Center for Health Care Strategies

Building Resilient and Sustainable Sobering Care Programs in California and Beyond

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In April 2026, the Center for Health Care Strategies (CHCS) partnered with Smith-Bernardin Consulting to host two office hours sessions focused on developing, implementing, and sustaining sobering centers in California. This FAQ answers questions that emerged during those sessions. The office hours and this FAQ were made possible with support from the California Health Care Foundation (CHCF).

Model Development, Zoning, and Siting

1. How have communities generally responded to sobering centers?

Community responses to sobering centers vary widely. Some community members welcome them, while others resist them because of concerns about neighborhood impacts or misconceptions about sobering care. In many cases, opposition reflects "not in my backyard" sentiment, where residents may recognize a community need (e.g., frequent 911 calls related to public intoxication or limited access to treatment services), yet resist locating the services in their own neighborhood.

A common misconception is that sobering centers function like shelters for people experiencing homelessness, with long lines or groups gathering outside. In practice, sobering centers operate differently and do not maintain waitlists or queues. Some programs also conduct street outreach that provides regular engagement in nearby areas and prevents crowds from forming.

Community members may also fear that a sobering center will contribute to neighborhood decline by increasing visible substance use, homelessness, or crime. While sobering centers are not intended to solve all these issues, they can serve as an entry point to substance use care, homelessness resources, and other health and social services. Evidence does not indicate that sobering centers increase crime.

Another concern is the perceived "dumping" of intoxicated individuals from other parts of a city or county into the neighborhood where a sobering center is located. While the degree of concern varies across communities, programs can help address these concerns by providing transportation services and locating centers near public transit options.

Effective community engagement begins early and centers on mutual problem-solving, open dialogue, and visible safeguards. Programs should explain what sobering centers do and how they address local challenges; listen to residents' concerns; be transparent about their limitations (e.g., they cannot fill gaps in substance use care); and engage local champions who can build community trust.

Made possible through support from the California Health Care Foundation.

2. What zoning considerations are important when establishing a sobering center?

Zoning requirements for a sobering center are determined by local city or county land-use regulations. Depending on how the facility is classified under the local zoning code, it may be allowed in commercial, institutional, or residential zones, either by right or through a conditional use permit or other approval process. Early consultation with the local planning department can help identify applicable zoning requirements and any permitting or site-specific considerations. As most sobering center stays do not exceed 24 hours, this can limit additional licensing requirements. When evaluating locations, sites should be accessible and have adequate parking for referring partners.

3. Can heat or cold weather emergency centers be co-located with sobering centers?

Yes. Weather-related emergency centers can be co-located with sobering centers. There should be designated and sufficient seating, space, and privacy for people seeking weather shelter and those receiving sobering care.

Staffing Models

4. What is the recommended staffing model for a sobering center?

Recommended staff include a licensed health care provider who can conduct assessments and a peer professional with lived expertise who can support clients after periods of intoxication. Programs can add staff based on anticipated need of the community or to work with clients who may need more stabilizing care or may benefit from referrals to other resources or services. The National Standards for Sobering Care, developed by the National Sobering Collaborative, offers clear guidance on staffing and personnel.

5. What is the recommended overnight staffing model for a sobering center?

Overnight teams can include clinical staff, such as emergency medical technicians or licensed vocational/practical nurses, who can assess vital signs and determine whether a person can remain at the sobering center or needs emergency care. Programs can also identify health care practitioners, including on-call physicians or nurse practitioners or on-duty emergency department providers, who can advise on next steps. Other overnight staff, including peer support specialists, can focus on building relationships with clients and connecting them to behavioral health, housing, and other services. While clients may present at any time of the day, many sobering centers experience their busiest intake hours from mid-afternoon until just after 2 a.m.

6. Is it feasible for a sobering center to operate without medical staff?

Some programs operate without on-site health care professionals, while others that start without health care professionals later add them to their staffing model. Things to consider when staffing include: (1) the partners and organizations that will be referring clients; (2) the primary populations referred and their anticipated medical needs; (3) medical staffing available at other facilities, such as a jail; and (4) local regulations on staffing requirements. Regardless of the staffing model, programs should err on the side of caution. Sobering centers are intended to provide safe, short-term care for people experiencing uncomplicated intoxication. They are not emergency medical or psychiatric facilities, and not every case of intoxication is appropriate for a sobering center.

