

ALTERNATIVES TO CRIMINALIZING PUBLIC INTOXICATION: CASE STUDY OF A SOBERING CENTRE IN CALGARY, AB

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SUMMARY

Western society has for centuries treated public intoxication as a crime, based on the idea that those found drunk in public can be harmful – to themselves, to the people around them, and to the social values of the community. To this day, public intoxication is in many places still a criminal offence, including in Canada.

But what happens when, instead of approaching public drunkenness as a crime, we think of it as a symptom of larger problems? And what if, instead of routinely arresting those found drunk in public, we gave them a place to sober up, where they also have the opportunity to get help for other issues that may be contributing to the situation that put them there in the first place? As it turns out, this approach may provide a greater reduction in possible harm to the individual, others around him or her, and the broader community.

In Calgary, Alpha House's sobering centre facility takes this approach, welcoming clients who are not eligible for shelter in other, 'dry' facilities. Through its Downtown Outreach Addiction Partnership (DOAP), Alpha House actively works to divert publicly intoxicated people from law-enforcement responses by bringing them into the shelter, or finding other alternatives to incarceration. Once clients have been taken into Alpha House, workers are available and motivated to help clients address any addiction or mental-health issues they might be struggling with and, if appropriate, to assist them in finding secure housing.

During a twelve-month assessment period, the results of Alpha House's approach appears to be having a dramatic effect in helping those who have turned up publicly intoxicated, with apparent benefits for the community. During the period measured, there was a 50.1 per cent annualized decrease in the average number of days that clients were hospitalized, compared to the 12-month average prior to their intake into facility programs. There was a 62.6 per cent decrease in the number of times clients were hospitalized, a 50 per cent decrease in the use of emergency medical services, and a 42.4 per cent decrease in the number of times using an emergency room.

Most dramatically the study observed a 92.7 per cent decrease in the average number of days clients spent in jail compared to the year prior, and a 70.8 per cent decrease in the number of interactions with police. The number of times clients went to jail actually increased by 26.6 per cent, but that may have to do with Alpha House's staff encouraging clients to address outstanding warrants and charges during their program participation. Calgary Police Services, meanwhile, reports notable decreases in people being processed for public intoxication in its downtown unit facilitated by partnership with community-based organizations, such as Alpha House.

This is the crux of the harm-reduction approach: that holding cells should be a last resort for those publicly intoxicated people who cannot safely or effectively be helped through a sobering centre. But for those who are suitable for Alpha House's program, the effects appear to be highly encouraging, providing an option to divert people facing the difficult personal circumstances that might cause them to be publicly intoxicated, into a program where they can access medical support, addiction and recovery programs. We may never eliminate public intoxication, but if our goal in criminalizing it has been to reduce harm to the individual and those around him or her, the sobering-centre approach appears to provide a much more effective response.

Sobering centres will not and should not replace the need for medical intervention in some cases. They cannot replace the need for police custody as some clients cannot be safely assisted in such facilities. This means that the triage into sobering centres, health system and police custody will continue to be needed. Ultimately, a comprehensive approach to intoxication is necessary, one including sobering facilities along with a continuum of housing, health, and corrections responses that challenges the criminalization of addiction.

INTRODUCTION

Sobering centres provide a safe place for those under the influence of drugs and/or alcohol to sober up as a more effective alternative to police responses to public intoxication. Evidence suggests sobering centres are cost efficient and reduce emergency health services and police use; they can be important facilitators for vulnerable clients to connect to treatment and long-term housing. Such services can be effective vehicles for improving individual and community health and well-being as part of a set of comprehensive responses to intoxication.

In Calgary, Alpha House's sobering centre facility is an apt example of an effort to manage public intoxication more effectively. The Alpha House sobering centre operates as part of a continuum of services, including mobile outreach, detox and Housing First programs. Administrative data collected by Alpha House from its sobering centre, mobile outreach and four Housing First programs suggest considerable positive impact on client well-being as well as broader public-system utilization, particularly with respect to diverting costlier police and medical system responses to public intoxication.

Alpha House's target population consists of vulnerable persons with active addictions, often co-occurring with mental-health and physical-health conditions, long-term homelessness and poverty, as well as high interactions with public systems, particularly justice and health. This population is largely homeless, and often utilizes emergency shelters or sleeps rough in Calgary's downtown area. This visibility makes this population a concern from the public (and/or community) perspective as well.

Alpha's sobering centre model — which echoes findings from available international evidence on similar operations — suggests that a client-driven, harm-reduction approach offers promising results for long-term housing stability and public-system use.

The Alpha House case study provides an apt example of an approach that meets the needs of diverse policy and practice stakeholders to inform such discussions on dealing with a complex, vulnerable population. Evidence suggests the model presents clients with positive short- and long-term benefits, and notable reductions in the need for emergency medical and police responses.

The case study findings suggest that a client-focused, harm-reduction approach, which includes access to housing and treatment options, can have a marked positive impact on clients and the broader community, lessening the demand on police and emergency health responses.

The case study also suggests that while sobering centres are an effective approach to addressing public intoxication in the short term, a comprehensive approach to addiction and homelessness is nevertheless needed; such a response includes sobering facilities, along with a continuum of housing, health, and corrections responses, and challenges the criminalization of addiction.

This paper will begin with a review of the literature on sobering centres to contextualize current debates regarding sobering centres relevant to the Alpha House case study. It will then present findings from the Alpha House administrative data analysis, and discuss implications for policy and practice moving forward. The aim of the literature review discussion is to outline the basic tenets of sobering centres, their evolution, and evidence of impact, to inform ongoing debates with international findings on the issue.

Alpha House is one of several Canadian examples of sobering centres available.¹ What makes this case study particularly important is the availability of real-time data from the Homelessness Management

¹ There are sobering centre facilities in Toronto (Seaton House), Winnipeg (Main Street Project), Saskatoon (Lighthouse Stabilization Unit), Victoria (The Sobering and Assessment Centre), Surrey (Quibble Creek Sobering and Assessment Centre), Inuvik (Inuvik Wet Shelter), Edmonton (George Spady Centre), and Ottawa (Ottawa Inner City Health), for example – though no comprehensive listing was found across Canada at this time.

Information System (HMIS) used across the agency’s operations. The HMIS data provide an opportunity to longitudinally gauge trends across programs in the agency to assess impact, and reflect on implications for policy and practice.

EARLY BEGINNINGS: INTOXICATION AS A DISEASE AND AS CRIME

Sobering centres have a long history of operation, with some of the earliest examples recorded in Russia during the early 1900s. Other examples include “catch stations” in the former Czechoslovakia and drop-in centres in Denmark and Switzerland.² The motivation behind these attempts often centred on a longstanding concern with public intoxication.

There is evidence that the act of public intoxication has been a statutory offence for over 350 years in Europe — an approach carried to North America with colonization. This view of intoxication centres on the notion of harm: the inebriate harming him or herself; the inebriate harming those around him; and the harm presented by the act of inebriation to social values and norms.³ This criminal-justice view centres on the notion of intoxication as an individual choice, resulting in harm.

Concerns for the inordinate burden of chronic inebriation on the correctional system and police emerged in earnest during the 1960s. With the emergence of medical models to address addiction in the 1960s, the notion of alcoholism as a disease rose to influence public policy. This promoted the decriminalization of intoxication along with the introduction of a range of supports in an effort to both prevent the occurrence of and decrease the impact of public intoxication across Europe, North America, and Australia.⁴

As an example, the U.S. *Uniform Alcoholism and Intoxication Treatment Act* of 1971 notes that “because alcoholism is an illness, a homeless alcoholic could not avoid being drunk in public and therefore could not be punished for his public intoxication.” The act motivated the development of detoxification centres aiming to divert intoxicated people from police custody and into a health-care setting.⁵

It is important to also distinguish between the “public health” approach and the “medical model” as these are distinct in theory and practice with respect to alcohol-use disorders. The medical model generally considers alcohol as a disease — a prevalent view during the 1950s to 1960s as interventions for alcohol intoxication emerged. Importantly, this model was predicated on abstinence being the cure to alcoholism.

The public-health approach that emerged since the 1980s in response to the continuing social challenge of chronic inebriation and public intoxication, often coinciding with long-term homelessness and repeat public-system use, has centred on reducing harm among those considered most vulnerable, by decreasing consumption among heavy users.⁶

² S. Moore, V. Sivarajasingam and M. Heikkinen, “An Evaluation of the Cardiff Alcohol Treatment Centre Pilot” (Cardiff University Violence and Society Research Group Cardiff: Cardiff University, 2013).

³ M. R. Nusbaumer, “Hitting The Skids: Social Policy and the Control of Public Intoxication,” *Sociological Focus* 21, 2 (1988): 165-176; Australia. Australian Federal Police, *Use of Powers under the Intoxicated People (Care and Protection) Act*, 1994 (Vol. 11) (Commonwealth and Law Enforcement Ombudsman, 2008).

⁴ Nusbaumer, “Hitting The”; Australian Federal Police, *Use of Powers*; D. Griesbach, P. Russell and C. Lardner, “Services That Manage the Care Needs of Drunk and Incapable People: A Review of the Literature” (Scottish Government Social Research, 2009); Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

⁵ Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

⁶ Nusbaumer, “Hitting The”; Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

Importantly, public intoxication remains a criminal offence in many jurisdictions, including Canada. The public-health and medical models for addressing public intoxication continue to problematize the criminalization approach, creating varying stances impacting policy, regulation, and programmatic responses in daily practice. Sobering centres are initiatives at the crux of the continuing debate between the public-health, medical, and justice responses to intoxication.

