



Provincial Child and Youth Substance Intoxication and Withdrawal Guideline for Acute Care Settings

Acknowledgements and Commitments

Land Acknowledgment

As a provincial health improvement network, we operate on the unceded traditional and ancestral lands of First Nations across British Columbia (BC). Our main office is located on the traditional and ancestral lands of the Musqueam, Squamish, and Tsleil-Waututh Nations. We acknowledge the traditional and ancestral lands and territories of First Nations throughout BC in which the contributors to this resource work, live, and play. We also acknowledge the generations of First Nations, Métis, and Inuit from elsewhere in “Canada” who call these lands and waters home. We wish to honour the strength and beauty of the diverse Indigenous cultures, practices, beliefs, and values that have thrived on these lands for thousands of years.

Commitment to Eradicating Indigenous-Specific Racism

We are committed to eradicating Indigenous-specific racism and advancing Indigenous cultural safety and humility. We acknowledge the harms resulting from ongoing colonization, systemic discrimination, and Indigenous-specific racism that continue to impact Indigenous health and wellness inequities. We understand that we have a responsibility to identify, interrupt, and redress the impacts of colonialism on Indigenous peoples health and wellness and are committed to adopting and supporting culturally safe, humble, and trauma-informed practice and care that honour the inherent strength and resilience of Indigenous peoples and address Indigenous health and wellness inequities; embedding intentional and explicit consideration of Indigenous health and wellness through tools, resources, guidelines, processes, practices, and frameworks required for structural and systemic transformation; and continuing to educate our team through established programs and resources to build a more compassionate and informed workforce to create a meaningful, safe and healthy difference for Indigenous children, families and communities.

Some readers may not be familiar with the colonial context of Canada and its harmful legacies, nor of the ways in which Indigenous-specific racism has been hardwired into the policies, processes and practices of the health care system. If this history is unfamiliar, we strongly recommend that readers take the initiative to pursue additional learning to ensure we as a community identify and respond to Indigenous-specific racism, disrupt status quo ways of working that perpetuate systemic racism, and ultimately work towards creating a health care environment that is safe, equitable, and free of racism and discrimination for Indigenous children, youth, and

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families. This work is necessary to create an environment free of violence where First Nations, Inuit and Métis peoples are able to access and receive culturally safe, quality care.

A commitment to gender-inclusive language

Throughout this document, the terms “children,” “youth,” “families”, and “chosen supports” are utilized as broadly inclusive terms embracing Two-Spirit peoples, cisgender, transgender, gender non-binary, and gender non-conforming.

Acknowledging our Partners

The development of this guideline was co-led with BC Children’s Hospital. Child Health BC and BC Children’s Hospital acknowledge the contributions of our network partners and their participation on the Provincial Child and Youth Substance Intoxication and Withdrawal Working Group and Sub-Group members and the British Columbia Centre on Substance Use (BCCSU) Youth Health Advisory Council in developing this guideline.

The BCCSU Youth Health Advisory Council reviewed this guideline and contributed meaningful feedback from the perspective of young people. We extend our thanks to them and include the following statement from them:

The Youth Health Advisory Council has reviewed this guideline, and we acknowledge that our feedback was incorporated. We also want to emphasize the ongoing harms faced by young people who use drugs and young people experiencing poverty and homelessness in hospitals, healthcare, child welfare, criminal justice, and other institutional settings. We call for continued and meaningful engagement with young people at all drug policy tables. We really enjoyed working with this team specifically and how they listened to us and understood our needs.

While significant changes have been made, we acknowledge components of this guideline were first drafted for the September 2018 Child Health BC Provincial Substance Intoxication and Withdrawal Guideline for Children & Youth in the Emergency/Urgent Care Settings. We thank the contributors of the original 2018 provincial working group.

Guiding Principles

Child and Youth Centered Care

A philosophy that focuses on listening to young people and providing developmentally appropriate care according to the individual’s understanding of well-being and quality of life. Child and youth centered care emphasizes relationship building focused on trust and respect as well as collaboration between clinician(s) and a child/youth. Care should be individualized and involve a child/youth as active agents in clinical decision making. This includes identifying their chosen supports (e.g., family members, trusted advocates, Elders, friends, romantic partners, peers, other caregivers) and how they would like them to be involved.

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Family/Caregiver Support

An approach that recognizes families/caregivers, including other chosen supports such as trusted advocates, Elders, friends, romantic partners, peers, and other caregivers, in their key role of providing ongoing care and support to a child/youth. This approach is based in a philosophy that service delivery involves a partnership and recognizes that the child/youth's circle of support impacts their health, wellbeing, safety, and healing.

Strengths Based Approach

A strengths based approach emphasizes the identification and continued development of a child/youth and their family's strengths and resources. Building on the strengths of a child/youth promotes positive changes that are child/youth/family/caregiver centered and increases confidence. This can promote health and wellbeing while also supporting risk reduction.

Anti-Racism

Anti-racism is the practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is more than being "not racist" and involves taking action to create conditions of greater inclusion, equality, and justice.

Anti-Indigenous Racism

In the context of the colonial history of Canada, we acknowledge the historic and ongoing Indigenous-specific racism in the health care system. Indigenous-specific racism is the unique nature of stereotyping, bias, and prejudice about **Indigenous** peoples in Canada (First Nations, Metis, and Inuit) that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous peoples that perpetuates power imbalances, systemic discrimination, and inequitable outcomes stemming from the colonial policies and practices. All non-Indigenous clinicians and staff should undertake Indigenous cultural safety training and anti-Indigenous racism response training specifically focused on ending Indigenous specific racism and improving their ability to establish positive partnerships with Indigenous children, youth, and families seeking care.

Learning Links:

[In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care](#)
[San'yas Anti-Racism Indigenous Cultural Safety Training Program](#)

Cultural Safety and Humility

Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It notes the significance of holistic approaches where both traditional and western medicines are valued, which is known as two-eyed seeing. Cultural safety is an ideal that we are striving for where individuals feel safe when

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receiving health care. The desired outcome of safety can only be defined by the person receiving care.

Cultural humility is a life-long process of self-reflection and self-critique. It is foundational to achieving a culturally safe environment. Cultural humility begins with an in-depth examination of our own assumptions, beliefs and privilege embedded in our own understanding and practice. Cultural safety and humility are required when working with children/youth and their chosen support(s).

