From Grief to Action

Coping Kit

Dealing with Addiction in Your Family

From Grief to Action

From Grief to Action is a volunteer-based not-for-profit association working to improve the lives of young people with substance use disorders and their families and friends.

From Grief to Action (FGTA) promotes recognition of drug addiction as a health issue and, for anyone with a substance use disorder, supports a comprehensive continuum of care including harm reduction, treatment, and recovery, in order that they may achieve and maintain healthy, productive lives.

Through PARENTS FOREVER, our self-help group, we offer regular, ongoing support for parents and family members dealing with the day-to-day challenges of having a child or loved one with a substance use disorder. Without giving direction or passing judgment, we share our experiences, offer understanding and caring, and provide support whenever it is needed. By focusing on issues such as supporting while maintaining good boundaries, and by sharing information on treatment options, we learn to take care of ourselves, and, most importantly, find ways to maintain a relationship with our loved ones. To learn more: www.fromgrieftoaction.com/current-issues/public-policy-initiatives/family-support/free-resources-form/

FGTA also works to raise public awareness. In addition to writing letters and articles, appearing on talk shows, organizing public forums, providing speakers for group or public events, and working with schools and professionals on drug use education and prevention, our society produces educational materials.

Our Vision

Providing hope and support, resources and respect to families and friends affected by drug use.

Our Mission

From Grief to Action is a volunteer-based not-for-profit association in British Columbia. We are a voice and a support network for families and friends affected by drug use.

Purposes of the Society

- To promote recognition of drug use as a health issue.
- To raise public awareness of the needs and concerns of drug users and their families, and work towards overcoming stereotypes and marginalization.
- To provide and promote support for families and friends of drug users.
- To promote effective educational programs designed to prevent drug abuse.
- To promote and work towards the establishment of a comprehensive continuum of care for drug users which meets their needs for harm reduction, detoxification, treatment, and recovery, in order that they may achieve and maintain healthy, productive lives.

Other publications available from the website of FGTA:

- *Here to Help: Caring for Yourself and Other Family Members*
    - Provides information on how a loved one's mental illness and/or substance use can impact the family and provides suggestions for coping.
- *Parents in Action: A Guide for Setting-up and Running a Support Group*
- *Patients Helping Patients Understand Opioid Substitution Treatment*
- *Vancouver Coastal Health Mental Health and Addictions Family Involvement Policy*
    - Applies to all Vancouver Coastal Health/Providence Health Care mental health and addiction services, programs, and units, and provides a framework for family involvement in the care of their loved ones.

Additional support resources, including relevant journal articles, films, disability pension options, and tools from other organizations around the world, can be found under "Support Information" on the FGTA website.

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DISCLAIMER: No one should rely upon any part of this kit as a substitute for current advice from a physician or lawyer.

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It is our hope that this resource has proven beneficial to many BC families struggling with the problems associated with a substance use disorder.
We also wish to thank the many professionals working in this field for their ongoing understanding and support, especially Tony Trimingham of Family Drug Support (New South Wales, Australia), who produced a similar guide which gave us inspiration. We also thank the BC Centre on Substance Use, Canadian Mental Health Association—British Columbia Division, and Pivot Legal Society for their support in revising this updated version.

Most of all we thank those who are using their own experience to assist others struggling with their drug- related family issues and who have so generously shared their hard-earned wisdom and experience in the development of this coping kit for British Columbia.

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Thank-you to our partners for assisting us in updating the Coping Kit for province-wide distribution

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- The BC Centre on Substance Use – for providing staff and expertise in assisting us to update the content.
- The Pivot Legal Society – for updating the criminal justice section.
- Martland & Saulnier Criminal Defence Counsel—for their assistance in updating the criminal justice section related to young people.

We encourage our partners to help distribute the Coping Kit.
A digital version can be accessed on our website:
https://www.fromgrieftoaction.com/current-issues/public-policy-initiatives/family-support/free-resources-form/
A paper copy can be ordered through our contact page:
https://www.fromgrieftoaction.com/contact/general-contact/

BC Centre on Substance Use

The BC Centre on Substance Use (BCCSU) is a provincially networked resource with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction. The BCCSU's focus is on three strategic areas including research and evaluation, education and training, and clinical care guidance. With the support of the province of British Columbia, the BCCSU aims to help establish world leading educational, research and public health, and clinical practices across the spectrum of substance use. Although physically located in Vancouver, the BCCSU is a provincially networked resource for researchers, educators, and care providers as well as people who use substances, family advocates, support groups, and the recovery community.

Canadian Mental Health Association—BC Division

Founded in 1918, the Canadian Mental Health Association (CMHA) is a national charity that helps maintain and improve mental health for all Canadians. As the nation-wide leader and champion for mental health, CMHA promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness.

In BC, mental health, substance use, and addictive behaviour behavior have been within the scope of the organization since 2005. The CMHA is comprised of 14 branches and a provincial division. To learn more about CMHA BC Division, visit: www.cmha.bc.ca. To contact a branch in your community, click on "Find a CMHA branch serving your community" in the top web bar. CMHA in BC provides a wide range of innovative services and supports tailored to and in partnership with a broad base of stakeholders. Mental health begins where you live, learn, work, and play.

We take a person-centered approach

The *Framework for Support* is the central philosophy guiding our activities. This philosophy holds that the person with the lived experience is at the centre of any supportive health system. The goal of the *Framework* is to ensure that people experiencing mental illnesses and/or an addiction live fulfilling lives in the community.

Through their family of over 100 local, provincial, and national locations across Canada, CMHA provides a wide range of innovative services and supports tailored to and in partnership with our communities. Mental health begins where you live, learn, work and play. Together, we are making a difference.

Pivot Legal Society

Pivot Legal Society is a human rights organization located in Vancouver's Downtown Eastside. Pivot's mandate is to use the law to address the root causes of poverty, inequality, and social exclusion. Pivot's work is based on the philosophy that the law should be a tool that guarantees and protects the human rights of everyone, regardless of income, ability, gender, ethnicity, sexuality, occupation, or social condition. Pivot is currently working in four major focus areas; homelessness, police accountability, drug policy, and sex workers' rights.

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Introduction

When From Grief to Action 's (FGTA) founding members first got together, it was for mutual support. Were we in some way responsible for our children's drug use and/or addictions? What could we do to help them? And what could we do to help ourselves?

After much soul searching, research, and consultation with professionals working in the field, we decided to take action. Only concerted effort could bring about an educated public and a better network of needed services in BC. We resolved to speak out on our own behalf and that of families like ours.

Equipped with information and effective support, families can and do develop management and coping skills which enable them to face those challenges head on and to rebuild and strengthen family relationships.

The road to recovery may be long and arduous, with many unexpected twists and turns, but with enough information and support, families can work their way through to a brighter future.

Who this kit is for

This resource kit focuses on questions, issues, and practical problems faced by parents, guardians, and loved ones of people who use drugs. Whether you have a child or loved one who is just beginning to experiment with drugs or one who has developed an addiction (also called substance use disorder), this kit should be of value to you. This kit was primarily written by parents of young people. Although there is a focus on young people and information relevant to supporting them, it is hoped that this kit will be helpful for any family member or loved one who picks it up.

How to use this kit

This kit is designed to be absorbed in short, manageable chunks. The headings are self-explanatory, providing a brief road map to issues commonly faced by family members dealing with addiction and substance use disorders.

Because individual circumstances influence the complex or difficult problems associated with substance use, the kit does not pretend to provide definitive answers to these problems. Instead, it offers a summary of ideas and information which has proved helpful to families with drug-using members.

As you use this kit, bear in mind that when it comes to drugs and their impacts, information varies widely, and can be conflicting. This kit contains the most up-to-date and evidence-based information available on alcohol and other drugs, their impacts, treatment, and harm reduction options. FGTA recommends seeking advice from qualified professionals before embarking on a plan of action.

A NOTE ON LANGUAGE

The language we use to talk about alcohol and other drug use and addiction has changed a lot in a relatively short time. As researchers, the medical community, and those impacted by addiction have begun to understand more about drug use as a health issue, our language has shifted to reflect those new, more nuanced understandings. Some terms or phrases may be new to you, while others may be words you've heard and used before. This kind of language is sometimes called "person-first language", as it recognizes the humanity of people who use drugs and doesn't define a person based on one behaviour or medical disorder. Using this type of language has been shown to reduce stigma and improve people's ability to see themselves has having a health issue and seeking treatment for it. Below you will find a list of words you might be familiar with and a list of words that are now preferred by most people.

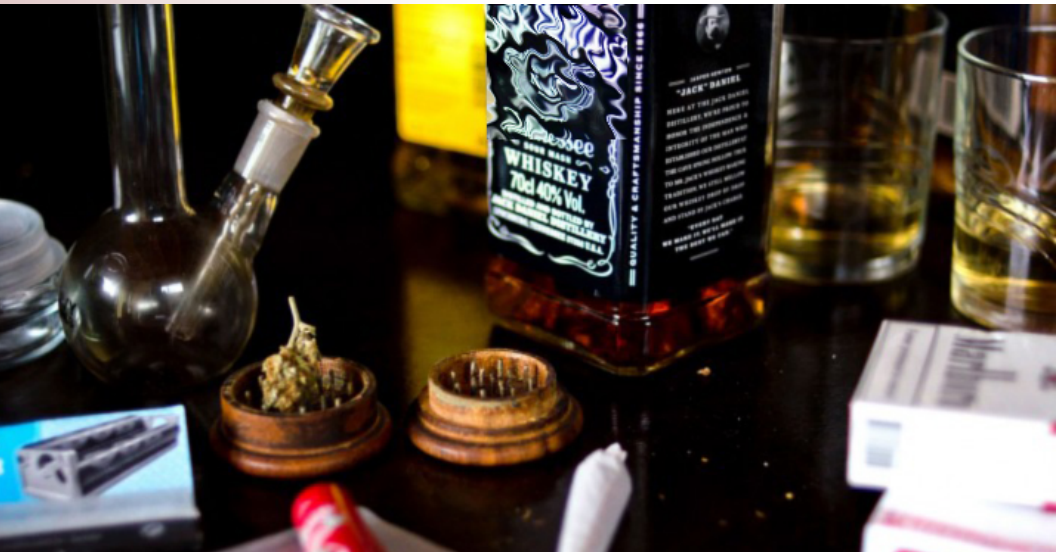
Older Term	New, Preferred Term
Addict, junkie	Person with a substance use disorder
Alcoholic	Person with alcohol use disorder
Drug problem, drug habit	Substance use disorder
Drug abuse	Problematic substance use
Drug abuser	Person with substance use disorder
Drug user, User	Person who uses drugs (or people who use drugs)
Clean, Straight (of a person)	Abstinent, not actively using
Clean (of a needle or syringe)	Sterile
Clean (of urine drug screen result)	Negative
Dirty (of urine drug screen result)	Positive
Former/reformed addict/alcohol	Person in recovery, person in long-term recovery
Methadone maintenance	Opioid agonist treatment (or OAT)

What is a drug?

A drug is any substance, other than food, taken to change the way the body or the mind functions. Drugs (including alcohol) can be legal or illegal, helpful or harmful. Some drugs may be helpful if used in certain ways (for example, taking prescribed medications as prescribed), and harmful if used in other ways (for example, taking more pills than prescribed or borrowing someone else's prescription).

Mood-altering drugs—also called psychoactive substances—are substances that can change or affect the way a person thinks, feels or acts. These drugs usually have physical effects as well, but the thing that sets them apart from other drugs is that they work on the central nervous system (the brain and the spinal cord), which may result in altered mental processes (e.g., thinking and feeling) and senses. Prescribed drugs in this category can be used to relieve pain, calm nervousness/anxiety, or aid sleep. Some, like nicotine (a stimulant), caffeine (a stimulant), and alcohol (a sedative), can be purchased legally and used by adults. Others, like heroin and cocaine, are illegal street-drugs. Cannabis (marijuana) is currently illegal but will be legal in Canada in late 2018. For some individuals, the consequences of prohibition and the criminalizing of people who use drugs causes as much or more harm than the actual physical effects of the substances they use.

Generally speaking, alcohol and most other drugs that people can develop an addiction to affect the brain's "reward circuit"—triggering the release of large amounts of dopamine (a feel-good neurotransmitter). It is this release of dopamine that causes intense pleasure (also called a "high" or euphoria).



Spectrum of Use

Alcohol and other drug use (also called “substance use”) can be understood as existing on a spectrum. Recognizing the spectrum of use may help in understanding why and how people use alcohol and other drugs.

This spectrum ranges from beneficial (for example, taking prescription medication as prescribed, ceremonial uses of tobacco) through non-problematic (e.g., recreational or casual use, like a glass of wine with dinner), to problematic (which may include use by minors, or negative impacts like binge-drinking or impaired driving) and finally chronic dependent (which would include the development of addictions or substance use disorders).

Beneficial

Use that has positive health, spiritual, and/or social impacts

e.g., pharmaceutical drugs used as prescribed; ceremonial uses of tobacco, peyote, or ayahuasca

Problematic

Use at an early age, or use that may have negative impacts for individuals, family/friends, communities, or society
e.g., use by minors or pregnant women, impaired driving, binge consumption

Non-problematic

Recreational, casual, or other use that has negligible health or social effects

Chronic Dependent

Use that has become habitual and compulsive despite negative health and social effects; e.g., addiction

First Nations Health Authority, Province of British Columbia and Government of Canada (2013), *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 Year Plan*

Where's the harm?

Most people who use drugs continue to manage careers, families, and life in general, all the while maintaining moderate or even heavy patterns of use. For others, alcohol or other drug use leads to the loss of jobs, relationships, and health.

Some harms may be attributable to the drugs themselves, and the effects they have on the body, brain or mind of an individual (e.g., alcohol can cause cognitive and liver damage, tobacco smoking can cause lung cancer, and stimulant use, such as cocaine or methamphetamine, can cause paranoia or insomnia). Sometimes people with an underlying or undiagnosed mental illness use alcohol or other drugs to help them cope with their illness (self-medicate), and, in some cases, non-prescribed drug use can aggravate and add complications to the underlying condition.

Many of the harms associated with drug use, however, are actually from the way that society treats drug use, and people who use drugs, rather than the drug use itself.

Prohibition—that is, making drugs illegal—contributes to discrimination and stigma against people who use drugs and leads people to hide their use due to fears of discrimination and criminalization. This discrimination and stigma can prevent people who use drugs from getting good quality, non-judgmental healthcare, safe housing, and employment.

Because of the need to hide drug use and potential negative experiences with the healthcare system, people may also use drugs in less safe ways, including using alone or sharing needles or pipes (which puts people at risk of acquiring HIV and hepatitis C), and they may not seek treatment for addiction or drug-related harms. The need to acquire alcohol or other drugs leads some to steal, deal drugs, or engage in sex work. It costs some their lives.

Another consequence of prohibition is that illegal drugs are often mixed with other substances, so, without access to drug checking equipment, it is impossible for a person to know exactly what they're taking or how strong it is.

The opioid overdose crisis in BC is an example of this—due to the 'war on drugs' approach to enforcement such as jail-time for possession and trafficking, more dealers have moved to trafficking fentanyl and other analogues in place of heroin, and in many cases added them into the illicit drug supply. These synthetic opioids are significantly more potent than heroin, meaning that a much smaller amount needs to be imported into the country for the same amount of profit, which significantly decreases the risk of being caught. These highly potent synthetic opioids are often added to street drugs and/or cut with other substances, making it very hard to know exactly what and how much a person is taking, increasing the risk of overdose including for those using opioids for the first time.

The lack of governmental regulation of these substances leads to a thriving black market, which can be accessed by young people under 19 fairly easily.

Individual drug effects may also be unexpected. They can differ with the weight,

height, and sex of a person, whether they've taken it before, where they are at the time (e.g., alone or with friends, at home or at a party), their general physical or mental health, and dosage strength. Physiologic changes (for example, pulse and blood pressure), reflexes, impulse control, and the ability to make decisions can be affected, making it easier to have an accident (such as drowning or falling), a motor vehicle crash (from impaired driving), or doing something one may later regret (such as having unsafe sex).

Each drug or the way it is used comes with its own "side effects." People who inject drugs can experience vein problems or blood-borne infections, such as HIV or hepatitis C; those snorting cocaine or methamphetamines may develop blemishes and runny noses or skin sores; and people who use opioids may develop chronic constipation. The use of alcohol and other drugs can lower the immune system, leading to frequent colds or other infections. Long-term use of these drugs have also been correlated with negative health effects, such as increased risk of cancer and heart disease with long term alcohol use.

Who is at risk?

Over the last few decades, science has broadened our understanding of some of the risk factors that make it more likely that one person will develop addiction over another.

We know that the development of a substance use disorder is very complex and involves may factors that intersect, including internal factors like genetics and external environmental factors such as law enforcement and stress. No one is sure why a small proportion of people who experiment with alcohol or other drugs will develop an addiction or substance use disorder, who is at risk, or why.

Additionally, certain traits, experiences, and co-occurring illnesses are associated with developing substance disorders. These include genetic factors; mental health conditions, such as attention deficit disorder, depression, post-traumatic stress disorder, and other mental health issues; early exposure to stress; impulsivity; and exposure to substance use at an early age.

There are many factors that influence the decision to experiment with alcohol and other drugs, as well as the progression for a small number of people into problematic substance use, including substance use disorders, with no one single cause.

Substance Use Disorders

The words used to describe problematic drug use and addiction have shifted over the years. What used to be called drug abuse, addiction, or dependence is now medically classified as a substance use disorder.[1] Substance use disorders may be substance-specific (for example, opioid use disorder or alcohol use disorder) or refer to a class of substances (e.g., stimulant use disorder, which includes cocaine and methamphetamines) Substance use disorders may be mild, moderate, or severe.

Substance use disorders are identified when at least two of the following are present:

(mild 2-3 symptoms; moderate 4-5 symptoms; severe 6 or more symptoms)

- Using the substance in larger amounts or over a longer period of time than intended
- Trying and failing to reduce or control use of the substance
- Spending a lot of time getting the drug, using the drug, or recovering from using it
- Cravings
- Use that results in a failure to fulfill obligations at school, work, or home
- Continuing to use the substance despite social or interpersonal problems caused or made worse by use
- Giving up or reducing important social, work-related, or recreational activities
- Repeatedly using in situations that are physically dangerous
- Continuing to use despite knowing about a physical or psychological problem likely caused by substance use
- Tolerance (needing more and more of the drug and/or being much less affected by the same amount usually used)
- Withdrawal (unpleasant symptoms that occur when someone who has become physically dependent on a substance stops or significantly reduces using that substance)

1 The Diagnostic and Statistical Manual of Mental Disorders is used as the authority in diagnosing mental health disorders and substance use disorders. The DSM-5 (2013) collapsed two categories, substance abuse and substance dependence, into the larger substance use disorder classification, with levels of severity.

Watch for the signs

Given that you're reading this, it's likely that you already suspect or know that your child or loved one is using alcohol or other drugs, and may be at risk of harms such as addiction or overdose. It's important to note that some of the following signs may not necessarily indicate substance use, but do indicate that something is going on that needs to be addressed and supported. If you're seeing some of the signs on the following page, it's really important that you talk to your child or loved one to determine what is going on, whether it's related to substance use, mental health issues, or other concerns, and what kind of support they might need.

Early indicators of substance use or other problems (risk factors that increase likelihood of adolescent substance use).
It is important to note that no single personality trait or indicators predicts the development of a substance use disorder.

- Be on the lookout for signs of depression, low self-esteem, and obsessive behaviours. If these statements sound familiar, pay attention.
    - o "No one likes me."
    - o "What's wrong with me?"
    - o "Why am I so different? Why don't I fit in?"
- If the young person in your life is a risk-taker or thrill-seeker, be alert. Drugs can have a certain glamour and appeal, and risk takers tend to experiment.
- People with diagnosed or undiagnosed mental health concerns may also use substances as a way to self-medicate; for example, to cope with anxiety or depression.

Behavioural signs of substance use

The following behaviours may indicate that your child or loved one is using substances problematically, although it's important to note that some of these signs can just be adolescent development markers. In any case, if they are causing concern to you or other family members, they indicate that something else is going on, whether substance use is occurring or not.

- Unusual or new sleeping patterns, including being up or out all night and sleeping all day or inability to sleep (Note: This is a different pattern than the common "sleeping in" of teenagers).
- Frequent requests for money and/or frequent bank withdrawals.
- Non-stop or rapid-fire talking, especially in a usually quiet person or lack of conversation in a person who was previously talkative.
- Changing habits (e.g., poor hygiene in someone who was once very neat and tidy).
- Frequent change of jobs (may be due to frequent absences).
- Severe mood swings, including reactions disproportionate to the situation.
- Loss of old friends and new friends with unspoken last names and/or with cell phone numbers that are blocked, or friends with known substance use.
- Falling or failing grades, skipping class, dropping out of school, or quitting/being fired from work.
- Secretive telephone conversations and secrecy about their comings and goings.
- Lying.
- Spending a lot of time alone and behind locked doors.
- Lack of motivation or lack of interest in activities they normally enjoy.

Physical and emotional signs of substance use

These will vary with the substance ingested and, like the behavioural signs above, not all of the following signs necessarily signal substance use but do indicate that something is going on that needs a compassionate approach to providing support, understanding, and possibly assessment by a health care provider and treatment. The best thing you can do if you notice one or more of the following signs is to talk to your child or loved one—open, non-judgmental communication is vital.

