



TASK FORCE ON ACUTELY INTOXICATED PERSONS AT RISK

**Final Report to Minister of Health & Social Services
December 31, 2010**



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Executive Summary

Recent events have demonstrated that we cannot rely on some of our current social agencies to provide appropriate care for acutely intoxicated persons at risk. The current standard of care may have been adequate in the past but societal expectations have changed. Historically management of an acutely intoxicated person at risk has been singularly the responsibility of law enforcement. The time has come to share that responsibility between law enforcement and health care.

These recent events have demonstrated a distinct lack of care and compassion by some individuals. The frequency and degree of these inappropriate behaviours, however, make us concerned that acceptance of these disrespectful attitudes may be systemic. Hence the first, and universal, recommendation we make is that all social agencies address attitudinal standards to assure that all acutely intoxicated persons at risk receive treatment with compassion, respect and dignity. This is the least that we should expect from those responsible for our care under circumstances when we are not able to care for ourselves.

Our second recommendation addresses a problem inherent to our Yukon society. We are a small population but must respond to all the problems of social structures orders of magnitude larger than ours. Typically we do what we do astoundingly well but equally we cannot deliver on all our needs. Unfortunately all too often our inadequacies are demonstrated only after someone suffers. The second recommendation of this task force is that we must become more proactive to identify the areas outside and between our silos of competency.

Our third recommendation is that we should rewrite the aged legislation that authorizes non-criminal detention for intoxication to bring it more in concordance with current social mores and accepted human rights. The new legislation should be more precise with respect to reasons for detention and the parameters under which that detention ceases.

Our fourth through ninth recommendations direct that we should move care for the acutely intoxicated persons at risk into a newly created sobering center with professional capability at the level of paramedic or registered nurse provider. This sobering center should be co-located with our detoxification unit, which should simultaneously elevate care standards to be able to provide medically managed withdrawal. If appropriately organized both facilities could integrate their staffing and, if so, should utilize expanded-role nurses for primary care. Both facilities should have a medical director to establish and direct protocols and standards of care. This new facility should embrace the philosophy of harm

reduction and should assume a position within the community as a refuge of safety and security during a time of personal vulnerability.

Our tenth, but significantly higher in priority, recommendation is that we must create a shelter in close proximity to the sobering center, which must be capable of accommodating acutely intoxicated persons. The shelter/sobering center/detox should ideally compose a continuum of care which participants can use, as circumstances and inclination might dictate, to achieve some degree of stability in what currently are lives of instability and vulnerability.

Our penultimate recommendation integrates outreach and care-on-the-street with the authority to detain non-criminally when acute intoxication creates a situation of risk and personal danger. Our intention is not to remove that authority from law enforcement officers but instead to expand it into the sphere of responsibility of outreach caregivers.

Our final, but highest in priority, recommendation is that immediate attention must be given to the untenable and unsustainable circumstances presently in effect at WGH ER. The current conditions at WGH ER are a direct consequence of decisions outside their control. They are admittedly stressed beyond capacity. Their needs and concerns must be addressed before a preventable, but predictable, disaster occurs.

The text of our report explains the reasons and bases for these recommendations.

Respectfully submitted,

Dr. Bruce A. Beaton

Chief James Allen



Foreword

Intoxicants are part of every modern-day society. Ever since man discovered the end point of the natural process of fermentation or realized that chewing on the leaf of a native bush could significantly increase his endurance and sense of well-being, he has used intoxicants. He soon learned that he could use these drugs, and many others, recreationally and has done so for literally millennia.

Today intoxicants are entrenched in our economic fabric. Society enjoys many benefits from the not-insignificant tax revenues generated from the licensed sale of intoxicants. These intoxicants, however, are not without serious adverse effects, both on the individuals who ingest them and on the society which sanctions them. The cost-benefit analysis of intoxicant use is one with which every society wrestles.

Some societies have judged the costs to exceed the benefits and have gone so far as to ban and prohibit the use of intoxicants. Invariably this action has produced criminal behaviour and created illegal economies. Other societies have liberalized the use of intoxicants and directed societal resources towards the adverse effects. No society has ever “solved” the problem of intoxicants, including our Yukon society.

This task force was created to address one of the many facets of intoxicant use, how to manage the acutely intoxicated individual. The following is our best attempt to provide guidance and advice to the Minister of Health and through him to our entire Yukon populace. Our report will not be limited to advice to only the current government but will be broader and will make suggestions that many individuals and agencies can hopefully use to create ultimately a better and safer society.

(Throughout this report we will use the third person singular pronoun “he” which has a masculine connotation. The reason for this artificial descriptor is the imprecision of the English language, which does not have a non-gendered third person singular pronoun. It is not in any way intended to imply that the problems identified, nor the conclusions proffered, apply only to men in our society. This problem has no preference. It affects men and women with equal virulence. Similarly any and all treatment modalities must be unisex in application. We write this report as we do simply because we find the terms *he/she*, *him/her*, and *his/hers* to sound affectational and stilted. Please accept our presentation but also acknowledge our intent.)

The Problem

In 2010 an enquiry, which investigated the death of an acutely intoxicated individual under detention in the RCMP cells, concluded. At exactly the same time as this enquiry report was being vigorously debated in and through our media another person died while a patient in our local detoxification facility.

This temporal coincidence led the Minister of Health to ask the question “Were these two episodes in fact only coincidental or do systemic weaknesses exist, which might be changed to prevent such occurrences in the future?” We have been tasked to address that question.

First and foremost we must place death from intoxicants in proper perspective. Acute intoxication is a state of significant morbidity and mortality. People hurt both themselves and others while acutely intoxicated. People die and even kill when acutely intoxicated. Similarly withdrawal, or progressing from a state of intoxication to a state of sobriety, is also a process associated with significant morbidity and mortality. Withdrawal causes illness and sometime death, even under ideal circumstances. No recommendations from this report, nor any other, will ever make the preceding statements invalid. The best we can ever hope to achieve is to improve risk of disease and injury and reduce the frequency of death consequent to intoxicant use.

To form our opinions and create our advice, we first had to understand the problem. In this vein we, Chief James Allen and Dr. Bruce Beaton, co-chairs of the Task Force on Acutely Intoxicated Persons at Risk, attempted to meet with all involved social agencies and many individuals to gain knowledge from their respective experiences and to hear their thoughts on areas potentially in need of change and/or improvement. We also attempted to hear the experiences first hand from individuals affected by use and abuse of intoxicants. Additionally we explored, both from the literature and by direct observation, the experience of others in their attempts to address this ubiquitous problem. Lastly we attempted to coordinate our activities with the *Review of Yukon's Police Force*, which simultaneously was investigating aspects of the same problem but from a different perspective. The reader will be the final judge of the success of our endeavours.

The Population Groups

To our analysis there appears to be three distinct population groups who constitute the acutely intoxicated persons at risk: those who are violent and dangerous, those who have significant medical needs and all others with the latter constituting the majority of clientele. Additionally there are other intoxicated individuals who interact with our social agencies, such as someone who is arrested for committing a crime while intoxicated or someone who has a significant medical problem while intoxicated. For these individuals, however, the intoxication is not the primary reason for intervention. Obviously all social agencies must make contingency plans for acutely intoxicated clients. Such individuals are peripheral to this report. We intend to confine our comments to those persons who are detained because they are intoxicated.

The specific needs and requirements of each of the above population groups must receive distinct consideration. They do not necessarily need to be assessed independently and can be integrated but provision for the unique needs of each group must be considered and accommodated. For example, an intoxicated person is inherently volatile and can quickly become violent and a danger to personnel. Provision for such a possibility might be a dedicated facility for violent and dangerous acutely intoxicated persons at risk or it might be staffing a care facility with personnel capable of containing a violent person within an environment conducive to defusing an explosive event. Similarly some acutely intoxicated persons at risk will undoubtedly require in-hospital care and all detainees will require some degree of health risk assessment. But not all individuals require assessment at Whitehorse General

Hospital Emergency Department. What level of medical care and assessment will be provided in-house and how best to utilize and coordinate off-site medical resources are decisions that require consideration. We will provide our advice and recommendations on these issues in this report.

Attitude

A common theme through almost all of our conversations was that the current attitude of many front line workers is detrimental to the ultimate health and well-being of the acutely intoxicated individual. If any attendee to intoxicated persons demonstrates repeatedly that he is not capable of acting with respect, recognizing dignity or acknowledging personal rights and freedoms, that person should not be allowed to continue to serve in that capacity. This is not a statement directed at any one agency nor any individual but must become a universal goal for all participants in the care and/or detention of individuals under the influence of intoxicants. One can easily become cynical or jaded as interaction with intoxicated persons is frequently trying and frustrating but all individuals in all social agencies must insure that such interactions are universally positive in nature and without retribution.

