Crisis Service Needs for People who are High or Intoxicated: Service Provider Perspective

Report three of a four-part research initiative

Crisis Model Working Group,
Toronto Drug Strategy

March 2009

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TABLE OF CONTENTS

	Page
Summary of key findings	3
Introduction and purpose of research	4
Methodology and limitations	5
Survey participants	6
Crisis responses: what help do people need?	7
Crisis service model development	8
System gaps: service provider knowledge and service availability	10
Service providers: time and workload	14
Conclusion	16
Acknowledgements	16
Appendix A: Survey tool	17
Appendix B: Estimated service provider time spent involved in crises related to substance use	18

SUMMARY OF KEY FINDINGS

Introduction: This report is the third component of a research project exploring an appropriate model for a 24-hour service for people having crises related to substance use. Input was sought from Toronto service providers about crisis service needs for people who are high or intoxicated. Surveys were completed by 334 service providers who regularly work with people experiencing crises related to substance use, in the following sectors: outreach, shelters, withdrawal management, substance use treatment, mental health, harm reduction, health centres, drop-in centres, hospital emergency departments, Toronto Emergency Medical Services (EMS), and the Toronto Police Service. For the purposes of this research, 'crisis' is defined as distress (mental and/or physical), paranoia, aggressive and/or violent behaviour, self-harm, suicidal thoughts, etc.

Overview: Based on the findings of this research, the proposed crisis service would form an important new link in an existing chain of services for people experiencing crises related to substance use. In this research, survey respondents identified specific features and aspects of service that should be included in this model to ensure that people in crisis receive appropriate support. Key elements of the existing service system were identified which have important roles in responding to substance use-related crises. Themes also emerged about gaps in services for people having crises related to substance use and concurrent disorders (mental health and substance use problems combined). Service providers in all sectors reported spending significant amounts of time helping people experiencing crises related to substance use, and that a dedicated service could positively impact their workload. The proposed crisis model must work effectively to improve service responses to people experiencing crises related to substance use, and to alleviate some of the pressure on current overstretched services, such as hospital emergency departments. These findings will be used in the development of the crisis service model, and to address the service context in which it will function.

A) Crisis service model features

The proposed service should be able to respond quickly and effectively to someone in crisis. The crisis service should provide a safe setting on a 24/7 basis, including:

- Assessment, stabilization and monitoring
- Medical services
- Referrals, case coordination and/or case management
- Short-term beds
- Mental health services
- Mobile service component

Formal agreements should be sought with diverse agencies for services to be provided onsite, and to ensure that services are available when a person is discharged.

Staff at the crisis service should be well-trained in crisis intervention and de-escalation using a calm, non-judgmental approach. They should be knowledgeable about substance use and concurrent disorders, and skilled in assessment of needs. There should be a high staff-client ratio, as intensive support will be required.

This service should assist hospital emergency departments by providing an alternate location where Emergency Medical Services (EMS) and police could bring clients/patients who are experiencing crises related to substance use. Under current legislation and regulations, EMS must transfer patients to hospital emergency departments. Flexible options in this legislation need to be explored to provide a viable, integrated alternative to hospitals.

B) Service system gaps: Provider knowledge & service availability

Survey respondents described an overstretched service system. Services that they perceived as important in helping people often had lengthy wait times and limited access, particularly for people having crises related to substance use. Sectors identified as having capacity-related issues included hospital emergency departments, withdrawal management and substance use treatment programs, shelters, and mental health crisis response programs. Survey respondents also identified the need for improved coordination between sectors to better serve people with complex needs, and to alleviate some of the pressure on busy services.

Survey respondents stated that in all sectors that work with people experiencing crises related to substance use, service providers should have expertise in de-escalation using a calm, non-judgmental approach. The primary role of the proposed service will be to assist people in crisis. However, this research suggests that a secondary role should be to help various sectors to improve their knowledge and capacity to work appropriately with people experiencing crises related to substance use or concurrent disorders.

INTRODUCTION & PURPOSE OF RESEARCH

The Toronto Drug Strategy (TDS) is a comprehensive approach to alcohol and other drugs based on prevention, treatment, harm reduction and enforcement. Several TDS recommendations are being implemented by working groups comprised of a broad range of government, institutional, community service and citizen representatives. One of these groups, the Crisis Model Working Group, is tasked with implementing TDS recommendation 27, which calls for the development of a model for a 24-hour service for people experiencing crises related to substance use.

The need for this crisis service was identified during the development of the Toronto Drug Strategy by several groups, from police to community agency staff to people who use drugs. A dedicated crisis service would reduce time and resource pressures on police services, ambulance services, and hospital emergency departments. In addition, it could provide a specialized crisis response to the particular needs of individuals who are high or intoxicated, and for whom traditional emergency services may not be the most effective or efficient response.

The proposed crisis model would prioritize service to people who have crises related to substance use or concurrent disorders (mental health and substance use problems combined), and who may be homeless, marginalized, and living in poverty. It would also be a resource to service providers who work with people when they are in crisis. There would be a particular focus to ensure that this service is accessible to individuals who do not or cannot readily access existing services due to systemic barriers, behavioural issues and other reasons related to their substance use.

The Crisis Model Working Group has directed and developed this exploratory research project to inform the development of the crisis service model, as described above. The research sought information to define this crisis service in terms of how it would operate, service gaps it could address, specific services it should include, and how it might link to existing services. This innovative project adds to the limited evidence base regarding service needs of people who are having crises related to substance use.

For the purpose of this research, 'crisis' is defined as distress (mental and/or physical), paranoia, aggressive and/or violent behaviour, self-harm, suicidal thoughts, etc. The research project has four components that together provide specific information to define and describe the need for this crisis service. These include:

1. A literature review to explore existing research for recommendations pertinent to services for people experiencing substance use related crises in an urban context;
2. Surveys of people who are regular users of alcohol and/or other drugs;
3. Surveys of service providers who respond to people when they are having crises related to substance use; and
4. A list of current Toronto services available to people who are high/intoxicated and in crisis

This is the third component of the research, and reports on the surveys of service providers who respond to people when they are having crises related to substance use. A summary report of each research component will be produced, and then integrated into a final report.