Australian sobering centres emerged in the 1980s and proliferated in the wake of the 1991 Royal Commission into Aboriginal Deaths in Custody as a means of reducing the harms resulting from a predominantly custodial response to public drunkenness. The recommendations of the commission were the impetus for decriminalizing public intoxication and the establishment of sobering centres in many states.⁷ In light of the uneven impact of police arrests of Aboriginal people, many Australian sobering-up centres focus on Aboriginal communities in rural areas.⁸

In the U.K., sobering centres are also present as part of the health response to intoxication, alongside a slate of harm-reduction approaches, including wet shelters and wet day-centres, which allow managed alcohol consumption on-site.⁹ Unfortunately, only limited reports on U.K. sobering centres could be found, though evidence from wet facilities provides important learnings of relevance to this discussion. Some work on sobering centres has recently emerged in the form of program evaluations and public-system impact studies, though this remains limited.¹⁰

In North America, sobering centres are also referred to as intox, low-barrier or damp shelters; in some cases, sobering centres refer to a service located within or beside a facility for longer-term treatment.¹¹ These centres are often co-located with longer-term detoxification services and some are even located near hospitals or medical centres. Intensive case-management support (employment, housing and health care, as well as help with treatment) is offered in certain instances to facilitate client transition to stability, from a housing and addiction-treatment perspective.¹²

DIVERSE SERVICE MODELS

Generally, sobering centres aim to ensure that those experiencing the effects of alcohol and/or drugs have access to a safe place to “sleep it off.” Most often, these sites are operated using a harm-reduction approach and are voluntary in nature; in other words, clients can leave at any point and cannot be held against their will.

⁷ Australian Federal Police, *Use of Powers*, 10.

⁸ Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

⁹ M. Reed, “Wet Shelters: The Benefits and Risks Associated with Alcohol-Administering Homeless Shelters — A Scoping Review” (Government of British Columbia, 2008).

¹⁰ Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

¹¹ Griesbach, Russell and Lardner, “Services That”; T. Podymow et al., “Shelter-Based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol,” *Canadian Medical Association Journal* 174, 1 (2006): 45-49.

¹² Canada. British Columbia. BC Housing, *Emergency Shelter Program: Sample Policies and Procedures for Emergency Shelters* (2013); Griesbach, Russell and Lardner, “Services That”; Houston Recovery Center website, “Got a question?” <http://houstonrecoverycenter.org/got-question/>; L. Karper et al., “Coordination of Care for Homeless Individuals with Comorbid Severe Mental Disorders and Substance-Related Disorders,” *Journal of Dual Diagnosis* 4, 2 (2008): 142-157; Main Street Project website, “Intoxicated Persons Detention Area (IPDA),” <http://www.mainstreetproject.ca/our-services/intoxicated-persons-detention-area-ipda/>; Reed, “Wet Shelters”; S. Smith-Bernardin and M. Schneidermann, “Safe Sobering: San Francisco’s Approach to Chronic Public Inebriation,” *Journal of Health Care for the Poor and Underserved* 23, 3 (2012): 265-270; United States. Department of Health and Human Services Center for Substance Abuse Treatment, “Detoxification and Substance Abuse Treatment: A Treatment Improvement Protocol,” *Treatment Improvement Protocol* Vol. 45 (2006).

Where intoxicated persons are deemed to be too dangerous to themselves or staff, they are generally held in police cells instead;¹³ further, where the facilities are not suited to meet the immediate health needs of the client, staff will triage clients to local emergency departments.¹⁴

Generally, sobering centre interventions are short-term in nature, and varying levels of integration with homeless-serving and health systems are in place. Most of the time, staff provide information on the effects of alcohol and/or drug use, housing and drug-treatment services in the area, as well as referrals where appropriate. Information is, in certain cases, provided to the family and friends of the client.¹⁵

In terms of core services, the Australian evidence suggests a number of common features, as well as notable differences; these are relevant across the models reviewed in the U.K. and North America as well. Notably, the client’s ability to leave at any time and not being detained against his or her will seems to be a notable difference that has most recently emerged.

TABLE 1 SOBERING CENTRE SERVICES AND FEATURES

Common Features	Differences among Services
<ul style="list-style-type: none"> • Police (or community-based patrols) deliver clients to the centre • Clients are showered • Clients’ belongings are removed and recorded (often for the clients’ own protection) • Clothing is laundered • Client is rehydrated • Client is left to “sleep it off” • Client is observed at regular intervals by staff trained in first aid and in the identification of withdrawal symptoms • Where appropriate, client is referred to treatment services 	<ul style="list-style-type: none"> • Clients are free to leave at any time and may not be detained against their will • Hours of operation vary • Some are affiliated to, or co-located with, detoxification and/or residential treatment facilities • Some are staffed predominantly by Aboriginal people (particularly in Australia) • Some work alongside a night patrol or other form of transport service • Some accept self-referrals • Some take young people and some do not • Some offer clients a small meal in the morning before discharge • Some have security rooms, in which it is possible to place aggressive persons • Services are operated by a variety of agencies in the public and volunteer sector¹

1. Griesbach, Russell and Lardner, “Services That,” 7-8.

A range of models exist in practice, influenced by a number of factors, particularly the level of decriminalization where the sobering centre operates. Another factor would be climate — as colder weather increases the risk for death from hypothermia during intoxication. Overcrowded emergency departments and high demand for emergency medical services can also create demand for alternatives, which include sobering centres. The availability of homeless resources such as drop-in centres, Housing First and supportive-housing programs can also influence the level of demand for such facilities and how they operate as part of broader service networks.

For example, many American states have not decriminalized alcohol intoxication, including California, which has the voluntary sobering program using a harm-reduction approach. The San Francisco Sobering Center cares for intoxicated clients historically treated via emergency services. The centre reported 1,682 unduplicated clients in 2011 who received sobering and health-care services following a harm-reduction approach, with promising benefits for both clients and the broader health and justice systems.¹⁶

In terms of services provided, the San Francisco Sobering Center employs registered nurses and medical assistants to assess clients at intake. Clients are provided with oral fluids and electrolytes, meals, shower facilities, and clean clothing. Clients are monitored closely for medical or psychiatric

¹³ Griesbach, Russell and Lardner, “Services That,” 6.

¹⁴ M. Brady et al., “The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia,” *Drug and Alcohol Review* 25, 3 (2006): 201-206; Australia. Government of Western Australia, “Policy and Procedure Templates: A Work in Progress” (2005); Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

¹⁵ Griesbach, Russell and Lardner, “Services That”; Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

¹⁶ Smith-Bernardin and Schneidermann, “Safe Sobering,” 267.

complications following comprehensive nursing protocols. If clients are too acute, they are transferred to the emergency department. Nurse practitioners and physician assistants provide urgent care and detoxification referrals.

The Cardiff Alcohol Treatment Centre (ATC) in the U.K. provides yet another example of the approach. The ATC is focused on diverting patients away from the local emergency department. The centre is a pilot, supported by the public health department, bringing together the expertise of health-care providers, police, street pastors and the voluntary sector with support from city council. The Cardiff ATC is unique in that it is led by nurse practitioners who are clinical decision-makers with the capacity to assess and discharge patients.¹⁷

Public safety is a key motivator in the creation of sobering centres internationally. Many efforts, often spearheaded by police and justice-system stakeholders, focus on reducing perceptions of downtown being “unsafe,” as an example. As previously mentioned, there is increasing concern in North America, the U.K. and Australia regarding the health and legal risks involved for intoxicated detainees in police custody. A common concern is the occurrence of deaths for inebriated detainees in police custody; thus, there is a need to reduce risk for detainees and police.¹⁸ As a result, some sobering centres have emerged as an alternative to police custody for detainees with intoxication-specific charges (as opposed to intoxication-related detainees, who still have to be processed for charges).

Resulting initiatives more closely tied to police and justice-system partners, such as those of Winnipeg at the Main Street facility, take on a different approach than what we see in San Francisco, or in the many Australian examples focused on a medicalized, harm-reduction model, by seemingly merging the drunk tank (holding cell), police-driven approach with the harm-reduction sobering centre model. The following section will provide an overview of these diverse approaches.

Another example is the Houston Sobering Center. During its early development, a City of Houston presentation to the public safety committee notes the following arguments for the centre’s creation:

- City jail operations cost US\$25 million per year; an estimated US\$4-6 million is attributed to public-intoxication cases;
- Incarcerating individuals whose only criminal behaviour is public intoxication diverts law enforcement resources from more serious or life-threatening crimes;
- Intoxicated individuals often pose a hazard to themselves as well as to the general public;
- Best practices elsewhere suggest a more cost-effective/long-term-option approach.¹⁹

To this end, the goals of the sobering centre are to provide:

- an alternative to jail;
- triage, observation and necessary outpatient services to manage intoxication; and
- opportunities for long-term treatment by linking detainees to appropriate social service agencies;
- time savers for patrol officers, allowing them to quickly return to their assigned neighbourhoods;

¹⁷ Moore, Sivarajasingam and Heikkinen, “An Evaluation,” 201.

¹⁸ Griesbach, Russell and Lardner, “Services That”; Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

¹⁹ United States. Texas. City of Houston, “Proposed Sobering Centre - Presentation to the Public Safety Committee” (2012), 2, <http://www.houstontx.gov/council/h/committee/20120228soberingcenter.ppt>.

