

Alcohol, cannabis, cocaine...
heroin, crystal meth, ecstasy...
mushrooms, inhalants, prescription

REGIONAL
DISPARITY

TAKE A
NUMBER

A Review of Youth Substance Use Services in B.C.

May 2016

SERVICES



NEED HELP WITH
TRANSITIONS

COMMUNITY
BASED

CUT
WAIT
TIMES

Non-judgmental



REPRESENTATIVE FOR
CHILDREN AND YOUTH

May 26, 2016

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting the report *A Review of Youth Substance Use Services in B.C.* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 6(b) of the *Representative for Children and Youth Act*.

Sincerely,

A handwritten signature in black ink, reading "meturpellafond", is centered on the page. The signature is written in a cursive, flowing style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Ms. Jane Thornthwaite, MLA
Chair, Select Standing Committee on Children and Youth

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Executive Summary

Substance use plays a key role in many critical injuries and deaths of youth who come into contact with the Ministry of Children and Family Development (MCFD). This reality – combined with concerns reported to the Representative by youth, families and professionals involved in substance use services in B.C. – prompted the Representative to examine the system of youth substance use services in the province.

Recent reports by the Representative have highlighted substance use as an issue of concern, including: *Paige's Story – Abuse, Indifference and a Young Life Discarded*; *Lost in the Shadows – How a Lack of Help Meant a Loss of Hope for One First Nations Girl*; and, *Still Waiting – First-hand Experiences with Youth Mental Health Services in B.C.* These reports show that substance use plays a significant part in the lives of many adolescents in B.C., and that youth often face difficulties accessing services and supports appropriate to their unique needs when it comes to alcohol and other drugs. Substance use by youth in B.C. has also become a more high-profile issue in recent months, with the Minister of Health and the Provincial Health Officer taking the unusual step of declaring a public health emergency after more than 200 fentanyl overdose deaths occurred in the first three months of 2016.

This review focuses on publicly funded specialized youth substance use services, how available these services are between and within health authorities across B.C. (e.g. hours of operation, age limits), and how responsive these services are to the unique needs of some distinct groups of youth (e.g. Aboriginal youth, LGBT2Q+¹ youth, pregnant and/or parenting youth). This review also examines the adequacy of important system components, including policy and standards, quality assurance and workforce capacity. While this report examines the availability of services such as residential treatment, it also focuses on other important components of a well-rounded system of care, including low-barrier community-based services. Residential treatment is not always the best or most appropriate service option for youth. Instead, many youth are adequately served by these community-based services.

The problems with youth substance use services that this report identifies are not unique. B.C.'s Office of the Auditor General recently released a performance audit of services in the adult tertiary mental health system, and many of the findings of that report echo the ones in this report, specifically: a lack of standards; a lack of quality assurance processes; a lack of clear province-wide direction; and, a lack of proactive planning.

The findings of this review point to numerous gaps in the system of youth substance use services. In fact, they reveal the absence of an actual “system” with no single entity responsible for the planning and provision of services and no clear navigational path for youth and their families to follow. Across the health authorities in B.C., substance use services for youth are piecemeal, with sometimes poorly resourced community-based services, and a shortage of withdrawal management and residential services for youth. From an overall provincial perspective, services and supports differ considerably between health authorities in terms of how easy or difficult it is for youth and their families to access services.

These gaps and program differences can leave youth and their families confused and frustrated. There are too few adequately resourced low-barrier community-based services to address youth needs before they become a crisis and too few treatment beds available when youth are ready to commit to residential

¹ Lesbian, Gay Bisexual, Transsexual, Transgender, Queer, Two Spirit. The plus sign acknowledges the evolving aspects of sexual and gender identities.

treatment. In fact, there are only 24 publicly funded treatment beds in B.C., and, although the Ministry of Health is not able to say how many youth ages 13 to 18 meet the criteria for a substance use disorder (and there is no way of knowing how many of those youth will need residential treatment), we do know that about 68,000 youth ages 15 to 24 meet this criteria – a clear indication that the 24 publicly funded treatment beds in B.C. is a miniscule number. Said one service provider: “*We do our best to provide service to as many youth as possible and prioritize based on risk, but it is a challenge.*”

A further barrier to youth receiving the help they need is the multi-jurisdictional environment of services and supports for youth. Youth encounter difficulty in moving from school or hospital emergency departments – where a substance use problem may first be recognized – to community-based services. Often when youth make this move, they can face wait times that can discourage them from seeking further supports, although it is vitally important to ensure that services are available while the motivation to seek help remains strong. This lack of collaboration between system partners means lost opportunities for early identification and intervention.

Youth can also face specific barriers when they try to access services, such as lack of flexibility in hours of operation, lack of accessible locations, lack of transportation and lack of flexible or developmentally appropriate service options. Youth from vulnerable or marginalized populations may be even more reticent about approaching service providers due to issues around trust or because service options are not culturally appropriate or sensitive to gender and sexual identity.

It must be noted that, in the process of conducting this review, many dedicated service providers were encountered whose efforts to build a system of care have been hampered by lack of funding, lack of priority for substance use services at both the health authority and provincial levels and lingering discrimination directed at those who struggle with substance use. Despite these limitations, these champions have attempted to create youth-friendly services built around best practice and research on what works. These people deserve appreciation for their dedication to helping youth who are struggling with substance use issues.

In addition to systemic problems with the availability and appropriateness of services, this review finds that provincial leadership and an accountable strategic plan are missing when it comes to providing a robust system of youth substance use services in B.C. – much as the Representative concluded in her 2013 report *Still Waiting – First-hand Experiences with Youth Mental Health Services in B.C.*

The lack of provincial attention to issues such as standards for all youth services, of accreditation of smaller service providers, of specific requirements for screening and assessment to match clients to services, of standards for case management, of quality assurance processes such as data collection, and of support for broad-based anti-discrimination efforts all combine to result in a patchwork of services with little overall ministry-level quality assurance.

Because governmental planning must go beyond high-level commitments to mental health and substance use (MHSU) services, this report recommends that these issues be addressed as the first step towards establishing a comprehensive system of substance use services for youth in B.C.

This report’s recommendations include establishing a single point of leadership and accountability within the provincial government to address youth substance use and mental health issues; developing and implementing a five-year strategic plan to create a comprehensive system to prevent and treat these issues; and undertaking a broad-based educational effort to eliminate stigma and discrimination toward youth with substance use problems.

Scope and Methodology

Scope

This report reviews the full range of publicly funded specialized substance use services for youth in B.C. ages 13 to 18. Despite this age scope, interviewees and survey responses included information on the needs of youth ages 19 to 24 and these findings have been incorporated into this report. The review focuses on services delivered by B.C.'s health authorities and their contracted affiliates and funded by the Ministry of Health (MoH).

Specialized services are those intended to meet the needs of youth seeking help with substance use issues and usually employ staff who are trained specifically in substance use issues, as opposed to a broader range of youth issues. Although services for youth with concurrent mental health and substance use challenges are an important part of the system of care, this report does not focus on these services in detail. Because this review focuses specifically on services offered to youth as part of the health system (see Figure 4), it also does not examine services provided by MCFD that are limited to a small population of youth justice clients only, or services offered by private facilities.² This review constitutes one of the most complete scans of youth substance use services in B.C. to date.

To determine the scope of this review, the Representative consulted key best practice documents for youth services (Currie, 2001; Winters, Botzet & Fahnhorst, 2011; Alberta Alcohol Drug Abuse Commission, 2016) along with the report of the National Treatment Strategy Working Group, a pan-Canadian group of experts in the field of substance use treatment (NTSWG, 2008). These documents were supplemented by a scan of available materials on adolescent substance use from MoH and the extensive academic and non-academic literature in this field. Figure 4 on page 21 illustrates the types of services considered to be in scope for this review. Unfortunately, due to resource limitations, it was not possible to survey and assess services in Tiers 1 and 2 (health promotion and prevention).

Methodology

Youth substance use services are primarily delivered by the five regional health authorities as well as the Provincial Health Services Authority and the First Nations Health Authority. Oversight and stewardship of these services is the responsibility of MoH. Because responsibility for these services is spread across the health authorities and MoH, assembling information on youth substance use services required the cooperation of service providers, health authority contacts, MCFD and MoH officials.

This report was prepared using various information-gathering tools to understand the range of services offered to youth, how available these services are and how responsive they are to the needs of specific groups of youth. The findings presented in this report are derived from these data.

Questions were developed using the materials described above. With the help of MoH and health authorities, in the fall of 2014 an on-line survey was sent to all publicly funded service providers who offer youth substance use services in B.C. Survey questions asked for information on the types

² Youth justice substance use services (offered by MCFD) include counselling for clients in custody and 25 beds of residential care for youth justice clients in the community. Despite these services being out of scope, they are listed in Appendix 3.

of services offered, geographic locations, hours of operation, referral processes, age mandates, services offered to subpopulations of youth (e.g. Aboriginal youth), the use of screening and assessment tools, mental health and other supports, and quality assurance processes such as data collection. Approximately 75 per cent of service providers in the province responded to the survey. Information on missing services was gathered through on-line research and through interviews with service providers and health authority representatives.

To supplement the information gathered in the surveys, interviews were conducted with representatives in each regional health authority, the Mental Health and Substance Use Agency of the Provincial Health Services Authority, the First Nations Health Authority and MoH. Interviews were held between March 2015 and January 2016. A thematic analysis of the interviews was conducted to determine the key issues.

This review was guided by an external advisory committee of experts in the field of substance use (see Appendix 1) who helped verify data collection methods and commented on findings of this review. Youth substance use services throughout B.C. exist in a dynamic environment where changes occur on a regular basis. To the best of our ability, the services mentioned in this report are current as of spring 2016.

All names of interview respondents have been kept confidential to protect their privacy.

What substances are we talking about?

In this review, the survey to service providers asked if they could provide youth with supports for addressing problems with any of the following substances:

- Alcohol
- Tobacco
- Cannabis products (e.g. marijuana, hash)
- Other illegal drugs such as cocaine, heroin, amphetamines, methamphetamines (e.g. crystal meth), MDMA (Ecstasy), hallucinogens (LSD, magic mushrooms, peyote, ayahuasca), ketamine, rohypnol
- Inhalants/solvents (e.g. gasoline, paint thinner, glue)
- Prescription medications either used as prescribed or in other ways (e.g. benzodiazepines such as diazepam, lorazepam, alprazolam; opioids such as fentanyl, oxycodone, codeine).

This list is may not be inclusive of every substance youth may be using. For more information on individual substances, please visit *Here to Help: Mental Health and Substance Use Information You can Trust* at: www.heretohelp.bc.ca.

Why this Report?

Section 6(b) of the *Representative for Children and Youth Act* outlines the following responsibility of the Representative: “. . . monitor, review, audit and conduct research on the provision of a designated service by a public body or director for the purpose of making recommendations to improve the effectiveness and responsiveness of that service, and comment publicly on any of these functions.” The Act defines “designated services” as including “addiction services for children,” for anyone under age 19.

Substance use challenges for youth are evident in the everyday work of the Representative for Children and Youth (RCY). One of the many responsibilities of the Representative is to assist, inform and advise children and their families with matters relating to designated services. In the course of performing these duties, RCY advocates hear many stories of youth who are struggling with substance use issues

and unable to find appropriate services when they need them. Sometimes these calls come from desperate parents and other times from youth themselves seeking assistance.

The Representative is also charged with the responsibility of receiving reports of critical injuries and deaths of children and youth who were in the care of MCFD or receiving reviewable services within the previous year. Data collected from these reports shows that during the period 2011 to 2015, 17 per cent of the approximately 1,500 critical injuries reported to the Representative were primarily attributable to substance use. These injuries included overdoses and other injuries where substance use was identified as an immediate cause. In the same time period, 14 (7.7 per cent) of the 183 deaths of children and youth were attributable to substance use. These are very conservative estimates since substance use often contributes to accidents or death but may not be classified as the primary cause of an injury or death.

