Crisis Service Needs of People who are High or Intoxicated

Report Two of a four-part research initiative

Crisis Model Working Group,
Toronto Drug Strategy

August 2008

Research Team: Louise Carruthers, Chantal Desgranges, Dawn Slykhuis, Jayne Caldwell

Contact:
Jayne Caldwell, Policy Development Officer
Toronto Drug Strategy Secretariat, Toronto Public Health
416-338-0625/ jcaldwe@toronto.ca

TABLE OF CONTENTS…

SUMMARY OF KEY FINDINGS

This is the second report of a four-part research project exploring an appropriate model for a 24-hour service for people having crises related to substance use in Toronto. Surveys were completed by 140 people who regularly use alcohol and/or other drugs, at drop-in centres, shelters, treatment and other programs. They were asked about service needs when they are high or intoxicated and in crisis. This is a summary of the key themes that emerged.

A) Importance of staff attitude and approach

When people are high or intoxicated and in crisis, it is vital that staff/ professionals work with them on a non-judgmental, supportive basis, regardless of the type of service provided. This finding will be important in the development of the crisis service model. In addition, it reinforces the importance of the approach to service used by all front-line emergency response staff in helping people through crises.

B) 24-hour safe place to stabilize

When high or intoxicated and in crisis, survey respondents wanted somewhere they could go on a 24-hour basis to stabilize in safety, away from other people involved in drug use, off the street, and where they would be supervised.

C) Health care: mental and physical health supervision

Health care for mental and physical health problems was identified as vital in a crisis response program. Currently, survey respondents use hospital emergency rooms because this care is provided when no other services are open. A dedicated service for crises related to substance use should include health care for mental and medical health needs.

D) Drug crisis telephone line

Respondents identified that a dedicated 24-hour drug crisis telephone line is desirable, providing an immediate response and ensuring anonymity.

E) Staff provide guidance, service access

In addition to working from a non-judgmental approach, respondents wanted staff to fulfill two key roles; providing guidance and information, and connecting them directly to a range of health care and treatment services.

F) Shelters

Respondents wanted more shelters, as they provide a place to stay when people are high/intoxicated and in crisis. In particular, some respondents wanted more shelters away from downtown, while others wanted a shelter specifically for drug users.

"Someone to talk to when you are down and out makes the difference between life and death."

"The attitude of staff is everything – not feeling like you're being judged."

"People say that addicts have attitude, but it probably has to do with the way the addicts are being treated by the professionals."

"I needed (treatment) help ASAP, and found the process difficult. There were hurdles everywhere from almost all agencies."

"If there was a voluntary drunk tank I would have used such a place eight times this year. I wouldn't have had to sleep outside and get a criminal record."

G) Access to withdrawal management and other treatment services

When people who are high or intoxicated are in crisis, they need quick access to withdrawal management/ treatment services. Survey respondents stated that it was too difficult to access the treatment system when they were ready to do so. They noted that when people are ready to enter treatment for substance use, services need to be available immediately or motivation is lost and people relapse.

INTRODUCTION

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, emergency medical 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 serve people who are homeless, marginalized, and living in poverty, and who are experiencing issues related to alcohol and/or other drug use. It would also be a resource to service providers who engage with people when they are high or intoxicated and 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 behavioural issues, homelessness and other reasons related to their substance use.

PURPOSE OF RESEARCH

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 might 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 evidence base regarding service needs of people who are high/intoxicated and in crisis.

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 high/intoxicated and in crisis; and
4. A list of current Toronto services available to people who are high/intoxicated and in crisis

This is the report from component two, surveys of people who are regular users of alcohol and/or other drugs. 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.

A total of 140 surveys were completed with individuals identified as regular users of alcohol and other drugs, hence potential users of this crisis service. Survey interviews were conducted by the four research team members. Survey participants received a $10 honorarium.

Stratified quota samples were used, with stratification by gender, service type and geographic location. There were fourteen survey sites, including drop-in centres, shelters, a street outreach program, harm reduction/ community health centre programs, withdrawal management programs, and substance use treatment programs. These sites reflected diverse geographic areas (by City of Toronto Community Council district), type of service, and population(s) served.