Many, if not most, members of society generally seem to have a bipolar attitude towards intoxicant use. It is generally condoned and frequently even encouraged. It, especially alcohol, is an almost necessary component of all social interaction. It can be a marker of social position, as exemplified by the presentation of expensive single malt Scotch whiskies and boutique wines. In some circles sharing of cocaine and other drugs is a sign of financial achievement and success. But let a person become dependent on or under the control of intoxicants and the attitude begins to change. It changes even further if an individual's dependency becomes blatantly obvious to others. This attitude grows into one of contempt if the dependency crosses into addiction with loss of personal self-respect and social appropriateness and becomes even more disrespectful as the affected individual descends towards the bottom of the scale of social status.

Most, if not all, of the agencies in the Yukon who deal with acutely intoxicated individuals are functioning at the brink of, or even frequently beyond, their efficient functional capacity. (We will address this issue in further detail later in this report.) When this capacity state has been attained an all-too-common response to an additional demand, especially if that demand is unpleasant, is to react less than compassionately to the individual who caused that demand. This phenomenon, defined as compassion fatigue, has been acknowledged and is the subject of a distinct recommendation in the report from the *Review of Yukon's Police Force*.

Persons of First Nations' ancestry constitute a majority of the individuals who are detained under the *Yukon Liquor Act*. Such individuals report, both directly and through representatives, they frequently are the recipients of inappropriate attitudinal behaviour, when detained while acutely intoxicated. It is not the intent of this report to explain the reasons for this behaviour but the statement was so frequent in our conversations that we accept the validity of the assertion.

The following recommendation is universal and over-arching and must be achieved irrespective of agency, venue, service or individual.

RECOMMENDATION #1: All individuals who are required, as part of their professional responsibilities, to manage or provide care for the acutely intoxicated person at risk must assure that all such persons are treated with compassion and dignity in a non-judgemental manner. This must become a systemic standard of behaviour. Managers are ultimately responsible for the behaviour of first line workers. If such standards cannot be achieved internally within all participating organizations, external resources such as training programs developed in conjunction with the Northern Institute of Social Justice at Yukon College should be utilized and should include First Nations' content and cross cultural awareness.

Silos of Competency

Every activity involving social need within the Yukon Territory confronts the same reality. We are a tiny population of about 35,000 people with all the needs of jurisdictions one hundred to one thousand times our size. The reality of all Yukon care providers is that they must respond to whatever presents at the door. With rare exception we always must open the door. The consequence of this insatiable demand, with limited capacity, is that invariably we perform beyond our limits. To most of us, this is the stimulation that creates our exceptionally rewarding and productive lives. Almost without exception we accomplish far more with far less than our southern counterparts. As a prime example our local detoxification facility, on almost a daily basis, provides necessary care unquestionably using inadequate resources and minimally trained personnel in a physical facility unsuited for its purpose. Yet they achieve quality outcomes remarkably well. But of course they do and of course they will and of course we expect nothing less. After all, this is the Yukon and they are Yukoners.

One of the problems of this system of overtaxed super-achievers is that the limits of one area of expertise rarely overlap any other. We have no capacity for redundancy. Each provider works within a silo of accomplishment. Each silo achieves remarkable outcomes within its own confines but all too frequently the requirements of a person in need will fall outside the limits of one silo but not within the limits of another. Expressed another way, the person in need may fall through the cracks. Whenever this is recognized, the response is to patch the crack. Rarely is the response to assess the quality of the floor or the adequacy of the foundation. With respect to care of the acutely intoxicated person at risk, the limit of our capacity has been demonstrated and exceeded. A perfect example of this is the responses to the two deaths in RCMP cells and Detox. Both agencies acted by moving outside their respective silos. They both recognized appropriately the need for more frequent medical assessment and began to send patients more readily to the Whitehorse General Hospital (WGH) Emergency Department (ER). In fact the frequency of ambulance transfers from RCMP cells to WGH more than doubled, comparing 2009 to 2010 Emergency Medical Services (EMS) statistics. (We do not have statistics to compare transfers from Detox to WGH but EMS personnel advise experientially of a recognizable and significant increase.) This response was probably appropriate. RCMP staff members receive training only to the level of basic first aid. They have no expertise in either assessing or managing the very real medical needs of the population group they have been tasked to detain. Similarly Detox does not provide on-site medical care. The upper limit of Detox staff credentialing is Licensed Practical Nurse (LPN) and many shifts do not provide even that level of expertise. Without any doubt, a higher level of medical care is necessary at both agencies to provide safely the services for which they are responsible within our society. But it appears that no one asked the question as to whether or not the similarly overtaxed silo of WGH ER was an appropriately resourced facility to use.

The conclusion of this section is not whether or not WGH ER is an appropriate facility to provide definitive medical care for an acutely intoxicated person at risk (We will address this issue elsewhere in this report.) but the fact that the decision to utilize WGH ER was made in isolation. It is an established fact that WGH ER provides emergency medical care at all hours of every day and cannot refuse any patient. Staff from both RCMP cells and Detox responded to their respective needs by transferring their problems, without consultation, to another silo of expertise.

Such actions and reactions will rarely produce either the sustainable or the effective system of care and treatment that the acutely intoxicated person at risk needs. In fact it usually demonstrates a capacity inadequacy in another agency. Communication and planning are the cornerstones required to create a foundation on which we can build a sustainable, effective and compassionate system of care.

RECOMMENDATION #2: Designated and identifiable members from the various agencies responsible for the care and wellbeing of the acutely intoxicated persons at risk should meet at least annually to address their respective issues in an attempt to identify both competencies and inadequacies, but especially to try to identify the gaps between their respective services. Members of this committee should include but not be limited to the policing services, acute medical care facilities, intoxication and addiction treatment facilities, outreach providers and all local and First Nations' governments.

Law Enforcement versus Health Care and Harm Reduction

The current model used to manage an acutely intoxicated person at risk functions entirely within the domain of law enforcement. This model has changed little, if at all, since the first days of Western societal incursion into the Yukon wilderness near the time of the Klondike gold rush. It is no longer acceptable simply to detain the intoxicated person. Today we expect that any and all agencies, once they accept responsibility for a person, will provide appropriate care, including a modicum of medical care, in an environment of respect and compassion.

Our current *Yukon Liquor Act* states in Section 92(1) the following:

“If a peace officer has reasonable and probable grounds to believe and does believe that a persons is in an intoxicated condition in a public place, the peace officer may....take the person into custody...” until “...the person in custody has recovered sufficient capacity that, if released, they are unlikely to cause injury to themselves or be a danger, nuisance or disturbance to others...”

While we fully acknowledge that we are not lawyers and do not pretended to be able to give a legal opinion, the *Yukon Liquor Act* appears to say that the sole reason for which a person can be detained is being intoxicated in a public place. Furthermore the endpoint of person's detention can include decisions about no longer being a nuisance or a disturbance to others. These parameters reflect neither the social norms nor the human rights standards of today.

While the intent of this document is not to be a comparison of legal acts across Canada, we do feel that it is important to describe the functional actions under legal authority in two urban center we visited, Vancouver and Winnipeg. Both jurisdictions function consistent with the philosophy that an intoxicated

person would be detained only if the detaining authority judged that person to be either a danger to himself or others. We heard that phrase used repeatedly. Furthermore it was apparent, both in conversation and action, that the phrase “danger to oneself” was generally interpreted as being a passive danger in the sense to mean that the intoxicated person was not able to protect himself either socially or against the elements. In both jurisdictions the endpoint of detention was when the intoxicated person had achieved a level of capacity such that he was then able to provide for himself. In neither jurisdiction was the endpoint sobriety. Additionally both jurisdictions intentionally attempted to release the person from detention prior to entering the medical state of withdrawal. Both jurisdictions retained full capacity to apply the criminal code to an intoxicated person, should his actions require it.

RECOMMENDATION #3: New legislation should be written to supersede Sections 91 and 92 of the current *Yukon Liquor Act* to define more precisely under what circumstances an acutely intoxicated person can be detained, what services will be provided to the detained person and what conditions must be met to cease the detention. This legislation should be consistent with current human rights standards and should allow for necessary and appropriate basic medical care while under detention.

The functional model in both Vancouver and Winnipeg was for risk reduction within a framework of respect for human rights. The human rights standard of today is such that an individual has a right to engage in unhealthy behaviour and is able to do so without personal restriction. At times, however, the behaviour in question, use of an intoxicant, could create a situation wherein the individual becomes at immediate risk consequent to excessive consumption of that intoxicant. Under these circumstances in both Vancouver and Winnipeg there exists the option to detain that individual in a safe environment, with temporary loss of some legal rights, until he has sobered up, or “come down”, sufficiently to re-establish his own capability for self-security.