Learning Link: [Creating a Climate for Change - First Nations Health Authority](#)

Rights of Indigenous Peoples

In 2019, the Declaration on the Rights of Indigenous Peoples (DRIPA) established the [United Nations Declaration on the Rights of Indigenous Peoples](#) (UNDRIP) as the province's framework for reconciliation, called for by the Truth and Reconciliation Commission's Calls to Action. To support its implementation, a provincial action plan was created to focus on upholding Indigenous rights and addressing the inequities experienced by Indigenous Peoples by achieving the highest attainable standard for health and well-being.

Learning Link: [BC Declaration on the Rights of Indigenous Peoples \(BC DRIPA\)](#)

Trauma and Violence Informed Care

Trauma informed care is informed by an understanding of the ways in which trauma and adverse childhood experiences can change an individual's neurobiology, emotional regulation, and capacity for adaptive social functioning. Traumas can occur as single events, repetitive trauma, developmental trauma, and intergenerational and historical trauma. A trauma and violence informed care approach acknowledges the impacts of systemic and interpersonal violence and structural inequities on a person's life. The experience of systemic and economic marginalization increases risk of adverse childhood events and trauma. Experiencing trauma increases the risk of children and youth developing substance use related concerns. Protective and resiliency factors can mitigate these risks.

Trauma and violence informed practice focuses on listening to child/youth voices and perspectives, optimizing choice and control where possible, creating and supporting safer spaces, and involving their chosen supports where possible (e.g., family members, trusted advocates, Elders, traditional healers, friends, romantic partners, peers, and other caregivers). These approaches support emotional regulation, relationship development, and improved engagement and retention in health care. It also requires an understanding of power imbalances between children/youth and health care providers and how this can undermine safety in healthcare settings with the potential for re-traumatization.

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Learning Link: [Trauma & Violence-Informed Care for Health & Social Service Providers](#)

Stigma Free Care

Stigma against people who use substances results in discrimination, impacts health outcomes, and may prevent children/youth from accessing care. Stigma reduction is an important aspect of the provision of substance use care for young people. Stigma reduction requires a change in behaviours, language and attitudes on the individual, social, structural, and systemic levels towards acceptance, respect, and equitable, judgment free treatment for all. Stigma reduction requires health care providers to understand how stigmatizing language and disrespectful behaviour can affect the way people see themselves and impact their health seeking behaviour in the future.

Learning Link: [Canadian Centre on Substance Use and Addiction Resources on Stigma](#)

Recovery and Wellness Oriented

Recovery and wellness-oriented care can be understood as a process of change through which children/youth work towards their recovery and wellness goals to move towards holistic health and wellbeing. A recovery and wellness-oriented approach focuses on strengths and emphasizes hope, autonomy and engagement for a child/youth experiencing substance use concerns to live a satisfying, meaningful and purposeful life. Recovery-oriented care recognizes that recovery looks different for each individual and includes goals extending beyond strictly reducing their substance use.

Harm Reduction

Harm reduction can be understood as policies, practices, and programs that promote health and aim to minimize death, illness, and injury and reduce health, legal, and social harms from substance use. Harm reduction involves a range of support services and strategies to encourage youth to make the safest and healthiest choices they can based on their current circumstances. Harm reduction acknowledges that abstinence from substance use is not a suitable treatment goal for all individuals. Harm reduction prioritizes the building of trust and connection between the child/youth and service provider, meeting them where they are at and prioritizing their identified concerns.

Child Rights Approach

Canada is a signatory on the United Nations Convention on the Rights of the Child (UNCRC), a legally binding human rights treaty that sets out protection, promotion, and participation rights for young persons under the age of 18. Respecting the rights of children and youth is crucial for protecting and promoting their health and well-being. Article 24 of the UNCRC requires that: “parties recognize the right of the child to the enjoyment of the highest attainable degree of health”. It is universally accepted that health includes mental health and wellness.

Learning Link: [Convention on the Rights of the Child in child-friendly language](#)

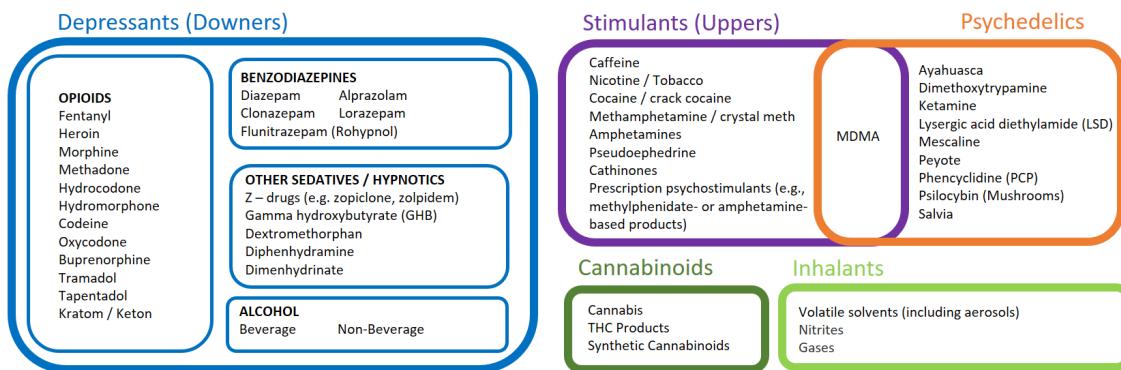
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Focus

The focus of this document is to guide [best and wise practices](#) for assessment, screening, and initiation of treatment and discharge planning for children and youth ages 10 to 18.99 years old* presenting intoxicated or undergoing [acute withdrawal](#) symptoms to acute care settings across British Columbia (BC). For additional guidance on treatment or toxicity information for intentional overdoses or unintentional ingestions/exposures, please consult BC Drug and Poison Information Centre (1-800-567-8911).

* *This guideline may contain relevant information for ages outside the scope of this document and clinicians may use their clinical judgement on a case-by case basis.*

This guideline includes recommendations for presentations related to intoxication and acute withdrawal from the following categories of substances. Please note the examples in each category are not an exhaustive list.



Site Applicability/Practice Level

This document applies to all health care providers working in acute care settings (as determined by your Health Authority (HA)), across British Columbia (BC). The focus of this document is to guide assessment, screening, initiation of treatment and discharge planning for children and youth ages 10 to 18 years old.