All survey sites were agencies/services where people who are regular users of alcohol and other drugs are known to attend across a social service/health care continuum. Survey participants were recruited by agency staff at each site as they have the best knowledge regarding their clients, and were therefore well equipped to determine the most appropriate candidates for the survey. Agency staff were briefed on the survey purpose and process in order to ensure appropriate referrals to the interviewers.

The qualitative survey tool, attached as an appendix, was designed to gather information from the target population regarding service needs and gaps for people experiencing substance use related crises. Information was sought regarding types of help desired, current service usage, the nature of perceived helpful or unhelpful services, and services that respondents would like to see developed or expanded. Some demographic data was also collected to provide descriptive context.

In this qualitative study, a grounded theory approach was used in data analysis. 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

The research was potentially limited by small sample size (140 surveys). However this qualitative study was intended to describe service needs, not to quantify them. The demographics captured are for descriptive purposes only. Surveys were conducted in English only at agencies where English is the language used by the agency. Hence, we did not capture information from respondents who are not able to communicate in English, and/or who do not attend English speaking services.

As interviewers relied upon agency staff to refer participants for surveys, there are possible limitations around this process, such as inappropriate referrals. However, these risks were mitigated by the method and processes used. Further, as there were fourteen agencies from diverse sectors represented, it is expected that the potential limitations related to particular staff referrals should be balanced by the number and diversity of agencies involved.

TERMINOLOGY USED BY PARTICIPANTS

It is important to note that survey respondents were not always specific in the language they used when discussing services, particularly the following:

- The terms 'detox'/'withdrawal management' and 'treatment' were often used interchangeably, without necessarily specifying which part of the treatment sector they were referring to.
- Some respondents referred to both 'hospitals' and 'emergency departments' interchangeably.
- The type of service mandate or assistance provided by outreach programs was often not specified.
- When respondents noted using a telephone service, these were not necessarily crisis services. For example, some people used the Street Helpline, which is mandated for information and coordination, not crises.

SURVEY PARTICIPANTS

The proposed service would respond to substance use-related crises experienced by people who are homeless, marginalized, and living in poverty. Demographic information was solicited to ensure a representative sample of people who might use this service. Participants were asked their age, gender, and whether or not they were First Nations, Metis or Inuit.* The survey sample in this research reflects the demographics of participants in recent studies of homelessness in Toronto[1], although the numbers of youth, women and transgendered/transsexual people are higher in this study.

Figure 1: Age of Respondents

15-24:	20	*(14.3%)*
25-34:	29	*(20.7%)*
35-44:	44	*(31.4%)*
45-54:	40	*(28.6%)*
50+:	7	*(5%)*

Surveys were completed with 140 people. Respondents identified their gender as follows: 73 male (52.1%), 60 female (42.9%), and 7 transgendered/transsexual (5%). Their ages ranged from youth to senior citizens, however, the majority were between 35 and 44 years of age, as per *Figure 1*. In this survey sample, 28 participants (20%) identified as First Nations/Metis/Inuit.

Surveys were completed in agencies that potential crisis service users are likely to attend. There were 14 agencies with a broad range of service mandates, including drop-in centres (4), shelters (3), harm reduction/community health centre programs (2), withdrawal management programs (2), substance use treatment programs (2), and a street outreach program (1). These agencies were located across Toronto.

The number of people completing surveys in each geographic area (City of Toronto Community Council District) was:

- Toronto-East York – 76
- North York - 20
- Etobicoke-York – 20
- Scarborough - 24

Figure 2: Drugs used regularly

Crack cocaine/ cocaine:	87
Alcohol:	59
Marijuana:	40
Heroin:	21
Oxycontin/ percocet:	12
Opiates:	12
Methadone:	8
Ecstasy:	8
Benzodiazepine/ valium/ diazepam:	6
Magic mushrooms:	3
Crystal methamphetamine:	3
Ketamine:	2
Barbituates:	1
GHB:	1
Hashish:	1
LSD:	1
Unspecific *(e.g. "pills")*:	5
"Painkillers"/ "downers":	5
"Speed":	3
"All"/ "everything":	3

Participants were asked to name the drugs that they used regularly. The drugs most frequently used were crack cocaine/ cocaine, and alcohol, as per *Figure 2*. The average number of substances named per person was two.