Background

This report draws from a health promotion perspective that views substance use as a health concern rather than a moral matter. A health promotion perspective echoes the pronouncements of the 1986 World Health Organization's (WHO) *Ottawa Charter*, which acknowledges the wider influences that affect health, including income disparities, geographic location, and experiences of discrimination based on Aboriginal status, race, sexual and gender orientation or physical and mental ability. This approach also goes beyond an individualistic and disease-oriented view of substance use and draws our attention to a variety of factors including life events, our family and community contexts, our biology and physical self and our choices, all of which help to shape substance use (*Here to Help*, 2013). Indeed, a health promotion approach is part of a wider shift from the prevention of harms to the promotion of positive environments that support child and youth well-being (Campie et al., 2015).

Substance Use: Why Language Matters

This review does not use words such as “abuse” when describing youth substance use. “*Terms such as ‘substance abuse’ have moral overtones. Abuse connotes an action where there is an abuser and a victim. Substances cannot be victims and it is not clear who is experiencing the abuse. But the term suggests moral culpability of the person using the substance and this is inaccurate and unhelpful.*” (*Here to Help*, 2013). It is important to remember that some youth who have substance use challenges have suffered abuse and calling their relationship with substances “abuse” is potentially triggering and clinically inaccurate.

This review also draws from a model that provides a holistic alternative to the biomedical model of illness (Borrell-Carrio, Suchman & Epstein, 2004). The bio-psycho-social-spiritual approach to substance use applied here recognizes that health issues such as problematic substance use derive from a multidimensional context, and that recovery must address all of these dimensions of life.

What are substances and substance use?

Put simply, substances are chemical “*compounds that affect activity in the brain and body*” (BC Partners for Mental Health and Addictions, 2013). Any substance that can change the way we feel, think and behave is a psychoactive substance (i.e. mind-altering). These include not just illegal substances such as cocaine, heroin and cannabis, but also legally regulated substances such as caffeine, alcohol and some prescription medications (e.g. benzodiazepines, opioid-based painkillers, some medications for Attention Deficit Hyperactivity Disorder). Far from being new inventions, some of these substances have been around in various forms for thousands of years (Ibid).

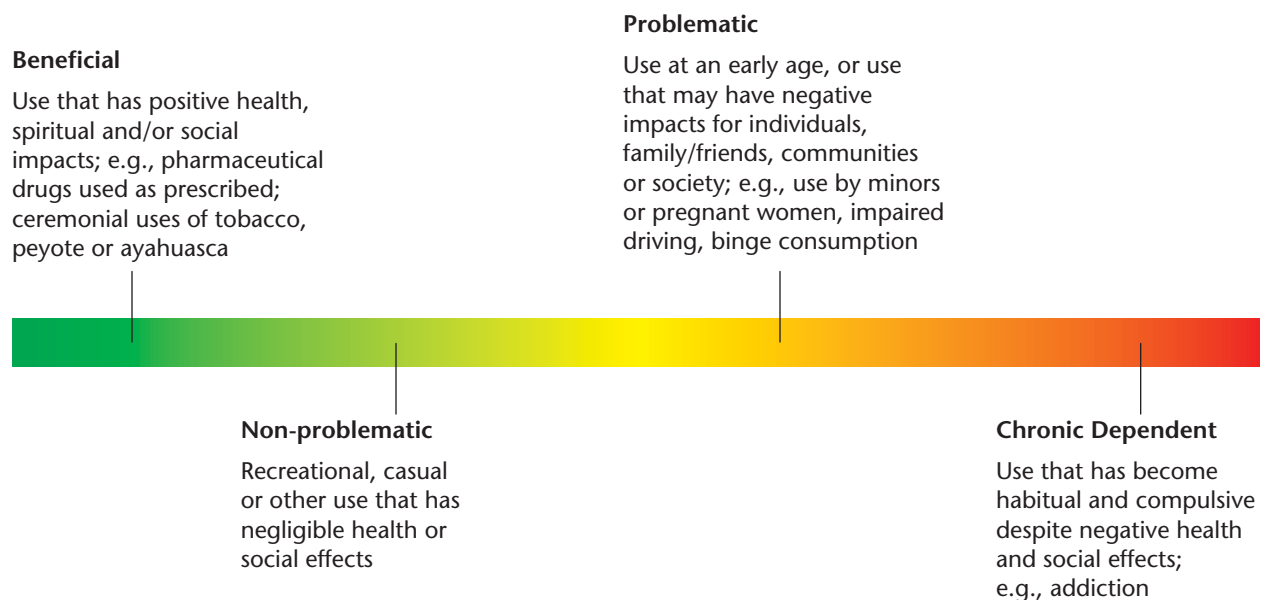
How a substance affects a person can depend on a number of factors (Ibid):

- the type of substance, its dose (e.g. how much), and its potency (e.g. beer versus spirits)
- the user (age, gender, substance use history including tolerance, mental health, overall physical health, etc.)
- the context of use (how much, how often, method of use – i.e. ingestion, smoking, injection – the atmosphere of the setting, with or without other substances).

There is a tendency to lump all illegal substances together as somehow more dangerous than substances that are available over-the-counter in pharmacies or by prescription. But substances such as pharmaceutical opioid-based painkillers (i.e. fentanyl) can also be risky, given the potential for users to become dependent or to overdose on these medications. Alcohol also carries significant health risks from both long-term heavy use (e.g. liver failure) and also from binge drinking that can result in alcohol overdose and accidents.

Substance use can be understood as a spectrum from beneficial use, to non-problematic use, to problematic use and chronic dependency as depicted by the diagram below from *A Path Forward: BC First Nations and Aboriginal Mental Wellness and Substance Use – 10 Year Plan* (First Nations Health Authority & B.C. Ministry of Health, 2013).

Figure 1: The Spectrum of Substance Use



Source: First Nations Health Authority. *A path forward: BC First Nations and Aboriginal mental wellness and substance use – 10 year plan*

Substance use can begin at one point along this spectrum and progress to more problematic use at a later time. For some people, use of one substance may be beneficial while use of another substance is problematic or harmful. While some people develop chronic dependency that may require intervention, many others do not, and many people who use substances suffer few, if any, harms and some benefits. As this spectrum suggests, the harms of substance use do not only stem from chronic use. Substance use can also be harmful from one-time use such as impaired driving leading to car accidents.

The purpose of seeing substance use along a spectrum is to help focus policies, programs and services along a continuum of approaches to promote health, prevent illness and reduce risks and harms. This approach to services and supports focuses not only on helping young people to make healthy choices but also on creating environments in which healthy choices are promoted and possible (Ibid).

Why do young people use substances?

The Representative recognizes the reality that some level of risk-taking by adolescents is normal and that young people, similar to adults, use substances for a variety of reasons. Sometimes young people use substances to:

- “Feel good” – have increased feelings of power, self-confidence, increased energy, or to relax and promote satisfaction
- “Feel better” – to reduce social anxiety and stress or to relieve the distress associated with trauma and abuse
- “Do better” – by increasing their performance, keep going, etc.
- Discover new feelings/insights or because of curiosity (*Here to Help*, 2013, p. 3).

The reasons youth use substances are also important to understanding their risks (e.g. using substances because of curiosity versus using substances to compensate for life’s difficulties and deficits) (Ibid). The likelihood of developing substance use problems increases when young people are using substances over the long term to deal with problems such as lack of housing and/or past experiences of abuse and neglect (Ibid., 2013, p. 5).

Survey data from the *B.C. Adolescent Health Survey* indicates that youth were most likely to use substances for fun (65 per cent), because their friends were using them (33 per cent) or because they wanted to experiment (28 per cent). Youth with mental health or emotional concerns were more likely than their peers to use substances to manage stress or sadness and were more likely to have used substances other than marijuana and alcohol. Youth with a physical disability or long-term illness (such as diabetes or asthma) were more likely than youth without physical issues to use substances to manage their pain. Youth with a chronic health condition or disability were not only more likely to be earlier marijuana users but were also more likely to be current heavy users (Smith et al., 2014).

The Role of Human Rights

Respect for human rights is a dynamic factor that can shape patterns of harmful substance use. Similar to adults, youth have a right to the best possible health services as outlined by Article 24 of the *UN Convention on the Rights of the Child*. Proper access to health care services can be undermined by discriminatory attitudes and behaviour of health care workers.

Applying a human rights framework to substance use can help us recognize how state-level policies can contribute to substance-related harms. The violation or neglect of young people’s rights, including their rights to information, education, recreation and an adequate standard of living, can increase the risks of problematic substance use. In Canada, systematic violations of human rights, such as the lasting negative effects of residential schools on Aboriginal communities, can also increase the likelihood of problematic substance use in adolescence and later in life. These examples reflect the mutually reinforcing and dynamic relationship between human rights, health and concepts such as risk and vulnerability (Gruskin, Plafker & Smith-Estelle, 2001).

Protective and risk factors

Numerous issues – rather than one key factor or experience – influence the development of substance use problems in young people. One of the most prominent approaches for describing risk and protective factors is the social-ecological model, which categorizes influences into levels depending upon their proximity to the individual. Below is a list of potential risk factors for problematic substance use by youth, organized according to level of influence:

- individual (personality, developmental delays, early use of substances, social skills deficits) (Schwartz et al., 2007; Wekerle et al., 2009)
- family and other adults (low family economic status, mental illness, family conflict, coercive or poor parenting skills, lack of parental monitoring, neglect, sexual and physical abuse) (Ryzin et al., 2012; Feldstein & Miller, 2006)
- peer (peer rejection or peer influence on risk-taking behaviours)
- school (lack of academic progress and success, commitment to school)
- community (neighbourhood poverty, income disparity) (B.C. MoH, 2006)
- government policies that can have a direct impact on the lives of individuals (e.g. residential schools, lack of access to health care, lack of evidence-based public health policies on alcohol and other drugs) (Allison et al., 1999; Connell et al., 2010).

Some groups of youth are at higher risk of experiencing problematic substance use, including runaway and street-involved youth, youth in custody, youth with co-occurring mental health issues, sexually abused and exploited youth, First Nations, Inuit and Métis youth, gay, lesbian, bisexual and questioning teens, and youth who have been maltreated (Ministry of Health Promotion, 2010; Wekerle et al., 2009).

Evidence also suggests that protective factors and assets can help shield youth from substance use problems. These include:

- positive, caring relationships with adults inside and outside the family and supportive peers (Youngblade et al., 2007)
- school and community safety, school achievement
- interpersonal connection beyond the family, including larger community involvement and engagement
- healthy government policies that govern appropriate access to substances (Ministry of Health Promotion, 2010; National Alcohol Strategy Working Group, 2007).

What do we know about youth substance use in B.C.?

The *B.C. Adolescent Health Survey (AHS)* of youth ages 12 to 19 who are enrolled in public schools suggests that the use of substances among B.C. youth has declined substantially over the past five to 10 years. Nonetheless, substance use is still fairly common amongst youth in B.C.

In the 2013 *AHS*, 21 per cent of surveyed youth had tried smoking, not including ceremonial tobacco, with the most common age of first smoking experience being 14 to 15 years. A total of 45 per cent of youth reported having tried alcohol; most reported first trying alcohol at the age of 14. Rates of youth

Background

binge drinking in the past month fell from the 2008 level of 44 per cent to 39 per cent, with males and females reporting similar rates. The use of marijuana continued to decrease, with 26 per cent of youth reporting ever having used it and the most common age of first use being 14. Only four per cent of surveyed students reported ever having tried ecstasy, while one to two per cent had tried crystal meth, ketamine or GHB (Gamma-Hydroxybutyric acid, aka the “date rape drug”). Overall, 17 per cent of B.C. students surveyed had tried at least one substance other than alcohol or marijuana (Smith et al., 2014).