METHODOLOGY

The research project and methodology was developed by the Crisis Model Working Group. A subcommittee of four working group members functioned as the research team. The project was approved in a formal review process by the Toronto Public Health Planning and Policy Directorate.

This research project elicits the perspectives of service providers who work with people when they are having crises related to substance use, about the needs of people in these situations, and appropriate service responses. 'Crisis' was defined as distress (mental and/or physical), paranoia, aggressive and/or violent behaviour, self-harm, suicidal thoughts, etc.

Stratified quota samples were used, with stratification by service type, population served, and geographic location. A total of 334 surveys were completed with service providers who respond to people when they are high/intoxicated and in crisis. There were 38 participating agencies from 11 sectors including drop-in centres, harm reduction programs, health centres, hospital emergency departments, mental health programs, outreach programs, shelters, substance use treatment programs, withdrawal management programs, Toronto Emergency Medical Services (EMS), and the Toronto Police Service. Survey participants were recruited by agency service managers. Surveys were completed anonymously; several key interviews were conducted by research team members.

The qualitative survey tool, attached as Appendix A, was designed to gather information from service providers regarding service needs and gaps for people experiencing substance use-related crises. Information was sought regarding types of help needed, the existing service system, estimated work time involving substance use related crises, potential impact of a crisis service on current workload, and services that respondents would like to see developed or expanded.

In this qualitative study, a grounded theory approach was used in data analysis. Survey data was grouped by sector for initial analysis, then all groups were treated as a whole body of data. Thematic analysis of the survey data was conducted to develop a conceptual framework capturing the experience and opinions of survey participants. An iterative coding procedure was used. Analytic codes were reviewed and adjusted in relation to previous codes and the understanding of the data. Themes were developed through this coding procedure to develop a detailed understanding of survey responses.

LIMITATIONS

Although 334 surveys were completed by 38 agencies in 11 sectors, the number of surveys completed varied significantly by sector. As a result, for some sectors the samples are too small to be representative of the sector as a whole. There are limited surveys from agencies mandated to serve First Nations/Metis/Inuit people, although attempts were made to elicit participation. There are also limited surveys from Etobicoke-York, although attempts were made to gather more surveys from this area. However, it should be noted that many surveys were completed by service providers outside the area whose catchment area also includes Etobicoke-York.

Most surveys were completed by staff onsite at participating agencies. As participants were recruited by service managers, there is the risk that agency staff might not have been completely honest in their responses. However, this risk was mitigated as participating agencies were fully informed as to the research context and agreed to adhere to the survey process from the outset of the research.

SURVEY PARTICIPANTS

Surveys were completed by service providers in 11 sectors who work with people when they are high/intoxicated and in crisis. In total, 334 surveys were completed staff from 38 service agencies/programs. Most surveys were completed by individuals providing direct service, with some management-level participation.

Number of surveys by service sector:

Toronto Police Service	74	Mental health programs	19
Shelters	54	Substance use treatment programs	19
Outreach programs	43	Emergency Medical Services	15
Drop-in centres	32	Hospital emergency departments	10
Withdrawal management programs	30	Harm reduction programs	10
Health centre programs	28		
		Total:	334

Number of surveys by client group served:

Adults (18+)	63	First Nations/Metis/Inuit	5
Men	23	Transgendered/ transsexual	2
Women	18	Serving all groups	208
Youth (16-24)	15		
		Total:	334

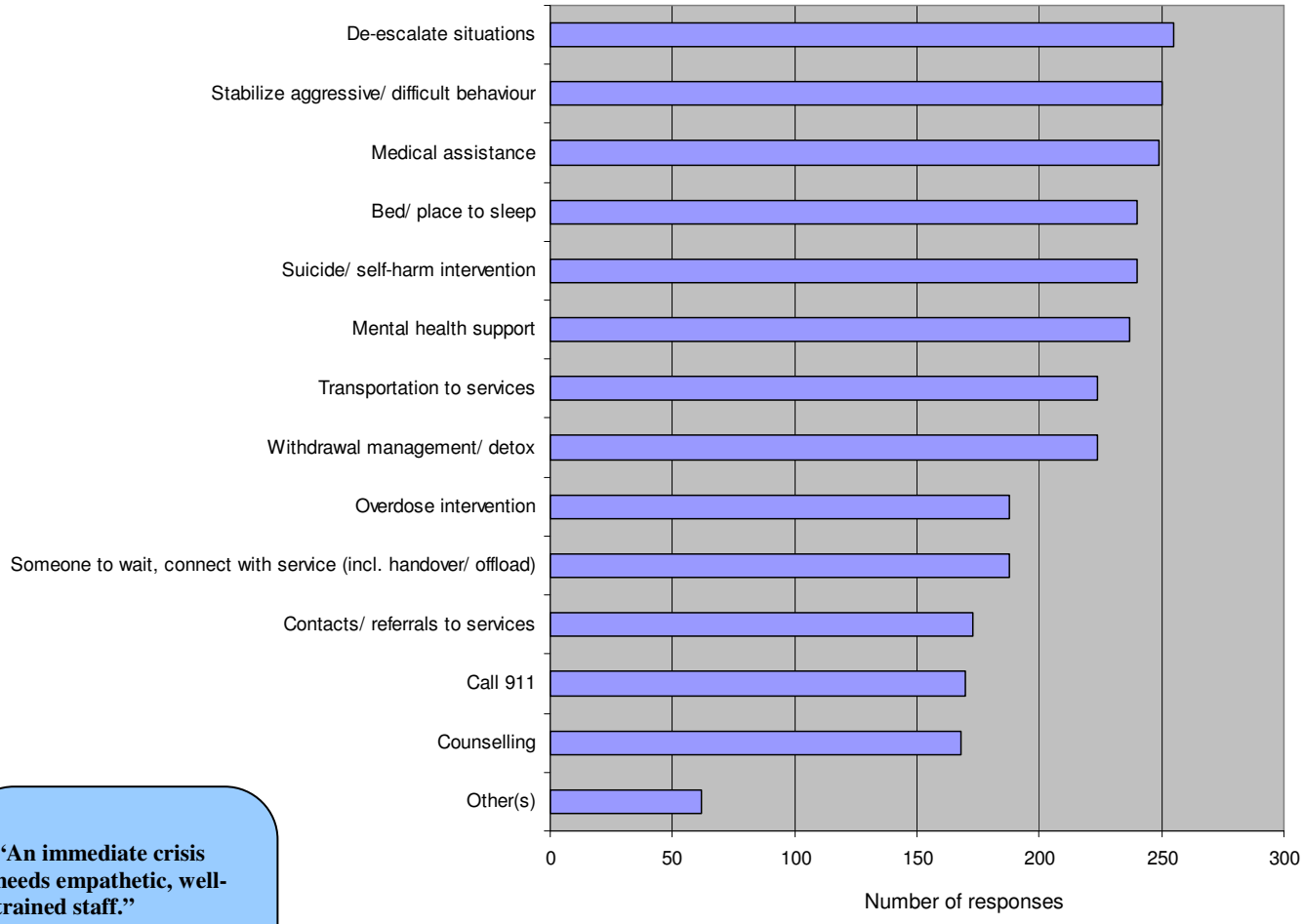
Number of surveys by City of Toronto Community Council district:

City-wide (no catchment area)	159
Toronto-East York	136
North York	24
Scarborough	13
Etobicoke	2
Total:	334

CRISIS RESPONSES: WHAT HELP DO PEOPLE NEED?

Service providers were asked to identify the types of assistance people need when they are high or intoxicated and in crisis. There was common agreement across sectors regarding supports and services that people believe are important; their combined responses are shown in Chart 1. De-escalation and stabilization supports were seen as essential. Medical services and overdose intervention, suicide prevention and mental health support were also viewed as crucial. Beds were identified as vital, as were withdrawal management (detox) services. Transportation was seen as a key need, as was someone to accompany the client/patient as they wait for help to be provided. Counselling, and referrals to various other services were cited as important. Links with emergency services were also highlighted.

Chart 1: Types of help people need when they are high/intoxicated and in crisis



"An immediate crisis needs empathetic, well-trained staff."
Health centre staff

"Clients that are high or intoxicated sometimes just need somewhere to crash where they can be safe, and someone to speak with after."
Drop-in centre staff

CRISIS SERVICE MODEL DEVELOPMENT

Overall, survey respondents described an overstretched system of health and social services. The proposed crisis service should be an important link that strengthens the service chain. This research found a need for the proposed crisis service to be well-connected to the existing system so that clients/patients receive the most appropriate support, and to help services function more effectively. The primary mandate of the service would be to provide assistance to people experiencing crises related to substance use or concurrent disorders (mental health and substance use problems combined).

In this research, themes emerged about the characteristics of services that are helpful when people are high or intoxicated and in crisis. These are important to note for the development of the crisis service model. Services were identified as helpful if they offered one or more of the following:

- immediate de-escalation
- assessment of needs
- stabilization
- medical and/or mental health services
- expertise in crises related to substance use.

Services were also found to be helpful if they worked in a supportive, effective manner with both clients/patients and other service providers.

"We need a place police can take these persons and know that they will be held and cared for..."
Police officer

"We need a place with one-stop shopping: detox, deal with the crisis, plan for safety… case management if appropriate."
Emergency dept. staff

"Another type of facility other than E.R./detox/jail is needed as none of these are available due to the client's situation."
Mental health staff

"Many of these individuals need aftercare and ongoing support."
Emergency dept. staff

Service model features

All eleven sectors identified the need for a 24-hour crisis facility with multiple services offered onsite, a 'one-stop shopping' model. Survey respondents noted that it was important to have one place with a variety of services available onsite, and links with a range of sectors to address needs identified by the client/patient. Key aspects of service that this facility should provide were de-escalation, assessment of needs, stabilization and monitoring, health supports, and referrals into other services. It was also noted that many crises occur after other services are closed, therefore this service should operate on a 24/7 basis.

Survey respondents viewed medical and mental health services as vital in ensuring that people stabilize safely. They stated that having these services available at the proposed crisis facility would mean that clients/patients without serious medical needs could potentially be diverted from hospital emergency departments. In order to ensure that hospital diversions are possible, survey respondents stressed that this service must operate on a 24-hour basis. Currently, hospital emergency departments are the default service after 'office hours'. During the day and/or evening, agencies such as drop-in centres, outreach and harm reduction programs frequently assist people in crisis, including bringing them to hospitals. However, these small, community-based programs often have limited service capacity and resources.

Survey respondents made reference to 'sobering', 'chilling out' or 'coming down' as needs that this service should accommodate. Respondents stressed the importance of supervised stabilization until the person is sober or no longer 'under the influence' of alcohol and/or other drugs. A place where people could 'come down' or stabilize in safety was seen as critical, serving the client/patient in a more holistic way than is possible in the current system. All eleven sectors noted that beds should be available for brief stays for the purposes of stabilization and monitoring. Providing amenities for basic needs, particularly food and shower facilities, was also seen as important for stabilization.