** Recent studies regarding homeless people in Toronto highlight the overrepresentation of First Nations/ Metis/Inuit peoples among that population.*

CURRENT SERVICE USE

The Crisis Model Working Group designed the survey to explore and gather information about people's crisis needs when they are high or intoxicated, and perceptions of current agency/service responses to these crises. Respondents were asked what people needed in general when they are high or intoxicated and in crisis, which services they used, which agencies/services they found most and least helpful, and the reasons for this. They were also asked what crisis response services were needed in Toronto. Common themes emerged across the survey questions. These findings were echoed whether people were talking about crisis service needs, or agencies they used if they were having a crisis related to substance use.

In order to identify current services people used when they were high or intoxicated and in crisis, survey respondents were provided with a list of service types, from which they could choose any or all of the services listed. The average number of services currently used by respondents was five. The five services chosen most frequently were drop-in centres (13.3%), outreach programs (13.1%), 'detox' services (12.2%), shelters (11.9%) and hospital emergency rooms (10.3%). The full list of services and the frequency with which they were chosen by respondents is noted in *Figure 3*.

Respondents were also asked about agencies or services that they found most and least helpful when they were high or intoxicated and in crisis. Services identified as most helpful were shelters, withdrawal management/ treatment programs, harm reduction programs, hospitals, outreach programs and drop-in centres. Four of these services were identified as helpful because the staff were non-judgmental, and available to talk to; these were drop-in centres, outreach services, withdrawal management/treatment programs, and harm reduction programs. Responses were mixed about withdrawal management/treatment programs. Although these programs were seen as helpful because of their non-judgmental staff approach, they were also noted as 'least helpful'. The reason for this was system access. Respondents stated that they found it difficult to enter these services when they needed to, and reported lengthy waiting periods for services within the sector.

Responses were also mixed about shelters and hospitals. Shelters were noted as helpful because they provided beds, although there were mixed views about shelter staff. While some respondents found shelter staff supportive, others felt that they were judgmental toward drug users.

Hospitals were seen as helpful because of the medical and mental health services that were provided, and because they were available when other services were closed. However, respondents repeatedly stated that they felt hospital staff held judgmental attitudes toward drug users.

In addition to hospitals, the other key service noted as least helpful was the police. Police were noted as least helpful for two reasons. The first reason was that respondents feared arrest and/or jail, and the second was the perception of judgmental attitudes of police toward drug users.

It is notable that when asked about agencies/services that were 'least helpful', 23 respondents (16.4%) either said "none", or had no answer. Possible reasons for this include an unwillingness to identify 'least helpful' services, or that some people are not experiencing difficulty with existing services.

Hospitals:

"Staff get burned out so you get treated less than human."