- fewer public-intoxication-related calls requiring officer intervention — hence more time officers can direct to other, more pressing crime and disorder issues.²⁰

The resulting Houston Center for Sobriety is owned and managed by the Houston Recovery Center LGC, a non-profit service provider. The centre opened in April 2013 with funding from the City of Houston and has the physical capacity for 68 men and 16 women, totalling 84 beds.²¹

The Houston Center for Sobriety provides short-term monitoring and management of those arrested for public intoxication. Instead of taking the arrestee to jail, officers bring him or her to the facility. Staff provide basic health screening and monitor for complications during sobering, if this is appropriate to the client’s program. Clients may be provided the opportunity to meet with a Recovery Support Specialist who assesses client needs, identifies appropriate resources and provides referrals and connections to those resources. For clients who may be experiencing substance abuse, homelessness, domestic violence or mental-health or medical problems, a licensed chemical-dependency counsellor can provide counselling, assessments, and referrals to treatment.²² Notably, the centre is still voluntary:

While a person must be checked in to the sobering center by a member of the police department, all services thereafter are strictly voluntary. Although we encourage those brought in to stay until they have reached sobriety, those who choose to leave are not detained. Upon release, individuals have the option of calling a cab, a friend or family member, or asking for a referral. Only those who are willing to accept assistance in transferring to a recovery facility will be provided with the transportation to do so.²³

The Winnipeg Main Street Project operates the Intoxicated Persons Detention Area (IPDA) in co-operation with Winnipeg Police Service to provide a safe and secure environment for individuals detained under the Intoxicated Persons Detention Act. This facility has 20 units and the staff to closely monitor detainees for up to 24 hours, “or until such time as they are deemed safe to be released into the community.”²⁴

Paramedic staff are onsite 24 hours a day to assess clients. Detainees are subject to video surveillance and monitoring; aftercare supports and resources information is provided at discharge.²⁵

The IPDA initiative is part of a larger range of supports available that also includes a 75-bed emergency shelter and 25-unit detoxification centre.

Interestingly, in September 2012, the New South Wales Government in Australia announced a trial for two new different sobering centre approaches. The centres opened in 2013 for 12 months, operating Friday and Saturday nights and on major event days like long weekends.²⁶

The aim is to test how mandatory and voluntary approaches impact alcohol-related violence and anti-social behaviour by intoxicated people “acting in a manner that puts themselves or others at risk, and placing them in a secure and safe location until they sober up.”²⁷ Notably, the mandatory centre is operated by police, in contrast to the non-profit-run Winnipeg centre.

²⁰ *ibid.*, 2-12.

²¹ Houston Recovery Center website, “Got a question?”

²² Houston Recovery Center website, “About Us,” <http://houstonrecoverycenter.org/about-us/>.

²³ *ibid.*

²⁴ Main Street Project website.

²⁵ *ibid.*

²⁶ NSW Police Force website, “Fact Sheet: Sobering Up Centres,” http://www.police.nsw.gov.au/__data/assets/pdf_file/0009/254295/Sobering_Up_Centres_Fact_Sheet.pdf.

²⁷ *ibid.*, 1.

TABLE 2 MANDATORY AND VOLUNTARY APPROACHES

Approaches	Operator	Admission Criteria	Holding Criteria
A <u>mandatory</u> centre established at cells in Sydney	Police	<ul style="list-style-type: none"> • Be aged over 18 years; • Have failed to obey a move-on direction issued by police due to an intoxicated state; • Must be potentially violent and/or acting in an anti-social manner and/or at risk of serious harm. 	People are forcibly held in the police-run mandatory centre for continuing to pose a risk to safety after police have asked them to move on.
Two <u>non-mandatory</u> centres to service the Eastern Beaches and Wollongong	Non-government providers	<ul style="list-style-type: none"> • Be intoxicated; • At risk of serious harm to themselves or others and/or be a public nuisance; and, • Consent to being admitted to the centre. 	People must agree to being admitted to a non-mandatory centre.

BEYOND THE CRIMINALIZATION DEBATE

This testing of the divergent approaches points to the ongoing tension between the public-health, medical, and justice discourses on inebriation and its criminalization. This ongoing tension will likely continue, because concern over public safety, high system use, chronic homelessness and effective use of taxpayer dollars are ever present in public discourse and policy responses.

Interestingly, one promising response to manage the negative impacts of detaining intoxicated persons in police cells has been to staff these with forensic medical and nursing personnel. Research suggests this can reduce negative health impacts and increase immediate support for the client, as well as facilitate treatment referrals.²⁸ In this manner, detainees may be suitable for referral to a sobering centre or continue to be held in police custody, while being regularly monitored for their own safety.²⁹

A growing trend is to restructure police services so that initial medical contacts are made by custody nurses.³⁰ Studies found that the use of custody nurses can improve the operational efficiency of health-care services offered in police-custody suites. One study found that nurses had faster response times, comparable consultation times and were perceived by custody staff as more approachable than their medical colleagues in providing handover information as well.³¹

In the U.S., the San Francisco Sobering Center engages complex, marginalized, high-cost individuals who are chronically homeless and high system users. Clients’ individualized plans include co-ordination with ambulance personnel, case-management and primary-care services, and mental-health and recovery services.³²

The more recent introduction of Housing First has made an impact on sobering centres in this regard as well. Housing First is essentially a harm-reduction, recovery-oriented approach focused on quickly moving people from homelessness into housing and then providing supports necessary to maintain it.³³

²⁸ L-H. Man, “Dealing with alcohol-related detainees in the custody suite: Findings” (Home Office Research, Development and Statistics Directorate, 2002), 178.

²⁹ Griesbach, Russell and Lardner, “Services That,” 43.

³⁰ A. Deehan et al., “Drunken detainees in police custody: is brief intervention by the forensic medical examiner feasible?” *Criminal Behaviour and Mental Health* 8 (1998): 214-221; A. Deehan, E. Marshall and E. Saville, “Drunks and disorder: Processing intoxicated arrestees in two city-centre custody suites” (Home Office, Police Research Series Paper, 2002), 150; D. Best et al., “The role of forensic medical examiners and their attitudes on delivering brief alcohol interventions in police custody,” *Criminal Behaviour and Mental Health* 12 (2002): 245-235.

³¹ Griesbach, Russell and Lardner, “Services That,” 122.

³² Smith-Bernardin and Schneidermann, “Safe Sobering,” 267.

³³ Stephen Gaetz, “Housing First” (Homeless Hub, 2013), <http://www.homelesshub.ca/housingfirst>.

Rather than requiring homeless people to first resolve the challenges that contributed to their housing instability, including addictions or mental-health issues, Housing First approaches emphasize that recovery should begin from a stable housing environment.³⁴

System planning is a method of organizing and delivering services, housing, and programs that coordinate diverse resources to ensure efforts align with homelessness-reduction goals.³⁵ Rather than relying on an organization-by-organization, or program-by-program approach, system planning aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders.³⁶

In this sense, the recent move towards system planning and integration, represented by the program-level service co-ordination work of Housing First initiatives, presents an important opportunity to develop more holistic approaches to responding to co-occurring issues of mental health, addiction, criminal-system involvement and housing instability.³⁷ Alpha House's undertaking of permanent supportive housing and Housing First intensive case management is an example of the integration of sobering centres with broader systems approaches to addressing homelessness.

SAFETY NOTES

Sobering centres are subject to a number of service standards of practice depending on their jurisdiction. For instance, the U.K. Drugs and Alcohol National Occupational Standards³⁸ and Australian Care and Protection of Intoxicated Persons Standard set out requirements in relation to record keeping and staff training and qualifications for working in sobering facilities.

The Australian standards establish minimum requirements for the manner in which a licensed person is to provide a caring service, pursuant to act. Further, the Western Australian Alcohol and Other Drug Sector Quality Framework (2005) sets out performance-expectations policies and procedures and quality-assurance measures for service providers.³⁹

In Australia, if an intoxicated individual has committed a crime, he or she is charged with a criminal offence and taken into police custody. If, in the view of the police or the sobering-up centre staff, an individual is seen as *potentially* violent or aggressive, the individual is not seen as appropriate for

³⁴ Stefancic, Ana, Benjamin F. Henwood, Hilary Melton, Soo-Min Shin, Rebeka Lawrence-Gomez, and Sam Tsemberis. 2013. "Implementing housing first in rural areas: pathways Vermont." *American Journal of Public Health* no. 103 Suppl 2:S206-S209; Tsemberis, S., L. Gulcur, and M. Nakae. 2004. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis." *American Journal of Public Health* no. 94 (4):651. Alberta Human Services. *Adopting a Housing First Approach* 2012. Available from Adopting a Housing

³⁵ A. Turner, "Beyond Housing First: Essential Elements of a System Planning Approach to Ending Homelessness," University of Calgary School of Public Policy Research Paper 7, 30 (2014): 1-26, <http://policyschool.ucalgary.ca/sites/default/files/research/turner-housingplan-onl.pdf>.

³⁶ See Turner, "Beyond Housing" for a discussion on this.

³⁷ Canada. Health Canada, "Best Practices: Concurrent Mental Health and Substance Use Disorders" (2002).

³⁸ M. Crane and A. Warnes, *Wet Day Centres in the United Kingdom: A research report and manual*, Commissioned by the King's Fund and Homeless Directorate (Sheffield Institute for Studies on Ageing: University of Sheffield, 2003); Federation of Drug & Alcohol Professionals, *Developing Standards of Practice in the Drugs & Alcohol Workforce: A Practical Guide from the Federation of Drug & Alcohol Professionals* (Federation of Drug & Alcohol Professionals, 2012).

³⁹ These standards are available online: <http://www.fdap.org.uk/documents/Vision%20thing%20practitioners%20%20managers.pdf>; <http://www.legislation.act.gov.au/di/2004-177/current/pdf/2004-177.pdf>; http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?EntryId=179&Command=Core_Download&PortalId=0&TabId=211.

admission to a sobering-up shelter. These individuals are held instead in police cells for their safety and the safety of staff.⁴⁰

In a review of the Miinosa House Sobering Centre, in the Australian city of Campbell, the following guidelines are outlined with respect to client safety:

An intoxicated person is free to leave the Shelter at any time. If staff assess a person as still intoxicated when seeking to leave or when the Shelter closes, staff will either seek to locate a responsible adult to collect the person and ensure their safety, or refer the person to an appropriate service for support and monitoring until they recover. If those options are not possible, staff will notify police (as required by s 9 of the IPCP Act, which specifies that when an intoxicated person considered to be a danger to themselves, another person or property leaves or is about to leave a licensed place, police must be notified).⁴¹

Diversion from custody into a sobering-up facility does not mean that charges will not be laid against an individual. Some facilities had a “security room” in which to place dangerous or aggressive persons. The Albion Street Shelter in New South Wales is an example; however, the centre’s staff actively lobbied not to have to receive violent and dangerous persons.⁴² Given the risks of acute intoxication, aggressive actions, unpredictable behaviour, and medical emergencies, staff are required to check on clients frequently in order to ensure their safety.⁴³

In North American facilities, strict admission protocols are in place that aim to appropriately triage clients to a qualified medical provider. Often, medical staff are on-site to make this determination in real time.⁴⁴

When the evidence on detoxification centres was examined to complement the findings on sobering centres, an even more complex picture emerged. Best practices in operating detox centres from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. paint a very clear picture of responses to intoxication requiring medical expertise to ensure patient safety.⁴⁵

A complex set of processes is needed to appropriately assess and stabilize detox clients: this adds a medical-intervention focus to the discussion on sobering centres, as a fulsome assessment is needed to determine whether someone is safe in a sobering centre or requires more intensive medical placement.⁴⁶

These standards of practice point to the fact that community-based sobering centres will not and should not replace the need for medical intervention in some cases. Sobering centres also cannot replace the need for holding cells, as some clients are simply too complex/“dangerous” to be safely assisted in such a facility. This means that the triage to sobering centres, health system and police will continue to be needed. Nevertheless, best practices suggest a harm-reduction approach be used across these services, tied into broader public-health, homelessness and public-safety strategies.⁴⁷

⁴⁰ Griesbach, Russell and Lardner, “Services That.”

