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Item No. 11.1.5
Halifax Regional Council
June 29, 2021

TO: Mayor Savage and Members of Halifax Regional Council

SUBMITTED BY: Original Signed by
Jacques Dubé, Chief Administrative Officer

DATE: May 21, 2021

SUBJECT: Alternative Approaches to Public Intoxication: Feasibility of Sobering Centres and Managed Alcohol Programs

ORIGIN

February 25, 2020 Regional Council motion (Item 16.1):

MOVED by Councillor Smith, seconded by Councillor Mancini

THAT Halifax Regional Council request a staff report that investigates the feasibility of implementing or supporting sobering centres and/or managed alcohol programs. This report should include:

1. Jurisdictional scan of other municipalities that have sobering centres and/or managed alcohol programs including Campbell River BC & Port Albany BC models. This should also outline financial contributions or budgetary impacts directly to Police and overall budgets.

2. Stakeholder engagement that includes service providers that support individuals who are experiencing homelessness and/or drug using population, such as Mobile Outreach Street Health (MOSH), Housing & Homelessness Partnership & Direction 180. Also including organizations that support African Nova Scotian, and Indigenous communities.

3. Data that outlines the number of individuals that have been placed in public intoxication cells in HRM, repeat intakes (i.e., the number of placements annually vs. the number of unique individuals placed), number of deaths, serious injuries, or other investigations related to the care of detainees in HRP or RCMP detention, and demographic data (i.e., age, race, gender ,etc. of individuals detained) if collected.

MOTION PUT AND PASSED

RECOMMENDATIONS ON PAGE 2

LEGISLATIVE AUTHORITY

Halifax Regional Municipality Charter, S.N.S. 2008, c.39

> 59(3) In addition to matters specified in this Act or another Act of the Legislature, the Council may adopt policies on any matter that the Council considers conducive to the effective management of the Municipality.

RECOMMENDATION

1. It is recommended that Halifax Regional Council direct the CAO (or designate) to work with provincial government staff and other key stakeholders to examine potential changes to existing alcohol policies and regulations at the municipal and provincial levels to reduce harmful patterns of alcohol consumption.

2. It is recommended that Halifax Regional Council direct the CAO (or designate) to work with partners to develop options for Regional Council's consideration for establishment of a sobering centre in HRM.

EXECUTIVE SUMMARY

The above motion directed staff to investigate innovative approaches to address public intoxication in the municipality, specifically, the feasibility of Sobering Centres and Managed Alcohol Programs. This motion reflects ongoing efforts of Halifax Regional Municipality (HRM) to identify and implement pathways toward a more holistic, coordinated approach to community safety and wellbeing.

Public intoxication, a summary offence under Nova Scotia's Liquor Control Act (LCA), can result in an individual to be taken to the Prison Care Facility (PCF). While the LCA enables officers to take the individual to any available treatment service, hostel, or facility, currently there are no suitable alternatives to the PCF for intoxicated individuals needing supervision due to intoxication.

The research[1] from this staff report suggests that there are two main groups affected by this summary offence:

- The first group represents marginalized populations with complex needs. These individuals are smaller in number but higher in frequency of contact with police and health care services. They are most disadvantaged by a law enforcement approach to public intoxication.

- The second group represents heavy episodic consumers of alcohol. These individuals are greater in number but lower in frequency of contact (based on unique contacts) to the criminal and health care systems. They are most disadvantaged by cultural norms around alcohol consumption, and alcohol regulations that reinforce these norms.

Based on these findings, a two-pronged approach is recommended. The first focuses on prevention by working with provincial government staff and other key stakeholders to examine potential changes to existing alcohol policies and regulations at the municipal and provincial levels to reduce harmful patterns of alcohol consumption with the goal of reducing harmful patterns of alcohol consumption. The second, focuses on diversion, recommending that staff return to Regional Council with concrete options for the

[1] The research and recommendations for this staff report were supported through a partnership with the Harvard Kennedy School, which enabled HRM to become a client of a Master of Public Policy student. This student conducted a Policy Analysis Exercise for HRM, as a partial degree requirement. Please see Bedatsova, M. 2021. *Public intoxication in Halifax Regional Municipality: Alternatives to policing*. Harvard Kennedy School.

development of a sobering centre, tailored to the needs of marginalized populations with complex needs. The goal of this approach is to steer HRM toward a more health-based approach to public intoxication, reduce barriers to health and addiction services, and provide more ap services that better serve the needs of this population.

BACKGROUND

The above motion directed staff to investigate innovative approaches to address public intoxication, specifically, the feasibility of Sobering Centres and Managed Alcohol Programs as alternatives to police responses to the issue. More recently, there has been a global reimagining of public safety and evaluation of the criminal justice system as the most appropriate tool to address social and health related issues. Locally, the Board of Police Commissioners has struck a defunding the police committee,[2] and Regional Council has directed staff to initiate two broad reviews of policing and public safety.[3]

This work is situated as part of ongoing efforts by HRM to identify and implement pathways toward a more holistic, coordinated approach to community safety and wellbeing through its Public Safety Strategy and Social Policy Framework. Both recognize the complex nature of social issues and the need for comprehensive, systemic solutions. They aim to carve out the important role the municipality plays in addressing these, despite not having a mandate to directly deliver health or social services.

Since the 1960s, views on alcoholism have evolved from failures of the medical model of treating alcohol use disorder as a 'disease' toward a more holistic approach that recognizes the complexity of addiction, and focuses on addressing the myriad of factors contributing to it. Housing First and harm reduction approaches centre on reducing negative effects and behaviours associated with substance use, in contrast to reducing the user's consumption of the substance. By 'meeting people where they are at' and reducing the harms that come from homelessness and/or addiction these approaches can reduce stigma and improve health outcomes.[4]

Across Canada, Housing First, public health, and harm reduction approaches are effective, evidence-based responses to addiction.[5] Provincially, recent innovations to addressing substance use also signal a shift toward reducing the stigma and discrimination faced by people who use substances, particularly among marginalized communities. In 2021, The Nova Scotia Health Authority (NSHA) directed funding to support overdose prevention sites in the province as a part of its broader Opioid Use and Overdose Framework.[6] The onset of the pandemic of Covid-19 led to provincial funding for a pilot Managed Alcohol Program run by local community organization, Mobile Outreach Street Health (MOSH).

These innovations align with HRM's Public Safety Strategy (2018-2022, which prioritizes reducing the harmful use and effects of substance use, including alcohol).[7] Some harm reduction approaches are embedded in HRM service delivery through naloxone kit distribution and safe needle disposal practices. In 2019, Regional Council directed staff to initiate stakeholder consultations for the co-development of a

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[2] Halifax Board of Police Commissioners, Special Meeting, Aug 17, 2020 https://www.halifax.ca/city-hall/boards-committeescommissions/august-17-2020-board-police-commissioners-special

[3] Halifax Regional Municipality. April 20 2021. Reimagining Public Safety: Review of Enforcement Delivery and Role of Police Agencies in HRM. https://www.halifax.ca/sites/default/files/documents/city-hall/regional-council/210420rc1114.pdf

[4] For instance, a review of Housing First, Streets to Homes program in Toronto showed that the number of justice system services individuals used decreased dramatically once in housing, including a 75% decrease in the number of individuals using the PCF, a 56% decrease in the number of individuals arrested, and a 68% reduction in those detained in jail. City of Toronto Staff Report. January 19, 2019. Cost Saving Analysis of Enhanced Streets to Homes Program. https://www.toronto.ca/legdocs/mmis/2009/ex/bgrd/backgroundfile-18574.pdf

[5] Canada was a pioneer in harm reduction in response to rising rates of HIV infection among people who inject drugs. Hyshka, E., Anderson-Baron, J., Karekezi, K. et al. Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduction Journal* 14, 50 (2017). https://doi.org/10.1186/s12954-017-0177-7

[6] Province of Nova Scotia Opioid Use and Overdose Framework: https://novascotia.ca/opioid/; Investments to Support Overdose Prevention Sites https://novascotia.ca/news/release/?id=20210205003

[7] Halifax Regional Municipality. 2017. Public Safety Strategy 2018-2022. https://www.halifax.ca/sites/default/files/documents/city-hall/regional-council/Public_Safety_Strategy.pdf

municipal substance use strategy. Accordingly, this report evaluates the effects of public intoxication more holistically, situating these two interventions within the context of broader policy tools to address problematic substance use in HRM.

Alcohol consumption in HRM
Nova Scotia—Halifax in particular—has a relatively high rate of heavy drinking: 22.7%, compared to 19.3% in Canada.[8] Cultural norms around drinking are well established, embedded in Halifax's legacy as a port town, and dominant military and university cultures, the problems of which were emphasized by Dr. Clairemont in his roundtable report on violence in the HRM. A recent study by the Canadian Institute of Substance Use Research gave the province a score of F in an evaluation of its alcohol policies.[9] The costs of alcohol weigh heavily on all of our economic, social, health and criminal justice systems in Nova Scotia, accounting for 37.3% of overall costs, and above the Canadian average.[10] In terms of criminal justice costs (policing, courts, and corrections), Nova Scotia ranks 3rd of all provinces and territories in costs of alcohol per person, costing each Nova Scotian $264/ year.

Legal Context of Public Intoxication
Despite advancements in public health approaches to substance use, enforcement is commonly used to regulate or control negative or risky behaviours associated with public intoxication. In Nova Scotia, public intoxication is not a criminal or indictable offence, but a summary offence under Nova Scotia's Liquor Control Act (LCA). Section 87 prohibits intoxication in public, granting authority to charge an individual under the Act if a peace officer believes the individual to be intoxicated.[11] Tickets may be served by a police officer, a peace officer or a special constable (including a bylaw enforcement officer appointed as a special constable).[12] Currently in HRM, HRP and RCMP respond to public intoxication service calls.

The LCA enables the officer to take the individual into custody, *or to any available treatment service, hostel, or facility*. Individuals detained may be issued a Summary Offence Ticket (SOT) and taken to the PCF at Police Headquarters in downtown Halifax, or both. Once issued a SOT, the individual has the option of paying an out of court settlement (currently $134 for Public Intoxication) or appearing in court. Since public intoxication is not an indictable offence, it does not appear on an individual's criminal record. Failure to address the offence (through payment of fine or in court), may result in a condition, and a breach of this condition can lead to a criminal charge.

Disproportionate impact on people experiencing homelessness
Because of the nature of the offence, the consequences associated with it, and conditions (and potential breaches of conditions) placed on those unable meet the costs, people living in poverty, facing addiction, and/or experiencing homelessness are at higher risk for this offence and the consequences associated with it, including potential criminal charges if conditions are breached. Importantly, some cases of public intoxication are a consequence of individuals with addiction not having the privilege of being able to consume alcohol at home.[13]

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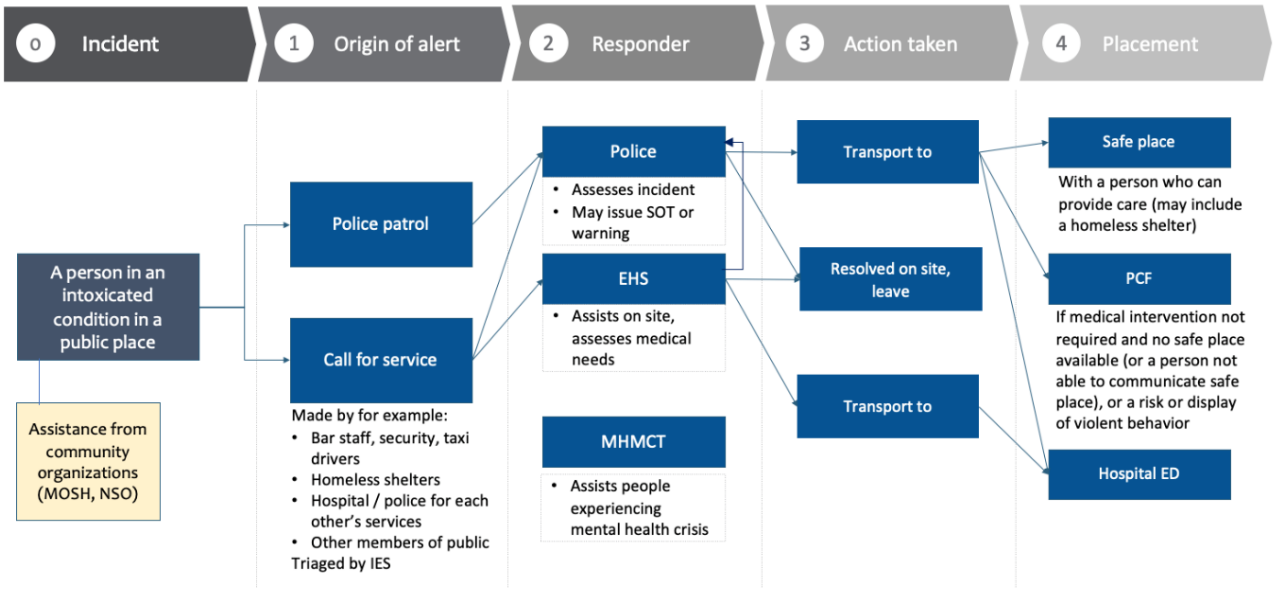
[8] Canadian Centre on Substance use and Addiction. 2021. Canadian Substance Use Costs and Harms. https://csuch.ca/explore-the-data/
[9] Canadian Institute for Substance Use Research. 2021. Reducing Alcohol-Related Harms and Costs in Nova Scotia: A Policy Review. University of Victoria https://www.uvic.ca/research/centres/cisur/assets/docs/report-cape-ns-en.pdf
[10] Canadian Substance Use Costs and Harms; Nova Scotia Department of Health and Wellness. 2011. 2011 Nova Scotia Alcohol Indicators Report. https://novascotia.ca/dhw/publications/Alcohol-Indicators-Report-2011.pdf
[11] Province of Nova Scotia. 2019. Liquor Control Act, Section 87. https://nslegislature.ca/sites/default/files/legc/statutes/liquor%20control.pdf
[12] Nova Scotia Department of Justice. Summary offence Ticket Booklet. Province of Nova Scotia. https://www.novascotia.ca/just/regulations/sots/nssotbooklet.pdf
[13] Amber Kellen et al., "Homeless and Jailed: Jailed and Homeless," The John Howard Society of Toronto, 2010: 1-42, http://johnhoward.on.ca/toronto/wp-content/uploads/sites/5/2014/09/JHS-Toronto_Report-Homeless-and-Jailed.pdf; Robert Hartmann McNamara, "Policing the Homeless: Policy, Practice, and Perceptions," Policing: An International Journal of Police Strategies and Management 36, no. 2 (2013): 357-374.

