
500,000+	28.3%	15	44.8%	13	38.9%	7
Total	100.0%	53	100.0%	29	100.0%	18
Median Household Income	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
$40,000-$49,999	17.0%	9	6.9%	2	0.0%	0
$50,000-$69,999	50.9%	27	55.2%	16	72.2%	13
$70,000+	32.1%	17	37.9%	11	27.8%	5
Total	100.0%	53	100.0%	29	100%	18
Annual Calls for Service Received	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
0-99,999	24.3%	9	19.2%	5	—	—
100,000-499,999	40.5%	15	34.6%	9	—	—
500,000+	35.1%	13	46.1%	12	—	—
Missing	—	16	—	3	—	—
Total	100.0%	53	100%	29	N/A	N/A
Sworn Size	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
Small (1-49 officers)	4.8%	2	6.9%	2	—	—
Midsize (50-999 officers)	64.2%	27	51.7%	15	—	—
Large (1,000+ officers)	31.0%	13	41.4%	12	—	—
Missing	—	11	—	—	—	—
Total	100.0%	53	100%	29	N/A	N/A

C. Analytic Strategy

The Police Survey is organized across four conceptual areas: (1) organizational policies and practices; (2) data collection and use; (3) impact of COVID-19; and (4) utility of sobering centers. The Police Survey includes 44 items based on a mixture of fixed and free response options.

The Sobering Center Survey is organized across five conceptual areas: (1) organizational details; (2) sobering center services; (3) sobering center data; (4) law enforcement partnership; and (5) impact of COVID-19. The Sobering Center Survey includes 65 items based on a mixture of fixed

and free response options. Each survey takes about 15 to 20 minutes to complete. Copies of the survey instruments can be found in the Appendix B.

Due to the lack of existing information on the relationship between law enforcement and sobering centers, the analyses presented within this report are descriptive and based on a cross-sectional research design. Survey responses were downloaded from the web-based *Qualtrics* platform and analyzed using Stata and SPSS, statistical software programs for data science. Analyses include frequencies and summaries of open-ended responses. The tables presented include a count ("N") of how many respondents answered the item or series of items, as well as percentages ("%") for each response option. For Likert scale responses, a mean (average) score is provided, along with a standard deviation score, to measure the dispersion of responses. There is variability in how many agencies completed survey items as some did not answer all survey items. Results presented herein are based on valid responses—that is, the percentages shown are based on how many agencies responded to the survey item. Thus, the "N" for each survey item might vary. Additionally, some survey items instruct respondents to "select all that apply"; therefore, the percentages presented do not add up to 100%.

Where feasible, crosstabulation analyses are presented to compare groups of respondents to groups of responses. Due to the small number of respondents, police agencies were only grouped by size—small to midsize agencies were combined (less than 1,000 sworn officers; n=17) and compared to large agencies (1,000 or more sworn officers; n=12). No crosstabulations are presented for sobering center responses due to the smaller number of responses, making sub-group comparisons unreliable. In addition, for Likert scale responses from police agencies measuring attitudes (*Benefits of Sobering Center Use*, *Officer Views on Sobering Centers*, and *Perceptions of Obstacles*), we combined measures for each of the three areas to develop additive scales. We conducted ANOVA and Kruskal-Wallis tests to observe differences between groups. However, given the limited sample size, we failed to have enough statistical power to detect any significant differences at $p = 0.05$ amongst groups based on region or agency size.

V. FINDINGS FROM THE NATIONAL SURVEY OF POLICE DEPARTMENTS

This section of the report contains results on the responses from police agency representatives. Respondents were asked a series of questions regarding their organizational policies and practices, data collection and use, the impacts of COVID-19, and the utility of sobering centers. Responses from the 29 responding police agencies are provided and analyzed herein (63% response rate).[2] The percentages and mean scores are based on valid responses, excluding missing ones.

A. Organizational Policies and Practices

First, police agencies answered general questions regarding how often and in what capacity they utilized sobering centers in their jurisdiction. As described previously, a sobering center is a "facility that provides short-term recovery, detoxification, and recuperation from the effects of acute alcohol or drug intoxication." As shown in Table 2, nearly all responding agencies (92.9%) agreed they used a sobering center fitting this definition, and, of these, 96.2% confirmed the center was still operational.

Agencies were also asked how they utilized these sobering centers when handling inebriated individuals. All 26 responding agencies used sobering centers agency-wide rather than by a specific unit. Similarly, all responding agencies indicated they use sobering centers for non-violent inebriated individuals with no other criminal activity. Still, some agencies were mandated to use the center by policy (34.6%), while the majority (65.4%) left the decision to use sobering centers to officer discretion. Most agencies (69.2%) still allow officers to conduct public intoxication arrests as the sole charge for individuals.

As shown in Table 2, over half of responding agencies indicated they guide officers on their use of sobering centers with formal written policies (55.6%), followed by informal practice (25.9%). Notably, nearly 20% of responding police agencies do not provide officers with any formal or informal guidance regarding the use of sobering centers. Most agencies also reported their officers occasionally make arrests inside the sobering centers based on client behavior after arriving at the sobering facility (63.0%).

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[2] Note that two of the responding agencies—the Charleston Police Department and the Cambridge Police Department—reported that they did not use a sobering center as identified in the prompt, so they do not have responses beyond Question 3 in the survey. It is unknown why Charleston Police reported they do not use the sobering center in Charleston, but it is possible that the Charleston Center does not accept law enforcement referrals. As for Cambridge Police, public intoxication is not a crime in Massachusetts. Therefore, law enforcement officers are not allowed to transport intoxicated individuals to locations with medical staff—per Massachusetts State Law, these individuals must be brought to the sobering center by emergency services personnel. That is why officers do not drop off at the CASPAR in Cambridge.

Table 2. Police Department Practices Regarding Sobering Center Use (n=29)

	Response Options	% of Respondents
Does your agency use a sobering center?	Yes	92.9%
	No	7.1%
Is this sobering center still operational?	Yes	96.2%
	No	3.9%
Is the sobering center used agency-wide or by particular units?	Agency-wide	100.0%
	Particular Units	0.0%
Do your officers use the sobering center for non-violent inebriated persons?	Yes, mandated by policy	34.6%
	Yes, but discretionary	65.4%
Are your officers allowed to conduct a public intoxication arrest as a sole charge?	Yes	69.2%
	No	30.8%
Does your agency have a specific policy describing officers use of sobering centers?	Yes, formal policy	55.6%
	Yes, informal practice	25.9%
	No	18.5%
Does your agency make arrests from within the sobering center?	Yes	63.0%
	No	37.0%

To examine the impact of agency size on the type of policy guiding officer use of sobering centers, we ran a crosstabulation analysis, presented in Table 3. Agencies were grouped as small to midsize (less than 1,000 officers) and large (1,000 or more officers). As shown, those with a formal written policy and those with no policy are slightly more likely to be large agencies, whereas those who rely on informal practice are more likely to be small to midsize agencies.

Table 3. Comparison of Agency Size Regarding Agency Guidance for Officer Use of Sobering Center (n=27)

Does your agency have a specific policy or SOP which describes how officers should use sobering facilities?	**Small to Midsize (n=15)**	**Large (n=12)**
Yes, formal policy	46.7%	53.3%
Yes, informal practice	85.7%	14.3%
No	40.0%	60.0%

As shown in Table 4, agencies responded to various questions to measure training officers on sobering center policies or practices. Most agencies (80.8%) reported implementing training on this topic. Of the 20 agencies who provided valid responses about this training frequency, most (85.0%) only conducted training once after the policy/practice was implemented. Two agencies reported officers complete training two to three times per year, and one other agency conducts training annually. This training format varies across agencies; ten agencies reported using multiple formats. The most common format for training related to sobering centers is roll-call training (66.7%); this includes seven agencies which utilize *only* roll-call training. Nearly half of the agencies used dedicated in-service training (47.6%), but this was frequently in conjunction with other types of training. One-third of agencies use online training (33.3%), and 19.0% reported testing officers' knowledge of the policy/practice. Three agencies used rollcall and in-service training (11.1%), and one reported using all four types of training.

Also shown in Table 4, the length of training on sobering centers is often short; about 38% conducted their training in 30 minutes or less, and two-thirds of agencies completed training in one hour or less. Agencies who reported "other" indicated the training was integrated into their field training/new employee familiarization or their mandatory 40-hour Mental Health Interventions Training. Finally, agencies were asked how frequently supervisors encouraged and reinforced the use of sobering centers to their officers. Nearly one-third reported supervisors did so every 3-4 months (30.8%) or once a month (30.8%), while a slightly smaller percentage reported supervisory reinforcement of the use of sobering centers as often as once a week (26.9%).

Table 4. Police Training Practices Related to the Use of Sobering Centers (n=29)

	Response Options	**% of Respondents**
Are officers trained on using the sobering center?	Yes	80.8%
	No	19.2%
How often are officers trained to use sobering facilities?	Once per month	0%
	2-3 times per year	10.0%
	Once per year	5.0%
	Once, after policy implementation	85.0%
	Never	0%
In what ways are officers trained? [select all that apply]	Roll call training	66.7%
	Dedicated, in-service training	47.6%
	Online training	33.3%
	Tested on knowledge of policy	19.1%
Length of training (in hours)	30 minutes or less	38.1%
	30 minutes to 1 hour	4.8%
	1 hour	23.8%
	1 to 2 hours	9.5%
	2 hours	14.3%
	Other	9.5%
How frequently do supervisors encourage the use of sobering centers to officers?	Never	3.9%
	Seldom (1 per year)	7.7%
	Sometimes (every 3-4 months)	30.8%
	Often (1 per month)	30.8%
	Frequently (1 per week)	26.9%

We used a crosstabulation analysis to examine the impact of agency size on training for sobering center use, presented in Table 5. As shown, agencies reporting activity 2-3 times per year are all small to midsize agencies. Those who reported training officers once per year are all large agencies. Agencies reporting train only once after the policy/practice is implemented are more frequently small to midsize agencies.

Table 5. Comparison of Agency Size Regarding Training Frequency for Sobering Center Use (n=20)[3]

How often are officers trained to use sobering facilities?	**Small to Midsize (n=12)**	**Large (n=8)**
2-3 times per year	100.0%	0.0%
Once per year	0.0%	100.0%
Once after policy implementation	58.9%	41.2%

In the surveyed jurisdictions, it was not common for state laws or municipal ordinances to be in effect to guide the use of sobering centers in their jurisdiction. Specifically shown in Table 6, 69.2% of responding agencies reported there were no state-level laws regarding the use of sobering centers, and a higher percentage (88.5%) disclosed there were no municipal ordinances related to the use of sobering centers in their jurisdiction. Instead, some departments have created formal written agreements with sobering centers in the form of memorandums of understanding (34.6%), contracts (7.7%), or other documents (7.7%). Of the nine agencies with memorandums of understanding, only one agency (11.1%) reported also having state law or municipal ordinances to guide their use of sobering centers. Asked about whether there is a financial cost for their agency to operate, partner, or utilize the sobering center, the majority (84.6%) of the 26 responding agencies indicated they do not incur any financial costs. In contrast, the remainder (15.4%) described a fixed cost associated with their use of sobering centers.

Most agencies allow officers to transport individuals to facilities (92.3%), and if they do not, clients can find their own transportation to the facility or are dropped off by Emergency Medical Services (EMS). The responding agencies who allow officer transports reported these drop-offs were generally quick. Approximately 45.5% of respondents indicated it takes officers less than 10 minutes, and 50.0% noted it takes 10 to 20 minutes; only one agency reported the process taking longer than 20 minutes (4.6%). Two of 26 agencies reported contracting transportation services out to another entity (7.4%).

[3] N is based on the respondents who indicated that they trained on sobering center use.

Table 6. Policies and Costs Related to Police Use of Sobering Centers (n=29)

	Response Options	% of Respondents
Do you have state-level laws on police use of sobering centers?	Yes	15.4%
	No	69.2%
	Unknown	15.4%
Do you have municipal ordinances on police use of sobering centers?	Yes	7.7%
	No	88.5%
	Unknown	3.9%
Formal agreement with the sobering center in your city?	Yes, MOU	34.6%
	Yes, service contract	7.7%
	Yes, Other	7.7%
	No	38.5%
	Unknown	11.5%
Financial cost for your agency to use the sobering center?	Yes	15.4%
	No	84.6%
What is the form of this cost?	Fixed	100%
	Per # of subjects	0%
	Other	0%
Do sworn officers transport intoxicated individuals?	Yes	92.3%
	No	7.7%
Average time for officers to drop off individuals at a sobering center?	< 10 min	45.5%
	10 - 20 min	50.0%
	> 20 min	4.6%
Does your agency contract with another entity to transport to sobering centers?	Yes	7.4%
	No	92.6%

Table 7 presents crosstabulation analyses of responses to average officer drop-off time by agency size. This table suggests the shortest officer drop-off periods (less than 10 minutes) are equally likely to occur in small to midsize and large agencies; more extended drop-off periods (longer than 10 minutes) are far more prevalent in small to midsize agencies.