Physical Signs

- Rapid weight loss or weight gain
- Sores on hands, legs, or face
- Glazed or runny eyes, pinpoint or enlarged pupils
- Bone aches and pains, runny nose, sweating, restlessness, stomach upset
- Needle marks (also called “track marks)
- Slurred speech
- Recurrent itchiness and compulsive scratching
- Sniffing, runny nose, or nose bleeds
- Blackened fingers
- Blackened teeth or excessive dental decay
- Clothes and hair smelling like tobacco or marijuana

Emotional Signs

- Poor self-control
- Depression or low mood
- Apathy
- Irritability or increased anxiety
- Mood instability

Signs of Substance Use Around the House

Many of the below signs could have multiple explanations, while others are much more likely to indicate substance use. If you see one or more of the below signs, talk to your child or loved one. As with the other possible indications of substance use, open non-judgemental communication is vital.

- Blackened spoons, knives, or foil. These are used to cook (heat) drugs or to make pipes.
- Dismantled ballpoint pens or glass tubes. These are used for smoking crack or meth.
- Rolled up bloody tissues. Snorting some drugs can make your nose bleed.
- Dented pop cans or other containers with little holes in the dent. These are used as pipes.
- Corners torn off magazine papers and other squares of paper. These are used to make flaps to carry drugs.
- Syringes and small spoons. These are used for injecting opioids (like heroin), crystal meth, or cocaine.
- Watered down liquor.
- Aerosol cans or tubes of glue. These are inhaled or “huffed.”
- Two or more of the products used in a home-based crystal meth lab (e.g., acetone, hydrochloric acid, ammonia, ephedrine). Other signs of a crystal meth lab include amber staining on the wall, counters, and furniture, and a very strong odor of ammonia, ether, or a smell similar to cat urine.
- Missing prescription medication, money, or other valuables.

Some people who use drugs start by taking legal, over-the-counter medications commonly found in a lot of households.

There is a common misconception that if a medication is not a prescription and can be purchased by anyone, that it is safe even when consumed in large amounts. Over-the-counter medications can be just as dangerous as prescription medications and, if taken incorrectly, can have life-long, life-threatening, or even fatal consequences.

Examples of over-the-counter medications that may be used problematically include Benadryl, Benylin and other cough suppressants, Gravol, anti-histamines, ephedrine and pseudoephedrine products, Tylenol, codeine, Aspirin, and other pain relievers, and sleep aids.

Because of the availability of over-the-counter medication in many households and at pharmacies, experimentation can occur easily. It is important to keep all medications within a secure area and be aware of when medications are missing.

Some over-the-counter medications are also sometimes used as additives or to "cut" (add bulk) to illegal street drugs.

A Note of Caution

As noted above, many of the behavioural, physical, and emotional signs of alcohol and other drug use listed here could have completely different explanations. If you are concerned that something is going on with your child or loved one, this is the time to increase communication so that you can better understand your child or loved one's circumstances.

So much depends on your ongoing relationship with this person.

> *"My son was articulate, good looking and very charming—and always a risk taker. He was the first to try skateboarding and to ski double black runs and, at age 15, he took a risk that would forever change his life and the lives of those who loved him.*
>
> *He tried smoking heroin, and before he knew it he was hooked."*

People use alcohol and other drugs for a variety of reasons and in a variety of ways. The reasons that someone tries using alcohol or other drugs may be different from the reasons they continue to use them.

Most people who try drugs will not develop a substance use disorder—in fact, the majority do not**.**

Some types of substance use are considered very common and normal in our society. These include drinking wine with dinner, toasting celebrations with champagne, or using tobacco for spiritual and ritual reasons. These uses are rarely questioned. So asking why people use alcohol and other drugs is often really asking one or more of the following questions:

1. Why do people try alcohol or other drugs?
2. Why do people develop problematic substance use including substance use disorders?

Why do people try alcohol and other drugs?

Substance use in youth is very common, although rates of use of both alcohol and other drugs have been declining in BC and Canada over the past decade A 2017 survey of high school students in Ontario found that almost 43% of students in grade 7-12 had used alcohol in the past year, and 37.8% of students grade 9-12 had used other drugs in the past year. 44% of students between grade 7-12 reported no use of any drug (including alcohol and cigarettes). Data for BC is less recent (2013) and measures substance use a little differently, but shows similar rates, with 42% of youth aged 12-19 having used alcohol in the past year, 26% having used cannabis (marijuana), and 17% having used a drug other than alcohol or cannabis.

There are many reasons why people might try drugs. In addition to the fact that alcohol and many other drugs can induce euphoria and other pleasurable sensations, below are some of the common factors that have been identified by research into substance use initiation. Not all of these may apply to your loved one.

Peer substance use

Having peers who use alcohol or other drugs can normalize substance use; young people may also feel pressure (internal or external) to fit in with their peers by using alcohol or other drugs

Beliefs about substance use

Alcohol and other drug use viewed as normal and pleasurable activities for adolescents.

Lack of impulse control

Adolescents and young adults have significantly lower impulse control than adults. This can lead to risk-taking, novelty-seeking, and sensation-seeking behaviour, including trying alcohol and other drugs.

Drug availability

Alcohol or other drugs being easily obtained and generally around increase the likelihood of trying alcohol and other drugs

Emotional and physiological factors

Hyperactivity, inattention, early aggressive behaviour (in boys), increased frequency of negative emotions (in girls), and sociability have all been linked to trying alcohol and other drugs.

Substance use normalized in the home

Parents using alcohol or other drugs and/or a general perception of using being acceptable.

Why Do People Develop Problematic Substance Use, Including Substance Use Disorders?

Most people who try alcohol or other drugs will not develop problematic substance use. However, a small number of people who use alcohol or other drugs will develop problematic substance use, including substance use disorders (see page 9 for more information on substance use disorders).

In recent years, science has broadened our understanding of some of the risk factors that make it more likely that one person will develop addiction over another. The development of a substance use disorder is very complex and involves may factors that intersect. Some of the factors that have been associated with the development of problematic substance use and substance use disorders are listed below. Some, most, or none of these may be relevant for your child or loved one.

Early substance use initiation

Young people who first use alcohol or other drugs before 13 or 14 years old are more likely to develop problematic substance use later in life

Family history of substance use disorders

Poor peer relationships or poor social coping skills

Chronic stress

Studies have shown that chronic stress is a risk factor for developing substance use disorders and that life stress impacts treatment outcomes and relapse rates.

Academic failure

Peers with engaged in problematic substance use

Genetics

Recent studies from families and twins have revealed that genetic factors can contribute to the risk of developing a substance use disorder. For example, genes that regulate how the liver metabolizes drugs or genes that control the neurotransmitters in the brain could predispose a person to problematic substance use.

Adverse childhood experiences

Tesearch has shown that a higher number of adverse childhood experiences (ACEs) is associated with a higher likelihood of substance use in adulthood. ACEs include problematic substance use or mental illness in the home, childhood abuse, witnessing domestic violence, parental separation or divorce, and having a family member incarcerated.

Trauma

People with substance use disorders are significantly more likely to have experienced trauma than people without substance use disorders. There are many different causes of trauma, and the existence of trauma—whether recent or historical—may or may not have anything to do with that person's family of origin. Being aware of trauma—including intergenerational trauma, the potential use of alcohol and other drugs to cope and self-soothe, and the existence of trauma-informed treatment can be a very positive thing for those people who do have a history of trauma, allowing them to get treatment for substance use that is based in an understanding of the ways that trauma impacts people.

Brain changes

Some substances can change brain structures over time. These include the development of tolerance—needing to use more to get the same effect—cravings and physical dependence—needing to use a certain amount of the substance to prevent withdrawal symptoms. Dependence alone does not qualify as a substance use disorder, but it can change substance use from a pleasurable activity to one undertaken to avoid going into withdrawal.

Route of administration

Injecting or smoking substances (like opioids, cocaine, and crystal meth) causes an almost immediate, intense sensation. Because this intense feeling can fade much more quickly than other methods of use, it can lead to using more frequently in order to re-experience the initial rush or to avoid going into withdrawal.

Substance Use and Mental Health Problems

Mental health problems may precede, coincide with, result from, be linked to, be exacerbated by, or be mistaken for alcohol or other drug use.

If there is a history of mental health problems in your child or loved one's family, be on the alert. Illicit drugs may be used by a person to relieve symptoms of an undiagnosed mental health condition (in other words, self-medication) and/or they may be used in addition to or instead of prescribed medication for a diagnosed condition, they also may worsen existing symptoms of mental illness.

Substance use and depression can be linked, as alcohol and other drugs can suppress feelings of pain and other distress and uplift the mood for a while, but ultimately they can make depression and mood worse. Alcohol and other drugs may be used to cope with other conditions including anxiety, attention deficit disorder, and attention deficit/hyperactivity (ADHD) disorder. Children, adolescents, and adults with ADHD are more likely to use alcohol and other drugs than those without ADHD, start using alcohol and other drugs earlier, and are more likely to develop a substance use disorder.

A large proportion of people with a substance use disorder also have a mental health illness (frequently called co-occurring or concurrent disorders or a dual diagnosis), but many treatment services are not adequately equipped to address both problems together. It should be noted that, generally, specialized concurrent disorder treatment is best suited for individuals with severe concurrent mental illness and substance use disorders and individuals with mild/moderate symptoms (e.g., insomnia, anxiety, low mood) can be effectively treated by a primary care provider.

Finding treatment for an individual with moderate or severe co-occurring substance use and mental health disorders can, unfortunately, be difficult. BC Children's Hospital has an outpatient program for youth with concurrent disorders (age 12-24) and Foundry is a new provincial network providing care and referrals for youth aged 12-24 who need substance use disorder treatment, mental health illness treatment, or treatment for co-occurring disorders.

There are also many programs available for adults with moderate or severe co-occurring disorders—these are best accessed by a referral from your loved one's primary care physician or an addictions specialist.

Caution
If your child seems constantly depressed, stays in bed all day, becomes monosyllabic and lacking in facial expression or animation, expresses no interest or joy in anything they previously enjoyed, talks of suicide and death, or seems preoccupied with death, don't assume it is related to substance use. No substance makes you like this all the time.

If one or all of these symptoms is present, seek help immediately. 24-hour crisis lines are available at 1-800-SUICIDE (1-800-784-2433) if someone is suicidal, or 310-6789 (no area code needed) for mental health support.

Alcohol and Other Drugs at a Glance

The following section provides an overview of the substances your child or loved one may be using.

Each section provides an overview of the substance, known risks, harm reduction strategies (when applicable), and information about evidence-based treatment.

As shown in the Spectrum of Substance Use, the fact that your child or loved one is using one or more of the following substances does not necessarily mean that they are using them problematically or have a substance use disorder.

Harm reduction strategies are useful for anyone using alcohol or other drugs, with the goal of "meeting people where they are at" to promote safer use and open a door into treatment as needed.

Treatment information is provided for those who are using substances problematically and are ready to access treatment. The substance-specific treatment information below is provided to help you to support your loved one in making an informed decision. Treatment decisions should be made in partnership with your loved one's health care provider or an addictions specialist.

ALCOHOL

Alcohol is a depressant that alters the functioning of neurotransmitters (messenger chemicals) in the brain, which results in a slowing down parts of the brain and nervous system, which slows heartrate and breathing. This increases relaxation and reduces inhibition.

Depending on several factors, including the size of the person, how much and how quickly they drink, and whether they have developed tolerance, alcohol may cause reduced concentration, slurred speech, and blurred vision. Alcohol can also affect coordination and judgment and reduce impulse control. Drinking in moderation does not harm most people, but regular heavy drinking can contribute to a variety of health, personal, and social problems. At-risk (or "heavy") drinkers can experience harm without meeting the criteria for an alcohol use disorder (formerly and colloquially referred to as alcoholism).

Heavy or at-risk drinking can be understood as more than 15 standard drinks per week for men (or more than 3 drinks on one day) and more than 10 standard drinks per week for women (or more than 2 drinks on one day).

One 142 mL (5 fl oz) glass of wine

One mixed drink with 43 mL (1.5 fl oz) of liquor (such as vodka, gin, rye whiskey, scottch, brandy or rum)

One 341 mL (12 fl oz) glass of beer or wine cooler

At-risk drinkers face a high risk of developing health problems including liver disease and damage, heart disease, cancer, high blood pressure, stomach problems, and depression or anxiety. Personal, social, and legal problems may also develop, including relationship and family problems, poor work performance, financial difficulties, and legal problems.

Binge drinkers (drinking many drinks on one occasion, 5 for a male or 4 for a female) can risk internal physical damage, including brain damage, as well as overdose/ unconsciousness/coma. Alcohol can also increase risk-taking behaviour such as mixing drugs and having unsafe sex, and may lead to car accidents, fights, or other dangerous behaviour.

Mixing alcohol with other drugs increases the risk of harm, including increased risk of overdose if mixing alcohol with other sedatives like opioids (heroin, Percocet) or benzodiazepines (Valium, Ativan). Mixing over-the-counter or prescription drugs with alcohol can have negative outcomes, including altering the efficacy of the prescription medication, making a normally safe drug unsafe, increasing risk of overdose, or cause other unpleasant effects like nausea, vomiting, or dizziness.

The liver can only break down and get rid of a little less than one standard drink per hour (a glass of wine, a shot of spirits, or a beer all contain about the same amount of alcohol), depending on the size of the person.

Sobering up takes time. No amount of black coffee, cold showers, exercise, or vomiting speeds up the work of the liver or reduces the blood alcohol content. People who regularly drink can develop tolerance and will need to drink larger amounts of alcohol to get the same effects as before.

Regular drinkers can also develop physical dependence, meaning that they will experience withdrawal symptoms if they don't consume alcohol.

Risks

- There is no known safe level of alcohol consumption for pregnant women. Alcohol use during pregnancy has been linked with higher risk of miscarriage, stillbirth, premature birth, and low birth weight. The most serious outcome is fetal alcohol syndrome.
- Alcohol poisoning. Alcohol is a central nervous system depressant, and drinking too much can cause the body and nervous system to shut down to the point of unconsciousness, and, in severe cases, coma, with the accompanying risk of brain damage or death.
    - Signs of alcohol poisoning include low body temperature, slow heart rate, slow and labored breathing, loss of consciousness, clammy skin, and incontinence (urinating on oneself). If these signs are present, call an ambulance and do not leave the intoxicated person alone.
    - If someone is drinking and passes out or becomes unable to speak or move but is breathing and has a pulse, lay them on their left side, make sure their airways are clear, call an ambulance immediately, and do not leave them alone.

    - If breathing stops but a pulse can be felt, call an ambulance, and commence mouth-to-mouth resuscitation (if a pulse is evident, do not attempt CPR).
    - If no pulse or breathing is evident, call an ambulance and commence CPR (Cardio-Pulmonary Resuscitation).
- Many health problems are associated with at-risk drinking or alcohol use disorders. These include cardiovascular disease, liver disease, certain cancers, and hypertension (high blood pressure).
- Tolerance—needing more alcohol to achieve the desired effect—and physical dependence—needing to consume alcohol to avoid withdrawal symptoms—are risks of heavy drinking. Tolerance and physical dependence together are often an indication of an alcohol use disorder.

Harm Reduction

- Low-risk drinking: Drinking fewer than 10 drinks per week for women (and no more than 2 drinks on most days) and 15 drinks per week (and no more than 3 drinks on most days) for men decreases the risk of long-term health impacts.
- Drink 3 drinks or less (women) and 4 drinks or less (men) on any one occasion.
- Avoid mixing alcohol with: Driving, medications and other drugs, making important decisions.
- Drink slowly (e.g., 1 drink per hour) and alternate with water or another non-alcoholic drink.
- Eat before and while drinking.
- If someone falls asleep while intoxicated, roll them on their left side to avoid choking if they vomit in their sleep. If they are unconscious rather than asleep, call an ambulance.

Treatment

For a long time, and still in some places, the standard approach to alcohol use disorder was to withdraw (or "detox") by abruptly stopping drinking (sometimes called "going cold turkey") followed by participation in unstructured, peer-based groups (like AA or other 12-step fellowship groups). However, going cold turkey from alcohol can be very dangerous, with a small number of people who abruptly stop drinking alcohol without medical supervision experiencing serious health consequences including seizures and even death. If your child or loved one drinks large amounts frequently and is thinking about quitting, it is very important that they see a doctor first, who can assess their health and determine a treatment plan.

Evidence-based treatment for alcohol use disorder includes psychosocial interventions (such as motivational interviewing, cognitive behavioural therapy, and family-based treatment) and pharmacotherapy for withdrawal management and/or relapse prevention. The evidence supporting peer-based support groups (such as AA and other 12-step fellowship models) and residential inpatient treatment is mixed, but some people and their families may benefit from these approaches. Different treatments and approaches will suit different people, and more than one may have to be tried.

BENZODIAZEPINES

Benzodiazepines ("benzos", "bennies") are sedatives (that is, they are depressants) commonly prescribed to reduce anxiety, help insomnia, and relax muscles. They are also used to treat alcohol withdrawal and in some medical procedures.

Although benzodiazepines have useful short-term applications (for example, short-term anxiety relief, occasional insomnia), they also have many potential risks including physical dependency and addiction when used long-term.

Some people start using benzodiazepines on the advice of their doctor, for example, to manage anxiety, and then continue to use them longer than they were prescribed. Other people use them recreationally or to self-medicate.

Benzodiazepines (like alcohol and opioids) depress the central nervous system (brain and spinal cord) and have an additive effect when combined. Some people use benzodiazepines to enhance the effect of other sedatives like opioids and alcohol. This is very dangerous as it increases the risk of overdose. In fact, most overdoses are related to poly-substance use, rather than just one psychoactive medication alone.

Benzodiazepines generally come in the form of capsules or tablets, in various colours. People may have a prescription, steal from someone else's prescription, or buy them on the street.

Benzodiazepines are generally swallowed or taken sublingually (dissolved under the tongue), with effects felt between 30-120 minutes, depending on the specific benzodiazepine taken. Most have effects that will be felt for several hours.

Risks

- If your loved one has a prescription for benzodiazepines, they, or you with them, can speak to their health care provider to determine if benzodiazepines are the only option for the condition they are being prescribed for. As noted above, as benzodiazepines have very few evidence-based indications for long-term use and should be used with caution.
- Benzodiazepines should not be stopped abruptly after long-term use. Doing this can cause seizures, confusion, paranoid psychosis, and withdrawal symptoms. Withdrawal symptoms include insomnia, sweating, fatigue, upset stomach, and headache. Severe symptoms include paranoia, agitation, delirium (extreme confusion, restlessness, lack of awareness of your environment, disorientation, possible hallucinations), and seizures.
- Increased risk of car accidents, due to impairment in coordination, psychomotor skills, and judgment
- Side effects of benzodiazepines include memory and cognitive impairment, amnesia, depression, disorientation, clumsiness, and dizziness. Rare side effects include hallucinations and agitation. At low doses, most side effects are mild and may not be noticeable.
- Benzodiazepines can interact with medications including cold medication, pain medications, cough syrup, and some herbal products.
- Regularly using benzodiazepines for more than a few weeks can lead to physical dependence.
- Combining benzodiazepines with other sedatives (e.g., methadone, heroin, alcohol) is very dangerous. Signs of overdose include confusion, weakness, slurred speech, slow heartbeat, severe drowsiness, staggering around, respiratory depression (breathing very little or not at all), and losing consciousness. If this happens, call 911.

Treatment

Benzodiazepines taken long-term should not be stopped abruptly. This can be very dangerous. It is important that your child or loved one see their doctor to begin a slow, medically supervised, taper. The addition of cognitive behavioural therapy to a slow taper may help.

For some people, including those who face a high risk of harm or relapse or are not ready or willing to stop using benzodiazepines, a harm reduction strategy in which a long-acting benzodiazepine is substituted for their benzodiazepine of choice may be recommended by their health care provider. This prevents withdrawal and intoxication, and allows for psychosocial treatment to occur, which can help your loved one to reach stability. Once stability is reached, a long, slow taper might be considered. Patients at high risk, with a history of seizures, concurrent alcohol or other substance use disorders or other medical concerns, might benefit from attending inpatient treatment.

If your child or loved one was originally prescribed benzodiazepines, or were taking them to self-medicate (for example, for anxiety), the underlying condition should be treated.

CANNABIS (MARIJUANA)

Cannabis is the short name for the hemp plants Cannabis sativa or Cannabis indica. Marijuana (“weed”, “pot”, “dope”, “grass”, “ganja”) and hashish (“hash”) come from this plant.

Cannabis has been used for thousands of years in the manufacturing of products such as clothing and rope, as well as for medicinal and spiritual purposes. The chemical in cannabis that makes the user high is THC (tetrahydrocannabinol), and the higher the level of THC, the stronger the marijuana.

Cannabis is generally smoked in pipes, water pipes (“bongs”, “hookahs”), and vaporizers or rolled into cigarettes (“blunts”, “joints”, “doobies”). Cannabis can also be infused into oil and used as a tincture, swallowed as a capsule, or baked into food (these are often called “edibles”). Hash, sold in oil form or compressed blocks, is smoked (sometimes mixed with tobacco), and its higher concentration of THC makes it more potent.

The effects of cannabis are most intense during the first hour after smoking the drug, although they may persist for three to five hours. Edibles and capsules can take a longer time to take effect, as they need to be digested, which is impacted by any food in the stomach. Relatively small amounts of cannabis can produce a feeling of well-being and lethargy, a tendency to talk and laugh more than usual, redden the whites of the eyes, impair coordination, and reduce concentration.