In both jurisdictions provision for health care was an integral part of the safe and secure environment. In Vancouver both at the “drunk tank” at the Vancouver City Police jail and the sobering center attached to their detox unit, a registered nurse (RN) was in continuous presence and available immediately, limited only by other acute care demands. In Winnipeg, the Main Street Project (MSP), which is the facility where all detained intoxicated persons were accommodated, except those with serious medical needs or detained for criminal activity, assessed the need for on-site medical care. Initially MSP employed an extended-role paramedic and a dually certified RN/paramedic. The latter professional was able to advise MSP as to which of his two skill sets was of greater use. His conclusion was that his paramedic skills were preferable. MSP is currently recruiting six additional paramedics to provide 24/7 on-site care capability. Of note is Winnipeg’s experience of documentable benefit from on-site professional care. The presence of the paramedic reduced the number of ambulance transfers to the Health Science Center Emergency Department tenfold. Additionally the paramedics have been willing and able to expand their duties through transfer-of-function training to be able to perform tasks in-house such as dressing changes, infectious disease monitoring, immunizations, etc.

Accommodation in the Winnipeg sobering center is spartan and barely different than our current cells in Whitehorse. In response to our questions the director advised that the reason for the unpleasant appearance of the units is they provide an environment of maximum safety and minimum risk to clients when they are incapable of assuring their own safety. Every patient is viewed every fifteen minutes and assessed every hour but even that near-constant monitoring allows fourteen minutes of possible risk. Five of the twenty-five rooms have continuous video monitoring but the person responsible for

monitoring is also responsible for intake. It is possible for the client judged to be at maximum risk to spend several minutes without direct monitoring. A disaster could happen. Hence the environment must assure the least possible risk. Dedicated care and maximal safety are the cornerstones of the services provided at the Winnipeg sobering center, which delivers both simultaneously.

At Winnipeg's Main Street Project and Vancouver's InSite safe injection site and co-located OnSite narcotic detox facility, the risk reduction model has had the effect of creating an environment wherein both facilities are viewed by many on the street as a safe, non-judgemental haven. Simultaneously both have become accessible resources centers available and willing to assist their clientele whenever they make the decision that the time has come to change their lives. Do all of the alcoholics and drug addicts from the population groups served by these facilities become clean or sober? Of course not! Do many? It depends on the definition of "many." Do some? Absolutely! Do more than did prior to adoption of the risk reduction care model? Probably. But without a doubt the on-the-street lives of those who continue to abuse drugs and alcohol is much better and much healthier than under only the law enforcement model.

Many, and most probably most, of the individuals who are detained under the *Yukon Liquor Act* are chronic alcoholics and drug addicted persons who access their intoxicant of choice where it is most easily accessible, which is generally within the confines of the downtown area of Whitehorse. (We will address the issues of addiction further in this report.) Additionally most of the on-the-street individuals reside in or near downtown Whitehorse. If any future facility is to play a significant role in the lives of these people, it must be accessible and available to the public it serves. It is not by fluke that the Salvation Army is located literally within blocks of the Chilkoot Trail Inn, 98 Hotel, the Yukon River banks and most of Whitehorse's pubs.

Management of the acutely intoxicated person at risk cannot succeed without involvement and cooperation of the law enforcement professionals. But it is time for the pendulum to swing from pegged against the law enforcement side to some middle ground that accepts today's social mores, involves health care delivery and adopts a risk reduction philosophy.

While it is not part of the formal mandate of this task force, we were advised to coordinate our efforts with the *Review of Yukon's Police Force* to attempt to avoid conflicting recommendations, wherever possible. As participants in that very successful and engaging dialogue, we veritably appreciate that both the RCMP and the Department of Justice suffer from a loss of trust in the eyes of, most definitely, the First Nations' community and probably the Yukon populace in general. Consequently, as we must build a better tomorrow starting from the foundation of today, it would be formidable to attempt to create a new delivery model with a new attitude from within any of our current facilities. If we want to create a new and successful entity, it would be a bad idea to attempt to do so starting with two strikes against us.

RECOMMENDATION #4: A new sobering center should be created in downtown Whitehorse to be used as the facility where acutely intoxicated persons at risk are accommodated when they are detained under the *Yukon Liquor Act* or its replacement. The philosophy of this institution should be consistent with the social mores and human rights of today and should function under a harm reduction model.

RECOMMENDATION #5: This sobering center should have immediate access (i.e. on site) quality health care delivery at either the level of RN or paramedic training.

Detoxification and our Detox Facility

While it is not within the terms of reference for this task force to advise on our current detox facility, we heard time and time again in our conversations with the Yukon populace statements about our current detox service. Additionally our experiences in Vancouver and Winnipeg included direct involvement with their detox facilities. Hence we would be remiss not to share our experiences and hence our advice on this subject, which is closely attached to, and probably truly inseparable from, the management of the acutely intoxicated person at risk. In both Vancouver and Winnipeg their sobering centers and their detoxification units were co-located and allied, if not integrated.

To understand the difference between a detox facility and a sobering center one must first understand the physiology of intoxication and addiction. Intoxicants are chemicals which affect the central nervous system (the brain and the spinal cord). Intoxicants are “toxic” to the central nervous system (CNS). Many intoxicants affect other organ systems but all affect the central nervous system.

To be able to use specifics to create a general understanding, the following discussions will be specific to ethyl alcohol (ethanol or “alcohol”). Alcohol is our most common intoxicant. It is ubiquitous and easily available in mouthwashes, perfumes and colognes, vanilla extract and many over-the-counter medications in addition to the taxed and controlled beverages for sale in our pubs, lounges and liquor stores. Approximately 2/3 of the American public admits to consuming alcohol-containing beverages. As an intoxicant, ingestion of alcohol causes CNS symptoms including slurred speech, disinhibited behaviour, cognitive impairment, loss of coordination, unsteady gait, memory impairment and stupor or coma in a dose-related response. In other words, the more one consumes the greater the effect.

Being intoxicated is a state of significant risk for both morbidity and mortality, which is medical jargon to mean that being drunk puts one at risk of both injury/disease and death. Driving while intoxicated causes accidents, which can cause both injury and death. Excessive alcohol consumption can cause injuries consequent to loss of muscular control and diseases consequent to vomiting and the like. In fact ethanol is transiently toxic to almost every organ system in the human body. Additionally long-term use of alcohol can cause irreversible diseases, such as cirrhosis of the liver, ulceration of the stomach, dementia, paralysis and cancer. To repeat, being intoxicated puts one at risk of illness, injury and death while repeated intoxication increases these risks.

Alcohol can be measure in the blood and in a non-habituated person has a predictable response. With a blood alcohol level between .05 and .10g/l an individual usually exhibits impaired judgement and coordination, hence our standard of legal intoxication of .08g/l. This, however, does not mean that everyone who has a blood alcohol level of .08g/l will appear intoxicated. Drs. Ethan Cohen and Mark Su make the following statement in their article *Ethanol Intoxication in Adults* in Up-to-Date 2010: “...individuals with a history of chronic alcohol abuse and dependence can demonstrate little clinical evidence of intoxication (“tolerance”), even with high blood alcohol levels of greater than 400mg/dL” (.400g/l). In other words an individual can develop a tolerance for the effect of alcohol. In common parlance one learns how to “hold their liquor.” A non-habituated individual clears alcohol from the body at a relatively constant rate of .015 to .020g/l/hr. This person intoxicated at a level of .120g/l would sober-up to a level of .060g/l in 3-4 hours. A habituated person, however, will clear alcohol from the body at an increased rate of .030 to .035 g/l/hr. Hence this person could sober-up from .180 to .060g/l in the same 3-4 hours.

We have used the term “addiction” earlier. It is now time to define it. In simplistic terms a substance is addictive if (1) after repeated uses it requires more and more to achieve the same effect and (2) stopping use of the substance induces symptoms of withdrawal. We have already seen that habituated individuals require significantly greater quantities of alcohol to induce the same degree of intoxication. We also know that alcohol induces withdrawal symptoms when consumption either ceases or is withheld. Hence ethanol is an addictive substance, as are all narcotics (e.g., morphine, heroin, codeine and oxycodone), amphetamines (e.g. dexedrine, benzedrine and methamphetamine) and benzodiazepines (e.g., Valium, Librium, Serax and Ativan). Not everyone who uses any of these medicines will become addicted to it. In fact addiction is an unusual consequence of the use of these medications. Similarly not everyone who drinks alcohol becomes addicted to it nor does everyone who uses a narcotic for relief of pain. Medical science cannot predict who will become addicted but for those who do, the consequences are serious and potentially disastrous. Anyone experienced in addiction medicine, or the realities of life on the street, understands all too well another consequence of the biochemistry of addiction, the relief of withdrawal symptoms is readily obtained by ingestion of more of the addicting substance.

Equally alcohol withdrawal is a potentially serious phenomenon. The most severe form of withdrawal “delirium tremens (DTs)” is associated with a mortality rate of approximately 5%, which means that about 5%, or one out of twenty individuals who experience DTs will die. Alcohol withdrawal is a potentially lethal experience! It is not to be viewed lightly. Withdrawal symptoms begin approximately six to twelve hours after the last drink. The astute reader, using the formula given two paragraphs above, might logically conclude that an extremely intoxicated individual could experience withdrawal symptoms long before all the alcohol has been cleared from the body. That conclusion would be valid.