Table 7. Comparison of Agency Size Regarding Officer Transport Time (n=27)

On average, how long does it take officers to drop off individuals at a sobering facility?	Small to Midsize (n=15)	Large (n=12)
Less than 10 minutes	50.0%	50.0%
10 to 20 minutes	72.7%	27.3%
Longer than 20 minutes	100.0%	0.0%

Specific agency policies can also impact how officers use their local sobering centers. Some substances, for instance, prevent agencies from transporting an intoxicated person to a sobering center.[4] While 44% of respondents indicated no intoxicants mentioned on the list would prevent transport, some agencies reported certain restrictions. As shown in Table 8, the substances which

[4] We are unable to determine whether it is agency policy or sobering center policy that limits specific types of subject intoxicants for transport to sobering centers.

most commonly restrict officers' ability to transport individuals to sobering facilities are methamphetamine (37.0%), opioids (29.6%), hallucinogenic or psychedelic substances (25.9%), inhalants (18.5%), and stimulants (18.5%).

Table 8. Substances Preventing Officer Transport of Individuals to the Sobering Center (n=29)

Subject intoxicants that restrict officers from transporting to the sobering center [select all that apply]	**% of Respondents**
Methamphetamine	37.0%
Opioids	29.6%
Hallucinogenic/Psychedelic substances	25.9%
Inhalants	18.5%
Stimulants	18.5%
Psychotherapeutics (Nonmedical use)	14.8%
Tranquilizers	14.8%
Sedatives	14.8%
Marijuana	11.1%
Pain Relievers	7.4%
Alcohol	7.4%
Other	3.7%

B. Data Collection and Use

When asked if police agencies collect information on officers who drop off clients at sobering centers, only 23.1% reported not collecting this information. As shown in Table 9, most agencies collected a variety of information, including officer name (65.4%), officer badge/ID number (61.5%), the officers' division/assignment (50.0%), the location of the pick-up (50.0%), and other information (19.2%). The additional information reported by these agencies included the type and location of the call, duration of the call, case number, and call for service number. Also shown in Table 9, most agencies also collect some information on the clients brought by officers to sobering centers, including client name and date of birth (69.2%), location of the pick-up (65.4%), home address (42.3%), and demographic information (34.6%). Information classified as "other" included information from medical services, anything provided in the police report, veteran status, homelessness status, and what substance they used. Approximately one-third of responding agencies reported records gathered by agencies on their use of sobering centers were subject to "sunshine laws" (i.e., open to public inquiry).

Approximately 61.5% of police departments reported using statistical information about officers' use of sobering centers to adjust their agency practices (such as allocating more resources to districts with greater use). A few agencies (23.1%) track how much officer time is saved by center utilization. Nearly two-thirds (65.4%) of responding agencies reported there are specific areas where officers are more likely to use the services of a sobering center, including areas close in proximity to the sobering center (25.0%) or where there are large homeless populations

(62.5%). Other examples of specific areas where officers are more likely to use sobering centers included areas with downtown bars and in the nightlife district (12.5%).[5]

Table 9. Police Department Reported Data Collection and Use (n=29)

	Response Options	% of Respondents
Officer information collected sobering center diversions [select all that apply]	Name	65.4%
	Badge/ID Number	61.5%
	Location of pick up	50.0%
	Division / Assignment	50.0%
	Other	19.2%
	No information is collected	23.1%
Intoxicated individual information collected sobering center diversions. [select all that apply]	Name and date of birth	69.2%
	Demographic data	34.6%
	Home address	42.3%
	Location of pick up	65.4%
	Other	15.4%
	No information is collected	11.5%
Are these data open to public inquiry?	Yes	33.3%
	No	66.7%
Does your agency review sobering center use statistics and make adjustments?	Yes	61.5%
	No	38.5%
Does your agency track officer time saved by sobering center use?	Yes	23.1%
	No	76.9%
Are there specific areas where officers are more likely to use sobering centers?	Yes	65.4%
	No	34.6%
Where are those areas?	Close to the sobering center	25.0%
	Near homeless populations	62.5%
	Other	12.5%

In consideration of differences regarding the use of sobering center statistics, we ran crosstabulation analyses based on agency size. As shown in Table 10, it appears agencies who agree they use statistics and those who disagree they use statistics about sobering center use are slightly more frequently reported by small to midsize agencies.

Table 10. Comparison of Agency Size Regarding Use of Sobering Center Statistics (n=26)

Does your agency review any statistics about sobering center use and make adjustments accordingly?	**Small to Midsize (n=15)**	**Large (n=11)**
Yes	56.2%	43.8%
No	60.0%	40.0%

[5] Two free responses were recoded into existing categories that the explanations given by respondents matched (i.e., areas with homelessness).

C. Impact of COVID-19

The COVID-19 pandemic impacted the ability of approximately two-thirds (69.2%) of responding law enforcement agencies to continue using their jurisdictions' sobering centers. As shown in Table 11, these operational impacts included limited capacity in sobering centers (83.3%), as well as changes to transportation (44.4%), formal policies (27.8%), and informal practices (27.8%).

Table 11. Impact of COVID-19 on Police Use of Sobering Centers (n=29)

	Response Options	% of Respondents
Has COVID-19 impacted officers' use of the sobering center?	Yes	69.2%
	No	30.8%
How has COVID-19 impacted officer use?[select all that apply]	Formal policy has restricted use	27.8%
	Informal practice has restricted use	27.8%
	Sobering center has limited capacity	83.3%
	Transport has changed	44.4%

Responses to the impact of COVID-19 on officers' use of sobering centers were analyzed using crosstabulation comparisons. Results, shown in Table 12, suggest those who agreed COVID-19 impacted officers' use of sobering centers appear to be located in small to midsize agencies. Alternatively, those who reported COVID-19 had no impact were more frequently large police agencies.

Table 12. Comparison of Agency Size Regarding the Impact of COVID-19 on Sobering Center Use (n=26)

Has COVID-19 impacted officers' use of the sobering center?	**Small to Midsize (n=15)**	**Large (n=11)**
Yes	55.6%	38.9%
No	37.5%	50.0%

Eight agencies provided open-ended responses to a question asking about other changes COVID-19 may have had on police agencies' use of sobering centers. Two general themes emerged from these responses. First, four agencies saw a reduction in the number of people using the center based on reduced numbers of beds in facilities, social distancing requirements, closures for cleaning, and center closures in general. The other four agencies reported experiencing a reduction in calls to police and had to reduce their responses to in-person non-emergency calls operationally, including transport to sobering centers and the ability to jail persons under the influence of drugs or alcohol.

D. Utility of Sobering Centers

Agencies were asked to respond to survey items measuring the benefits of sobering center use, their perceptions of patrol officers' views on sobering centers, and the obstacles to their agency's use of sobering centers.[6] Most police agencies reported positive perceptions about the benefits of their officers using sobering center services. As shown in Table 13, respondents were asked to indicate how much they agreed with a series of statements, with responses ranging from 1 (strongly disagree) to 5 (strongly agree). The mean score and standard deviations for each statement are displayed in Table 13. The average score for each statement was between 4 - 'agree' and 5 - 'strongly agree,' demonstrating the representatives largely agreed sobering centers saved officer time/resources, presented a better alternative for individuals than jail, connected the individual to additional resources/services, and saved resources from hospital and emergency departments.

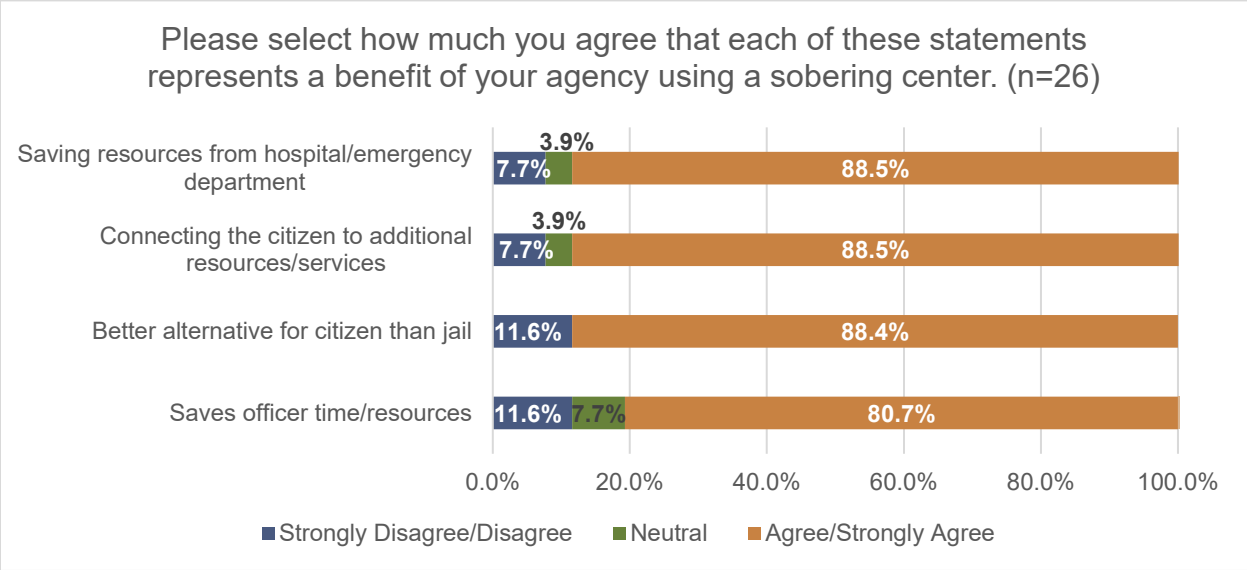
Table 13. Agency Representative Perceptions of Benefits of Sobering Center Use (n=26)

Please select how much you agree that each of these statements represents a benefit of your agency using a sobering center...	**Mean**	**Standard Deviation**
Saving resources from the hospital/emergency department	4.23	1.11
Connecting the individual to additional resources/services	4.27	1.12
Better alternative for the individual than jail	4.31	1.19
Saves officer time/resources	4.23	1.24

Demonstrated graphically, Figure 2 shows the overwhelming majority agreement that sobering centers saved resources from hospital and emergency departments (88.5%), connected the individual to additional resources/services (88.5%), presented a better alternative for individuals than jail (88.4%), and saved officer time/resources (80.7%).

[6] For Tables 13 through 15 presenting attitudinal measures (Benefits of Sobering Center Use, Officer Views on Sobering Centers, and Perceptions of Obstacles), we combined measures for each of the three areas to develop additive scales, and conducted ANOVA and Kruskal-Wallis tests to observe differences between groups. However, given the limited sample size, we failed to have enough statistical power to detect any significant differences at $p = 0.05$ amongst groups based on region or agency size.

Figure 2. Sobering Centers Perceived Benefits to Police Agencies



When asked to openly describe any additional benefits police agencies thought sobering centers might have, eight agencies expressed similar opinions to those reflected in the survey questions. These comments were largely positive and focused on how providing individuals access to free, low-cost help was more beneficial to the individual than an arrest or potential criminal record and viewed the use of a sobering center as a more direct tactic to address the root causes of substance use. Two agencies also stated using sobering centers saved them valuable service time, court time, and reduced booking costs in comparison to arresting these individuals. Only one agency expressed reservations about the benefits associated with the use of sobering centers. Specifically, they voiced concern their sobering center may be abused for their services by individuals and perceived they only provide benefits in the short-term for their clients.