Admission Criteria and Referrals

7. What are typical admission criteria, including for pregnant people and people at risk of suicide?

Sobering centers typically accept adults age 18 and older who are intoxicated by alcohol or other substances, have stable vital signs with no obvious medical conditions, and do not exhibit violent behavior. Programs should keep admission criteria as inclusive as possible.

Acceptance of pregnant individuals is left to staff's clinical judgment. Staff should assess whether the person's condition requires a level of monitoring or emergency care that exceeds what the sobering center can provide. A pregnant person who shows no signs or symptoms of pregnancy complications may be appropriate to remain in the center; anyone showing such signs should be referred to a higher level of care instead.

Sobering centers may accept people at risk of suicide if they can agree to a safety plan and be safely managed under staff supervision within the center's level of care. Anyone at risk of suicide should be placed within continuous staff line of sight, and the space should be free of items someone could use to harm themselves. Additional guidance on admission criteria can be found in section one of the *Blueprint for Sobering Care in California: Implementation Guide*.

8. What are best practices for responding to client walk-ins during overnight hours who do not meet admission criteria?

Overnight staff should be empowered to make decisions that prioritize staff and client safety. If a person who self-presents to the center does not meet admission criteria, staff can ideally engage them to better understand their needs and determine if an appropriate alternative is available. Referral options can include an emergency shelter or drop-in center or a mental health receiving center. Depending on service access within the community, additional options may include detoxification, urgent or primary care, and mental health services. As able, staff should consider individual safety if there are no viable alternatives to the sobering center and refusing entry may increase risk of harm; an example is inclement weather. Staff may prefer to allow entry to a sobering center during inclement weather to provide a safe, indoor space to a person who self-presents. More guidance can be found in section one of the *Blueprint for Sobering Care in California: Implementation Guide*.

9. Does someone need a field-based medical assessment before transport to a sobering center?

Field-based medical assessment and triage, such as a physical exam or health screening, is not required to transport someone to a sobering center. Law enforcement officers and other referring parties, such as street outreach teams, may transport someone to a sobering center without conducting a physical exam. The emergency medical system does work differently, as ambulance personnel conduct field-based assessments on all patients to determine the most appropriate destination (e.g., trauma center, pediatric emergency department, stroke center). In communities with a sobering center, local emergency medical services (EMS) can collaborate with sobering providers to establish field-based triage criteria specific to sobering care. EMS personnel will conduct their assessment and refer to these triage criteria to determine if a person meets admission criteria. If the patient consents, they will then transport that person to a sobering center.

Best practices for engaging emergency medicine and hospital/emergency department partners can be found in section three of the *Blueprint for Sobering Care in California: Implementation Guide*.

10. How can programs ensure a steady flow of referrals?

To ensure steady referrals, program leaders should engage community partners before and after opening a sobering center. Ways to engage community partners and support smooth, steady referrals include:

- Secure leadership buy-in early — ideally during development of the sobering center — although it is not too late to start later if partners are willing to meet to assess current needs and see how the sobering center could help in their day-to-day work;
- Attend law enforcement briefings or huddles regularly;
- Conduct ride-alongs with referring agencies (e.g., police, EMS) to understand their workflows and identify potential barriers to referral;
- Identify and cultivate a champion in law enforcement who can advocate for the program from the inside;
- Attend emergency department staff meetings — frequently in the period before and the first few months after opening, then periodically (e.g., every six months) thereafter;
- Build a presence in new-hire onboarding for referring agencies, so referral pathways are part of standard training from the start;
- Provide first responders with pocket reference cards outlining referral criteria and procedures; and
- Share brief, regular updates — a monthly or quarterly one-pager — with community leadership to maintain visibility and support.

Throughout all of this, the priority stays the same: safe, appropriate care. Referral numbers will follow — programs should never feel they have to trade care or safety to reach them.

Evidence and Outcomes

11. Where can readers find evidence that sobering centers contribute to improved outcomes and/or lower costs to Medicaid?