Vulnerable Populations Compared to the General Population

- **LGBT2Q+ youth:** Gay or bisexual adolescents were more likely to have tried substances and were more likely to have tried alcohol and other drugs before they were 12-years-old (Smith et al., 2010).
- **Aboriginal youth:** The rate of Aboriginal youth who first tried alcohol or marijuana at the age of 12 or younger has declined during the past decade. However, Aboriginal youth most commonly tried marijuana at age 13 or 14, younger than the general population (Tsuruda et al., 2012).
- **Street-involved youth:** While the *AHS* provides valuable information on youth enrolled in school, it may not capture the realities of youth who are street involved and/or not attending school. Other studies have found that 85 per cent of these youth had tried alcohol; 94 per cent had tried marijuana and this population was often introduced to marijuana before becoming street-involved. Street-involved youth were also more likely than youth in school to have used other drugs (Smith et al., 2007). Research in Vancouver shows that vulnerable youth are involved in very high overall rates of substance use, with increasing use of crystal meth and crack cocaine over time (Phillips et al., 2015).

The potential harms of youth substance use

While most young people who use substances do not experience significant harms, problems can occur. These problems can be viewed in two distinct ways: diagnostically in terms of medical disorders or in terms of the effects of substance use on overall functioning. Some of the better documented harms of substance use for adolescents include:

- **Cognitive and neurological development:** Because adolescence is a unique period of brain and physical development, substance use can have more negative effects at this stage than later in life. This is especially the case for adolescents under the age of 16.
- **Mental health:** Heavy and long-term substance use may exacerbate pre-existing mental health issues such as depression and anxiety, or in extreme cases may lead to psychosis. Some mental health conditions may also precipitate substance use as a means of coping.
- **Physical health:** Physical harms from substance use can be caused by non-chronic use, and even one-time use. Binge drinking (defined as more than five drinks for males, or four drinks for females at one occasion) can put adolescents at risk of short-term harms related to physical health. In adolescents, these harms are likely associated with accidents such as falls, drinking and driving and interpersonal conflicts resulting in violence, including sexual assault.

- **Social functioning:** Substance use can impair social functioning because of both episodic binge use and long-term chronic use. Effects on social functioning include poor decisions, lower school attendance and educational attainment, conflict with peers, family members, teachers and others, violence, or having problems with the police.
- **Dependence/Disorders:** Some youth who use substances may become emotionally or physically dependent on those substances. A “substance use disorder” refers to a psychiatric diagnostic category based on clinical criteria.

Data from B.C. show that, among youth who used alcohol or other substances in the past year, more than half (52 per cent) reported negative consequences resulting from their substance use. Most commonly, students reported being told they had done something they could not remember (37 per cent), passing out (28 per cent) or suffering an injury (14 per cent). In addition, 24 per cent of students who had ever had sexual intercourse reported using substances before they had sex. Overall, five per cent of students felt they needed help for their alcohol, marijuana or other drug use (Smith et al., 2014).

Statistics Canada estimates that in 2012, approximately 68,000 youth and young adults ages 15 to 24 were classified as meeting criteria for any of the measured substance use disorders (alcohol dependence, alcohol abuse, cannabis dependence, cannabis abuse, other drug dependence [excluding cannabis], other drug abuse [excluding cannabis]) in the previous 12 months (Statistics Canada, 2015). This same estimate is not available for younger youth.

Why is it important to respond to youth substance use?

A growing body of literature shows that substance use by adolescents is on the decline in Canada. This decline is part of a longer term trend that shows that the rate of adolescent substance use has fluctuated since at least the 1960s. Despite the current downward trend, many adolescents still suffer from the ill effects of substance use, sometimes profoundly so. However, in some quarters, adolescent alcohol use is considered an acceptable rite of passage, while any use of illegal drugs is deemed unacceptable. The reality is that youth use a variety of substances. The substance they most commonly use is alcohol, although 17 per cent of youth in B.C. report using a substance other than alcohol or marijuana (Smith et al., 2014). While most youth do not experience harms because of use and will not require specialized services, a small subset of youth experience difficulties ranging from dependency, to other health impacts, to injuries and even death from overdoses, accidents and violence.

The patterns of youth substance use differ from those of adults, in part because of associated factors that are specific to adolescence and early adulthood, including emerging identity challenges, pressure from peers, performance expectations at school, family stress or discord and problems with self-esteem (Currie, 2001; Charles & Alexander, 2007; LaMarre, 2012). Because of the distinct patterns of youth substance use, as well as the challenges of adolescence, it is important to provide services to youth that are able to address these differences.

What do youth say works?

Best practice documents on youth substance use services emphasize the need to ensure youth are consulted about their substance use service needs. Ensuring that youth voices are part of system and service planning also accords with the UNCRC, particularly Article 12 which guarantees the right of children and youth to give their opinions and to have their voices taken seriously.

Recent Canadian reviews of provincial substance use services in B.C. and Ontario provide valuable insights into what youth say is essential to developing services that can successfully engage, support and meet their needs. These studies found that youth living with concurrent mental health and substance use challenges reported being more likely than their peers to approach multiple services in a year and seek out practitioners such as doctors or nurses (Cox et al., 2013). Although the majority of youth felt that the services they accessed were useful, youth with complex needs were more likely to find specific types of services easier to access, such as youth clinics and drop-in centres. Harm reduction³ approaches were seen as positive, as were peer support and/or mentorship programs that allowed for both formal and informal support (Chaim et al., 2013).⁴ Male youth felt that the most helpful services were those that incorporated job training or recreational opportunities, while female youth felt that relationships with staff were most important (Ibid; Cox et al., 2013).

Many of the youth participants in these studies commented on the compounding effects of discrimination based on substance use when combined with mental health concerns or homelessness (Ibid; Cox et al., 2013). Youth described this discrimination as a potential barrier to accessing services, and highlighted the importance of non-judgmental approaches and relationship building to ensure that they engaged with needed services (Chaim et al., 2013).

Youth felt that services should not only address substance use issues, but that they should acknowledge the underlying factors related to these issues (Ibid). Participants in the studies identified the following service gaps:

- lack of services in rural areas and safe neighbourhoods
- too few counsellors in schools or in the community
- limited options for youth with concurrent disorders who were not in crisis but still required services, and
- lack of accessible and affordable services to engage youth or provide employment opportunities (Cox et al., 2013).

Additionally, youth suggested that substance use services could be improved by ensuring that clients continue to be supported as they transfer from one service to another and as they transition into adulthood (Cox et al., 2013).

³ Harm reduction accepts the reality that sometimes people, including youth, use substances. Harm reduction includes policies, programs and practices with a goal of reducing the adverse health, social and economic consequences of the use of legal and illegal psychoactive substances without necessarily requiring abstinence.

⁴ Note Chaim et al., includes youth ages 12 to 24 and this review considers youth 13 to 18 years of age. Despite these differences, the findings of Chaim et al., are still relevant for understanding what youth more generally say about what works in terms of services.

Other issues that were identified as key to successful service outcomes include:

- providing flexible programs
- allowing youth to set their own goals for treatment services
- recognizing youths' individual circumstances
- being forgiving of mistakes, and
- supporting youth in finding viable alternatives to using substances (Chaim et al., 2013).

Youth Suggestions for Change

These excerpts are taken from a 2013 report from the McCreary Centre Society (Cox et al., 2013) that profiles the experiences of young people who have struggled with substance use and mental health challenges:

- Youth who were successfully managing their substance use explained that having their basic needs met had a positive impact on their drug use and mental health.
- Adults who are in positions to offer support (such as counsellors, social workers, and youth workers) must be trained to accept that they should provide support to youth, even if that youth is not yet ready to open up and talk with them.
- Anyone who is approached for help should be non-judgmental and welcoming and understand the barriers that youth with multiple challenges face.
- Detox places must be available immediately when youth seek help. There are key moments when youth are prepared to accept that they need help or when they overcome their fears and are ready to enter treatment. If these opportunities are missed, this can result in young people disengaging from services.
- Services must be offered in every community, but youth also need the option to seek help outside their home community if this is a more appropriate option for them.
- Services should be advertised widely throughout every community in places where youth hang out, so that youth know help exists and how they can access it.
- The transition out of residential services needs to be less abrupt. Have a place where former residents can stay that is less structured than the residential placement but still provides access to trained support staff and a safe space to sleep. Such a place would allow youth to reintegrate back into the community at their own pace.

What are the best practices for service delivery?

The Representative's review of peer-reviewed research and best practices for services confirmed that substance use services for youth have undergone a significant transition in the last 20 years. Service options have moved away from a primary focus on an abstinence-only recovery model towards a plurality of service options that emphasize a bio-psycho-social-spiritual model of substance use that recognizes the complex origins of substance use problems. The rise of this model has been accompanied by the recognition that no one approach will suit all individuals, and that different populations have different service needs. These developments have been accompanied by calls for an integrated, system-wide approach to planning and delivery of services (NTSWG, 2008).

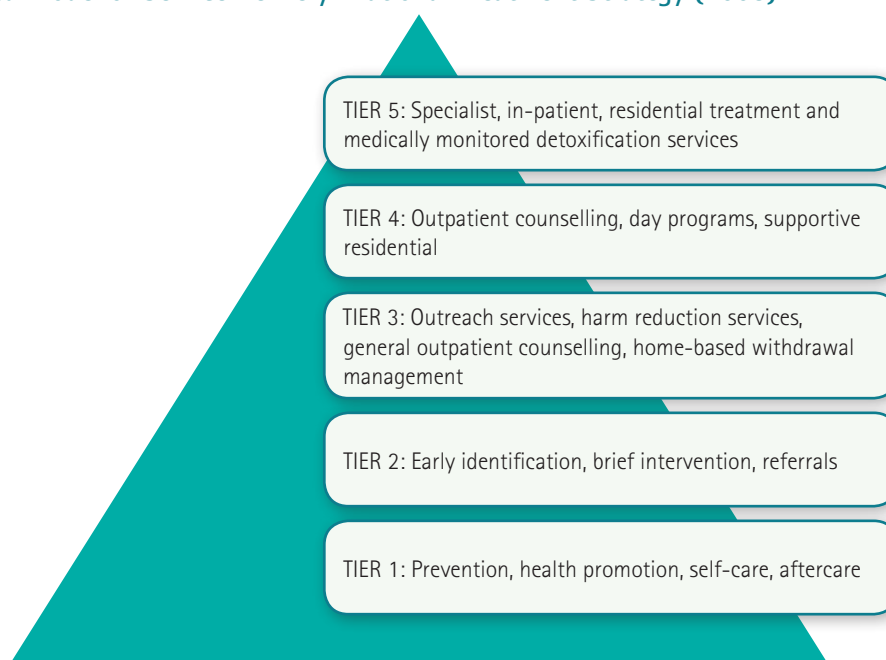
The WHO recommends that health services, including substance use services, be organized as a system – in other words, as a set of organizations, people, and other resources whose primary purpose is to address the needs of youth who require assistance with substance use problems (WHO, 2007). Other research into the design of substance use systems recommends that services should be offered on a continuum from least intensive to most intensive (NTSWG, 2008; Rush, 2010; American Society for Addiction Medicine, 2015; B.C. MoH, 2010; Winters et al, 2011; B.C. MoH, 2011).