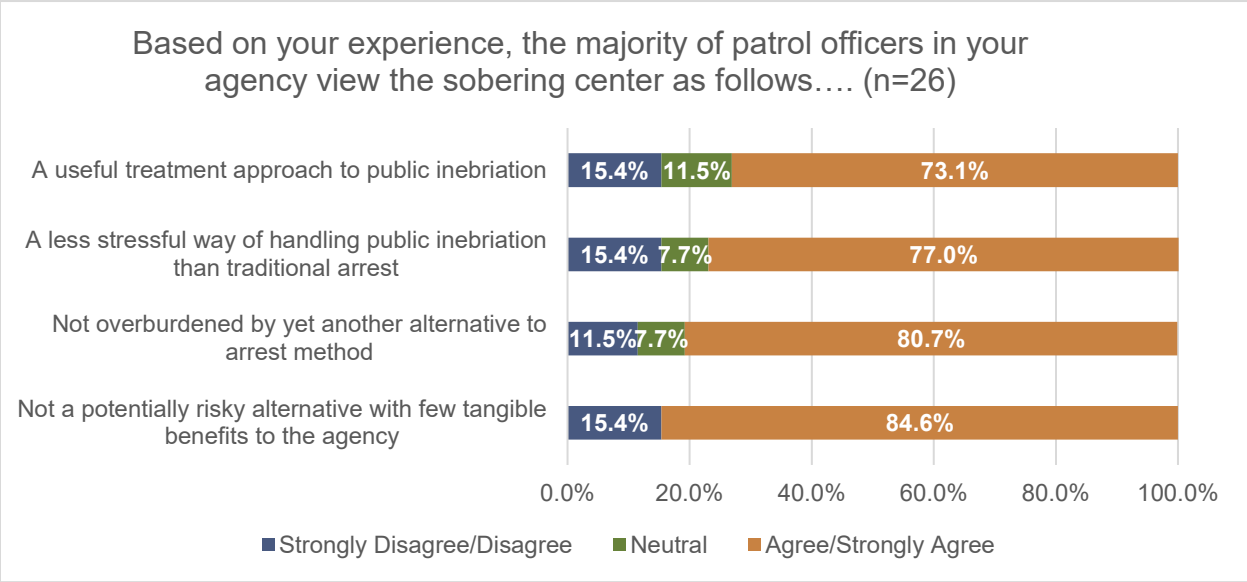
To get a clearer picture of how other officers in the police agencies may view sobering centers, respondents were asked to estimate their perceptions of how most patrol officers view certain aspects of their local center, with responses ranging from 1 (strongly disagree) to 5 (strongly agree). The mean score and standard deviations for each statement are displayed in Table 14. As shown, most agencies' respondents agreed officers felt it was a useful treatment approach to public inebriation (mean = 3.88) and a less stressful approach than a traditional arrest (mean=3.92). Additionally, most agencies' respondents disagreed sobering centers were a potentially risky alternative with few tangible benefits (mean = 2.12) and disagreed officers felt overburdened by another alternative to arrest (mean = 2.12).

Table 14. Police Agency Representative Perceptions of Officers' Views on Sobering Centers

Based on your experience, the majority of patrol officers in your agency view the sobering center as follows…(n=26)	Mean	Standard Deviation
A useful treatment approach to public inebriation	3.88	1.03
A less stressful way of handling public inebriation than traditional arrest	3.92	1.02
A potentially risky alternative with few tangible benefits to the agency	2.12	0.91
Overburdened by yet another alternative to arrest method	2.12	0.86

Shown graphically in Figure 3, most agencies' respondents agreed officers felt the sobering center was a useful treatment approach to public inebriation (73.1%), agreed it was a less stressful approach than a traditional arrest (77.0%), that it did not overburden them as another alternative to arrest (80.7%), and agreed it was not a potentially risky alternative with few tangible benefits (84.6%).[7]

Figure 3. Officer Perceptions of Sobering Centers



Agencies were asked if they had any additional perspectives they wished to share to the research team in an open-ended response. Two agencies expressed general frustration about how many resources are devoted to transporting individuals to the center, and how it may create liability issues for officers when they do not wish to go to the center. While some officers may not see the full benefits of sobering centers as a criminal justice diversion, two departments reported their officers wanted their sobering centers to be larger or its use to be more widespread. They suggested getting direct experience with transporting individuals to the sobering centers had the effect of improving officers' opinions about the usefulness of these centers.

[7] The last two survey items were reverse coded for ease of presentation in a single graph.

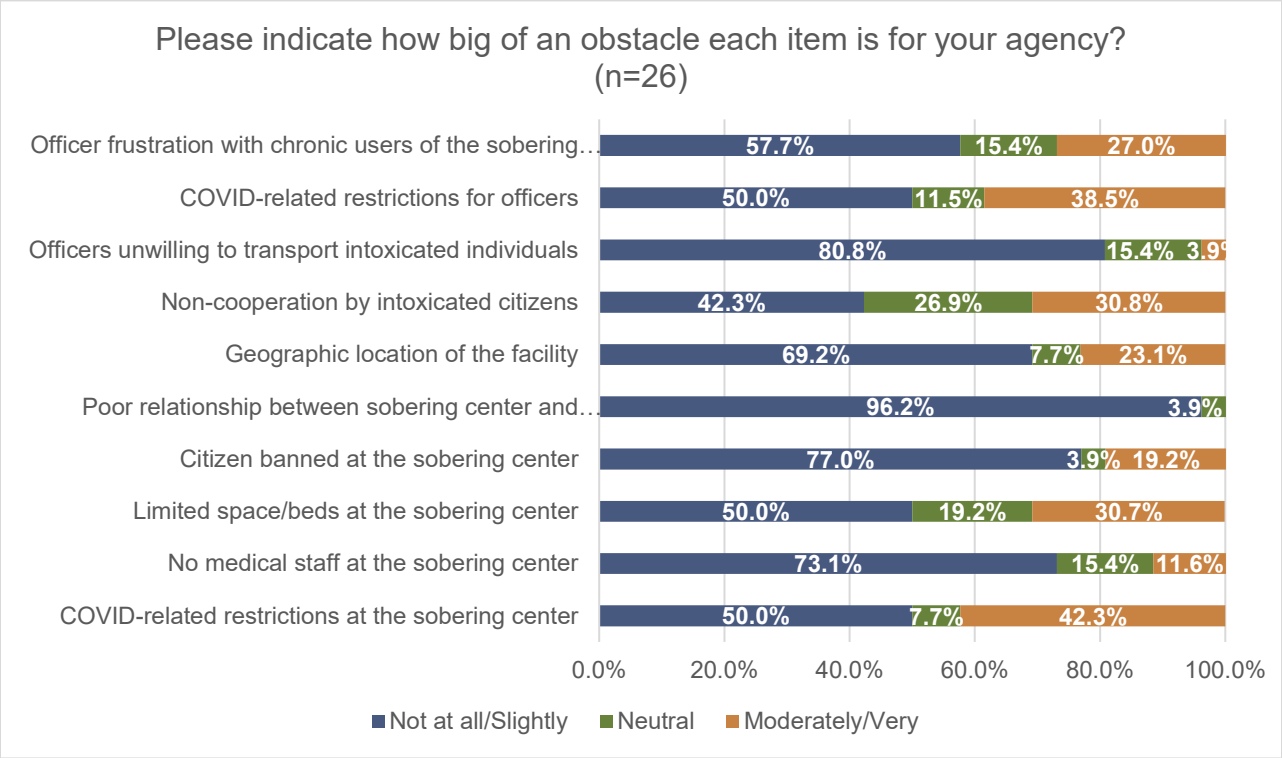
Finally, police agencies were asked about potential obstacles that may prevent officers from using sobering centers. These issues included the geographic location of the facility, non-cooperation by intoxicated individuals, officers being unwilling to transport intoxicated individuals, COVID-related restrictions for officers, COVID-related restrictions at the sobering center, lack of medical staff at the sobering center, limited space/beds at the center, individuals being banned at the center, officer frustration with chronic users of the center, and a poor relationship between the police agency and the sobering center. Respondents indicated their agreement to the extent of each obstacle presented with responses ranging from 1 (Not at All) to 5 (Very). As shown in Table 15, however, many of the issues agencies were asked about did not appear to present a large obstacle to their use of sobering centers. Indeed, only one obstacle received a neutral mean score ('non-cooperation by intoxicated individuals'), while all others indicated average response scores of 'not at all' or 'slightly.'

Table 15. Police Agency Representative Perceptions of Obstacles to Agency's Use of Sobering Centers

Please indicate how big of an obstacle each item is for your agency to use a sobering center... (n=26)	**Mean**	**Standard Deviation**
Officer frustration with chronic users of the sobering center	2.35	1.33
COVID-related restrictions for officers	2.69	1.54
Officers unwilling to transport intoxicated individuals	1.69	1.01
Non-cooperation by intoxicated individual	3.00	1.36
Geographic location of the facility	2.00	1.36
Poor relationship between sobering center and police agency	1.15	0.46
Individual banned at the sobering center	1.96	1.34
Limited space/beds at the sobering center	2.62	1.42
No medical staff at the sobering center	1.92	1.26
COVID-related restrictions at the sobering center	2.85	1.54

The frequency of agreement for the items shown in Table 15 is also shown graphically in Figure 4. The most frequently reported obstacles appear to be COVID-19 related, with agreement center-related restrictions (42.3%), and officer-related restrictions (38.5%) are most frequently seen as agency obstacles to sobering center use. The next obstacle agencies most commonly reported being a moderate to very big concern was non-cooperation by intoxicated individuals (30.8% of respondents). When asked if there were any other obstacles agencies faced, four agencies expressed a general need for support from the community and integrating families of clients who may need to use center services, as well as clarification on changing policies from COVID-19.

Figure 4. Obstacles for Police Agencies to Using Sobering Centers



E. Summary of Findings

This section detailed survey responses from 29 police agencies within jurisdictions with operational sobering centers. Police agency representatives were asked a series of survey questions regarding their organizational policies and practices, data collection and use, the impacts of COVID-19, and the utility of sobering centers.

All responding police departments reported using sobering centers agency-wide for non-violent inebriated individuals with no other criminal activity. Additionally, most agencies permit officers to transport individuals to sobering centers, and drop-offs typically take 20 minutes or less. The shortest officer drop-off periods (less than 10 minutes) are equally likely to occur in small to midsize and large agencies; more extended drop-off periods (longer than 10 minutes) are far more prevalent in small to midsize agencies.

Nearly half of agency respondents indicated their agency had a formal, written agreement with the sobering center in their jurisdiction. In terms of officer discretion, approximately 56% of sobering centers indicated they guide officers on their use of sobering centers with formal written policies, followed by informal practice (25.9%). Agencies who rely on informal practice are more likely to be small to midsize agencies. Importantly, we found nearly 20% of responding police agencies do not provide officers with any formal or informal guidance regarding the use of sobering centers. This is an important finding not measured in prior research.

Regarding officer training for sobering center use, a majority of respondents (81%) reported they train their officers on the use of sobering centers. The format and length of this training varies but is typically one hour or less and often roll-call based. Agencies who reported training 2-3 times per year were all small to midsize agencies, whereas those who reported training officers once per year were all large agencies. We also found most respondents indicated supervisors often or frequently encourage or reinforce officer use of sobering centers.

We found police agencies collect a combination of data on officers who drop-off clients to the sobering center and the client themselves. This information typically includes officer name, badge number, officer division/assignment, and location of pick-up, as well as client name, date of birth, location of pick-up, home address, and demographic information. Police agencies use these data to adjust officers' sobering center use and better understand the areas in their jurisdiction where officers are more likely to need sobering center resources. Despite collecting data, only 62% of agencies reported they use the statistical information gathered about officers' use of sobering centers to adjust their agency practices (such as allocating more resources to districts with greater use). Further, only 23% of agencies track officer time saved by sobering center utilization.

The COVID-19 pandemic impacted 69% of police agencies' use of sobering center services. These operational impacts included limited capacity in sobering centers (83.3%), as well as changes to transportation (44.4%), formal policies (27.8%), and informal practices (27.8%). We found agencies who reported COVID-19 impacted officers' use of sobering centers appear to be located in small to midsize agencies. Alternatively, those who reported COVID-19 had no impact were more frequently large police agencies.

Finally, we found many police agencies reported experiencing multiple benefits from their use of a sobering center, with the majority agreement from survey respondents that sobering centers saved resources from hospital and emergency departments (88.5%), connected the individual to additional resources/services (88.5%), presented a better alternative for individuals than jail (88.4%), and saved officer time/resources (80.7%). Police agency respondents were also asked about potential obstacles preventing officers from using sobering centers. We found many of the issues agencies were asked about did not appear to present a large obstacle to their use of sobering centers. The most frequently reported obstacles appeared to be COVID-19-related, with agreement center-related restrictions (42.3%) and officer-related restrictions (38.5%) are most frequently seen as agency obstacles to sobering center use. The next obstacle agencies most commonly reported being a moderate to very big concern was non-cooperation by intoxicated individuals (30.8% of respondents). The remaining obstacles, such as facility location, individuals being banned, and officers being unwilling to transport, were infrequently reported to be obstacles to police officer use of sobering centers.

VI. FINDINGS FROM THE NATIONAL SURVEY OF SOBERING CENTERS

This section of the report contains results pertaining to the responses from sobering center representatives. Respondents were asked a series of questions regarding their operating policies and procedures, services offered, available data or statistics, law enforcement partnerships, and the impact of COVID-19. Of the 46 operational sobering centers we surveyed, we received responses from 18—representing a response rate of 39.1%. Ten of the eighteen respondents (55.6%) were directors, three were coordinators (16.7%), two were managers (11%), one was a medical services supervisor, and one did not disclose their position. Please note the responses below represent the views of the individual filling out the survey on the center's behalf—responses may not necessarily reflect all perceptions of staff at each facility. Percentages presented are based on valid responses to survey items, excluding missing responses.

A. Organizational Details

Sobering centers have commonalities and differences regarding the organizational details of their programs, including hours of operation, co-location with other services, organization type, treatment model, and written policy. All but one of the responding sobering centers (94.1%) report their program is open 24/7; the one facility not open around the clock operates Thursday through Monday. Approximately 58.8% of responding sobering centers follow an inebriate alternative model. Other treatment models include medical detoxification centers, social model detoxification, and residential treatment. Finally, three-quarters of the responding sobering centers report having a written document defining their operations.