Published research on sobering care focuses on outcomes related to stability until functional sobriety, short- and long-term health care costs, engagement in treatment and housing, and criminal justice involvement. More information on sobering center care research can be found on the National Sobering Collaborative's website.

12. The admission data at our sobering center show a high number of returning clients. How should a program address having a high number of returning clients?

A high number of returning clients may not be a red flag — it is often a sign the program is working. Recovery is rarely linear, and a first visit is not always the last. Clients should feel safe returning when they need services. Repeat visits often mean:

- A program has built meaningful trust within the community; and
- The program is reaching a high-need population in the community.

To respond constructively, look at your utilization data for patterns:

- Where clients are coming from (referral vs. walk-in);
- What has changed in the other systems they interact with;
- Shared demographics or needs you could address on the next visit; and
- Whether clients are ready and able to step up to a higher level of care.

Trauma-Informed Practices and Substance Use

13. How are sobering centers embedding trauma-informed practices into organizational culture and day-to-day operations?

Sobering centers are implementing practices such as voluntary admission, short-term, non-permanent denial of service protocols, and supports for returning clients. In most programs, clients have the choice to enter and leave voluntarily. Denial of care protocols allow staff to temporarily refuse admission until certain behaviors have resolved. Sobering centers are also aimed at caring for and stabilizing individuals in the short term; clients are not required to change their substance use or participate in substance use treatment to continue using sobering services.

14. Are there best practices for managing substance use within a facility?

There are several approaches to consider, including (1) storing a client's belongings during a visit and returning them upon their departure from the sobering center; (2) monitoring areas of the center, such as bathrooms, to keep clients safe and reduce risks of overdose; (3) providing supplies, such as test strips and disposal bins, as legally permitted; and (4) engaging clients using a harm reduction, non-punitive approach, understanding that some may continue to use substances.

Financing and Sustainability

15. What funding sources are typically used for sobering center start-up costs, including infrastructure?

Funding sources that can be used to help build and start up a sobering center include: (1) community benefit investments from nonprofit health systems; (2) general funds from the city or county and/or funds from the behavioral health or public health departments; and (3) direct investments from the sheriff's department or local jails.

16. Where can programs obtain funding to support ongoing sobering center operations?

Most programs braid funding, so they use funding from at least two sources, and often up to six sources. Most programs rely on city, county, and/or state funding sources. Examples include:

- Prevention grants for programs serving people in the early stages of alcohol or other substance use disorders;
- State opioid response grants that support opioid-use prevention, treatment, and recovery;
- Direct funding from city or county law enforcement agencies, sheriff's offices, behavioral health departments, health departments, or public health departments; and
- County- or state-level ballot measures that generate tax or bond revenue for public safety, crisis response, or criminal justice reform.

Examples of financing opportunities through Medi-Cal (California's Medicaid program) and CalAIM are available in section four of the *Blueprint for Sobering Care in California: Implementation Guide*. The companion *Blueprint for Sobering Care in California: Financial Toolkit* can help California organizations estimate costs, revenue streams, and financial sustainability and optimize strategies under CalAIM's Community Supports program and other funding sources.

Related Resources

- **Sobering Centers Explained: An Environmental Scan in California, 2025 Updates –** This explainer shares findings from California sobering centers and offers practical insights on implementation, sustainable operations, and effective cross-system partnerships. *(CHCF, November 2025)*
- **Blueprint for Sobering Care in California: Implementation Guide** and **Blueprint for Sobering Care in California: Financial Toolkit –** The guide and accompanying financial toolkit support stakeholders in developing, contracting for, implementing, and sustaining sobering care. *(CHCF, November 2025)*
- **Developing and Sustaining Sobering Centers: Perspectives from California –** This panel discussion explores how cross-sector collaboration and CalAIM resources can support sobering center development, operations, and sustainability. *(CHCS, December 2025)*
- **Building a Cross-Sector Approach to Sobering Centers in Santa Cruz County, California** – This profile describes the services, staffing model, funding, and benefits of sobering care in Santa Cruz County and offers recommendations for other communities interested in establishing similar programs. *(CHCS, September 2025)*
- **National Sobering Collaborative** and **Sobering Care Standards** – The National Sobering Collaborative supports sobering centers nationwide and developed these standards as a framework for assessing programs.