Need to Know

- Substance intoxication and withdrawal can be life-threatening and require a planned and coordinated approach to assessment and treatment.
- A presentation to hospital is an opportunity to screen for substance use related concerns and provide early intervention for the risks associated with substance use, including withdrawal syndromes.

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Guideline

Substance intoxication and withdrawal can be life-threatening and require a planned and coordinated approach to treatment. Emergent presentations can include intoxication, withdrawal, an interaction between substances and medications, or an exacerbation of mental health or physical health concerns in the context of substance use. Intoxication and withdrawal symptoms can differ among the different classes of substances. Assessment and treatment can include addressing acute medical concerns, supportive symptom management, safety planning, and if applicable treatment of a substance use disorder and/or concurrent disorder(s) where care is aligned with the child/youth's goals. People may present in acute withdrawal, or experience acute withdrawal when admitted to hospital for intoxication or another condition (e.g., medical, and/or psychiatric). It is important to note that a person's physiological, psychological, and behavioural reaction(s) to a substance depends on:

- Characteristics of the individual (e.g., age, size, sex, nutrition, mood)
- Trauma history (single events, repetitive trauma, developmental trauma, and intergenerational and historical trauma)
- Co-morbid medical and mental health concerns
- Pharmacology (pharmacokinetics and pharmacodynamics) of the substance(s) used
- Dosage and route of the substance(s) taken
- Side effects or unwanted effects of the substance(s) used
- The environment in which the substance(s) were used (Where? Who was the source? Was there coercion? Was it consensual?)
- Substances used in combination (including medicines, other substances, naturopathic remedies)
- Previous experience and tolerance with substance(s)
- Lack of awareness of what substances have been ingested or the potency of substances

Children/youth who use substances may have experienced inequitable care. Many youth who use substances have expressed not feeling safe interacting with healthcare providers and accessing healthcare (British Columbia Centre on Substance Use, 2022). Negative stereotyping and profiling leads to discriminatory behaviour by healthcare providers and poorer quality of care. As a consequence of historical and ongoing white supremacy, racism, discrimination, colonialism and social and economic inequality, Indigenous youth with substance use concerns are disproportionately impacted (Sikorski et al., 2019; Turpel-Lafond & Johnson, 2020). Through engagement, relationship building, anti-racist, and non-judgmental approaches to care, we can all contribute to more positive experiences for children/youth and their chosen support(s). When children/youth feel supported, safe, and physically comfortable, it can mitigate risks such as: choosing to leave before hospital/administrative discharge, vulnerability for toxicity events (overdoses), discomfort and stress, decreased participation in care, and/or lack of engagement with treatment services.

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A presentation to hospital is an opportunity to screen for substance use related concerns, and provide early intervention for the risks associated with substance use, including withdrawal syndromes. Youth may not present with classic signs and symptoms of withdrawal or substance use disorders. Intervention can be helpful even for experimental substance use. Treatment planning should be individualized and tailored to the child/youth's goals and respect that this may not always align with the goals of the healthcare team. This includes outlining supports such as pain management, mental health care, Opioid Agonist Therapy (OAT), harm reduction education and services, and coordinated discharge planning linking to community resources.

Engagement

Interactions with children, youth, and their chosen supports (e.g., family members, trusted advocates, Elders, traditional healers, friends, romantic partners, peers, other caregivers) should always be approached from a strengths-based perspective, with a trauma informed lens, and with attention to cultural safety and humility. Child and youth centered care emphasizes relationship building that is focused on trust and respect, as well as collaboration between healthcare providers and the child/youth. Always offer choice to the child/youth wherever possible to balance power and establish safety and trust.

Systemic racism within the healthcare system has led to harmful experiences that result in distrust of the system and its providers. We have the responsibility to create culturally safe and appropriate environments of care. When providing care to Indigenous children/youth and their chosen supports, be mindful of the impacts of colonization and inter-generational trauma, and recognize the inherent strengths of traditional and land-based practices.

- Relational practice is foundational to engagement.
- Health care providers should ensure they have completed the Indigenous Cultural Safety and Cultural Humility education required and/or recommended by their health authority (In Plain Sight Recommendation #20, TRC Call to Action #23); understand implicit biases and intersectionality; and have self-reflect on their personal values, assumptions, and belief structures.
- Healthcare providers should check in with themselves and consider their own assumptions about child/youth substance use and their overall position of power and privilege.
- Utilizing engagement strategies throughout all encounters with children/youth and their chosen supports is a key component of quality care and improves safety and comfort for all.
Learning Link: [Tips for engaging children and youth in acute care settings](#)
- When working with children/youth who use substances it is important to be open and curious and use respectful, non-judgmental, non-stigmatizing, developmentally appropriate, and gender inclusive language.
- Use language the child/youth is most comfortable with and let them guide the conversation.
 - Clinicians can open the conversation by asking the child/youth's name and pronouns.
To support relationship building, if you use the wrong name or pronouns acknowledge your mistake and use correct name/pronouns moving forward.

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- Use the child/youth's name whenever possible rather than "a person who" or a "child/youth who..." but continue to use people-first and non-stigmatizing language (i.e., "(name) uses opioids" vs "(name) is an opioid user").
- Instead of using the medical term for a substance the child/youth may prefer a street name (e.g., weed in place of cannabis). **Learning Link:** Refer to [Appendix A](#) for common street names for substances.
- Use strengths-based language. Focus care planning on the child/youth's own goals with respect to substance use, recovery and/or harm reduction.
- Ask child/youth if they would like access to cultural support/resources. For self-identifying Indigenous children/youth, ask if they would like to be connected with cultural wellness supports such as Indigenous patient navigators, liaisons, Elders, or traditional healers, recognizing their inherent right to traditional medicines and health practices (UNDRIP Article 24; TRC Call to Action #22). Individualized cultural supports and resources should be offered as early as possible to support children/youth and their families during their visit and through transitions in care.

Informed Consent, Confidentiality and Information Sharing

Informed Consent

Concerns related to informed consent are complex. The summary below may not provide the sufficient level of detail required for each unique situation. Please refer to your Health Authority specific guidance on consent to health care.