The collation of the above information leads us to several conclusions: (1) alcohol and other intoxicants are common and readily available, (2) acute intoxication put one at risk for disease, injury and death, (3) long-term and chronic use of intoxicants increases that risk, (4) alcohol has the potential to cause addiction, (5) withdrawal from alcohol also puts one at risk for an additional set of causes of injury, disease and death.

(All of the above statements are with reference to the individual. There are multiple and significant consequences of alcohol use to society as a whole but these issues are beyond the scope of this report. We, however, must note this perspective. Other investigators expectantly will address the social and societal consequences of drug and alcohol abuse.)

How can we use the above knowledge to create an effective treatment system for the acutely intoxicated person at risk? First we can create legislation that will allow us to protect and provide care for that person when he is not capable of doing so. Our current *Yukon Liquor Act* provides this authority but needs improvement. (**See Recommendation #3**) Secondly the acutely intoxicated person at risk needs detention in an environment which can provide necessary and appropriate care in a timely fashion. (**See Recommendations #4 and #5**) Lastly we need to improve the level of care available to acutely intoxicated persons at risk when they experience the consequences of ceasing use of their addictive substance.

RECOMMENDATION # 6: The level of care at our current detoxification facility should be increased to provide medical detoxification.

Our current detox facility does an incredible job given the personnel and resources currently available. They, however, are absolutely limited by their physical environment. They are operating to capacity and probably beyond. Their intake “room” is actually the reception area just inside the front door. There exists no privacy at a time of maximum vulnerability for their newest patient. In fact the option for privacy does not even exist as the person doing the intake assessment must simultaneously monitor patients in acute withdrawal. Both tasks require assessment by the most skilled worker currently on duty. The option for a dedicated intake assessment in a space that respects the privacy of the new patients and allows the care worker to create an individualized care treatment program does not exist. Additionally the level of care provided by necessity at Detox is frequently well beyond the scope of practice of all currently employed personnel. The director of the facility made the direct and unambiguous statement to us that her staff must, not infrequently, treat patients in stage three withdrawal, i.e. DTs. This they do without medical supervision and without symptom-directed therapy. This is well below the accepted current standard of care and today’s best practice models. The current level of care puts Yukoners at risk. We are capable of doing better and should do so.

Opportunity for Intervention

The entire prior discussion has been about how to provide better care for the acutely intoxicated person at risk. The mandate of this task force is to “... advise the Minister of Health and Social Services on options, and suggested priority areas for action, for appropriate and effective ways to deal with acutely intoxicated persons at risk of harming themselves or others.” Our mandate is specific and was not intended to be a wide-ranging analysis to include either prevention of intoxicant abuse or interventions to prevent relapse by persons at risk. All care providers and system managers, however, fully acknowledge that both of these issues are problems desperately in need of solution. We would be remiss to fail to include proactive measures that could possibly assist easily and readily with these problems if they closely ally with our issues. We have previously recommended the creation of a downtown sobering center for treatment of acutely intoxicated person at risk (**Recommendation #4**). We also have recommended elevation of the standards at our current detoxification facility (**Recommendation #6**) and have implied that the current physical facility is inadequate to achieve the stated standard of care. Both Vancouver and Winnipeg have their sobering center and their detox co-located. This is a logical, and probably necessary, corollary to the creation of a new sobering center.

RECOMMENDATION #7: The newly created sobering center should be co-located with an expanded detoxification facility.

Recommendation #7 achieves several benefits. The staff of both facilities must include qualified care practitioners. It is only logical that these two teams should be integrated, not duplicated. Standards of care, while not identical, have much in common. The medical advisor, or medical director, depending on the philosophy of system creation, could establish integrated standards of care and responsibility of duties. Crisis intervention protocols, which will invariably be needed at both facilities, could be achieved with one supply of medication and equipment. There would be no need for duplication of training for crisis management. Integration within a global care community (**See Recommendation # 2**) would involve only one representative.

Another significant, but from a very different perspective, benefit of integrating the two facilities would be for the patient. An individual frequently makes the decision to seek help to change the direction of his life at times of crisis. One such time is when detained for an episode of acute intoxication. While both the Vancouver and Winnipeg experience is that few individuals take advantage of the opportunity to enter detox directly from the sobering center, both agencies create that opportunity and try to facilitate that transition. Vancouver has two detox beds dedicated for sobering center clients. Winnipeg facilitates, but does not invariably guarantee, such a transition. Both, however, fully acknowledge that successful movement towards a life of sobriety is best achieved if the patient's request for help meets the opportunity to provide support.

Both Winnipeg and Vancouver view the detention of the acutely intoxicated person at risk differently than we currently do here. Neither facility uses sobriety as the end point of detention. Both facilities attempt to get their clientele out of detention and back to their own resources as soon as they are assessed to no longer be a danger to themselves or others. We were quite surprised when we initially confronted that philosophy but now agree with it. Our first reaction was that the purpose behind the philosophy was to save resources. We now believe we were wrong and their intentions were in fact a healthier and safer (and more consistent with personal rights and freedoms) attitude. The typical detainee in either jurisdiction was detained rarely longer than four to six hours. The goal was to allow each individual to return to his chosen life, if no longer in danger, before he started to experience withdrawal symptoms. If he so chose, he could avoid withdrawal by resuming consumption. As we discussed in the previous paragraph, he also had the choice and opportunity to enter detox directly. Their experience is that no more choose to maintain an intoxicant-free life after imposed sobriety than do so when offered the opportunity initially. Additionally, as discussed elsewhere, going through the withdrawal process involves significant risk to health and even life itself. Furthermore to quote Drs. Joseph R Volpicelli, MD, PhD and Scott A Teitelbaum, MD from an article entitled *Ambulatory Alcohol Detoxification* from Up-to-Date 2010, "The intensity of withdrawal symptoms, including seizures, increases with successive episodes of withdrawal, a phenomenon known as "kindling." Hence making a patient go through withdrawal is not only potentially, but veritably, harmful and probably should not be undertaken without a reasonable expectation of additional benefit. Our new detox/sobering center must consider this concept when establishing new standards and protocols.

The preceding paragraph demonstrates a fact that almost all members of the Yukon community poorly appreciate. Addiction medicine is a very new, very complicated and not-yet-completely understood area of medicine. Both Vancouver and Winnipeg provide effective and safe care using minimally credentialed personnel but both systems have highly trained and uniquely qualified directors and medical advisors. Dr. Sharon Lazeo M.D., a local practitioner contracted to provide medical care to patients at Detox, shared with us that she has very little opportunity to upgrade her skills locally and has minimal support to acquire the unique skill set required to provide appropriate care to her clientele. None of the current staff at Detox has any specific professional training to qualify them for the demands of their positions. No members of the local RCMP constabulary who are responsible for the wellbeing of their detainees have any specific training directed at the medical needs of the acutely intoxicated. No member of the Whitehorse General Hospital has expertise in addiction medicine.

RECOMMENDATION # 8 Personnel at the new sobering center/detox unit should be trained and educated in the specifics of addiction medicine as it pertains to their individual duties. The unit should have a medical director who has either training or experience in addiction medicine. Annual on-site training for personnel directly responsible for primary care and treatments and

tertiary level training for the medical director should be established as part of the care delivery process.

RECOMMENDATION #9: The staffing complement at the new sobering center/ detox facility should include primary care nursing personnel capable of assessing and treating most medical needs of both the acutely and chronically intoxicated persons. The job descriptions of these professionals should include a commitment to communicate with EMS and ER personnel, family physicians and out-of-Whitehorse care providers on behalf of their patients. In the event that a patient in care does not have a family physician, nursing personnel should attempt to establish such a relationship and, until that relationship is created, assume ongoing responsibilities for primary care. A medical director should be employed to establish, and subsequently assure maintenance of, standards of care and primary care protocols. These new professionals should be in addition to all current Detox employees, who would continue to work as front line care providers.

Care Outside of Whitehorse

Management of the acutely intoxicated person at risk outside of Whitehorse creates significant and unique problems due primarily to the difficulties of small numbers and limited resource capabilities. Needless to say we cannot build staff and maintain sobering centers in every Yukon community. Equally the time frame of detention, ignoring totally the prohibitive costs and the not-insignificant risks during transport, precludes transfer of every acutely intoxicated person into Whitehorse. Hence the reality is that every community must develop a local plan, using local personnel and resources, to care for those in need. These resources are most likely limited to RCMP members, community nurses, family and concerned citizens, with limited support from social workers and clergy. Physical facilities are limited to RCMP cells and the nursing station. The decision as to where is best to provide interim care must be individualized based on the medical needs of the patient. Community nurses use the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale to make decisions about transfer to WGH and symptom-directed treatment for management of alcohol withdrawal. We found it very enlightening that none of the interviewed nurses knew about the detention clause of the *Yukon Liquor Act*, while all were well versed in application of the *Mental Health Act*. A direct consequence of our video conferences was that a copy of the Yukon Liquor Act was distributed via the YTG Department of Community Nursing to all nursing stations. Interviews with community RCMP officers elucidated the problem of monitoring in the cells in the community, which is usually performed by poorly paid community members with a minimum of first aid and detention management training. Recruitment for this service within the communities appears to be a significant problem. Care by family member, however, is more readily available and better utilized in the smaller communities compared to Whitehorse. No community provides facility for shelter or supported housing as part of any addiction treatment program locally although some first nations' governments and individuals do attempt ad hoc addiction treatment usually involving a back-to-the-land philosophy.