Current Approach to addressing Public Intoxication in HRM
When public intoxication concerns arise, the response pathway are determined by the type of risk and risk level associated with the incident. A typical response model is illustrated below: [14]



Typical Response to Public Intoxication

The model underscores: (a) the dependency on police; and (b) the limited options for placement once an individual is in police or EHS care. Not all individuals are taken to the PCF. Only those that pose a risk to themselves or others; do not require medical care; and for whom no alternate safe space could be found.[15] Outstanding or new criminal charges may also require officers to detain the individual in the PCF.

Implications of the current approach include:

- Lack of support structures to adequately address the needs of individuals with substance use disorder
- Potential for reliance on enforcement approach to addressing a health care issue
- Potential pathways for criminalization, particularly for marginalized population[16]
- Inadequate, ineffective, and costly use of police resources

The Discussion section of the report presents an analysis of current scale and context of public intoxication in HRM, and then explores potential solutions to the problem. It concludes with a discussion and rationale of the recommendations identified at the outset of this report.

DISCUSSION

While the culture of alcohol use and legal context of public intoxication help to understand how individuals are placed in the PCF, the issue itself is complex, cutting across domains of alcohol regulation, consumption, addiction, mental health, cultural norms, and social supports such as housing and income

[14] This response model is not a formal protocol, but general practice outlining how officers respond to intoxicated individuals. As noted, the LQA leaves considerable room for discretion in how officers respond to incidents.
[15] Police note that individuals will only be taken to the PCF an alternative safe space cannot be identified: a place where a responsible, with consent from sober adult to monitor the individual. If significant health risks are identified, the individual would be transferred to care of EHS or taken directly to the Emergency Department by police.
[16] Turner, A. 2015. Alternatives to Criminalizing Public Intoxication: Case Study of a Sobering Centre in Calgary, AB. *School of Public Policy Research Paper, University of Calgary*. DOI: https://doi.org/10.11575/sppp.v8i0.42530

security. This complexity is reflected in the scale of the issue, along with the typical populations charged.

Service Demands: Police
Most calls for service do not originate as a Section 87 LCA offence, rather call categories such as assist citizen, suspicious person, unwanted person or noise complaint may relate to issues of public intoxication (see Attachment A, figure 1). If it is a factor, officers may issue a SOT and from there the individual may be taken to the PCF. Between 2015-2020, there were a total of 10,186 intakes to the PCF, or 4.68 per day.[17]

During the 2015-2019 period, there had been a declining trend in the number of intakes to the PCF (Figure 2, Attachment A). While the cause of this decline is unknown, potential reasons may include:

- Proactive patrols of the entertainment district by HRP's Downtown Enforcement Unit
- Greater efforts made by officers to identify alternative safe spaces to transport individuals
- Implementation of the Housing First approach, which in providing housing to individuals with frequent interactions with police, has reduced their interactions with law enforcement.[18]

The onset of Covid-19 and subsequent provincial lockdown co-related with a steep decline in PCF intakes in 2020 (Figure 3, Attachment A). This is likely due to:

- the closure of bars and cabarets
- the enhanced use of hotel stays for people experiencing homelessness
- the introduction of a pilot Managed Alcohol Program administered through MOSH and funded by the Department of Health and Wellness
- Increased efforts by police to divert intakes to the PCF to limit the spread of Covid-19 among prison population.

While the downward trend may continue, it is unlikely that the low intake numbers seen in 2020 will be sustained once the economy fully reopens. Indeed, alcohol consumption rates have risen during Covid-19,[19] while alcohol regulations have lessened.[20] The number of homeless and street involved people has also grown during this time. It is likely that rates of public intoxication will rise, along with a corresponding demand for police service.

Service Demands: Alcohol Related Emergency Hospitalizations
Along with higher rates of alcohol consumption, Nova Scotia has the highest rate of hospitalizations entirely related to alcohol in Central and Eastern Canada.[21] Because Emergency Departments (EDs) are another terminus for intoxicated persons, data from ED intakes can help identify the scale of the problem in HRM. Notably, ED visits related to alcohol consumption have *not* declined since the onset of Covid (Figure 4, Attachment A). While these data are inclusive of all ED visits related to alcohol intoxication, alcohol withdrawal, and alcoholism, they illustrate a steady trend, even slightly rising since 2015.

While these aggregate data provide a sense of the scale of the issue in HRM, what follows provides context on who is most likely affected by public intoxication, where and when. This information helps identity most effective solutions, in that they would be more likely to either prevent or divert intakes to the PCF based on the needs of the populations affected.

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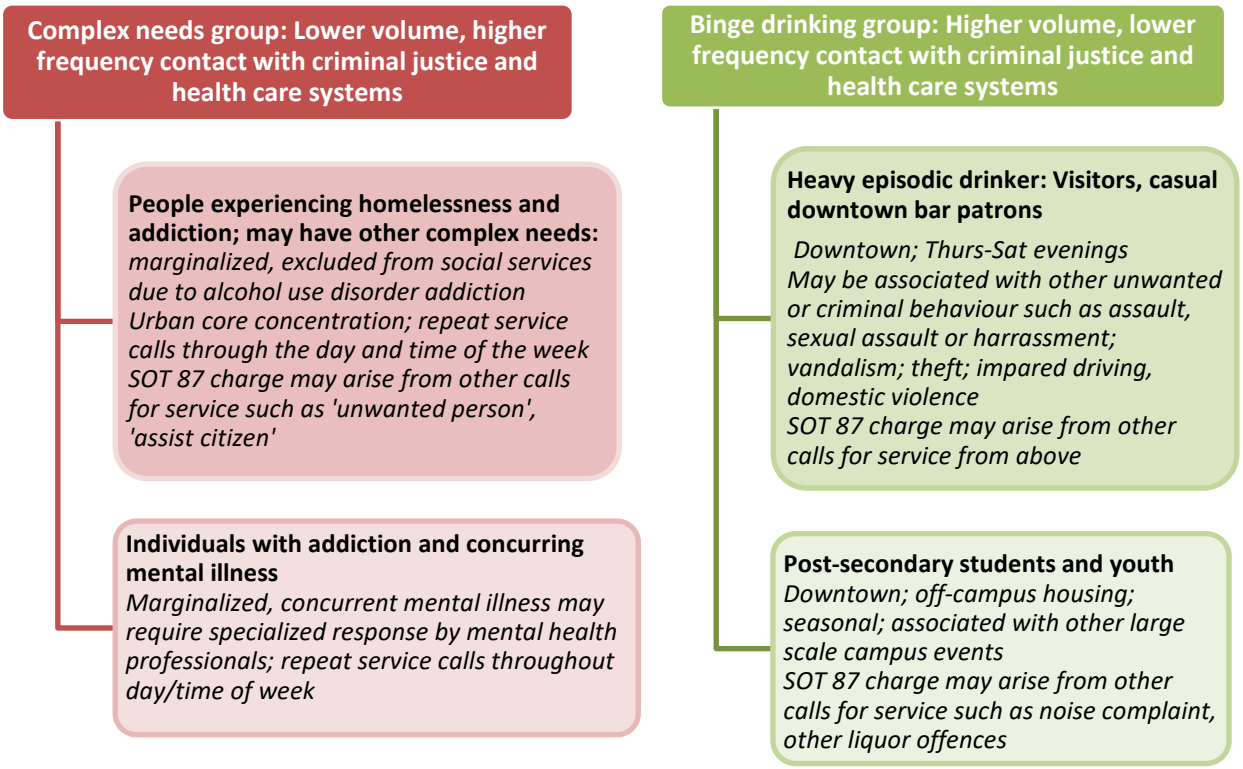
[17] As noted, not all individuals issued a SOT are taken to the PCF.
[18] Research Nova Scotia, "Halifax Housing First Initiative - Final Evaluation Report
[19] Nanos Research. 2020. Covid-19 and Increases in Alcohol Consumption. Canadian Centre for Substance Use and Addiction https://www.ccsa.ca/covid-19-and-increased-alcohol-consumption-nanos-poll-summary-report
[20] On September 29, 2020, Regional Council approved amendments to AO 53 (municipal alcohol policy) that expanded locations where alcohol could be served in HRM. Halifax Regional Municipality. 2020. Addition of sites to Administrative Order 53. https://www.halifax.ca/sites/default/files/documents/city-hall/regional-council/200929rc071.pdf; Nova Scotia Liquor Commission. 2020. Annual Report. https://www.google.com/search?q=nova+scotia+liquor+commission+annual+report&rlz=1C1GCEB_enCA928CA928&oq=nova+scotia+liquor+commission+ann&aqs=chrome.1.69i57j0i22i30l2.16435j1j4&sourceid=chrome&ie=UTF-8
[21] Canadian Institute for Health Information. Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI; 2017.

Who is affected by Public Intoxication?

Available data suggests that there are two main types of populations: complex needs groups and heavy episodic (binge) drinking groups. Each of these can be further divided into sub-populations, broken down in the graphic below. These typologies were developed through interviews with key stakeholders, including police, health care providers and promotors, security services, and homeless serving organizations to better understand patterns visible in administrative data. They were then used to help explain observable differences in admissions to the PCF.[22]



The first group represents marginalized populations with complex needs. These individuals are smaller in number but higher in frequency of contact with police and health care services. They are most disadvantaged by a law enforcement approach to public intoxication.

The second group represents heavy episodic consumers of alcohol. These individuals are greater in number but lower in frequency of contact (based on unique contacts) to the criminal and health care systems. They are most disadvantaged by cultural norms of alcohol consumption and alcohol regulations that reinforce these norms.

While repeat intakes form a relatively small share of the number of all individuals booked into the PCF (around 14%) they form a much higher share of total intakes: 35-40% (Figure 5 Attachment A).[23] The repeated intake category likely includes a range of frequencies, i.e. some individuals who were booked twice, others who were booked seven times. Interviews with patrol officers indicated that it is not uncommon to receive a service call for the same individual three to four times in a 24-hour period.

Emergency Department data demonstrates a similar, though more acute trend. ED visits by repeat intake comprise 60-70% of all visits. A small number of very frequent patients formed 40% of all visits.

[22] The available data from the PCF is not granular enough to estimate the size of these groups. The data did not allow for an analysis of how many people in the PCF experienced homelessness for instance.

[23] Repeat clients are those that had one or more intake within three-year intervals (2015-2017; 2018-2020)

Demographic composition of PCF clients

Gender

In terms gender, the proportion of female intakes comprises only one-fifth of total intakes on average, which is to be expected as heavy drinking is more prevalent among males than females.[24] However, the proportion of females in the PCF has been rising since 2015 (Figure 6 Attachment A), although why or to what extent female intakes comprise repeat vs unique bookings remains unclear. Anecdotal reports by officers suggest female intakes are more likely to be among the unique vs repeated category, coming primarily from the bar district. They also noted that it is generally easier to place female clients in an alternative 'safe' space with friends or family than males, which may explain their relatively low prevalence rate in the PCF, compared to their proportion of the homeless population in HRM (estimated at around 40-45%), but not their growing share of intakes.

Age

Younger people are the most likely age group booked to the PCF. Those aged 20-34 comprised 50% of total intakes on average across the six years of data examined. People aged 20-24 and under also form a growing share of intakes, (Figure 7, Attachment A) from 5% in 2015 to 22% in 2019. Possible reasons could be the sizable post-secondary population in HRM, alongside a documented rise in heavy drinking among younger people.[25] More research is needed to understand why this cohort is growing in terms of intakes to the PCF.

Race

Racial data was not available. Given that African Nova Scotians and Indigenous peoples are overrepresented in provincial and federal incarceration rates, as well as in rates of homelessness, understanding the racial composition of this population is a critical gap in understanding the nature of the problem and potential solutions to address it.[26] Further research is needed to understand the racial composition of intakes.

Geographic and Temporal Patterns

In general, PCF data on time of intakes, along with stakeholder interviews on location of incidents suggests a high volume of weekend calls linked to the bar district, combined with a steadier stream of repeated users across the downtown core. Greater details on these patterns is discussed below.