A key recommendation of the NTSWG is the adoption of a tiered continuum of service delivery for substance use services (2008). The tiered model is based on the following service-delivery principles, all of which are as appropriate to youth as they are to adults:

- A “one-size fits all” approach will not meet the diversity of service needs of either youth or adults.
- Every door should be the right door – people should be able to enter the system of care through multiple doors (e.g. emergency departments, schools, community-based services) and coordination of links between services and supports is the responsibility of the system, not the person.
- Collaboration and coordination of services, as well as system planning, monitoring and evaluation, and health information should be seamless and should allow for information sharing between appropriate partners.
- Services should be available within a reasonable distance and travel time from one's home or should be facilitated by other means.
- Individuals should be matched to services appropriate to their needs using valid screening and assessment tools, and services should recognize that peoples' needs change over time and are different according to developmental issues.
- Where multiple services are available, individuals should be able to choose between available options.
- The principle of “least intrusive care” as a first option should be upheld, meaning that intensive services, such as residential services, are not always appropriate for most youth (Health Canada, 2002).

The NTSWG recognizes that effective service provision will cut across traditional ministerial and sectorial boundaries. Specialized substance use services, for example, may need to be integrated with mental health, primary care, pharmaceutical services and home and community care (Ibid, p. 8). Services and supports within and between the tiers may be dispersed across these traditional boundaries. A tiered model of service provision is depicted in Figure 2 (NTSWG, 2008). Each level of the pyramid represents a group of services that use similar levels of service or clinical intensity and similar eligibility criteria. The lower tiers of the pyramid include less intensive services offered to a broad range of youth. The higher tiers of the pyramid include more intensive services and are usually reserved for young people who need the most support with substance use problems. The focus of the Representative's review is on specialized substance use services for youth typically offered in Tiers 3 through 5.

Figure 2: Tiered Model of Service Delivery: National Treatment Strategy (2008)



Adapted from: NTSWG, 2008.

Tier 1 services are initiatives that encourage general wellness and focus on prevention strategies for the population as a whole. Examples of Tier 1 services include health promotion, self-care and aftercare programs.

Tier 2 services are more targeted in nature and aim to provide early intervention or self-management programs for individuals who are at risk of developing substance use or mental health problems. These options may include brief intervention programs, initiatives for early identification of mental health and substance use issues, or referrals to other health professionals.

Services in Tier 3 are intended for individuals who have acknowledged problems with substance use or mental health issues. These services – including outreach, harm reduction, community-based counselling and withdrawal management – are intended to provide support and crisis management as well as plan for services to address the identified issues.

Background

Tier 4 services include specialized care options such as outpatient counselling, supportive residential programs and day treatment. These services are intended to assist people who are in need of more intensive forms of care or require targeted service options to address specific problems (Rush, 2010).

The NTSWG recommends that services and supports in Tier 5 address only the needs of people with highly acute, highly chronic and highly complex substance use and other problems, for whom lower-tier services and supports are inadequate. Tier 5 services and supports help link people with highly complex concurrent substance use and mental health problems to the full range of needed assessment and support services including residential or hospital-based services (e.g., residential programs for the treatment of concurrent disorders, and hospital-based medical withdrawal management services) (NTSWG, 2008, p. 19).

What gaps have already been identified?

Research in Canada indicates that the following barriers exist to accessing youth substance use services:

- lack of programs
- geographical inaccessibility of services
- lack of outreach
- lengthy wait times

In addition, programs have been faulted for not adopting adequate screening and assessment practices that would help direct youth to appropriate levels and types of care (Tombourou, 2007). While centralized services can be financially efficient, the lack of services in rural and remote areas can be a significant barrier to accessing services for some youth. The same applies to language and gender differences and the social stigma associated with problematic substance use (AADAC, 2006; Currie, 2001; LaMarre, 2012).

A number of challenges have been identified with youth substance use services in B.C. and in Canada more generally, including:

- the need for a more collaborative and integrated approach to substance use and mental health issues that would challenge the way services exist in silos
- better integration of promotion, prevention and stigma reduction initiatives with services and supports, and
- more support for youth during transitions between service types, between mental health and substance use services, between hospital-based emergency rooms and substance use services, and between adult and youth services.

This same research has found that transitions can be further complicated by the complex nature of the care system, failure to use standardized screening tools and a lack of available clinical staff. Across Canada, there is considerable regional variation in service delivery and differing approaches to clinical practice. Youth may not know what services exist to help them, or they may not meet restrictive requirements for entry into services. Long wait times for services, a dearth of youth-friendly approaches and limited tracking of service utilization and client outcomes may lead to youth being lost from the system before they can receive the help they need (Chaim et al., 2013; Association of Addiction Specialists and Allied Professionals of B.C., 2010; B.C. Medical Association, 2009; Virgo Consultants & Island Health, 2014).

A review of substance use services in Island Health illustrates the strengths in youth substance use services systems, including strong leadership and staff members with many years of substance use experience, high staff morale and meaningful engagement with agencies that provide contracted services to youth. A number of school districts engage in collaborative work with Island Health substance use services, and youth detox and prevention services have been identified as successful in a number of communities, as have harm reduction and community-based services that include a focus on outreach, prevention and intervention and support of basic youth needs (Virgo Consultants & Island Health, 2014).

Who is responsible for service delivery in B.C.?

B.C. Ministry of Health

Since the 1980s, publicly funded substance use services have been the responsibility of various provincial government ministries, including those responsible for health, children and families and, at one time, the Ministry of Labour. Since 2001, substance use services have been located in MoH.

MoH is responsible for policy development and direction, overall allocation of resources and oversight of services, while health authorities are responsible for the planning, delivery of services and allocation of resources at the Health Service Delivery Area (HSDA). Unlike the adult mental health system, which is the sole responsibility of MoH, most substance use services for youth are delivered by the health authorities while MCFD is responsible for substance use counselling in youth custody centres and residential substance use programs for sentenced youth.⁵ MCFD is also responsible for the delivery of community-based mental health services for children and youth, while health authorities deliver child and youth hospital-based mental health services, with the exception of the Maples Adolescent Treatment Centre.⁶ Forensic Psychiatric Services for youth in the justice system are also delivered by MCFD.

A review of MoH policy documents reveals that there are few specifics on how a system of care for substance use problems should be delivered to youth. The MoH *2015/16 – 2016/17 Service Plan* makes little mention of substance use, although it commits government to: “Provide a full continuum of high quality mental health and substance use services within each health authority to better integrate services within the larger care network” (B.C. Ministry of Health, 2015a, p. 9) and to develop “access to addiction treatment, including an additional 500 addiction spaces by 2017” (Ibid., p. 9). This plan also builds on a commitment by government to the integration of primary and community care built around inter-professional teams and functions (Ibid.).

The Minister of Health’s 2015 mandate letter from the Premier commits the health minister to ensuring renewal of the balance of the provincial mental health and substance use plan, *Healthy Minds, Healthy People (HMHP)* (Clark, 2015). *HMHP* takes a “whole systems” approach, defined as working in partnership with other public systems including education, social services, housing, law enforcement, courts and corrections. *HMHP* contains specific actions government will undertake to support the

⁵ Youth under community justice supervision (e.g. probation) are referred to available outpatient counselling, day programs and withdrawal management.

⁶ The Maples provides a number of programs and services to address the needs of youth ages 12 to 17 with significant psychiatric and behavioural difficulties. All programs and services are holistic in their approach and include participation of the family or alternate caregivers as well as the professionals in their home community. In most programs, there are both residential and non-residential options. The Maples is the responsibility of MCFD.

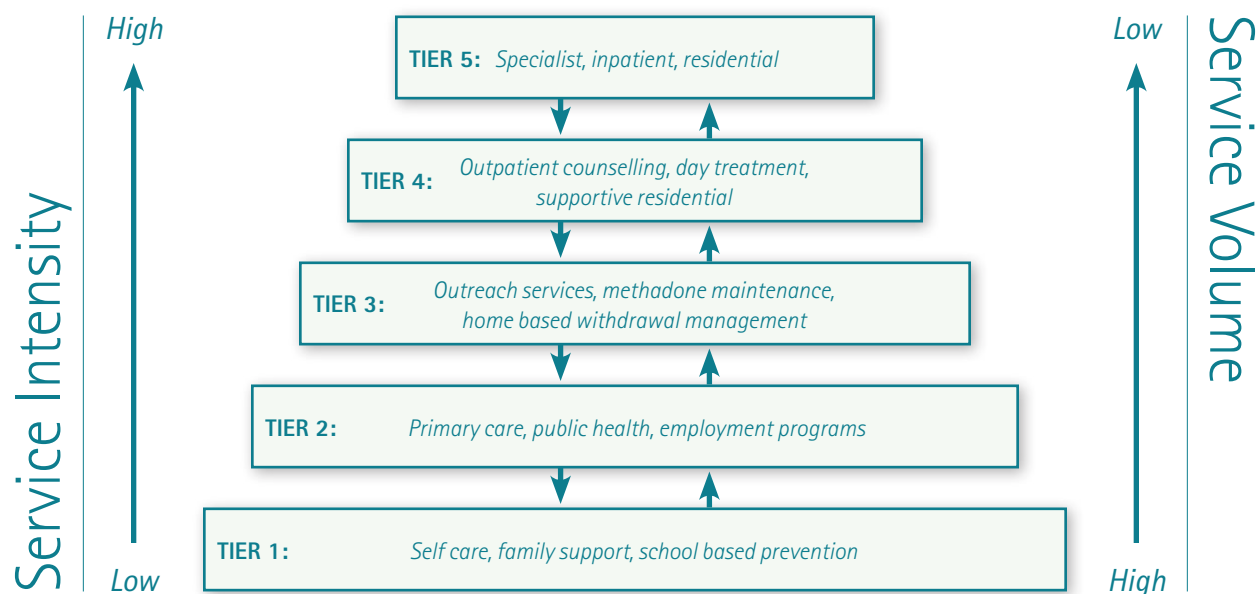
Background

delivery of mental health and substance use services and it uses a tiered approach to the delivery of services. But *HMHP* does not commit government to the development of mental health and substance use as a whole system with all the required system supports such as policy and standards, workforce development capacity, and performance measurement and accountability/quality improvement. Nor does the plan commit government to fully assessing the need for substance use services specifically for youth or identify, specifically, the required functions or service delivery types that should be available to youth.

Other MoH policy documents support a tiered model of service provision somewhat analogous to the National Treatment Strategy described previously. One of the few documents that specifically describes government expectations for youth substance use services is the 2011 MoH document, *Service Model and Provincial Standards for Youth Residential Substance Use Services*. This document draws on the values espoused in *HMHP* and an earlier MoH planning document entitled, *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (2004).

Figure 3 is taken from the 2011 document and illustrates what a tiered continuum of services would ideally look like for youth. Like the NTSWG tiered model, this model shows universally delivered health promotion programs at the bottom of the pyramid and increasingly specialized services at the upper levels. These standards also reiterate the values of the NTSWG and emphasize that there should be no wrong door or entry point into the services.

Figure 3: Tiered Continuum of Services



Source: B.C. MoH. (2011). *Service model and provincial standards for youth residential substance use services*.

It is unclear what role *HMHP* plays in government planning, as other strategic directions have come to the forefront in recent years. A 2014 MoH document, entitled *Setting Priorities for the B.C. Health System*, sets out strategic and operational priorities for the delivery of health services in B.C. Priority two in this document places an emphasis on implementing a system of primary and community care “built around inter-professional teams and functions.” A recent discussion paper released by MoH appears to mandate the health authorities to establish Primary Care Homes for all health-related concerns. The

Primary Care Home is understood to be a full-service family practice linked to a health authority or health authority-contracted interdisciplinary teams that offer assessment of mental health and substance use problems, and referrals to more intensive MHSU services. The Primary Care Home is meant to be formally linked to a designated specialized MHSU integrated service centre where individuals with moderate to severe problems could access services. The MHSU team would consist of a cross-section of mental health and substance use professionals who can provide care and also coordinate the delivery of other more specialized services (B.C. MoH, 2015b). A discussion of this proposal in the light of the findings of this report is included in a later section.