⁴¹ Australian Federal Police, *Use of Powers*, 11.

⁴² Griesbach, Russell and Lardner, “Services That,” 14.

⁴³ Podymow et al., “Shelter-Based.”

⁴⁴ Houston Recovery Center website, “About Us”; Houston Recovery Center website, “Got a question?”; Smith-Bernardin and Schneidermann, “Safe Sobering”; United States, “Detoxification.”

⁴⁵ United States, “Detoxification.”

⁴⁶ *ibid.*

⁴⁷ Australia, “Policy and”; Australia. Government of Western Australia, “The Western Australian Alcohol and Other Drug Sector Quality Framework” (2005); Griesbach, Russell and Lardner, “Services That”; Moore, Sivarajasingam and Heikkinen, “An Evaluation.”

EVIDENCE OF IMPACT

In terms of the evidence for best and promising practices, the literature generally confirms positive client and system impacts resulting from the harm-reduction approach to sobering centre operations. Evidence for the impact of mandatory approaches has not been located to date.

The main objectives of sobering centres are to give people a safe place to sober up from the effects of alcohol or drugs and divert people from police custody. Evidence from Australia indicates that sobering centres are largely effective in both of these regards.⁴⁸ These services were perceived to be much safer than holding intoxicated individuals in police custody.⁴⁹

An evaluation of a sobering-up shelter in Canberra, Australia found that those who accessed the service were receiving physical and emotional care, support and brief interventions tailored to their individual circumstances, including referrals to other services. The service had no critical incidents over an 18-month period.⁵⁰

A Drug and Alcohol Office of Western Australia study noted that between 1992 and 2005, the number of police detentions of intoxicated persons declined by 84 per cent from 12,346 in 1992 to 1,972 in 2005. This is directly attributed to the availability of sobering centres. The study indicated that sobering services resulted in reduced:

- police time and resources previously involved in detaining and monitoring intoxicated people in lock-up;
- use of court time and resources;
- levels of domestic violence and other problems associated with alcohol abuse; and
- burden on hospitals, because of fewer hospitalizations for alcohol-related illnesses and accidents.⁵¹

The same study reported that in 2005, the 14 sobering centres had a combined cost of \$3,547,190 (Australian dollars): an annual average cost per centre of \$253,370 and an average \$183 per admission. Sobering centres were considered to be “very cost-effective as they avoid costs that would otherwise be incurred if people had been detained or admitted to a hospital.”⁵² Cost-effectiveness depends partly on the size of the facility and how well it is used.

A 2004 evaluation of the Walangary sobering centre determined that it was successful in keeping intoxicated people out of detention: since its inception in 1999, the number of indigenous people incarcerated fell from 173 in 1999, to 99 in 2000, and 33 in 2001.⁵³

In the long term, there is some evidence from Australia that sobering-up services can potentially encourage the development of other services to address alcohol-related problems. In Western Australia, the development and expansion of a state-wide network of sobering centres was attributed to leading to the subsequent development of a variety of programs, including community patrols, outreach, homeless

⁴⁸ M. Brady et al., “The role”; Australian Federal Police, *Use of Powers*; Australia, “The Western”; Griesbach, Russell and Lardner, “Services That”; P. Stempel et al., “Indigenous drug and alcohol projects: elements of best practice,” Australian National Council on Drugs Research Paper 8 (2004).

⁴⁹ Australia. Parliament of Victoria, “Drugs and Crime Prevention Committee Inquiry into Public Drunkenness,” Discussion Paper (2000).

⁵⁰ Griesbach, Russell and Lardner, “Services That.”

⁵¹ Australia. Government of Western Australia, “Utilisation of Sobering Up Centres, 1990–2005” (2007), A-12.

⁵² *ibid.*

⁵³ P. Stempel et al., “Indigenous drug,” 47.

support, alcohol and other drug education, as well as community support for initiatives to restrict the availability of alcohol.⁵⁴

In the U.K., the recent evaluation of the Addiction Treatment Centre in Cardiff suggests that when the centre is open, there are statistically fewer alcohol and assault-related attendances in emergency departments, suggesting that the pilot successfully diverted health-service use.⁵⁵

The 2013 evaluation concluded that the pilot program:

- reduced risk of harm to those who use the city centre at night;
- reduced ambulance waiting time at the emergency department;
- improved ambulance capacity in the community; and
- diverted those exhibiting severe intoxication away from the emergency department.⁵⁶

In North America, there is little evidence in the literature about the impact of sobering centres on police arrests for public drunkenness, though there is widespread belief that sobering centres can and do provide a direct benefit to the police by reducing the amount of time they spend managing intoxicated individuals.⁵⁷

In terms of outcomes, these centres have had few formal evaluations, however they are attributed to have reduced instances of arrest due to intoxication and provided benefits to clients in the immediate term. Less is known about longer-term connections to housing and treatment, though this is a promising direction to integrating sobering centres into larger homelessness and public-health responses that address the underlying issues related to intoxication in the first place.⁵⁸

One available evaluation of the San Francisco Sobering Center reports that up to 29,000 encounters inappropriate for emergency services were avoided by diverting chronic-inebriate care away from the ER into the centre. The lower inappropriate number of visits helped decrease emergency department overcrowding and enabled more effective operations. Additionally, the transportation services from police, ambulance, and emergency department to the centre allows emergency services and beds to be available sooner to receive new calls and clients.⁵⁹

The operating cost of approximately \$1 million annually from the Department of Public Health for this 24/7 operation is about \$2,700 per day, roughly the cost of a single ambulance ride and emergency department visit (combined ranges of \$1,850 to \$3,800). “With an average census of 10 to 14 clients a day, the cost avoidance to the City is substantial.”⁶⁰

Long-term, the San Francisco initiative demonstrates improved health of chronic alcoholics by engaging complex, marginalized, high-cost individuals. Up to 70 per cent of the highest users of multiple systems come through the sobering centre and receive individualized plans, which include co-ordination with ambulance personnel, case-management and primary-care services, mental-health and recovery services, and the public guardian.

⁵⁴ Australia, “Utilisation of”; Griesbach, Russell and Lardner, “Services That.”

⁵⁵ Moore, Sivarajasingam and Heikkinen, “An Evaluation,” 27.

⁵⁶ *ibid.*, 41.

⁵⁷ Griesbach, Russell and Lardner, “Services That.”

⁵⁸ *ibid.*

⁵⁹ Smith-Bernardin and Schneidermann, “Safe Sobering,” 267.

⁶⁰ *ibid.*

THE ALPHA HOUSE CASE STUDY

Currently, public intoxication continues to be criminalized in Canada. The Criminal Code, under Section 175, provides ground for charges of disorderly conduct (causing disturbance).⁶¹ Provincially, the Alberta Gaming and Liquor Act 89(1) allows peace officers to take an intoxicated person into custody and outlines the prohibition of public intoxication and consumption under sections 89 and 115.

There is limited evidence on the effectiveness of sobering centres in Canada, which makes the Alpha House an important contribution to the body of evidence. Despite the continued criminalization of public intoxication, attempts at curbing the burden of arrests and detentions on Canada's correctional and health systems exist here as well. Wet and damp shelters (intox) do exist across the country, aiming to improve the health and well-being of vulnerable populations and reduce impacts on public systems.⁶² It is important that their impact on clients and the community is assessed to inform programming and policy in a systematic manner moving forward.

Alpha House was created as a response to the issues facing Calgary during the early 1980s: increasing use of city cells by intoxicated individuals in the downtown core as result of a growing visible population of rough sleepers with underlying addictions issues. This was supported by a grassroots community effort to address the needs of vulnerable groups with complex addictions and mental-health needs. This period witnessed the redevelopment of the downtown core, which included a new city hall and revamped 7th Avenue in preparation for the 1988 Winter Olympic Games.

To respond to the growing visible population of rough sleepers, a committee including the solicitor general and the Alberta Alcohol and Drug Abuse Commission commenced research to explore solutions, which concluded with the opening of Alpha House in 1981, operating a combined sobering centre and detox facility with 50 and 20 beds respectively. With growing demand, a \$9.1-million expansion in 2009 had grown services to over 120 beds in the sobering centre facility, 30 beds for detox and 12 transitional housing beds, and a new health clinic. The detox centre provides support for withdrawal management where medical services are offered on-site through a partnership with the Calgary Urban Project Society.

Alpha House's mission as a charitable non-profit agency is to provide safe and caring environments for those affected by alcohol and drug addiction. Services follow the philosophy of self-determination and harm reduction. This means that rather than requiring sobriety, services meet clients "where they are at" and build responses around their needs, minimizing harm and promoting well-being.