The majority of sobering centers (67.5%) report being co-located with other programs/services. Co-located programs vary largely depending on the site. Still, responses include day centers for individuals experiencing homelessness, transitional living programs for veterans, community crisis centers, residential programs, outpatient programs, prevention programs, DUI centers, sober living programs, family programs, behavioral health treatment services, detox programs, perinatal programs, recovery programs, the mental health division of a police department, and medication-assisted treatment programs.

As demonstrated in Table 16, most sobering centers (82.4%) are housed as a part of a non-profit organization. Stand-alone sobering centers were the second most common organization classification for respondents, followed by being part of a department of health or public health agency, being run by local government, and being part of the criminal justice system.[8] One sobering center indicated being organized as "other" and was funded through a proposition with the Behavioral Health Department. Finally, while three-fourths of responding sobering centers indicated they have an operating agreement or other document defining their sobering centers, four centers (25%) reported they do not have a document defining their operations.

[8] Four centers reported multiple answers (i.e., a stand-alone center that is run by local government); therefore, the percentages exceed 100%.

Table 16. Sobering Center Organizational Details (n=18)

	Response Options	% of Respondents
Is your program open 24/7?	Yes	94.1%
	No	5.9%
Are you co-located with other programs?	Yes	67.5%
	No	23.5%
What treatment model does your center follow?	Inebriate alternative	58.8%
	Medical detoxification center	11.8%
	Other	29.4%
How is your center organized? [select all that apply]	Part of non-profit organization	82.4%
	Stand-alone sobering center	23.5%
	Part of dept. of health	11.8%
	Run by local government	11.8%
	Part of criminal justice system	11.8%
	Other	5.9%
Do you have a document that defines center operations?	Yes	75.0%
	No	25.0%

There is wide variation in reported annual budgets, ranging from $150,000 to $3 million, the distribution is shown in Table 17. Centers were asked to describe how their budget was determined using an open-ended survey item, and many centers indicated their budget was created through considerations of operational costs like rent/mortgage, staff salaries, materials, forecasting estimates, etc.

Ten sobering centers provided responses about how they were funded, reporting a variety of partial and full funding sources. Five centers are supported fully through city, county, and/or state funding. One center is completely funded through police or sheriff department funds, and one was completely funded through grants. Three centers are funded through a combination of sources. Eleven centers indicated they rely on some type of grant funding, including city, state, federal, and philanthropic grants. Additionally, participants were asked if there were specific funding mandates based on the funding sources previously indicated. The majority of sites (69.2%) indicated no mandates were present, whereas 30.8% indicated there were mandates. The centers with funding mandates reported mandates related to allowable expenses outlined by the City and mandates related to utilization rate, data reporting, and general responsiveness to information requests. Finally, the majority of sobering centers (69.2%) do not have competition in their current market. Where competition is present, it comes from other sobering or detoxification centers, hospitals, and other sources.

Table 17. Sobering Center Organizational Details (n=18)

	Response Options	% of Respondents
What is the annual budget for your center?	$0 - $249,999	22.2%
	$250,000-$499,999	11.1%
	$500,000 - $749,999	11.1%
	$750,000 - $999,999	0.0%
	$1 Million - $3 Million	44.4%
	$3 Million or more	11.1%
How is your center funded? [Select all that apply]	Municipal/City	40.0%
	County	20.0%
	State	30.0%
	Grant	10.0%
	Police or Sheriff's Department	20.0%
	Hospital	10.0%
	Other	20.0%
What types of grant funding do you rely upon? [select all that apply]	Municipal/City	45.5%
	State	54.6%
	Federal	18.2%
	Philanthropic	27.3%
	Other	36.4%
Do you have specific funding mandates?	Yes	30.8%
	No	69.2%
Do you have competition in your current market?	No	69.2%
	Yes, other centers	15.4%
	Yes, hospitals	7.7%
	Yes, other	7.7%

B. Sobering Center Services

Sobering centers were surveyed regarding their services and functions, including staffing, client referrals, admission processes, and capacity. These details are described in the sections below.

Staffing

Table 18 details sobering center staff and contracted staff positions, defined as those who are directly interacting with clients, at respective sobering centers[9]. The majority of sobering center staff (85.7%) are non-specialized. Respondents also commonly reported Drug/Alcohol Counselors, Nurses (Registered, CNA, LPN), and EMTs as positions within sobering centers. In addition to asking what positions sobering center staff hold, respondents were asked what positions contracted staff hold. Most centers did not rely on contracted staff, but three centers reported using nurses, security, physicians, and non-specialized staff as contracted staff.

[9] This survey does not query administrative staff positions, who do not interact with staff.

Table 18. Sobering Center Staffing (n=18)

What staff positions do you employ that directly interact with clients? (Select all that apply)	**% Center Staff**	**% Contracted Staff**
Non-specialized staff	85.7%	7.1%
Drug/Alcohol Counselor	42.9%	0.0%
Nurse (Registered, CNA, LPN)	35.7%	7.1%
EMT	28.6%	0.0%
Social Worker	21.4%	0.0%
Paramedic	14.3%	0.0%
Case Manager	14.3%	0.0%
Security	7.1%	7.1%
Nurse Practitioner/Physician's Assistant	7.1%	7.1%
Physician	0.0%	7.1%
Not applicable/missing	7.1%	78.6%

Referrals

Respondents were asked to select all possible referral sources to better understand how clients are referred to sobering centers. Almost all sobering centers indicated accepting referrals from more than one source. As demonstrated in Table 19, the majority of respondents (69.2%) indicated they accept referrals from law enforcement. In addition, 61.5% of sobering centers accept referrals from the emergency department, and over half of sobering centers surveyed indicated accepting walk-ins or self-referrals. Less common referral sources included EMS/ambulance, non-center outreach, outreach by sobering center staff, and courts—approximately one or two sobering centers indicated referrals from those sources. When asked about active street outreach, six of the thirteen sobering centers reported engaging in this practice.

Table 19. Referral Sources for Sobering Centers (n=18)

How are clients referred? [select all that apply]	**% of Respondents**
Law Enforcement	69.2%
Emergency Department/ER	61.5%
Walk-In/Self-Referral	53.9%
Other	38.5%
EMS/Ambulance	30.8%
Outreach Teams (Not affiliated with Center)	23.1%
Outreach by Sobering Staff	23.1%
Court	23.1%

The nine sobering centers that indicated accepting referrals from law enforcement were asked about the average turnaround time for officers to return to patrol after making a drop-off at the sobering center. The open-ended answers ranged from zero to 35 minutes, with one-third of centers indicating a turnaround time of 10 minutes.

To further understand the referral sources of sobering centers, respondents were asked to indicate the estimated percentage each source comprised of the total client referrals—each center's

reported breakdowns are presented in Table 20. Only nine sobering center representatives provided responses for this survey item, demonstrating the largest percentage of referrals are from law enforcement agencies or self-referrals.

Table 20. Percentage of Sobering Center Referral Sources (n=9)

	Law Enforcement	Emergency Room	EMS	Self	Outreach by Non-center Staff	Outreach by Staff	Court	Other
Agency 1	1.6%	53.2%	—	25.3%	1.6%	—	6.0%	12.3%
Agency 2	10.0%	10.0%	—	50.0%	—	—	—	30.0%
Agency 3	—	—	—	—	—	—	—	100%
Agency 4	20.0%	10.0%	5.0%	55.0%	—	—	—	—
Agency 5	93.0%	—	—	5.0%	—	—	—	2.0%
Agency 6	95.0%	5.0%	—	—	—	—	—	—
Agency 7	80.0%	—	—	8.0%	—	10.0%	2.0%	—
Agency 8	—	—	—	95.0%	5.0%	—	—	—
Agency 9	54.0%	11.0%	20.0%	—	—	—	—	15.0%

Capacity

Next, sobering centers were asked about client admissions and intake processes. The maximum capacity of sobering centers is illustrated in Table 21, including both the pre-pandemic and during COVID-19 thresholds. It is evident there is much variation in capacity across centers, ranging from three beds to 84 beds pre-pandemic. Almost all sobering centers reduced total capacity during COVID-19, with an average decreased capacity of about 38% for both men and women. It is important to note one sobering center shut down entirely during COVID-19 and could not serve its community. Also of note, one sobering center ("Agency 11") serves as an outlier in these survey results by slightly increasing capacity during the pandemic. In addition, this agency does not separate men and women but instead has non-gendered dorms/beds.

Table 21. Client Capacity of Sobering Center (n=13)

	Maximum Capacity (pre-pandemic)		**Maximum Capacity** (mid-pandemic)		**% Change**	
	Men	**Women**	**Men**	**Women**		
Agency 1	10	3	0	0	-100%	-100%
Agency 2	20	10	20	10	—	—
Agency 3	2	1	2	1	—	—
Agency 4	9	6	5	3	-44%	-50%
Agency 5	6	4	5	3	-16%	-25%
Agency 6	28	12	20	6	-29%	-50%
Agency 7	2	2	1	1	-50%	-50%
Agency 8	8	8	4	4	-50%	-50%
Agency 9	30	15	10	10	-66%	-33%
Agency 10	25	25	15	15	-40%	-40%
Agency 11	15 (non-gendered)		17 (non-gendered)		+13%	+13%
Agency 12	68	16	34	8	-50%	-50%
Agency 13	30	10	12	4	-60%	-60%

Table 22 denotes the reported minimum, maximum, and average length of stay for clients at a sobering center. There was wide variation in the average length of stay across responding sobering centers, with the average client stay at a sobering center ranging from 5 to 96 hours, depending on the sobering center. A dash indicates the sobering center answered not applicable, meaning there is no requirement. Only one of the thirteen responding sobering center representatives indicated holding clients on an involuntary basis.[10] To prevent escape from clients held involuntarily, the sobering center has "officers remain on site until [the] client is locked in [the] room." The center also indicated doors have two locks and a latch to aid security. Although only one sobering center reported holding clients involuntarily, the majority of sobering centers (69.2%) indicate there are consequences for individuals who try to leave without authorization, which usually involves calling law enforcement.

Table 22. Sobering Center Length of Stay in Hours (n=13)

Type of Hold	**Average**	**Minimum**	**Maximum**
Voluntary	5	—	—
	8	4	23
	8	—	24
	8	2	23.5
	8	—	12
	10	—	11
	10	10	24
	18	0	23
	23	1	23
	24	4	—
	96	—	—
	—	—	—
Involuntary	8	2	23.5

Admissions

Sobering centers share many of the same regulations regarding intake and admissions policies, as shown in Table 23. For instance, all thirteen responding representatives reported their sobering center has an age restriction for the clients they serve, and all have a specific protocol for deciding whether to admit clients intoxicated by drugs or alcohol. When asked to provide open-ended details on these protocols, most centers report including the individual's ability to participate in the intake process, ability to walk, or being within a certain blood alcohol content (BAC) range based on a breathalyzer test.

In addition, 92.3% of sobering centers indicate they accept clients intoxicated on drugs beyond just alcohol, and 76.9% have a medical screening or triage protocol they use to determine if a potential client is appropriate for their center. The ten respondents who reported having a medical screening protocol were asked what the screening consists of and who conducts the

[10] Note this facility determines its involuntary hold due to their interpretation of the Oklahoma state statute regarding holding inebriated individuals.

screening. Elements included in the medical screening commonly include a breathalyzer of blood alcohol content (BAC) screening (90%), blood pressure (80%), blood glucose level (60%), blood oxygen level (60%), patient medical history (50%), a physical examination (20%), and other measures (30%). The medical screening was typically conducted by medically trained staff.

Table 23. Sobering Center Admissions Protocols (n=18)

	Response Options	% of Respondents
Do you have age restrictions for your clients?	Yes	100.0%
	No	0.0%
Do you have a protocol for admission of clients who are intoxicated?	Yes	100%
	No	0.0%
Does your center accept clients intoxicated on drugs beyond alcohol?	Yes	92.3%
	No	7.7%
Does your center have a medical screening protocol?	Yes	76.9%
	No	23.1%
What does this screening consist of? [Select all that apply]	BAC screening	90.0%
	Blood pressure	80.0%
	Blood glucose	60.0%
	Blood oxygen level	60.0%
	Medical history	50.0%
	Other	30.0%
	Physical exam	20.0%

As demonstrated in Table 24, the most common reasons sobering centers deny admissions to clients include violence, unresponsiveness, or a BAC level that is too high. Additionally, when describing "other" reasons, sobering center representatives commonly reported refusal to participate or other medical needs. When asked which forms of intoxication their center *does not* accept, only four centers reported they would not accept clients using certain types of substances.[11] If a client is found to be medically inappropriate for the sobering center, most sites (84.6%) refer them to a hospital emergency department, and 15.4% answered that clients are referred to other services/programs. Sobering centers were asked what percentage of their clients are determined to be medically ineligible or deemed inappropriate for admission to the center. Of the 11 sobering centers that provided open-ended responses to this question, a majority (82%) indicated less than 10% of clients were ineligible for admissions, and the majority of these (7 out of 9) reported less than 5% of clients were determined to be medically ineligible.