B.C. health authorities

Substance use services for youth are delivered by the five regional health authorities: Northern Health, Interior Health, Fraser Health, Vancouver Coastal Health and Island Health, as well as by the Provincial Health Services Authority (PHSA) and the First Nations Health Authority (FNHA). Similar to adult services, youth substance use services are delivered either directly by a health authority or by contracted community-based organizations. In addition, there are privately funded service options in B.C. which are beyond the scope of this review.

The PHSA is responsible for specialized programs and services provided through its agencies, including BC Mental Health and Substance Use Services (BCMHSU). BC Children's Hospital, another agency of the PHSA, offers a concurrent disorders out-patient program to youth from across B.C. (BC Children's Hospital, 2016).

Each health authority organizes youth substance use services according to HSDAs and delivers services along a continuum through prevention, early intervention, withdrawal management (detox), counselling, day and residential and after-care services. In four of the five regional health authorities, services are managed by regional mental health and substance use directors. Only Island Health maintains a separate sub-portfolio of youth substance use services, although this portfolio sits inside an overall mental health administrative unit.

The findings of the Representative's survey of substance use service providers found that, provincially, approximately 75 per cent of substance use services for youth in B.C. are delivered by contractors and the remaining 25 per cent are delivered directly by the health authorities.

Contracted services potentially bring both challenges and strengths to the system of care. As one health authority respondent noted, sometimes there can be a lack of clinical consistency among providers even in the same geographic location, resulting in potentially contradictory approaches to substance use. Some health authorities also lack standard contract language, which is reflected in differing mandates and expectations among service providers. At the same time, contracted service providers offer flexibility and can potentially be leaders in innovation and change in the system of care because they are not run by large health authorities. Overall, respondents noted that how well contractors are integrated into the system of care depends on key factors such as leadership from health authorities, and the availability of training and other professional development opportunities that help support a shared understanding and approach to substance use.

Background

Only Northern Health delivers most of its youth substance use services directly, rather than through contractors. Northern Health offers mental health and substance use services to both adults and youth via teams of generalist workers of varying sizes. With the exception of Prince George and Terrace, these teams do not include workers who specialize in youth services or in substance use issues alone.

All regional health authorities have integrated mental health and substance use services into one administrative portfolio. The organization of services is illustrated in Appendix 2.

Aboriginal youth and the system of care

Efforts are being made in Canada to establish culturally appropriate and safe services for Aboriginal adults and youth who are facing substance use issues (Health Canada and the National Native Addictions Partnership Foundation, 2013). The *Transformative Change Accord*, an agreement between the federal government, the B.C. provincial government and the B.C. First Nations Leadership Council to close the social and economic gap between First Nations and other British Columbians, opened the door to the emergence of the FNHA (FNHA, 2015a). As of Oct. 1, 2013, the FNHA assumed responsibility to plan, design, manage, deliver and fund the delivery of First Nations health programs across B.C., including mental wellness and substance use programs (FNHA, 2015b). One of the promised actions of recent agreements between the province and First Nations in B.C. was to develop a mental health and substance use plan. *A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use – 10 Year Plan* is the result and is meant to guide regional and local planning and action when it comes to key issues (FNHA, 2015a).

A Path Forward acknowledges the role of social issues in shaping substance use problems, including the history of colonization and its wide-ranging effects such as poverty, racism and systemic discrimination, child apprehension, over-representation of Aboriginal people in the justice system, loss of tradition, territories, land and culture as well as disparities in health outcomes (FNHA and B.C. MoH, 2013). As the introduction to the plan notes, it is not meant to be prescriptive and therefore does not describe or require specific programs for youth with substance use problems. It does set out a series of principles that should guide planning and emphasizes the importance of an Aboriginal worldview that highlights concepts such as wholeness, balance, the importance of relationships with family, community, ancestors and the natural environment.

The plan does not distinguish between adults and youth in its strategic directions and actions. Instead of a pyramid of services, this plan conceptualizes a continuum of care as a circle that rotates between holistic wellness, community care, integrated care and specialized care.

Analysis

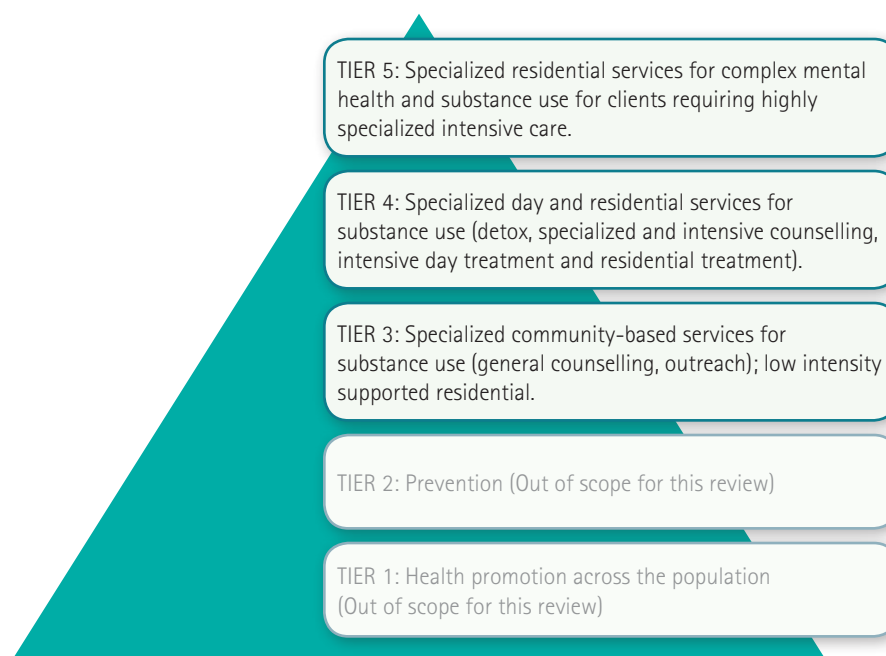
This review focuses on substance use services provided to youth in B.C. in Tier 3 through Tier 5, as depicted in Figure 4. As the NTSWG model suggests, services in Tiers 3 and above are more specialized and focused and are usually available to youth seeking help with persistent substance use problems. The findings and analysis of this review consider the issues of availability, accessibility and responsiveness of these services, along with a review of leadership issues in the youth substance use system of services.

Key Finding: Overall availability of services varies considerably throughout the province

Although provincial-level planning and policy documents mandate each health authority to provide a comprehensive system of services, the actual scope of these services varies considerably between health authorities. Findings from the Representative's review confirm that all regional health authorities offer at least some specialized substance use services for youth. Most of these services are offered as either out-patient community-based services, or as residential services that include withdrawal management (detox), specialized treatment or supported recovery safe housing. Two health authorities also offer out-patient day treatment programs. Three health authorities (Vancouver Coastal, Fraser and Northern Health) offer Tier 4 residential treatment programs for the general youth population. See Appendix 3 for a list of services by health authority and service type.

The diagram below shows a simplified version of the service types considered in this review, including the ones noted in Tiers 3 to 5. Although important services are offered in Tiers 1 and 2, these services are out of scope for this review. Despite these limitations, survey and health respondents provided valuable insights about services in Tiers 1 and 2. These findings are included in a text box on page 23.

Figure 4: Service Types Considered in this Review



Community-based services

Finding: The availability of community-based services is a very important part of services for youth.

The availability of youth residential treatment programs tends to receive public scrutiny. However, many youth can be adequately served in their home communities by face-to-face, community-based services that specialize in youth substance use issues. Unlike specialized residential services, community-based services are more likely to be offered close to home, do not require youth to interrupt school and work responsibilities, and sometimes provide supports directly to families. Community-based services can also be cost effective while providing lower barrier, easily accessible services that are often asked for by youth.

In B.C., community-based youth substance use services include a mix of outreach, drop-in, face-to-face counselling, support and psycho-educational groups, family therapy, screening, assessment and referrals to other services. Outreach services are a particularly important component of youth services, given that youth may face challenges adhering to requirements for scheduled and formal appointments with professionals. The availability of outreach services can help extend service contacts to youth in their natural environment, including schools and other youth spaces.

This review reveals that the majority of substance use supports for youth in B.C. are offered by community-based organizations. Although these services are thinly spread in some areas of the province, all health authorities reported that they offer community-based services, including outreach and face-to-face counselling. These services span both Tier 3 and Tier 4 in terms of specialization and intensity. About two-thirds of service providers who completed the survey for this review indicated that their services are located in urban areas.

Community-based services in Vancouver Coastal Health, Interior Health and Fraser Health are offered by a wide range of contractors as well as in-house by each of these health authorities. Services in Northern Health are offered in-house with the exception of positions funded in Friendship Centres.

Discovery Youth and Family Substance Use Services, a program of Island Health, is unique in B.C. in that it is the only health authority-operated and youth-focused substance use service in the province. This program is supplemented by specialized community-based services offered by contract affiliates in locations not covered by Discovery Youth and Family Substance Use Services. Strong leadership in the field of youth substance use at Island Health has benefited service provision in this region. Service providers report that access to training, common intake and assessment tools, and support for working together have produced a more seamless approach to addressing youth substance use.

Prevention and Early Intervention for Youth Substance Use Problems

Despite the fact that services in Tiers 1 and 2 were not included in this review, service providers and health authority respondents emphasized the importance of these services. As Figure 4 illustrates, health promotion and prevention of substance use problems underscore any proper continuum of care. In fact, prevention and health promotion activities can occur at any point in the provision of services. Research suggests that drug prevention initiatives must embed substance education in larger health promotion efforts that help students learn critical skills needed to make healthy decisions. Prevention programs in schools also appear to be more successful when they include a number of strategies and occur over a number of years (Hyska, 2013). These programs contrast significantly with prevention efforts focused solely on the “*notion that drug use is the product of an individual’s susceptibility to peer pressure*” (Hyska, 2013). Early childhood, school-age years and adolescence are key points for prevention and early intervention of problems that may contribute to harmful substance use later in life. Early intervention is also important to preventing and recovering from mild problems before they become more severe (B.C. MoH, 2010, p. 10).

These findings suggest that school-based programming is an important part of the continuum of substance-use services, but must be guided by evidence-based principles about what is most effective. Health authority respondents noted the challenges of incorporating these services into their programming and urged the province to establish standards for prevention and health promotion work.

Health authority respondents report that prevention programs are transitioning away from older models of drug education that focused exclusively on knowledge about substances, substance effects and consequences. Research has demonstrated that these programs are not effective at reducing substance use (Child Health Policy Centre, 2010). Some health authorities support school-based education prevention and health promotion programs. These programs range from Kindergarten to Grade 7 prevention-based programs that educate youth about substances, to supports for teachers and community members, to school-based alternatives to suspension programs. Interior Health, Island Health and Fraser Health contract with service providers to do school-based programming. Vancouver Coastal Health is also notable for its long-standing partnership with the Vancouver School Board to support School-Aged Children and Youth (SACY). SACY offers four streams of programming, including: a youth prevention and engagement program; S.T.E.P., a three-day structured alternative to suspension; a parental engagement stream; and curriculum and teacher training.

The MoH, with the Centre for Addictions Research of B.C. (at the University of Victoria), has developed various health promotion materials for children, youth and adults. The Representative’s report, *Growing Up in B.C. – 2015*, featured one of these resources, IMinds, a school-based program that helps children and youth develop “substance use competencies” that can foster a healthier relationship with substances in the formative years and into the future.

Despite MoH’s support for the development of excellent health promotion materials on substance use, there remains no standards or specific guidance from the province on how health promotion activities related to substance use should be integrated into a system of care. Several survey and health authority respondents suggested that provincial-level health promotion and prevention standards would help guide the implementation of these important services, and give health promotion and prevention of substance use problems a higher profile in their health authority.