Once someone begins to recover from the crisis, survey respondents perceived that this was a key time to connect them with other resources in the community to help them stabilize over the long term, and prevent future crises. They noted several sectors that could be important for referral partnerships, including withdrawal management and treatment services, health services, housing services and supports, and harm reduction education and services. Other research has demonstrated that when people have substance use-related crises, referrals from staff can assist people to seek change in their lives. For example, in a study of injection drug users and non-fatal overdose, when drug users received treatment information at the time of crisis intervention, a significant number sought treatment within 30 days after their last overdose.[1]

Staffing

A recurring theme in this research was that staff working with people when they are high or intoxicated should be knowledgeable about substance use and concurrent disorders. Survey participants perceived that staff knowledge and expertise are critical to successful de-escalation and stabilization with people using alcohol and/or other drugs. Appropriate staff selection and training should ensure that crisis service staff use a calm, non-judgmental approach in working with clients/patients, and are skilled in assessing needs. The use of this approach was related to successful crisis resolution, and to providing service on a 'low threshold' basis. 'Low threshold' program design ensures that all aspects of service are accessible, particularly to people who have multiple needs, including difficulty communicating, and/or challenging behaviour. Survey respondents in diverse sectors noted that the proposed crisis service should use an approach comparable to that of a drop-in centre. Successful drop-in centres use an "intentionally informal" approach to service, which includes responsiveness, flexibility, and a holistic approach to client needs.[2]

In order to provide a safe, welcoming environment, survey respondents noted that high levels of staffing will be required. Providing service to people with multiple, complex needs is intensive, particularly if they are high or intoxicated and in crisis.

Mobile service responses

In addition to the fixed site program, mobile services were perceived as vital in responding effectively to crises. Assisting people as quickly as possible was noted as a priority by survey respondents. Mobile services were seen as important because they can respond immediately, assess the situation, and begin to de-escalate the crisis. Transportation to services was also seen as a vital service element. Respondents noted that people in crisis may have no way of getting to services, particularly after 'office hours'.

Toronto Emergency Medical Services (EMS) regulatory challenge

In this research, Toronto's emergency ambulance service was cited as having a critical role in responding to people in crisis. They were highly valued for their medical expertise, in addition to their multiple roles of assessment, monitoring, transportation, and connection to hospital services. EMS and other service providers described frustration with long waiting times at busy hospital emergency departments, which slow down EMS and other service providers who wait with people until they are served.

"Most (agencies) have no resources to deal with both intoxication and crisis at once, especially with aggressive behaviour."
Treatment staff

"Patients usually have to be medically stable and not suicidal to use any agency."
Emergency dept. staff

"Any service that does not have resources to deal with intoxication and crisis simultaneously, e.g. shelters, is unhelpful."
Emergency dept. staff

"A resource where EMS could take an off the street patient would be beneficial, especially those with alcohol-related problems that do not require medical clearance, but should be supervised."
Paramedic

EMS responses to this survey noted that significant time could be saved if paramedics were able to bring appropriate patients to the proposed crisis service instead of a hospital emergency department. However, these respondents also noted that currently this would not be possible as EMS is limited by legislation/regulation as to where they may transport and 'offload' patients. The proposed crisis service must ensure that appropriate medical services are available onsite, so that EMS may advocate for flexibility in legislation and regulations in order to make use of this alternate service.

[1] Pollini, Robin A. McCall, Lisa et al. Non-fatal overdose and subsequent drug treatment among injection drug users. Drug and Alcohol Dependence, Vol. 83, 2006. 104-110.
[2] Toronto Drop-in Network. Good Practices Toolkit. 2007, 1A2-1A3. www.toronto.ca/housing/info-agencies-toolkit.htm.

SYSTEM GAPS: PROVIDER KNOWLEDGE & SERVICE AVAILABILITY

As discussed, the proposed crisis service would form one new component in the existing service system. In this research, several sectors were noted as having key roles in helping people experiencing crises related to substance use. However, issues were identified regarding service availability and capacity within these sectors. The services that were found to be the 'least helpful' were described as having one or more of the following characteristics:

- difficult to access
- lengthy wait times
- low levels of staffing
- little expertise/knowledge in how to work with people who have problems related to substance use or concurrent disorders, including in crisis de-escalation and behaviour management with people who are high or intoxicated.

These limitations are important to note as the crisis service would need to operate in partnership with programs across the service system. In order for this service to provide clients/patients with a full range of appropriate supports, it must integrate with a range of services through partnerships, referrals, and coordinated service provision. The proposed crisis service will be unique, and will be well-positioned to help existing agencies and services improve their capacity to respond to people having crises related to substance use or concurrent disorders.

Service Provider Knowledge and Expertise:

In this research, expertise in working with people having crises related to substance use was seen as critical in responding appropriately in these situations. Successful de-escalation and initial stabilization were related to the manner in which the client was approached by the service provider. A non-judgmental, calm approach was associated with successful stabilization of a person in crisis. The use of a judgmental, dismissive attitude or insensitive, aggressive approach was associated with a lack of knowledge in this area.

Staff working in treatment sector programs were acknowledged for their expertise in working with people who experience crises related to substance use or concurrent disorders. They were seen by survey respondents as knowledgeable and capable in these situations. However, this was not the case for other sectors. Hospital emergency departments, police and shelters were perceived as lacking knowledge about substance use or concurrent disorders, and how to work with people having problems related to these conditions. Survey respondents noted that service providers in these sectors sometimes used an insensitive, judgmental approach in working with people having substance use-related crises, which resulted in a lack of appropriate support being provided, or quick discharge from services with no follow-up.

Both hospital emergency departments and shelters were noted as unable to manage people who were high or intoxicated, particularly if their behaviour was disruptive. These sectors were described as dismissing people in these situations rather than taking time to de-escalate, stabilize and fully assess their needs. Police were noted to sometimes use an aggressive approach when it may not have been necessary, and which could have the effect of escalating the crisis situation. Survey respondents also noted that these sectors are very busy with demand overwhelming capacity for service, competing priorities, and staff resources that are over-stretched. In particular, shelters were identified as having too few staff to respond appropriately to people experiencing substance use-related crises.