We authors of this report hope that the proposed sobering center/detox facility can ultimately become a resource and possibly a referral treatment center for use by the primary care providers in the outside-of-Whitehorse communities.

Shelter and Housing

One of the most critical and immediate needs of the acutely intoxicated person at risk is shelter, especially during our six months of inclement weather. Frequently successfully withdrawn patients occupy beds at Detox because they have nowhere to go while they wait for residential treatment. Many acutely intoxicated persons intentionally create a circumstance wherein they will be detained in the RCMP cells only because they need shelter. Some repeat this nightly. RCMP personnel readily admit they are reluctant to release a client into the middle of the Yukon winter night with occasional consequences of extending the stay into the realm of withdrawal. Detox is not an option for the acutely intoxicated. Some individuals have burned their bridges at the Salvation Army shelter. Some people, especially women, have expressed the opinion that they have no where to turn if they are acutely intoxicated and in danger. The street people and the homeless in the Yukon need access to a no-questions-asked shelter at night.

The Main Street Project in Winnipeg has addressed this need by creating such a shelter in co-location with their sobering center and detox. Clients of the sobering center, when no longer in need of detention but with no place to go, can walk around the corner from the sobering center exit to the shelter entrance for the rest of the night. Acutely intoxicated persons can enter the shelter voluntarily. People in fear can access security in the shelter. The advanced-skills paramedics provide a modicum of medical care in the shelter. A hot drink, but not a meal, is available in the shelter. The Yukon needs such a facility.

RECOMMENDATION #10: A night time shelter, accessible to both the acutely intoxicated and those seeking a harbour of safety and security, in co-location with or near to the sobering center/detox facility should be created.

Night time shelter is the first step in what ultimately is the pinnacle of care and rehabilitation of the chronic alcoholic and/or long term addict - supported housing. While it is not within the mandate of this task force to address the treatment modalities for chronic disease, we would be derelict to not discuss how our recommendations can be used as building blocks as part of a larger picture. Many, if not most, chronic alcoholics and long-term addicts suffer from dual diagnoses with mental illness. Most of this same population have lost the capacity to provide even the most basic of human needs, food and shelter. If they ever are going to either get the necessary mental health treatments they need or rebuild their personal capabilities for self-reliance, these interventions require stable housing. Life in a shelter, while better than life on the street, will rarely be sufficiently stable to provide effective interventional therapies. Success unequivocally requires housing. But cost effective housing with a likelihood of successful interventions begins with the provision of basic shelter. Ottawa has a very functional system of shelters and housing. They have four shelters (one for only women) with increasing degrees of responsibilities and control. The shelter-using population self-selects which shelter to use. Individuals from any of the shelters can make application to the limited number of (wet or dry) available short-term housing beds with ultimate access to permanent and supported housing. But preferential access, based on likelihood of success, is given to those, everything else being equal, who use the higher responsibility shelter. In other words, demonstration of some degree of personal responsibility on the street is used to define who gets access to the limited resources of supported housing. Equally the shelter of higher responsibility is able to provide a greater amount of intervention, including access to medical, mental health and dental care, management of medication use and even social and spiritual therapies. To

complete this picture, we must make sure that the reader understands that all three of these shelters are literally within blocks of each other and all are within the boundaries of Ottawa's skid row.

Outreach and Care on the Street

At a meeting with EMS personnel, one of them shared the observation that if he is attending to a patient on the street and an RCMP officer arrives on the scene, the intensity of the interaction with the patient escalates. The reasons for this are many and beyond the scope of this document. Many other interviewees, however, have confirmed this observation. In fact one of the proposed recommendations from the *Review of Yukon's Police Force* will address this issue. Several years ago Winnipeg understood this reality and created an agency named Downtown Winnipeg BIZ (It was initially funded by the downtown business community, hence the "BIZ"). Part of the responsibilities of the BIZ workers, also known as "redcoats" is to detain and transport acutely intoxicated individuals to the sobering center. In fact the BIZ outreach workers now deliver a majority of all admissions to the center while the police deliver a minority, despite the fact that redcoats are currently on the street less than 24/7. This function is only part of the duties of BIZ workers. The biggest part of their job is outreach. They provide support and care for the homeless and street people on the streets of Winnipeg.

At this point in our report we want to discuss the program in Winnipeg in greater detail because they have achieved something unique, and very desirable, in their system. We stated earlier that all persons detained due to intoxication are taken either to hospital or the sobering center at the Main Street Project. We have just stated that a majority of those persons in need are detained, under appropriate legal authority, by BIZ workers. But we also stated that the primary function of the BIZ workers is outreach. Winnipeg has achieved a functioning system wherein the outreach street workers, who have credibility and acceptance by the street people, are also the authorities who detain, restrain and transport these same people when they are acutely intoxicated and in danger. This seems like a contradiction in roles. But it works in Winnipeg because, to our interpretation, the sobering center is not seen as a place for punishment but instead as a place of safety and security in a time of need. We do not believe that a person can voluntarily enter the sobering center but unequivocally many enter willingly, even if physically detained. Inspector Brian Cyncora of the Winnipeg Police Service, whose office is at the Main Street Project, made the point that, with respect to an acutely intoxicated person at risk, a police officer has the responsibility of enforcement, while an Outreach worker has the responsibilities of enforcement, intervention and prevention. The successes of the Main Street Project and Downtown Winnipeg BIZ demonstrate the benefits of including outreach and care in the system of law enforcement and detention.

The following recommendation is similar to a proposed recommendation from the *Review of Yukon's Police Force*.

RECOMMENDATION # 11: An intervention team, which includes a peace officer authorized to detain under the applicable legislation, should be established to respond to calls for service within the Whitehorse city limits involving acutely intoxicated persons at risk.

Whitehorse General Hospital Emergency Department

As mentioned earlier in this report, Whitehorse General Hospital (WGH) Emergency Department, usually referred to as the ER, is the only Whitehorse medical facility capable of providing physician services all hours of the day or night every day of the year. Because of this, many facilities and agencies use it as back-up at times when they do not provide in-house medical service. Recent changes in the standards of care requiring immediate medical assessment at RCMP and Detox have had significant deleterious effects on WGH ER. EMS transfers from RCMP cells to WGH have more than doubled comparing 2009 to the first six month of 2010. This has created not only a significant increase in volume but also an exponential increase in acuity. Acutely intoxicated persons require significantly more attention than does the average ER patient. ER care providers cannot put an acutely intoxicated person into a cubicle and expect him to wait quietly until a physician is available to assess. In truth an acutely intoxicated should never be left unattended in any environment with access to items that can be used to cause injury or harm. Envision the typical ER cubicle with a gurney and step stool, privacy sheets on a hanging track, a bedside table holding typical assessment and treatment equipment, a sink and faucet with soap and disinfectant solutions, a wheeled IV pole with at-the-ready IV solutions and several bivalved outlets on the wall with masks and tubing. Now envision placing a severely intoxicated person in that environment and leaving him alone while one of the only two nurses on duty leaves to attend to the other dozen patients similarly in need to attention. It is a disaster waiting to happen.

In addition the acutely intoxicated patient is frequently loud, obnoxious, demanding and disrespectful. This behaviour creates additional stress and disruption in an inherently stressful environment.

Our ER providers have responded to this crisis in the manner that all conscientious care givers, who must attend to a patient who cannot wait, would - they jump the queue. Those who cannot wait get immediate attention while those who can wait will be seen as soon as possible. The reality of ER care dictates this response but, needless to say, this frequently creates significant dissatisfaction in those who have already been waiting patiently and probably for a long time before the arrival of the intoxicated patient. Realizing that this problem demands a different solution the administration of the ER department has made internal adjustments such as changing a chaired-and-couched family consultation room immediately adjacent to the nursing station into a barer room to better accommodate and observe the intoxicated patient. In addition they have increased staffing by “temporarily” offering casual employment. They also have increased capacity by using beds from the Surgical Day Care unit during the hours when this unit is usually closed. All these measures are “stop-gap” with the intended purpose of providing a better, but not good, level of care in response to an unexpected demand placed on them consequent to decision made without consultation by other agencies. (**See Recommendation # 2**) The impact of these decisions has had profound impact on not only WGH ER but also WGH security, the admission department, the medical ward, the cleaning and maintenance staff and even the Operating Room.