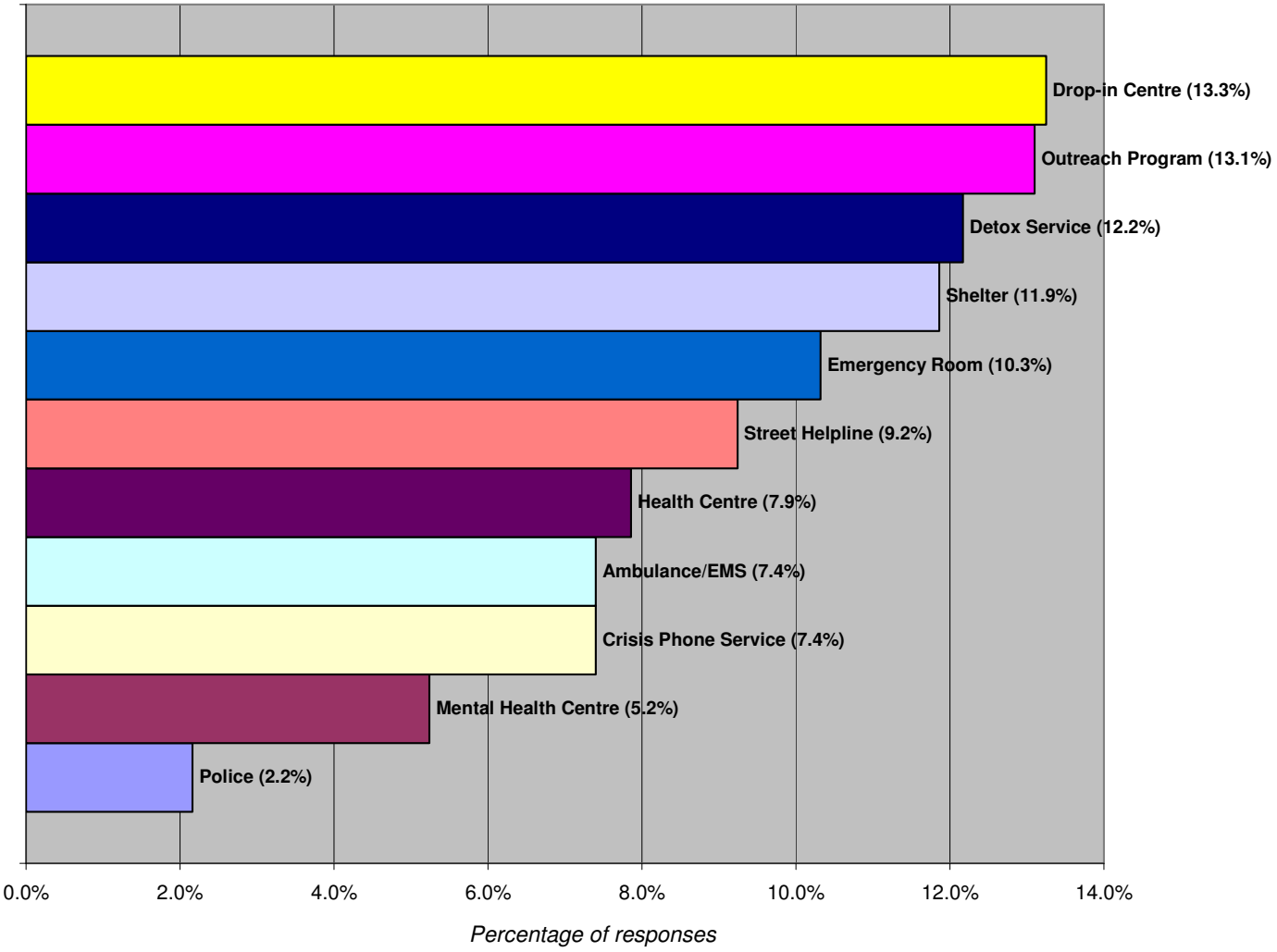
"You may not get compassion (or) understanding. They think you're just another druggie."

Police:

"Depends on individual officers, but most have too much attitude."

"If you're known as a drug user, it becomes a big barrier."

Figure 3: Services currently used when high/intoxicated and in crisis



FINDINGS: CRISIS SERVICE NEEDS

Importance of staff approach

The most significant finding from this research was that people who are high or intoxicated and in crisis want help from service providers to be delivered in a non-judgmental, supportive manner. The importance of this type of staff approach was stated repeatedly, throughout all questions asked. It was the most common reason given for choosing specific services over others.

"(The) attitude of staff is all-important. Staff need to want to do what they're doing."

"Sometimes all it takes is a friendly face to snap me out of something."

"Staff are there for the people, not the paycheque. (They) go the extra mile to help out"

"(Staff) will help you no matter who you are or what you've done."

When asked about what people needed in a crisis when they were high or intoxicated, the most frequent response was a non-judgmental person to speak with. Respondents wanted someone supportive to talk to, to help them to calm down and 'come down' without adding further stress to already difficult situations. Related to this, there were several suggestions that it would be helpful to have staff available who 'had been there', or whose personal experience would contribute to their understanding of what people were going through in crises related to substance use.