Finding: Despite the existence of community-based services in each region, some services lack youth specialization and are often small in size. Due to small population size, many rural communities lack youth specialists.

Lack of youth substance use specialization in some areas: Adolescence is characterized by a distinct period of psychological, physical and emotional development and adolescents can experience substance use problems differently from adults. Professionals in this field must be able to combine evidence-informed approaches with the ability to work effectively with youth populations (e.g. understanding adolescent development, ability to connect with and meet youth where they are at) (CCSA, 2014).

The majority of community-based youth substance use services in B.C. report that they offer some level of specialization, either in working with youth or in substance use services, although survey responses indicated that there is little consistency between service providers in their understanding of specialization or their reported ability to provide some of the clinical supports necessary to support specialization. There were also mixed results with some service providers regarding using validated screening and assessment tools. Due to insufficient critical mass to justify caseload specialization, some contractors in smaller communities offer services to youth as part of a generic youth/adult service.

There appear to be significant differences in the level of specialization in community-based services offered across the province. These differences are exacerbated by a lack of provincial standards for community-based services, and lack of standardized contract language that would require minimum levels of staff competencies and specialization. In addition, some health authorities do not require that all contracted service providers be accredited by external bodies (e.g. Accreditation Canada).

Small program size: While there are numerous community-based substance use services programs in B.C., many of these programs are very small with less than one full-time employee providing services to youth. As one service provider put it:

“It would be helpful to have more than one employee carrying out all these services [in our area]. Due to our geographic location we are not able to provide services to [our full region], even though our contract indicates that services should reach out to this area.”

This means that throughout the province, community-based services can also vary significantly from one service provider to another in terms of available resources. Some services, for example, provide outreach to schools and youth centres and others provide only office-based counselling.

Withdrawal management services (detox)

Finding: The availability of withdrawal management services varies considerably throughout B.C.

Withdrawal management services – also known as detox – are services that help youth safely withdraw from alcohol and other drugs. These programs are usually short in nature, lasting from five to seven days, and are offered in a residential setting, as a day program, or even at home, depending on the needs of the youth. Currently, withdrawal management programs are located in each health authority, although the scope of these services varies considerably depending upon location. Most services are residential. VCH has two residential withdrawal management programs. One provides daily medical support. This support includes a physician and nurse who provide daily outreach from an integrated primary care clinic, and

youth can continue with this primary care clinic after discharge. Island Health has one specialized youth withdrawal management facility with five non-medical beds, as well as 14 family care homes for non-withdrawal management support (all offered through contracted service providers). Interior Health has two youth beds available in Kamloops; two beds in family care homes in the Thompson Cariboo and one bed available in Cranbrook. Fraser has a six-bed unit that provides “medically monitored” services as well as mobile services for youth. Northern Health offers one bed in Prince George. In April 2016, the Interior Health Authority announced that it was adding four youth withdrawal management beds in the Central Okanagan (Interior Health Authority, 2016). In the absence of withdrawal management services, youth may be detoxing in hospitals, where there may be a lack of substance use specialization, or at home without any supports.

Caution must be exercised about the models of care used in withdrawal management for youth.⁷ Because youth often have different needs from adults (given the typically shorter duration of substance use and the likelihood they will experience less severe withdrawal symptoms), they may be more likely to need safe places to manage their withdrawal, that are connected to housing and other supports, rather than formal medically monitored withdrawal management programs. Most health authorities reported that they need more withdrawal management services, but they also emphasized that youth rarely need only withdrawal management support, but often need to be linked to longer-term housing options that can support them as they move forward.

Supported residential services

Finding: More supported residential services are needed to ensure the best outcomes for youth.

Supported residential services are meant to provide a safe and stable environment for youth with substance use problems. Supported residential services may be accessed by youth who are awaiting other services or continuing with day treatment or community-based counselling. Service providers noted the importance of these services:

“Areas for improvement would be additional residential supported recovery programs for both genders that provide day programming and life skills for youth in recovery.”

Island Health is the only location where supportive recovery services have been well integrated into the system of care. Both Interior Health and Northern Health have no supportive recovery beds.

⁷ Some health authorities report that they can sometimes use acute care beds for withdrawal management.

Case Study – Sarah

Sarah is showing signs of severe mental health challenges, including debilitating anxiety that began in her early teens. She struggles with completing her homework, although her teachers report that she is doing well when she is at school. By her mid-teens, her anxiety has become worse and she is using illegal substances on a regular basis to alleviate her anxiety and social phobia. Her family knows that she is having challenges with both her substance use and mental health and the school has recommended that Sarah receive community-based counselling services for substance use. Her family has not been able to find a residential program that is anywhere close to home, and the community agency does not have the resources to address both Sarah’s mental health and substance use issues. At 16, Sarah goes to the emergency room at the local hospital because of her anxiety, where she is referred to MCFD Child and Youth Mental Health Services who begin seeing her immediately. She is diagnosed with multiple mental health challenges and is referred for a more in-depth mental health assessment. At the same time, she has not been showing up for school, is often missing from home and is drinking heavily and using illegal drugs. Within a couple of months of her emergency department visit, Sarah dies of a drug overdose while alone.

Residential services for substance use problems

Finding: B.C. lacks sufficient residential beds, Tier 5 services and safe, low-threshold housing for youth.

One of the key findings of this review is that specialized Tier 4 services (e.g. medically monitored withdrawal management, supportive recovery residential facilities or homes, day treatment and intensive residential treatment) are not readily available in the majority of places in B.C.

B.C. has a total of 24 Tier 4 beds offered in just three of the province’s five health authorities. Peak House, located in Vancouver and operated by Pacific Youth and Family Services, is a Tier 4 residential facility with eight beds, and routinely has a three-month wait time to access its services. Peak House will also accept referrals from other health authorities. In Vancouver, the Urban Native Youth Association offers a five-bed program available to Aboriginal youth from around the province with a wait time of up to one month. Fraser Health offers an additional four beds at its residential program, Last Door.

Residential Substance Use Services for Youth in B.C.

As Appendix 3 shows, there are only 24 publicly funded residential substance use treatment beds to serve the needs of all youth in B.C. Statistics Canada estimates that approximately 68,000 youth in B.C. ages 15 to 24 met the criteria for a measured substance use disorder (alcohol dependence, alcohol abuse, cannabis dependence, cannabis abuse, other drug dependence [excluding cannabis] or other drug use [excluding cannabis]) in the previous 12 months (Statistics Canada, Table 105-1101). While the majority of these youth will not need residential treatment services, this data suggests that 24 publicly funded beds are unlikely to come close to meeting the need. This compares unfavourably to the number of beds for residential substance use treatment for youth involved in Community Youth Justice Services (25) for a population of about 1,600 youth (MCFD, 2014).

The other major residential facility in B.C. is the Nechako Treatment Centre with seven beds, located in Prince George and operated by the Northern Health Authority. The wait time for this facility can vary from no wait, to one to two days. The Nechako Treatment Centre has recently begun accepting referrals from other health authorities. (Appendix 3 provides more information on these services)

Delays in access to residential services can lead to relapse, thus it is vital to ensure that readily available and accessible services are part of the continuum of care (Fraser Health Authority, 2015, p. 24).

As of spring 2016, B.C. does not have a residential Tier 5 service that can address the needs of youth struggling with a complex mix of substance use and mental health challenges. Tier 5 services are intended for youth (or adults) who show evidence of highly chronic and highly complex substance use and other problems such as diagnosed mental health disorders, and for whom services in the lower tiers have not been adequate. Tier 5 services link people to a full range of assessments and supports including residential programs for the treatment of concurrent mental health and substance use problems (Rush, 2010, p. 628). VCH has announced that it intends to open a 10-bed hospital unit for youth with mental health and substance use challenges at the Hope Centre at Lions Gate Hospital in North Vancouver. The unit will be available to youth ages 13 to 18 who reside in the VCH region and is expected to open in spring 2017 (VCH, 2016). While this is welcome news, the needs of youth with concurrent mental health and substance use challenges living outside VCH remain unaddressed. There are also beds at B.C. Children's Hospital that can be used by children and youth with concurrent psychiatric concerns and problematic substance use. Treatment is limited to the immediate psychiatric concerns, support for withdrawal from substances, and potential consultation with clinicians in the provincial Concurrent Disorders Program, but ongoing treatment for substance use issues is generally provided by community partners.

Case Study: Glen

Glen is a youth in government care who was removed from his family due to parental neglect. As a result, he does not have the same “natural” supports (e.g. parents and other caregivers) as other kids. By 17, Glen is experiencing numerous challenges, including substance use. Recognizing that Glen could use some help, his guardianship worker refers him to a youth community-based substance use program. Glen is initially not that interested in seeing a substance use counsellor but, when they meet for the first time, he discovers that the counsellor is non-judgmental and willing to work with Glen at his pace. Over a period of a few months, Glen continues to see his counsellor even though he disappears for weeks at time and continues to use substances. But each time he resurfaces, he is able to reconnect with the substance use counsellor. About six months down the road, the counsellor helps Glen get into a supportive recovery program where he stays for a few months. After a disagreement with the staff over house rules, Glen leaves and finds himself homeless and couch-surfing. Glen also loses touch with his MCFD social worker and has few supports in his life. At the same time, he has remained in intermittent touch with his substance use counsellor, who has not closed the door on Glen.

When Glen turns 19, he has nowhere to live because he is no longer connected to MCFD. He begins using substances more heavily, including crystal meth. One night, he turns up at the hospital Emergency Room because he is experiencing symptoms of psychosis due to his crystal meth use. After the visit to the ER, Glen again seeks out his substance use counsellor and asks for help. Because substance use services have flexible age mandates, Glen is able to get some assistance, including entry into a residential treatment program where he is able to restore his physical and mental health, and begin planning for the future, including school, work and living independently.

These changes do not mean that Glen’s struggles with substance use are over, but illustrate that the journey can be a long one, even lasting a lifetime. What makes the difference for Glen is the willingness of the substance use counsellor to stick with him without judgment. This approach keeps Glen engaged in services even if only occasionally. Glen’s counsellor uses a harm reduction approach that recognizes that abstinence is not always a realistic goal. This approach also acknowledges that youth and adults alike will find more success in substance use services when they are ready, willing and able to make the most of services.

After care programs

Finding: B.C. lacks formal after-care supports for youth.

Although many community-based services reported that they offer after-care supports, these services are often an informal component of these programs. After-care is an important part of a system of care, particularly following discharge from residential facilities when support is needed for newly acquired skills and prevention of relapse (AADAC, 2006; P.E.I. Department of Health, 2007). After-care can be offered in a variety of formats but often includes weekly follow-up, in group and other formats. There is a dearth of supporting literature on best practices for after-care, although a small body of research has emerged that supports a number of approaches, including face-to-face supports and Internet and other digital media approaches such as texting to help youth engage with post-treatment recovery supports (Gonzales et al., 2014).

The closure of youth residential treatment beds: The Crossing at Keremeos (Portage)

The youth residential treatment facility located in Keremeos, also known as The Crossing, was established in April 2009 as a response to public and political pressure to provide more residential substance use treatment beds for youth ages 14 to 18 struggling with substance use issues. The facility, located in the Interior Health Authority, was operated by Portage, a non-profit agency that runs similar facilities in Ontario, Quebec and Atlantic Canada. Together, the Fraser and Vancouver Coastal Health Authorities provided oversight to this facility. Almost as soon as it opened, concerns arose that the care provided by Portage relied too heavily on a peer-to-peer support model. This model did not provide adequate clinical services that could address the needs of youth with complex mental health and substance use problems who require more clinical counselling and/or psychiatric care. The Crossing also experienced long-standing problems with under-utilization of the facility. There were concerns that the facility was too far away from the Lower Mainland making it difficult for parents and other loved-ones to visit youth, and for youth to transition back to home.