"Anyone helping in a crisis needs training about how to deal with drug users, not based on control, but what the person needs at the time…e.g. tell them 'There is no threat', 'I'm not going to hurt you' …"
Health centre staff

"Hospitals are dismissive and unable to deal with disruptive behaviours."
Health centre staff

"Uniformed officers can escalate the situation."
Police officer

"Police need to have training to help in these situations."
Outreach staff

It is clear from the findings of this research that staff in sectors that work with people who are high/intoxicated and in crisis should have expertise in de-escalating aggressive or disruptive behaviour and resolving crises using a calm approach and a non-judgmental attitude. Staff should receive specific training in working with people who have problems related to substance use and concurrent disorders, including how to appropriately assess their needs.

This finding is consistent with a Toronto study of suicidal, substance-using men who frequently use the hospital emergency department, which suggested that emergency department staff should use specific interventions to de-escalate crises and prevent disruptive behaviour, as well as to manage suicidal behaviour.[3] In addition to assisting people in crisis, a secondary role for the proposed crisis service would be to work with service providers in various sectors to improve their knowledge and capacity in responding to people having crises related to substance use.

a) Lack of knowledge about community service resources

In this research, survey respondents from hospital emergency departments, EMS and police rarely made note of community service agencies, other than substance use treatment services or shelters. Services such as drop-in centres, outreach programs, and harm reduction programs, who work regularly with people having substance use related crises, were typically not mentioned. This absence may indicate that these 'institution-based' services may not have had opportunities to work with community-based services, and may not be well-informed as to their mandates or expertise, or the types of work that they do. If this is the case, it speaks to the need for more communication between these agencies and programs about each others' roles and services provided. This type of information exchange could improve communication and service coordination between agencies, providing a benefit to vulnerable individuals who are using services across the system.

"E.R. staff need to be low on control, and high on relationship-building, both with staff and patients."
Withdrawal mgt. staff

"A service is helpful based on how effective the service providers are at de-escalating the presenting crisis, and recognizing potential risks to client or others…"
Shelter staff

"We have nowhere to place people when they are very intoxicated."
Shelter staff

"Detox is helpful if you could get people in."
Health centre staff

"We need more detox beds available."
Police officer

"More access to detox beds is needed."
Drop-in centre staff

Service Availability:

Survey respondents noted that people having problems related to substance use may have a range of service needs, from health, to housing and other ongoing supports. They also highlighted issues related to the availability of services in sectors that play key roles in supporting people who experience crises related to substance use, including long waiting periods or difficult access. Improving access to existing services would benefit clients/patients, as well as the various service providers trying to help them. Sectors identified as having issues related to service availability and capacity were withdrawal management (detox), hospital emergency departments, substance use treatment, shelters, mental health crisis programs, and housing.

a) Withdrawal management services

Withdrawal management (detox) services were seen as valuable for providing stabilization and support to people experiencing crises related to substance use, and then monitoring that stability. Survey respondents viewed residential withdrawal management services as important in helping people who need respite from substance use in a supervised setting. They perceived detox program staff as being knowledgeable and capable in working with people in crisis having substance use problems, as well as working cooperatively with service providers. They highlighted the important role of detox services in linking people into the rest of the treatment system when they are ready to stop using alcohol and/or other drugs. Withdrawal management services and hospital emergency departments were also noted as the only facilities open 'after office hours'.

All eleven sectors surveyed stated that more withdrawal management beds and services are needed. Respondents stated that there were not enough beds in the system, that beds were always full, and that it took much too long for someone to enter a residential program. Some sectors also reported the need for more medical withdrawal management beds for individuals with severe substance use problems. One potential role of the proposed service would be to work with the withdrawal management sector to problem-solve around bed availability for people in crisis.

[3] Spence, Julia M. Bergmans, Yvonne. Strike, Carol et al. Experiences of substance-using suicidal men who present frequently to the emergency department. Canadian Journal of Emergency Medicine, 10(4), July 2008, p.339.

b) Hospital services

Survey respondents wanted more hospital crisis services and beds to be available when needed. They valued highly the medical expertise and mental health services that hospitals can provide, and viewed hospitals as an appropriate crisis response setting. However, they were frustrated by lengthy wait times in emergency departments. As noted above, emergency departments and withdrawal management programs were stated to be the only facilities available when all other services are closed.

c) Mobile crisis response services

In this research, survey respondents noted that an immediate response to someone in crisis was important, and recommended that the proposed crisis service have a mobile component. EMS and police were both seen as critical services in this research, in part because of their quick arrival onsite in crisis situations. Survey respondents noted that police were particularly helpful in situations where a person is violent, and/or in danger of harming themselves or someone else.

Police Mobile Crisis Intervention Teams (MCITs) were also viewed as helpful for the unique crisis intervention services and expertise they provide. MCITs are police officer-nurse teams working out of several Toronto police divisions in partnership with local hospitals. These teams may be called in by first responder police teams in situations where someone is 'emotionally disturbed'. Survey respondents noted that MCITs are able to address both health assessment and safety concerns. They were seen as having expertise in de-escalating and working effectively with people in crisis, regardless of whether or not they were high or intoxicated. Although survey respondents from several sectors noted how helpful MCITs are in these crisis situations, some capacity issues were noted. MCITs operate seven days per week, from 1:00-11:00 p.m., based upon assessed peak hours for 'emotionally disturbed person' calls. Survey respondents would like to see MCITs extended city-wide, and available on a 24/7 basis. Pursuant to this research, we are informed that the Toronto Police Service is planning for MCITs to be operational city-wide in the near future.