Ensuring that a non-judgmental approach is used can help front-line responding staff to stabilize people more effectively when they are high or intoxicated. For example, front-line staff report that people having a stimulant-related crisis can be agitated and paranoid with symptoms such as accelerated heart rates and high blood pressure. In these situations, it may be that the calm, non-judgmental approach described by respondents in this study may reduce threats to the individual's health. In addition, the risk may be reduced that someone experiencing this type of crisis may 'act out' and threaten or harm the service provider. Opportunities should be sought to engage diverse service providers in discussions on this subject, with consideration given to the development of appropriate training to address this need across sectors over time.

The importance of the non-judgmental, supportive approach to service described by survey respondents is reflected in other service models and research. In Glasgow, Scotland, a study was completed of homeless people with mental health and substance use problems, in which non-judgmental staff relationships were the main criterion by which respondents judged services, and were a key factor in their willingness to use a service.[2] In Itasca County, Minnesota, local ambulance providers work with 'Community Response Team' members who specialize in mental health for "behavioral health transport" calls. Protocols include the use of "supportive therapeutic communication techniques, patient-centered listening, and awareness of non-verbal communication of the caregiver and the patient."[3]

24-hour place to stabilize

In addition to a non-judgmental approach by professionals, there were other key suggestions for the proposed crisis service. Safety and stabilization were common themes through responses to all questions. When survey participants were asked what people needed when they were high or intoxicated and in crisis, 'a safe place to go' was a key response. People also talked about the importance of having somewhere to sleep or stay overnight, while others talked about having somewhere to calm down or 'come down.' Some simply needed a positive, stable environment.

"(Need a place) for people that are sick and tired of being sick and tired."

"People have crises at the weirdest hours."

Shelters were seen as helpful because they provided a bed, and somewhere to stay when people were high or intoxicated and in crisis. As a result, respondents wanted more shelters. Several people specified that more shelters were needed in Toronto's inner suburbs, in places such as Scarborough and the Weston-Lawrence

area. Others wanted shelters whose mandate was specifically for people who use drugs. This may be in part because of respondents' mixed views of shelter staff. As stated earlier, although some saw them as supportive, others viewed them as judgmental towards drug users. Implementing training for shelter staff regarding substance use may help to resolve this issue.

Respondents wanted a service for substance use-related crises to be available 24 hours, seven days weekly. A few people even noted that when high or intoxicated and in crisis they have gone to the hospital to stay overnight in safety, as nothing else was open.

Health care: mental and physical health supervision

Respondents valued the medical and mental health supports that were provided in hospital emergency departments. They also noted that while other services such as community health centres and some drop-in centres offered part-time health services onsite, the hours and capacity are limited. The proposed crisis service model should consider providing emergency medical and mental health services to address these various health needs. These services should be available particularly during evening, overnight and weekend hours.

Staff to provide guidance, and help accessing services

Survey respondents highlighted two key roles that they viewed as vital for staff; to provide guidance, advice and information, and to help people to directly access a range of health care and treatment services. Some people may not fit easily into existing service systems, as they may have problems communicating, and their behaviour may be aggressive, unsociable, or disruptive. Difficulties such as these may be exacerbated when people are high/intoxicated and in crisis. People may have multiple needs, such as medical problems and/or mental health problems, in addition to substance use treatment needs. They may also need help finding other resources such as shelter or housing supports.

Staff need to help people to better navigate service pathways. They can ensure that both the individual and the referring agency understand what is being asked or required, and may act as an advocate where necessary. The value of these roles, particularly after a crisis, is echoed in a Baltimore study which found that injection drug users who overdosed were more likely to attend treatment when they received information and referrals directly after an overdose episode, from overdose response staff, rather than being added to waiting lists.[4]

Currently, several drop-in centres, outreach programs and shelters offer this type of support on a 'low threshold' basis. This means that people may enter these programs with few barriers to service, including no intake or limited intake procedures, and an understanding of challenging behaviour. However, drop-in centres and outreach programs are only able to provide service during specific hours, often during the day from Monday to Friday, with a few exceptions. Shelter services and capacity also vary by program hours.