Learning Link: [Consent to Healthcare: Procedure for Minors and Mature Minors](#)

- Health care providers must seek informed consent before providing treatment.
- The [Infants Act](#) applies to anyone under the age of 19. Section 17 of the Infants Act provides that if certain requirements are met, a minor may provide consent to medical treatment.
Learning Link: [Legislative Guidance on Consent of "Minors" Infants Act](#)
- Health care providers are ethically obligated to involve children/youth in transparent discussions involving their health and treatment at every stage of decision making.
- In emergent situations¹ where the child/youth and/or guardian is not able to provide informed consent, health care providers have a duty to provide necessary treatment to preserve life until informed consent can be obtained (i.e., when the child/youth regains consciousness and is assessed for capacity to provide informed consent, or the minor's legal guardian can be contacted).
 - A minor may give consent to, or decline healthcare, if a health care provider is satisfied that the minor has capacity to consent, and the decision is deemed in their

¹ Emergent situations are defined in section 12 of the [BC Health Care \(Consent\) and Care Facility \(Admission\) Act](#).

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best interest. Capacity is demonstrated if the minor: understands the need for the proposed treatment/ intervention; understands what the health care involves; shows appreciation of the benefits and risks of receiving or not receiving health care; applies values to the decision; and makes a decision that is consistent with these values and consistent over time. If the provider has any doubt as to whether the proposed health care is in a minor's best interests, obtain a second opinion, as necessary.

- "Best Interests" means that the health care is, in the Most Responsible Practitioner's (MRP) clinical judgment, medically advisable, and would benefit the patient when balancing potential benefits and harms.
- Determination of "Best Interests" is also informed by child/youth wishes and is respectful of their culture and belief systems; considering relationships with chosen supports and the importance on their mental, emotional, physical, and spiritual well-being.
- For an Indigenous minor, "Best Interests" also includes maintaining the Indigenous minor's connection to their community, and to learning and practicing Indigenous traditions, customs, and language. This is in alignment with the rights of Indigenous children as described in the [United Nations Declaration on the Rights of Indigenous People](#) (UNDRIP) (UN General Assembly, 2007) and in the [Principles of Reconciliation](#) prefacing the Truth and Reconciliation Commission (TRC) (Truth and Reconciliation Commission of Canada, 2015).
- If a minor is deemed incapable of providing informed consent, the legal guardian is responsible for decision making in these circumstances, independent of the child/youth's agreement. The health care provider must make every reasonable effort to obtain informed consent from the minor's legal guardian. This should not delay treatment in emergency circumstances where there is a duty to preserve life. An explanation with rationale for the treatment should be provided as soon as possible after the event.
- A minor's capacity to consent should be reassessed for subsequent healthcare decisions as capacity may shift over time and is decision specific.
- In non-emergent situations, where a minor, or the guardian(s) of a minor, does not consent to health care and, two medical practitioners are of the view that the health care is necessary to preserve the child/youth's life or to prevent serious or permanent impairment to their health, the child/youth is considered to be in need of protection and the duty to report process should be followed as per below.
 - When there is reason to believe a child/youth is in need of protection, there is a duty to report the matter under the authority of Section 14 of the [BC Child, Family and Community Service Act](#). Contact the Ministry of Children and Family Development (MCFD) (1-800-663-9122) to make a report. If you are aware that an

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Indigenous child and family service law applies to the child/youth you can make the report to the applicable Indigenous authority providing services under that law. If you are unsure whether an Indigenous child and family service law applies to a child/youth or how to make a report under it, the report should be made to MCFD. Providers should also refer to their Health Authority's Child Protection policy.

- A child/youth does not need to be in the care of MCFD or an applicable Indigenous authority to obtain a Court Order authorizing the required care. The Director may apply for a court order authorizing the health care to be provided to the minor. Refer to Section 29 of the BC [Child, Family and Community Service Act](#).

Confidentiality and Information Sharing

- Children and youth have the right to confidentiality, and we need to respect a child/youths' wishes in relation to who is given information about their situation.
- Sharing information with chosen supports may be helpful in supporting treatment goals when done respectfully in partnership with the child/youth and with their consent.
- Personal health information can be shared with healthcare providers who form a patient's circle of care (e.g., specialists, lab technologists) for the purposes of ongoing care and treatment. For more information refer to Doctors of BC [Privacy and Security in the BC Health Care System Today](#).
- Disclosure without the consent of a capable minor is a breach of confidentiality. Disclosures may be considered when: 1) it is necessary for urgent medical treatment of the individual and consent cannot be obtained in a timely way; 2) compelling circumstances exist that affect the health or safety of any individual; 3) there is a need to contact a relative or friend of an injured, ill, or deceased individual; and/or 4) there is a duty to report the matter under the authority of Section 14 of the BC [Child, Family and Community Service Act](#) or applicable Indigenous child and family service law.
 - Refer to the [Freedom of Information and Protection of Privacy Act](#) section 33(3)(a) and (c) and section 18(1)(b), (k), and (l) of the [Personal Information Protection Act](#).
 - Healthcare providers should not assume that personal health information must be disclosed based on a mere request by a law enforcement authority. For more information refer to the College of Physicians and Surgeons of BC [Disclosure of Patient Information to Law Enforcement Authorities](#).
- Having a conversation about confidentiality and information sharing with a child/youth supports relationship building, trust, and youth centered care that is collaborative and reflective of a child/youth's priorities and needs.
- Confidentiality and the limits of confidentiality should be discussed with children and youth. It should be noted that breaking a child/youth's confidentiality may erode their trust in the healthcare system and lead them to disengage from potentially lifesaving care in the future.
- If there are emergencies in which healthcare providers consider contacting parents/guardians against a child/youth's wishes, they should:

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- Discuss with the child or youth the emergency circumstances in which they are obligated to inform parents/guardian.
- Be clear about the level of risk to the child or youth (or others) they are seeking to prevent.
- Discuss the child or youth's reasons for keeping information private to discover if there are better and safer ways to decrease this risk.
- See [Appendix B](#) for information sharing decision support tool.

Learning Link: [Best Practice Guide](#) on information disclosure for youth with mental health and substance use concerns

General Assessment & Treatment

Children/youth presenting intoxicated or in acute withdrawal require a comprehensive physical assessment, mental status assessment, suicidality and self-harm screening, patient history, substance use screening, and psychosocial assessment (Glowacki et al., 2022). Collateral information can support the assessment. During assessment and treatment provide environmental supports and calming interventions such as minimizing stimuli (e.g., quiet, reduced lighting) and offering for a support person to be present whenever possible. Close monitoring and frequent reassessment are required due to the increased risk of medical and psychiatric complications in children and youth. Substance specific guidance is provided in [Supporting Document: Table of Assessment and Treatment Recommendations \(Appendix D\)](#).