Toronto's mental health crisis response services were also viewed as important by survey respondents. These programs provide telephone support to people who call in distress, and a few have mobile teams who can offer in-person support. However, survey respondents noted that mental health crisis programs often do not provide service to people when they are high or intoxicated, which is a serious service gap. The proposed crisis service should work with mental health crisis response services to resolve this issue.

d) Shelters

Respondents from multiple sectors, including the shelter sector, expressed frustration that shelters do not consistently serve people who are high or intoxicated. Several respondents noted the need for more staff onsite to work with people who have complex needs, and require more intensive support. A unique program cited repeatedly in these surveys was the Annex Harm Reduction Program at Seaton House. This program was viewed as successful in providing housing and stability for homeless men with severe substance use problems, and who may also have behaviour issues related to their substance use. This program also provides case management services for residents.

"Hospitals with skilled and empathetic nurses are helpful."
Outreach staff

"Patients in crisis often remain with EMS for long periods of time until they can be assessed by the ER physician…. not beneficial for EMS or the patient."
Paramedic

"Police are helpful if an individual is violent."
Outreach staff

"Police MCITs are better for the patient and EMS workload."
Paramedic

"The police MCIT deals with issues right away."
Mental health staff

"Most phone crisis lines will not talk to anyone who sounds high or drunk."
Health centre staff

"Mental health crisis services should expand their service to include people who are intoxicated."
Harm reduction staff

"Shelters can't manage people who are high and in crisis. They send them away."
Mental health staff

"Shelters never want to take people. They say it's too dangerous."
Police officer

d) Residential substance use treatment services

The need for improved availability of residential substance use treatment services was highlighted by survey respondents, who were frustrated by long waiting lists. For example, someone might wait weeks before a treatment program bed became available. Residential treatment was perceived by survey respondents as a service that should be available as soon as an individual identifies that they would like to attend, or their motivation may be lost. This capacity issue was seen as perpetuating cycles of problematic substance use, as well as poor mental and physical health.

f) Housing

Housing was also identified as a critical gap, particularly for people who are involved with the treatment system. Survey respondents perceived that insufficient supportive housing was available for people having problems related to substance use and/or concurrent disorders. Multiple sectors noted the need for a range of supportive housing options, from harm reduction housing, to 'dry' housing for people who have completed treatment.

g) Aftercare/case management

Survey respondents viewed aftercare and case management as important services to ensure that an individual's needs were being met on an ongoing basis. Existing case management programs were seen as having limited capacity. Given the critical role of case management services, especially in supporting people with complex needs, this may be an appropriate function to embed in the proposed crisis service.

"Existing mental health and detox services leave wide cracks for patients with dual diagnosis and co-morbidities and behaviour problems and there are capacity issues - additional services are greatly needed."
Emergency dept. staff

"There should be after-care homes for people coming out of treatment with levels of support …"
Health centre staff

SERVICE PROVIDERS: TIME AND WORKLOAD

Estimated time responding to substance use-related crises

All sectors surveyed reported that a large proportion of their work time involves helping people with crises related to substance use. The proposed crisis service could help service providers by taking on some of this responsibility, and assisting people in crisis more quickly and effectively than the current service system. Survey respondents were asked to estimate the percentage of their work time that is spent with people who are high or intoxicated and in crisis, and also on documentation and follow-up; this data is compiled in Chart 2. The complete data is attached as Appendix B.

Across sectors, service providers reported spending large amounts of time with people having substance use-related crises, including on documentation and follow-up. For example, hospital emergency department respondents estimated that 49% of their time is spent helping people in these situations. For Toronto EMS and police respondents, the estimates were 45% and 44% respectively. There are serious financial and service implications to these estimates.

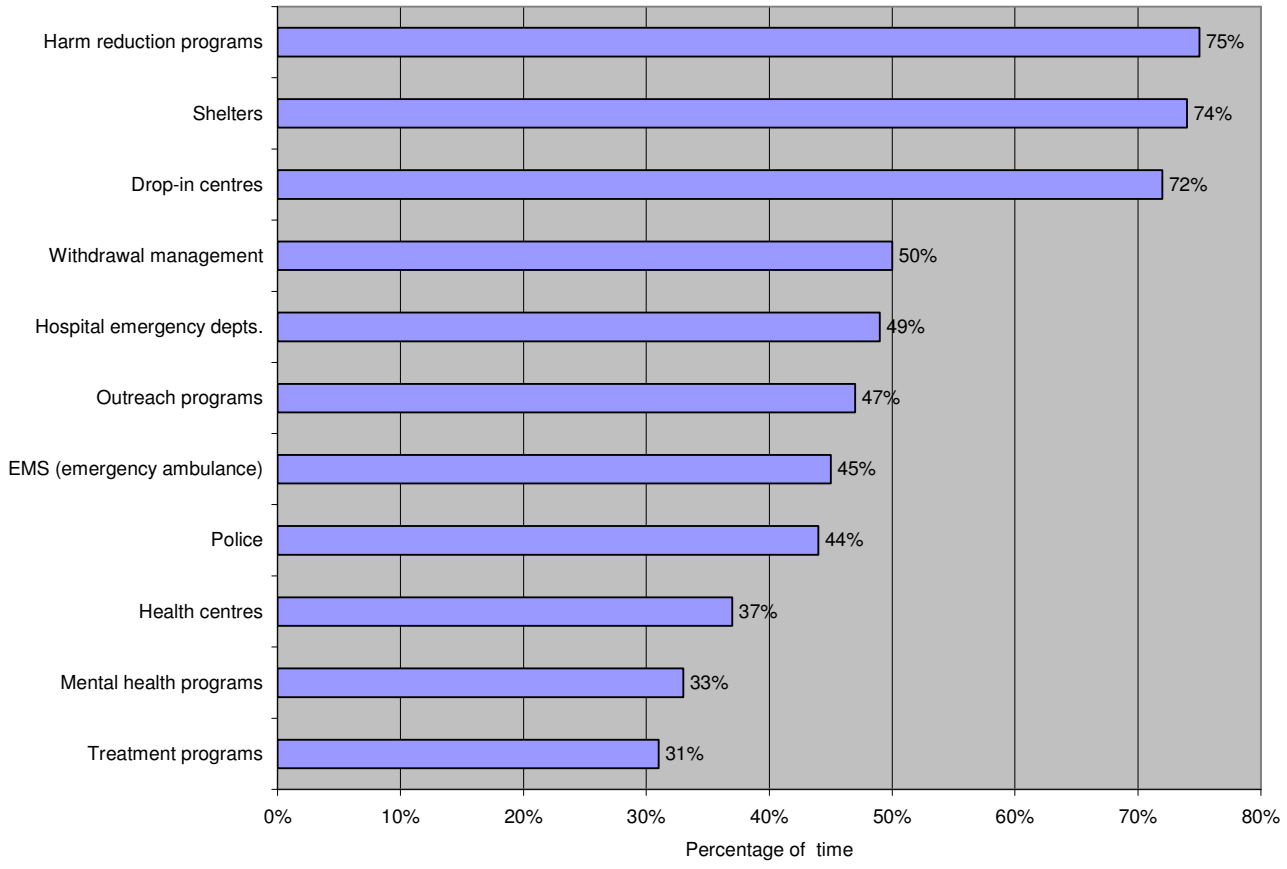
Not surprisingly, the highest estimates of time in this survey are from staff in programs that work on a daily basis with people who use alcohol and/or other drugs, such as harm reduction programs, shelters and drop-in centres. Staff in these sectors noted that individuals in crisis often sought their help because they have established trusting relationships. In addition, these programs function as a system of last resort, in that they work with people who are not well-served by mainstream services. However, they do not have the resources or capacity to meet the current demand for crisis support.