Cannabis can also affect one’s ability to drive. Higher doses make these effects stronger. A person’s perception of time, sound, and colour may become distorted or sharpened. Feelings of excitement, anxiety, or paranoia and confusion may also increase.

Cannabis will be legalized in Canada in October 2018—although the policy specifics are unknown at this point, it is known that cannabis will be legal for adults to purchase and possess.

Risks

- While most people who use cannabis will not develop problematic substance use, it is possible to develop problematic cannabis use, including cannabis use disorders. Approximately 10% of regular cannabis users will develop a cannabis use disorder.
- Small amounts of cannabis do not appear to produce lasting harmful effects, and withdrawal is minimal or nonexistent from all but regular, heavy continuous use. However, frequent or heavy smokers may experience some negative effects, including decreased motivation, reduced memory and learning abilities, impaired attention, and reduced ability to process complex information. All these faculties will recover once the person stops or reduces use.
- Using cannabis at an early age (particularly before 16 years old) is associated with the development of health, social, and educational problems.
- Some regular users find that they start to feel like they need cannabis because it has become important in their daily lives, usually to relax, unwind, counter stress, or to make them feel at ease in social situations.
- Cannabis impairs depth perception, coordination, attention span, concentration, and slows reaction time. These factors can impair the ability to drive safely.
- It is unclear whether smoking cannabis is linked to lung cancer, however, heavy cannabis smoking is associated with airway inflammation and chronic bronchitis symptoms.
- Extreme reactions from cannabis intoxication are very rare. There have been isolated reports of people becoming disoriented or suffering hallucinations or behavioural disturbances.
- There is a possible link between regular, heavy use of cannabis and the onset of schizophrenia, however, it's not clear whether cannabis use causes latent symptoms to emerge or whether people with emerging symptoms use cannabis to cope with those symptoms. There is some evidence suggesting that continuing to use cannabis can worsen symptoms in those who have schizophrenia. Cannabis use does not cause schizophrenia.
- A fatal overdose from the ingestion of cannabis is close to impossible. However, ingesting huge amounts has been known to cause toxic psychosis, which can include paranoid delusions, confusion, hallucinations, and amnesia. These symptoms usually resolve within a week of stopping use. Smoking or eating too much can result in confusion, panic, paranoia, agitation, and feeling out of control.
- Those withdrawing from cannabis may experience sleeping problems, anxiety, sweating, loss of appetite, irritability and an upset stomach. These symptoms usually disappear within a few days, although sleep disturbances may last longer. Withdrawal symptoms, if not supported and managed, are a major determinate of relapse among individuals seeking treatment for cannabis use disorder.

Treatment

There are several behavioural treatments that have shown promise for cannabis use disorders. They include cognitive behavioural therapy, contingency management (which ties a target behaviour like abstinence to rewards), and motivational enhancement therapy. To date, there are no evidence-based pharmacotherapies for the treatment of cannabis use disorder.

COCAINE

Cocaine hydrochloride (“coke”, “blow”, “snow”, “flake”) is a central nervous system stimulant derived from the leaves of the coca plant. Cocaine may be bought in the form of a white powder or a free-base form (crack), which comes as a “rock” or crystal. Powder cocaine can be snorted, injected, or ingested, while crack is smoked. Most street cocaine is heavily cut with various additives and may contain other contaminants, including (in parts of BC) fentanyl and other synthetic opioid analogues, which can cause an opioid overdose in someone who thinks they are only doing cocaine. Smoking crack gives quicker effects than soluble cocaine because it is more concentrated. Pure cocaine is rarely found on the street.

Cocaine is a stimulant which makes most people feel euphoric (really, really good), full of energy, alert, and talkative. Their senses are often heightened, including sexuality, while their need for sleep and hunger are decreased. Some people, however, have a different response and feel calm, with increased confidence and self-control.

Short-term effects can occur rapidly after a single dose of cocaine, and can last anywhere from a few minutes to a few hours. Immediate effects include a feeling of euphoria, wellbeing, increased alertness, and energy. Other effects may include feeling agitated, nervous, and unable to relax.

Long-term use of cocaine can, for some people, lead to anxiety, panic attacks, hallucinations, delusions, paranoia, and erratic, sometimes violent, behaviour.

Most people who use cocaine use it infrequently. However, the effects of cocaine tend to wear off quickly so people often take a number of small doses in quick succession.

Risks

- People who use cocaine are at high risk of developing a cocaine use disorder (up to 1 in 6 cocaine users may develop a cocaine use disorder), with heavy use, injection, and smoking all increasing the risk.
- Negative side effects of cocaine use can include anxiety, increased pulse and blood pressure, panic attacks, paranoia, impaired judgment, hallucinations, sleep disturbance, restlessness, picking at the skin, sweating, nausea, and weight loss.
- Cocaine psychosis may occur in those with a cocaine use disorder. Symptoms include delusions, hallucinations, paranoia. Delusions can include the feeling of something (like insects) crawling under the skin.
- Long-term use of cocaine is associated with cognitive (brain) impairment, including attention, decision-making, verbal memory, and coordination of movement and visual perception, as well as high-risk sexual behaviour and suicidal thoughts and attempts. It's not clear, however, if suicidal thoughts and attempts are due to cocaine use or other factors (such as mental health, poverty, or trauma).
- If cocaine is snorted, nosebleeds are common, and damage to blood vessels may lead to holes in the supporting tissues of the nose. Breathing difficulties and lung damage can occur from smoking freebase cocaine (also called "crack"). Cardiac problems and strokes are both increased in people who use cocaine.
- Skin sores and lesions are also common in heavy cocaine users. Some of these are directly due to the cocaine use and some are due to picking at skin (sometimes because of delusions of insects under the skin).
- When cocaine is used along with alcohol, the two drugs combine in the bloodstream to produce cocaethylene. Cocaetheylene has effects that are similar to cocaine, although less potent. These effects last significantly longer and may increase the toxic effects of cocaine.
- As with all injection drug use, injecting cocaine increases risk for contracting blood-borne illnesses like hepatitis C and HIV. The short effect of cocaine can lead to a high number of daily injections, which increases the chance of reusing or sharing needles.
- Deaths arising directly from cocaine use are rare but possible, with most due to secondary conditions such as heart attacks or brain damage.
- Withdrawal occurs after stopping or reducing heavy or prolonged cocaine use. Cocaine withdrawal symptoms include tiredness, vivid, unpleasant dreams, trouble sleeping or too much sleep, decreased appetite. and agitation
- Overdose can happen from even a small amount of cocaine, depending on tolerance. Effects of overdose include heart failure, seizures, and breathing can become weak or stop entirely. Lay the person on their left side and DIAL 911 if someone:
    - Has an irregular heart rhythm or elevated heart rate, very high blood pressure, very high body temperature, altered breathing, nausea, severe anxiety, sweating, seizures, confusion, stroke, psychosis, or tremors.
    - Passes out or becomes unable to speak or move
    - If the person has stopped breathing but still has a pulse,

commence mouth-to-mouth resuscitation—not CPR (Cardio-Pulmonary Resuscitation, which has the purpose of restoring the pulse).
- If the person has no pulse and is not breathing, commence CPR.

Harm Reduction

- If your child or loved one is injecting cocaine, encourage them to use sterile injection equipment (like needles and cookers) and to avoid sharing equipment.
- Encourage your child or loved one to use drug checking services, where they exist.
- If your child or loved one is smoking freebase cocaine (crack), encourage them to use their own mouthpiece and avoid sharing pipes or mouthpieces.
- Use wire screens rather than steel wool or "Brillo" pads.
- Encourage your child to avoid mixing alcohol and cocaine.
- Additional harm reduction strategies and locations for harm reduction supplies can be found at www.towardtheheart.com/safer-use.

Treatment

Psychosocial treatment interventions are recommended for cocaine use disorder, as no pharmacological treatments have been found to be consistently effective. Psychosocial treatment interventions include individual or group drug counselling, intensive outpatient therapy, cognitive behavioural therapy, and contingency management (which ties a target behaviour like abstinence to rewards).

Treatment interventions are chosen based on the severity of the cocaine use disorder. While psychosocial treatment interventions have shown to be effective in reducing cocaine use, they are unfortunately not sufficient for many people.

Research into pharmacological treatment options is ongoing, but at this point there are no pharmacological treatments that are supported by evidence.

ECSTASY

Ecstasy (MetheleneDioxyMethAmphetamine or MDMA) is a synthetic drug which causes euphoria, increased empathy and well-being, and heightened sensations.

Also known as “XTC”, “Molly”, “E”, and “X”, it is usually sold as small tablets (often decorated with icons or phrases) in a variety of colours and sizes, in capsule form, or as powder which can be taken orally, snorted or, rarely, injected. Its euphoric, mood-altering effects make it a popular party drug. The effects generally appear in about an hour and commonly last 4-8 hours.

Ecstasy can generate a number of responses, both pleasurable and not, including: increased feelings of self-confidence, wellbeing, and closeness to others; a rise in blood pressure, body temperature, and pulse rate; jaw clenching and teeth grinding; sweating and dehydration; nausea, vomiting, and anxiety.

Many ecstasy users experience a “hangover” effect—including loss of appetite, irritation, insomnia, depression, memory impairment, and lethargy.

Tolerance to ecstasy can build quickly, meaning that taking the same amount won’t have the same effect. Unlike some other drugs, taking more ecstasy may not cause the initial and desired effect, because using ecstasy frequently causes serotonin (a brain chemical) depletion, which reduces the “high” from ecstasy and can cause depression. Addiction to MDMA is very rare.

Risks

- What is sold as ecstasy or MDMA is often cut with other substances or may be something else entirely. Some of these substances have similar effects to MDMA, while others can be quite toxic.
- Ecstasy increases body temperature and can result in dehydration when paired with dancing all night. This overheating and dehydration can lead to heart failure, strokes, seizures, kidney failure, and even death.
- Ecstasy is sometimes referred to as the "love drug" because it commonly makes users feel warm and loving. Ecstasy can also heighten sexual desire, intensify sexual experience, and decrease inhibitions, making unprotected/unsafe sex more likely.
- Those with high blood pressure, a heart condition, liver problems, diabetes, asthma, epilepsy, or depression or other mental illness are most at risk from the potential side effects of ecstasy and should avoid using it.
- Mixing ecstasy with other drugs can be dangerous, causing a toxic interaction. This includes some prescription medications, including ritonavir, a medication used to treat HIV, and a type of antidepressant called monoamine oxidase inhibitors (e.g., phelzine (Nardil) and trancylpromine (Parnate)).
- Some people who use ecstasy will develop symptoms of addiction including tolerance, cravings, withdrawal, and continuing to use despite negative consequences.

Harm reduction

- If using ecstasy, it is important to stay hydrated. However, drinking too much water can also cause harm by upsetting the electrolyte balance in the body. Hyperhydration (water intoxication or drinking too much water) can even cause death, excessive water drinking causes the sodium (salt) levels in the blood to get too low. Hyperhydration with use of MDMA is very rare.
- Encourage your child or loved one to use drug checking services, where they exist.
- Watch for signs of heat exhaustion. These include heavy sweating, fainting, nausea or vomiting, a fast but weak pulse, general weakness, and cold, pale and clammy skin. If these symptoms are present, the person who has taken ecstasy should go to a cool place, lie down, loosen their clothing, and apply damp cloths to as much of their skin as possible. If they vomit and continue to vomit, medical attention should be immediately sought.
- Watch for signs of heat stroke. This is much more serious than heat exhaustion. Symptoms include a body temperature above 103°F (39.4°celcius), seizures, unconsciousness, a rapid and strong pulse, and hot, red, dry, or moist skin. If these signs appear, call 911 then move the person to a cool place, and apply cool, damp cloths to the skin or put them in a cool bath.

Treatment

MDMA does not cause physical dependence and there are very few studies on the prevalence of substance use disorders for people that use MDMA. Recommended psychosocial treatment interventions include cognitive behavioural therapy, building coping skills, and support groups when combined with cognitive behavioural therapy and/or building coping skills. There are no recommended pharmacological treatments at this point.

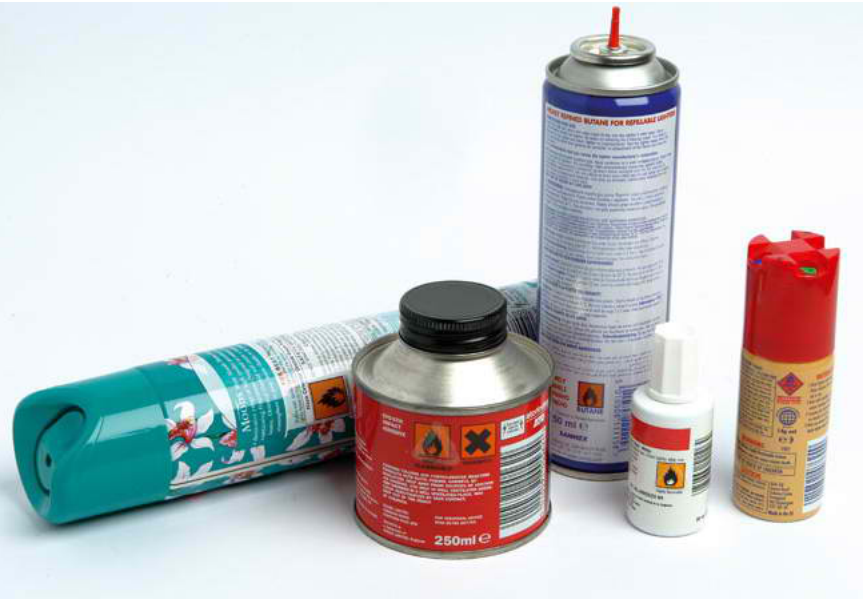
INHALANTS

People become affected from breathing in the fumes (sniffing or “huffing”) of various volatile substances, including glues, aerosols, canned air (also called gas dusters), liquid paper thinners, butane gas, nitrous oxide, and gasoline. Solvents depress the central nervous system and act quite similarly to alcohol. However, because they are inhaled and go directly into the bloodstream, solvents act much more quickly.

Most inhalants have everyday uses and were never meant to be consumed or inhaled. There are four categories of inhalants, which cover hundreds of different inhalants. These include volatile solvents (e.g., acetone, cleaning fluids, paint thinner); aerosol products (e.g., cooking spray, spray paint, and hair spray); nitrites—also called “poppers” (e.g., amyl nitrite, cyclohexyl nitrite); and gases (e.g., nitrous oxide, butane). Because they are widely available for a variety of purposes, it is easy and cheap to acquire inhalants.

Glues and aerosol can contents are commonly inhaled from a small plastic bag held over the mouth and nose. Others are inhaled directly from their containers or soaked into a piece of cloth. Some substances, like nitrous oxide (found in whipped cream dispensers), are very cold and can freeze the skin. The pressure in the canister can also damage the lungs.

Inhalants cause an immediate and short-lived effect. People new to inhalants may experience excitement followed by drowsiness. Using more often leads to euphoria, vivid fantasies, and exhilaration, with some people experiencing increased confidence and giddiness. Unpleasant effects include nausea, blurred vision, slow reflexes, dizziness, vomiting, and light sensitivity.



Risks

- Sudden sniffing death occurs after extended inhalation of highly concentrated inhalants causes an irregular and rapid heartbeat that can lead to heart failure and death. This can occur after only one session and when inhalation is followed by strenuous exercise or stress.
- Inhalant use can cause recklessness through reduced inhibition and increased sense of power.
- People who use inhalants sometimes suffocate because they use a bag to sniff and can pass out with the bag still around their nose and mouth. Another risk is vomiting and then choking on that vomit while unconscious.
- There are significant health risks associated with long-term use of inhalants, including impairments in memory and concentration, depression, paranoia, and damage to kidneys, heart, brain, liver, lungs, blood, and bones.
- Using inhalants while pregnant can harm the fetus, including birth defects, premature birth, or still birth.
- Nitrous oxide has some risks that are specific to it, which include lack of oxygen if sniffing pure nitrous oxide, losing motor control (which can lead to falls and other injuries), frostbite, lung damage, and nerve damage.
- Nitrites also have specific risks associated, including an increased risk of sexually transmitted infections like HIV and hepatitis C (some people use nitrites to increase pleasure during sex), and possibly a weakened immune system.

Harm reduction

- Plastic bags should not be placed over the head. Small bags or bottles reduce the risk of passing out and suffocating.
- Avoid using in small, enclosed spaces (the reduced oxygen supply might lead to loss of consciousness).
- Don't smoke while sniffing, as the substances are highly flammable.
- Call an ambulance if a person passes out after sniffing, or if you are otherwise concerned about them.
- Avoid using alcohol or other drugs while sniffing.
- Know how to help in an emergency. The basics are:
    - Lay the person on their side to prevent choking if they vomit.
    - Take away what they have been sniffing and make sure they are breathing clean air.
    - If the person is conscious, keep them calm and relaxed until they have completely sobered up. Don't chase them or get them stressed or panicked.

Treatment

To date, cognitive behavioural therapy and contingency management (tying rewards to targeted behaviours like abstinence) have been helpful for some people, but more research is needed in order to identify the most effective treatment options for people with inhalant use disorders.

METHAMPHETAMINE

Methamphetamine (“meth”, “crystal”, “jib”, “speed”, “ice”, “crank”,” glass”, “side”, or “tina”) is a powerful synthetic central nervous stimulant. Although it has been used for medical purposes in the past (and still is, in a limited manner, in the United States), methamphetamine is not legally available in Canada due to its high potential for addiction and negative side effects.

Methamphetamine comes in tablets, capsules, chunks, powders, and off-white crystals. It is cheap, easily obtained, and made in small illegal labs with toxic, over-the-counter ingredients. The purity, strength, and effect varies widely, due to the variety of chemicals and processes used in manufacturing.

Methamphetamine can be snorted, smoked, injected, or swallowed, with smoking and injection providing immediate effects. Snorting produces effects within 3 to 5 minutes, and swallowing takes 15 to 30 minutes to produce effects. These methods produce euphoria, but not the intense rush and instantaneous effects of smoking or injecting. In this way, routes of administration play a role in potential for addiction. Effects can last from 4 to 24 hours, depending on the amount and purity of the drug. Users can become tolerant to the pleasurable effects but continue to feel the agitation associated with physical stimulant effects.

Methamphetamine causes euphoria, sexual enhancement, restlessness, decreased need for sleep and food, increased alertness and energy, and talkativeness.

Short-term negative effects of methamphetamine include sweating, jaw-clenching, irritability, anxiety or panic, elevated blood pressure and breathing rate, headache, increased heartrate, insomnia, and teeth grinding.

Risks

- Once methamphetamine wears off, it often leaves people feeling depressed and tired, which can lead to binge use in order to stave off those feelings. This increases the risk of health risks and the development of dependence and stimulant use disorders.
- Long-term risks of methamphetamine use include tooth decay, weight loss, sores and skin picking, trouble sleeping, increased risk of stroke and heart disease, irritability, aggression, anxiety, paranoia, memory impairment, and hallucinations.
- High risk sexual behaviours are common in people who use methamphetamines, increasing the risk of acquiring HIV and hepatitis C. Injection drug use also increases risk of acquiring these blood-borne infections.
- Some people (between 8-27%) of people using methamphetamine experience methamphetamine-induced psychosis. Symptoms include hallucinations, paranoia, and delusions of being persecuted.
- Acute methamphetamine intoxication can result in elevated blood pressure, severe agitation, overheating, seizures, elevated heart rate, psychosis, and coma.
- Withdrawal symptoms include headaches, shortness of breath, fatigue, depression, stomach pain, and hunger. Withdrawal symptoms generally resolve without treatment and within 14 days of stopping use, however, depressive symptoms can last longer.

Harm Reduction

- Don't use alone.
- Don't share pipes.
- Encourage your child or loved one to use drug checking services, where they exist
- Pipes can be cleaned by burning off the residue and scrubbing it with alcohol wipes.
- Smoke should not be held in, rather it should be exhaled immediately.
- More harm reduction strategies and locations for supplies can be found at www.towardtheheart.com/safer-use.

Treatment

Psychosocial treatment interventions are recommended for stimulant use disorders including methamphetamine, as no pharmacological treatments have been found to be consistently effective. Psychosocial treatment interventions include cognitive behavioural therapy, contingency management, and the Matrix Model (a 16-week, behavioural approach combining family education, individual counselling, drug testing, behavioural therapy, 12-Step support, and encouragement for non-drug related activities), and intensive outpatient therapy.

Research into pharmacological treatment options is ongoing, but at this point there are no pharmacological treatments that are supported by evidence.

OPIOIDS

Opioids are a class of substances that activate opioid receptors in the brain. Opioids are commonly used for pain management and, at high doses, can cause euphoria.

Examples of opioids include heroin, codeine, morphine, oxycodone, fentanyl, methadone, buprenorphine/naloxone, and oxycodone. Opioids may be prescribed or obtained illegally, and are consumed in a variety of ways including swallowing a pill, snorting, inhaling (similar to smoking), smoking, wearing a patch, or by injecting. Some opioids, like morphine, are derived from the opium poppy, while others are synthetic (e.g., fentanyl) or semi-synthetic (e.g., oxycodone).

Opioids used at a high dose cause euphoria, followed by a relaxed warm feeling and the disappearance of fear and worry. The person using opioids may appear to be falling asleep where they sit or stand. At higher doses, the pupils of the eyes narrow to pinpoints, the skin becomes cold, and breathing is slower and more shallow. Opioids cause large amounts of dopamine (a brain chemical that makes you feel really good) to be released. In response to that, the brain starts to produce less dopamine, reducing the ability to experience pleasure and requiring larger amounts of the drug to feel the pleasurable effects of the drug. Eventually, what started as a pleasurable activity becomes a constant battle to avoid going into withdrawal (sometimes called being “dope sick”).