Due to these concerns, in 2013 the B.C. Mental Health and Substance Use Agency (BCMHSU) of the PHSA assumed responsibility for the facility and began working with Portage to redevelop its clinical model. In the fall of 2014, Interior Health halted the intake of new clients at Portage due to non-compliance with Community Care licensing requirements. A number of problems had been identified with its physical kitchen, nutrition program, employee files (incomplete for licensing) and managerial operational processes. In the spring of 2015, Portage announced that it was pulling out of operating this facility. The Crossing at Keremeos closed at this time and the BCMHSU began developing alternatives for the funding previously allocated to The Crossing. In May 2016, the B.C. government announced that it will reopen the Keremeos site with a 22-bed residential treatment facility for youth ages 17 to 24, starting in 2017. The facility will be operated by an as-yet-undetermined contractor.

While it is important to offer more residential options for older youth and young adults, funding must also flow to services along the tiered continuum, including community-based services, and specifically to services for younger youth where they live.

Key Finding: The accessibility of some services is limited by restricted hours of operation, limited age mandates, long wait times and inadequate information on where to find services.

Services to youth must be youth-friendly and adept at meeting youth on their terms. Services are accessible when they use a variety of youth-friendly modes of service provision, have very limited wait times, have flexible age mandates, are available beyond a nine-to-five schedule, do not require regular attendance or adherence to strict rules and extensive disclosure, and are not punitive. In B.C., these criteria are generally not met.

To assess the overall availability of services, this review examined the days and times of service provision, the hours of operation and the modes of service delivery used by providers and services available throughout the province, as well as entry criteria such as wait times and age mandates.

Locations and Hours of Operation

Finding: Locations and hours of operation of youth substance use services make it challenging for youth to seek help.

Flexibility in the days and hours of operations as well as the ways services are delivered can make it easier and more likely that youth will look for help. The majority of community-based services in B.C. operate only during weekdays. Just a few urban-based outreach and community-based services reported weekends and/or weeknight program hours, and only two drop-in services reported offering 24/7 programming. Service providers noted the lack of funding to extend their hours of operation to evenings and weekends.

The majority of service providers reported offering their programs on a one-to-one or group in-person basis, although some did have telephone or videoconference options, including some community-based services. Several health authority interviewees suggested that services should be made available to youth through the Internet or through social media. The ability of these agencies to provide these services was hampered by health authority concerns about the privacy and security of data.

Service Providers' Voices

"Our agency is chronically underfunded and we could offer more services for longer hours over more days if we were funded properly."

"Our hours of service need to better accommodate youth beyond Monday to Friday, 8:30 a.m. to 4:30 p.m."

Age Mandates

Finding: Age mandates for substance use services generally do not reflect the need for flexibility, leaving gaps that can allow younger youth and transition-age youth to fall through the cracks.

While some services are flexible with regard to minimum age, in general, services are provided to youth between 13 and 20. The survey data indicated that the group most likely to request services is youth, between the ages of 16 and 17. Despite flexibility about age mandates, there are no services offered specifically for youth younger than 12. Availability of developmentally appropriate services for younger youth continues to be a gap in the system of care in B.C. This is especially the case for some marginalized youth who are more likely to begin using substances before age 10 and who are usually faced with multiple life challenges (Wekerle et al., 2009).

Services for Young Adults

Despite the limited age scope of this review (13 to 18), health authority respondents expressed concerns about the lack of services for young adults between the ages of 19 and 24. These young adults may not be ready for adult services, but also do not fit well with younger youth. One service provider noted that B.C. Residential Care regulations⁸ do not allow anyone younger than 19 to be housed with individuals over 19 in residential services, although services can apply for exceptions. Both VCH and the Fraser Health Authority are notable for having taken steps to redefine age mandates to be more sensitive to the developmental needs of youth and young adults. As a consequence, the majority of the service providers located in this region have flexible age mandates and will accept young adults older than 19. These concerns were also reflected in the comments from the service provider surveys:

Service Providers' Voices

"Age can be a barrier for youth to access developmentally appropriate services. Young adults who are between 19 and 25 are often unable to access the type of service required, as adult substance use services are tailored to more severe and persistent conditions."

"Substance use-specific residential services have a clear cut-off for community licensing, but the developmental differences between a 19-year-old and 50-plus individual attending a detox program can make the service inaccessible and inappropriate for youth/young adults. Providing substance use resources for young adults 18 to 25 would address this gap in service."

"We had to create a waitlist for 19- to 24-year-olds simply to manage the caseload. We have two full-time counsellors to work for all [of our local area] for youth 12- to 24-years-old who are faced with substance use challenges themselves or those of someone close to them. We do our best to provide service to as many youths as possible and prioritize based on risk, but it is a challenge. Young people are vulnerable simply due to their age and thus deserve to be provided timely, strength-based, client-directed service."

Previous reports released by the Representative have also documented the challenges older youth and young adults face when they seek mental health and other services, especially youth who are leaving government care (*On Their Own*, Representative for Children and Youth, 2014; *Still Waiting*, Representative for Children and Youth, 2013).

⁸ Section 46 (2) (c) of the *Community Care and Assisted Living Act* (Residential Care Regulation) states: "A licensee must not do any of the following: (c) accommodate persons less than 19 years of age if persons over 19 or older are also accommodated in the community care facility." By Order-in-Council facilities licensed under the *Community Care Act* can be granted special licensing to provide services to youth and young adults in same facility.

Finding: Many services have realistic program entry rules that reduce barriers to access.

At least some part of the continuum of care for youth should have relaxed entry rules to ensure that youth can easily access these services. Rules that require youth to maintain abstinence to receive services, or services that only address only one type of substance, for example, can act as barriers to accessing services.

The survey results indicated that the majority of all service providers allow youth to continue to take physician-prescribed medications while receiving services, and that almost all of these services do not require youth to completely withdraw from illegal drugs and alcohol to receive services. Tobacco and inhalants are the least likely substances to be addressed by providers, but very few respondents reported specifically that tobacco does not fall under their mandate and could not be addressed, if necessary. In addition to substance issues, one program reported being able to address Internet and gaming problems, if required. Very few community-based services or day treatment providers require sustained abstinence from youth while participating in their programs. However, the majority of withdrawal management and supportive or specialized residential services do require youth to abstain from substance use.

Finding: Locating youth substance use services is challenging without a one-stop source that lists all services, making it difficult for families and youth to find supports.

Youth and families need to know where to go and who to contact if they need substance use services. The province provides two main ways to for youth and parents to find out about services in their area. One is an interactive map of youth mental health and substance use services co-developed and managed by the MoH and MCFD, and the other is HealthLinkBC, which provides on-line and telephone-based information on health conditions and on available services. A scan of services listed on both HealthLinkBC and the interactive map reveals that neither contains a full list of all available youth substance use services.

Health authority interviewees also reported that other system partners do not seem to be fully aware, on a consistent basis, of all available service in their regions (e.g. schools, primary care physicians, emergency departments). This lack of clarity about available services compounds the difficulties that families and youth face when they want to access appropriate supports and will require a cross-system response from a variety of partners (e.g. schools).

Finding: Flexible referral pathways help reduce barriers to access for youth and families.

One of the strengths of community-based services is that almost all permit youth and their families to self-refer, thereby ensuring that youth do not need to meet onerous entry criteria (e.g. full and on-going abstinence) or pass through a gatekeeper such as a physician. Most of the community-based programs in B.C. also allow a variety of other referral pathways including family physicians, substance use clinicians and other professionals. Some service providers reported having further flexibility in referrals, reporting that parents, teachers, school districts or youth justice organizations could refer youth to their programs.

Wait Times

Finding: Wait times for youth needing more intensive substance use services are considerable in some places.

Even short wait times for services can pose a significant structural barrier for youth. Wait times can discourage youth from entering services and can increase attrition from services as youth life circumstances shift (Health Canada, 2008, p. 6). Research with vulnerable youth in Vancouver has demonstrated that wait times are a key barrier to accessing services (Phillips et al., 2015). This same research has demonstrated that inability to access services is not only common among vulnerable youth, but is associated with transition to injection drug use (DeBeck et al., 2016).

Overall, wait times varied by service type. About one-third of the providers of day treatment programs reported a wait time. About half of the supported recovery providers reported a wait time. As reported previously in this review, services such as Peak House have wait times averaging about 30 days, with an average of 54 days in 2014/15 (Pacific Youth & Family Society, 2015). Almost all withdrawal management programs reported having a wait time but those wait times were short, lasting one to three days. However, even short wait times can be a barrier for some youth for whom the window of opportunity is short-lived due to personal circumstances such as homelessness.

On the other end of the spectrum, about 65 per cent of service providers do not have a wait time for community-based services such as counselling. Where wait times for community services existed, service providers linked their existence to increasing requests for services by youth.

Case Study: Cheryl and John

Cheryl is a single mom with two children including a 16-year-old son, John, and a 13-year-old daughter. Cheryl has been experiencing a great deal of conflict with her son about his substance use and his resistance to attending school. Feeling desperate for support, Cheryl approaches the local community-based youth substance use service to get help with her son's drug use. Like many parents in her situation, she is fearful about her son's substance use and she wants him to stop using and seek substance use services. Cheryl is fortunate because the local youth substance use service also provides supports to parents and caregivers and she is able to receive face-to-face counselling even as her son decides he does not want to access services. After seeing the counsellor for a few months, Cheryl chooses to participate in a support group that focuses on mindful practice as a way of de-escalating conflict between parents and teenage children. Through this group work, Cheryl addresses the volatile relationship she has with her son. This group work also helps her to explore her approach to parenting, and these efforts decrease her reactivity to John's behaviour. Because of the changes he sees in his mother, John becomes interested in accessing counselling and group services that help him address his life challenges. He is now considering seeking further supports to address his substance use challenges.

Family/caregiver involvement and support

Finding: Capacity to provide family or caregiver supports is lacking in some areas of B.C., as is the perceived value of these services.

Parental involvement in adolescent services and recovery increases the likelihood of a successful experience. This may include family counselling with or without the young person, and/or active family involvement from the beginning to the end of the process. Planning for youth services and supports may need to address family dynamics and the needs of family members.

The majority of community-based service providers reported that they provide some level of family supports. These supports range from counselling for families and parent support and education groups to referrals to other agencies that support families. Some services involve families in the development of plans of care, and some services reported they will see parents and other caregivers even when youth are not ready for services. The more intensive the services, the more likely they were to report that they provide supports to families. This was particularly true for residential services, which offer consistent and sometimes quite intensive supports to families, including regular meetings between parents or caregivers and youth, parent/caregiver groups, and family involvement in the development of a either a post-service transition plan or a plan for family reunification.

However, despite these positive indications, some service providers reported that their capacity to provide family supports was limited by lack of resources or by lack of training on how to support families. Most health authority representatives indicated that they need increased capacity to provide family supports and increased recognition from their health authorities of the value of these services.

Family supports are particularly well-developed at Island Health, where both Discovery Youth and Family Substance Use Services and contractors are able to provide a coherent set of supports for families. These supports include one-on-one counselling and support groups for parents, as well as a workbook designed to support parents entitled *Recognizing resilience: A workbook for parents and caregivers of Teens Using Substances* (Island Health, 2015). This workbook is also accompanied by a companion document for practitioners (Island Health, 2016).

Service Providers' Voices

"We need more funding to hire family specialists so the whole family is treated, not just the 'identified patient'. Substance use is often a systemic issue and we need to focus on the whole family. The resources are not there to be able to do that. We work with youth but if nothing is changing within the family system then the success for the youth is going to be limited depending on the situation."