Locations

Downtown Halifax followed by the South End and North End were cited as the main areas of calls. More specifically: the downtown bar area, particularly near cabarets and Pizza Corner, and to a lesser extent Spring Garden Road. The South End, where there are higher concentrations of off-campus housing, is an area of concentration, particularly during the start of the school year and during holidays and special events. In the North End of Halifax, calls for service are more common near shelters and the area in and around Scotia Square.

Times

As expected, given the geography, the highest call volume is on the weekends, commencing around 6:00 pm until 5:00-6:00 am (Figure 8, Attachment A). Saturdays are the busiest day of the week. The effect of the onset of Covid-19 and the closure of bars and restaurants underscores this temporal trend, as the

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[24] The Canadian Community Health Survey illustrates differences between heavy drinking among males and females, and by age. In 2018 for instance, Canadian males were more likely (23.5%) to report heavy drinking than females (14.8%). The highest proportion of heavy drinking for both sexes was among those aged 18 to 34. In this age group, 33.5% of males and 23.8% of females identified as heavy drinkers Statistics Canada. 2019. Health Facts Sheets: Heavy Drinking, 2018. https://www150.statcan.gc.ca/n1/pub/82-625-x/2019001/article/00007-eng.htm

[25] Annual survey data from Nova Scotians, aged 18-34, illustrate growth in heavy drinking between 2015-2019. Statistics Canada. Table 13-10-0096-01 Health characteristics, annual estimates DOI: https://doi.org/10.25318/1310009601-eng

[26] Affordable Housing Association of Nova Scotia.2018. Point in Time Count. https://www.homelesshub.ca/sites/default/files/attachments/2018%2BHalifax%2BPoint%2Bin%2BTime%2BCount%2BReport.pdf; Correctional Service Nova Scotia. 2018. Key Indicators Report 2017-2018. https://novascotia.ca/just/publications/docs/Correctional-Services-Key-Indicator-Report-2017-18.pdf

intakes remained relatively flat throughout the week that year. In terms of seasonality, the peak time for intakes is in the summer months: July through September, (Figure 9, Attachment A), evident even in the modest spike in the numbers during 2020. Some holidays also co-relate with spikes in intakes: St. Patrick's Day, New Year's Eve or Natal Day (Figure 10, Attachment A).

Harm in the PCF

Protocol in the PCF requires officers to check on the wellbeing of individuals in the cells every 15 minutes, including awakening individuals who may be sleeping. Cells are also equipped with live feed cameras for video surveillance. If an individual requires medical care after intake, EHS paramedics are summoned.

In Nova Scotia, the Serious Incident Response Team (SiRT) investigates all serious incidents that arise from actions of police, including instances of injury or death in the PCF. Out of the 25 investigations that were conducted between April 2015 to April 2019 relating to HRP officers, two were connected to public intoxication intakes.[27] Of these investigations, one resulted in death in 2016.[28] The second incident in the SiRT database was a suicide attempt in 2016.

An incident from 2013 in the SiRT database is worth highlighting as it falls into the typology of the complex needs group identified above and underscores the lack of alternatives to care for individuals in this group. The report details the circumstances of an individual who died in hospital after being transferred from the PCF. The individual was well known to police due to issues related to public intoxication. On September 4, EHS transported the individual to hospital for an ankle injury. Once treated, he was released and HRP was called to book the individual for public intoxication and hold him until sober for his safety, since he had nowhere else to go. He was released later that evening and the following day police responded to a call from a member of the public about the same individual unable to get up after falling on a path. Responding officers rebooked him for public intoxication. Several hours later he was found to be unresponsive and transported to the QEII, where three days later he died of a brain injury likely sustained during his fall on the path.[29]

[27] Based on review of SiRT annual reports and individual reports of all investigations relating to Halifax Regional Police officers or officers in the Halifax detachment of RCMP between 2015 and now. Annual reports and investigation reports can be found at: https://sirt.novascotia.ca/publications

[28] Scott. J.L. November 3, 2017. Summary of Investigation: SiRT file 2016-016. SiRTJune 16, 2016 Referral from Halifax Regional Police. Serious Incident Response Team, Nova Scotia https://sirt.novascotia.ca/sites/default/files/2016-016_Summary%20of%20Investigation%20HRP_Rogers.pdf

[29] MacDonald. RJ. January 18 2016. Summary of Investigation: SiRT file 2013-023. SiRT. Sept 5, 2013 Referral from Halifax Regional Police. Serious Incident Response Team. Nova Scotia. https://sirt.novascotia.ca/sites/default/files/reports/2013%20-023_Summary_%20of_%20Investigation.pdf

OPTIONS

Options draw from the Motion that led to this report, existing literature, experience in other jurisdictions, the local context, and Regional Council's directives on holistic approaches to public safety and social policy. Conceptually, they are grouped into preventative (upstream) solutions and diversion (downstream) options, with the two options in the motion mapped on to this framework as illustrated below.

Options: Prevention and Diversion Framework

<table>
<tr><th colspan="2">Preventive (upstream) options</th><th colspan="2">Diversion (downstream) options</th></tr>
<tr><td>Alcohol consumption

Preventing and reducing harms related to alcohol consumption</td><td>Intoxication in public

Preventing intoxication in public places</td><td rowspan="2">Response

Who responds to public intoxication incident and what action is taken</td><td>Placement

Appropriate service for intoxicated persons care</td></tr>
<tr><td colspan="2">Managed Alcohol Programs</td><td>Sobering Centres</td></tr>
</table>

Preventative approaches address and minimize the root causes of public intoxication. In many cases, the upstream measures may offer a more effective and desirable response to the problems associated with public intoxication. For instance, a MAP would in theory prevent Section 87 incidents from occurring for some of those in the complex needs group, thus reducing the need for police involvement.

Diversion focuses on mitigating the consequences associated with public intoxication by providing alternatives to the PCF, such as sobering centres. As noted in the diagram above, a sobering centre would not reduce police involvement in the response model but would provide an alternative to the PCF for some intakes. Figure 11 in Attachment A captures a fuller range of existing and potential solutions in relation to the populations most affected by public intoxication identified in the research and consultations. The remainder of this section discusses the rationale for the recommended approaches to the issue.

Prevention: Managed Alcohol Programs

A full overview of Managed Alcohol Programs (MAPs) including a jurisdictional scan is provided in Attachment B. In short, MAPs support people experiencing chronic homelessness or housing instability who have alcohol dependence by providing tailored amounts of alcohol to participants on a regular, controlled basis. MAPs aim to "decrease or prevent alcohol-related harms by reducing heavy episodic drinking, use of non-beverage alcohol, public intoxication, drinking in unsafe settings and high costs associated with police and emergency services while increasing access to primary care and other health and social services".[30] MAPs stabilize clients by helping them manage their alcohol consumption, which enables them to take better control of their well-being and address other needs, such as health and financial stability.

Staff does not recommend the municipality take the lead on implementing this option (full assessment in Attachment C). Municipal governments in Canada typically do not play a significant role in creating or governing MAPs given their characterization as addiction harm reduction programs and the provincial government is funding a piloted scattered-site MAP. Thus, the optimal role for HRM is to support the province and its partners with this approach, should it continue beyond the pilot phase.

[30] Pauly et al., "Community Managed Alcohol Programs in Canada."

This support could include helping to facilitate relationships to raise awareness of MAPs, building trust and buy-in for the program, ensuring compatibility of land use and zoning, and/or considering other ways that could support the development of a residential MAP and/or on-site brewing.

Instead, the **recommended preventative approach** is to examine potential changes to existing alcohol policies and regulations at the municipal and provincial levels. Specifically, staff recommend dedicating staff to work with provincial government staff and other key stakeholders to examine potential policy and regulatory changes to reduce harmful patterns of alcohol consumption. Part of this work will involve ensuring HRM's municipal alcohol policy reflects shared values of community safety and wellbeing.

Given the high share of public intoxication cases connected to the Downtown bar scene, carefully balanced, evidence-based and agile policies, tailored to HRM's context, could be a highly effective lever to substantially reduce PCF intakes (as the experience of bar closures in 2020 has shown on the sharp decline of PCF intakes). Literature documents effectiveness of policies such as outlet density, bar opening hours, advertising, and responsible server training in reducing harmful effects of alcohol consumption (on the intoxicated persons themselves and other community members affected by secondary effects of intoxication, which may include aggression, higher risk of domestic violence, impaired driving or others).[31]

Important considerations on legislative/policy changes
Any potential prevention solutions must be considered from a systems-level approach. For instance, some research on policy levers to address public intoxication recommends removing the charge of public intoxication as a summary offence. While this approach would reduce stigma, without the necessary infrastructure in place it may not address the problem of the use of the PCF to address the risks that come from public intoxication. In Australia, where many states removed it as an offence, individuals were booked for other offences, some even more serious than the SOT charge, as the issues associated with the problem did not subside.[32] In Rhode Island, a legislated mandate for a health-based only response to public intoxication quickly led to congestion in emergency departments due to a lack of other treatment centres.[33]

Diversion: Sobering Centres
A full overview of Sobering Centres (SC) is provided in Attachment B. A sobering centre is a place where intoxicated individuals can sleep off effects. The main goal is to provide an alternative to jail and/or emergency departments as a place to 'sleep it off'. Most are open 24 hours, and clients typically spend several hours, or stay overnight, at the centre. They often have a dual purpose: to further the health and well-being of clients and to realize financial savings by diverting individuals away from more costly alternatives.[34] In many cases, SCs connect individuals to appropriate resources, including basic health care and/or withdrawal management programs, thus reducing barriers clients often face in accessing health and social services.

Importantly, from a municipal stakeholder perspective, a sobering centre would provide a safe, convenient alternative to the PCF for individuals charged with public intoxication. Police, both HRP and RCMP, would be able to transport individuals to the Sobering Centre thus enhancing the response options available to police when dealing with this issue. Unlike a MAP, where direct involvement by police is not necessary for its success, a sobering centre's success *depends* on the cooperation of police to direct and drop off appropriate clients to the centre. Ideally, Emergency Departments would also be able to discharge clients to the centre, as well other community agencies whose clients may be too intoxicated for service, as both are a source for police service calls for public intoxication. Accordingly, the success of a sobering centre

[31] The Chief Public Health Officer, 2016. "Alcohol Consumption in Canada: The Chief Public Health Officer's Report on the State of Public Health in Canada 2015."
[32] Victoria State Justice Department. August 2020 Expert Reference Group on Decriminalizing Public Drunkenness, "Seeing the Clear Light of Day." https://www.justice.vic.gov.au/public-drunkenness
[33] Warren, "Intoxicated, Homeless, And In Need Of A Place To Land."
[34] Turner, Alina. 2015. "Alternatives to Criminalizing Public Intoxication: Case Study of a Sobering Centre in Calgary, AB." *SSRN Electronic Journal*. http://www.ssrn.com/abstract=2627799 (March 22, 2021).

requires that stakeholder standards of privacy, security, and medical needs are all adequately addressed and resourced appropriated. Success requires the municipality's participation as an invested stakeholder in its development, implementation, and governance.

There are two main models: universal and tailored. The primary difference is that the latter model caters to subpopulations affected by public intoxication. Both models would offer benefits in terms of creating suitable alternatives to the PCF. Additional key benefits would be the ability to connect people to existing services, which is particularly valuable for people facing barriers to access. However, sobering centres also come with risks, such as risk of violence or medical complications, or disruptions to the neighborhood where the centre is located. Critically, the success of the sobering centre will depend on the relationships between key stakeholders, in particular the level of trust and cooperation among community, police, EHS and SC staff during the intake process and when complications arise.

Each model, universal and tailored, also has distinct benefits and risks which are fully detailed in Attachment C. Given the assessment, the tailored SC is the recommended approach. This model is designed to better service individuals who are not well serviced within the existing continuum of care. Other key reasons for this recommendation include: lack of certainty around clientele; the level of complexity needed to design and implement a universal model; and the substantial financial investment for a universal model. It is also more feasible to mitigate the risks associated with this type of service delivery while also enabling an expansion of services for the complex needs group identified in the ED and PCF data. Finally, a tailored sobering centre can be implemented at a smaller scale as a proof of concept, and potentially expand to a universal depending on the results and lessons learned. Most importantly, a tailored Sobering Centre would provide an important foundation for a public health approach to public intoxication and could help fill existing gaps in service for the complex needs group. This model is designed to better service individuals who are not well serviced within the existing continuum of care.

Because of the central role for the municipality in a sobering center, staff recommends identifying options for the development of a tailored sobering centre and returning to Regional Council with potential model(s) for consideration. This will specify:

• Community Need • Client Population • Key requirements • Scope • Stakeholder Analysis • Required Partnerships	• Evaluation Criteria for Selection • Risk Assessment • Recommended Approach • Success Measures • Funding and Resources Requirements from HRM and other partners for implementation

Budget and PCF impacts of recommended approaches
Because the analysis of recommended approaches was limited by availability and granularity of data, it was not possible to estimate the impact sobering centres or managed alcohol programs (or other interventions) would have on the number of intakes to the PCF, or potential cost savings. However, it is likely that a tailored sobering centre would not have a significant impact of PCF intakes given the relatively small proportion of intakes that would potentially be diverted. The options for a Sobering Centre that will come forth for Regional Council's consideration would strive for a more detailed assessment of costs with resource requests, identified in the 2022/23 budget.