- Complete primary assessment and immediate interventions for stabilization (Airway, Breathing, Circulation, Disability, Exposure).
 - The physical exam should assess for signs of [toxicromes](#). See [Supporting Document: Table of Assessment & Treatment Recommendations by Substance](#).
 - In patients with profoundly decreased level of consciousness or respiratory depression refractory to initial antidotes, consider mixed substance ingestion.
- Complete secondary assessment including but not limited to a full set of vital signs (including blood pressure and temperature), Pediatric Early Warning Score (PEWS), neurological status (Glasgow coma scale), and mental status exam.
 - Temperature should be assessed due to risk of hypo- or hyperthermia dependent on substance taken and/or prolonged environmental exposure (Castro-Rodriguez et al., 2022; Shah & Baum, 2018).
 - Rule out possible medical or biological reasons for the presentation. Medical conditions may have symptoms that could be confused with substance intoxication or withdrawal. Examples include head injury, acute infection, chronic neurological disease (encephalopathy, epilepsy), electrolyte imbalance, cerebrovascular accident, hypoglycemia, metabolic disease (diabetes mellitus, adrenal gland involvement, thyroid disease), psychosis, severe liver disease, or cardiac conditions (rhythm disorders, congenital or acquired cardiopathy).

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- Assess for concurrent acute conditions such as head injury, recent sexual or physical abuse, pregnancy, skin integrity (cellulitis, phlebitis, abscesses, irritation, or rashes), and dehydration and/or impacts of malnourishment.
- Ask about what substance(s) they used, frequency, quantity, route of use and when they last used and assess for withdrawal symptoms. Ask about previous medical complications of use, such as overdose or complicated withdrawal.
 - For examples of substance specific tools for assessing withdrawal see [Supporting Document: Table of Assessment & Treatment Recommendations by Substance](#).
 - Note: The child/youth may have ingested more than one substance or be unaware of other substances that may have been ingested. You may not be able to determine what substance(s) and/or how much was used.
 - Collateral information can support the assessment including the review of PharmaNet for history/current list of medication(s) used.
- Assess specifically for suicidality and self-harm related to substance use.
- Order point of care glucose and serum toxicology (ethanol, acetaminophen, or salicylates).
- Depending on clinical circumstances, consider: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and intracranial imaging,
- Consider urine drug test (UDT).
 - The results of these tests can inform assessment of risk and are useful for ongoing treatment planning and interventions post-acute stabilization, including withdrawal management. It also supports harm reduction education with the child/youth by providing feedback about their substance use and a potentially toxic substance supply.
 - Results may not identify all types of substances or distinguish between members within a single class of medications. Conventional UDTs may not detect synthetic or semi-synthetic substances (Shah & Baum, 2018). It is important to understand the limitations and know what other medication(s) the child or youth may have been prescribed (e.g., psychostimulants, benzodiazepines).
 - See [Appendix C](#) for information on interpreting UDTs.
- Provide environmental supports and calming interventions such as minimizing stimuli (e.g., quiet, reduced lighting) and offering a chosen support person to be present whenever possible to prevent agitation (see [CHBC Least restraint Hierarchy of Safety](#)). Prompt treatment of increased agitation and/or changes in mental status may decrease safety risk to self-and/or others. Refer to [CHBC Chemical Restraint Algorithm](#) for treatment of increased agitation.
- Children/youth who appear to have stabilized after being intoxicated should be further assessed for any possibility of withdrawal. Early identification and treatment for withdrawal can prevent potentially life-threatening complications, reduce

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agitation, and support acceptance of ongoing assessment and treatment planning. It may also reduce rates of patient-initiated discharge and associated risks.

- Reassess and consider escalating to higher level of care as required per Canadian Triage Acuity Score (CTAS), PEWS, and/or health authority guideline/standards.

Substance Specific Assessment and Treatment

Medical stabilization is the priority for children and youth presenting to hospitals intoxicated or experiencing acute withdrawal symptoms. Antidote administration (where appropriate), observation, and supportive symptom management are the most common interventions described in literature (Pianca et al., 2017; Shah & Baum, 2018) and existing guidelines (Bukstein, 2021; Percival et al., n.d.; The Royal Children's Hospital Melbourne, n.d., 2019a, 2019b, 2020b, 2020a). Detailed guidance on assessment and treatment recommendations by substance is outlined in [Supporting Document: Table of Assessment and Treatment Recommendations \(Appendix D\)](#).

Consultations

Clinicians are encouraged to access site/regional health authority resources following local Child Youth Mental Health Substance Use (CYMHSU) pathways and/or consult provincial resources.

- [24/7 Addiction Medicine Clinician Support Line](#) (1-778-945-7619) is available 24 hours a day through the BC Centre on Substance Use (BCCSU) for questions regarding management (for physicians, nurse practitioners, pharmacists, registered nurses and psychiatric nurses, midwives, and addictions support staff in Indigenous communities).
- [BC Drug and Poison Information Centre](#): (1-800-567-8911) is available 24/7 for treatment or toxicity information for intentional overdoses or unintentional ingestions/exposures. Health professionals needing therapeutic drug information (i.e., not emergency), can also call the Drug Information Line Monday to Friday, 9 am to 4 pm at 1-866-298-5909 (note: this service is not for the public).
- [BC Children's Compass Program](#) (1-855-702-7272) is available Monday to Friday 09:00 to 17:00 and supports providers with information, advice, and resources about care for children and youth (0-25 years) living with mental health and/or substance use concerns (accessible to all providers).
- [FNHA Virtual Substance Use and Psychiatry Service](#) (1-833-456-7655) is available Monday to Friday 09:30 to 17:30. This service can support healthcare providers in ensuring that local knowledge is incorporated in care planning and that there is continued support between appointments. The substance use service is available for children/youth 12 years and up.
 - [Rapid Access to Consultative Expertise \(RACE\)](#) for Addiction Medicine is available Monday to Friday 08:00 to 17:00 (for physicians, medical residents, nurse practitioners, and midwives).