[11] These substances varied across the four centers, but were reported to include: alcohol, hallucinogenics, inhalants, marijuana, methamphetamines, opioids, pain relievers, psychotherapeutics (non-medical use) sedatives, stimulants, tranquilizers. The center who indicated they did not accept alcohol was self-described as a social model detox and residential treatment facility. They also reported that they closed in July 2020 after their pilot phase of opening because they did not have law enforcement buy-in.

Table 24. Sobering Center Ineligibility Practices (n=18)

	Response Options	% of Respondents
What factors make clients ineligible? [select all that apply]	Violent	90.9%
	Unresponsive	72.7%
	BAC too high	63.6%
	Verbally abusive	27.3%
	Chronic client	0.0%
	Other	45.5%
Where do you refer clients who are medically inappropriate for your center?	Hospital	84.6%
	Shelter	—
	Other	15.4%

Services

Once a client is determined to be eligible and admitted to the sobering center, services are provided. Four of the 13 responding sobering centers provide *healthcare* services to clients during their stay, and eight provide *social or behavioral* services to clients. Table 25 details the counts of the types of services clients are offered through sobering centers. Of the four sobering centers that provided responses on medical services, all provide vital sign assessment and monitoring, alcohol level assessments via breathalyzer, and Narcan.[12] Additionally, all eight responding sobering centers provide shelter referrals and motivational interviewing. Most of these sobering centers also offer screening for and education on substance abuse disorders and housing referrals. All other services vary across centers.

Table 25. Sobering Center Services Provided

Healthcare Services [select all that apply] (n=4)	(n)	Behavioral Services [select all that apply] (n=8)	(n)
Vital Sign assessment/monitoring	4	Shelter referrals	8
Alcohol level assessment	4	Motivational interviewing	8
Narcan	4	Screening for substance use disorders	7
Wound care	3	Education on substance abuse disorders	7
Manage and administer the client's medication	3	Housing referrals	6
Anti-nausea medication	3	One-to-one counseling	5
Oral Medication for alcohol withdrawal	2	Follow-up, post-discharge	5
Medication-assisted treatment	1	Bus or Public transport passes	5
Provide written prescriptions	1	Health insurance enrollment	4
Urine drug screenings	1	Transportation via sobering center van	4
Medical referrals, post-discharge	1	Case management (continue after discharge)	3
Phlebotomy	—	Accompaniment to appointments	3
Intravenous fluids	—	Other	3
Injectable medications	—	Group counseling	2
Primary care	—	Intensive case management	1
EKG	—		

[12] Narcan is a prescription medicine used to treat narcotic/opioid overdose during emergency situations.

Finally, sobering centers were asked if they conduct follow-ups with previously discharged clients. Approximately two-thirds (66.7%, eight sobering centers) reported their centers do follow-up, while one-third do not. Of those who do not complete follow-up with clients, all indicated neither they nor an outside organization engaged in client follow-up.

C. Sobering Center Data

Sobering center representatives were asked a series of survey questions regarding the use of data in their organization. Specifically, they were asked to provide estimates of clients served along with the ways they collect, report, and use their sobering center data. Table 26 details the estimated number of clients served pre-pandemic and during the pandemic from the twelve responding centers. There is wide variation in the estimated number of clients served during 2019 (pre-pandemic) and 2020 (during the pandemic). For example, one sobering center reported serving ten clients, whereas another sobering center reported serving 13,325 clients. The average number of clients served decreased by an average of 22% from 2019 to 2020. Three-quarters of sobering centers decreased the number of clients served due to the pandemic. Two sobering centers' capacities to serve were not affected by COVID-19, and the number of clients served stayed the same. One agency served as an outlier in these data and increased the number of clients served by over 50%. Sobering centers were also asked to estimate what percentage of their clients are repeat clients; responses ranged from 2% to 70%. One-quarter of respondents indicated 20% of their clients are repeat clients.

Table 26. Sobering Center Estimations of Clients Served (n=12)

	2019, Pre-Pandemic	2020, Mid-Pandemic	% Change
Agency 1	1,500	500	-66%
Agency 2	1,300	700	-46%
Agency 3	10	10	--
Agency 4	750	723	-4%
Agency 5	360	310	-14%
Agency 6	1,280	1,091	-15%
Agency 7	55	55	--
Agency 8	1,279	681	-47%
Agency 9	4,018	3,032	-25%
Agency 10	13,325	11,261	-15%
Agency 11	1,273	2,026	+59%
Agency 12	2117	1191	-44%

Finally, sobering centers were asked to detail client discharge distributions, shown in Table 27. While the distribution for each discharge option varies by sobering center, the most common discharge type is self-care, followed by discharge to a homeless shelter, and to family/friends. No sobering center indicated death as a discharge option in the percentage breakdown, however when asked directly if a client fatality ever occurred at their center, 41.7% of the twelve responding centers indicated they had experienced a client fatality at some point in their operation.

Table 27. Sobering Center Client Discharge Patterns (n=9)

	Self-Care	Inappropriate Behavior	Detoxification	Rehabilitation/ Treatment	Homeless Shelter	Family/ Friends	Other
Agency 1	47.4%	—	—	40.7%	—	5.9%	6.0%
Agency 2	—	—	50.0%	—	30.0%	—	40.0%
Agency 3	10.0%	10.0%	60.0%	1.0%	10.0%	9.0%	—
Agency 4	40.0%	—	—	40.0%	2.0%	8.0%	—
Agency 5	14.0%	1.0%	3.0%	—	2.0%	80.0%	—
Agency 6	92.0%	—	—	—	—	—	8.0%
Agency 7	—	20.0%	—	—	10.0%	70.0%	—
Agency 8	80.0%	10.0%	—	—	—	—	10.0%
Agency 9	10.0%	2.0%	35.0%	35.0%	5.0%	5.0%	8.0%

Data Collection Practices

When asked about their data collection practices, sobering centers reported using a variety of methods to track data, including using an off-the-shelf electronic database like Excel (36.0%); paper forms later entered electronically (27.3%); a custom-made electronic database (27.3%); and paper forms not entered electronically (9.1%). Additionally, 83.3% of the twelve responding sobering centers track client demographic information to determine usage patterns; most centers (72.7%), however, do not publish or publicly share demographic information. The 27.3% that do publicly publish/share demographic information do so through Homeless Management Information System (HMIS), annual presentations to the city/county, or annual performance reports. Twelve responding sobering centers reported the ways they use client data, such as in internal, routine reviews (83.3%), to measure effectiveness of service referrals (75%), to monitor repeat clients (66.7%), for budgetary considerations (50%), to track savings to community (8.3%); one sobering center (8.3%) reported information was not used.

Table 28. Sobering Center Data Collection Practices (n=18)

	Response Options	% of Respondents
How do you currently track data for sobering clients?	Off-the-shelf electronic database	36.4%
	Paper forms, entered electronically	27.3%
	Customized electronic database	27.3%
	Paper forms, not entered electronically	9.1%
Do you track client demographic information?	Yes	83.3%
	No	16.7%
Is this information publicly published or shared?	Yes	27.3%
	No	72.7%
In what ways do you use client demographic data? [Select all that apply]	Internal, routine reviews	83.3%
	Budgetary review	50.0%
	Monitoring repeat clients	66.7%
	Measuring effectiveness of service referrals	75.0%
	Information is not used	8.3%
	Other	8.3%
Do you share data with any other healthcare entities?	Yes	66.7%
	No	33.3%
Do you track employee data? (n=12)	Yes	83.3%
	No	16.7%
Do you allow previous patients to work at your center?	Yes, as employees	50.0%
	Yes, as volunteers	8.3%
	Yes, as both	25.0%
	No	16.7%

Shown in Table 28, two-thirds (66.7%) of the responding sobering centers share data with other healthcare entities. When data was shared, it was typically to other referral/treatment partners or health departments. The types of data sobering centers most often share with healthcare agencies include demographics, referral data, frequency of stays, performance measures, insurance status, and follow-up information.

Regarding employees, one-quarter of the responding sobering centers allow previous patients to work at the center as volunteers and staff, 50% allow previous patients to work as staff, 8.3% allow them to work as volunteers, and only 16.7% do not allow previous patients to work at their center. The majority (83.3%) of the twelve responding sobering centers reported they track employee data.

D. Law Enforcement Partnership

This section of the national sobering center survey results focuses on the partnership between sobering centers and law enforcement agencies from the perspective of the sobering center representative. Table 29 demonstrates 66.7% of sobering centers have a formal partnership with law enforcement agencies, while 33.3% do not. Further, when asked if sobering centers have an informal partnership with law enforcement, 75% indicated an informal relationship, while 25% did not.

Table 29. Partnerships with Local Law Enforcement Agencies (n=18)

	Response Options	% of Respondents
Formalized partnership with local law enforcement?	Yes	66.7%
	No	33.3%
Informal partnership with local law enforcement?	Yes	75.0%
	No	25.0%

Sobering center representatives were asked with open-ended questions to describe their formal and informal relationships with law enforcement and to describe any barriers to their partnerships with these agencies. As part of formal partnerships with law enforcement agencies, sobering centers highlighted regular meetings with law enforcement, having established memorandums of understanding, the use of formal screening tools and protocols for utilization of sobering centers, and providing an alternative to arrest. Informally, sobering centers serve as a resource to law enforcement, and law enforcement serves as a referral source for sobering centers.

Common barriers reported by sobering centers include changing law enforcement culture to embrace the use of alternatives beyond arrests or emergency departments. Relatedly, some sobering center representatives noted there might be some misunderstanding in the law enforcement field about the scope and limitations of sobering centers. Additionally, one sobering center described one barrier to law enforcement partnerships was intoxicated individuals had to be screened elsewhere before being brought to sobering facilities.

E. Impact of COVID-19

As previously mentioned in Parts II and III regarding services and data, the COVID-19 pandemic impacted the responding sobering centers' operations. Responding sobering centers' client capacity decreased by an average of 38%, and the number of clients served decreased by an average of 22%. Table 30 shows the types of preventative measures or operational changes sobering centers implemented due to COVID-19. Most sobering centers (75%) did not provide on-site COVID-19 testing.

Table 30. Sobering Center COVID-19 Preventative Measures [Select all that apply] (n=12)

	% of Respondents
Providing all clients and staff with PPE	100.0%
Maintaining social distance among and between clients and staff	83.3%
Restricting the number of clients admitted	66.7%
Changing the physical layout of the center	66.7%
Restricting the number of individuals entering the center	66.7%
Routine health screenings of staff	50.0%
Routine health screenings of clients	50.0%
Routine testing of staff	41.7%
Routine testing of clients	41.7%

All sobering centers surveyed reported providing clients and staff with personal protective equipment (PPE), and 83.3% of sobering centers reported maintaining social distance among and between clients and staff. While only three sites had the capacity for on-site testing, 41.7% of sobering centers indicated they were conducting routine testing of both staff and clients. Further, 50% of sobering centers reported routine health screening for both staff and clients. Many sobering centers took preventative actions beyond testing and screening staff and clients. For instance, 66.7% of sobering centers restricted the number of individuals permitted to enter the center, restricted the number of clients admitted to the center, and changed the physical layout of the center.

Finally, sobering centers were asked how their provided services changed during the COVID-19 pandemic. The most common changes included reducing capacity, adhering to state guidelines, and implementing new safety protocols. Additionally, some sites were forced to shut down at least temporarily.

F. Summary of Findings

We received survey responses from representatives across 18 different sobering centers in the United States (39% response rate). Survey items measured organizational details, finding the sobering centers report variation in these details. For instance, while the majority (58.8%) disclosed they followed an inebriate alternative model, 12% followed a medical detoxification model, and approximately 30% followed "other" models, which respondents described as social model detoxification and residential treatment models. All but one center reported they were open 24/7. Interestingly, 25% of centers did not report having written documents defining their operations.

Most sobering centers (67.5%) report being co-located with other programs/services, and these programs/services varied greatly. Additionally, most sobering centers (82.4%) are housed as a part of a non-profit organization—only a few centers reported operating as a stand-alone. There was wide variation across annual budgets (ranging from $150,000 to $3M), funding sources,

funding mandates, and reliance on grant funding. The majority of sobering centers employ full-time staff that are non-specialized, and only three sobering centers reported any use of contracted staff. Finally, there is wide variation in reported center capacity, ranging from three to 84 beds (pre-pandemic).