Withdrawal occurs when someone has developed a physical dependence to opioids and abruptly stops using them. Withdrawal has been described as the worst flu you can imagine, with symptoms including anxiety, agitation, cold sweats and/or hot flashes, diarrhea and cramping, muscle twitches, yawning, and a runny nose.

Opioids bought on the street are frequently mixed (or “cut”) with other substances to increase profits. These may include non-harmful substances like lactose or harmful contaminants including fentanyl and other synthetic opioids. Currently in BC, there is a public health crisis of street opioids (and other non-opioid drugs) being contaminated with fentanyl, carfentanil, and other highly potent synthetic opioids. Without testing one’s drugs, it is impossible to know what is in them.

These synthetic opioids significantly increase the risk of overdose, as they tend to be much stronger than heroin and the exact contents and strength are rarely known, especially when someone thinks that they are buying heroin and receive heroin mixed with an unknown amount of fentanyl. Fentanyl and other synthetic opioids have also been found in other drugs including cocaine, leading to opioid overdoses in individuals who do not think they’re taking opioids.

Risks

- The development of tolerance to opioids is different for each person but can develop rapidly, requiring higher and higher doses just to feel "normal" and avoid withdrawal symptoms.
- Adverse effects include nausea, vomiting, itching, and constipation. Constipation can last for days or weeks and can lead to hospitalization and serious illness.
- People who inject opioids are at increased risk of hepatitis C and HIV. These risks disappear when people consistently use sterile injecting supplies and techniques.
- The unknown strength and contents of illicit opioids increases the risk of overdose, especially in the context of the current opioid overdose crisis in which highly potent synthetic opioids are being added to heroin and other drugs.
- Overdose. Opioids depress breathing. In an opioid overdose, breathing is so depressed that it slows dangerously or stops entirely, preventing oxygen from getting to the brain and other vital parts of the body and, without intervention, can cause death.
- Most overdoses are accidental, resulting from mixing opioids with other sedatives (like alcohol or benzodiazepines), taking a high dose after losing tolerance (for example after going through "detox" or not using in a long time), using for the first time, or taking opioids mixed with highly potent synthetic opioids. The majority of fatalities with overdoses occur when the person is alone.

Signs of overdose

- Being unable to wake up. If they don't respond to shaking and calling their name, they are in trouble.
- Slow breathing or no breathing.
- Snoring, choking, or gurgling sounds when breathing.
- Blue lips and nails.
- Cold clammy skin and/or sweating profusely.
- Tiny pupils.

Overdose intervention

- If someone passes out or becomes unable to speak or move but is still breathing and has a pulse, lay them on their left side and CALL 911.
- If the person is not breathing, first CALL 911, then start giving rescue breaths (1 breath every 5 seconds) then evaluate. If they are still not breathing, and you or someone else have it on you, administer naloxone. Keep giving rescue breaths. If their breathing does not improve, give a second dose of naloxone. When the paramedics arrive, tell them what substances were taken (if known), how many doses of naloxone were administered, and how long the person has been unresponsive.

- There is an acronym that can be used to remember the steps in responding to an overdose: SAVE ME:

  S - STIMULATE
  If the person is unresponsive, call 911
  A - AIRWAY
  Check airway and make sure it is open (not blocked by anything)
  V - VENTILATE
  Give 1 breath every 5 seconds
  E - EVALUATE
  Are they breathing on their own? If not:
  M - MEDICATION
  Administer 1mL of naloxone into a muscle (thigh, buttock, upper arm) and keep giving rescue breaths
  E - EVALUATE AND SUPPORT
  If their breathing has not improved significantly, administer another dose of naloxone and continue to give rescue breaths

- It is important to know that, while naloxone reverses the effects of opioids, it is temporary. Someone who took a very large amount can go into distress again when the naloxone wears off, which is why it's important that they go to the hospital.

Harm Reduction

- Anyone who is using opioids or spends time with those using opioids should have a take-home naloxone (Narcan) kit. Take-home naloxone kits are available at many places including some pharmacies and clinics as well as harm reduction sites. A list of sites can be found here: http://towardtheheart.com/naloxone or you can talk to your pharmacist.
- Don't use alone. Most overdose deaths happen when people use alone and don't have anyone to help if they are in distress. Supervised consumption sites and overdose prevention sites have staff and/or volunteers on site who can respond to overdoses.
- Test a small amount first, then increase slowly.
- Use only one drug at a time. Mixing opioids with alcohol, benzodiazepines, or other sedatives is dangerous and increases the risk of overdose.
- General health impacts risk of overdose. Being run down, sick, or having a chronic illness can all increase the risk of overdosing.
- Be aware of tolerance. If someone hasn't used opioids in a while or they are using opioids for the first time, their tolerance will be quite low, putting them at higher risk of overdose.

Treatment

Opioid agonist treatment (methadone, buprenorphine/naloxone, slow release oral morphine, injectable opioid agonist treatments) is an evidence-based treatment for opioid use disorder that provides relief from withdrawal symptoms and cravings in people with opioid use disorder. It has been shown to be much more effective than withdrawal management ("detox") alone in terms of keeping people in treatment, helping them to stop using opioids, and significantly reducing the risk of overdose, blood-borne infections (like HIV or hepatitis C), and death. More information on opioid agonist treatment can be found on page 44.

Although considered the standard approach for a long time, recent studies have found that withdrawal management alone ("detox) for opioid use disorders is associated with very high rates of relapse putting individuals at high risk of overdosing and acquiring HIV and/or hepatitis C if they relapse. Individuals with opioid use disorders should work with their primary care provider or specialist to devise a treatment plan that promotes long-term recovery, rather than attending short term "detox" stays with no access to other treatments.

OTHER DRUGS ("CLUB DRUGS")

Ketamine

Ketamine ("special K", "super K", "K") is an anesthetic used primarily in veterinary medicine and less commonly in human medicine. Ketamine is sometimes sold as or mixed with ecstasy. Effects of ketamine include vivid dreams, numbness in the body, hallucinations, blurred visions, and a feeling of the brain being disconnected from the body (called "dissociation"). Ketamine used recreationally is usually sold as a white powder, capsules, or tablets, and may be snorted, mixed into drinks, or dissolved and injected. Large doses of ketamine can lead to being withdrawn, a racing heart, difficulty breathing, and loss of consciousness. Because of its anesthetic properties, people who have taken it may injure themselves without knowing it. Ketamine is sometimes referred to as a "date rape drug" as it can be used to facilitate sexual assault, when given to someone without their knowledge.

PCP

PCP ("Angel Dust") is another party drug similar to ketamine. High doses of PCP can cause seizures and coma, and interactions between PCP and sedatives like alcohol and benzodiazepines can also cause a coma.

GHB

GHB (gamma-hydroxybutyrate; "G", "fantasy", "liquid ecstasy", or "liquid X") is a depressant which causes drowsiness, slows breathing, and slows the heartrate. GHB is usually sold as a clear liquid in small vial. It has no smell and either no taste or a very mild salty taste that is easily covered by other flavours. GHB may also be bought as a white powder or capsule. GHB causes euphoria and sedation. It is also used to facilitate sexual assault and is sometimes referred to as a "date rape drug." The line between a pleasant dose and a risky dose is very thin, with higher doses leading to drowsiness, dizziness, nausea, and vomiting. An overdose can cause difficulty breathing, convulsions, a low heart rate, and death. Long-term use can lead to tolerance (needing to take more to have the same effect) and physical dependence (which leads to unpleasant withdrawal symptoms if stopped abruptly). If your child or loved one has developed a physical dependence on GHB, it is important that they see a doctor as unsupervised withdrawal from GHB can be dangerous.

PSYCHEDELICS

Psychedelics (sometimes known as hallucinogens) are a group of drugs which can change a person's perception, making them see or hear things that don't exist. They can also produce changes in thought, sense of time, and mood. They vary widely in their origin and chemical composition.

Some psychedelics occur naturally. These include psilocybin, which is found in certain mushrooms ("magic mushrooms"), DMT, which is found in ayahuasca (a traditional Amazonian medicine), mescaline from the peyote cactus, and Salvia divinorum (or "salvia"), a plant in the mint family that can produce psychedelic effects. Others, such as LSD (commonly known as "acid") are manufactured in laboratories. People consume psychedelics in a wide variety of ways, including swallowing as a pill or liquid, brewing into a tea, snorting, and smoking. Route of administration depends on the specific substance.

Plants containing psychedelic substances have been used for a long time across a variety of cultures for medical and spiritual purposes. Synthetic psychedelics were developed in the 20th century, becoming popular in the 1960s and early '70s. Some psychedelics last for hours, while others (like DMT and salvia) have short-lived effects.

The psychedelic experience (often called a "trip"), varies from person to person, drug to drug, and episode to episode, and can range from feeling good and even having spiritual or mystical-type experiences to an intensely unpleasant experience (referred to as a "bad trip"), which can include feelings of anxiety, fear, or losing control. Other effects are a sense of time passing slowly, feelings of unreality, separation from the body, and a loss of boundaries between the self and the rest of the world. Intense sensory experiences, such as brighter colours, and a mixing of the senses (like hearing colours) may also be felt. Both positive and negative feelings may be felt during the same drug experience.

Risks

- Having a “bad trip” can lead to panic, distress, paranoia and aggression. If this happens, the person should be reassured that they are under the influence of a drug and that the experience will pass, and be calmed down as much as possible. If they remain in extreme distress, they should go to the emergency department for care.
- Drugs may not contain what they are sold as, making effects unpredictable and potentially dangerous. Use drug-checking services, where they exist.
- Although rare, some users experience some drug-like effects long after (e.g., weeks or even months) after an initial trip. There is also evidence that existing mental illnesses such as psychosis, depression, and anxiety can be triggered or made worse by psychedelic substances.
- Fatalities or accidents can occur as a result of tripping in unsafe environments (for example, near water or a bridge) as psychedelics affect both perception and behaviour and can lead to disorientation and risk-taking. Driving while under the influence of psychedelics can also be very dangerous.
- People should never take LSD or other psychedelics alone, and one person should always remain sober to deal with any problems that may arise.
- Collecting and consuming wild “magic mushrooms” can be risky, as there is a significant risk of accidentally ingesting a poisonous toadstool or species of mushroom.
- Although physical dependence does not develop with regular psychedelic use (meaning that there are no withdrawal symptoms when abruptly ceased), some regular users may find that they start to feel like they need psychedelics because it has become important in their lives, for example for anxiety reduction or to have novel experiences.

Treatment

Psychedelics are generally considered to not lead to addiction or chronic dependent patterns of use.

TOBACCO

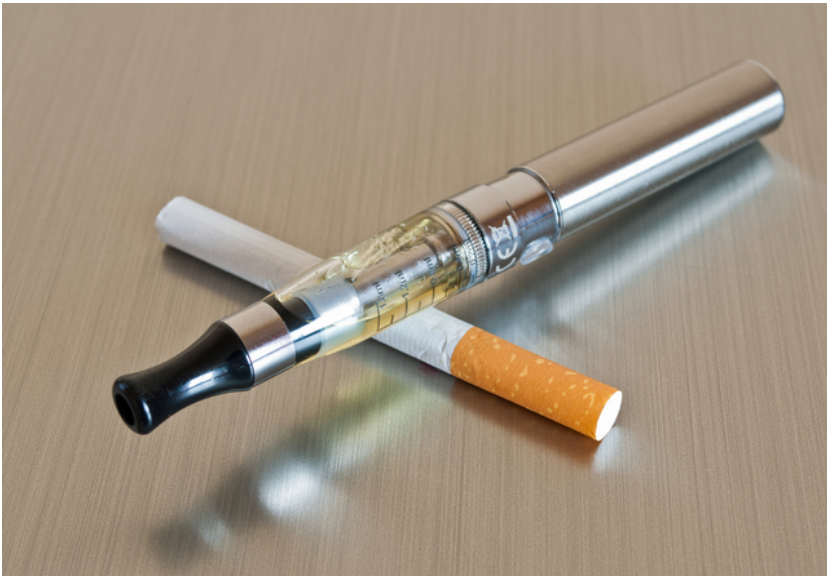
Tobacco is a plant that has been used for thousands of years for spiritual, healing and other cultural purposes by indigenous peoples in North, Central and South America.

The tobacco plant contains nicotine, which has both depressive and stimulating effects, the regular use of which can often lead to addiction. Tobacco is most commonly smoked in cigarettes, but may also be smoked in pipes or cigars, chewed, sniffed, or held inside the lip or cheek. Nicotine is also sometimes ingested using e-cigarettes or vaporizers ("vaping"). E-cigarettes are not well-regulated, meaning that the contents vary significantly between brands. Recent evidence suggests that e-cigarettes or vaping are less harmful than smoking regular cigarettes, however, the long-term health impacts of e-cigarettes are not known.

Tobacco smoking is the number one cause of preventable disease and death in Canada.

Tobacco use significantly increases the risk of developing cardiovascular (heart) disease, pulmonary (lung) disease, developing ulcers, developing osteoporosis, and is linked to a number of other cancers and diseases.

When a regular smoker user quits tobacco they will often experience symptoms of withdrawal, including irritability, cravings, anxiety, insomnia, restlessness, and difficulty concentrating. Some people who quit using tobacco experience depression. If this is the case, they should discuss it with their primary care provider.



Risks

- Lung cancer.
- Higher risk of or linked to other cancers including mouth, throat, stomach, kidney, bladder, stomach, cervix, and colon.
- Higher risk of cardiovascular disease, including heart attacks and strokes.
- Higher risk of respiratory disease, including chronic bronchitis and emphysema.
- Weaker immune system leading to frequent colds and other illnesses.
- Pregnancy complications (miscarriage, low-birth rate, premature birth).
- Second-hand smoke also harms those around the smoker. It is linked to heart disease, lung cancer, and strokes in adults, and asthma, ear infections, respiratory infections, and sudden infant death syndrome in infants and children.

Treatment

There are pharmacological (medication) and non-pharmacological approaches to quitting tobacco. Combining the two options increases the chance of successfully quitting. Pharmacological options include nicotine replacement therapy (for example, the patch or gum), which reduces cravings and lessens symptoms of withdrawal. Bupropion (brand names Zyban and Wellbutrin) is a prescription medication that reduces the desire to use tobacco. Varenicline (brand name Champix) is a prescription medicine that reduces both cravings and withdrawal symptoms. Your child or loved one should speak to their doctor about these medications. If your child or loved one and their primary care provider decide that medication is the right choice, up to 12 weeks of nicotine replacement therapy, bupropion, or varenicline is covered by MSP in British Columbia.

Non-pharmacological approaches include behaviour modification like making lifestyle changes (for example, stress management, exercise, relaxation techniques), reducing the time spent with other smokers, using substitutes like gum or carrots to help manage cravings, and accessing support like a counselor, telephone hotline, or support group. The website www.quitnow.ca can help people in BC wanting to quit tobacco or nicotine. Their services can also be accessed by phone at 1.877.455.2233 or by texting “QUITNOW” to 654321.

Learn all you can about substance use and substance use disorders. Read books and articles, research local addiction services, attend your local meetings of Alcoholics Anonymous, Narcotics Anonymous, Alanon/Alateen, and Nar-anon, and consider accessing counselling and/or other support groups. Visit the BCCSU family portal on the website for a list of resources including support groups in BC.

The Here to Help website (www.heretohelp.bc.ca) is another great resource for family-friendly information. However, use a cautious degree of scepticism when you read information online, as the quality of information on substance use and addiction can be inaccurate, misleading, or for the purposes of generating profits.

See the Resource Section for some examples of reputable informational sites below and talk with your health care provider if you have any questions.
In addition to building your knowledge on substance use, there are other strategies you may consider, depending on your child or loved one's age, your relationship with them, and their particular circumstances.

Consider doing the following:

- Provide accurate information for your child or loved one. Scare tactics can easily backfire as they may erode trust if they have been scientifically discredited or found to be untrue for your child or loved one. Don't preach, just try to open a discussion or leave information around the house.
- Do not judge your child or loved one as weak, stupid, or lacking in will power because she or he is unable to control their substance use. Addiction is a disease and can happen to anyone. It knows no boundaries.
- Take heart. While it may seem that young people take all their cues from their peers, parental values and attitudes win out more often than you think.
- Don't be afraid to talk to your child or loved one's friends, if age-appropriate. If you avoid and alienate the peer group your child or loved one has chosen, you will also alienate your child or loved one.
- Try to ensure that your child or loved one's friends know the risks of alcohol and other drug use, appropriate harm reduction strategies, and can recognize overdose symptoms and act quickly. This is particularly important with younger teenagers and substances such as crystal meth, ecstasy, cocaine, prescription drugs, and alcohol. Friends are the most likely to be able to keep tabs on unusual behaviour.
- Talk to the parents of your children's friends, if age-appropriate.
- Talk with your children's teachers and other adults in their lives that spend time with them (if appropriate)
- If your child or loved one is getting medical care or addiction treatment, while their health care providers have to respect their confidentiality and not share private medical information, you are allowed to share any information that you think is relevant. This can help provide a clearer clinical picture for their health care provider.

Using alcohol or other drugs can lower inhibitions and increases the likelihood that a person may engage in high-risk behaviours such as risk unprotected sex, or impaired driving, or will participate in other high-risk behaviours such as fighting, stealing, and trading dares. Having open and honest conversations about high-risk behaviours and strategies to mitigate that risk will help your child or loved one make safer choices.

These conversations may include the following:

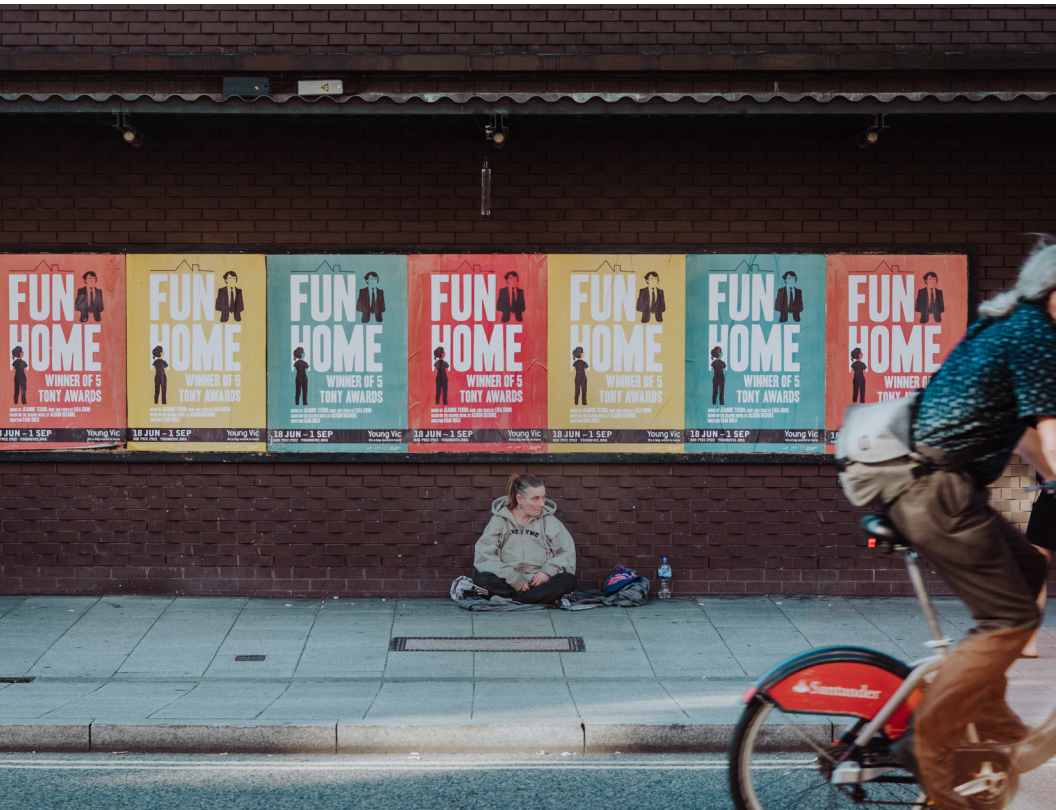
- Talk to your child or loved one (if appropriate) about safer sex, including condoms and other forms of birth control use and consent. The rule about using a condom and other forms of birth control applies generally, but extra vigilance is required because alcohol and other drugs can interfere with good judgment, causing loss of inhibitions and impulse control.
- Stress that your child or loved one can call you at any time of the night to be picked up, or that you will pay for a cab ride home (as long as this is something that you are willing to do).
- Encourage the designation of a "voice of reason" for their group. This individual should commit to being sober for the night or event and can look for signs of drug overdose or a bad reaction and can be responsible for seeking help, should things go wrong. They may also be a designated driver.