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Screening, Brief Intervention, Referrals, Harm Reduction & Discharge Planning

Admission to acute care settings is an opportunity to use screening, brief intervention, and referral to treatment (SBIRT). SBIRT is an evidence-based approach that supports children and youth to increase insight and awareness regarding substance use and motivation to change. Screening is used to identify a child/youth's place on a spectrum from non-use to substance use disorder, in order to deliver an appropriate response. Screening with all children/youth should occur as soon as the child/youth can safely participate. The child/youth's current substance use in the context of psychosocial stressors should also be considered. Brief intervention is based on motivational interviewing techniques aimed at understanding the benefits and concerns surrounding substance use, and developing realistic and attainable child/youth centered goals to support wellness.

Children/youth, and their chosen supports benefit from effective discharge planning and transition processes. When a child/youth visits an acute care setting for substance intoxication and/or withdrawal, it is expected that a discharge plan with child/youth centered treatment goals (including appropriate referrals) and harm reduction education is developed following stabilization, in collaboration with the child/youth and chosen supports. The discharge planning process should be a collaborative process that begins as soon as the child/youth arrives at the emergency department or is admitted to an inpatient unit.

Screening

- When the child/youth can safely participate, all children and youth presenting to acute care settings for substance intoxication or withdrawal concerns should be screened for substance use disorders (Bukstein, 2021; Krebs et al., 2021). The [CRAFFT 2.1+N](#) or [S2BI](#) are validated options for substance use screening that are child/youth specific (Knight et al., 2002; S. Levy et al., 2014; S. Levy & Shrier, 2015).
 - Having this conversation with the child/youth privately may facilitate open and honest disclosures. If parent/caregiver or other chosen support is present, ask to give privacy for a moment and then explain to child/youth that you will be taking a substance use history and ask if they prefer for parent/caregiver or chosen support to be present or not.
- Take a detailed substance use history, using an open and non-judgmental approach. Offer an explanation as to why it is important to their ongoing care and how the information is going to be used. Ask about age of first use, what substance(s) they use, frequency, quantity, route of use, when they last used, and assess stage of change to support harm reduction and treatment planning with the child/youth.
 - The stage of change model describes the stages people go through when changing their behaviour: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, maintenance, and/or re-occurrence (Centre for Addiction and Mental Health, 2023).

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- Identifying the individual's stage of change can help pair specific treatment recommendations with their own identified goals. Motivational interviewing techniques can be utilized to help guide the individual along the stages of change.
 - ***Learning Link: [The Stages of Change Model - YouTube](#)***
- All children and youth presenting with intoxication and withdrawal should have an assessment completed to screen for co-occurring psychosocial and mental health concerns. Examples of tools to support assessment include [HEARTSMAP](#) (Virk et al., 2018), [HEADSS](#), [HEADS-ED](#) (Cappelli et al., 2012; Newton et al., 2017), and the [DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Child Age 11-17](#). Psychiatry consultation may also be required, following your health authority process.
- Thank the child/youth for sharing information with you and ask if they have any questions.

Brief Intervention

Brief intervention is used to raise child/youth awareness of the benefits and concerns surrounding substance use, elicit internal motivation for change, and help set behavior-change goals, ideally using a motivational interviewing approach (Diestelkamp et al., 2016; Foxcroft et al., 2016; Kohler & Hofmann, 2015; S. J. L. Levy & Kokotailo, 2011; Newton et al., 2013; Yuma-Guerrero et al., 2012).

- Use of brief intervention should be guided by the screening that is conducted.
- Provide feedback on the screening results to the child/youth.
- Advise the child/youth through education that includes but is not limited to the risk(s) associated with substance use.
- Build on the child/youth's strengths to promote positive changes.

Referral to Supports and Services and Creating the Discharge Plan

- Referral to supports and services is intended to facilitate access to and engagement in specialized services and coordinated care for a child/youth.
- Consider consultation or referral to an addiction provider if there is an identified risk for substance use disorder based on screening completed.
- Engage the child/youth and chosen support(s) (as appropriate) in setting goals for wellness and provide relevant resources and referrals.
 - Individualized, multi-dimensional approaches to treatment are valued by youth and allow them to work toward futures not defined by substance use and mental health crises.
 - To support developing a holistic care plan (e.g., mental, physical, spiritual, and emotional) explore supports that respects the individual's culture, customs, values, and beliefs (UNDRIP Article 24; TRC Call to Action #22; A Path Forward Strategic Action J3).
 - Youth may prefer treatment modalities that give them more control and subject them to less surveillance.

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- Pharmacotherapies should be presented as one piece of a larger plan that includes housing, employment, income, social, and cultural supports.
- Medications for substance use disorders such as opioid agonist therapy (OAT), psychotropic medications, or nicotine replacement therapy (NRT) should be discussed with youth and should include discussion on what kind of medication would work best for them, potential timelines, and the possibility of tapering doses.
- Inform child/youth and chosen supports about the voluntary nature of community resources.
- Complete referrals to appropriate inpatient and/or outpatient community services.
- If safety concerns have been identified, complete a safety plan prior to discharge with the child/youth and chosen supports.
- Address any questions and education requirements including harm reduction.
- Ask youth if they have any other health questions or concerns (i.e., sexual health) and connect them to appropriate community resources.

Harm Reduction

Harm reduction involves a range of support services and strategies to encourage children/youth to make the safest and healthiest choices they can based on their circumstances. Harm reduction aims to promote health and prevent and minimize harm (death, illness, and injury) related to substance use and the broader social context in which people use substances. It is also an approach to care that acknowledges that abstinence from substance use is not a suitable treatment goal for all individuals. Harm reduction prioritizes the building of trust and connection between the child/youth and service provider, meeting them where they are at and prioritizing their identified concerns.

- Ask child/youth what harm reduction strategies they currently use (if any)
- Encourage child/youth to use in a safe environment such as a [supervised consumption service, overdose prevention site](#), or with trusted peers.
- Encourage child/youth not to use substances alone and if using alone to consider the [Lifeguard](#) Application's "Use Alone" timer that will send emergency services to a user's location if a person becomes unresponsive after consuming substances.
- Recommend they start by taking a small amount and wait to see how it affects them before using more e.g., "Start low and go slow."
- Recommend they only use one substance at a time. For more information on mixing medicine, alcohol and drugs share www.drugcocktails.ca .
- Recommend testing substances using fentanyl tests and/or drug-checking services to screen substances where available. See available [drug checking locations](#).
- Review safer substance use practices, including where to access sterile supplies (e.g., syringes, pipes) and safer consumption services and overdose prevention sites.