Alpha House defines its approach to harm reduction as follows:

Harm Reduction philosophy considers risk taking behavior as a natural part of our world and suggests that our work should be focused on minimizing the harmful effects of these behaviors, rather than focusing solely on the cessation of the behavior.

Harm Reduction philosophy requires the involvement of those individuals who are the intended recipients of programs and services in the creation of these same services and programs and/or the delivery of programs and services that are designed to serve them. These programs and services must be offered in a non-judgmental and non-coercive manner.

⁶¹ Canada. Criminal Code — R.S.C., 1985, c. C-46.

⁶² BC Housing, *Emergency Shelter*; Podymow et al., "Shelter-Based"; Reed, "Wet Shelters."

Harm Reduction philosophy recognizes that poverty, social class, racism, homophobia, social isolation, past trauma, and other social inequities have an impact on people’s vulnerability to, and capacity for, effectively dealing with risk taking behavior.⁶³

Alpha House also operates 12 short-term housing beds for those needing stabilization post-detox or leaving other facilities. The sobering centre, transitional beds and detox are all operated out of the same downtown facility. Analysis of administrative data was not available for the transitional beds or detox, thus these are not included in the HMIS analysis.

Notably, Alpha partnered with the Calgary Urban Project Society to develop the Downtown Outreach Addiction Partnership (DOAP) in 2005, which provides mobile outreach to marginalized addicted populations to mitigate police, bylaw-enforcement and emergency-medical involvement where it is not necessary. In 2010, Alpha House began operating DOAP on its own. DOAP staff co-ordinates access to a range of medical, shelter, housing and addiction programs to connect clients and also provides transportation to various shelters and facilities. Case management is also provided along with supported referrals to necessary services.

Since 1992, the homeless population in Calgary grew rapidly to over 4,000 counted in 2008 at a point in time. Similarly, rough sleepers, who were much more visible, were also growing in numbers — estimated to reach over 500 any given night. The Plan to End Homelessness, launched in 2008, aimed to address the issue head-on, infusing new funding and ideas, such as Housing First, in a systematic effort to restructure Calgary’s response from one of managing homelessness, to ending it.

Combined with the continued redevelopment of Calgary’s downtown during the economic upswing during this period, additional pressure to manage public intoxication and resolve the homelessness challenge led to the evolution of the DOAP team into a Housing First program that provided case-managed supports and housing location to chronic and episodic homeless clients.

Alpha’s Housing First slate of programs grew from an initial focus on encampments of rough sleepers to include four program streams. These collectively employ 40 staff to support 161 clients in scattered-site housing (rental units in the market) and 75 clients housed in Alpha-operated place-based, harm-reduction, supportive-housing buildings. As a result, 431 individuals have been re-housed since 2008.

In terms of operating budgets, Alpha House’s 2013–14 program costs break down as follows for a combined total of \$9,637,534. Most funds come from the provincial government, along with a number of smaller grants and donations.⁶⁴

TABLE 3 ALPHA HOUSE OPERATION BUDGET

Sobering Centre	DOAP	Detox	Housing First
\$2,158,527	\$1,521,900	\$1,605,000	\$4,352,107

Sobering Centre Facility Analysis

The sobering centre facility is operated 24 hours per day, seven days a week in the downtown area near the Calgary Stampede grounds, where considerable redevelopment has occurred in recent years. The facility provides shelter on a 24-hour basis for intoxicated individuals and is operated under a harm-reduction, voluntary model. Staff provide supervision and monitoring to ensure clients are safe, as well as food and liquids to ensure appropriate levels of hydration. Medical services are offered on-site, as well as a detox facility for those seeking this service. Staff also assist clients with system navigation:

⁶³ Alpha House website, “Resources: Basic Principles of Harm Reduction,” <http://alphahousecalgary.com/Resource.html>.

⁶⁴ Alpha House’s budget information was provided by Kathy Christiansen, Executive Director of Alpha House.

obtaining identification, access to housing, employment, social supports, etc. Clients can self-refer, or be brought in by outreach workers, police, or ambulance.

The percentage of people who self-identify as Aboriginal in Calgary is 2.8 per cent, whereas Aboriginal people make up 42.3 per cent of Alpha House shelter users.⁶⁵ Because of the high number of Aboriginal people using the centre, considerable effort has been placed on providing access to cultural supports. An elder works out of the facility and regular sweats and ceremonies are offered through a partnership with the Aboriginal Friendship Centre. More recently, recognizing the unique needs of women, Alpha House started the Women of Alpha group, which meets as a support group on a regular basis. Moving forward, Alpha House is seeking funds to develop a women-specific housing program.

It is important to highlight that, because of Alpha House's mission to assist those facing addictions using a harm-reduction model, the facility is often welcoming clients who are otherwise not eligible for shelter in other "high barrier" or "dry" facilities. This effectively streams higher-needs, complex clients with active addictions into the facility (the Calgary Drop-In Centre also provides intox beds). Managing community relations is an ongoing effort to demonstrate the centre's contribution to public safety and community well-being.

In terms of the HMIS data obtained from the sobering centre, a total of 69,617 entries from 3,480 unique clients were analyzed from Feb. 1, 2013 to Feb. 1, 2014. As most, if not all, of these clients were inebriated or had active addiction issues, this presents a considerable diversionary service for Calgary police and medical services. Note that, due to the 2013 floods in Alberta, the facility's data collection was hampered, bringing overall figures down — likely by at least 5,000 interactions.

The majority of unique sobering centre clients were male (2,793, or 80.3 per cent); there were 681 females (19.6 per cent). The average age across all shelter users at first intake was 39; most clients were either in the 25–35 or 36–50 age range, at 29.5 per cent and 37.6 per cent respectively. Aboriginal people were over-represented at 42.3 per cent (1,473) of the total unique clients.

The majority of clients (62.7 per cent) had seven stays or fewer; 82.7 per cent stayed 30 times or fewer and 90 per cent stayed 60 times or fewer. Note that a stay refers to one entry in the shelter. However, about 3.8 per cent stayed between 61 and 90 times, and 5.8 per cent stayed more than 90 times. There were 39 clients who had 211 entries or more, and 126 who had over 121 stays in the 365 days of the study period (Table 4).

⁶⁵ See Statistics Canada, NHS Profile, Calgary, CMA, 2011 (2014), <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CMA&Code1=825&Data=Count&SearchText=Calgary&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=825&TABID=1>.

TABLE 4 SOBERING CENTRE STAYS PER CLIENT

Number of Stays	Number of Clients	Per Cent of Total
1-7 stays	2192	62.7%
8-14 stays	331	9.5%
15-21 stays	182	5.2%
22-30 stays	178	5.1%
31-60 stays	262	7.5%
61-90 stays	134	3.8%
91-120 stays	75	2.1%
121-150 stays	48	1.4%
151-180 stays	25	0.7%
181-210 stays	14	0.4%
211-240 stays	14	0.4%
241-270 stays	9	0.3%
271-300 stays	8	0.2%
301-330 stays	2	0.1%
331+ stays	6	0.2%

The 39 clients of the sobering centre who stayed 211 or more times totalled 10,808 entries or 15.5 per cent of the total entries in the time period. Looking at this group, most were male (82.1 per cent) — consistent with the overall data. However, 58.9 per cent were Aboriginal, compared to 42.2 per cent of the total. The average member of this group of frequent users was 44 years of age — which is five years older than the overall client group.

The data suggest that the facility is primarily used for short-term stays, however there is a core of service users who could be targeted for tailored (and more cost-efficient) housing-and-supports interventions, as they are effectively living in the facility for most of the year.

DOAP Mobile Outreach

The agency's DOAP program is a mobile-outreach transportation service that aims to divert police/correctional responses to public intoxication by bringing those identified as publicly intoxicated to shelter facilities or provide other alternatives to incarceration. The service is well-known and used by clients, non-profit providers and public-system partners, including police and medical services. DOAP operates 22 hours per day, seven days per week.

In total, 17,294 interactions from 3,450 unique clients were analyzed from Feb. 1, 2013 to Feb. 1, 2014. HMIS data demonstrates notable usage of the service by public systems (police, transit police, health) to divert clients into alternative services.

In terms of demographics, DOAP clients were primarily male (2,533, or 73.4 per cent); 914 were female (26.5 per cent). Caucasian clients (1,859) made up the largest overall ethnic group, at 53.9 per cent. Aboriginal people were over-represented at 36.8 per cent (1,271) of the total unique clients. About 8.8 per cent or 302 clients were visible minorities; the largest visible minority reported was African/Caribbean (4.0 per cent). At intake, most clients were either in the 25–35 or 36–50 age range at 26.4 per cent and 37.8 per cent respectively. Young adults comprised a smaller proportion, with 408 individuals, or 11.8 per cent of total clients. There were 13 children (under 18 years) also reported.

The notable over-representation of Aboriginal people among the sobering centre and DOAP programs suggests tailored interventions with a cultural focus are needed, along with further analysis of specific service needs that will have the greatest impact.

The most common service provided by DOAP was transportation (16,920), which made up 97.8 per cent of all interactions. About 1,298 referrals came from the Calgary Police Service, representing a notable number of interventions with this system. Similarly, reported referrals from transit (548), emergency medical services (287), hospitals (2,633), security (265) and business (589) demonstrate the broad use of the service to divert the impact on public system and the broader community (Table 5). About 17.8 per cent (3,085) of pick-ups and 16.9 per cent (2,927) of drop-offs were at medical facilities or services. A further 1,161 pick-ups (6.7 per cent) were from Calgary Police Service, transit, bylaw enforcement or security.

Most often, DOAP drop-off locations for clients are sobering centres or low-barrier shelters (Alpha House and the Calgary Drop-In Centre). This demonstrates the important link in service between the sobering centre and the mobile outreach to divert clients from public systems.