Preventing fatalities

- Make sure that your child or loved one and their peer group know:
- Mixing drugs is extremely dangerous. Mixing alcohol with other sedative drugs (sometimes called “downers”) like opioids (heroin, fentanyl), benzodiazepines, or GHB is very dangerous and significantly increases the risk of overdose.
- Using alone is dangerous and should be avoided. Most opioid overdose deaths occur when someone uses alone.
- Signs of a bad reaction to drugs or overdose should not be ignored. If somebody passes out, is incoherent, or a sleeping person has laboured or rattling breath, is snoring in an unusual way, or can’t be woken up, it is crucial to call an ambulance—DIAL 911.
- That the Good Samaritan Drug Overdose Act means that someone at the scene of an overdose will not be charged with simple possession or for breaching probation or parole if 911 is called for medical assistance.
- That street drugs, particularly street-acquired opioids, have been largely tainted with fentanyl and other synthetic drugs which significantly increases the risk of overdose and death. This is true of drugs beyond heroin and other opioids, and may include methamphetamine or cocaine.
- If they are injecting opioids, needle exchange distribution sites, overdose prevention sites, and supervised consumption sites and overdose prevention sites can be found here: http://towardtheheart.com/safer-use.
- Where to get a take-home naloxone kit (see http://towardtheheart.com/site-finder for a list of sites) and how to administer naloxone. An online naloxone training is available at http://www.naloxonetraining.com.
- If somebody is unconscious but still breathing normally, lay them on their side and pull the head back slightly to stretch the neck so their breathing will be unobstructed. If necessary, clear their airway of vomit or mucus and roll the person on their side. Do not put anything in their mouth.
- The signs of an opioid overdose:
    - Unresponsive—doesn’t move and can’t be woken
    - Slow or not breathing
    - Choking or gurgling sounds or snoring
    - Blue lips or nails
    - Cold or clammy skin
    - Tiny pupils
- How to respond to an opioid overdose—call 911, give rescue breaths, and administer naloxone. (See p. 43 for more information on responding to an opioid overdose.)
- Be ready to give ambulance staff information about what has been taken so that treatment can be administered effectively and immediately.
- It is better to deal with an unpleasant situation than for someone to suffer brain damage or death.

"At 14 I got into raves, and gave up good friends because I thought they were too immature for me. I got into drug use more heavily and started using crystal meth. This led to being on the streets. That was not fun. I didn't care about anything, like my new 'friends'—friends because they want your money or your drugs.

One day I went to my parents and asked for help. I have come out of it with tools and skills that a normal person would never have. I'll be able to pass them on to my children."



It's possible that your child or loved one may end up living on the street or spending a lot of time on the street while sleeping at friend's houses or staying in shelters.

Some parents feel that they need to apply "tough love"—that they cannot allow their child to live at home if he or she is lying, stealing, or otherwise destroying domestic peace and order. In other situations, leaving home may feel like the best choice a person using alcohol or other drugs has.

There are many reasons why people end up living on the street—they may leave home as a young person due to conflict, childhood abuse, or other untenable situations, or they may lose their housing as an adult for a variety of reasons.

If your child or loved one is living on the street, try to maintain contact, and make safety a priority. Offer to buy a coffee or a meal or just spend time together. You may wish to deny requests for money, as they may use cash to buy drugs. That is a decision you will need to make.

For many parents, a child's return home will depend on at least honest attempts to deal with problematic substance use. Only you can decide what conditions you will be comfortable with. Just make sure you are clear at the time of return what your boundaries are and then stick to them.

While there are many reasons young people leave home, research has shown that the following factors increase the chances of them coming home: Renewing trust, having open and honest communication, and all parties accepting responsibility for any actions that negatively impacted their relationship and may have contributed to the young person's decision to leave home.

If your child does come home, be prepared to listen and try not to judge. Your child may have broken the law in a variety of ways to get money for food or drugs.

What you hear may be deeply disturbing, but try to focus on the positive. Your child is off the streets now. This may be an opportunity for a fresh start. Emphasize the continuing need for safe practices and new habits.

Remember, you can be open and forgiving and still maintain your boundaries.

This Can't Be Happening...

Many people find it very hard to accept the truth about their child or loved one's addiction. It may be tempting to hear what you want to hear and see what you want to see rather than accept an unpleasant reality, but denying that reality can be dangerous ... for your child or loved one and for the rest of your family.

Families' initial reactions often fall into four stages: Denial ("head in the sand," hearing only what you want to hear); emotional responses (anger, grief, stress, shame, guilt); control ("do what I say," "let's fix this," scapegoating, trying to rescue); and chaos and confusion (trying to set limits which are overturned, feeling powerless and incompetent; broken trust).

These stages can often overlap, and be repeated again and again. Families need to get support, develop awareness, and get effective professional help and education. Success and hope depend on having strategies in place (both personal and interpersonal), having access to support options, taking care of your emotional, physical and spiritual wellbeing, and strengthening family relationships (see "Taking Care of Yourself" on p. 76).

Communicating with your child or loved one

The pioneering Australian family support group Family Drug Support (fds.org.au) boils down its advice to three points:

Listening

This is the most underused yet most important communication skill. LISTEN, LISTEN, LISTEN.

Honesty

No matter how difficult, having everything out in the open is the best policy. If you can, find ways to encourage your child or loved one to speak by being open and honest with them. Honesty and openness, rather than hiding your agenda and strategizing to get what you want, allows you to role model the way you would like to communicate and treats your child or loved one with respect.

Looking for Cues

People who use drugs tend not to want to talk much about their drug use, problems, or feelings. Occasionally they will drop a hint or say they need to talk. It is important that you make yourself available and listen as calmly as you can. Try to choose a suitable moment.

What about siblings?

If you are a parent reading this resource, you may be worried about your other children (if applicable). Beyond the emotional impacts of having a sibling dealing with problematic substance use, if your child is living in your home, the health and safety of other members of the family, especially younger ones, may be at risk from pills, powders, or needles left lying around.

Siblings can be strongly affected by their sibling's substance use. They may experience many of the same emotions and worries as you do, from worries about the health and safety of their sibling, to frustration and resentment at the attention and energy that the family spends on their sibling. Siblings may try to protect their parents by being "perfect," for example, excelling in school and taking on emotional and physical tasks from their parents. Helping your children access support, which may be a counsellor, support group, or other resource, can help them to develop healthy coping strategies. Everyone is different and will have different responses and needs. Tailoring your approach to each child will help you to best support them and help them access appropriate external support.

Keep everyone "in the loop," and remember to check often to see how all family members (including you) are faring.

> *"My younger brother and I experimented with drugs and alcohol during university. I went to law school, quit the drugs, and slowed the drinking. My brother continued to experiment with drugs and started drinking more heavily.*
>
> *You don't see yourself as the 'good' kid. We grew up together, were friends, experimented together, and got into trouble together, but he sees me as the 'good' kid. That's a heavy role to take on, and you can resent it if the 'bad' sibling gives you a hard time. Not only are you having to cope with your own feelings and frustrations with what's happening with your sibling and coping with your parents' pain, but you're given a label on top of that, and end up being resented for it. That's hard."*

Acceptance is not the same as approval

Because of media stereotypes, community attitudes, stigma, legal considerations of illicit drug use, and, possibly, internalized stereotypes, it may be very difficult to accept that a loved one is using alcohol or other drugs. Whether they have just started using substances or use them more often, our children and loved ones make choices of their own volition. It can be hard to accept the choices that they are making. However, accepting the truth of your child or loved one's experience is an important part of being able to support them and help them make informed choices (for example, using harm reduction techniques or accessing treatment). Accepting that your child or loved one is using substances is not the same as approving of it. It is simply dealing with the reality of what is.

For some people who use alcohol or other drugs, substance use will become increasingly problematic as they develop tolerance and become dependent. Family support will always be a positive factor, but the choice to begin treatment, moderate or reduce use, or completely abstain remains the decision of the person using drugs.

Much as you may wish, you cannot make them do what they do not want to do. This is something the family has to learn to accept as fact. However, by becoming and remaining informed, showing your love and being there for them, you can help them to regain and exercise control over their own lives and choices.

Parents whose children have developed substance use disorders usually say in hindsight, "If only I'd known then what I know now."

> *"I had a good relationship with my mom, but she told me I couldn't come around anymore if I was not staying clean. She had to do that to try to better her own life. My parents weren't going to bail me out again. I had been taking advantage of them. That was how I hit bottom. I was heavily wired on heroin and cocaine, injecting both together. I was a real hurting unit."*

Parental and family support has been shown to be one of the strongest factors in successful treatment and recovery from substance use disorders.

Family support may look very different from person-to-person and even from day-to-day with the same person. It is important, when supporting a child or loved one with problematic substance use, to rely on your own judgment of the situation while consciously setting boundaries that make sense for you. Depending on your choices and boundaries and other people's belief systems, you may hear that you are "enabling" your child or loved one when, for example, helping them to access harm reduction services that keep them safer. However, you know your child or loved one best, what you're willing to do, and what will keep your loved one as safe as possible given their current behaviour and situation.

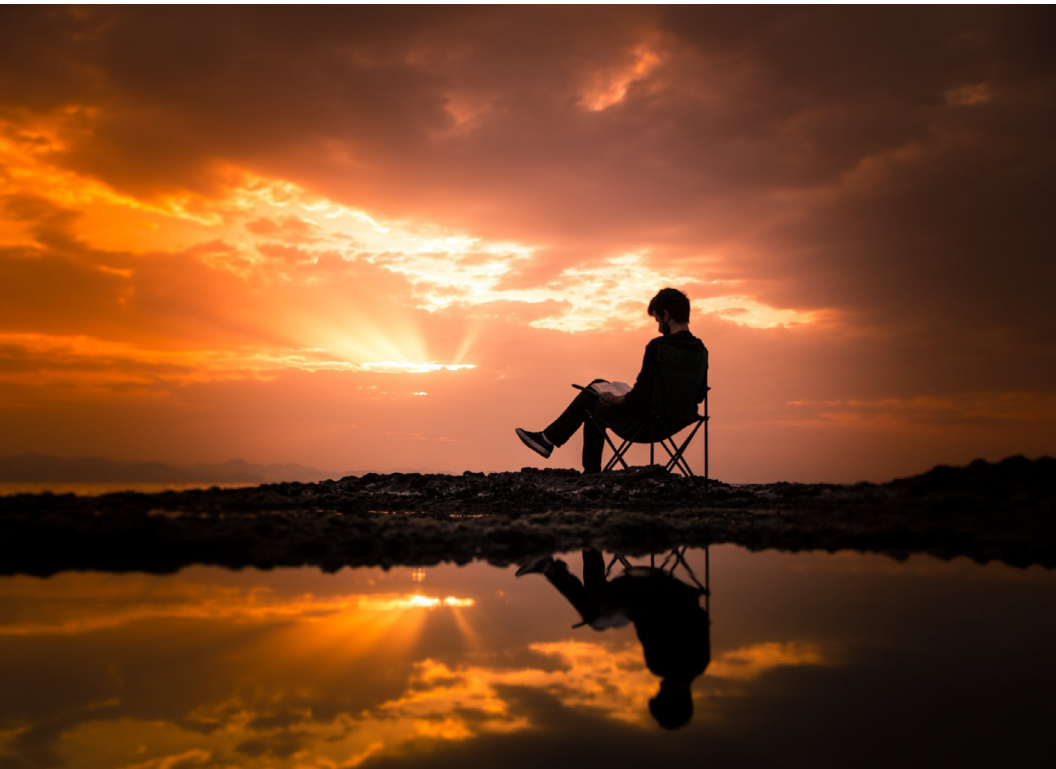
Family members do have the capacity to influence their loved one's substance use both positively or negatively. Influence is strengthened when the person using drugs is given family support. Family members can grow, adapt, and build their skills, knowledge, and expertise to deal with drug issues in their own family. Changing your thinking from a focus on "problems" to a focus on "solutions" can help you to best support your loved one.

Here are some other things to consider when deciding what kind of support you are able and willing to provide for your child or loved one:

- If your child or loved one lives with you, be honest with yourself and your family members about the behaviour you are prepared to accept from a loved one who is using alcohol or other drugs. This may have to be a group effort if the family is to survive the experience intact. Open and direct family communication is usually the most constructive approach.
- All family members can play a part in change. However, effective change can be and often is still achieved with one or two supportive and committed members of the family.
- Don't accept physical or psychological abuse as normal—it is never OK for you to be mistreated or abused by anyone.
- Make sure the person using alcohol or other drugs understands the boundaries that you are setting and the consequences that will result from failing to adhere to them. It's up to you to follow through.
- Try not to let pity take over. Your child or loved one may resent feeling pitied and you may find it harder to maintain the boundaries you've set if coming from a place of pity.
- If your child or loved one does leave home, try to stay in contact and offer support where possible (see p. 54, "Life on the Street" if they are living on the street).

- Be prepared to revise your decisions should circumstances change. Sometimes it's hard to know what to do, and this is, after all, uncharted territory for all of you. All you can do is make the best decision you can at the time for your situation.
- Supporting your child or loved one to get addiction treatment may be your goal, but it is important to remember that, ultimately, your child or loved one will choose whether or not treatment is right for them at this point.
- Success for family members and friends is being able to say that you have done all that was reasonably possible to improve the situation. Acknowledgment of achievements (even if things seem to be going badly) is an important part of this process.

"I found it very hard to develop clear emotional boundaries for myself. I would try to be calm and logical, but very soon my anger and hurt would take over and it was difficult not to say things I would later regret. So I wrote my son a letter expressing my feelings, trying not to be judgmental, and letting him know how much I loved him. Although it did not seem to make much of an impression at the time, later on he told me he kept it and referred back to it and it did help."



Deciding to Get Help

No matter how worried you are or how negative the consequences you're seeing from your child or loved one's alcohol or other drug use, you can't force your loved one to change or access treatment if they aren't ready. Recognizing where your loved one is at and how they feel about their substance use may help you to have realistic expectations and better support them. This is sometimes referred to as the 'stages of change' or the transtheoretical model.

- Your child or loved one may not see any problem with their substance use and has no intention to change their behaviour (pre-contemplation).
- Your child or loved one has recognized that there is a problem with their substance use but has mixed feelings about stopping or reducing their use and hasn't decided to make any changes (contemplation).
- Your child or loved one has recognized that there is a problem with their substance use, wants to change their behaviour, and is starting to make a plan to change it (preparation).
- Your child or loved one has recognized that there is a problem with their substance use and has started to make changes to their behaviour. Making these kind of changes take a lot of energy and your loved one may get frustrated if they do not see rapid changes (action).
- Your child or loved one has made significant changes to their behaviour and is working to maintain their behaviour, which may be reduced use or abstinence (maintenance).

Identifying and understanding how your child or loved one feels about their substance use, whether they want to change their behaviour, and what their goals are will help you to better support them. It's important to remember that your preferred goal may be very different from their goal. For example, you might wish that they'd stop alcohol and/or other drugs entirely, while they may want to reduce or control their use or to stop using one substance (for example, heroin) while continuing to use another (for example, marijuana).

In order to identify where your child or loved one is at and how they feel about their substance use, you could ask yourself the following questions:

- Are they quite happy and not willing to think about the need to change?
- Are they concerned enough to be thinking about their substance use and more aware of the negative aspects?
- Have they identified the need to change and started to make plans?
- Are they taking steps to change?
- Are they maintaining the changes needed to attain their goals?

Someone who sees little issue with their use is unlikely to seek or stay in treatment, but may be open to implementing harm reduction strategies, for example, carrying a naloxone kit with them if they are using opioids (or may be exposed to other drugs cut with fentanyl or other synthetic opioids) or their friends use opioids, using sterile syringes if they are injecting, using a clean pipe if they are smoking meth or crack, getting their drugs checked where possible, or taking taxis and other transportation services to avoid impaired driving. This may not be the outcome you're hoping for, but try to remember that reducing harm and increasing safety is a positive goal, and that keeping lines of communication open without judgment is an important part of supporting your loved one.

Consider accepting the possible, rather than demanding the ideal.

"My son is almost 21 and is in prison, where I visit him every two weeks. My husband had our son arrested. He was on heroin and cocaine, living at home, and it was unmanageable. The police were constantly there, and we got tired of living that way. I don't think my son knew what to expect in prison. Ironically [before his arrest], drugs weren't easy to get. He's surrounded by drugs in prison. When he was first in jail, he phoned regularly to get me to make deposits to a bank account so he could buy drugs. If he didn't get the money, he stood a good chance of getting beaten up. Now he has been off drugs for 53 days, on his own, using willpower. If somebody had told me that six months ago, I wouldn't have believed it."

Your likely first response to your child or loved one's substance use will be to seek out treatment options. Before doing so, it is important to understand what constitutes treatment, and which treatments are available and best-suited for which substance use disorders.

The next section, "Supporting a Loved One to Access Treatment" provides an overview of treatment types and important information related to accessing treatment. For information on evidence-based treatment options for specific substances, see "Alcohol and Other Drugs at a Glance" in this document.

Unfortunately, it must also be said that the treatment system in BC has significant gaps and inconsistencies. Although considerable effort is going into improving the system, finding appropriate treatment may require persistence and advocacy to find the right program or care provider for your child or loved one.

Many parents and other loved ones have found their own voices to be a strong tool to get their child or loved one the help that they need. Be prepared to learn how the system works and to advocate for your child or loved one.

A brief list of resources follows.

Resources for Finding Treatment Options

If your child or loved one is between the ages of 12-24, they can access Foundry, which is building a provincial network of integrated health and social services and provides evidence-based mental health and substance use care. All Foundry centres provide primary care, substance use and mental health services (including opioid agonist treatment at many sites), and can provide referrals to other services in the community when needed. In communities where Foundry Centres do not yet exist, your child or loved one's primary care provider can refer them to child and youth mental health and substance use services through their local health authority.

For older adults, their primary care provider may be able to provide addiction care or refer them to an addictions specialist or other treatment options.

You or they may also call the Alcohol & Drug Information and Referral service at 1-800-663-1441 or access your health authority's mental health and substance use services. A map of services in BC can be found at: https://www2.gov.bc.ca/gov/content/mental-health-support-in-bc/map

Additional information on finding addictions services can be found on the FGTA website at www.fgta.ca or through HealthLink BC at www.healthlinkbc.ca.

Supporting a Loved One to Access Treatment

For a long time, the standard approach to treating substance use disorders was to withdraw (or "detox") from a drug by abruptly stopping taking it (sometimes called "going cold turkey") followed by participation in unstructured, peer-based groups. However, detoxing from certain substances is very dangerous. For example, detoxing from alcohol without medical supervision and management can lead to seizures and even death for a small number of people. Detoxing from opioids is also dangerous but for a different reason: Withdrawal management ("detox") alone for opioid use has been shown to have almost universal relapse rates, with very high risks of overdose (because the person's tolerance has dropped) as well as acquiring HIV and hepatitis C (from shared injection equipment).

It is important to note that "detox" facilities may be an important first point of contact for many people who use substances, however, withdrawal management alone should never be considered substance use treatment. Rather than starting a withdrawal (or "detox") only approach, more and more evidence is showing that many substance use disorders require ongoing treatment. Treatment can be understood as ongoing care for a substance use disorder that is delivered by a trained health care provider. Treatment may be inpatient (where you stay) or outpatient (going every day or several times a week) and might include medication, evidence-based psychosocial treatments, residential treatment and recovery services, or a combination.

The best thing you can do when supporting your child or loved one to get help with their substance use disorder is to encourage them to see their physician or nurse practitioner. They may need to be referred to an addictions specialist in order to get the best and safest care. They will be able to work with your child or loved one to determine the best approach to safely managing their substance use disorder and connecting them to appropriate services. Even if you live in a rural or remote area, physicians and nurse practitioners have access to a consultation line where they can talk to an addiction medicine specialist Monday to Friday. Ask your child or loved one's health care provider if they have utilized this service in the care of your loved one or child. More information at www.raceconnect.ca/.

Below is an overview of treatment options. More specific information for each substance is given in "Alcohol and Other Drugs at a Glance" in this document, starting on p. 25.

Definitions

Addiction treatment

Ongoing or continued care for substance use disorder delivered by a trained care provider. Addiction treatment may be provided in outpatient or inpatient settings and may include medication, evidence-based psychosocial treatments, residential treatment, recovery services, or a combination. In isolation, withdrawal management, harm-reduction services, low-barrier housing, and unstructured peer-based support would not be considered "addiction treatment", however, these services can play an important role in connecting individuals to treatment. Treatment can be understood as a range of interventions that help people change their lives so that they can prevent the adverse health and social consequences of problematic substance use, including substance use disorders. Goals may range from achieving and maintaining abstinence to controlling one's use or finding other ways to minimize harm or maximize health and well-being.

Withdrawal Management

The use of medical management (which may include medication) to reduce withdrawal symptoms and withdrawal-related risks when an individual stops using opioids, stimulants, alcohol and/or other drugs in pursuit of abstinence. This terminology represents a deliberate shift away from the use of "detox" or "detoxification" to refer to medically supervised withdrawal from substances. Withdrawal management alone (that is, without further treatment) is not considered addiction treatment. It should be noted that unsupervised alcohol withdrawal can be very dangerous, and withdrawal management alone (that is, "detoxing" without further treatment) from opioids has a very high rate of relapse and is strongly recommended against.

SAFETY WARNING
Quitting alcohol abruptly (or "cold turkey") can be very dangerous for those who drink very heavily, including those with an alcohol use disorder. Risks include seizures and death. Someone wanting to stop drinking must see a health care provider first to ensure their safety.

Withdrawal management alone ("detox") for opioid use disorders is associated with very high rates of relapse putting individuals at high risk of overdose and acquisition of HIV and/or hepatitis C if they relapse. Individuals with opioid use disorders should work with their primary care provider or specialist to devise a treatment plan rather than attending detox. If individuals choose to take a withdrawal management only approach, they should be carefully informed of the risks and sign a waiver.