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- Offer a Take Home Naloxone Kit and training to all youth who use substances as they may also witness someone overdose due to the toxic illicit drug supply (Koh et al., 2020; Love et al., 2022).
- Provide evidence-based information on substances (e.g., percentage of alcohol in beer versus hard liquor)

Indigenous harm reduction moves beyond a focus on individual safety and includes undoing the harms of colonialism that place Indigenous people at a higher risk of harm from substance use (Interagency Coalition on AIDS and Development (ICAD), 2019). A decolonized and Indigenized approach is strengths based, re-connects children and youth to culture, and focuses on building relationships with the interconnected natural, human, and spiritual worlds. This can include connecting children and youth to Elders, traditional healers, community, and traditional practices, such as opportunities to participate in ceremonies, Indigenous arts and crafts, storytelling, language revitalization, and traditional land-based activities (TRC Call to Action #22; A Path Forward Strategic Action J).

Learning Link: [Indigenous Harm Reduction](#)

For more information on harm reduction and reducing risk review the following resources:

- [Toward the Heart](#)
- [Overdose prevention and supervised consumption sites](#)
- [Canada's Low Risk Drinking Guidelines](#)
- [Canada's Lower Risk Cannabis Use Guidelines](#)
- [BCCSU Risk Mitigation Guidance Update](#)

Communicating the Discharge Plan

- Engage with the child/youth and their chosen support(s) in determining who receives information about them (see [Appendix B](#)) and seek permission to share this information with other providers in their ongoing care team such as:
 - Primary care provider
 - Specialist provider
 - Substance use services
 - Existing mental health clinician(s) or other wellness supports (e.g., Child Youth Mental Health clinician, school clinician)
- Share the discharge plan with identified service providers. When possible, provide a warm handover to support youth connection to the service.
 - If follow up appointments have been scheduled or are required, ensure child/youth and/or chosen support(s) are aware of details or the need to arrange appointments.

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Related Documents

Provider Resources

Type of Resource	
General Resources	<ul style="list-style-type: none">• Compass Mental Health• BC Centre On Substance Use• Child Health BC Mental Health and Substance Use Initiatives
Guidelines	<ul style="list-style-type: none">• Child Health BC Least Restraint Guideline• Consent to Healthcare: Procedure for Minors and Mature Minors• Canada's Low Risk Drinking Guidelines• Canada's Lower Risk Cannabis Use Guidelines• BC Centre on Substance Use Opioid Use Disorder Youth Guidance
Education	<ul style="list-style-type: none">• Substance Use / Concurrent Disorders Toolkit• Engagement and Relationship Building Learning Activities• Mental Health Screening and Assessment Learning Activities• Supporting Emotional Regulation Learning Activities• Trauma Informed Practice Guide• Trauma & Violence Informed Care Toolkit - Equip Healthcare
Indigenous Health	<ul style="list-style-type: none">• United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) Report• Principles of Reconciliation• Truth and Reconciliation Commission of Canada: Calls to Action• In Plain Sight Report• Indigenous Harm Reduction (fnha.ca)
Working with Youth	<ul style="list-style-type: none">• BCCSU Harm Reduction Calls to Action and Youth Voices on Treatment Report• Gender Inclusive Language
Harm Reduction	<ul style="list-style-type: none">• Toward the Heart• Lifeguard App• Indigenous Harm Reduction (fnha.ca)• Overdose prevention and supervised consumption sites

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Family and Youth Resources

Type of Resource	
Youth Focused Support and Information	<ul style="list-style-type: none"> • Foundry (Direct clinical support in addition to information) • Youth Mental Health and Wellbeing Wellbeing.gov.bc.ca • Drug Cocktails • SMART Recovery Teen and Youth Support Program • Young People and AA • British Columbia Region of Narcotics Anonymous
Information and Supports for Families / Caregivers	<ul style="list-style-type: none"> • Kelty Mental Health • Family Smart • Wellbeing by the Ministry of Mental Health and Addictions • Here to Help : From Grief to Action Coping Kit • Addiction. The Next Step Toolkit • SMART Recovery Family and Friends • Alanon Family Groups • Naranon Family Groups
Alcohol and Drug Information Referral Service	<ul style="list-style-type: none"> • Contact ADIRS toll free at 1-800-663-1441
Harm Reduction	<ul style="list-style-type: none"> • Toward the Heart • Lifeguard App • Indigenous Harm Reduction (fnha.ca) • Overdose prevention and supervised consumption sites

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Definitions

“Acute withdrawal” is defined as a “group of symptoms of variable clustering and severity occurring after persistent (can be as little as a few days) use of that substance.” (Percival et al., n.d.)

“Best Practice” means a practice that has been shown by research and experience (including lived and living experience) to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.

“Indigenous” in Canada is an overarching term that includes First Nations, Inuit, and Métis peoples, either collectively or separately. It is the term many Indigenous individuals in Canada prefer and is part of the title in the *United Nations Declaration on the Rights of Indigenous Peoples*. One should ask Indigenous individuals, families, and communities how they want to be identified.

“Toxicdrome” A toxicdrome (toxic syndrome) is characterized by a classic constellation of symptoms and signs due to the toxic effects of chemicals in the body. Toxicdrome recognition is important for rapid detection of the suspected cause and helps focus the differential diagnosis to those few chemicals which have similar toxic effects (The Royal Children’s Hospital Melbourne, 2020b)

“White Supremacy” is the idea (ideology) that White people and the ideas, thoughts, beliefs, and actions of White people are superior to Indigenous and Black People and People of Colour and their ideas, thoughts, beliefs, and actions. The term “White supremacy” also refers to a political or socio-economic system where White people enjoy structural advantage and rights that other racial and ethnic groups do not, both at a collective and an individual level.

“Wise Practices” are strengths-based actions, tools, principles, or decisions that are culturally appropriate and community driven. Wise practices recognize the wisdom in Indigenous communities, cultures, traditions, languages and knowledge. The concept of wise practices recognizes that culture matters.