None of the agencies surveyed are mandated to respond only to people in crisis. The proposed crisis service should alleviate pressure on the existing service system, for example by accepting clients/patients more quickly than is possible in other services, and by diverting them entirely from hospital emergency departments.

"Clients who are in crisis take up a lot of resources in terms of the time that workers need to spend with them."
Drop-in centre staff

"A great deal of time can get taken up with crisis management. "
Shelter staff

Chart 2: Estimated percentage of time spent on crises related to substance use



Crisis service: potential impact on workload

Service providers participating in this research reported that there would be positive impacts on their workload if a specific 24-hour service existed to help with crises related to substance use. Across sectors, respondents stressed the need for clients/patients to receive appropriate support and interventions, and to receive them quickly regardless of their substance use and/or mental health problems. Respondents stated that it can be frustrating and stressful when services cannot accommodate their clients/patients, or are busy dealing with other important priorities, and so cannot help quickly enough.

When asked to describe the impact on their workload if a 24-hour crisis service existed, survey respondents said that having a dedicated service would free up significant time for them to do other work. Survey respondents from various sectors, particularly Toronto Emergency Medical Services (EMS) and police, noted that the proposed service could reduce time spent waiting in hospital emergency departments.

Service providers described how stressful and challenging it can be to assist people in crisis. They noted that it often takes a significant amount of time working intensely to de-escalate and stabilize someone. Following the crisis intervention, there is documentation and follow-up work to be completed, in addition to trying to connect the client/patient with other services and supports.

Another potential benefit of the proposed crisis service is the prevention of 'burnout' because of the alleviated workload. Burnout is defined as "a mental or physical energy depletion after a period of chronic, unrelieved job-related stress…"[4], and is a prevalent issue in human services sectors.

A recent report by the Canadian Institute for Health Information about mental health and homelessness demonstrates the potential for the proposed crisis service to alleviate some of the service burden in emergency departments. This report stated that 35% of emergency department visits, and 52% of hospital stays by homeless people were for mental health and behaviour disorders. Of this number, substance use was the most common mental health problem recorded for homeless people (54%). In this study, Toronto accounted for 78% of all emergency department visits by homeless people in Ontario.[5]

"This would significantly reduce police downtime *(e.g. waiting in hospitals)*."
Police officer

"It would significantly decrease our waits in E.R.s"
Paramedic

"There would be enormous impact where agencies are short-staffed…"
Withdrawal mgt. staff

"Sometimes we find we can't take intoxicated clients anywhere."
Outreach staff

"It would allow more attention to be focused on the other clients."
Shelter staff

"It would be a huge benefit and source of help for our clients, especially after hours."
Treatment staff

"For EMS, the only option is medical and E.R.s"
Paramedic

[4] Mosby. Mosby's Medical Dictionary, 8th Edition. Elsevier, 2008.
[5] Canadian Institute for Health Information. Improving the Health of Canadians: Mental Health and Homelessness. Ottawa: CIHI 2007.

CONCLUSION

This research explored the crisis service needs of people who are high or intoxicated, from the perspective of service providers in 11 sectors who work with this population. Survey respondents provided valuable information that will be important as the Toronto Drug Strategy Crisis Model Working Group completes its mandate to develop an appropriate service model for people experiencing crises related to substance use in Toronto.

Based on the findings of this research, the proposed crisis service would form an important new link in an existing chain of services for people experiencing crises related to substance use. In this research, survey respondents identified specific features and aspects of service that should be included in this model to ensure that people in crisis receive appropriate support. Key elements of the existing service system were identified which have important roles in responding to substance use-related crises. Themes also emerged about gaps in services for people having crises related to substance use and concurrent disorders (mental health and substance use problems combined). Service providers in all sectors reported spending significant amounts of time helping people experiencing crises related to substance use, and that a dedicated service could positively impact their workload. The proposed crisis model must work effectively to improve service responses to people experiencing crises related to substance use, and to alleviate some of the pressure on current overstretched services, such as hospital emergency departments. These findings will be used in the development of the crisis service model, and to address the service context in which it will function.