Overview of Treatment Options

Treatment interventions and supports for substance use disorders can be understood as existing on a continuum of care, including pharmacological (for example, opioid agonist treatment with medications such as methadone or buprenorphine/naloxone or methadone) and non-pharmacological (e.g., cognitive behavioural therapy, counselling). Many people will benefit from accessing care at multiple points along the continuum, for example, receiving buprenorphine/naloxone and traditional Indigenous healing practices, or inpatient residential treatment followed by outpatient treatment. Treatment options in BC are available both privately and publicly.

Types of treatment options

- Outpatient treatment—services are accessed during the day and usually involve 1 or 2 group therapy sessions per week.
- Youth-specific treatment—may include opioid agonist treatment and psychosocial treatments tailored to youth.
- Intensive outpatient treatment—may include counselling and group therapy 3-5 days per week.
- Residential treatment—intensive treatment in a structured residential context.
- Pharmacotherapy—evidence-based pharmacological (prescription medication) treatment for certain substance use disorders. For example, opioid agonist treatment for opioid use disorder (see below for more information on opioid agonist treatment). Pharmacotherapy options can be used in combination with the treatment options listed above.

Other kinds of substance use services

- Harm reduction programs—these aim to reduce the health, social, and economic harms associated with drug use. Harm reduction programs include needle exchanges, take-home naloxone kits, and overdose prevention sites.
- Overdose prevention sites—locations where people can use drugs with trained staff or volunteers who can provide education on safer consumption practices, provide harm reduction supplies, and respond to overdoses.
- Supervised consumption sites—staff supervise and monitor clients for signs of overdose, provide education on safer injection practices, and refer to primary care and addiction care.
- Drug checking services—currently being scaled up in BC, but available in some overdose prevention and safe injection sites.
- Safe supported housing—housing with associated support services.
- Street outreach programs—support services and bridges to the system of care.
- Supportive recovery services—longer-term transitional housing and support services.
- Pregnancy support services—support services to at-risk pregnant women and their families.
- Withdrawal management—medical management to prevent withdrawal symptoms from certain substances.

OPIOID AGONIST TREATMENT

Opioid agonist treatment (OAT)—most commonly in the form of buprenorphine/naloxone (brand name Suboxone®) or methadone is an evidence-based treatment for opioid use disorder.

Opioids are substances that bind to and activate (or "turn on") opioid receptors, providing relief from withdrawal symptoms and cravings in people with opioid use disorder. OAT can be understood as a medication used to provide relief from withdrawal symptoms and cravings in people with opioid use disorder. OAT is the recommended first-line treatment for opioid use disorder in British Columbia because it has been shown to be much better than withdrawal management ("detox") alone in terms of keeping people in treatment, helping them to stop using opioids, and significantly reducing the risk of overdose, blood-borne infections (like HIV or hepatitis C), and death.

If your child or loved one has an opioid use disorder, it is likely that they will be offered OAT along with other care that includes provider-led counselling, long-term monitoring of substance use care (to identify relapse and adjust medication dosage as needed), comprehensive preventive and primary care, and referrals to psychosocial treatment interventions and supports.

Some people think that opioid agonist treatments (for example buprenorphine/naloxone and methadone) are just "substituting one drug for another," however, as science advances, it has become clear that long-term, unmanaged opioid use disorder causes changes in the brain and body. More and more evidence is showing that the best and safest treatment for opioid use disorder is medication. This allows individuals to stop having to focus all their time and effort (including sometimes turning to crime and other high-risk activities) in order to stop the very painful withdrawal symptoms that emerge if they haven't taken opioids recently. This also prevents people from having to take risky street drugs that may be tainted with fentanyl and other synthetic opioids.

Other benefits of OAT include connecting individuals to health care and other services, helping bring stability to their lives (which might include housing, employment, or other services), and removing the risk of overdose from street opioids contaminated by fentanyl, carfentanil, and other synthetic opioids.
OAT should be considered a long-term treatment. Studies have found that people have the best outcomes (including the lowest risk of relapse) when they receive OAT for at least one year. Some people will take OAT for a long time, while others may decide with their health care providers that they would like to lower their dose or come off it entirely. It is very important that people work with their prescriber to very slowly taper off of OAT and be monitored for relapse throughout the tapering period.

In BC, there are three kinds of OAT that are commonly used (buprenorphine/naloxone, methadone, and slow release oral morphine). Buprenorphine/naloxone is the preferred first choice, due to its improved safety profile and the flexibility it affords people. Unlike methadone, which is the most commonly prescribed OAT in BC, buprenorphine/naloxone has a better safety profile, including much lower risk of respiratory depression and overdose, and can very commonly be prescribed as "take-home" doses. This means that people on buprenorphine/naloxone, once they have stabilized on the medication, can often go to the pharmacy once a week or once every

two weeks to receive their medication. Some people on methadone have to go to the clinic every day, while others have to go a few times a week.

Slow-release oral morphine is another kind of OAT used in BC. It is used much less frequently and is generally prescribed for people who tried buprenorphine/naloxone and/or methadone and found they still had cravings and withdrawal symptoms and continued to use illicit opioids. People receiving slow-release oral morphine generally have to go to the pharmacy every day to receive their medication.

PharmaCare covers OAT under the income-based Fair PharmaCare plan for those who qualify, as well as 100% coverage under PharmaCare Plan C (for those on income assistance) and Plan G (for those who demonstrate clinical and financial need for certain psychiatric medications).

Some primary care doctors prescribe buprenorphine/naloxone (also called Suboxone®), while a specialist may need to be seen to be prescribed methadone or slow-release oral morphine. Talk with your doctor to determine if they prescribe these medications. If your loved one has tried OAT before and not been able to stop using illicit opioids, their doctor might suggest injectable OAT. Injectable OAT is a more intensive treatment program where people go to a clinic or pharmacy up to three times a day to self-administer certain medications (hydromorphone or diacetylmorphine) under supervision. It is very well supported by evidence for people with severe opioid use disorder who have not benefitted from other OAT options. Even if you live in a rural or remote area, physicians and nurse practitioners have access to a consultation line where they can talk to an addiction medicine specialist Monday to Friday. Ask your child's health care provider if they have utilized this service in the care of your loved one or child. More information at www.raceconnect.ca.

If your child or loved one is considering opioid agonist treatment, a helpful resource to read before they start is "Patients Helping Patients Understand Opioid Substitution Treatment" by the Canadian Institute for Substance Use Research (formerly the Centre for Addiction Research of BC).

Selecting a treatment option

It is recommended that you read the treatment information relevant to the specific substance or substances your child or loved one is using in the "Alcohol and Other Drugs" section starting at p. 25 and support your child or loved one and their primary care provider and/or addictions specialist to make an informed choice on the right treatment approach for your child or loved one.

If your child or loved one chooses residential, intensive out-patient, or outpatient treatment through their family practitioner, there are several factors to consider in helping your child or loved one decide which is the right option for them. These include:

- Age range of the clients (especially important for youth)
- Waitlist and admission requirements
- Philosophy and approach of the program (and alignment with your child or loved one's goals)
- Whether pharmacological treatments are allowed and incorporated into treatment (especially important with opioid agonist treatment)

- Type of treatment offered and whether it is evidence-based
- Whether they have physicians on hand to supervise medically managed withdrawal
- Qualifications of all staff and presence of addictions specialists (i.e., physicians or nurse practitioners who specialize in addiction medicine
- Licensing and accreditation
- Services for family members (e.g., support groups) and family involvement in treatment
- Discharge plans and after-care

For a checklist of questions that can help guide you and your child or loved one's information gathering, you can visit the FGTA website at www.fgta.ca.

Withdrawal Symptoms

There may be instances in which your child or loved one and their health care providers decide that withdrawal is appropriate.

For example, when starting opioid agonist treatment with Suboxone® (buprenorphine/naloxone), people need to abstain from opioids for 12-24 hours (on average) before taking their first dose. This ensures that they don't get sick when they start taking it, but requires that they experience mild-to-moderate withdrawal symptoms. This is because of the way that Suboxone® works in the body—it is very sticky (i.e., has a "high affinity") for the receptors in the brain and body where opioids attach, which can make someone go into withdrawal if they take it while they still have another opioid in their system.)

Withdrawal management may be appropriate for certain other substances like stimulants. Withdrawal management should not be attempted unless on advice of a medical professional and with full and informed consent of your child or loved one regarding the risks and alternative treatment options. If your child or loved one's doctor or nurse practitioner recommends withdrawal management, for example, for stimulant use disorder, your child or loved one may wish to have medical supervision. Medical supervision is not always necessary for stimulant withdrawal, but may be considered. In this case, you or your child or loved one can call Access Central for a referral to a withdrawal management (detox) service in your community. It can be accessed toll-free at 1.866.658.1221.

If your child or loved one decides with their health care provider that withdrawal management at home is appropriate, they will need support. Withdrawal symptoms may be mild or severe, depending on the drug, the amount used, and how long the person has been taking the drug. There may be things your loved one can do to minimize the discomfort from withdrawal symptoms—they should speak with their treatment provider about this.

Possible withdrawal symptoms are on the following page.

Withdrawal Symptoms

Substance	Symptoms	
Opioids	• Flu-like symptoms • Agitation or anxiety • Muscle aches • Insomnia • Excessive yawning	• Sweating • Abdominal cramping, diarrhea, nausea, and/or vomiting • Dilated pupils • Goosebumps/cold sweats • Mood-swings
Alcohol	• Anxiety or nervousness • Depression • Fatigue • Irritability • Nightmares	• Sweaty, clammy skin • Insomnia • Loss of appetite, nausea, or vomiting
Stimulants	• Agitation and restlessness • Depressed mood • Increased appetite • General discomfort	• Fatigue • Vivid and unpleasant dreams • Headaches

Your support role during withdrawal in your home

If your child or loved one has decided, with their health care provider, to pursue at-home withdrawal management, there are some things you can do to support them.

A support person succeeds by remaining positive and calm and creating a safe and comforting atmosphere in the home. The person who can help the most is the one who knows the individual and has done a bit of preparation. Speaking with your child or loved one's health care provider can help you plan for the process.

You may have to take time off work and get some additional assistance for looking after other family members such as younger children or elderly parents, explaining to them what is happening.

Friends, family, or others who may cause stress or arguments as well as friends who currently use the substance your child or loved one is withdrawing from should be discouraged from visiting during this period.

If the person should have a seizure, experience chest pains, become unconscious, hallucinate or have other worrying symptoms, call an ambulance immediately. Dial 911.

You can help by:

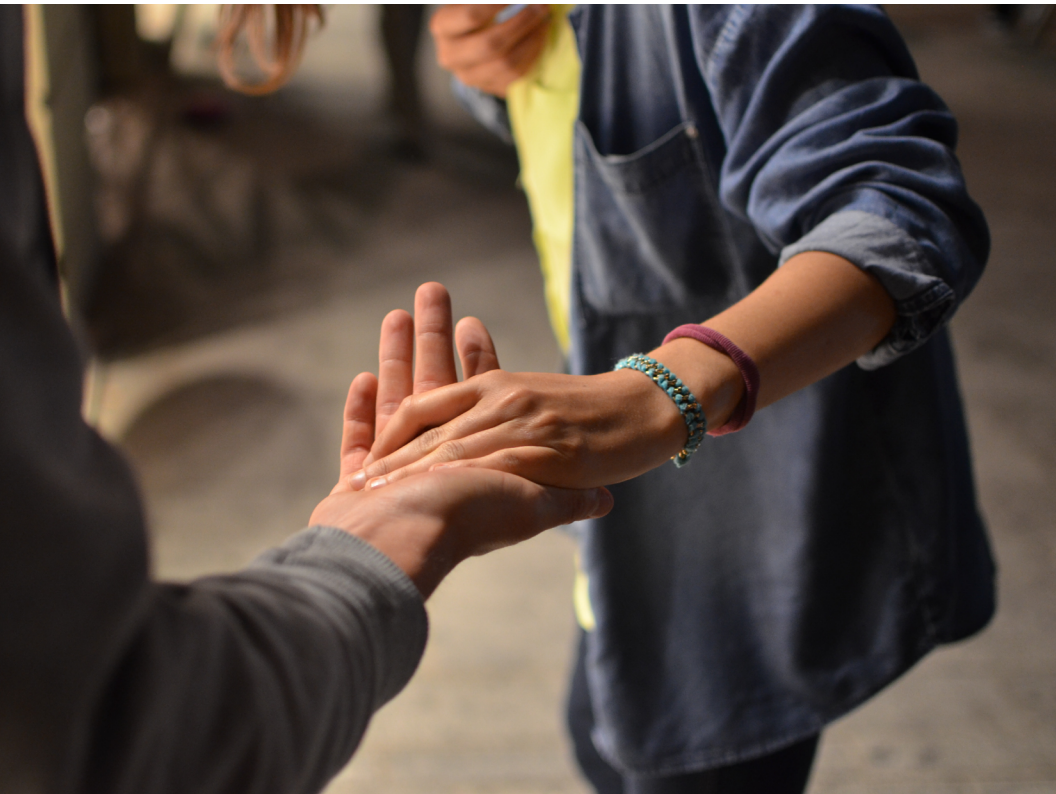
- Understanding that withdrawal is not treatment, but, when indicated by their health care provider, may be a necessary part of starting treatment for certain substance use disorders.
- Understanding that alcohol should not be stopped “cold turkey” for someone who has developed dependence. This needs to be assessed by a health care provider.
- Understanding that physical withdrawal symptoms may get worse before they get better.
- Being patient and willing to listen (try not to argue at this time).
- Trying to not take things said in anger or distress personally. People undergoing withdrawal are generally in extreme discomfort.
- Helping the person to manage any physical pain and discomfort. Your child or loved one can discuss with their doctor in advance if there are any appropriate medications or other strategies to minimize discomfort and pain (e.g., Gravol, acetaminophen, ibuprofen, Imodium).
- Encouraging them to drink (about 2 litres of fluid a day to avoid dehydration) and eat small amounts of healthy food (soup, rice, noodles, vegetables and fruit).
- Encouraging relaxation. Controlled relaxed breathing, meditation, listening to audiobooks or music, and having a warm bath or shower can all help with relaxation.
- Helping to distract and reassure the person regarding cravings. Remind them of these five D’s:
    - Do an activity—Watch a video, play cards, or listen to music.
    - Delay—Encourage them to put off making any decisions for an hour.
    - Drink plenty of fluids—Especially water.
    - Discuss—Remind them to look at their reasons for wanting to stop using.
    - Do some gentle exercise—Go for a walk, stretch, do yoga or other gentle movement.

"I was always really sociable and had a lot of friends. Everything I ever did, I went all out. When I was about 14, I started smoking pot. I always said I would never smoke cigarettes, but started that, too. I said I would smoke weed and never go any further, but friends started doing acid and mushrooms and I went all out again. At about 16, I started doing cocaine a lot on weekends. I was drinking heavily, too. I was good at hiding everything because I was rarely sober. I guess things just seemed normal.

I smoked cocaine every day for two years. At one point, I thought people could just quit, but I found I couldn't. I cleaned out RRSPs, mutual funds, and savings accounts. I didn't see a future. I lost my girlfriend, other friends. I would cry myself to sleep and then each morning wake-up and resolve not to do cocaine. Wanting to kill myself was a regular thought.

I was spending $3,000 a month on rock cocaine, and occasionally doing heroin to come down off coke. One day, about 30 pounds lighter than I should have been, and borrowing money, I was drinking with my brother who said, 'You aren't doing very well, are you?'

I talked to my parents the next day and started four years of treatment."



Recovery can be understood as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Recovery includes support to change old patterns of behaviour (which might include things like stealing and other high-risk activities in order obtain drugs) and may include finding new friends who are also in recovery or who do not have problematic substance use.

Different people will have different personal definitions of recovery and personal journeys towards recovery. For some people, that may include abstinence from all alcohol and other drugs including opioid agonist treatment. Others include opioid agonist treatment in their definition of recovery. For some others, it may involve abstinence from certain substances (for example, cocaine) while continuing to use other substances non-problematically (like an occasional glass of wine with dinner).

Although it is certainly difficult, the good news is that recovery is possible and that the paths to recovery—while diverse and sometimes difficult—are very well worn.

Setbacks and relapses

Setbacks and relapses are very common, and should be understood as a normal and common part of the path to recovery, rather than a sign of moral failure or weakness.

In some situations, relapse might be an indication that your child or loved one's treatment plan needs to be modified. For example, with opioid use disorder, relapse is often a sign that their opioid agonist treatment dose needs to be modified or other supports are needed.

Substance use disorders change or "rewire" parts of the brain. Depending on your child or loved one's situation, they may also be dealing with complicated and difficult issues related to their health (including mental health), housing, employment, and other factors. Responding with a non-judgemental and compassionate approach can help you to best support your child or loved one if they relapse or experience another type of setback. Hold onto the thought that substance use disorders are chronic conditions and relapses are a normal part of recovery and that change takes time, steady effort, and support.

And remember to celebrate wins, no matter how large or small. Each step towards recovery, however small, is something to be proud of.

2 This definition borrowed from: Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery. In: Substance Abuse and Mental Health Services Administration, ed. Rockville, MD: SAMHSA; 2012.

“I am a single parent of a child who is almost 30. My son is in recovery.

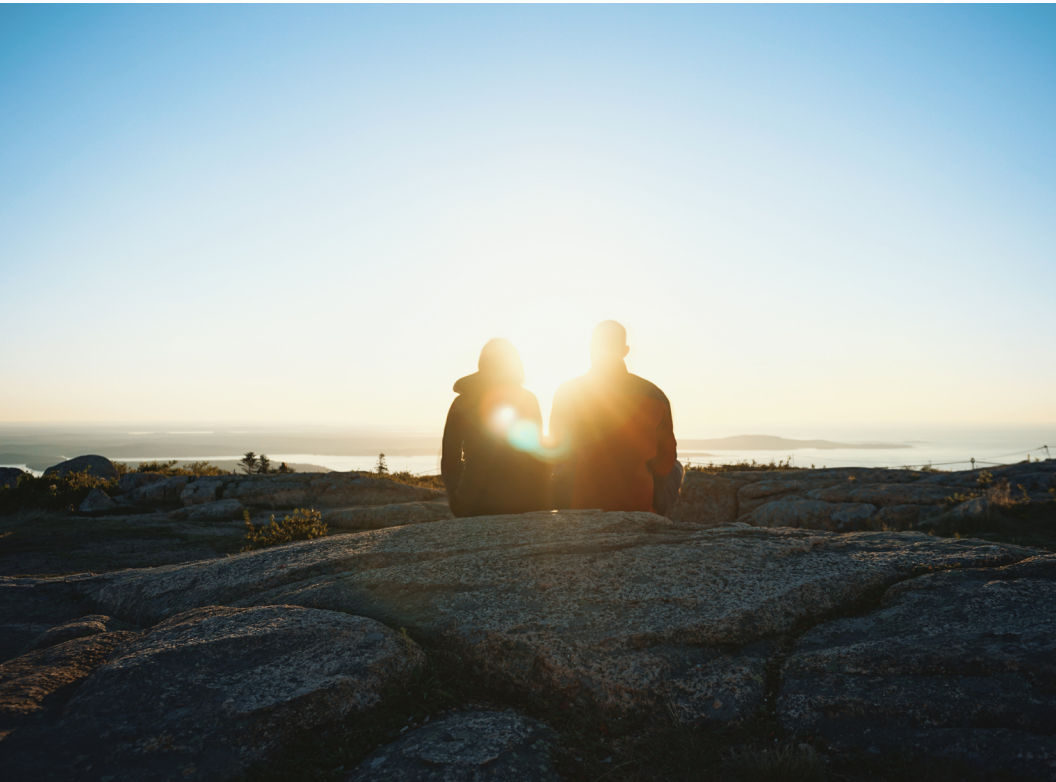
He gets better and better at being who he is and at being drug free. He started with pot, beer, and cocaine. From there it was a steady decline. It became a habit. We could talk about anything, but he hid his problem.

He didn’t get to see his father before he died and that threw him into a funk. He had no answers any more on who he was. Even though he was 23, he hadn’t grown up a lot. He couldn’t concentrate, couldn’t hold a job. At first, we just thought he was lazy, but then he admitted he had a problem. We got him to detox. Things were getting better. For a while it was good. It seemed antidepressants helped. The rest of the family prayed a lot, and cried a lot, while my son went into treatment again and again.

We were proud of all the baby steps along the way.

At one point I wondered if I’d ever be proud of him again, and I am. I’m really proud. He’s come a long way.

The message? Never give up hope and faith and love.”



> *"I have been clean for a year. With the help of a 12-step program, I learned how to stay clean, and made a lot of good friends. I work a full-time job now and things are going well. I don't spend much time alone. I attend a lot of meetings. I don't hang out with my old friends. People who have been clean for a long time tell me what to do and I do it. I try to have as much fun as I can. My life today is great."*

Being in recovery (what some people call "going straight"), especially after a long period of alcohol or other drug use, can be extremely difficult for some people. Boredom can be a very real problem for people who aren't yet stable enough to find employment or volunteer work or return to education.

Goals are important, but if they add up to "wanting it all and wanting it now"—new life, new job, new car—a person in treatment and/or recovery can feel defeated by their own ambitions.

Alcohol and other drugs can suppress feelings of all kinds, so expect a roller coaster of emotions, including guilt, shame, anger, and/or fear about the past and future. Regular support from a good counsellor is invaluable.

Be sure your child or loved one knows the particular danger of a relapse after a long period of abstinence. The size of the dose to which they had previously become accustomed may now be enough to cause an overdose.

How about you?