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	Cynthia Russell	Clinical Nurse Specialist – Mental Health
Fraser Health	Bill Bousquet	Indigenous Cultural Advisor
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Provincial Sub-working Group on Substance Specific Guidance

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Appendices

- [Appendix A: Common Street Names for Substances](#)
- [Appendix B: Child & Youth Information Sharing Decision Support Tool](#)
- [Appendix C: Interpreting Urine Drug Tests \(UDT\)](#)
- [Appendix D: Assessment and Treatment Recommendations by Substance](#)

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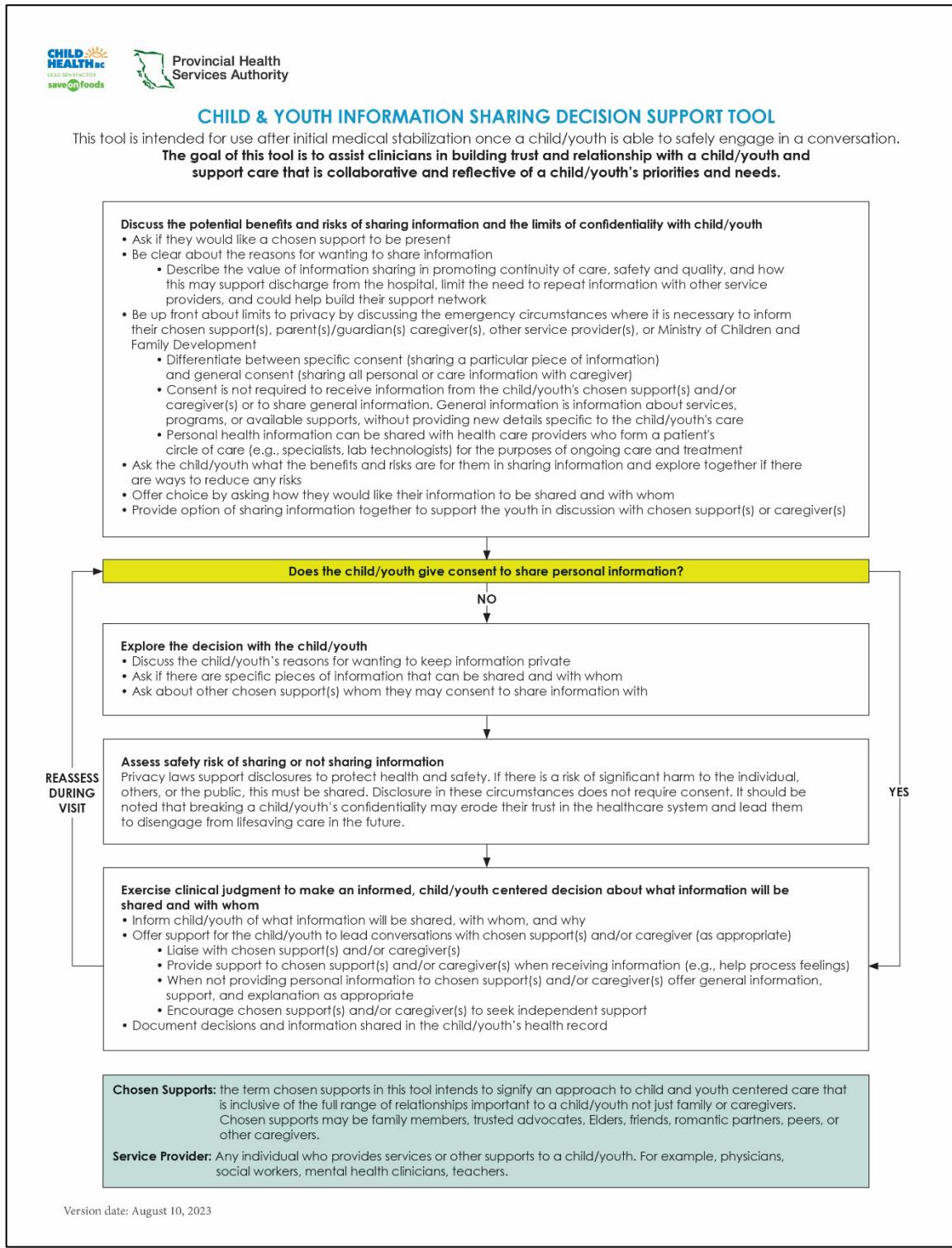
Appendix A: Common Street Names for Substances

There are many names used for different substances. These names can be abbreviations or reflect the substance's colour, shape, place of origin, or how it affects behaviour. The names being used are highly variable between regions and can change rapidly. The following list is a glossary of common "street names" used in British Columbia at the time of publication and is subject to change.

	Generic Name	Street Names
Depressants (Downers)	Codeine	Lean and Sizzurp (codeine cough syrup)
	Fentanyl	Down, pants, fent
	Heroin	Smack, hard stuff, horse, junk, point, H, dope, China white (heroin w/ cocaine – speedball)
	Benzodiazepines	Bars, Benzos, Blues, Chill Pills, Downers, Nerve Pills, Planks, Tranks, Xans, Xannies
	Gamma hydroxybutyrate / GHB	G, GH, juice, liquid ecstasy, liquid x, fantasy
Stimulants (Uppers)	Amphetamine	Speed, bennies, glass, crystal, crank, pep pills, uppers
	Cocaine	Coke, blow, lines, coca, coco, snow, powder, Charlie, dust, snowflake
	Crack Cocaine	Crack, rock, freebase
	MDMA	Ecstasy, E, XTC, X, molly, Love Drug,
	Methamphetamine	Meth, crystal meth, side, speed, jib, ice, crank, glass, chalk, crystal,
Psychedelics	Ketamine	Special K, K, Vitamin K, Ket, Ketty
	LSD	Acid, Acid Cap, blotter, micro, microdots, bulls eye, big D
	Mescaline	Peyote, mesc, mess
	PCP	horse, angel dust, TH, Peace Pill, Crazy Eddie
	Psilocybin / Mushrooms	Mush, magic mushrooms, shrooms
Cannabinoids	Cannabis	Marijuana, weed, pot, bud, green, herb, flower, hash
	Synthetic cannabinoids	K2, spice
Inhalants		Glue, gas, sniff (solvents), whippets (nitrous oxide), poppers, snappers, aromas

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Appendix B: Child & Youth Information Sharing Decision Support Tool



Version date: August 10, 2023

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Appendix C: Interpreting Urine Drug Tests (UDT)

This resource is available on the Child Health BC website as a Print File PDF.

https://www.childhealthbc.ca/mhsu/interpreting_urine_%20drug_tests/printfile

Appendix D: Assessment and Treatment Recommendations by Substance

This table is available on the Child Health BC website as a Print File PDF.

https://www.childhealthbc.ca/mhsu/table_assessment_treatment_by_substance

Effective Date:	DD-MMM-YYYY			
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