Drop-in centres, outreach programs and some shelters are further constrained as they operate with limited staff and facility resources. Programs may not have staff available to spend in-depth time with someone who is high/intoxicated and in crisis. Further, if someone is behaving in a challenging way, there may not be physical space in which to accommodate them safely, away from other people. A further limitation is the difficulty that these programs have in linking clients with larger institutions and government services due to system 'silos', and confidentiality issues.

Drug crisis telephone line

Although most respondents described the need for a place or facility where they could go for help, the need for a 'drug crisis hotline' was also identified. This would be a 24-hour telephone number that people could call, and speak to someone who would listen, talk, and offer support on a non-judgmental basis. Several people specified that it should ensure anonymity and be provided free of charge. Currently, there are telephone services offering crisis services and information in Toronto, however they are not mandated to serve people who are high or intoxicated.

FINDINGS: ADDITIONAL SERVICE NEEDS

While the survey focused on crisis service needs and issues, other related themes arose. Three themes in particular were noted by survey respondents. These issues have been raised elsewhere, including in the Toronto Drug Strategy, however they bear repeating here.

Access to withdrawal management and other treatment services
As noted earlier, withdrawal management and treatment program staff were seen as helpful when people were high or intoxicated and in crisis. However, these services were also broadly seen as difficult to access. This is significant, as immediate access to withdrawal management/ treatment services was one of the key needs identified by respondents when people are high or intoxicated and in crisis. They perceived that the more difficult the system is to access, the more frequently people relapse, or even give up trying to get help. Several people noted that they had made multiple fruitless attempts to enter withdrawal management/ treatment programs. People described feeling blocked by the system when trying to access treatment because of unavailable services, or requirements to wait several weeks for service.

Treatment system:

"There's a short window when you have the courage to deal with it."

"When you're ready for treatment, you need to get in in 6-12 hours, not weeks."

"Detox should be at least two weeks, then on to other stages of treatment, not street or shelter."

"Why do I have to be in extreme crisis before I get help? People are held on the street."

Research also supports survey respondents' perception that immediate access to withdrawal management/treatment services is critical when people are high or intoxicated and in crisis. The need for quick access to service has been reflected in considerable other research, such as a U.S. study of crack cocaine users which found that when program access was provided quickly, study participants were more likely to attend treatment appointments and stayed longer in these programs.[5]