> *"I feel terrible saying this, but since Abbey's been clean I'm finding it much more difficult than I expected. She's up and down like a roller coaster, demands all my time, and is so hyperactive compared to when she was strung out or hanging about the house. She either never stops talking or she's in a black mood, and she wants everything now. The other day I almost wished she'd hit up again just so I could get some peace."*

Your child or loved one is in treatment and/or recovery. Right now you're probably feeling relieved and optimistic, but prepare yourself for dealing with the "new" person on new terms. Some find it very difficult to give up the relationship they established while their child or loved one was using, so get help if you need it. Look for supportive environments where you can talk and be heard. The support group you relied on during those bad old days is great, even after your child has achieved recovery.

Remember, you may find it difficult during this period to avoid becoming overly involved in your child or loved one's treatment or recovery. And you may feel even more anxious than you did before, worried that saying "no" to your child or loved one could contribute to a relapse. However, if you have practised self-care all along the way, this new relationship, and the detachment process that goes with it, should be easier.

May I be granted the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

(Serenity Prayer)

When you spend most of your time worrying about and supporting your child or loved one and other family members, it can be easy to neglect yourself. Taking care of yourself is just as important. Below are some of the lessons we have learned in supporting our children and loved ones.

- Don't blame yourself. Guilt is not a useful emotion. Other people's actions generally do not cause addiction.
- It is natural to feel anger, hurt, and disappointment.
- Admit it when you've blown it, apologize, and move on.
- Focus on what you can do, and let go of what you can't. Nobody can force someone with a substance use disorder into treatment or recovery.
- Educate yourself. This handbook is a good start, but there's a lot of information out there, and you'll want to choose good sources. Try the websites and other resources you find at www.fgta.ca or the family portal at www.bccsu.ca.
- Stay connected. This is a time when you need to reach out to your family and friends, not to withdraw because of feelings of shame. You'll be amazed at how understanding most people will be, especially if you talk about addiction as a disease.
- Explore paths you may not have tried before. Many find daily readers like Al-Anon's One Day at a Time helpful during difficult times, and this may be a time to investigate your own spirituality. A list of resource books is also available at the end of this section.
- Get support! You don't have to go through this alone, and you don't have to stick with the first counsellor you meet. Find a counsellor who you feel comfortable with, ideally one who specializes in substance use. Keep trying until you find one you can work with. Counselling BC has an online tool that can help you find professional counsellors and psychotherapists who are registered with a recognized professional body in BC and allows you to search by location, areas of practice, approaches, and language spoken. This tool can be accessed at http://counsellingbc.com/counsellors.
- Consider joining a group for those impacted by substance use. This may be in addition to or instead of finding a counsellor. There is no substitute for personal experience, and self-help groups (Parents Forever, Parents Together, Al-Anon, Nar-Anon) offer mutual support from people who have been there and are still struggling with addiction issues. The BCCSU website has a list of support groups in BC.
- Consider accessing Family Smart's Parents in Residence and Youth in Residence Program, which provides peer support, mentoring, help with system navigation, and information for youth or young adults with substance use challenges and families and caregivers of youth or young adults with substance use challenges.

- If there is no group in your area, start one. FGTA offers a guide for setting up and running a support group. It can be found in the "Family Support" section of www.fgta.ca.
- Don't let embarrassment or shame get in the way of taking action. Others in your community are bound to be struggling as you are. You just need to find one another.
    - Try posting a notice of a meeting at your local church, community or health centre. Let health and other professionals in the field know what you are planning, and get their help in advertising and organizing the gathering. In other words, get creative. You have nothing to lose but your isolation. Tried and true advice from across Canada has been published in the Parents in Action guidebook which you can download from the Family Support section of www.fgta.ca.
- Keep an eye on your own health and well-being. Self-care is not only essential but can also demonstrate healthy coping techniques for your child or loved one dealing with problematic substance use. Maintaining and supporting your own physical and emotional health allows you to best support your child or loved one and other family members. Try to eat well and exercise regularly (and encourage everyone in your family to join you). Go to events, go for a walk, and spend time with others you find supportive. Talk to your GP or other health professional if you need more help than you're getting now. Other ideas for self-care include:
    - Getting enough sleep
    - Eating enough nutritious food
    - Having enough down time
    - Setting healthy boundaries
    - Spending time with friends
    - Getting outside into nature
    - Doing an activity or hobby you enjoy
    - Creating nourishing rituals and routines
    - Moving in a way that feels good
    - Eating your favourite food
    - Spending time with pets
    - Therapy or counselling
    - Taking necessary medications
    - Writing in a journal
    - Exercising or other physical activity

Above all, don't give up on your own life, dreams, and goals. You will survive—one day at a time.

Books

The following is a list of books that others dealing with their child or loved one's substance use have found helpful.

Addict in the Family: Stories of Loss, Hope, and Recovery / Beverly Conyers, 2003

Addiction: A Mother's Story - My Son's Descent into Addiction and Where It Took Us / June Ariano-Jakes, 2011

After Her Brain Broke: Helping My Daughter Recover Her Sanity / Susan Inman, 2010

Beautiful Boy: A Father's Journey Through His Son's Addiction / David Sheff, 2009

Beyond Addiction: How Science and Kindness Help People Change / Jeffrey Foote, Carrie Wilkens, Nicole Kosanke, Stephanie Higgs / 2014

Chasing the Scream: The First and Last Days of the Drug War / Johann Hari, 2015

CLEAN: Overcoming Addiction and Ending America's Greatest Tragedy / David Sheff, 2013

Drug Addiction and Families / Marina Barnard, 2006

Everything Changes: Help for Families of Newly Recovering Addicts / Beverly Conyers, 2009

Inside Rehab: The Surprising Truth About Addiction Treatment - and How to Get Help that Works / Anne M. Fletcher, 2013

In the Realm of Hungry Ghosts: Close Encounters with Addiction / Gabor Mate MD, 2010

Love Her as She Is: Lessons From a Daughter Stolen by Addictions / Pat Morgan, 2000

Loving an Addict, Loving Yourself: The Top 10 Survival Tips for Loving Someone with an Addiction / Candace Plattor, 2010

Loving Someone in Recovery: The Answers You Need When Your Partner Is Recovering from Addiction / Beverly Berg MFT PhD, 2014

Memoirs of an Addicted Brain: A Neuroscientist Examines his Former Life on Drugs / Marc Lewis, 2011

Wasted: An Alcoholic Therapist's Fight for Recovery in a Flawed Treatment System / Michael Pond, 2016

Unfortunately, due to the continued criminalization of substance use, many people with a substance use disorder or addiction will find themselves involved with the criminal justice system.

If an individual suspected of an offense is older than 12 but younger than 18, they are considered a "young person" under Canadian law, and they will be investigated under the terms of the federal Youth Criminal Justice Act ("YCJA").

The YCJA, which applies across Canada, makes allowances for an accused individual's mental and emotional immaturity. For example, in most cases, police must consider whether "extrajudicial measures"—such as taking no action, warning or cautioning the young person, or referring the young person to a community program—would be sufficient prior to initiating a court proceeding.[3]

If a suspect is 18 or older they will be investigated as an adult, under the terms of the Criminal Code of Canada and related legislation.

In law, a "child" is an individual who is under the age of 12. In the below sections "young person" refers to individuals between 12 and 17, while adult refers to those 18 and older.

Differences between Youth Custody and Adult Custody

Youth Custody Services has a fundamentally different mandate from BC Corrections.

If a young person between 12 and 17 years old is incarcerated, they will be placed in a Youth Custody Center (YCC) managed by Youth Custody Services, a division of the Ministry of Children and Family Development, rather than an adult facility operated by either BC Corrections or the Correctional Service of Canada.

Young people detained in YCCs are not called "inmates" but "residents." This term reflects the basic aim of youth custody—not simply for detainment but to provide stable and controlled circumstances in which the young person may develop in a healthy way (by continuing with school, for example).

3 In British Columbia, youth custody is further regulated under the Youth Justice Act and the Youth Custody Regulation.

The goals of youth custody are set out in the Youth Custody Services mission and vision statements.

Mission of Youth Custody Services

Youth Custody Services contributes to public safety by providing a safe, healthy and supportive environment with a range of integrated, evidence-based programs which address the individual risk and needs of residents, thereby promoting positive outcomes for youth, families and the community.

Vision of Youth Custody Services

To deliver high quality, youth-centred services that complement community based youth services, which engage, involve and share responsibilities with youth, families and communities.

The goals of adult facilities also leave room for rehabilitation and reintegration, but are decisively less supportive of those incarcerated. For example, the mission of Correctional Service Canada:

> The Correctional Service of Canada, as part of the criminal justice system and respecting the rule of law, contributes to public safety by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control.[4]

There are currently 19 adult correctional facilities located throughout BC. What facility an individual ends up in depends on a number of factors, including the seriousness of their offence and the length of their sentence. There are currently only two Youth Custody Centers, located in Prince George and Burnaby.

How to Access Your Child or Loved One in a Youth Custody Centre

When young people come into custody, the parents or legal guardians will receive an information package from the centre explaining everything needed to visit and receive calls from their child or ward.

Youth Custody Centre rules restrict visitors. The young person must request permission to schedule a phone, video, or in-person visit and all visits to youth in custody must first be approved by their probation officer, in conjunction with centre staff.

If parents or other legal guardians wish to visit, they place their request with the facility. Young people are also asked which family members they would like to come and visit them, and may choose to not receive visits from certain people.

If you do not live near the institution where your child or loved one resides, the centre may help coordinate other options so that you can see your child or loved one through the Family Visitation Support Program. This program is available if your child or loved one is serving 30 days or more. The Case Management

4 http://www.csc-scc.gc.ca/about-us/index-eng.shtml

team can assist families with funding support related to hotel accommodations, transportation, meals, and other miscellaneous travel costs. You may also "visit" by video, which is arranged through your local community youth probation office.

Families are seen as important to the rehabilitation process and so you can expect that centre staff will help you stay connected with your child or loved one, notify you of any serious injuries, and address your concerns in a timely manner.

How to find out if your child or loved one is in Youth Custody

Phone or visit the nearest facility to book a visit; if your child or loved one is not there, the booking clerk will say so. Usually, a young person in custody has a probation officer in the community assigned to their case.

A phone call to the probation officer is also very informative. If you are unsure who the assigned youth probation officer is, you can contact the youth probation office. You can find a list of youth probation offices in your community by utilizing the "search" function on www.bc211.ca.

Your Access to an Adult Child or Loved One in Custody

How to find out if your adult child or loved one is in a pre-trial centre
If your adult child or loved one has been arrested, BC's privacy laws prevent the police from notifying you, and your adult child or loved one may choose not to call you. However, you may place a request for a visit by calling the Corrections Branch via the BC Government Inquiries line. Identify your adult child or loved one by name and birthdate. This step will be necessary even if your adult child or loved one has been arrested before; a detainee's visitors list does not remain on record. Upon locating your adult child or loved one, the facility's staff will encourage them to call you. You can also search by name on the Court Services Online website (https://justice.gov.bc.ca/cso/esearch/criminal/partySearch.do), which provides access to the public court record. You can search by name to see if charges have been laid against your child or loved one as well as if they are currently in custody and any upcoming court dates.

For a full list of correction facilities that may be used for pre-trial detention, check the website www.pssg.gov.bc.ca/corrections.

Planning a visit to adult custody

To arrange a visit, check with the appropriate facility, as visiting hours and booking procedures may vary. Your child or loved one must give the name of potential visitors to corrections staff prior to you booking a visit. Visits are permitted to last 1 hour or less and your child or loved one is entitled to a minimum of two hours of visits per week. You must be 19 years of age or older to book a visit, and must first register to clear a background check. Call 24 hours in advance to book a visit.

Children are permitted only if they are accompanied by a birth parent or legal guardian and if the inmate has obtained approval for the visit.

You will need to bring:

- Two pieces of ID—one piece must be picture ID.
- A quarter for locking jackets, wallets, keys, etc. in a pay-per-use locker, as you are not permitted to take anything into the visiting area.

You will be scanned with a metal detector before entering the visiting area. An ion test for drugs may be requested.

You will be assigned a cubicle, and communication with your child or loved one will be via hand phone or speaker unit. Conversations and actions will be monitored.

Money

Your adult child or loved one will have an account in which money can be deposited for services such as phone calls, haircuts, or canteen items (snacks, toiletries, writing materials, etc.). If money is sent through the mail, it must be in the form of a money order in your child or loved one's name. Cheques are not accepted. Cash will only be accepted for a direct deposit at the facility.

Phone calls

Your adult child or loved one will not be permitted to receive telephone calls. They can call you collect or you can deposit money into their account so they can have money added to their ID card for phone calls.

If they call you collect, the charge is $1.75 per call. A non-collect call costs your adult child or loved one $0.90. When your adult child or loved one calls you from custody, you will hear the following message when you pick up the phone: "This is a call from a BC Correctional Facility. This call is from [person's name]. You will/not be charged for this call. If you do not wish to receive this call, press 5; otherwise, press 0."

Do not press 5, as calls to you from all correctional facilities will be blocked. Then, to reopen access, you will have to write a letter that gives the caller permission to try reaching you again.

Mail

Mail can be sent via the regular postal service and is subject to drug scanning on arrival at the facility.

Refrain from using stickers or metallic or sparkly pens when addressing an envelope; these letters will be returned to the sender.

If you are dropping off mail during a visit, the letter must be properly addressed (including return address) and must not be sealed.

Emergencies

In an emergency, you can call the main line at the detention centre. If that does not work, you can also call the probation officer, lawyer, or you can try contacting the facility's chaplain; the chaplain might be able to get a message to your adult child or loved one.

Addictions counselling

If treatment or a conditional sentence for your child or loved one is an option, an appointment with the addictions counsellor should be requested as soon as your child or loved one has entered a corrections facility. The counsellor will be able to help your daughter or son complete applications to community-based public agencies and services. Parents may need to contact rehabilitation centres on behalf of the inmate, as some centres and recovery houses will not accept calls from a correctional facility.

Attending Court with a Young Person or Adult Child

Clothing for court appearances

If your child or loved one is in pre-trial detention, they will be given clothing by the centre (sweat pants and sweat shirt). This clothing will be worn for court appearances as well.

When you arrive at court

You may be screened as you enter the courthouse, so bring as little with you as possible. There will be a master list of court appearances posted somewhere near the entrance of the courthouse; this will specify in which courtroom and at what estimated time your child or loved one's case will be heard. There may be last-minute changes to the assigned courtrooms—be sure to check with the sheriff on duty. Court appearances seldom run on time, so you may have to be at the courthouse for almost a full day of waiting. Keep this in mind if you are booking time off work to attend.

Parental support counts

Your presence in the courtroom reflects well on your child or loved one. In some cases, in the youth system, you may be granted permission to speak about your child or loved one. Talk to their lawyer about this. Alternatively, your child or loved one's social worker may address the court after being introduced to the court by their lawyer, or if the judge asks them directly. This usually occurs at a bail hearing or sentencing.

For adult children or loved ones, you may be able to submit a letter of support for a bail hearing or sentencing hearing. In this case, talk to either duty counsel or their lawyer about this option.

Legal proceedings can be very daunting, particularly if you do not understand the vocabulary commonly used. Below are some of the terms that you may encounter.

INSTITUTIONS

Youth Court: The court that hears the majority of criminal cases involving accused youth aged 12 to 17. In particularly serious cases, Crown counsel may seek an adult sentence, but the trial will still occur in youth court.

Provincial Court of British Columbia: The court in which the vast majority of adult criminal cases are tried. This is the court for "summary conviction" offences such as mischief or theft under $5,000. An accused may elect to be tried in provincial court for certain "indictable offences" such as robbery or breaking and entering.

Supreme Court of British Columbia: The trial court for the most serious criminal charges. For certain "indictable offences" such as robbery or breaking and entering, an accused may elect to be tried in Supreme Court. If the trial is set for Supreme Court, the accused may have the choice of trial by judge alone or by a judge and jury (which mode of trial to elect is an important decision for which the accused will generally require the advice of experienced counsel.) The BC Supreme Court also hears some appeals from Provincial Court.

Drug Court: A specialized court in which certain adult persons accused of drug- or drug-related charges to support their addiction are allowed to opt for a court-supervised course of treatment and rehabilitation as an alternative to a jail sentence. The usual candidates for drug court are persons who have engaged in trafficking to support their own addictions.

First Nations Court: Different from other provincial courts, First Nations court focuses on healing and community, making sure that everyone who is involved in a case has a chance to be heard. The goal of sentencing is to strengthen both the person convicted of a crime and their community.

British Columbia Court of Appeal: The highest court in the province. It hears appeals from the Supreme Court, and from the Provincial Court on some criminal matters.

Supreme Court of Canada: The highest court of Canada, the final court of appeals in the Canadian justice system.

WHO'S WHO

Accused (sometimes referred to as the "Defendant" or the "Prisoner"): The person charged with having committed a criminal offence. If the person is convicted, he or she is referred to as the "Offender."

Court Clerk (sometimes referred to as "Madame Registrar" or "Mr. Registrar"): The official responsible for managing the court files and keeping a record of the proceedings.

Crown Counsel (sometimes referred to as the "Prosecutor"): The lawyer who conducts prosecutions of criminal cases on behalf of the state, symbolized by the Crown. Crown counsel's role is to represent the interests of society rather than to act for any individual victim. This may be important for a parent or other loved one to remember when that person also happens to be the victim.

Defence Counsel: The lawyer who advises and acts for the accused in court. Communications between defence counsel and the accused are strictly confidential, unless the accused chooses to waive that privilege to share information with their parents or others. Parents should remember that defence counsel must take instructions from the accused—even if the parents are paying the legal bills. "Legal Aid" (publicly funded legal representation) is generally available to a young person facing criminal charges and may be available to an adult accused who lacks the financial means to hire a lawyer. Further information can be found at the Legal Services Society: www.lss.bc.ca.

Duty Counsel: The defence counsel who is on call at the courthouse to provide free legal assistance to an unrepresented accused. Generally, duty counsel is the first lawyer seen by an accused who has been arrested and is awaiting a bail hearing. Duty counsel can provide legal advice about charges, court procedures, and legal rights, and can represent someone at a bail hearing, but cannot take on a whole case or represent someone at trial.

Justice of the Peace: These are judicial officers who preside over some preliminary court matters, including bail hearings and early court appearances. Justices of the Peace are called "Your Worship" in court, though this tradition is shifting to "Your Honour".

Provincial Court Judge: The judge who presides over hearings and trials in provincial court. This judge is addressed in court as "Your Honour." Trials in provincial court are tried by a judge without a jury.

Supreme Court Justice: The judge who presides over hearings and trials in Supreme Court. This judge is addressed in court as "My Lord" or "My Lady." Trials in Supreme Court may be tried by a judge alone or by a judge and jury.

Sheriff: The uniformed officer who is responsible for maintaining security in court and for movement of prisoners to and from court.

PRE-TRIAL PROCEDURE

Bail: The pre-trial release from custody which may be granted by a judge. The simplest form of bail is a release on an "undertaking" by the accused to appear in court when required. More onerous forms of bail may carry various conditions and may be secured by a cash deposit or by the promise of a "surety" to pay a specified amount if the accused fails to abide by the terms of the bail. In some cases, a parent may act as a surety to secure the release of the accused. However, anyone who acts as a surety should be aware that they are assuming a heavy responsibility and may be taking a financial risk. In some cases, a young person may be placed "in the care of a responsible person" if the youth justice court or a justice is satisfied that certain conditions have been met.

Bench Warrant: A court order authorizing the arrest of a person. Judges will generally issue a bench warrant if an accused fails to appear in court when required.

TRIAL

Arraignment: The court procedure in which the accused's name is called, the charge is read, and the accused pleads guilty or not guilty. Be aware that a plea of "not guilty" is not a claim of innocence but rather the exercise of the accused person's right to a trial and to the presumption of innocence until proven guilty. That being said, whether or not a person pleads guilty, and at what stage in the proceedings, can impact the sentence they receive.

Examination: The formal interrogation of a witness by a lawyer. During "examination in chief" a lawyer uses open-ended questions to obtain evidence from a witness who supports their client's version of events. During "cross-examination," the lawyer for the opposing party tries to undermine the evidence of that same witness.

Preliminary Inquiry: A pre-trial hearing conducted in provincial court to determine whether there is sufficient evidence to proceed to trial. These hearings are only available for certain, more serious offences, where the trial is to be in Supreme Court. Crown counsel calls and examines key witnesses who, in turn, are cross-examined by defence counsel. The provincial court judge who presides over the preliminary inquiry does not make findings of fact or decide questions of guilt or innocence.

Trial: The court hearing for the determination of whether the accused is guilty or not of the offences charged. The Crown bears the onus of proving the guilt of the accused "beyond a reasonable doubt." The Crown calls witnesses first and then, after the Crown's case is closed, the accused has the right to choose whether or not to testify and/or call other witnesses. The accused is under no obligation to prove his or her innocence.

Sentencing Hearing: The hearing for the determination of the court-ordered consequences of a conviction, after the accused has either entered a plea of guilty or has been found guilty at the conclusion of a trial. The judge must consider a range of factors and principles before deciding what sentence is "fit" for the individual offender in the particular circumstances of the case. The judge's discretion over sentencing may be limited by a mandatory minimum jail sentence required by law for certain serious offences.

The judge hears submissions from both counsel and also reviews other relevant materials that may be filed at the hearing, such as a criminal record, a statement by the victim about the impact of the crime, reference letters about the character of the offender, and a plan for treatment and rehabilitation if the offender does not have to go to jail. In some cases, counsel may request and the judge may order a pre-sentence report by a probation officer outlining background information about the offender, often including some family history.