TABLE 5 DOAP REFERRAL SOURCES

Referral Source	Number	Per Cent
Alpha House	3,906	22.6%
Drop-In Centre	2,796	16.2%
Self	2,200	12.7%
Calgary Police Service	1,298	7.5%
Sheldon Chumir (Hospital)	1,293	7.5%
Found outside by referral source	932	5.4%
Foothills Medical Centre	617	3.6%
Business	589	3.4%
Transit	548	3.2%
Concerned citizen(s)	420	2.4%
Other Agencies	416	2.4%
Rockyview Hospital	379	2.2%
Peter Lougheed Hospital	338	2.0%
Emergency Medical Services	287	1.7%
Security	265	1.5%
Mustard Seed Centre Street	202	1.2%
Renfrew Detox Centre	119	0.7%
CUPS (agency)	103	0.6%
Residence	112	0.6%
YWCA	97	0.6%
No Data	68	0.4%
Salvation Army	71	0.4%
Bylaw	59	0.3%
Greyhound	72	0.4%
Mustard Seed Foothills	51	0.3%
Medical appointment	27	0.2%
WISH (agency)	23	0.1%
South Health Campus	6	0.0%
Total	17,294	100.0%

About 43.3 per cent of clients had one DOAP interaction; 77.8 per cent had between one and five interactions. However, 5.1 per cent of clients (177) had 21 or more interactions. Of these, 0.9 per cent (31) had more than 51 interactions. As in the case of the frequent users of the sobering centre, the DOAP data point to a core of service users who could benefit from a more concerted housing and support effort.

Housing First Programs Analysis

At the time of the data collection, 431 individuals had been re-housed since 2008 by the Alpha House slate of Housing First programs; individuals were primarily accessing services as result of their addictions. To assess impact, Housing First program data from a total of 229 available HMIS unique client records were analyzed from Q1 of fiscal 2008/09 and Q3 of 2013/14 for the following programs:

- Housing — Alpha House (intensive case management, scattered-site housing)
- Permanent Supportive Housing: Community — Alpha House (scattered-site housing)
- Permanent Supportive Housing: Place-based — Alpha House (place-based housing)
- Veterans Building — Alpha House (place-based housing)

The two Housing First scattered-site programs house clients in rental throughout Calgary and provide case-management supports to facilitate ongoing housing stability and access to necessary medical, social integration, income supports, etc. The agency is able to leverage existing mainstream services, including social assistance, by using program funds from Alberta Human Services via the Calgary Homeless Foundation to provide clients with rent subsidies to meet market costs. The program budgets have some flexibility to accommodate damages to units in some cases, as well as some utility and set-up supports (furniture, bedding, etc.).

The case managers use a client-driven approach to locate housing type and neighbourhood, while facilitating positive relations with landlords, and conflicts are mediated to maintain tenancy. Case managers work with the clients to address a range of needs, including facilitating access to medical services, dealing with outstanding charges, court appearances, etc. When clients need to be re-housed for any of a range of reasons, case managers support such transitions as well. The length of stay in the program is about 18–24 months, however, given the complex needs of clients, the program does not impose a strict exit time and works with each client to develop an individual plan.

Alpha House's two permanent supportive-housing programs are also focused on long-term homeless clients with addiction as well as mental health issues in some cases. The programs are run according to a harm-reduction philosophy but deliver housing and supports in a place-based fashion. Alpha House operates three buildings owned by the Calgary Homeless Foundation as permanent supportive housing for 75 clients. One of the three buildings is restricted to those who served in the Canadian Forces, using Homeless Partnering Strategy and Human Services funds. Another building targets Aboriginal clients, though it is not restricted to this group exclusively.

The place-based programs provide on-site case-management support for clients, similar to the scattered-site models. However, the buildings are also supervised by staff and specific activities are provided to create a sense of community and safety within the sites. The programs do not have a length-of-stay limit: they are intended for long-term supports to the highest level of needs among Alpha's clients.

With respect to the HMIS data, it is important to note that the analysis in this paper is presenting the scattered-site and place-based programs together. Analysis of each of the programs was undertaken to gauge variances, however this merits a broader discussion and is beyond the scope of this paper.

It is of note that the various streams of services have diverse program models and housing forms in practice, along with varying eligibility criteria. For example, the veterans program requires participants to have served in the Canadian Forces, and its clients tend to have lower rates of mental-health and addictions issues reported at intake compared to other programs.

Further, because some programs deliver housing using scattered-site rental versus place-based housing, service models and intake criteria differ further. To this end, we present the findings from the four Housing First programs to gauge relevant trends for the paper regarding client/system involvement (health and police/legal system respectively over 12 months prior to intake), health conditions (addiction, mental health, fetal alcohol spectrum disorders, etc.), as well as key demographics (gender, age, ethnicity).

It is important to note that Alpha House aims to operate its slate of services in a co-ordinated fashion. The sobering centre, DOAP and Housing First programs are currently using HMIS, which allow us to analyze client flow through these services, though it is of note that the detox, transitional housing and medical services were not captured in this data. HMIS data shows that there were 3,709 unique clients served by Housing First and sobering centre programs; 156 were served by both. In other words, about 68.1 per cent of Housing First clients were also served by the sobering centre. This is of relevance as Housing First programs targeting sobering centre clients will contribute to the overall intoxication response.

Note that the time period examined for the sobering centre and DOAP (2013–14) was different from that for the Housing First programs (2009–2014). What this does suggest however is that a notable source of Housing First clients are coming through sobering centre facilities, or at least are using both programs during the course of their interaction with Alpha House.

TABLE 6 SHELTER AND HOUSING FIRST CLIENTS

Total Shelter and Housing First Unique Clients	3,709
Shelter and Housing First Duplicates	156
Shelter Only	3,402
Housing First Only	151

Similarly, there were 3,679 unique clients served by Housing First and DOAP; about 222 (6.0 per cent) were served by both. This means that about 96.9 per cent of Housing First clients were also DOAP clients. Clearly, there is notable sharing of clients among the programs, though this is not exclusive, suggesting that the varying approaches reach the target population using diverse strategies to broaden access.

TABLE 7 DOAP AND HOUSING FIRST CLIENTS

Total Housing First and DOAP Unique Clients	3,679
Housing First and DOAP Duplicates	222
Housing First Only	118
DOAP Only	3,339

About 76.4 per cent of the Housing First clients self-reported an addiction issue at intake, which is of relevance given the focus on Alpha House’s impact on intoxication. Note, however, that clients may initially be reluctant to self-identify such issues.

The majority of Housing First clients were male (79.5 per cent); 17.5 per cent were female. Most clients were either in the 36–50 or 51–64 age range at intake, at 48.0 per cent and 33.6 per cent respectively. The average age was 48—notably higher than that of the sobering centre average of 39 years.

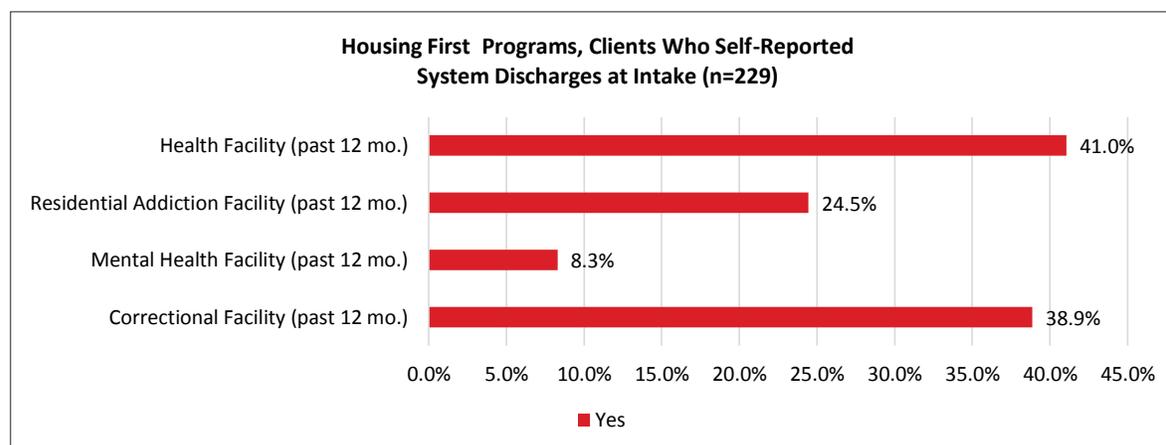
Caucasian clients made up the largest overall ethnic group at 67.7 per cent, higher than those served in the sobering centre (46.7 per cent). About 3.9 per cent of clients were visible minorities — less than half the proportion reported in the sobering centre (8.5 per cent). Aboriginal people were over-represented at 24.5 per cent of the total unique Housing First clients. This is nonetheless a lower percentage than that reported by sobering centre clients served in 2013/14 (42.2 per cent). The lower percentage of Aboriginal and visible minority clients in the Housing First programs is notable and should be explored further with program staff to facilitate better representation in future program cohorts.

About 84.3 per cent of clients reported being chronically homeless and 10.5 per cent were episodically homeless.⁶⁶ This is aligned with the requirement from funders of the program to target Housing First to these groups. Most chronically homeless clients (72.5 per cent) had been homeless for three years or more.

In terms of system involvement, about 20.5 per cent of clients reported having had foster care involvement during their lifetime, though only 3.9 per cent, or nine clients, reported having child intervention involvement at intake. Further, 10.5 per cent reported having exposure to/or were fleeing domestic violence at intake.

At intake, 60.7 per cent and 62.9 per cent reported having had involvement with the health system and police/legal system respectively over the prior 12 months. Figure 1 outlines actual discharging from various facilities reported with respect to the 12 months prior to entry in the program, demonstrating considerable potential for better linkages with medical and correctional facilities to facilitate appropriate and supported discharge practices that promote housing stability and reintegration.

FIGURE 1 HOUSING FIRST PROGRAMS, SELF-REPORTED DISCHARGES AT INTAKE



⁶⁶ See the government of Alberta’s definitions of chronic and episodic homelessness online at: <http://humanservices.alberta.ca/homelessness/14630.html>.