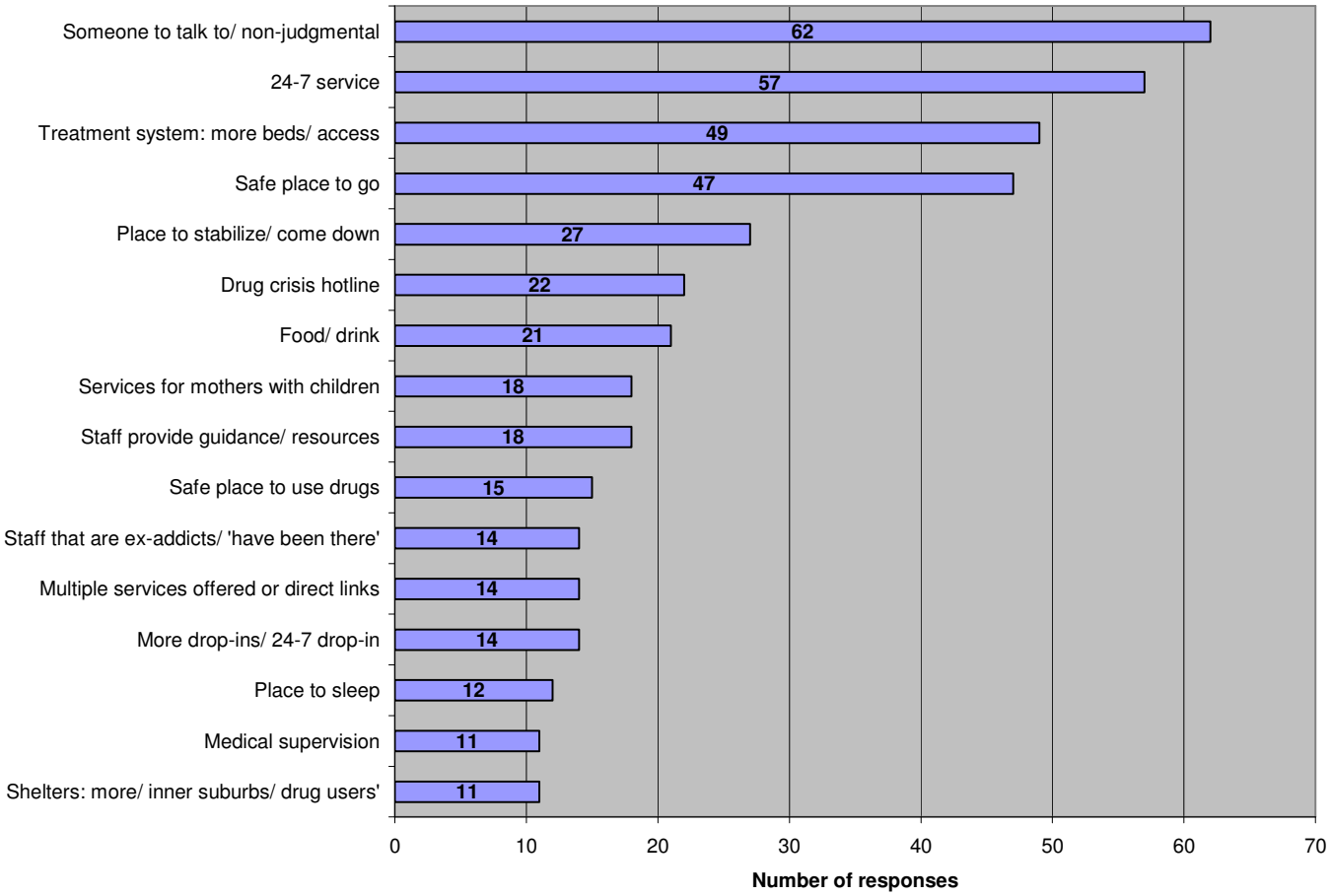
The crisis service model to be developed will need to coordinate with, or complement, existing service systems, including the withdrawal management/treatment sector. Ensuring access to withdrawal management/ treatment services quickly after a substance use-related crisis may help to reduce the number of people having problems related to alcohol and/or other drugs.

Residential treatment for mothers with children
Survey respondents noted the need for a residential treatment service where mothers could stay with children. In the current system, a single parent who wishes to go to residential treatment for substance use must either leave their children with family, or ask child welfare agencies to take their children temporarily into care. The former was not an option for individuals with no available family. The latter was seen as undesirable, as respondents perceived that involvement with child welfare agencies meant giving up control of, or access to, their children and the circumstances in which they would live as a family. No single model was identified by respondents, however, several suggestions were made for a supportive residential home where mothers could go with their children, with both treatment and child care supports onsite. This idea is supported by research, including a U.S. review of 50 residential treatment programs for pregnant and parenting women. This review showed significant improvements in the health, treatment and economic outcomes for these women and their children as a result of their participation in these programs.[6]

Safe place to use drugs
Respondents also suggested that there should be a safe place to use drugs. Some people made reference to Vancouver's supervised injection site as a program they would like to see in Toronto. Currently, some people

use illegal drugs in circumstances that are unsafe. Safety and safe places were common threads throughout all survey responses. People mentioned issues of safety to do with drug dealers, other drug users, and unsafe environments, in addition to concerns such as disease transmission.

Figure 4: Crisis services needed in Toronto



CONCLUSION

This research explored the crisis service needs of people who are high or intoxicated, from the perspective of 140 people who are regular users of alcohol and/or other drugs. Survey respondents provided valuable information that will be important as the Crisis Model Working Group develops an appropriate service model for people experiencing crises related to substance use in Toronto.