Over the longer term, changes to alcohol policy, regulation and social norms may have the greatest impact on the volume of intakes overall, given the proportion of intakes that comprise the group that would most benefit from such changes. This in turn would likely result in an overall decline in demand on police services for *all* incidents where alcohol is a contributing factor.

FINANCIAL IMPLICATIONS

If required, the costs to contract a consultant to develop options for a sobering centre is estimated at $25,000. Although this is an unbudgeted expenditure, these costs can be accommodated within the existing CAO budget due to staff vacancies.

RISK CONSIDERATION

There are no risks associated with the recommendations in this report. All known risks have been identified in the body of the staff report.

COMMUNITY ENGAGEMENT

Please consult Attachment D for a list of external stakeholder and community consultations.

ENVIRONMENTAL IMPLICATIONS

No environmental implications were identified.

ALTERNATIVES

Regional Council could choose not to approve the recommendations.

ATTACHMENTS

Attachment A: Graphs and charts from PCF and ED administrative records
Attachment B: Overview of Managed Alcohol Programs and Sobering Centres
Attachment C: Evaluation of Managed Alcohol Programs and Sobering Centres for HRM feasibility
Attachment D: Stakeholder and Community Consultations

A copy of this report can be obtained online at halifax.ca or by contacting the Office of the Municipal Clerk at 902.490.4210.

Report Prepared by: Amy Siciliano, Public Safety Advisor, sicilia@halifax.ca

ATTACHMENT A: CHARTS AND GRAPHS

Adapted from Bedatsova, M. 2021. ***Public intoxication in Halifax Regional Municipality: Alternatives to policing.*** *Policy Analysis Exercise, Harvard Kennedy School Master in Public Policy Candidate 2022, Harvard Kennedy School.*

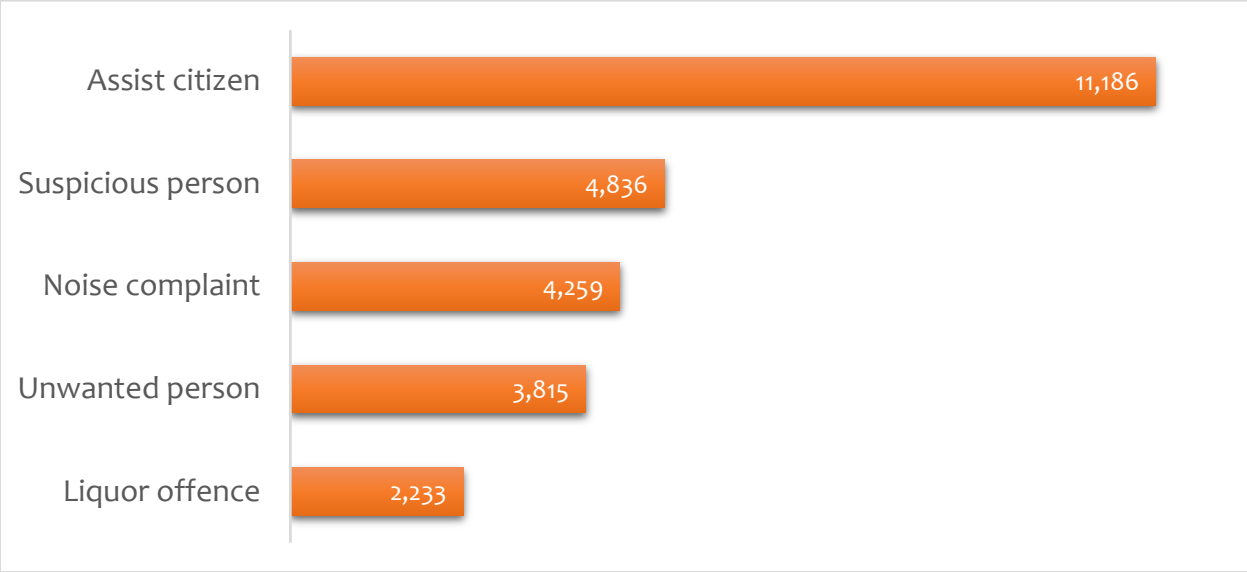

Figure 1: Annual number of calls (in 2018) for some of the most frequent call categories that could result in Section 87 offences (public intoxication). In the same year, the total number of calls resulting in police being dispatched was 123,543. This means these five categories (out of 97 categories) represent ~21% of all calls for police service. Source: Police Service Review 2018, Perivale and Taylor

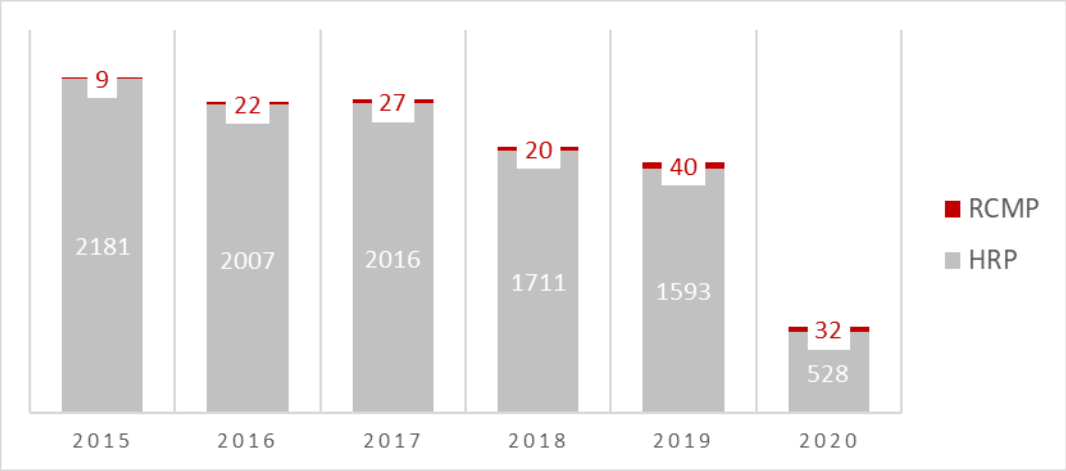

Figure 2: A declining trend of Public Intoxication Intakes to the PCF 2015-2020
Source: HRP and RCMP administrative records

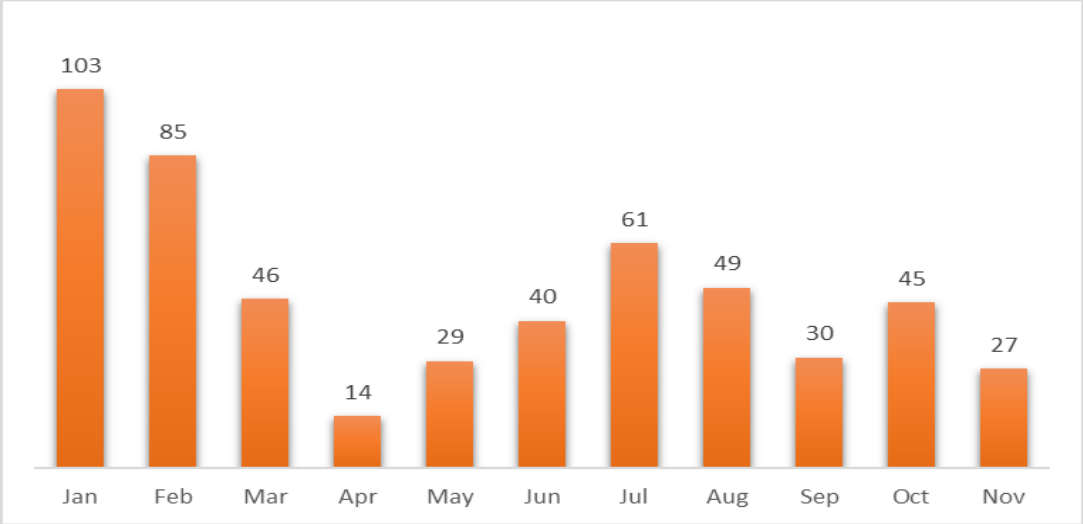

Figure 3: PCF intakes for Public Intoxication in 2020, illustrating a large drop in intakes at the onset of Covid-19
Source: HRP administrative records (excludes RCMP)

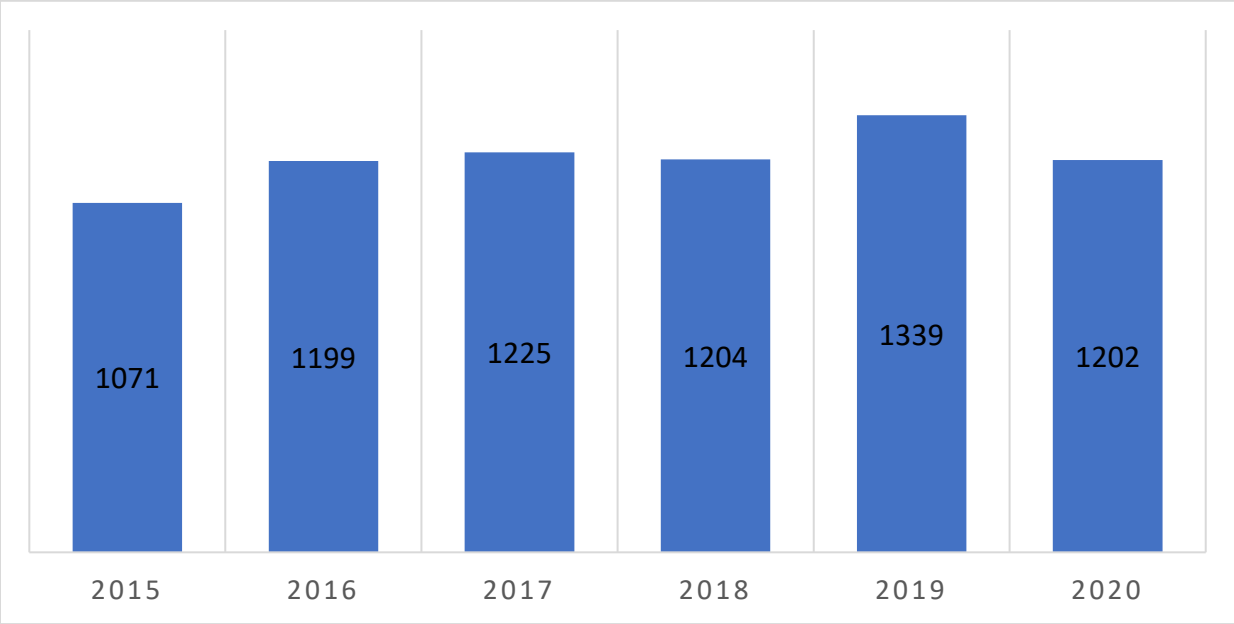

Figure 4: Alcohol-related Emergency Department intakes Visits with alcohol-related discharge diagnosis , four Central Zone hospitals, 2015-2020: includes public intoxication, alcohol withdrawal, alcoholism.
Source: Nova Scotia Health administrative records

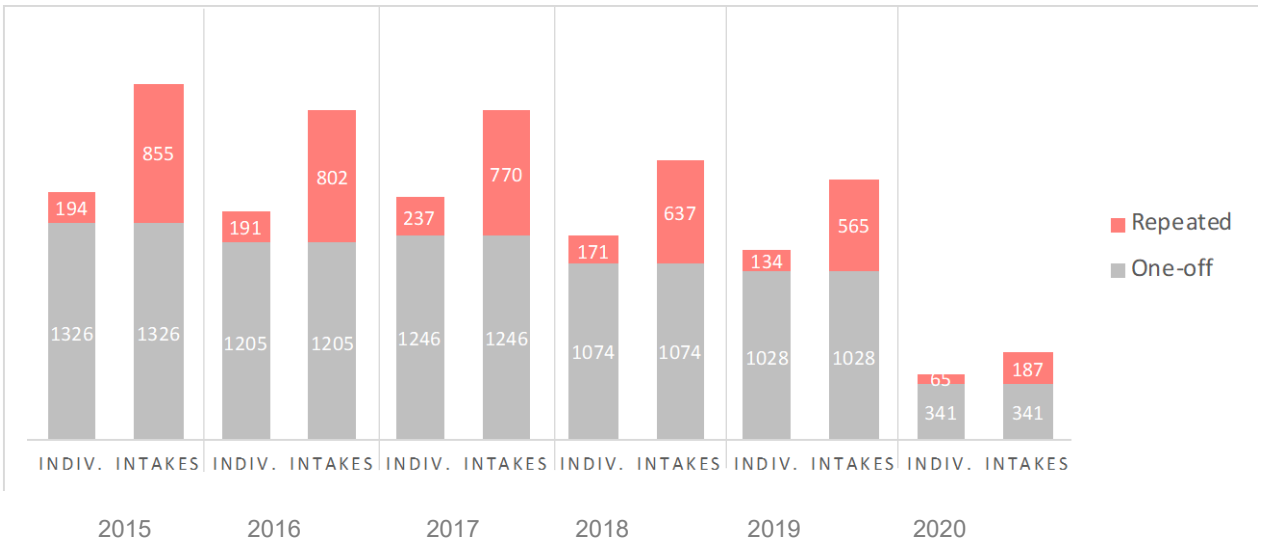

Figure 5: Unique vs Repeat intakes to the PCF: Repeated users form a small share of all individuals but 35-40% of all intakes Source: HRP administrative records (excludes RCMP)