These are:

- **Chronic:** Those who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.
- **Episodic:** A person who is homeless for less than a year and has had fewer than four episodes of homelessness in the past three years.

A high number reported having treated/untreated ongoing health conditions:

- 66.8 per cent — physical-health condition
- 37.6 per cent — mental-health condition.
- 76.4 per cent — addiction/substance-abuse issue.

A small proportion (3.5 per cent) or eight clients reported having fetal alcohol spectrum disorders (treated and/or untreated). Notably, these conditions were self-reported, and over time program staff report clients as either feeling comfortable admitting to these issues, or report uncovering them through the course of accessing program services, including access to medical supports, diagnosis and treatment.

Program Impact

To assess program impact, 141 unique client records that were available both for intake and for a 12-month assessment were compared for the same clients. The data available suggest a notable percentage of the clients having achieved permanent housing as well as decreases in self-reported involvement with the police or the health or legal system.

About 67.4 per cent of clients reported in their 12-month assessment as having achieved permanent housing in the past three months (Table 8). A further 31.2 per cent reported that they had not achieved permanent housing in the past three months. About 45.4 per cent of clients reported involvement with the health system in the past three months; 27.0 per cent reported involvement with police or the legal system in past three months during the 12-month assessment.

TABLE 8 HOUSING FIRST PROGRAMS, SYSTEM INVOLVEMENT AT THREE AND 12 MONTHS

	Involvement with the health system in the past three mo. (12-Month Assessment) (n=141)		Involvement with police or the legal system in past three mo. (12-Month Assessment) (n=141)	
Yes	64	45.4%	38	27.0%
No	60	42.6%	85	60.3%
Declined to Answer	0	0.0%	1	0.7%
Don't Know	5	3.5%	5	3.5%
Blanks	12	8.5%	12	8.5%
Total	141	100.0%	141	100.0%

It is important to note that comparison with reported system use at intake is done with caution. The intake questions are asking clients to report system usage over the past 12 months, whereas the 12-month assessment asks about the past three months only.

Nevertheless, looking at public-system usage rates reported over the 12 months prior to intake compared to rates over the three months prior to the 12-month assessment, we estimated the three-month rate to apply over 12 months (multiplied by four) for the same 141 unique clients (Table 9). Using this, the following suggested reductions and increases in public-system usage emerged:

- Number of days hospitalized: 50.1 per cent decrease;
- Number of times hospitalized: 62.6 per cent decrease;
- Number of times using emergency medical services (EMS): 50.0 per cent decrease;
- Number of times using an emergency room: 42.4 per cent decrease;

- Number of days spent in jail: 92.7 per cent decrease;
- Number of times in jail: 26.6 per cent increase;
- Number of interactions with police: 70.8 per cent decrease; and
- Number of court appearances: 44.4 decrease.

Notably, the number of times in jail increased, though days in jail decreased. Conversations with program staff suggest that during the course of program participation, clients are encouraged to address any outstanding warrants and charges. This leads to negotiations with respect to jail time that reduce the overall time spent in custody, although the number of times increases. Over time, as these issues are addressed, staff proposed that this divergence could be reduced as overall involvement with the corrections system is reduced.

TABLE 9 HOUSING FIRST SYSTEM INTERACTIONS

	Number of days hospitalized	Number of times hospitalized	Number of times using emergency medical services	Number of times using emergency room	Number of days spent in jail	Number times in jail	Number of interactions with police	Number of court appearances
Average at intake (past 12 months)	8.4	1.9	2.1	2.7	14.0	2.4	15.8	2.2
Average at 12-month assessment (past three months)	1.1	0.2	0.3	0.4	0.2	0.8	1.1	0.3
Projected 12-month assessment data for past 12 mo. from three mo.	4.2	0.7	1.0	1.5	0.9	3.0	4.3	1.2
Estimated change	4.2	1.2	1.0	1.1	13.1	-0.6	11.5	1.0
Per cent estimated change	-50.1%	-62.9%	-50.0%	-42.4%	-93.5%	25.6%	-72.6%	-44.4%

In terms of impact on mental-health conditions, comparing treated and untreated health conditions, notable improvements are suggested, with exceptions for addictions/substance-abuse issues (Table 10). Further examination on the divergence presented by the data on addictions is recommended, however program staff suggest that many clients are unwilling to admit these issues at intake and, as they become comfortable with staff and are engaged in conversations about their challenges, they become much more open. In other cases, they may not be aware of such challenges and unable to voice them during the intake process.

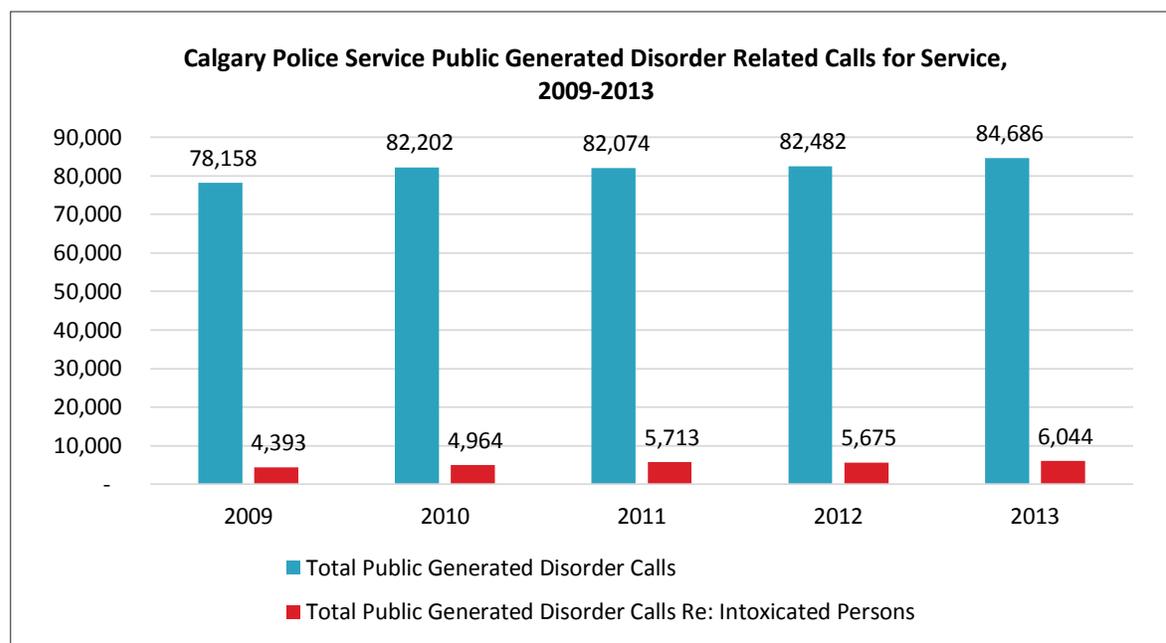
TABLE 10 HOUSING FIRST PROGRAMS, ONGOING CONDITIONS

		Ongoing Physical-Health Condition		Ongoing Mental-Health Condition		Addiction/Substance-Abuse Issue	
No	Intake	48	34.0%	78	55.3%	27	19.1%
	12 mo.	46	32.6%	76	53.9%	26	18.4%
Yes: Treated	Intake	27	19.1%	18	12.8%	23	16.3%
	12 mo.	55	39.0%	24	17.0%	20	14.2%
Yes: Untreated	Intake	54	38.3%	31	22.0%	79	56.0%
	12 mo.	24	17.0%	29	20.6%	89	63.1%
Yes: Both Treated and Untreated	Intake	2	1.4%	3	2.1%	2	1.4%
	12 mo.	11	7.8%	6	4.3%	2	1.4%
Blanks	Intake	10	7.1%	11	7.8%	10	7.1%
	12 mo.	5	3.5%	6	4.3%	4	2.8%

Calgary Police Services Impact

In 2013, the Calgary Police Service (CPS) reported 6,044 public-generated social-disorder calls regarding intoxicated persons.⁶⁷ Data were available to examine changes in public calls regarding intoxicated persons since 2009, as shown in Figure 2; unfortunately, it is unclear how many of these relate to the target population served by Alpha House. Historical CPS data were not available to assess the impact of the opening of Alpha House sobering facility in 1981 on police responses or intoxication.

FIGURE 2 CALGARY POLICE SERVICE, PUBLIC GENERATED DISORDER RELATED CALLS RE: INTOXICATED PERSONS

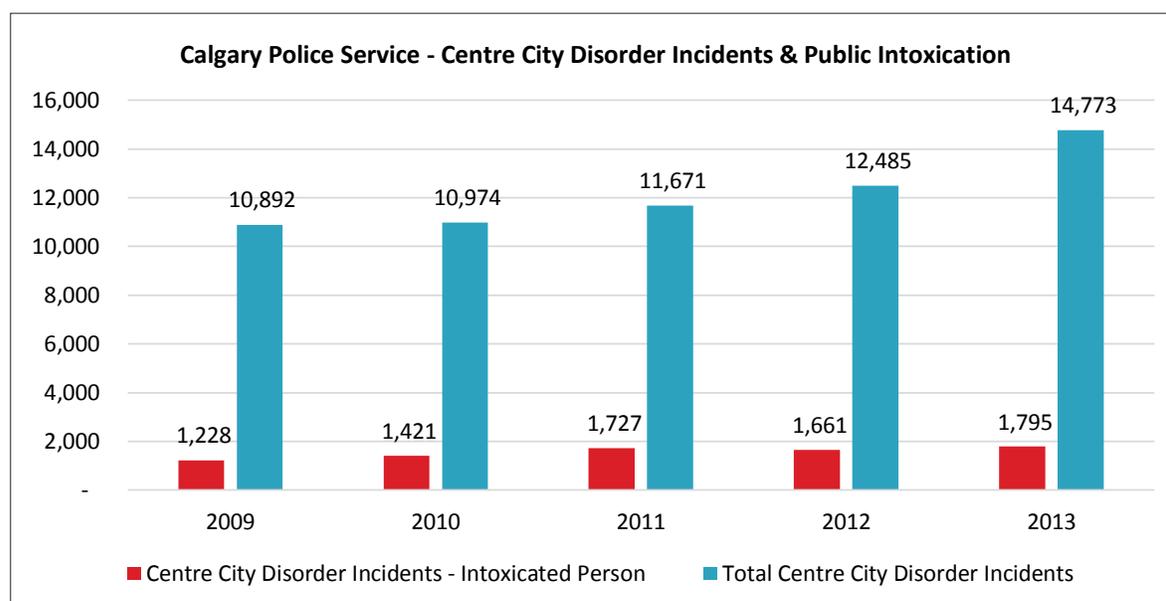


⁶⁷ Calgary Police Service, *Annual Statistical Report 2004–2008* (Calgary, Alta.: Calgary Police Service, 2008), <http://www.calgary.ca/cps/Documents/statistical-reports/2004-2008-annual-statistical-report.pdf>; Calgary Police Service, *Annual Statistical Report 2009–2013* (Calgary, Alta.: Calgary Police Service, 2013), <http://www.calgary.ca/cps/Documents/statistical-reports/2013-annual-statistical-report.pdf>.