Currently, when people experience substance use-related crises, they use an average of five services. The top services used were drop-in centres, outreach programs, 'detox' services, shelters and hospital emergency rooms. Respondents also identified most and least helpful services. The most commonly stated reasons for these choices had to do with how they felt they were treated by front-line staff, and access to services. These themes were repeated throughout the survey, as respondents identified aspects of service that are important to people experiencing crises when they are high or intoxicated. Findings included the need for staff to work from a non-judgmental, supportive approach, regardless of the service being provided. Survey respondents identified key roles for staff in the proposed crisis service; to provide guidance and information, and to help directly link people to other services such as treatment. Respondents wanted 24-hour access to a safe place where they could stabilize. A 24-hour drug crisis hotline was also proposed. The crisis service model will also need to identify how it will integrate/coordinate with the existing systems that provide services to people who are high or intoxicated and in crisis.

In addition to findings specific to the development of a crisis service model, respondents also noted related service needs which are pertinent to substance use-related crises. For example, people talked about current difficulties in accessing services in the substance use treatment sector, including a lack of residential treatment services for mothers with children. They also suggested that a safe place to use drugs would be beneficial.

This report is the second component of a four-part 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 single-purpose service models only. 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 of the men and women who participated in this research. In addition, thanks to the staff at each of the fourteen agencies who welcomed us into their programs and directed us to their clients/members to speak with them. We are also grateful to Gregory Kim and Dr. Carol Strike who made time to advise us in developing the methodology.

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 of people who use alcohol and other drugs

1. Have you completed this survey before? Y/ N 2. Do you use alcohol and/or other drugs on a regular basis? Y/N

3. Gender: M F TS/TG 4. Age: _____ 5. First Nations/ Metis/ Inuit: Yes / No

Drug(s) of Choice: _____

6. Generally speaking, when people are high or intoxicated and in crisis from using, what kind(s) of help do they need?

7. What types of services do you currently use if you are high or intoxicated and in crisis from using? Please check all that apply.

☐ Emergency Room ☐ Health Centre ☐ Police ☐ Drop-in centre
☐ Shelter ☐ Street Helpline ☐ Detox service ☐ Ambulance/ EMS
☐ Outreach program ☐ Mental health centre ☐ Crisis phone service

Other(s) _____

None: Why Not? _____

8. When you were high or intoxicated and in crisis from using, what agencies or services were most helpful to you, and why?

9. When you were high or intoxicated and in crisis from using, what agencies or services were least helpful to you, and why?

10. What types of service for people who are high or intoxicated and in crisis from using would you like to see in Toronto? (This could be anything – whether it does or does not exist now.)

11. Is there anything else you would like to add about services for people who are high or intoxicated and in crisis from using?

END NOTES

[1] Khandor, E. and Mason K. The Street Health Report 2007. Toronto, September 2007. and
City of Toronto Staff Report. Street Needs Assessment: Results and Key Findings. Toronto, June 20, 2006.

[2] Ferguson, I. Petrie, M. Stalker, K. Developing accessible services for homeless people with severe mental distress and behavioural difficulties. Draft report to Greater Glasgow Health Board Primary Care Team, University of Stirling, December 2004.

[3] Itasca Crisis Response Team Helps Local Ambulance Agency; EMS Reaps Some Surprising Outcomes. Best Practices in Emergency Services (7): July 2008. www.emergencybestpractices.com

[4] Pollini, R.A. McCall, L. Mehta, S.H. et al. Non-fatal overdose and subsequent drug treatment among injection drug users. Drug and Alcohol Dependence: 2006, 82, p.104-110.

[5] Festinger, D.S. et al. From telephone to office. Intake attendance as a function of appointment delay. Addictive Behaviors: 2002, 27, p. 131-137.

[6] Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dept. of Health & Human Services. Benefits of Residential Substance Abuse Treatment for Pregnant and Parenting Women. September 2001.