If the offender is Indigenous, the court must take into account the adverse background cultural factors facing Indigenous peoples. A sentencing judge is required to take into account all reasonable alternatives to incarceration for Indigenous offenders.

Family members may attend court to support the accused, and the judge may give parents an opportunity to speak if they wish to be heard. The accused has the right to the last word before sentence is pronounced. Some have nothing to add to what has been said on their behalf; some choose to express remorse and a determination to turn their lives around.

SENTENCING OPTIONS

Youth Sentencing

Reprimand: A reprimand is essentially a stern lecture or warning from the judge in minor cases in which the experience of being apprehended, taken through the court process, and reprimanded appears to be sufficient to hold the young person accountable for the offence.

Absolute Discharge: A finding of guilt but not a criminal conviction. This is a confusing distinction, but in short, a person who is given an absolute discharge can honestly say they have never been convicted of a criminal offence (e.g., on a job application). An absolute discharge is entered on an offender's criminal record, but is cleared a year later as long as there have been no further criminal incidents.
Conditional Discharge: Described under "Adult Sentencing" below.

Fine: An order to pay a fine up to $1,000. The amount, time of payment, and terms of payment are determined by the court.
Restitution/Compensation: An order to make restitution of any property gained through commission of a crime or to pay money to compensate for loss of property or damage to property, loss of income, or special damages for personal injury arising from the crime.

Restitution to Purchaser: An order that the young person must compensate the person who unknowingly bought property obtained through crime where an order has been made that the property must be returned to its owner.
Personal Service Order: An order that the young person compensate a person in kind or by way of personal services at the time and on the terms that the court may fix for any loss, damage, or injury suffered by that person.

Community Service: An order that the young person must perform a community service at the time and on the terms that the court may fix.

Prohibition Order: The court may make any order of prohibition, seizure, or forfeiture which is permitted under the Criminal Code of Canada.
Probation: A probation order is a court order to "be of good behaviour" for a set period of time, up to a maximum of two years for a young person. A probation order generally includes various conditions such as that the offender report to a probation officer, obey a curfew, avoid certain areas known for drug use, and take part in a program of treatment. A probation order may be added to a jail sentence or may be imposed in the form of a "conditional discharge" or a "suspended sentence." Probation cannot be imposed if the global sentence of imprisonment is greater than 2 years.

Intensive support and supervision order: This sentencing option provides closer monitoring and more support than a probation order to assist the young person in changing their behaviour.

Non-residential order: This order requires the young person to attend a program at specified times and on conditions set by the judge. It can be crafted to address the particular circumstances of the young person; for example, the order might target specific times and days when a young person is unsupervised and tends to violate the law.

Deferred custody and supervision order: This sentencing option allows a young person who would otherwise be sentenced to custody to serve the sentence in the community under conditions. If the conditions are violated, the young person can be sent to custody. This order is not available to the court for offences in which a young person caused or attempted to cause serious bodily harm.

Custody and Supervision Order: An order that the young person serve a period of time in custody.

Intensive rehabilitative custody and supervision order: This order is a special sentence for serious violent offenders. The court can make this order if:

1. The young person has been found guilty of a serious violent offence (murder, attempted murder, manslaughter, or aggravated sexual assault) or an offence in which the young person caused or attempted to cause serious bodily harm and for which an adult could be imprisoned for more than two years and the young person had previously been found guilty at least twice of such an offence;
2. The young person is suffering from a mental or psychological disorder or an emotional disturbance;
3. An individualized treatment plan has been developed for the young person; and
4. An appropriate program is available and the young person is suitable for admission.

Adult Sentencing

Fine: An order to pay an amount of money at the court registry within a time period fixed by the judge. A fine goes into the public purse; it is not to be confused with restitution or a compensation order, which goes to a victim. However, judges seldom impose fines or compensation orders on persons suffering from an addiction, for the practical reason that such persons usually lack the means to pay (and have difficulty holding onto money).

Restitution/Compensation Order: Money the court orders an offender to pay a victim as compensation for losses to the victim as a result of the crime. This might cover, for example, lost wages or damaged property.

Probation: A probation order is a court order to "be of good behaviour" for a set period of time, up to a maximum of three years. A probation order generally includes various conditions such as that the offender report to a probation officer, obey a curfew, avoid certain areas known for drug use, and take part in a program of treatment. A probation order may be added to a jail sentence or may be imposed in the form of a "conditional discharge" or a "suspended sentence." Probation cannot be imposed if the global sentence of imprisonment is greater than 2 years.

Absolute Discharge: A finding of guilt but not a criminal conviction. This is a confusing distinction, but in short, a person who is given an absolute discharge can honestly say they have never been convicted of a criminal offence (e.g., on a job application). An absolute discharge is entered on an offender's criminal record, but is cleared a year later as long as there have been no further criminal incidents. If an individual receives an absolute discharge as an adult, it can still show up on a vulnerable sector check or in future sentencing proceedings.
Conditional Discharge: Similar to an absolute discharge, except that the offender is sentenced to a period of probation (up to three years), and the conditional discharge is removed from their criminal record as long as the probation is successfully completed.

Suspended Sentence: A sentence of a period of probation which results in a criminal record and which remains "suspended" in the sense that an offender who breaches probation can be brought back to court to be re-sentenced. (Usually, in lieu of re-sentencing, the Crown lays a new, separate charge of breach of probation.)

Conditional Sentence (not to be confused with a conditional discharge or a suspended sentence): A sentence "served in the community" which resembles a probation order but is regarded as a more serious entry on a criminal record than a suspended sentence, and often carries more stringent terms amounting to those of house arrest. Also, an offender who breaches a term of a conditional sentence risks having to serve the remainder of the sentence in jail. A conditional sentence may be used to compel an offender to reside in a residential treatment centre or in a recovery house.

CUSTODIAL INSTITUTIONS

Youth Custody Centre*: Jail for persons under the age of 18. Youth Custody Centres* are run by the provincial government through Youth Custody Services, a division of the Ministry of Children and Family Development (MCFD).

Pre-trial Centre: The lock-up facility for accused persons who are detained in custody to await their court appearance. Young persons are held at the Youth Custody Centres for pre-trial detention if they have not received bail.

Provincial Correction Facility: Jail for adults sentenced to a period of incarceration of less than two years. Provincial facilities are managed by the provincial government through BC Corrections.

Federal Penitentiary: Prison for adults sentenced to a period of incarceration of two years or more. Federal penitentiaries are run by the federal government through Correctional Services Canada.

Information Resources

- Justice Education Society: Youth and Crime resources
  - Young Offenders: https://www.justiceeducation.ca/legal-help/crime/youth-and-crime/young-offenders
  - Youth Charged with a Crime: https://www.justiceeducation.ca/legal-help/crime/youth-and-crime/youth-charged-crime
  - Young People and Criminal Law: https://www.justiceeducation.ca/legal-help/crime/youth-and-crime/young-people-and-criminal-law
  - Youth Court: https://www.justiceeducation.ca/legal-help/crime/youth-and-crime/youth-court

- Legal Rights for Youth: Crime
  http://www.legalrightsforyouth.ca/crime

- Clicklaw: Young People and the Law:
  http://wiki.clicklaw.bc.ca/index.php?title=Young_People_and_the_Law#Young_people_and_criminal_law

- People's Law School: Consequences of a Youth Record
  https://www.peopleslawschool.ca/publications/consequences-youth-record

- Law Students' Legal Advice Program Manual: Chapter 2 – Youth Justice
  http://www.lslap.bc.ca/manual.html

- Department of Justice: The Youth Criminal Justice Act Summary and Background
  http://www.justice.gc.ca/eng/cj-jp/yj-jj/tools-outils/back-hist.html

- Aboriginal Legal Aid:
  http://aboriginal.legalaid.bc.ca/

- Gov.bc.ca: Youth Justice
  https://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/understanding-criminal-justice/youth-justice

- Gov.bc.ca: Youth Services
  https://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/services-and-resources/youth-services

- The Canadian Bar Association: Young People and Criminal Law
  https://www.cbabc.org/For-the-Public/Dial-A-Law/Scripts/Youth-and-the-Law/225

- The Canadian Bar Association: Youth Justice Court Trials
  https://www.cbabc.org/For-the-Public/Dial-A-Law/Scripts/Youth-and-the-Law/226

- Gov.bc.ca: Glossary of Criminal Justice Terms
  https://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/justice-terms

- Irwin Law's Canadian Online Legal Dictionary
  https://www.irwinlaw.com/cold

Legal Resources

- Legal Services Society of BC
  www.lss.bc.ca

- Access Pro Bono
  www.accessjustice.ca

- UBC Law Students Legal Advice Program
  www.lslap.bc.ca

- Native Courtworker and Counselling Association of British Columbia
  http://nccabc.ca/

- Ombudsperson: An official appointed by the government to investigate complaints against public authorities. To contact an ombudsman, your son/daughter in custody will find a toll free number is posted on all units.
  www.ombudsman.bc.ca

- Find out about alcohol and other drugs and addiction as early as possible. Take the time to equip yourself so that you can speak from a base of knowledge.
- Make it clear that you really want to know what your child or loved one is thinking and feeling.
- Remember that many young people experiment with alcohol and other drugs and remain recreational users without developing problematic use.
- Discuss substance use with your child or loved one, particularly health and safety issues. If your child or loved one is using alcohol or other drugs, encourage harm reduction (safer sex, not mixing drugs, eating properly, using clean needles, carrying a naloxone kit; see p. 42).
- When confronted with an intoxicated person, deal only with immediate safety issues.
- If you are worried or afraid, call a friend or the authorities for support.
- Let your child or loved one know how their substance use is affecting the rest of the family and what behaviours you are not prepared to accept.
- Decide whether you are willing to give or lend your child or loved one money. Some people are willing to give their child or loved one money, even when they know it will likely go to buying alcohol or other drugs. Other people are not.
- Avoid the “bad” label, and try to remember that your loved one is dealing with addiction and needs compassion and support.
- Consider joining From Grief to Action to add your voice to the movement for an evidence-based, easy to navigate substance use system in BC that provides timely treatment and support. Every member strengthens our Society’s voice when we speak out for public funding of addiction treatment resources in BC. All membership is kept in confidence unless you choose to go public.
- Stay connected, even if your child or loved one is not living in your home, through phone calls and care packages.
- Be supportive, maintain contact, and never give up hope.
- Try not to feel guilty. Get on with your own life.

Addiction: A harmful behavioural preoccupation, generally accompanied by a loss of control, and a continuation of or craving for the behaviour despite negative consequences. Addictions may develop around a range of behaviours, including chronic dependent substance use. Addiction is a complex bio-psycho-spiritual phenomenon, which has multiple contributing causal factors that can start early in life and be compounded over the life course.

Addiction treatment: Ongoing or continued care for substance use disorder delivered by a trained care provider. Addiction treatment may be provided in outpatient or inpatient settings and may include medication, evidence-based psychosocial treatments, residential treatment, or a combination. In isolation, withdrawal management, harm-reduction services, low-barrier housing, and unstructured peer-based support would not be considered "addiction treatment".

Dependence: Dependence develops when someone's body becomes used to the presence of a certain substance and requires that substance in order to avoid unpleasant withdrawal symptoms. This is not the same as developing an addiction or substance use disorder.

Detox: see "Withdrawal Management" below.

Drug: A mood-altering (also called "psychoactive") substance other than food which is consumed to change how a person thinks, feels, or acts. May be legal (tobacco, alcohol) or illegal (street heroin, cocaine). Many drugs have medical purposes (pain relief, anxiety relief, sedation) but may also be used for non-medical reasons such as fun, to cope with difficult emotions or experiences. May also be used to prevent withdrawal symptoms and cravings (when one is physically dependent).

Harm reduction: Policies, programs, and practices that aim to reduce health, social, and economic harms (e.g., transmission of HIV, overdoses) associated with the use of psychoactive substances, for those unable or unwilling to stop using. Harm reduction can be understood as a practical response that helps keep people safe and minimize death, disease, and injury when engaging in high-risk behaviour. Harm reduction examples include needle and syringe exchange programs, take-home naloxone kits, supervised injection or consumption services, and outreach and education programs for high-risk populations. Additional information on harm reduction and sites to access take-home naloxone kits can be found at www.towardtheheart.com.

Illicit Drug Use: Illicit drug use includes both illegal and non-medical substance use. For example, using street heroin is illegal, while Oxycontin may be medical (and licit) if used as prescribed or illicit if used by someone it wasn't prescribed for or used in higher quantities than was prescribed. Mutual-support/peer-support programs: Support that is provided through a network of peers through meetings, open discussions of personal experiences and barriers to asking for help, sponsorship, 12-step programs, and other tools of recovery. Examples include Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery®, and LifeRing® Secular Recovery.

Naloxone (brand name Narcan): A medication used to block or reverse the effect of opioids. It is used to reverse opioid overdoses and is commonly available in British Columbia through take-home naloxone programs.

Opioids: Substances commonly prescribed for pain management that bind to and activate opioid receptors in the brain, suppressing the ability to feel pain. At high doses, opioids can cause euphoria (feeling really good), dysphoria (feeling really bad), and respiratory depression (lowered breath rate). Opioids may be prescribed or obtained illegally. Depending on the opioid type, formulation and individual preference, opioids are consumed via ingestion (swallowing a pill), inhalation (similar to smoking), transdermal delivery (a patch), or subcutaneous, intramuscular or intravenous injection.

Opioid agonist: Any substance that binds to and activates opioid receptors, providing relief from withdrawal symptoms and cravings in people with opioid use disorder, and pain relief if used for chronic pain management. Oral opioid agonists used for treating opioid use disorder include methadone, buprenorphine, and slow-release oral morphine.

Opioid agonist treatment (OAT): Opioid agonist medications prescribed for the treatment of opioid use disorder. OAT is typically provided in conjunction with provider-led counselling; long-term substance-use monitoring (e.g., regular assessment, follow-up, and urine drug tests); comprehensive preventive and primary care; and referrals to psychosocial treatment interventions, psychosocial supports, and specialist care as required.

> *Methadone*: The most common form of opioid agonist treatment, used to prevent withdrawal symptoms and cravings in people with opioid use disorder. In Canada, it is generally administered as a liquid people drink once per day. Many people receiving methadone treatment need to attend a pharmacy multiple times per week (or every day) to receive their medication.
>
> *Buprenorphine*: The recommended first-line treatment for opioid use disorder in British Columbia. Similar to methadone, it prevents withdrawal symptoms and cravings in people with opioid use disorder. Buprenorphine has a significantly better safety profile than methadone, with much less risk of respiratory depression. This improved safety profile also allows many people to receive "take-home" doses rather than visiting the pharmacy every day. In Canada, buprenorphine is combined with naloxone to prevent diversion (e.g., injecting or selling the medication). The naloxone does not have effects unless it is injected in which case it will induce some withdrawal symptoms in physically dependent opioid users.
>
> *Slow-release oral morphine*: A 24-hour slow-release formulation of morphine that is taken orally once per day to prevent withdrawal symptoms and cravings in people with opioid use disorder. It is currently approved for pain management in Canada, and its use for treatment of opioid use disorder would be considered off-label. It is generally considered for treatment in those who have not benefitted significantly from buprenorphine/naloxone and/or methadone.

Injectable opioid agonist treatment: An evidence-based treatment for people with severe opioid use disorder who have not benefitted from other OAT options. Injectable OAT (iOAT) is a more intensive treatment program where people go to a clinic or pharmacy up to three times per day to self-administer hydromorphone or diacetylmorphine under supervision.

Opioid antagonist: Medication that works by blocking opioid receptors, preventing the body from responding to opioids. Opioid antagonist medications may be used to reverse an opioid overdose by displacing and replacing opioids in opioid agonist receptors (e.g., naloxone or Narcan®). An opioid antagonist called naltrexone is also used to support continued abstinence from both alcohol and opioids.

People Who Use Drugs: A term for people who use drugs that is generally preferred over terms like "junkie", "addict", or "user", which may be experienced as pejorative and offensive. This term is used to recognize the humanity of people who use drugs, and to recognize that drug use is only one aspect of who they are and not their entire identity.

Problematic Substance Use: Psychoactive substance use that results in or increases risks for physical, psychological, economic, social, or other problems for individuals, families/friends, communities or society. The most commonly recognized type of problematic substance use is chronic dependent use or addiction, but other instances or patterns of use can also be problematic. Problematic substance use is not necessarily dependent on the legal status of the substance used, but rather on the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm.

Psychoactive substances: See "Drug." The terms can generally be used interchangeably.

Psychosocial supports: Non-therapeutic social support services that aim to improve overall individual and/or family stability and quality of life, which may include community services, social and family services, temporary and supported housing, income-assistance programs, vocational training, life-skills education, and legal services.

Psychosocial treatment interventions: Structured and/or manualized (guided by a standardized manual) treatments delivered by a trained care provider that incorporate principles of cognitive behavioural therapy, interpersonal therapy, motivational interviewing, dialectical behaviour therapy, contingency management, structured relapse prevention, biofeedback, family and/or group counselling. Psychosocial interventions may include culturally specific approaches such as traditional healers, elder involvement, and Indigenous healing ceremonies.

Residential treatment: Treatment for substance use disorders provided in a structured live-in, therapeutic setting. The duration of residential treatment programs ranges from several weeks to months, depending on the individual, approach, and the setting. Residential treatment programs potentially include some, or all, of the following elements: withdrawal management, pharmacological treatment, psychosocial treatment interventions, medical management, individual and group counselling, peer support, education, and harm reduction.

Stigma: The beliefs and attitudes about people who use drugs, including those with substance use disorders, that lead to negative stereotyping and prejudice against them and their families. These beliefs are often based on ignorance, misinformation, moral judgment, and misunderstanding. Discrimination, which often emerges from stigmatizing beliefs and attitudes, refers to the various ways in which people, organizations, and institutions unfairly treat people living with a substance use disorder. Stigma and discrimination can often act as barriers to accessing health care, housing, and addiction treatment. Additionally, related systemic discrimination such as racism, poverty, sexism, and colonization can compound the stigma and discrimination experienced by people who use drugs and their families.

Substance Use: The intentional consumption of a psychoactive (that is, mood-altering) substance in order to modify or alter consciousness. Both legal and illegal psychoactive substances exist. Legal psychoactive substances include alcohol, tobacco, caffeine, and some medications. Illegal psychoactive substances include cocaine, heroin, and cannabis (which will become a legal psychoactive substance in Canada in late 2018). Humans have used psychoactive substances throughout human history and for a variety of reasons. These include spiritual or religious, social, medical, and scientific reasons, as well as for pleasure. The effects of substance use can range from positive to very problematic, depending on why, how, how much, and how often someone uses it.

Substance Use Disorder: Formerly called substance abuse or substance dependence, and informally referred to as addiction, substance use disorders happen when the chronic use of alcohol and/or other drugs causes significant impairment in function and health. This might include health problems, disability, or inability to meet responsibilities at school, work, or home. Substance use disorders can be mild, moderate, or severe. Symptoms of substance use disorders can include cravings, inability to control use (for example, being unable to cut back on drinking), continuing to use despite negative consequences, and withdrawal symptoms. Opioid use disorder, tobacco use disorder, and alcohol use disorder are examples of substance use disorders.

Trauma: Trauma can be understood as an experience that overwhelms an individual's capacity to cope. Trauma can result from a series of events or one significant event. Trauma may occur in early life (e.g., child abuse, disrupted attachment, witnessing others experience violence, or neglect) or later in life (e.g., accidents, war, unexpected loss, violence, or other life events out of one's control). Trauma can be devastating and can interfere with a person's sense of safety, sense of self, and sense of self-efficacy. Trauma can also impact a person's ability to regulate emotions and navigate relationships. People who have experienced trauma may use substances or other behaviours to cope with feelings of shame, terror, and powerlessness.

> *Intergenerational Trauma*: The transmission of historical oppression and unresolved trauma from caregivers to children. The concept of intergenerational or historical trauma was developed by Indigenous peoples in Canada in the 1980s to explain the cycle of trauma they were seeing in their communities due to the residential school system, loss of culture, and colonization more broadly. May also be used to describe the emotional effects, adaptations, and coping patterns developed when living with a trauma survivor.

Trauma-Informed Practice: Health care and other services grounded in an understanding of trauma that integrate the following principles: trauma awareness; safety and trustworthiness; choice, collaboration, and connection; strengths-based approaches, and skill-building. Trauma-informed services prioritize safety and empowerment and avoid approaches that are confrontational.

Tolerance: Tolerance develops when the normal amount of a drug or medication no longer causes the same effects, requiring more to be taken to achieve the desired effect.

Withdrawal: Withdrawal occurs when someone who has become physically dependent on a substance stops or significantly reduces that substance. Withdrawal symptoms vary somewhat with the specific substance but often include restlessness, agitation, insomnia, and anxiety. Depending on the substance, it can also include severe flu-like symptoms (opioids), seizures (alcohol and benzodiazepines), and paranoia (cocaine).

Withdrawal Management: The use of medical management (which may include medication) to reduce withdrawal symptoms and withdrawal-related risks when an individual stops using opioids or alcohol in pursuit of abstinence. This terminology represents a deliberate shift away from the use of "detox" or "detoxification" to refer to medically supervised withdrawal from substances. It should be noted that unsupervised alcohol withdrawal can be very dangerous, and withdrawal management alone (that is, detoxing without further treatment) from opioids has a very high rate of relapse. See page #43 for more information.

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