Sobering centers were surveyed on client referrals, acceptances, and the services they offer clients. Almost all sobering centers indicated accepting referrals from more than one source, with the most common sources being law enforcement, emergency departments, and self-referrals (walk-ins). All responding sobering centers indicated they have specific protocols guiding the decision to admit or reject clients who are intoxicated on drugs or alcohol. Most commonly, protocols include the individual's ability to participate in the intake process, ability to walk, or being within a certain blood alcohol content (BAC) range based on a breathalyzer test. Nearly all responding sobering centers (92.3%) indicate they accept clients intoxicated on drugs beyond alcohol, and 76.9% have a medical screening/triage protocol to determine if a potential client is appropriate for their center. The reported reasons sobering centers deny admissions to clients include violence, unresponsiveness, a BAC level that is too high or other medical needs, and refusal to participate in the admissions process. It is uncommon for a sobering center to deny admission based on the substances used by the client. If a client is determined to be medically inappropriate for the sobering center, most sites (84.6%) refer them to a hospital emergency department. Most centers report it is relatively infrequent clients are denied admission (less than 10% of all clients).

Once admitted, sobering centers typically provide healthcare services (30% of responding centers) or behavioral health services (61.5%) to clients, although these services vary by site. There is wide variation in the reported average length of client stay, ranging from five to ninety-six hours. Most stays are voluntary, meaning the client can leave whenever they choose, but one center reported holding clients on an involuntary basis. Approximately two-thirds (66.7%) of respondents reported their center does follow up with clients, while one-third does not.

While most sobering centers decreased capacity due to COVID-19, some still served many clients during the pandemic. When asked about the estimated number of clients served in 2020 (mid-pandemic), responses ranged from 10 to 11,261. Sobering centers were also asked to estimate what percentage of their clients are repeat clients; responses ranged from 2% to 70%.

About two-thirds of sobering centers report having a formal partnership with law enforcement agencies, and about 75% have an informal partnership with law enforcement agencies. As a part of the formal partnership with law enforcement agencies, sobering centers highlighted regular meetings with law enforcement, having established memorandums of understanding, the use of formal protocols to use sobering centers, and providing an alternative to arrest. Informally, sobering centers serve as a resource to law enforcement, and law enforcement serves as a referral source for sobering centers. Common barriers described by sobering centers include changing law enforcement culture to embrace the use of alternatives beyond arrests or emergency departments. Relatedly, some sobering center representatives expressed law enforcement might hold some misunderstanding about the scope and limitations of sobering centers.

VII. DISCUSSION

The findings documented in this report are part of the first phase of a broader research study designed to examine the utility of sobering centers as an alternative to arrest. We developed separate quantitative surveys for police agencies and sobering centers to better comprehend the relationship between law enforcement and sobering centers on a national level, identify the perceived benefits of using sobering centers, and understand the types of challenges or obstacles both types of agencies encounter. Our research builds on previous literature that has primarily focused on sobering centers' operations but lacked the police perspective. Previous research has also often been limited to case studies, whereas the current research allows us to present a nationally representative description of the similarities and variations in the use of sobering centers as an alternative to arrest across jurisdictions. Finally, our research is the first to assess the national-level impacts of the COVID-19 pandemic on the operations of sobering centers. Collectively, the findings from this phase of the research study provide important and innovative insights into national patterns of police use of diversion to sobering centers over the use of arrest for public intoxication.

A. Overview of the Findings

Through our identification of the 53 sobering centers across the country, we identified some patterns in the concentrations of these locations, such as:

- Over half of centers (56.6%) were in the Western region of the U.S.
- Centers were concentrated in both small cities (34% with less than 100,000 residents) and in large cities (28.3% with more than 500,000 residents).
- Approximately 51% of sobering centers are in cities with a $50,000-$70,000 median household income (50.9%); meaning it is not necessary for a city to be affluent in order to establish and maintain a sobering facility.
- A majority (64.2%) of the police agencies in the jurisdictions with sobering centers were midsize agencies and were most commonly agencies who receive 100,000 to 499,000 calls for service each year.

Of the 53 jurisdictions identified with sobering centers, representatives from 29 police agencies and 18 sobering centers completed the surveys (response rate of 63.0% for police agencies and 39.1% for sobering centers). Respondents did not dramatically differ from the regional and size patterns found in the 53 jurisdictions, though our respondents did slightly underrepresent jurisdictions on the West Coast and overrepresent the Midwest and large cities. While other research studies have identified and surveyed sobering centers, none have examined the factors associated with their locations (such as region, population size, etc.).

All responding police departments reported using sobering centers agency-wide for non-violent inebriated individuals with no other criminal activity. In practice, however, the majority of respondents agreed there are specific areas within their jurisdiction where officers are more likely to utilize the sobering center; these include areas with large homeless populations, areas

close in proximity to the sobering center, and downtown or entertainment districts. Over 60% of agencies leave the decision to refer individuals to sobering centers to officers' discretion, but over 55% guided officer decision-making by formal written policies. Another 26% shaped officer decision-making regarding sobering centers based on informal practices. We found agencies with formal written policy are most likely to be large agencies whereas those who rely on informal practice are more likely to be midsize agencies. The majority of agencies (80.8%) reported implementing training on when and how officers should use sobering facilities. We found training format varies across agencies, but agencies that train 2-3 times per year are most likely to be midsize agencies, and those who reported training officers once per year were all large agencies. Nevertheless, we found nearly 20% of agencies do not train officers on how they should use sobering centers, and if they do train, the vast majority of agencies only train once after the policy/practice was implemented. Importantly, we also found many agencies indicate supervisors often or frequently encourage or reinforce officer use of sobering centers. These details provide important insights into our first research question—what guides officer decision-making for using sobering centers as an alternative to arrest.

The results of both surveys indicated formal or informal relationships between sobering centers and law enforcement agencies are common but vary in practice. For example, approximately half of the police agencies reported having a formal written agreement with sobering centers. Partnerships can also include regular meetings between the two agencies, establishing formal protocols for the use of sobering centers, and law enforcement serving as a referral source for sobering centers. This is the first systematic information about how these partnerships operate across the US.

Responding police agencies held overwhelming positive views about the benefits of using sobering centers as an alternative to arrest for inebriated individuals. The perceived benefits included benefits to police officers and sobering center clients alike. For example, respondents from both surveys indicated the process for dropping off individuals at a sobering center was quick and efficient, with the majority of police respondents reporting saving officer time and resources are major benefits of sobering center use. Similarly, both police and sobering center representatives perceived sobering centers as providing a better alternative for inebriated individuals than jail, with the added benefit of offering clients additional resources or follow-on services, although available services vary by site. This is consistent with previous literature finding sobering centers can result in significant economic benefits for the criminal justice system and emergency healthcare providers by saving time and costs (Marshall et al., 2021).

Conversely, outside of COVID-related restrictions, only a few obstacles to sobering center use were identified as a moderate or very big issue by more than 20-30% of police agency representatives. These obstacles to sobering center use include non-cooperation by intoxicated individuals, limited center capacity, geographic location of the sobering center, and officer frustration with chronic users. Common barriers described by sobering center respondents include changing law enforcement culture to embrace the use of alternatives to arrest and addressing misunderstanding among law enforcement personnel about the scope and limitations of sobering centers. The development of a formal MOU and increased officer education about

sobering center operations might address some of these perceived barriers. Although the majority of responding police agencies train their officers on the use of sobering centers, the format, length, and frequency of this training vary across agencies. Again, this is the first research to document these perceptions of police and police patterns on policies and practices to use sobering centers.

Our research confirms earlier descriptive studies that individual sobering centers vary in terms of their treatment model, capacity, budget, and services provided (Warren et al., 2016). Operationally, there are considerable differences across sobering centers who responded to our survey. For instance, while the majority (59%) reported using an inebriate alternative model, 12% followed a medical detoxification model, and approximately one-third used "other" models described as social model detoxification and residential treatment. Notably, there is no clear definition for an inebriate alternative model, but these models usually provide an alternative space to take inebriated persons in place of jail or an emergency department. In contrast, medical detoxication requires a different staffing level so the facility can provide medical services to inebriated individuals. There was also wide variation across annual budgets, funding sources, funding mandates, and reliance on grant funding. Sobering centers reported wide variation in client capacity, the average length of client stay, the percentage of individuals who are repeat clients, and the services provided. Finally, three-quarters of the responding sobering centers report having a written document defining their operations. Interestingly, 25% of centers did not report having written documents defining their operations.

Our survey indicated congruence among responding sobering centers in the sources of referrals, admission protocols, and screening criteria for client acceptance. Almost all sobering centers commonly accepted referrals from more than one source, including law enforcement, emergency departments, and walk-ins. A similar finding regarding the wide variety of referring parties is demonstrated in other studies (Smith-Bernardin, 2021; Warren et al., 2016). All responding sobering centers indicated they have specific protocols guiding the decision to admit or reject clients; most included the individual's ability to participate in the intake process, ability to walk, or being within a certain BAC range based on a breathalyzer test. Indeed, establishing these types of protocols is seen as best practice (Smith-Bernardin, 2021).

Nearly all responding sobering centers indicate they accept clients intoxicated on drugs and alcohol, though a few centers noted restrictions on admittance for particular substances. Most centers reported denials for client admission occur less than 10% of the time. These findings are in line with previous research (Smith-Bernardin, 2021). The reported reasons sobering centers deny admissions to clients include violence, unresponsiveness, BAC above a certain threshold or other medical needs, and refusal to participate in the admissions process. Approximately two-thirds of respondents reported their center does follow up with clients after release, while one-third does not.

Finally, although the COVID-19 pandemic delayed the administration of the national surveys for over a year, this postponement allowed the research team to revise the survey instruments to include questions to systematically assess how the pandemic impacted police use of sobering

centers and sobering center operations. Representatives from both types of agencies reported COVID-19 reduced admission capacity in most sobering centers and resulted in changes to policies and the implementation of preventative measures or other safety protocols.

B. Limitations and Recommendations for Future Research

Our research is the first to systematically survey law enforcement agencies and sobering centers to better understand patterns of policies and practices within these organizations and the relationships between them. Additionally, this research is the first to assess the impacts of COVID-19 on sobering center operations and their use as an alternative to arrest. This research provides critical insights into the patterns of partnerships among police and sobering centers, adding clarity to poorly document details on this topic. Nevertheless, it is important to acknowledge the limitations of the current research and provide direction for future research in this area.

First, during our scan of the field, including information provided by the National Sobering Collaborative, it is possible we missed operating sobering centers. Further, our team had to identify a sobering center representative to complete the survey. While we used our best judgment[13] to locate the appropriate representative, some may have been misidentified and unsure about how to proceed with the survey they received. Additionally, some organizations may not consider themselves to provide sobering services, but we categorized them as sobering centers. Those organizations may not have filled out the survey for this reason, and we cannot exclude that possibility.

Although the response rate for the police department was fairly robust (63%) and consistent with the literature on police survey response rates, the response rate for sobering centers was 39%. It is possible the response rate was higher for police departments because they were more familiar than sobering centers with our research team, who typically work directly with law enforcement agencies. Irrespective of the reason for the difference in response rates, it is possible our samples are not nationally representative and that non-response bias impacted our findings, particularly for sobering centers. For instance, compared to the 53 jurisdictions identified with operational sobering centers, police agency respondents overrepresent agencies from the Midwest (24.1% of respondents vs. 9.4% overall), overrepresent agencies serving 500,000 or more residents (44.8% of respondents vs. 28.3% overall), and overrepresent large police departments (41.4% of respondents have 1,000+ sworn officers versus 31.0% overall jurisdictions with 1,000+ sworn officers). Sobering center respondents underrepresent sobering centers in the West (38.9% of respondents vs. 58.5% overall). These sampling biases may have impacted our research findings. Ideally, future research should be based on a larger, more representative sample of sobering centers providing researchers with more statistical power to examine the reasons for differences

[13] Based on information provided online, through email, or through telephone conversations.

across sobering centers and the implications of these differences for client outcomes, the centers' relationships with police agencies, and the impact on arrests.

Third, some agencies did not answer all survey items, and sometimes agencies appeared to answer related survey items inconsistently and seemingly contradict themselves. Further refinement of the survey instrument should be considered to increase complete responses across questions and resolve the likelihood of inconsistencies.

Fourth, our research collected survey responses from a single representative within each agency. Sobering center staffs are considerably smaller than most police agencies. The police survey instructed respondents to fill out items based on their experiences and perceptions of officers' viewpoints within their agency to minimize this bias. Still, it remains possible provided responses reflect the perceptions of the responding individual and not necessarily those of the larger organization. Similarly, the sobering center survey asked the respondents to describe barriers to a partnership with law enforcement, which may not reflect the views of the whole organization. Future research should consider surveying all officers and staff within an organization to provide more diverse perceptions of sobering centers and their partnerships with police. We recommend additional research designs should be employed to enhance the field's understanding of the utility of sobering centers as an alternative to arrest. For example, Phase II of the current research study includes an in-depth examination of five case study sites, using data provided by both the law enforcement agency and the sobering center. The quantitative data from these agencies is supplemented with focus groups with patrol officers in each jurisdiction to better understand what factors influence and impede their decisions to use sobering centers.