"It would get people the help they need."
Police officer

"There should be a detox facility with medically trained staff where a patient is able to stay to detoxify and still be supervised, e.g. if patient has trouble walking."
Paramedic

"A crisis centre is needed that is fully dedicated to people in crisis with full funding and manpower to deal with issues and provide follow-through."
Shelter staff

This report is one component of a larger exploratory research project. There has been little published research which looks at overall crisis service needs and appropriate crisis service models for people who are high or intoxicated. Most related research has considered specific aspects of service, specific substances used, or service models focusing on mental health. When completed, this project as a whole will help to fill this gap, providing information specific to the Toronto context.

ACKNOWLEDGEMENTS

The Crisis Model Working Group and Toronto Drug Strategy Secretariat thank each person who participated, and the 38 vital services and agencies for whom they work. We are grateful to Dr. Joyce Bernstein who made time to advise us in reviewing the methodology and survey tool. Thanks also to Pam Sethi, who assisted with data analysis for this report. Thanks particularly to the research team, a subcommittee of the Crisis Model Working Group: Louise Carruthers, Chantal Desgranges, and Dawn Slykhuis who dedicated considerable time from their busy schedules to this project.

Survey: Crisis Services for people who use substances and are high/ intoxicated

Please note: 'Crisis' may include distress (mental and/or physical), paranoia, aggressive and/or violent behaviour, self-harm, suicidal thoughts, etc.

1. What immediate help do people need when they are high or intoxicated and in crisis? Check all that apply.

☐ De-escalate situations	☐ Medical assistance	☐ Suicide/self-harm intervention
☐ Mental health support	☐ Counselling	☐ Stabilize aggressive/ difficult behaviour
☐ Overdose intervention	☐ Bed/ place to sleep	☐ Withdrawal management/ detox
☐ Contacts/ referrals to services	☐ 911	☐ Transportation to services

☐ Someone to wait and connect them with help or treatment (including handover/ offload to health services)

☐ Other(s) _____

_____

2. What agencies/services are most helpful in dealing with people who are high or intoxicated and in crisis, and why?

3. What agencies/services are least helpful in dealing with people who are high or intoxicated and in crisis, and why?

4. Not including documentation and follow-up, what per cent of your work hours do you spend with people who are high or intoxicated and in crisis? _____%

5. What per cent of your work hours are spent on documentation and follow-up resulting from the above situations? _____%

6. If a 24-7 crisis service existed where people in these situations could attend/ be brought, what would the impact be on your workload?

7. What type(s) of service for people who are high or intoxicated and in crisis would you like to see in Toronto? *(This could be anything, from change to existing services, to a completely new option.)*

Thank you very much.

Chart 3: Percentage of work time spent with people who are high or intoxicated and in crisis, not including documentation/ follow-up

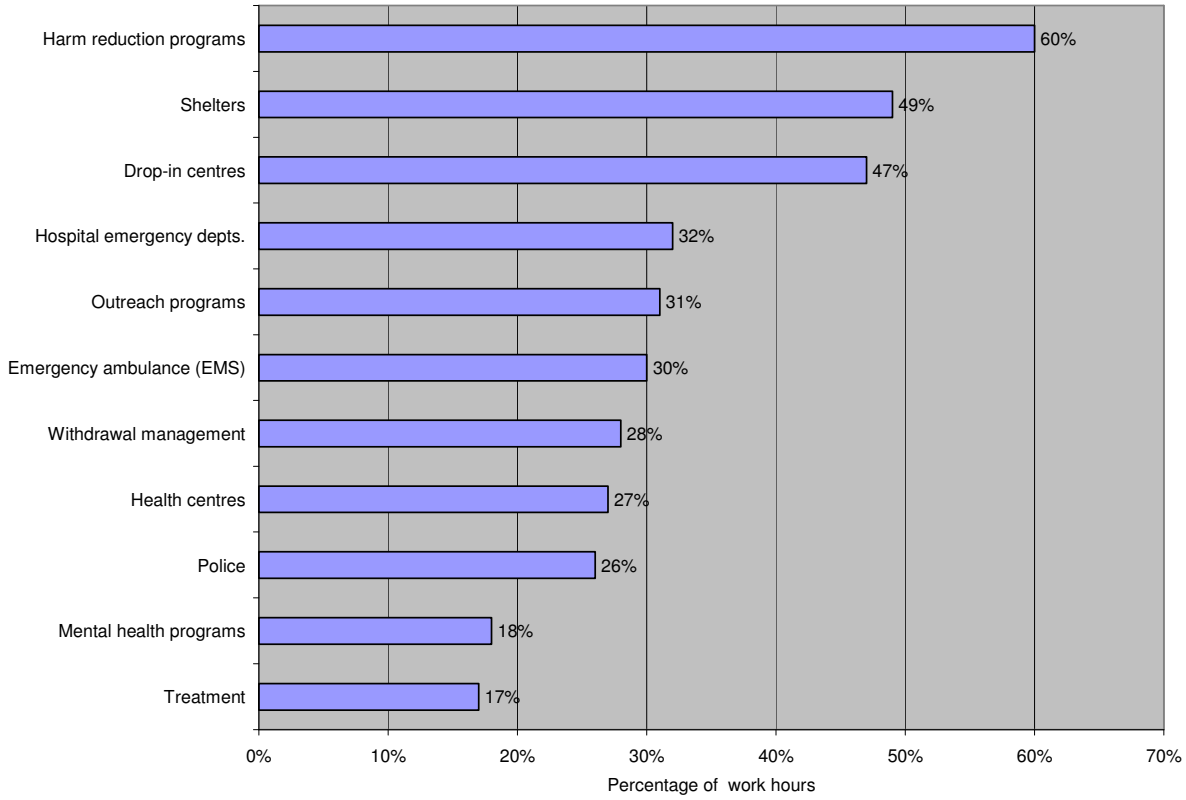


Chart 4: Percentage of work time spent on documentation and follow-up resulting from substance use-related crises