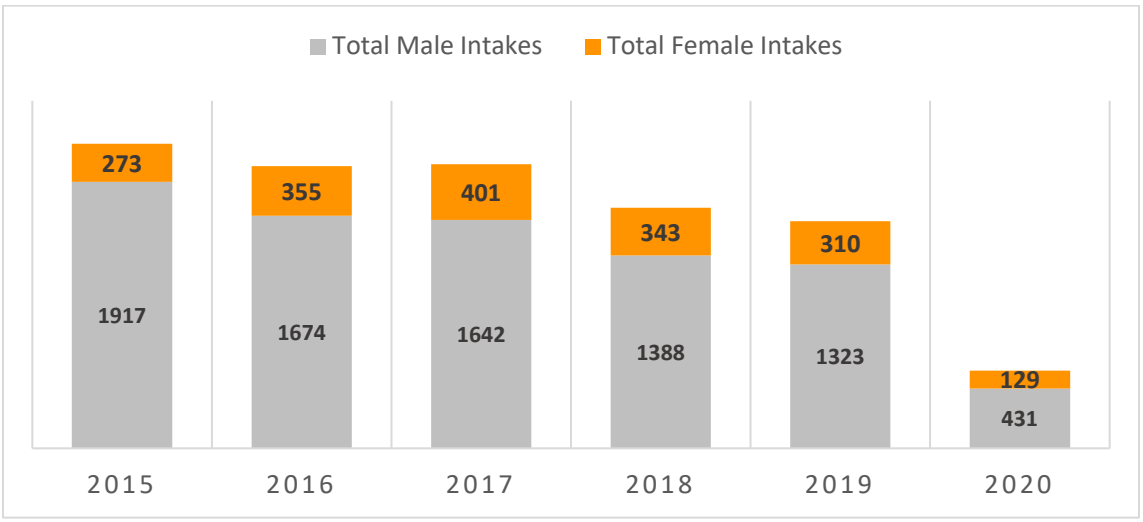

Figure 6: PCF intakes for LCA Section 87 offence, by sex, 2015-2020 illustrates a growing share of female intakes Source: HRP and RCMP administrative data

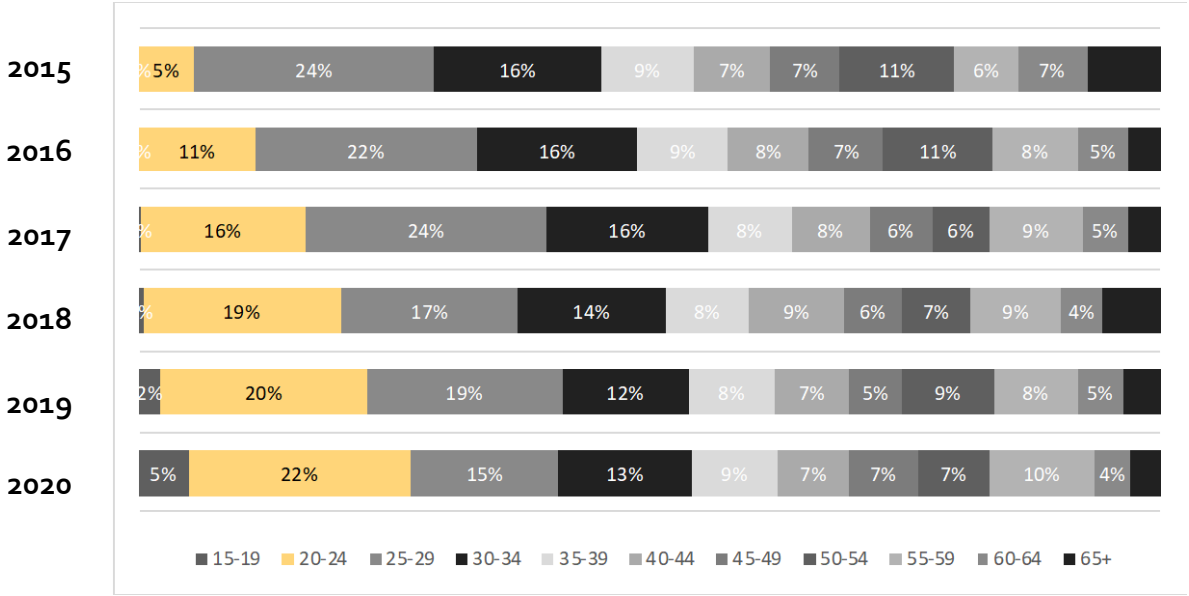

Figure 7: PCF intakes for LCA Section 87 offence, by age range share, 2015-2020. Younger people <24 form a growing share of intakes, ~22% of all intakes in 2019
Source: HRP administrative records (Excludes RCMP)

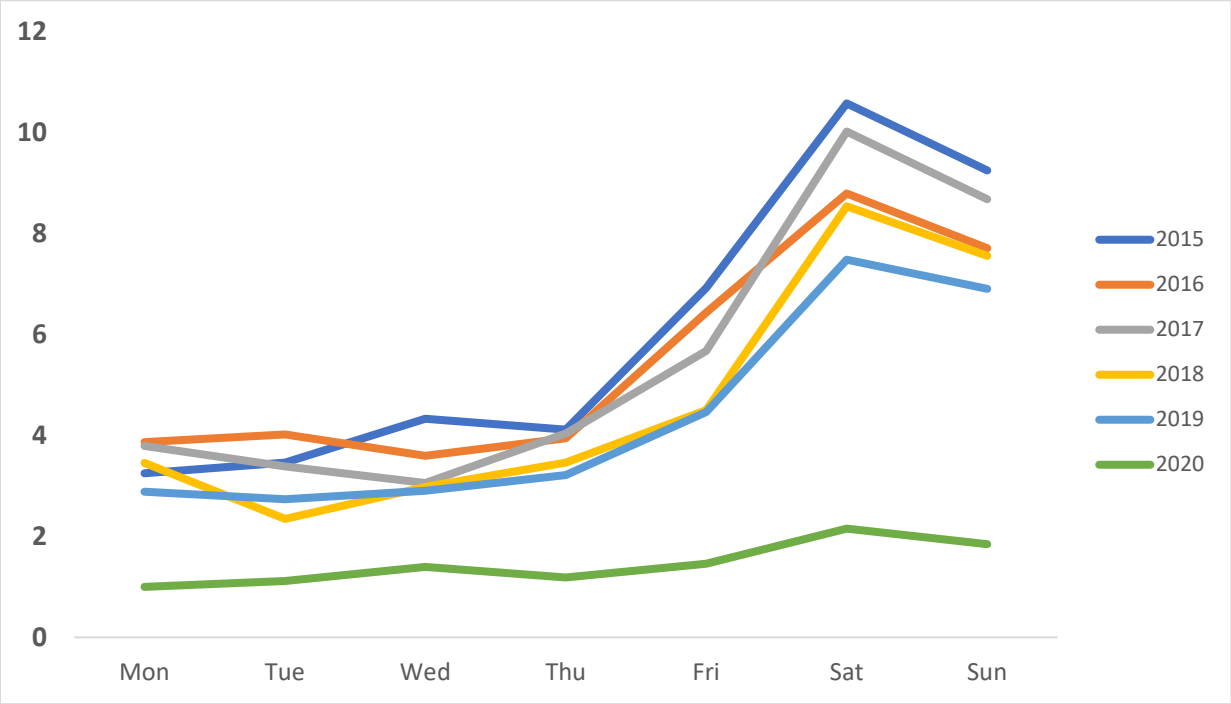

Figure 8: Average number of Intakes to PCF, day of the week
Source: HRP administrative records (RCMP data excluded)

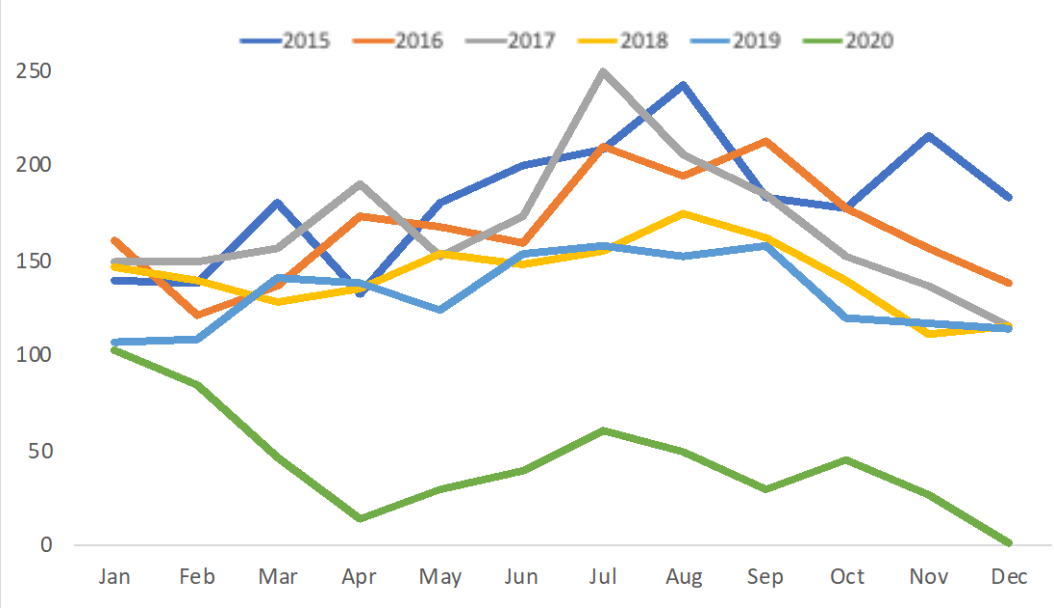

Figure 9:Average number of intakes, by month 2015-2020
Source: HRP administrative records (RCMP excluded)

Year	Date	# of intakes	Day
2015	14 Mar	24	Sat
2015	28 Nov	23	Sat
2015	30 Aug	21	Sun
2015	1 Nov	19	Sun
2015	28 Feb	18	Sat
2016	18 Mar	23	Fri
2016	1 Jan	22	Fri
2016	20 Aug	22	Sat
2016	2 Apr	20	Sat
2016	3 Apr	18	Sun
2017	1 Jan	23	Sun
2017	1 Jul	23	Sat
2017	30 Jul	20	Sun
2017	25 Feb	19	Sat
2017	6 Aug	19	Sun

Year	Date	# of intakes	Day
2018	30 Jun	17	Sat
2018	1 Dec	16	Sat
2018	18 Mar	14	Sun
2018	10 Nov	14	Sat
2018	19 May	13	Sat
2019	14 Sep	16	Sat
2019	17 Mar	14	Sun
2019	7 Apr	14	Sun
2019	26 May	14	Sun
2019	13 Jan	13	Sun
2020	11 Jan	9	Sat
2020	29 Feb	8	Sat
2020	25 Jan	7	Sat
2020	30 Jan	7	Thu
2020	26 Feb	7	Wed

Figure 10: Top five days for PCF intakes yearly 2015-2020
Source: HRP administrative records

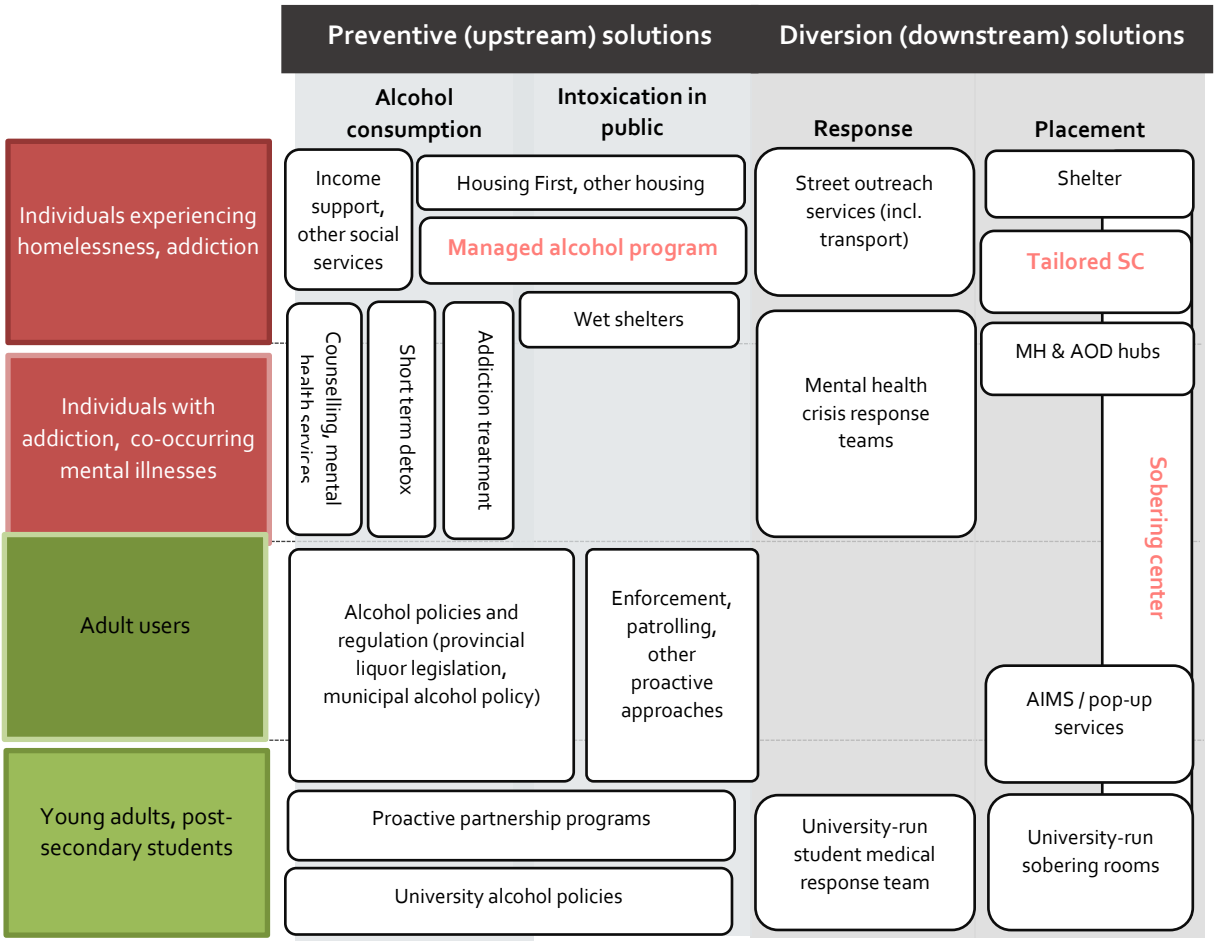

Figure 11: Range of existing and potential prevention and diversion solutions to public intoxication