The breadth of the medical needs of the acutely intoxicated person at risk is such that in fact assessment by an ER physician is usually not even appropriate. Undoubtedly there will always be times when an acutely intoxicated person will need to go to the ER and/or be admitted for in-hospital care. Uncontrolled seizure activity, a suspected subdural hematoma, severe orthopaedic trauma, diabetic ketoacidosis induced by excessive and prolonged alcohol abuse and the like will always need ER assessment and in-hospital care. But these are medical conditions in an intoxicated person, requiring an

intense level of care, not the primary problems and consequences of acute alcohol abuse. Such problems require assessment and usually treatment at a facility dedicated to and capable of treating the common consequences of both acute and chronic intoxication. WGH ER is not such a facility.

A permanent and sustainable solution to WGH's problem ultimately must be achieved. This must include reducing much of the current volume overload. Until that goal is achieved an interim, but specifically directed, method of accommodating the overload at WGH must be created.

RECOMMENDATION #12 Department of Health must coordinate with Whitehorse General Hospital administration to alleviate rapidly the staffing and physical resource crisis of care of acutely intoxicated persons at risk in the Emergency Department until a better and more sustainable solution involving medical care in dedicated facilities can be created.

Prevention and After-Care

While it is not the mandate of this task force to advise on the issues of prevention of either primary disease or relapse and we will not make recommendations on either of these issues, we cannot consider the problems of the acutely intoxicated person at risk without making some comments about both these problems. While we have made well-constructed recommendations on how best to manage the acutely intoxicated person, would it not be better to reduce the need for these services? Similarly many of the persons who receive treatment for an episode of acute intoxication will require similar intervention in the future. Would it not be beneficial, both to the individual and to society, to reduce the likelihood of relapse?

Addiction is a very complex problem. An addicting substance produces the previously discussed reactions in only a small subset of the people who are exposed to it. Even prolonged use of alcohol or narcotic analgesics usually does not produce addiction. But when it does, it is permanent and irreversible. Medical science has long sought a marker to predict who will become addicted but has never found one. Many believe in the existence of an addictive personality characterized by dependency, lack of personal security and confidence, low esteem, inability to deal well with stress and impulsive behaviour. But undoubtedly many individuals with these traits tolerate addictive substances without any adverse sequelae.

The boundary between addiction and substance abuse is unclear and probably recognizable only after the fact. Many individuals abuse intoxicants initially as an escape mechanism, only ultimately to develop an addiction. It is impossible to predict who will develop an addiction but, until we develop a reliable marker, the question is moot. The more we can reduce the need to abuse intoxicants, the fewer addicts we will produce and, in fact, the fewer acutely intoxicated persons we will have. Personal issues, such as childhood abuse and neglect, need to be minimized. Individuals who have already suffered such abuses need consistent and long-term treatments. Systemic issues with personal consequences, such as residential school effect, destruction of cultural values, induction of dependency and poverty, need attention. Understanding what factors inhibit personal development and wellbeing will ultimately produce a healthier population with less need to turn to chemicals for escape and solace. Reducing

poverty and homelessness will allow individuals to achieve personal fulfillment and similarly reduce the need to abuse.

The problem of relapse is even more frustrating. Very few, if any, external interventions ever prevent a relapse. Undoubtedly punishment and incarceration do not. Legally mandated treatment programs have been abysmal failures. Even imposed sobriety and involuntary detoxification with supported withdrawal fail far more often than they succeed. For the addicted or chronically abusing individual, relapse is the norm and long-term abstinence is the rarity. But occasional successes do occur, giving us all hope that we can achieve more. If one interviews alcoholics and addicts who have achieved sobriety, one consistent characteristic of their success reappears - they had decided it was time to change. No one made them change; they decided to change. Our role in such successes is one of facilitation, not imposition. Many of these individuals will state that their decision came at some time of crisis. We can increase the chance of success by making resources available at times of crisis. One such potential crisis is detention for acute intoxication. Therefore we should make the opportunity to achieve sobriety easily available at this time of crisis. We should make it as simple as walking through an adjacent doorway from the sobering center into the detox unit. Equally the success of detox unequivocally depends on removing incentives to relapse. Housing needs to be assured. Family and community support needs to be in place. Personal success needs to be a possibility from the perspective of the newly sober or clean person. Without these parameters addressed, the likelihood of failure will increase. And failure begets failure. And it costs us all. Time and time again! The successes, although few and far between, are worth the investment.

Costs

Creating facilities and services as suggested above will cost significantly. We have attached vague and imprecise costing estimates. Our figures are inherently imprecise so as to allow YTG latitude with respect to planning and implementation. Acknowledgedly it is YTG's responsibility and prerogative to do the due diligence with respect to any, or all, of our recommendations and, in truth, a definitive cost analysis of our recommendation would be an intense fiscal exercise, well beyond the scope of this inquiry.

We do, however, want to make two statements in addition to our costing inclusions. We have made no estimates of any cost savings. To make fair analysis one must equally consider the reduction of current expenditures such as EMS transfers. Earlier in this document we briefly discussed the savings the Main Street Project in Winnipeg made in EMS transfers by employing paramedics onsite. Our local EMS service reports that, during one ten-week period in April 2010, nearly half of all events were alcohol related and almost 15% included acutely intoxicated persons with over one quarter of all calls requiring RCMP assistance. While we can never expect to reduce these statistics to zero, the Ottawa experience demonstrated that successful interventions did reduce one individual's use of EMS services from several times weekly to exactly zero over several consecutive years. Most of the EMS transfers also require assessment at WGH, which compounds the costs to include very expensive facility and personnel resources.

The paragraph above explores actual costs and cost savings consequent to alcohol abuse. In addition drug and alcohol abuse creates immense, though less precisely defined, social cost in the spheres of

family destruction, community disruption and loss of personal achievement and fulfillment. Countless millions in social infrastructure costs are presently incurred to address these needs. Again we can never expect to reduce these costs to zero but every dollar spent to repair the damage caused by drug and alcohol abuse could better be spent to improve opportunities, for example, at the beginning of life and throughout the educational process. These would become dollars invested, not dollars spent.

The final point we wish to make with respect to costs is a reiteration of a point we made in passing in the second paragraph of this report, "Society enjoys many benefits from the not-insignificant tax revenues generated from the licensed sale of intoxicants." Only last week in Friday, December 10th edition of the *Whitehorse Star*, the following headline appeared: "Soaring suds sales boosted YLC ledger." The article contained the summary of sales and profit reported for the 2009/2010 fiscal year for Yukon Liquor Corporation (YLC). YLC grossed \$30.3 million and netted \$7.1 million with increased profits of \$750,000. While we fully acknowledge that YTG has already budgeted to expend the expected annual profits from YLC, last year's performance undoubtedly outperformed expectations. In our opinion, and the opinion of multiple interviewees, YTG should precisely dedicate a percentage of YLC profits towards the treatment of alcohol-induced problems. This 2010 windfall of \$3/4 of a million would be a good start.

Conclusion

This report is our best attempt to produce legitimate, achievable and locally applicable recommendations of management strategies for appropriate and effective ways to deal with acutely intoxicated persons at risk of harming themselves or others, consistent with the mandate of this task force. We hope that Minister Glenn Hart, Minister of Health and Social Services, will be pleased with our report and will be able to implement many, if not all, of our recommendations. It has been our pleasure to assist him with his responsibilities.

Following this Conclusion will be an analysis of each recommendation with options for inception and integration and a prioritization of the recommendations.

Respectfully submitted

Dr. Bruce A. Beaton, MD

Chief James Allen, CAFN



Priority of Recommendations with Options

RECOMMENDATION #12 Department of Health must coordinate with Whitehorse General Hospital administration to alleviate rapidly the staffing and physical resource crisis of care of acutely intoxicated persons at risk in the Emergency Department until a better and more sustainable solution involving medical care in dedicated facilities can be created.

Other agencies and facilities have begun to use WGH ER as their source of acute medical care for all significantly intoxicated persons. WGH ER was not, and is not, prepared to handle this sudden and unexpected increase in volume of difficult at-risk patients. They have responded with interim measures but need urgent, if not immediate, assistance to provide adequately for this group of persons in need of care. The recent increase in demand for services at WGH, and most specifically WGH ER, has overwhelmed their anticipated staffing requirements, taxed their physical layout and has created an environment at risk of a significant and predictable disaster. They need assistance urgently.

Alleviation of their interim needs is the most urgent of all our recommendations and assumes the position of first priority.

RECOMMENDATION #1: All individuals who are required, as part of their professional responsibilities, to manage or provide care for the acutely intoxicated person at risk must assure that all such persons are treated with compassion and dignity in a non-judgemental manner. This must become a systemic standard of behaviour. Managers are ultimately responsible for the behaviour of first line workers. If such standards cannot be achieved internally within all participating organizations, external resources such as training programs developed in conjunction with the Northern Institute of Social Justice at Yukon College should be utilized and should include First Nations' content and cross cultural awareness.