Future research may want to consider the long-term impacts of COVID-19 on sobering centers to assess what restrictions remained over time and the length of time to return operations to full capacity. During our semi-structured interviews before our national survey's administration, we met with sobering centers that were forced to move locations or shut down at least temporarily due to COVID-19. Our study found most centers had to significantly reduce capacity and implement other measures to increase COVID-19 prevention. These restrictions were also commonly cited as a barrier to police use of sobering centers. Future research should measure how long these restrictions remain in place and what impact this might have on arrests, jail admissions, and emergency department admissions. As of October 2022, there are still sobering centers operating with COVID-19 capacity restrictions. Research may also examine if economic concerns precipitated by the COVID-19 pandemic resulted in the closure of any centers. Anecdotally, some centers have expressed concerns over the longevity of their operations, particularly as they compete with other social service agencies for municipal and state funding. Smith-Bernardin (2021) also identified funding as a primary, continued challenge faced by many sobering centers.

C. Recommendations

Based on the findings in this report, we offer a series of recommendations for police agencies and sobering centers.

1. **Police agencies should explicitly adopt formal policies about sobering center use.** We recommend all police agencies develop a formal, written policy describing the circumstances under which officers should and should not drop off intoxicated individuals at their local sobering center. We also recommend this policy is developed in collaboration with representatives from the local sobering center to ensure the guidance is appropriate for their facility. Agencies with a current formal policy should consider reviewing it with their local sobering center representatives to confirm there is no misunderstanding of the scope or limitations of the center, particularly if it was not collaboratively developed at its inception. Qualitative remarks from sobering center staff in the survey suggested officer misunderstanding was sometimes a barrier to effective partnerships.
2. **Police agencies should continue to train and reinforce officer use of sobering center diversions for publicly intoxicated individuals.** We found nearly 20% of agencies do not train officers on how they should use sobering centers. If they do train, the vast majority of agencies only train once after the policy/practice is implemented. We recommend specific refresher training on sobering center use and routine circulation of memos or orders reminding officers of the sobering center resource for all agencies. We also advise agencies collaborate with their local sobering center on this training. Bringing a sobering center representative into the police department would likely increase familiarity and officer receptivity to the program while simultaneously dispelling myths about these facilities.
3. **Collect and use data that demonstrates police resources saved.** Our survey found most police and sobering center staff perceived sobering centers save police time and resources. However, our survey also demonstrated some agencies collect no information on drop-offs, and while 62% of agencies reported they use data to adjust agency practices, 77% of agencies do not track officer time saved. We recommend agencies develop a method to document sobering center use and analyze these data for both adjusting agency practices and measuring resources saved.
4. **Sobering Centers should proactively enhance their partnerships with local law enforcement**. While our research demonstrated most centers have a formal or informal relationship with the police and/or sheriffs in their jurisdiction, there is still a sizable minority of centers who reported no relationship. We recommend these centers find some way to develop or enhance their partnerships, as this will likely increase collaboration and reduce barriers in the future.

D. Conclusion

The current study builds upon the available literature by including the perspectives of police officials on the utility of sobering centers through the implementation of a national assessment of

the operations, practices, and perceived benefits and obstacles to partnering with sobering facilities. Of critical importance, these 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. This is the first study to empirically demonstrate this shared perspective, suggesting to policymakers and police executives that other jurisdictions with public intoxication concerns would likely benefit from using this arrest alternative and those police agencies would support this diversion program.

The findings from this study propel us forward by providing national-level insights on the patterns of police use of this arrest alternative, police agency guidance for officer decision-making, and the impact of COVID-19—this is the first study to our knowledge that examines these outcomes. Considering these findings, we recommend police agencies consider how they guide (informally vs. formally) officer discretion, how frequently they train officers for 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.

The most frequently reported barriers to police use of sobering centers were related to COVID-19, followed by non-cooperation by inebriated individuals. This suggests agencies may benefit from enhanced training on dealing with non-cooperation and navigating the evolving changes due to COVID-19. Survey findings indicate officers unwilling to transport intoxicated individuals and ban lists at sobering centers – common anecdotal barriers to effective sobering center use – do not appear to affect most agencies. These reported barriers will be explored further during Phase II of this research, where we engage in patrol officer focus groups to assess decision-making during contact with inebriated persons. Phase II of our research study delves into the impacts of opening sobering centers in five jurisdictions and will provide critical insights into how police and sobering centers partner to reduce the use of arrest as a solution for public intoxication.

From the sobering centers side, many facilities reported operations consistent with prior research, particularly on the wide variation in operating size, costs, staffing, and capacity. Other important findings include the impact of COVID-19 limiting the number of clients they can serve. It is unknown how long these restrictions will remain, and future research should explore these long-term effects. Our research team will continue to explore the use of sobering centers as an alternative to arrest during the remaining phases of this research study. Through our case study analyses with five jurisdictions, we will assess the impacts of these facilities on intoxication-based arrests, patterns in admission geography, and explore officer decision-making. The research will also explore patterns in repeat client use and what makes repeat clients different than single-use clients. This research will provide valuable insights into how sobering centers are used as an alternative to arrest by police, and information can be used to guide best practices for police-sobering center collaboration.

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IX. APPENDIX A: LIST OF RESPONDING AGENCIES

Table 31. List of Responding Police Agencies

Albuquerque, NM, Police Department	Denver, CO, Police Department	Salinas, CA, Police Department
Alexandria, VA, Police Department	Houston, TX, Police Department	San Antonio, TX, Police Department
Austin, TX, Police Department	Indianapolis, IN, Police Department	San Diego, CA, Police Department
Bakersfield, CA, Police Department	Kansas City, MO, Police Department	San Francisco, CA, Police Department
Baltimore, MD, Police Department	Los Angeles, CA, Police Department	San Jose, CA, Police Department
Bethel, AK, Police Department	Montpelier, VT, Police Department	Santa Barbara, CA, Police Department
Billings, MT, Police Department	Nashville, TN, Police Department	Tulsa, OK, Police Department
Cambridge, MA, Police Department	Oklahoma City, OK , Police Department	Vancouver, WA, Police Department
Charleston, SC, Police Department	Portland, ME, Police Department	Wichita, KS, Police Department
Delano, CA, Police Department	Rapid City, SD, Police Department	

Table 32. List of Responding Sobering Centers

Anchorage Safety Center (Anchorage, AK)	Fresh Start Detox and Sobering Center (Medford, OR)
Sobering Center of Austin (Austin, TX)	Room in the Inn (Nashville, TN)
Maryland Crisis Stabilization Center (Baltimore, MD)	Public Inebriate Alternative (Oklahoma City, OK)
Lighthouse - Public Inebriate Program (Berlin, VT)	Milestone Recovery Emergency Shelter (Portland, ME)
CASPAR Emergency Services Center/Shelter (Cambridge, MA)	Empire Recovery Center (Redding, CA)
Totah Sobering Center (Farmington, NM)	Sun Street Center (Salinas, CA)
Houston Recovery Center (Houston, TX)	Janus of Santa Cruz (Santa Cruz, CA)
Reuben Engagement Center (Indianapolis, IN)	Metropolitan Development Council – Tacoma Detoxifcation (Tacoma, WA)
Kansas City Assessment and Triage Center (Kansas City, MO)	Substance Abuse Center of Kansas (Wichita, KS)

X. APPENDIX B: SURVEY INSTRUMENTS

POLICE SURVEY INSTRUMENT:

In this survey, we reference "sobering centers" which refer to facilities that provide short-term recovery, detoxification, and recuperation from the effects of acute alcohol or drug intoxication. These may also be referred to as detoxification centers or public inebriate alternatives and may operate as an alternative to jail (for public intoxication arrest) or emergency departments. Please keep these types of facilities in mind when responding to the survey items below.

Part 1. Organizational Policies and Practices

1. **What is the name of the law enforcement agency you are representing?**

   _____

2. **Please list your contact information**

   Name: _____

   Email:_____

3. **Does your agency use a sobering center, as defined by the prompt above?**
   a) Yes
   b) No

4. **Is this sobering center still operational to the best of your knowledge?**
   a) Yes
   b) No

5. **Given a non-violent inebriated person with no other criminal activity, do your officers to use the sobering center in your city?**
   a) Yes, they are mandated by policy
   b) Yes, but it is at their discretion
   c) No

6. **Given the existence of a sobering center in your jurisdiction, are your officers allowed to conduct a public intoxication arrest as a sole charge?**
   a) Yes
   b) No

7. **[If No selected] Under what circumstances would a person who is in-custody solely for a PI-charge be taken to a jail rather than a sober center?**

_____

_____

_____

8. **What are the forms of subject intoxicants which do <u>not</u> allow officers to transport to the sobering center? [select all that apply]**

Alcohol	☐
Opioids	☐
Stimulants	☐
Hallucinogenic / Psychedelic substances	☐
Marijuana	☐
Inhalants	☐
Methamphetamine	☐
Tranquilizers	☐
Sedatives	☐
Psychotherapeutics (Nonmedical use)	☐
Pain Relievers	☐
Other	☐

9. **Is the sobering center used agency-wide or by particular units?**
   a) Agency-wide
   b) Particular units; Please list:

   _____

10. **Does your agency have specific policy or SOP which describes how officers should use sobering facilities?**
    a) Yes, formal written policy
    b) Yes, informal practice
    c) No
    d) I don't know

11. [If A OR B selected for #10] **If yes, would you be willing to share the policy with our research team?**
    a) Yes
    b) No

12. **Are officers trained on the policy or practice describing when and how officers should use sobering facilities?**
    a) Yes
    b) No

13. [If A selected for #12] **Approximately, how often are officers trained to use sobering facilities?**

a) Once per month
b) 2-3 times per year
c) Once per year
d) Only once, immediately after policy/practice was implemented
e) Never

14. [If A selected for #12] **In what ways are officers trained on the policy or practice to use sobering facilities? [select all that apply]**

a) Roll call training
b) Dedicated, in-service training
c) Online training
d) Tested on knowledge of policy / practice
e) Other: _____

15. [If A selected for #12] **Approximate length of training**:_____ hours

16. How frequently do supervisors (sergeants and lieutenants) encourage/reinforce the use of sobering centers to their officers?

a) Never
b) Seldom (1 per year)
c) Sometimes (every 3-4 months)
d) Often (1 per month)
e) Frequently (1 per week)

17. Do you have state-level laws in regarding police use of sobering centers for nonviolent inebriants within your jurisdiction?

a) Yes
b) No
c) I don't know

18. Do you have any municipal ordinances in regarding police use of sobering centers for nonviolent inebriants your jurisdiction?

a) Yes
b) No
c) I don't know

19. Do you have a formal, written agreement with the sobering center in your city?

a) Yes, Memorandum of Understanding
b) Yes, Contract of Services
c) Yes, Other

d) No
e) I don't know

20. [If A, B, or C selected for #19] **Would you be willing to share a copy of this written agreement to our research team?**
a) Yes
b) No

21. Is there a financial cost for your agency to operate, partner, or utilize the sobering center?
a) Yes
b) No

22. [If A selected for #21] **What is the form of this cost?**
a) Fixed
b) Per # of subjects dropped off
c) Other

23. Do sworn officers transport intoxicated officers to sobering facilities?
a) Yes
b) No

24. [If B selected for #23] **How are intoxicated citizens dropped off to sobering facilities?**

_____

_____

_____

25. [If A selected for #23**] On average, how long does it take officers to drop off individuals at a sobering facility, from when they enter with an intoxicated individual to when they are able to leave?**
a) Less than 10 minutes
b) 10 to 20 minutes
c) Longer than 20 minutes
d) Unsure
e) Not Applicable

26. Does your agency contract with another entity to transport individuals to sobering centers?
a) Yes
b) No

27. Does your agency make arrests from within the sobering center? (for example, assault of an employee or another citizen)

a) Yes
b) No

Part 2. Data Collection & Use

28. Does your agency collect information on officers who drop off at sobering facilities? [Select all that apply]

a) Officer Name
b) Officer Badge/ID Number
c) Location of pick up
d) Officer Division / Assignment
e) Other (please list)_____
f) No information is collected

29. Does your agency record any information about the citizen being dropped off at the facility? [Select all that apply]

a) Citizen name and date of birth (identifying information)
b) Citizen demographic information (non-identifying information)
c) Citizen home address
d) Location of citizen pick up
e) Other (please list) _____
f) No information is collected

30. If you keep records related to your agency's use of sobering centers, are these records subject to "sunshine" laws (e.g. open to public inquiry)?

a) Yes
b) No

31. Does your agency review any statistics about sobering center use and make adjustments accordingly (e.g., allocate more resources to districts with greater use?)

a) Yes
b) No

32. Does your agency track officer time saved by sobering center utilization (beyond reduced jail and court costs)?

a) Yes
b) No

33. Are there specific areas in your agency's jurisdiction where officers are more likely to use sobering centers?

a) Yes
b) No

34. [If yes to # 33] **Where are those areas?**

a) t those in close geographic proximity to the sobering center
b) where there are large homeless populations
c) Other:_____ _____

35. How frequently are trends (i.e., upticks or declines) in arrests for public intoxication presented to patrol officers?