Adapted from Bedatsova, M. 2021. ***Public intoxication in Halifax Regional Municipality: Alternatives to policing.*** *Policy Analysis Exercise, Harvard Kennedy School Master in Public Policy Candidate 2022, Harvard Kennedy School.*

Managed alcohol programs (MAPs)

The Canadian Institute for Substance Use Research at the University of Victoria runs a national study that is dedicated solely to researching MAPs and provides extensive resources on the topic. Managed alcohol programs (MAPs) are a harm reduction approaches, alternative to abstinence-based approaches, focused on supporting people experiencing chronic homelessness or housing instability and alcohol dependence. The key feature of a MAP is the provision of tailored amounts of alcohol to admitted program participants on a regular, controlled basis. MAPs are commonly implemented in residential settings but can also take on other forms (detailed below).

Purpose: The main goal of managed alcohol programs is to "decrease or prevent alcohol-related harms by reducing heavy episodic drinking, use of non-beverage alcohol, public intoxication, drinking in unsafe settings and high costs associated with police and emergency services while increasing access to primary care and other health and social services".[1] MAPs aim to stabilize clients and help them manage their alcohol consumption, which enables them to take better control of their well-being and address other needs, such as health care and financial stability. MAPs are a tailored intervention to support vulnerable clients for whom abstinence goals are difficult to achieve (and the eligibility criteria to enter the MAP are tailored accordingly). Most of the MAPs can also be thought of as enhanced shelter or housing programs, helping clients obtain or retain housing.

Prevalence: MAPs have originated in and are largely implemented in Canada but other countries such as Australia[2], the US[3] and UK[4] are beginning to investigate or replicate the model. There were at least 23 MAPs operating across Canada as of March 2020[5] and many new MAPs have been stood up as a crisis response during the COVID-19 pandemic[6], including a scattered-site in HRM operated by MOSH (the first MAP in Nova Scotia).

Outcomes and evidence: The available evidence, mostly from the University of Victoria's MAP study, highlights that MAPs are generally successful in achieving the stated outcomes of improving the

[1]Pauly, B., M. Brown, J. Evans, E. Gray, R. Schiff, A. Ivsins, B. Krysowaty, K. Vallance, and T. Stockwell. "'There Is a Place': Impacts of Managed Alcohol Programs for People Experiencing Severe Alcohol Dependence and Homelessness." *Harm Reduction Journal* 16, no. 1 (December 2019): 70. https://doi.org/10.1186/s12954-019-0332-4.

[2]"A Novel Service for Homeless People with Severe and Intractable Alcohol Dependence | NDARC - National Drug and Alcohol Research Centre." Accessed March 29, 2021. https://ndarc.med.unsw.edu.au/blog/novel-service-homeless-people-severe-and-intractable-alcohol-dependence-0

[3] California Health Care Foundation. "Homelessness and COVID-19: Innovation Snapshot — Alcohol Management Program Pilots," n.d., 5.

[4] Carver et al., "Investigating the Need for Alcohol Harm Reduction and Managed Alcohol Programs for People Experiencing Homelessness and Alcohol Use Disorders in Scotland."

[5] University of Victoria, CISUR. "Alcohol Harm Reduction Is Saving Lives - University of Victoria." Accessed March 29, 2021. https://www.uvic.ca/news/topics/2020+covid-managed-alcohol-programs+news

[6] University of Victoria, CISUR, CMAPS. "Overview of Managed Alcohol Program (MAP) Sites in Canada," 2020. https://www.uvic.ca/research/centres/cisur/assets/docs/resource-overview-of-MAP-sites-in-Canada.pdf

physical and mental well-being of participants[7]. The one potentially mixed outcome has to do with how MAPs manage alcohol consumption outside of the program (i.e. what are the rules about consuming alcohol beyond the served amounts and how are these enforced).[8] This can affect the results about the impact of MAPs on overall alcohol consumption (though overall reduction of alcohol consumed is not necessarily one of the explicit goals of the programs). The studies also document the cost-effectiveness of MAPs.[9]

Models of MAPs

CMAPS study identifies three main models of managed alcohol programs:

1) MAPs as enhanced residential / housing programs

In this most frequently employed model, when entering the MAP, participants are also provided housing, either in a shelter setting or as a more long-term oriented supportive housing type. Providing the managed alcohol is a crucial component of these programs that helps the people who may have the most complex combinations of vulnerabilities access and retain housing. The most prominent example is perhaps Ottawa's Shepherds of Good Hope's model of shorter-term shelter service combined with a long-term supportive housing model for people who 'graduate' from the shelter program. While residential MAPs are in many ways similar to the Housing First approach, they provide a distinct service and do not necessarily share all the same features and principles.[10]

2) Non-residential MAPs as stand-alone alcohol-serving programs

These programs are not as common, but the new MAP started in HRM could be classified under this model. In this model, the MAP is not associated with a specific housing program but could instead serve a range of clients in different settings during the day (including people who are unsheltered, or people staying in different housing units, as in the case of HRM). The major goal of this model would be to maintain individual's freedom – which was perceived as a major benefit by people with lived experience of homelessness and AUD (in Vancouver).[11] However, this type of MAP, if provided to people staying on the streets, fails to ensure physical safety and protection from criminalization and victimization – which the affected individuals report to be another crucial need.

3) Hospital-based MAPs

Hospital-based MAPs are also not as frequent a model, but they can provide important support to people who require intensive medical care for other reasons and for whom detoxing from alcohol while

[7] Pauly et al., "Finding Safety"; Pauly et al., "'There Is a Place'"; Stockwell et al., "Does Managing the Consumption of People with Severe Alcohol Dependence Reduce Harm?"

[8] Chow, Clifton et al. 2018. "Counting the Cold Ones: A Comparison of Methods Measuring Total Alcohol Consumption of Managed Alcohol Program Participants: Counting the Cold Ones." *Drug and Alcohol Review* 37: S167–73.

[9] Hammond, Kendall HLTH:EX. "A COST-BENEFIT ANALYSIS OF A CANADIAN MANAGED ALCOHOL PROGRAM." : 24.

[10] Schiff, Rebecca et al. 2019. "Managed Alcohol Programs in the Context of Housing First." *Housing, Care and Support* 22(4): 207–15.

[11] Crabtree, Alexis et al. 2018. "Perceived Harms and Harm Reduction Strategies among People Who Drink Non-Beverage Alcohol: Community-Based Qualitative Research in Vancouver, Canada." *International Journal of Drug Policy* 59: 85–93.

in a hospital may not be optimal. Alcohol is served to patients to prevent or treat symptoms of withdrawal.[12]

Beyond these broad models, MAPs also differ according to several features:

- Number and composition of MAP participants
- Admissions criteria
- The extent of other services provided (e.g. food, case management, health care, counselling, culturally appropriate resources)
- Alcohol administration and sourcing
- Policies and monitoring procedures for consumption outside of the program
- Funding models and contribution requirements
- Explicit program goals (e.g. reduce overall consumption or only reduce non-beverage alcohol consumption)

Examples of MAPs where municipalities play a role:

MAPs are typically run or funded by provincial health authorities but in a limited set of examples, municipal governments have played a funding role. These examples include:

Seaton House Annex Program, Toronto, ON

City population: 2.93M

The MAP has been operated since 1997 within the Annex Harm Reduction Program, which is a satellite program of Seaton House, a shelter for people experiencing homelessness opened in 1931. The MAP serves primarily clients between 30 and 60 years old with severe alcohol use with prescribed alcohol doses between 7.30 am and 11 pm and has a capacity of up to 100 participants. **The program is funded by the City of Toronto,** with contributions from participants for alcohol consumed.[13]

Shepherds of Good Hope MAP, Ottawa, ON

City population: 994,837

The MAP in Ottawa was initially developed in 2001 for a homeless shelter operated by the Shepherds of Good Hope and expanded in 2010 to include a residential housing program The Oaks. The shelter has a 24-bed capacity (8 for males, 4 flex beds for males or females), and up to 4 day-client spaces; the residential program has 55 units in 2 buildings. Residents of both programs are administered hourly doses of alcohol by staff between 7:30 am to 9:30 pm. The goal of the program is to transfer shelter-based MAP participants into the permanent residential housing facility once stabilized. The programs are funded primarily through a partnership with Local Health Integration Network and Inner City Health, residents contribute to the cost of alcohol. **Funds for the purchase of a real estate for the**

[12] Brooks, Hannah L., Shehzad Kassam, Ginetta Salvalaggio, and Elaine Hyshka. 2018. "Implementing Managed Alcohol Programs in Hospital Settings: A Review of Academic and Grey Literature: Managed Alcohol Programs in Hospital." *Drug and Alcohol Review* 37: S145–55.

[13] McMaster Health Forum. 2019. "Rapid Synthesis: Determining the Features of Managed Alcohol Programs.": 32

residential housing program were provided by the City of Ottawa within its Affordable Housing Program, which also continues to provide per diem operating funding.[14]

Kwae Kii Win MAP, Thunder Bay, ON

City population: 110,172

This Managed Alcohol Program has been operating in Thunder Bay's Shelter House since 2012. The program serves clients of all genders out of which 100% identify as Indigenous. Clients are served administered doses of alcohol every 90 minutes between 8 am and 11 pm and are provided supportive housing as part of the program. **Municipal funding from the City of Thunder Bay accounts for ~15% of operating costs,** with federal (HPS) and provincial (Trillium) funding accounting for ~15%, client contributions from social assistance for ~20% and additional federal and provincial grants for remaining ~50%.

[14] University of Victoria, CISUR, CMAPS, "Overview of Managed Alcohol Program (MAP) Sites in Canada"; McMaster Health Forum, "Rapid Synthesis: Determining the Features of Managed Alcohol Programs"; Ontario Non-Profit Housing Association, "The Oaks. Innovations In Housing Stability."

Sobering centers

A sobering center can be broadly characterized as a place where intoxicated individuals can sleep off the effects of intoxication. A study by Warren et al (2016) mapping the sobering centers in the United States defines them as "a facility where actively alcohol-intoxicated clients can safely recover from acute intoxication, including alternatives to jail and emergency departments, as well as drop-in centers. This excludes long-term (>2 nights) housing, medical detoxification, and residential substance use treatment centers….".[15]

Purpose: The main goal of sobering centers is to provide an alternative to jail and/or emergency departments as a place to stay for intoxicated individuals. They often have a dual purpose – to further the health and well-being of intoxicated people by providing a more appropriate destination than police cells and to realize financial savings by diverting individuals away from more costly alternatives[16]. In many cases, the explicit or implicit goal is also to connect individuals to appropriate resources, including detox and treatment and thus function as an important entry point to the system of care.

Prevalence*:* Sobering centers exist across Canada and beyond. At least 35 SCs are currently operating in the US[17], in 14 different states[18]. Many of these sobering centers were created relatively recently, suggesting growing prominence of the model. Sobering centers are also common for example in Australia, where they were created in response to recommendations of the Royal Commission into Aboriginal Deaths in Custody.[19] The State of Victoria's new public health response model to public intoxication is predicated on the creation of sobering centers infrastructure across the state.[20]

There is no comprehensive resource or research project that maps the sobering centers operating in Canada. Building on the 2015 study by Turner, this PAE has identified at least 11 centers (in line with the definition above), operating in larger cities like Calgary, Winnipeg or Saskatoon as well as in smaller communities such as Yellowknife, NWT or Campbell River, BC. Of these SCs, most (at least 7) are located in British Columbia and emerged in response to coroner's inquest into deaths in custody and as part of the provincial government's funding to create 500 substance-use treatment and intervention beds across the province.[21]

Outcomes and evidence: Evidence in the academic literature about the impact of sobering centers is limited, but anecdotal evidence from many program sites shows a significant drop in police intakes

[15] Warren, Otis et al. 2016. "Identification and Practice Patterns of Sobering Centers in the United States." *Journal of Health Care for the Poor and Underserved* 27(4): 1843–57

[16] Turner, Alina. 2015. "Alternatives to Criminalizing Public Intoxication: Case Study of a Sobering Centre in Calgary, AB." *SSRN Electronic Journal*. http://www.ssrn.com/abstract=2627799 (March 22, 2021).