There are no options for this recommendation. It has universal priority. We must achieve it. If we fail on this, no changes in staffing or creation of new facilities will succeed. If we cannot treat all our charges non-judgementally with compassion and dignity, we can never expect a positive outcome.

RECOMMENDATION #2: Designated and identifiable members from the various agencies responsible for the care and wellbeing of the acutely intoxicated persons at risk should meet at

least annually to address their respective issues in an attempt to identify both competencies and inadequacies, but especially to try to identify the gaps between their respective services. Members of this committee should include but not be limited to the policing services, acute medical care facilities, intoxication and addiction treatment facilities, outreach providers and all local and First Nations' governments.

Again there is no option for this recommendation. One of the most significant conclusions we reached as we did our research was not that any of our agencies or individuals acted inappropriately or inadequately. Each agency and every individual within that agency did his job well and consistent with expectation. Where we erred or failed was when one agency failed to integrate with another and when one person within an agency failed to communicate appropriately with someone in another agency. Our errors are of omission, not commission. Our boards are strong and don't need repair but our cracks are too wide.

RECOMMENDATION #3: New legislation should be written to supersede Sections 91 and 92 of the current *Yukon Liquor Act* to define more precisely under what circumstances an acutely intoxicated person can be detained, what services will be provided to the detained person and what conditions must be met to cease the detention. This legislation should be consistent with current human rights standards and should allow for necessary and appropriate basic medical care while under detention.

Option #1: Rewrite the legislation to make the rules under which we detain someone to become consistent with the standards of today. Our understanding of the ramifications of acute intoxication is far deeper than it was when our current legislation was created. Our ability to provide appropriate care is superior now to then. Our human rights standards have significantly changed. To what the effected person can transition and under what circumstances he can make that transition should be defined. We currently detain, probably illegally, persons under the influence of multiple intoxicants other than ethanol. We need to create better and more applicable legislation.

Option #2: Amend Section 92 of the *Yukon Liquor Act*. This is a markedly inferior option. Management of an acutely intoxicated needs more definition than six paragraphs of a single section in a 119-sectioned act about liquor.

RECOMMENDATION #10: A night time shelter, accessible to both the acutely intoxicated and those seeking a harbour of safety and security, in co-location with or near to the sobering center/detox facility should be created.

This recommendation, although numbered higher than others, is presented earlier in this summary because initially shelter then supported housing is, in our opinion, a necessary priority in the greater picture of effective intervention for ultimate success to achieve a stable, and hopefully clean or sober, life.

Whitehorse already has a shelter run by the Salvation Army. It has served this community long and well and continues to do so. In no way whatsoever do we intend to diminish the critical

function it serves in our community. It, however, is not available to acutely intoxicated individuals. The Salvation Army shelter in Ottawa does allow access by intoxicated clients. Hence this is a local decision. While we do not have verifiable understanding of the basis of this decision, we suspect it is along the lines of “Better to have a shelter that excludes some individuals than a shelter that provides safety and security to none.” But having no shelter accessible to acutely intoxicated persons is no longer adequate.

Option #1: Create a second shelter, ideally co-located with the sobering center/detox facility, which accepts acutely intoxicated individuals and allow the Salvation Army to continue its current policies and hence become a higher tiered shelter wherein we can introduce better access to treatment modalities.

Option #2: Work with the Salvation Army to solve the problems of security and safety to allow access to acutely intoxicated persons.

(Recommendations #4 through #9 are all interrelated and constitute a single priority. While it is possible to do only one or two of these six recommendations, the end product would be far inferior to the entire package and would be an inefficient use of resources, both economic and human.)

RECOMMENDATION #4: A new sobering center should be created in downtown Whitehorse to be used as the facility where acutely intoxicated persons at risk are accommodated when they are detained under the *Yukon Liquor Act* or its replacement. The philosophy of this institution should be consistent with the social mores and human rights of today and should function under a harm reduction model.

A new facility which removes care and management of a person detained while acutely intoxicated from the RCMP cells is universally desired. RCMP personnel are not trained to treat, or even assess, the medical needs of an acutely intoxicated person. While it would be possible to move medical care into the RCMP cells, unfortunately the RCMP has already lost public trust, especially in the area of care of the acutely intoxicated person. It will be far easier and much more successful to start with a clean slate in a new place with a new persona. Furthermore it is time to incorporate the new philosophy of harm reduction into the care model and this can be more easily done in a new environment.

Option #1: The question of where this new facility should be located is significant. Our recommendation is that it should be downtown, close to the common drinking areas. People will ultimately be released from detention and should have close proximity at that time to their social networks and personal resources. Additionally it will be easier to co-locate the new sobering center with Detox and with easier access to Alcohol and Drug Services (ADS) staff and resources if it is located in the downtown core.

Option #2: Department of Justice is in favour of locating a new detention center at Whitehorse Correction Center (WCC). They are well advanced in planning with good attention to staffing and resource access. This plan has several disadvantages from our point of view. First and foremost, WCC is a jail. Despite their best intentions, detention there will still be viewed as punishment. It will be difficult, if not impossible, to create a new societal perception within the

confines of a jail. Secondly their location in Takhini is not central, nor a part of either the social community or the treatment community. However, detention of violent and dangerous acutely intoxicated persons is a necessary consideration and a facility at WCC would be very desirable if this need is not addressed at the new sobering center. This is the Vancouver solution to the problem of the violent and dangerous detainee.

Option #3: Many of the medical care community advocate for location of a new facility on the campus of WGH. There are several benefits to this option, mostly having to do with ease of access to medical care and reduction of need for EMS transfers. Most of these benefits are reduced if the level of care at the sobering center (and co-located detox facility) is raised to provide such care in-house. There would continue to be benefits of ease of access to lab and imaging services, especially if the new facility were to be within the electronic walls of WGH.

Option #4: Upgrade the services provided in the RCMP cells. This is not a realistic option in our opinion but must be done if we do not move the detention center out of the cells.

RECOMMENDATION #5: This sobering center should have immediate access (i.e. on site) quality health care delivery at either the level of RN or paramedic training.

Option #1: Detention of the acutely intoxicated person at risk is no longer a matter strictly of law enforcement. Today it must encompass medical care. Attempting to access appropriate care off-site is both expensive and inadequate. Winnipeg's experience is that employing on-site paramedics was cost effective considering only the savings of EMS transfers. Additionally it is better and more appropriate care and addresses the problem of WGH ER (See Recommendation #12). If Detox is not co-located with the new sobering center (See Recommendations #6 & #9) Winnipeg's experience is that an advanced skilled paramedic is more appropriately trained for sobering center needs. Of note, Winnipeg's co-located detox facility is not a medical detox.

Option #2: Winnipeg's sobering center personnel are not medically trained but still make the decision as to when an intoxicated person is no longer a danger to himself or others. Several interviewees have raised concerns about liability if such decisions are made without professional consultation. It works in Winnipeg but we do recommend 24/7/365 on-site professional capability.

RECOMMENDATION # 6: The level of care at our current detoxification facility should be increased to provide medical detoxification.

Option #1: One of the most common suggestions we heard as we consulted was the need to expand our detoxification capabilities, both in scope and capacity. From a medical perspective our current facility performs far beyond its licensed standard of care. But they do what is the Yukon norm – no one else will do it so I must. But as we make the changes that we will soon be making, it is time to simultaneously upgrade the supported capabilities of Detox. We need to upgrade the training of the current personnel and employ higher certified professionals to create the standards to run a medical detoxification unit. (See Recommendation #8)

RECOMMENDATION #7: The newly created sobering center should be co-located with an expanded detoxification facility.

Option #1: This recommendation is actually the logical amalgamation of physical space requirements, human resources, community need and effective patient care. As discussed in the text of this report, success in achieving a life of sobriety is increased by making appropriate resources available when the person-in-need makes the decision to change. The easiest way to do this is to facilitate the move from detainee to patient-beginning-recovery by making it as simple as walking fifteen feet through a door, especially when the professionals who will provide care on the next step are the same people who have just been providing care in the sobering center. We should do everything we can to help an acutely intoxicated person move towards sobriety by making it just as easy to start the detox process as it is to find another drink. A minimum of two detox beds should be dedicated for transition directly from the sobering center.

RCMP statistics reveal that they had between 2000 and 2500 admissions to their cells in 2009 under the *Yukon Liquor Act*. Department of Justice has planned that they can accommodate this number of admissions with ten individual rooms. The current number of ten beds at Detox is probably close to adequate, but probably should be increased to fifteen, if these beds are retained only for patients in the process of detoxification. Design attention to layout for consideration of intake, privacy, safety of personnel, security of medication and the like must occur. Creative design might make it possible to interchange sobering centers beds with detox beds, if only transiently, and hence achieve a lower sum-total maximal need capacity.