a) Never
b) Seldom (1 per year)
c) Sometimes (every 3-4 months)
d) Often (1 per month)
e) Frequently (1 per week)

Part 3. Impacts of COVID-19

36. Has COVID-19 impacted officers' use of the sobering center?

a) Yes
b) No

37. [If Yes to #36] **How has COVID-19 impacted officer's use of the sobering center? [select all that apply]**

a) Formal policy has restricted or reduced its use
b) Informal practice has restricted or reduced its use
c) Sobering Center has limited capacity
d) Transport has changed

38. Has COVID-19 had other impacts on your agency's use of sobering centers that you would like to describe?

_____
_____
_____

Part 4. Utility of Sobering Centers

39. Please select how much you agree that each of these statements represent a benefit of your agency using a sobering center.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a) Saves officer time / resources	☐	☐	☐	☐	☐
b) Better alternative for citizen than jail	☐	☐	☐	☐	☐
c) Connecting the citizen to additional resources / services	☐	☐	☐	☐	☐
d) Saving resources from hospital / emergency department	☐	☐	☐	☐	☐

40. **Are there additional benefits you perceive? If so, please list:**

_____

_____

_____

41. Based on your experience, the majority of patrol officers in your agency view the sobering center as follows...

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a) A useful treatment approach to public inebriation	☐	☐	☐	☐	☐
b) A less stressful way of handling public inebriation than traditional arrest	☐	☐	☐	☐	☐
c) A potentially risky alternative with few tangible benefits to the agency	☐	☐	☐	☐	☐
d) Overburdened by yet another alternative to arrest method	☐	☐	☐	☐	☐

42. **Are there additional officer views you think should be noted? If so, please list:**

_____

_____

_____

_____

43. Please indicate how big of an obstacle each item is for your agency to use a sobering center.

	Not at All	Slightly	Neutral	Moderately	Very
a) Geographic location of the facility	☐	☐	☐	☐	☐
b) Non-cooperation by intoxicated citizens	☐	☐	☐	☐	☐
c) Officers unwilling to transport intoxicated individuals	☐	☐	☐	☐	☐
d) COVID-related restrictions for officers	☐	☐	☐	☐	☐
e) COVD-related restrictions at the sobering center	☐	☐	☐	☐	☐
f) No medical staff at the sobering center	☐	☐	☐	☐	☐
g) Limited space/beds at the sobering center	☐	☐	☐	☐	☐
h) Citizen banned at the sobering center	☐	☐	☐	☐	☐
i) Officer frustration with chronic users of the sobering center	☐	☐	☐	☐	☐
j) Poor relationship between sobering center and police agency	☐	☐	☐	☐	☐

44. Are there other obstacles to your agency's use of sobering centers? If so, please list.

_____

_____

_____

SOBERING CENTER SURVEY INSTRUMENT:

Part 1. Organizational Details

1. **Name of Center:** _____
2. **City & State of Operation**: _____
3. **What is your position at the center?**
   a) Director
   b) Coordinator
   c) Other: _____
4. **Is your program open 24/7?**
   a) Yes
   b) No

4A. If No, please specify your hours of operation:

_____

5. **Are you co-located with other programs?**
   a) Yes
   b) No

5A. [If Yes to #5] Please specify these other programs:

_____

6. **What treatment model does your center follow?**
   a) Inebriate alternative
   b) Medical detoxification center (able to provide medical care)
   c) Other: _____
7. **How is your center organized? [select all that apply]**

Stand-alone sobering center	☐
Part of department of health/public health	☐
Part of non-profit organization	☐
Part of for-profit organization	☐
Run by local government	☐
Part of criminal justice system	☐
Other (list): _____	☐

8. **Do you have operating agreements or some other document which defines how your center operates?**

a) Yes
b) No

8a. [If Yes to #8] **Would you be willing to share this agreement with our research team?**

a) Yes
b) No

9. What is the approximate annual budget for your center?
_____ dollars

10. Can you please describe how this budget was determined?

_____
_____
_____

11. How is your center funded?

Source	Select if Yes	% of annual funding
City	☐	__%
County	☐	__%
State	☐	__%
Grant	☐	__%
Police / Sheriff Department	☐	__%
Hospital	☐	__%
Other	☐	__%

12. What types of grant funding do you rely upon? [select all that apply]
a) Municipal/City
b) State
c) Federal
d) Philanthropic
e) Other

13. Do you have specific funding mandates based on the funding sources specified above?
a) Yes
b) No

14. [If yes to #13], what types of funding mandates do you have?

_____
_____

15. Do you have competition in your current market?

a) Yes, sobering or detoxification centers
b) Yes, hospitals
c) Yes, other
d) No

Part 2. Sobering Center Services

16. What positions are included on your staff, who are directly interacting with clients? (Check all that apply)

	Center Staff	Contracted Staff
Paramedic	☐	☐
EMT	☐	☐
Nurse (Registered, CNA, LPN)	☐	☐
Nurse Practitioner / Physician's Assistant	☐	☐
Physician	☐	☐
Case Manager	☐	☐
Social Worker	☐	☐
Drug/Alcohol Counselor	☐	☐
Security	☐	☐
Non-specialized staff	☐	☐

17. How are clients referred?

Entity	Select if Yes	Estimated % of total client referrals
Law Enforcement	☐	__%
Emergency Department/ER	☐	__%
EMS/Ambulance	☐	__%
Walk In/ Self-Referral	☐	__%
Outreach Teams (Not affiliated with center)	☐	__%
Outreach by Sobering Staff	☐	__%
Court	☐	__%
Other	☐	__%

18. If you partner with a law enforcement agency, what is the average turn around time for officers to return to patrol?

_____ Minutes [please list N/A if you do not partner with law enforcement]

19. Does your center engage in active street outreach to identify clients who may be appropriate for your center?

a) Yes
b) No

20. Does your outreach include follow up with previous clients?

a) Yes
b) No

21. [If no to #20] **Does a different organization engage in this follow up?**
List: _____

22. Does your center accept clients intoxicated on drugs beyond alcohol?

a) Yes
b) No

23. Which forms of client intoxication does your center <u>not</u> accept? [select all that apply]

Alcohol	☐
Opioids	☐
Stimulants	☐
Hallucinogenic / Psychedelic substances	☐
Marijuana	☐
Inhalants	☐
Methamphetamine	☐
Tranquilizers	☐
Sedatives	☐
Psychotherapeutics (Nonmedical use)	☐
Pain Relievers	☐
Other	☐

24. Do you have a specific protocol for deciding whether or not to admit clients who are intoxicated on drugs or alcohol?

a) Yes
b) No

16A. If yes, can you please describe your protocol?

_____

_____

_____

25. What is the maximum capacity of your center (pre-pandemic)?

____ Men

____ Women

26. What is the maximum capacity of your center (during the COVID-19 pandemic)?

____ Men

____ Women

27. Do you hold any clients on an involuntary basis?

a) Yes
b) No

28. [If yes to #27] **Can you please explain the law that allows for the involuntary detention?**

_____

_____

_____

_____

29. [If yes to #27] **What measures does your center take to prevent escape for involuntarily held clients?**

_____

_____

_____

_____

30. Are there consequences for individuals who try to leave your center without authorization?

a) No
b) Yes, Please describe:

_____

_____

31. Do you have age restrictions for your clients?

a) Yes
b) No

32. What is your minimum, maximum, and average length of stay? (Put N/A if there is no requirement)

Voluntary Stay	Involuntary Stay
Average _____ Hours	Average _____ Hours
Minimum _____ Hours	Minimum _____ Hours
Maximum _____ Hours	Maximum _____ Hours

33. Does your center have a medical screening (triage) protocol used to determine if a potential client is appropriate for your center?

a) Yes
b) No

34. [If yes to #33] What does this screening consist of? [Check all that apply]

- Physical examination ☐
- Patient medical history (including medication) ☐
- Blood oxygen level (pulse ox) ☐
- Blood Pressure ☐
- Blood glucose ☐
- Breathalyzer or blood alcohol screening ☐
- Other ☐

35. [If yes to #33] Who conducts the medical screening?

_____

36. If a client is determined to be medically inappropriate for your center, where do you refer them?

a) Hospital Emergency Department
b) Shelter
c) Other

37. What percentage of your clients are determined to be medically ineligible or inappropriate for your center?

_____%

38. Does your center have a procedure for client denial?

a) Yes
b) No

39. [If yes to #38] What factors make clients ineligible? [select all that apply]

a) Violent
b) Unresponsive
c) BAC is too high
d) Verbally abusive
e) Extreme repeat client
f) Other, Please list: _____

40. Do you provide healthcare services to clients during their stay?

a) Yes
b) No

41. [If Yes to #40] Please check all that apply

Vital Sign assessment/monitoring	☐
Alcohol level assessment via breathalyzer	☐
Oral Medication for alcohol withdrawal	☐
Drawing labs/phlebotomy	☐
Wound care	☐
Narcan	☐
Medication assisted treatment (Opioid Use Disorder)	☐
Manage and administer client's own medication	☐
Anti-nausea medication	☐
Intravenous fluids	☐
Injectable medications	☐
Primary Care	☐
Provide written prescriptions	☐
EKG	☐
Urine drug screenings	☐
Medical referrals, post-discharge	☐

42. Do you provide social or behavioral services to clients?

a) Yes
b) No

43. [If yes to #42] Please check all that apply

Screening for substance use disorders	☐
One-to-one counseling	☐
Group counseling	☐
Motivational interviewing	☐
Case management (continuing after discharge)	☐
Intensive case management	☐
Education on substance use disorders	☐
Shelter referrals	☐
Housing referrals	☐
Accompaniment to appointments	☐
Health insurance enrollment	☐
Follow-up, post-discharge	☐
Transportation via sobering center van	☐
Bus or Public transport passes	☐

Part 3. Sobering Center Data

44. Can you estimate how many clients you served in 2019 (pre-pandemic)? _____

45. Can you estimate how many clients you served in 2020 (during the pandemic)? _____

46. In your estimation, what percentage of your clients are repeat clients?

_____%

47. How many of these clients are frequently admitted (i.e. more than 3 times per year)?

___%

48. In your estimation, what percentage of your clients are Medicaid eligible under your state's Medicaid requirements?

_____%

49. Has your state expanded Medicaid services under the Affordable Care Act?

a) Yes
b) No

50. Have you ever had a client fatality at your center?

a) Yes
b) No

51. What percentage of clients transfer to each of the following discharge options?

Source	% of 2019 discharges
Self-care (no direct transfer to program/service)	__%
Discharged due to inappropriate behavior	__%
Detoxification (social or medical)	__%
Rehabilitation / Treatment program	__%
Shelter for homeless	__%
Family/Friends	__%
Death	__%
Other	__%

52. How do you currently track data for sobering clients?

a) Paper forms, not entered electronically
b) Paper forms, later entered electronically
c) Off the shelf electronic data base (E.g., Excel spreadsheet)
d) Custom-made electronic database

53. Do you track client demographic information to determine usage based on sex, race, age, etc?

a) Yes
b) No

54. Is this information publicly published or shared?

a) Yes; please list: _____
b) No

55. In what ways do you use this information? [Check all that apply]

a) Internal, routine reviews
b) Budgetary considerations
c) Monitoring repeat clients
d) Measuring effectiveness of service referrals
e) This information is not used
f) Other: _____

56. Can you please describe the state-level restrictions on the release of patient information in your state?

_____
_____
_____

57. Do you share data with any other healthcare entities (including local health departments and/or community-based healthcare providers)?

a) Yes
b) No

57A. If yes, which ones?

_____
_____

57B. If yes, what type of data do you share?

_____
_____

58. Do you track employee data?

a) Yes
b) No

59. Do you allow previous patients to work at your center?

a) Yes, as employees
b) Yes, as volunteers
c) Yes, as both
d) No

Part 4. Law Enforcement Partnership

60. Do you have a formalized partnership with your local police or sheriff's department?

a) Yes
b) No

60A. If yes, please describe:

_____

_____

61. Do you have an informal partnership with your local police or sheriff's department?

a) Yes
b) No

61A. If yes, please describe:

_____

_____

62. Can you briefly describe any barriers to partnerships with your local police or sheriff's department?

_____

_____

_____

Part 5. Impact of COVID-19

63. How have the services you provide changed during the COVID-19 pandemic?

_____

_____

_____

64. Does your center offer on-site COVID-19 testing?

a) Yes
b) No

64A. If yes, how many clients have tested positive for COVID-19? _____

65. What types of COVID-19 prevention measures have you put into place?

[Check all that apply]

Restricting the numbers of clients being admitted	☐
Changing the physical layout of your center to create appropriate spacing between beds	☐
Maintaining social distance among and between clients and staff	☐

Providing all clients and staff with appropriate personal protective equipment (PPE) such as masks, face shields and gloves	☐
Restricting the number of individuals who can come into your center to provide services	☐
Moving your center to a different location	☐
Routine health screenings of staff	☐
Routine health screenings of clients	☐
Routine testing of staff	☐
Routine testing of clients	☐