[1717] According to a recently published National Directory of Sobering Centers, compiled by the U.S.-based National Sobering Collaborative
[18] The National Sobering Collaborative, "Directory of Sobering Care Programs in the U.S."

[19] Drug and Alcohol Office, and Government of Western Australia, "Utilisation of Sobering Up Centres, 1990 - 2005."

[20] Victoria to Introduce Sobering-up Centres after Review Finds That Police Should Be the Last Resort." 2020. *the Guardian*. http://www.theguardian.com/australia-news/2020/nov/28/victoria-delays-decriminalising-public-drunkenness-until-2022 (March 20, 2021)

[21] "Additional 500 Substance-Use Treatment Beds Now Open in British Columbia | BC Gov News." 2021. https://news.gov.bc.ca/releases/2017HLTH0079-001046 (February 18, 2021).

after the creation of a sobering center (see for example evidence from Houston[22], Calgary[23] or Yellowknife[24]; however, in some cases, the drop may not be as sizable or sustainable, for example, Saskatoon, partly because of capacity constraints[25]). To the best knowledge of the author, evidence about other objectives of the sobering centers, such as improving the sense of safety and well-being of individuals affected by public intoxication is also limited to an even smaller number of anecdotal examples. In terms of cost savings, there is evidence showing SCs could have a potentially sizable impact on U.S. healthcare costs[26] but this compares SC as a diversion away from the ED (which is a more costly alternative than police cells).

On the flip side, concerns about safety and neighborhood disturbance around the location of the sobering center have been raised in some cases[27]. Moreover, incidents that could pose safety risks and require police intervention occasionally arise in the SCs. For most SCs investigated for this report, no major instances of harm have been noted, but recently published evidence from Portland, Oregon raises concerns. According to whistleblower's account, instances of serious harm and injury occurred repeatedly in the sobering center in Portland.[28]This highlights the need for careful implementation of the sobering center, including appropriate triage at intake, presence of trained medical staff on-site and rigorous governance and oversight mechanism.

Models: Marshall et al. (2020) conduct literature review on sobering centers and conclude that they 'vary greatly by practices, capacity, staff, and available resources'.[29] Broadly, there are two models:

<u>1) Sobering centers as centralized, universal alternatives to police cells and/or ED:</u>

The purpose of this type of sobering center is to provide a well-resourced alternative destination for intoxicated individuals that may divert vast majority of cases away from jails or emergency departments. The center thus serves a range of clients, including 'one-offs' as well as 'repeats'. The main purpose is to provide the necessary care and monitoring in a more friendly environment than police cells and in many locations, also to avoid having to charge people with an offence or a crime. Cost savings are frequently major part of the rationale, especially if created as alternative to ED which is extremely costly. Operationally, this type of sobering center was found in larger, urban areas where the demand and number of clients is higher. Medical personnel is generally part of the staff and in some

[22] Jarvis, Suzanne V. et al. 2019. "Public Intoxication: Sobering Centers as an Alternative to Incarceration, Houston, 2010–2017." *American Journal of Public Health* 109(4): 597–99.

[23] Turner, "Alternatives to Criminalizing Public Intoxication."

[24] Northwest Territories Health and Social Services Authority, "The Day and Sobering Centre; Update - Yellowknife City Council."

[25] Northwest Territories Health and Social Services Authority. 2019. *The Day and Sobering Centre; Update - Yellowknife City Council*.

[26] Scheuter et al., "Cost Impact of Sobering Centers on National Health Care Spending in the United States."

[27]Gabriela Panza-Beltrandi. 2021. "Here's How One Sobering Centre Works with Its Neighbours, Community | CBC News." https://www.cbc.ca/news/canada/north/sobering-centre-calgary-yellowknife-neighbours-1.5132238 (April 6, 2021).

[28] Maxine Bernstein, "Whistleblower Reveals Serious Injuries, Lax Oversight at Central City Concern's Sobering Station."

Pauly et al., "Finding Safety"; University of Victoria, CISUR, CMAPS, "Overview of Managed Alcohol Program (MAP) Sites in Canada"; McMaster Health Forum, "Rapid Synthesis: Determining the Features of Managed Alcohol Programs."[29] Marshall, McGlynn, and King, "Sobering Centers, Emergency Medical Services, and Emergency Departments," 38.

cases, police officer may be present on site as well or other safety measures taken (such as detaining individuals in locked rooms rather than large open areas with mats).

Based on the information uncovered in this research, this model is rare in Canada[30]. The most prominent example is the Protective Care facility in Winnipeg, although that facility has also been perceived as inadequate by some community members and criticized for essentially being an equivalent of police 'drunk tank' (and in Winnipeg, discussions about alternatives are ongoing).[31] However, the model seems to be more common in the U.S. in cities like Houston, Austin or Tulsa. These SCs are funded by the municipal governments, although it is important to note the different jurisdictional contexts.

2) Sobering centers linked to the homeless system of care:

The purpose of these sobering centers is to provide additional service on the continuity of care spectrum for individuals experiencing homelessness and AUD or other addiction. Typically, the SC fills the gap between a shelter and emergency departments (as some individuals may not be able to stay in the shelter but also do not require ED-level of care) or as more humane alternative to police cells for individuals unable to stay in shelters because of behavioral concerns or when staying unsheltered and police is called to respond. In practice, these sobering centers may also become a de-facto shelter, providing a place to stay on almost daily basis for a group of 'core' clients, especially in areas with insufficient shelter capacity. In this type of SC, the ratio of intakes per individual is typically very high.

Operationally, such sobering centers are often run by existing community organizations providing homeless or addiction services and funded through government grants, typically provided by local health authorities. The facility may be physically co-located with a shelter, detox, temporary housing or other services provided by the NGOs and offer counselling, case management or access to facilities such as laundry machines. The staff may or may not include health care workers (some centers are only staffed by social workers).

This model is more common among the Canadian SCs that were identified in the research. Examples include the Sobering and Assessment Center in Campbell River, Alpha House in Calgary, Combined Day Shelter and Sobering Centre in Yellowknife or Lighthouse Stabilization Unit in Saskatoon.

Beyond these two broad characterizations, these are the other key features that may differ across jurisdictions:

- The referral policy – how can individuals access the SC, particularly if walk-ins / self-referrals are allowed and if the SC is connected to an outreach and transport service
- Whether the stay must be voluntary
- The extent of supportive services provided (e.g. case management, health care, addiction services, peer support)
- The type of drug allowed (mainly alcohol vs. other drugs as well)

[30] Information about Canadian SCs was collected on case-by-case basis: interviews with 5 SCs, evaluation reports of 2 SCs (Calgary Alpha House and Yellowknife) and review of website, newspaper articles and other informal sources for the remaining SCs.

[31] Laura Glowacki. 2017a. "No More Drunk Tank: Community Leader Seeks New Approach to Public Intoxication | CBC News." *CBC*. https://www.cbc.ca/news/canada/manitoba/holistic-approach-intoxication-winnipeg-1.4110031 (February 12, 2021).

- Triage, intake and assessment process and criteria
- Sleeping arrangement (bed vs. mats, female vs. male areas etc.)

What the vast majority of sites have in common is 24/7 opening hours, the need to be intoxicated to enter, no use allowed while on site and the acceptance of clients referred by the police (although the share of clients that are brought in by police differs substantially across sites, especially depending on whether the site accepts walk-ins).

Examples of SCs, incl. role of municipalities: In Canada, it is more common for health authorities to oversee and fund sobering centers but in some cases municipalities also play a role, providing the sobering center's funding. In the United States, City governments play a leading role much more frequently. Examples of the SC models where municipalities play a role include:

Main Street Project's Protective Care facility in Winnipeg, MB

City population: 705,223

Winnipeg has one sobering center – 20-bed Protective Care facility run by non-profit Main Street Project where intoxicated people are taken by the police. **Operations of this facility (except the paramedics permanently stationed on the site) are funded from Winnipeg Police Services grant of ~$700k**[32] (even though the expenses in fiscal year ending March 2020 were in fact almost ~$100k higher, leading to funding deficit which has been an ongoing issue[33]). It is also worth noting that while the funding is allocated by Winnipeg, it comes from a funding pool provided by the Provincial government to deliver services, such as public safety.

Transitional Emergency Shelter Program (TESP) in Ottawa, ON

City population: 934,243

TESP is a program run by the non-profit organizations Shepherds of Good Hope and Ottawa Inner City Health that 'provides specialized supports for chronically homeless individuals who have trauma, physical and/or mental health challenges, and/or addiction issues' (thus, it has other functions beyond the sobering center). According to financial reports, **City of Ottawa funds TESP through a municipal grant, to the amount of ~$800,000 - 900,000 per year**.[34]

The Sobering Center serving Austin and Travis County in Austin, Texas, USA

City population: 950,807

In 2017, the city and county created a nonprofit organization, Austin Travis County Sobriety Center Limited Government Corporation, with board members to oversee the operation of the sobriety center. The center has 24-bed capacity pre-COVID and appr. 25 full-time staff members. City of Austin

[32] Booke & Partners. 2020. "Main Street Project, Inc. Financial Statements; March 31, 2020." http://www.manitoba.mb.ca/asset_library/en/finances/pchs/main_street_project_inc.pdf (April 6, 2021)

[33] "Winnipeg Shelter to Close Intoxicated Persons Unit during Day without Funding Boost." 2021. https://ca.news.yahoo.com/winnipeg-shelter-close-intoxicated-persons-194443074.html (February 23, 2021).

[34] Welch LLP. 2020. *Financial Statements for Shepherds of Good Hope*. https://www.sghottawa.com/wp-content/uploads/2020/07/Shepherds-of-Good-Hope-fs20-Signed.pdf (April 6, 2021).

provides grant funding for the operations of the center and Travis County provides the building space (and covered initial refurbishment costs). **City government, through its Public Health department, provides majority of the funding to cover the center's ~$1.8M expenses**.[35]

San Francisco

City population: 874,961

San Francisco Sobering Center is a collaborative program created by the City's Department of Public Health in collaboration with the non-profit Community Awareness and Treatment Services (CATS) and other community partners. It is a 12-bed facility focused on serving people who are alcohol-dependent and experiencing homelessness, with **City and County of San Francisco providing financial support through the General Fund**[36].

[35] Huber, Mary. 2021. "A Year after Launch, Austin's Sobering Center Sees Positive Results — but Also Turbulence." *Austin American-Statesman*. https://www.statesman.com/news/20191101/year-after-launch-austins-sobering-center-sees-positive-results---but-also-turbulence (March 23, 2021)

[36] Smith-Bernardin, Shannon, Adam Carrico, Wendy Max, and Susan Chapman. 2017. "Utilization of a Sobering Center for Acute Alcohol Intoxication" ed. Kennon J. Heard. *Academic Emergency Medicine* 24(9): 1060–71

Adapted from Bedatsova, M. 2021. ***Public intoxication in Halifax Regional Municipality: Alternatives to policing.*** *Policy Analysis Exercise, Harvard Kennedy School Master in Public Policy Candidate 2022, Harvard Kennedy School.*

Managed alcohol programs and two types of sobering centers (universal and tailored) were evaluated along three broad criteria:

- value or usefulness of the solution (including in terms of impact on intakes to Prisoner Care Facility, well-being of the people, public safety and use of resources);
- operational feasibility or realizability of the solution (in terms of financial costs, logistics, other pragmatic constraints); and
- overall level of support for the solution among key stakeholders.

The symbols  the evaluation score based on each three above criteria, capturing the overall attractiveness along that criterion. Fuller circles represent better ratings in terms of higher value, better feasibility, or higher level of support for the solution.

Managed Alcohol Programs (MAPs)

A MAP in Halifax is presently supported by the provincial government together with MOSH, the organization operating the MAP). This section focuses on a broader assessment of MAPs as a solution to public intoxication in HRM.

In terms of key **features,** the most promising model is the residential model, particularly combination of the short-term transitional housing program with a longer-term supportive housing program to which participants can graduate.

Evaluation

Value of the solution

Incorporating a MAP into the range of services will better support people experiencing homelessness and severe alcohol dependence who may be underserved by the current system. MAPs would help **improve health and well-being** of these individuals

- Residential MAPs would also **help house part of the population currently staying unsheltered** and thus contribute to addressing the growing issue of homelessness in HRM
- By helping to stabilize its clients, MAPs could have a **sizable impact on the number of police interactions and PCF intakes** for public intoxication, as well as other situations that may prompt police interaction such as panhandling (access to more detailed data about PCF intakes by repeated users would be helpful to estimate the size of potential diversion).
- The reduced pressure on services could also generate **cost savings** for HRM (particularly in terms of freeing up HRP resources) as well as the province (by reducing the need for intoxication related ED visits and potentially costs associated with courts)

Operational feasibility

MAPs can operate at a small scale (4-10 participants), in conjunction with existing services, which makes them more easily adjustable and scalable. This means in HRM, they could be provided **by different organizations across different sites**

- However, the research has shown that **municipal governments in Canada typically do not play a significant role in creating, administering or operating MAPs**, given their characterization as addiction-related harm reduction programs. The pilot scattered-site MAP run by MOSH is presently being funded by the Department of Health and Wellness.