Option #2: Create a new autonomous sobering center and attempt to upgrade the current Detox. This is a step forward in the treatment of the acutely intoxicated person at risk but misses an opportunity to make cost-effective and logical improvements to the detox unit.

RECOMMENDATION # 8 Personnel at the new sobering center/detox unit should be trained and educated in the specifics of addiction medicine as it pertains to their individual duties. The unit should have a medical director who has either training or experience in addiction medicine. Annual on-site training for personnel directly responsible for primary care and treatments and tertiary level training for the medical director should be established as part of the care delivery process.

Option #1: This rapidly expanding and extremely complex field of medical care requires expertise beyond that of the standard medical degree. We have practitioners who are willing to provide service in this area but they need specific training to develop the skill set that can be delivered locally. They should have experiential training, which could be as short as a few weeks if it also is used to develop an open relationship for ongoing consultation and communication. This field is growing so rapidly that annual Continuing Professional Development (CPD) is necessary. The medical director must have directed and continuing specific training to use to create and direct our new facility but primary care personnel will also need training to assure success of this new enterprise.

Option #2: Outside expertise can be used to create and oversee our new facility and use their experience to decide what, when and how ongoing training should be delivered. This is a much inferior option as it is far better to train local professionals, who understand the uniqueness of our circumstances, who can then use these skills to create and deliver a local service than to rely on outside expertise, who typically would be inclined to modify their model to fit our environment with only minimal understanding of the our truly unique territory.

RECOMMENDATION #9: The staffing complement at the new sobering center/ detox facility should include primary care nursing personnel capable of assessing and treating most medical needs of both the acutely and chronically intoxicated persons. The job descriptions of these professionals should include a commitment to communicate with EMS and ER personnel, family physicians and out-of-Whitehorse care providers on behalf of their patients. In the event that a patient in care does not have a family physician, nursing personnel should attempt to establish such a relationship and, until that relationship is created, assume ongoing responsibilities for primary care. A medical director should be employed to establish, and subsequently assure maintenance of, standards of care and primary care protocols. These new professionals should be in addition to all current Detox employees, who would continue to work as front line care providers.

Option #1: This recommendation is to describe the professional staffing of an integrated sobering center and detox. Earlier in this report we advised that either a paramedic or an RN could be used as the professional in a sobering center but this recommendation is intended to advise that if the staff's are integrated, the primary care expertise should be that of an RN.

Option #2: This is a do-it-or-don't-do-it option. We expect that many of the population group will not have an identified family physician and hence do not have any access to continuing care. This new care team could now assume a primary care role in the lives of these frequently indigent people and provide more than episodic care. This would be an ideal opportunity to introduce salaried nurse-practitioners into our care system to provide primary care to a population group usually without access to primary care.

Option #3: The current contract between ADS and their physician makes the following statement: "Yukon requires the services of a physician to provide necessary medical services to clients under the care of Alcohol and Drug Services..." We envision the new medical director to assume the role of team leader and program co-ordinator and to transfer primary care to expanded-role RNs. The current contract for half-days-twice-weekly service is totally inadequate if the intent is for all primary care to be provided by a physician.

Option #4: This is not actually an option but we want it absolutely clear that we advise that all current Detox providers continue to serve in the new facility.

RECOMMENDATION # 11: An intervention team, which includes a peace officer authorized to detain under the applicable legislation, should be established to respond to calls for service within the Whitehorse city limits involving acutely intoxicated persons at risk.

Option #1: The current outreach service of the No-Fixed-Address Van could easily be expanded to accommodate authority to detain to assure the safety of the acutely intoxicated persons at risk. This service already has the trust of the population they serve and would dually contribute to the wellbeing of their clientele but also would assist in creating the perception of the new sobering center as being a harbour of safety, not another focus for punishment.

Option #2: Kwanlin Dun First Nation's (KDFN) justice division could be expanded to assume this authority. There are several benefits to this option including a more functional relationship with a majority of the target population, a pre-existing infrastructure and a stated desire by the First Nation community to assume a greater degree of responsibility in areas in which their people are primarily affected. A single meeting with KDFN's Director of Justice produced considerable initial enthusiasm.

Option #3: EMS providers could be empowered with the authority to detain. The benefit of this option is the existence of an infrastructure which already interacts with the affected individuals under many, but definitely not all, of the same circumstances which currently lead to detention by RCMP. There are two disadvantages with this option: it would be the most expensive option and EMS, as currently structured, would be capable of delivering only minimal outreach services. Additionally EMS staff view the authority for detention as something which could detrimentally change the relationship with their patients.

Option #4: Whitehorse City Bylaw officer's duties could be expanded to include this function. One benefit to this option would be that the infrastructure already exists. The downside is that the current service is primarily enforcement, not outreach, and hence would most likely continue in the model of punishment instead of care. This idea was only recently floated and as of today we have had no conversation with the City of Whitehorse.

**Task Force Report on Acutely Intoxicated Persons at Risk
Financial Considerations of Recommendations**

APPENDIX 1:

#	Recommendation	Option	O&M	Capital	Responsible Dept(s)
1	Sensitivity training and cross cultural awareness	None	Internal training, External training programs developed by Northern Institute of Justice and Yukon College	None	- HSS, Justice(RCMP), CS (EMS), PSC - Yukon Hospital Corporation - FN and other Governments - Yukon College - Northern Institute of Justice
2	Annual committee meetings	None	Meeting expenses, travel, honoraria, contracting Outcome of meetings could identify gaps requiring new programs or services	None	- HSS, Justice(RCMP), CS (EMS), PSC - Yukon Hospital Corporation - FN and other Governments - CYFN - NGOs and outreach providers
3	Changes in legislation - Yukon Liquor Act	1 Rewrite Legislation	May involve consultation costs	None	- Justice and Yukon Liquor Corp
		2 Amend Legislation	May involve consultation costs	None	- Justice and Yukon Liquor Corp
4	New sobering centre – Detention centre with harm reduction philosophy	1 New downtown	Personnel costs (RN or paramedic - 24/7/365 care), programming costs, additional overhead/equipment costs and lease costs – depending on who operates facility	Could involve land acquisition, construction costs or renovation costs	- HSS, - NGO - CS (EMS) - Justice (RCMP)
		2 Build at Jail	Est. \$1 million personnel and operating costs	Est. \$3 million	- Justice

		3 Build on WGH campus	Personnel costs (RN or paramedic - 24/7/365 care), programming costs, additional overhead/equipment costs and lease costs – depending on who operates facility	Construction costs	- HSS - Yukon Hospital Corporation
		4 Upgrade RCMP	Personnel (medical)	Renovation costs	- Justice (RCMP)
5	On-site health care at new sobering centre	1 Medical staff	Personnel costs (RN or paramedic - 24/7/365 care), programming costs, additional overhead/equipment costs	None	- HSS - CS (EMS)
		2 Non-medical staff	Personnel costs (non-medical staff), programming costs	None	- HSS - Justice (RCMP) - NGOs
6	Increased level of care at current detoxification facility – medical detoxification unit	None	Personnel costs (medical staff) Training costs (higher certifications) Programming and equipment costs	None	- HSS
7	Expand detoxification facility	1 Co-locate with sobering centre	Personnel costs (RN or paramedic - 24/7/365 care), programming costs, additional overhead/equipment costs, and training costs. (resources shared with sobering centre. see #4)	Renovation, building addition (increase of 5 beds) or new construction (see #4)	- HSS
		2	Personnel costs (medical staff)	Renovation, building	- HSS

		Upgrade	Training costs Programming costs	addition (increase of 5 beds) or new construction (see #4)	
8	Medical director and training	1 In-house expertise	Personnel costs (Medical Director with specialized training) Training costs - specialized Travel costs	None	- HSS
		2 Outside expertise	Contracting costs Training costs Travel costs	None	- HSS
9	Staffing at new Sobering Centre/ detoxification facility	1 RN's	Personnel costs (RN or paramedic - 24/7/365 care), programming costs, additional overhead/ equipment costs, and training costs.	None	- HSS - CS (EMS)
		2 Nurse practitioners	Personnel costs (salaried nurse practitioners), training costs, programming costs	None	- HSS
		3 Medical Director	Personnel costs, contracting costs, training costs, travel costs	None	- HSS
		4 Current staff	None	None	- HSS
10	Night time shelter	None	Transfer payment (Salvation Army) or lease costs Programming and personnel costs if operated by HSS.	Renovation or construction costs	- NGOs - HSS
11	Intervention team	1 Outreach	Transfer payment increase	None	- HSS (NGO) - Justice (RCMP)

	detain (including peace officer)	van			
		2 KDFN	Personnel and programming costs Legislation costs	None	- Justice and RCMP
		3 EMS	Personnel and programming costs Legislation costs	None	- Justice - CS (EMS)
		4 Bylaw	Personnel and programming costs Legislation costs	None	- Justice - City of Whitehorse