Looking at the data on the city centre only (Figure 3), it seems that calls regarding public intoxication have grown since 2009, although they decreased as a percentage of total disorder calls during the period. Again, it is difficult to discern which incidents relate to the target population served by Alpha House. Overall however, public-generated disorder calls regarding intoxicated persons are about five per cent of all total calls. Looking at the city centre specifically, this proportion is close to 13 per cent on average.

Reports from CPS confirm the impact of the partnership with Alpha House on public intoxication measures. In 2010, CPS reported its downtown arrest-processing unit saw about two people per day for public intoxication. In 2011, this was down to 1.3 per day on average — a 37 per cent reduction attributed to innovative alternatives and community partnerships. In this manner, holding cells are a “last resort.”⁶⁸ Unfortunately, available data are too broad to ascertain these specific trends.

FIGURE 3 CALGARY POLICE SERVICE, CENTRE CITY DISORDER INCIDENTS & PUBLIC INTOXICATION



Considering the number of calls made regarding intoxication to Alpha House’s DOAP transportation service as well as overall volume of intoxicated persons staying at the sobering centre in the analyzed 2013–14 period, the impact of not having these services available would likely be reflected in considerably higher call volume and police responses, particularly in the centre city area.

IMPLICATIONS

The Alpha House case study presents several implications of relevance to policy-makers and service providers. Firstly, it provides an example where sobering centre services can be leveraged as an entry point to longer-term housing and recovery supports. The ability of the agency to develop a continuum for those with higher needs and long-term sobering centre use to access a range of Housing First programs is central to the housing stability and public-system reductions HMIS data suggests.

⁶⁸ Nadia Moharib, “Calgary’s drunk tank drying up,” *Calgary Sun*, August 23, 2011, <http://www.calgarysun.com/2011/08/23/calgarys-drunk-tank-drying-up>.

The one-stop-shop approach to the provision of a range of supports for individuals with long-term housing instability and addiction challenges is an example of client-driven service integration where support type and intensity is guided by the needs of the target population.

Though not immediately evident in the HMIS data, working relationships among frontline Alpha House providers and police, bylaw enforcement, emergency medical services, as well as other non-profit services, enable the successful operation of the sobering centre, outreach and housing programs. Nevertheless, the data do point to the ongoing use of services by a core group of vulnerable clients who require additional effort to support ending the apparent cycling among facilities operated by public-system and non-profit providers. The capacity of Alpha House and its partners to develop a strategy to target common heavy system users will enable enhanced integration to emerge between key partners.

The approach also suggests that working relationships with allied health and corrections partners at the service-delivery level can be successfully leveraged to enhance client and community impact. The notable reductions in usage of health, jail, and police services achieved by Housing First interventions were a result of a concerted effort to enhance appropriate access to mainstream services once the client's basic needs, particularly housing, were addressed.

In particular, the ability to leverage co-ordinated case planning to ensure appropriate discharge planning is in place for heavy system users leaving correctional, treatment or health facilities can be a key means to enhancing current efforts.

With respect to public intoxication, it is evident that Alpha House serves a key role in the community. It allows police and medical services to divert clients into its facility, from which they can access additional services, including medical support, addiction and recovery programs, as well as housing. The linking of the DOAP program with the sobering centre and Housing First further facilitates reductions of visible public intoxication in the city core, curbing the need for emergency medical, police and bylaw-enforcement responses.

Nevertheless, the fact remains that the concern over visible forms of public intoxication continues to shape responses. Public intoxication continues to be criminalized, leading to ongoing tension between examples of a public-health, harm-reduction approach, such as Alpha House, and the pressure to "clean the streets." Alpha House does, however, present an important example where this tension can be managed, providing a harm-reduction response to lessen the need for police responses.

Of course, Alpha House remains only one agency among hundreds engaged in addictions and housing services in the city. Its response must be aligned with a broader, systematic approach to homelessness and addiction that challenges short-term responses.

The continued development of a systems response to homelessness, as suggested by the Plan to End Homelessness, is an important part of this approach; this will require continuation of funding to support housing options for this population, appropriately tailored to meet the needs of those experiencing homelessness, addiction and mental-health issues. The over-representation of Aboriginal people across Alpha House services suggest that further development of culturally appropriate interventions are required.

However, without an integrated approach that reaches across sectors to align police, corrections, health and homeless-serving systems, such efforts will remain limited in impact. The development of policy-level co-ordination among these systems can target reductions of sobering centre use, increased access to housing, addiction and medical supports, as well as decreased incidents of arrests for public intoxication among this complex client group. It is not feasible to eliminate public intoxication, but it is feasible to develop a systematic response to tackle the complex needs of a relatively small group of clients who are likeliest to be heavy users of several public systems.

This approach aligns with broader initiatives, such as the Integrated Justice Services Project,⁶⁹ funded by the Alberta Justice and Solicitor General under the Safe Communities initiative, which promotes innovative community-driven alternatives to incarceration, particularly for repeat offenders with long-term addiction, mental-health, and homelessness challenges.

Already, Calgary Police Services shifts in practice towards this approach are underway. This includes the operations of the Police and Crisis Team (PACT), beginning in 2010, where nurses and police officers work together to respond to social-disturbance calls with respect to this target group and offer alternatives to arrest or ticketing, as well as connecting individuals with housing and support resources in the community.⁷⁰ The more recent opening of the SORCe (Safe Communities Opportunity and Resource Centre) as a central access point to services, including housing, presents another initiative under the “safe communities” banner to develop such alternatives to justice responses.⁷¹

Alpha House is, and will continue to be, a key partner in these efforts as an example of effective community- and client-driven alternatives to police and correctional responses to addictions. The capacity of Alpha House’s programs to leverage relationships with frontline and policy-level stakeholders in the justice and medical sectors point to the important roles such services can play in shifting responses to complex populations from punitive approaches towards enhanced, client-driven integration that benefits multiple stakeholders.

CONCLUSION

The evidence presented in the review of the literature and the case study suggest that a harm-reduction approach to public intoxication shows significant promise, particularly when integrated in broader community-based system-integration efforts. While discussions on solutions where public intoxication and visible chronic homelessness are conflated, it is important to keep person-centred policy and program development front and centre. Available evidence suggests that, in order to tackle long-term addiction and mental-health issues, a client-directed approach may have the best chance at achieving outcomes that address the concerns of the diverse stakeholders involved.

Alpha House’s approach to leveraging the sobering centre and mobile outreach to provide access to a slate of Housing First programs is an example of the integration of sobering centres with broader systems approaches to addressing public intoxication, as well more complex issues including homelessness and addictions. Moving policy in this direction, rather than further criminalizing addiction, makes sense from a client, policy and community perspective.

Given the notable over-representation of marginalized, homeless individuals in sobering centre facilities, emerging critiques of these facilities centre on their lack of connectedness to broader initiatives to address root causes of addiction and homelessness common in repeat users. In some instances, sobering centres have, however, become key parts of system responses to addictions and homelessness acting as effective entry points to continuums of care. Alpha House presents an example of such an approach in a Canadian context.

⁶⁹ P. Thompson and J. Schutte, *Integrated Justice Services Project: Implementing Problem-Solving Justice* (Report prepared for Safe Communities and Strategic Policy, Edmonton, Alta.: 2010), 1-242.

⁷⁰ Calgary Police Service and Alberta Health Services, *PACT Police and Crisis Team 3 Year Pilot Funded through Safe Communities* (2011), [http://www.hscc.on.ca/Resource%20Library/Policing/Crisis%20Program%20Models/Calgary%20Police%20and%20Crisis%20Team%20\(PACT\)%202011-05.pdf](http://www.hscc.on.ca/Resource%20Library/Policing/Crisis%20Program%20Models/Calgary%20Police%20and%20Crisis%20Team%20(PACT)%202011-05.pdf).

⁷¹ SORCe, June 18, 2013 – June 18, 2014: A Year in Review (2014), <http://static1.squarespace.com/static/5119a54be4b0dcc6d897dc2b/t/53a20872e4b0d80b1acc28d5/1403127922587/SORCe+-+Year+In+Review.pdf>.

Research to date, as well as the case study presented, suggest that sobering centres can be effective vehicles for improving individual and community health and well-being as part of comprehensive responses to intoxication. Despite the ongoing tension between the public-health, medical, and justice responses to inebriation, such facilities can play a key role by providing safe places for clients to sober up, while offering access to longer-term services to address underlying issues.

Sobering centres will not and should not replace the need for medical intervention in some cases. Further, they cannot replace the need for police custody as some clients cannot be safely assisted in such facilities. This means that the triage into sobering centres, health system and police custody will continue to be needed. Ultimately, a comprehensive approach to intoxication is necessary, one including sobering facilities along with a continuum of housing, health, and corrections responses that challenges the criminalization of addiction.

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