Stakeholder support

A range of stakeholders expressed support for MAPs. MAPs are seen as a vital program among providers working with target population; police officers also commented on its usefulness and the role the new MAP has likely played in reducing incidents police respond to

- Although MAPs have initially been controversial and public opinion on them may vary, there has **not been instances of significant public pushback** encountered in this research in connection to MAPs operation, whether in HRM or other jurisdictions

Universal sobering center

Evaluation

Public value

The main benefit of any type of sobering center is provision of **more suitable, humane and *potentially* more cost-effective alternative** to PCF (especially for cases diverted from ED and over longer term). In some circumstances, SC can also be a better suited alternative compared to ED, as intoxicated patients are provided with more tailored care and frequent monitoring than may be possible in a busy emergency department. The longer-term cost savings may also potentially accrue if SC successfully helps to stabilize the clients with complex needs and connect them to resources, thus reducing public intoxication and demand for emergency response services

+ Presence of medical staff on site ensures adequate care is provided and **minimizes risk of harm** from medically related conditions that may not be caught by officers in PCF not trained to provide that level of care
+ Having a SC *could* potentially also **prevent escalations** that may arise when intoxicated person learns they are being taken to jail[1]
+ SC would have a crucial role to play in **connecting people to services**
+ Sobering center hand-off process should be designed to enable officers to return to duty efficiently. Having one universal, well-planned out SC where all eligible individuals can go makes this process easier
+ Universal model ensures that **everyone** who needs a place to sleep and is appropriate candidate **can access the service**. In tailored model, people are more likely to fall through the cracks (also, distinction between groups may be blurred and unhelpful in some cases)
- Key concern is that building this type of SC would require significant public investment and it is not clear if it generates the **value for money**, particularly if other preventive measures will already be taken. Question of eligibility is crucial - police officers state that many of the individuals currently taken to PCF for PI would not be suitable for SC due to risk of violence; and those who do not pose risk are better served by being transported home. This leaves relatively

[1] This has been highlighted as a potential benefit by a number of stakeholders but has not been investigated in academic literature about sobering centers

small subset of eligible clients (non-violent clients with no other place to stay and no acute medical concern) – who may be better served by tailored model.

- This model also **loses some of the benefits of specialization** possible with the tailored model (e.g. for homeless population, SC can be collocated with shelter or other services that make it easier for most vulnerable people to access)
- There are also questions about **appropriateness of combining different populations** with different needs and behaviors in one facility; particularly since this model has not been proven across Canada
- Concerns that sobering center **may encourage more alcohol consumption** have been expressed (either because the deterrence effect of staying in jail is removed, or people may be incentivized to drink more to gain access to the SC) but there is no evidence in literature that would either support or reject this claim
- It is possible that this model could also present **safety risks** relative to PCF if individuals become agitated and violent and police is not immediately present on site to respond. It should be expected that police will be called to assist occasionally, either in case a person wants to leave the SC but staff do not consider it safe for them or if incidents of violence arise. Continually improving triage can reduce these concerns.
- Depending on the location and features of the SC, concerns about public safety in the neighborhood areas related to congregation of intoxicated people have also been raised in other locations.

Operational feasibility

Fluctuating nature of public intoxication incidents in Halifax could pose operational problems, as the center may get **overwhelmed at peak weekend times** and remain mostly vacant for other parts of the week. This means flexible and unusual staff times may be have to be filled, which could complicate hiring and the cyclical pattern could create other logistical challenges

- **Finding organization suitable to run** this type of SC may prove difficult as broad range of expertise (combining heath care, addiction services and social work) is required. If HRM was to take on the creation of the center directly, it would require substantial new capacity and potentially complex network of partnerships to deliver different aspects of the service. Reliance on other stakeholders increases complexity of the undertaking
- **Finding appropriate facility** that meets the requirements (in terms of size, accessibility, geographical location) may also pose a challenge
- Depending on the availability of facilities, substantial **financial upfront investment** may be needed to develop or refurbish building for the new SC. Moreover, sustaining operating budget of the new SC would likely also mean net increase of costs (i.e. SC costs would not be fully offset by savings in other parts of HRM budget). This means HRM would have to find **additional funding in its budget** to dedicate to SC.
- Developing appropriate and clear referral, hand-off and triage protocols (and ensuring they meet existing legislative requirements) is a complex process that could pose barriers to implementation. **Liability concerns and confusion about procedures** could also create tension between SC staff, police, EHS and other agencies and hinder SC's operations
- Linked to this point, success of the SC hinges on **close collaboration and trust** between different organization, which takes time and practice to build
- **Substantial planning and preparation work** would be needed to get the center up & running
- Overall, it is a big undertaking which may be difficult to adapt to changing circumstances. Lack of proven models from Canada poses additional uncertainty and risks

Stakeholder support

Generally, stakeholders were not sure about the suitability of combining different populations in one center; more support for tailored SC expressed

- Universal SC also represents a more radical shift from current police practices, which might be met with more concerns and reservations
- Citizens may have mixed views about the funding requirements and impact on municipal budget. Further consultation of stakeholders, including public, would help ascertain overall level of support

Tailored sobering center (focused on complex needs group)

This type of sobering center would share many of the features, benefits and challenges of the universal SC so this assessment will focus on the differences and contrast between the two models. Compared to the universal model described above, the SC tailored to people experiencing homelessness and/or other complex needs groups may have the following features:

- **Smaller size,** around 10-15 beds; also open 24/7
- Similar staffing model but placing bigger focus on the case management component. Moreover, the medical staff would be more directly prepared to assist with withdrawal management and attend to range of health care needs, such as minor injuries
- Key proposed difference would be **broader range of services** offered in this tailored SC. The specific service model should be designed by working group of stakeholders but could include: basic health care services, separate area with beds to provide supervised medical withdrawal and intensive case management services, incl. referrals to detox, housing etc.
- Level of care, referral policy and hand-off process similar to the ones described above
- **Located in an existing facility,** such as homeless shelter. New Metro Turning Point building could be the best candidate
- Center should be **community-based**—relationships, cultural competencies, and expertise are essential for success. HRM would support as a funding partner, other levels of government should fund medical staff costs

Evaluation

Public value

Service **tailored to the most vulnerable groups** of people who have addiction. Although HRM already has shelters that accept intoxicated individuals-- SC would divert those going to PCF (when possible)

+ The possibility to **connect the centre with other needed services,** especially medical detox, would provide additional value and ensure more comprehensive level of support. Compared to the jail model, SC would enable people to address underlying needs and help stop the continued cycling through the system
+ The SC would also **help address the recent rise in homelessness** by providing additional shelter space and connecting people to longer-term resources (incl. MAP and housing)
+ The stable pattern of alcohol consumption among this population would ensure **better utilization of resources**

+ Given the substantial overrepresentation of Indigenous and African Nova Scotian population among people experiencing homelessness, the sobering center would also be an important **social justice** policy
+ Additional benefits outlined above (incl. more humane response, reduced risk of harm and potential freeing of police resources) still apply in this case
- **Key disadvantage is that this model would have significantly lower impact on the number of intakes into the Prisoner Care Facility,** but would reduce the number of repeat clients
- Concerns about unintended consequences of encouraging alcohol consumption and safety and public safety in the SC's surrounding area also remain and should be mitigated
  - Unknown how potential expansion of MAPs and other preventive measures may affect the required capacity of a SC. If a share of people currently experiencing absolute homelessness could instead be served by MAP or enter detox, that would be a positive outcome that would reduce the need for creating a new SC

Operational feasibility

Easier to secure logistically – there are clear candidates to run the center in HRM and potential locations available

- **Less costly** option overall, as the upfront investment and the ongoing operating costs would likely be lower due to possibility to use existing space and lower bed capacity of the center
- More flexible model that does not require as much upfront planning and investment and can be **adjusted more easily** to respond to the current needs and changing circumstances
- Procedural and **liability concerns also likely to be less significant** as police officers may already use the practice of driving people experiencing homelessness into local shelters for assistance in case of low levels of intoxication; this model would provide a dedicated place to stay for intoxicated individuals who do not pose safety risk but need more intensive care and monitoring due to higher level of intoxication (and potentially other needs)

Stakeholder support

Stakeholders working with the affected population see SC as valuable service; potentially also higher support among officers due to less radical change of practices and in public due to being a more targeted interventions that helps address homelessness and complex needs group

ATTACHMENT D: External stakeholder and Community Consultation
September 2020-March 2021

Category	Organization	Focus
Halifax context	NECHC/MOSH	needs of patients with mental health, addictions, homelessness, experience with MAP stood up for covid, interest in partnerships
Halifax context	Hospital Emergency Departments HRM	ED perspective - alcohol intoxication visits
Halifax context	members of Overdose Prevention Site Community Advisory Committee	review of harm reduction approaches, needs and gaps in service, feasibility of SC/MAP, potential for co-location of harm reduction services
Halifax context	Shelter Nova Scotia	homelessness and alcohol misuse, needs assessment
Halifax context	People's Clinic	ANS experience with addictions, lived experience, gaps in service, cultural compentency
Halifax context	Doctors Nova Scotia and Efry Society	support, partnerships resourcing from DNS, needs and gaps for HR services
Halifax context	Mik'maw Indigenous Friendshp Centre	Indigenous experience with addictions, cultural competency, decolonized approaches, harm reduction services existing, gaps in service
Halifax context	Street Navigator	Needs of the people experiencing homelessness, alcohol use
Halifax context	MOSH	Discussion about their MAP, outcomes, lessons learnt; other needs of the population, potential for other MAPs
Halifax context	Shelter Nova Scotia	Discussion about the needs of the people experiencing homelessness, gaps in service, interaction with police etc.
Halifax context	Salvation Army Centre of Hope	Needs of people who are homeless, interaction with police, Anchorage Program, their shelter
Halifax context	AHANS	Homelessness in HRM, link to addictions (how many people who don't have stable housing because of alcohol could be helped by a residential MAP) *Note: Jim recommended we talk to EJ from MOSH and Melissa at Shelter NS*

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Halifax context	Dalhousie University research	Dalhousie feasibility research: costs of healthcare, social, police and justice services among chronically homeless men and alcohol use disorder; qualitative data collection from potential MAP participants. Study is ongoing (completed interviews and got data from NSHA, other data still to be collected)
Halifax context	MOSH Housing First	HRM context, HF clients
Halifax context	Hospital Emergency Departments	ED perspective - alcohol intoxication visits
Halifax context	Dalhousie health promoters	Dalhousie alcohol harm reduction framework + views on sobering center
Halifax context	Dalhousie campus security	Dalhousie experience with students alcohol consumption, sobering center, cooperation with HRP
Provincial context	NSHA - harm reduction	harm reduction; Central Zone, public health
Provincial context	Department of Health and Wellness	Provincial approach, interest, experience with MAP
Provincial context	Mental Health and Addictions	alcohol policy HRM, harm reduction, gaps and needs for service; Central Zone, public health
Provincial context	Department of Justice	Sobering centres
Other cities / programs	City of Thunder Bay, Drug Strategy Coordinator	Sobering Centres (4) and MAP, experiences with programs in Tbay, support from city (financial, in kind), role of drug strategy in mobilizing stakeholder support and collaboration among sectors
Other cities / programs	Calgary, DOAP / Alpha House	Questions about DOAP + Calgary's mental health and addictions strategy
Other cities / programs	Cambridge Police Department, MA, USA	General approach to public intoxication in Cambridge; role of social workers in Cambridge Police
Other cities / programs	Retired deputy chief of Winnipeg Police,	Police persepctives of Sobering Centre (Intoxicated Persons Detention Centre); Winnipeg Alliance - collective impact approach to public intoxication

ATTACHMENT D: External stakeholder and Community Consultation
September 2020-March 2021

Other cities / programs	Winnipeg Downtown Community Safety Partnership	Downtown Community Safety Partnership - extended from the work of Alliance (collective impact approach to public intoxication); patrolling and transport service, focused on providing assistance, diverting social calls away from the police
Other cities / programs	Kenora Morningstar Centre	MAPs general information
Other sobering centres	Campbell River Sobering and Assessment Centre, run by Vancouver Island Mental Health Society	Standard questions about their SC, their experience (Campbell River model mentioned in Council request)
Other sobering centres	Quibble Creek Sobering and Assessment Centre (SAC), Surrey, BC	Standard questions about SC, their experience (responded to the CMNCP Information Request, additional details about the center in the document)
Other sobering centres	Main Street Project's IDPA (Intoxicated Person's Detention Area), Winnipeg, MB	Sobering Centre- Main Street Project also provides a range of other addiction services (incl. detox)
Other sobering centres	Duncan / Cowichan SC	Sobering centres
Other sobering centres	Nanaimo SC (Crescent House)	Sobering centres
Other sobering centres (uni)	Queen's University (Campus Observation Room - COR)	Sobering centres - University run
Other sobering centres (uni)	University of Guelph (CARR - Campus Alcohol Recovery Room)	Sobering centres- University run
Other sobering centres (uni)	University of Calgary (PASS - post-alcohol support space)	Sobering centres- University run