Key Finding: The majority of substance use services for youth in B.C. are not designed to meet the needs of specific youth populations.

Responsiveness is the willingness and capacity to provide programming that is appropriate to the specific needs of some groups of youth, including Aboriginal youth, LGBT2Q+ youth, pregnant and parenting youth, and immigrant and refugee youth. The following section looks at findings specifically regarding the availability of services that are deliberately designed to meet the needs of these groups of youth.

Immigrant and Refugee Youth

Finding: There is a lack of substance use services to support Immigrant and Refugee Youth

Services for immigrant and refugee youth are important because these groups of youth are often exposed to social conditions that can contribute to substance use problems, including racism, disruption of home life and language difficulties (Hansson et al., 2010). Unfortunately, there are few to no substance use supports specifically for immigrant and refugee youth in B.C. and, in fact, several interviewees noted the dire lack of services for these youth.

Gender identity

Finding: Few services indicated that they are purposely designed to support the needs of young women or young men specifically, and only a handful of services reported that they could meet the needs of transgendered youth.

Research shows that girls and boys do not always experience substance use challenges in similar ways. Substance use and mental health challenges can be intertwined issues and often a response to experiences of trauma and violence, both of which can be gender specific. This means that boys and girls may react to violence differently and may be subject to abuse in different ways. The social meanings attached to substance use can also be different for boys than for girls. In addition, there are significant differences between girls, in economic status, cultural identity, family roles, sexual orientation, parenting and child care responsibilities, and intimate partner violence (Poole & Dell, 2005).

All services (including community-based and residential) offered by health authorities appear to be designed to provide services to both female and male youth. This does not mean that these services were designed for – and are appropriate for – girls and young women, or sensitive to differences between boys and girls. Some services indicated that they were sensitive to issues of gender identity, although that does not mean these providers offer services specifically for transgendered youth.

LGBT2Q+ youth

Finding: A lack of awareness exists across B.C. of the services needs of LGBT2Q+ youth.

Despite the fact that LGBT2Q+ youth are a diverse group, research shows that these youth are still subject to discrimination and violence based on gender and sexual identities, and have not been well served by traditional substance use services (Nuttbrock, 2012). It is important that services respect and support the diversity of ways that gender identity and sexual orientation can be experienced and expressed. In B.C., there is only one service provider that offers services specifically for this population of youth. PRISM is a Vancouver Coastal Health (VCH) program that offers clinical, education, information and referral services for LGBT2Q+ youth. PRISM also offers capacity-building training and information services for other VCH staff, other service providers, community members and others. PRISM's substance use services include the C.A.L.L. Out! Project, an alcohol and drug prevention initiative for youth ages 15 to 24. Across B.C., a very small number of other service providers indicated that they have specifically developed programming that is LGBT2Q+ friendly (VCH, 2014a; VCH, 2014b). Despite the lack of LGBT2Q+ specific services, there are also organizations in Vancouver that have a long history of working with diverse clients including Watari, PLEA, Peak House, and the Boys and Girls Club of Vancouver, as well as Island Health's Discovery Youth and Family Substance Use Services.

Services to Aboriginal youth

Finding: Culturally appropriate services for Aboriginal youth are few and far between in B.C.

Culturally appropriate substance use services for Aboriginal youth are not widely available in B.C. While all service options in the province report that they provide services to Aboriginal youth, these programs are not necessarily designed with Aboriginal youth in mind.

Notable exceptions to this include the Urban Native Youth Association (UNYA) in Vancouver, which provides residential services and out-patient counselling services to Aboriginal youth. UNYA has recently redeveloped its philosophy and values for its residential program to embrace a youth-centred, harm reduction approach that draws on cultural teachings to enhance youth wellness and healing. This program also recognizes the uniqueness of each youth and the role that social and historical events have played in shaping youth health challenges such as substance use.

Northern Health also funds a substance use worker in eight Friendship Centres throughout the region. These workers are mandated to provide services to youth and adults and are the only part of the Northern Health youth substance use service continuum that is contracted out. Interior Health has contracted with nine Aboriginal service agencies to provide a mix of mental health and substance use services, referrals and case management for Aboriginal youth with substance use problems. Fraser Health also funds a counsellor in the Mission Friendship Centre, and one position in Chilliwack to focus on Aboriginal needs.

Services for Aboriginal youth, like those for Aboriginal adults, are currently in transition. The FNHA has assumed responsibility for the programs that were formerly operated by Health Canada through the federal National Native Alcohol and Drug Abuse Program (NNADAP). These include the Nenqayni Wellness Centre located in Williams Lake, a four-month residential program for First Nations and Inuit female youth ages 13 to 17 from across Canada who use inhalants. There are also other programs, such as Carrier Sekani Family Services, the Hey'Way'-Noqu' Healing Circle in Vancouver and the Kackaamin Family Development Centre in Port Alberni (FNHA, 2015c). The FNHA is currently reviewing the

former NNADAP programs with an eye to developing a more comprehensive, culturally safe, and relevant approach to programming. Findings of this review have not yet been released. (A list of substance use services offered for youth by the FNHA is included in Appendix 3.)

The FNHA is also implementing a variety of programs throughout the province to support mental well-being for Aboriginal youth, adults and families. The type of services offered in each location depends on the needs and recommendations identified by regional sessions held throughout the province in 2014. Recommendations from these sessions were incorporated into Regional Health and Wellness Plans for mental wellness and substance use. These programs include youth suicide prevention, promoting mental wellness, early identification of emerging mental health and substance use challenges, mobile substance use services, continued supports after youth have completed a program of services, and health system navigators. The FNHA is also focusing on making all of its programs culturally safe and on prevention work where possible.

Northern Health is working with the FNHA on a proposal to create mobile support teams that will provide mental health and addictions services to First Nations people, both on- and off-reserve. These small teams will be located in a number of communities across the north to support integrated community primary care clinics and teams, and are an example of a model of service provision suitable for rural and remote areas.

Both Island Health and Northern Health report that they have been working with Aboriginal communities to encourage youth to attend their services and to collaborate on service provision and access to services. The Nechako Treatment Centre in Prince George, for example, reports that it makes Aboriginal healing practices available to Aboriginal youth who attend this program.

Services to pregnant and parenting youth

Finding: There are very few programs in B.C. that work with pregnant and parenting youth who have substance use issues.

To ensure the best outcomes for parents and children, services to youth who use substances and who are pregnant and/or parenting are vitally important. Pregnant and parenting youth who use substances face unique challenges, including intense discrimination that can discourage them from accessing much needed services such as pre-natal care. The Representative sees far too many cases where young parents – especially young mothers who use substances – are not provided with appropriate supports at the beginning of their pregnancies. Programs that work to engage parents must move beyond judgment and be able to address underlying issues that contribute to neglect and abuse, including parental responses to grief, loss and violence, support parents to participate in decision-making, establish positive relationships between professionals and parents, and ensure the availability of other supports such as transportation. The research evidence for non-judgmental, harm reduction-based interventions for young parents is encouraging (Nichols et al., 2012).

Supports to parents before, during and after the birth of children can contribute to healthy child development and appear to help reduce behaviour problems in children as they grow up (Ibid., p. 20). The evidence base suggests that developmental interventions that operate at different points in the life-course and in different settings are key to the success of these initiatives. The value of these programs is also enhanced by educational programs that support community awareness of child development and by developing programs that are sensitive to local needs and differences (Tombourou 2005, p. 83).

While few programs exist in B.C. for pregnant and parenting teens with substance use issues, there are some excellent service options for young mothers in some urban centres. Programs such as Fir Square Combined Maternity Care Unit at B.C. Women's Hospital, Sheway and the Maxxine Wright Centre are built around models of successful parental engagement specifically for pregnant women and mothers.

- The Maxxine Wright Community Health Centre in Surrey supports women who are pregnant or who have very young children and who are also impacted by substance use and/or violence and abuse. The centre provides a range of safe, non-judgmental services under one roof, including a hot lunch program, drop-in, medical and nursing care, alcohol and drug counselling, assistance with housing and income supports, access to a social worker and parenting programs (Attira, 2015).
- Sheway is a pregnancy outreach program located in the Downtown Eastside of Vancouver and supported through a partnership between VCH, MCFD, the Vancouver Native Health Society and the YWCA of Vancouver. The program provides health and social service supports to pregnant women and women with infants under 18-months-old who are dealing with substance use issues. The focus of the program is to help women have healthy pregnancies and positive early parenting experiences (Sheway, 2015).
- Herway Home in Victoria is for women who are pregnant or early parenting (with a baby six months of age or younger at intake) who are also affected by substance use and often mental health issues, violence and trauma. Once women are connected with Herway Home, they can stay with the program until their youngest child turns three. Herway Home provides one-to-one counselling and case management, outreach, advocacy, drop-in prenatal and postnatal care, primary care and a substance use recovery group along with pragmatic supports such as donations, food vouchers and bus tickets.

These integrated programs for pregnant and mothering women share common approaches, including being non-judgmental, women-centred, and drawing on harm reduction approaches. The pragmatic and non-judgmental approach used by these services helps to address societal stigma that often prevents substance-using parents from asking for help. These programs are associated with positive impacts on child development, growth, and emotional and behavioural function and with connecting women to pre- and post-natal care, improvements in housing and nutritional status and in retaining custody of children (Nichols, et al, 2012; Poole, 2000). Similar programs exist in other parts of Canada, including Toronto and Edmonton.

Valuing Youth Workers

All health authorities noted the willingness of their youth substance use staff and contractors to meet the needs of youth. As they said, there are many clinicians and social workers who have been working with youth substance use challenges for several years. They are more than willing to “go the extra mile” and are very skilled at youth engagement and at navigating formal and informal service options to ensure the best outcomes for their clients

“Workers try hard within the system that isn’t set up to work for them and their clients and they have learned to effectively and creatively work around that.”

“Youth services: strengths – incredible body of people who are very committed to youth; there’s almost like a special quality of people and extraordinary commitment to these kids, and to not give up and to be as engaged as they can. Don’t see the same numbers of committed people in the adult system. It’s almost like people in youth services go above and beyond, because they are so committed and passionate.”

Although the programs noted above have flexible age mandates, none of these programs are specifically designed for youth. Vancouver's Downtown Eastside-based Watari Services is the only agency in B.C. that offers a program for pregnant and parenting youth. Although not focused specifically on substance use, the *Transitioning to Independence for Pregnant and Parenting Youth* (TIPPY) program addresses the needs of homeless youth who are pregnant or parenting. This program provides housing for 10 young parents and their children and works with them to plan for the future, including providing life skills and parenting skills as well as options for addressing substance use (Watari, 2015). The program was previously funded by the Vancouver Foundation but, despite positive findings from an external review, the program does not currently have a government funder.

Services for marginalized youth

Finding: Outside of downtown Vancouver, there are very few low-barrier harm reduction programs specifically designed for marginalized youth.

Several health authority respondents were concerned that marginalized youth were not receiving the services they needed and stressed the importance of establishing more youth-oriented harm reduction programs that can both prevent the transmission of HIV and other blood-borne pathogens and operate as a pathway to other supports. Expansion of these programs can also build on excellent examples of successful youth harm reduction initiatives in B.C. (e.g. Anchors in Nelson).

As the data presented in the Background to this report show, there is a high prevalence of problematic substance use among youth who are marginalized. Additionally, some marginalized youth may not have received the early supports to help them cope with abuse and neglect. Professionals may be frustrated with what they perceive to be youth behaviours that are potentially risky to their health and well-being. But these youth may have responded to past abuse by not trusting adults, or challenging adult authority. Because of lack of trust in adults and in services, youth may test the boundaries of professionals or may seem uncooperative and unmotivated. In turn, professionals can respond by making these youth a low-priority because they seem to be difficult to connect with or “resistant to change.” Engaging these youth requires service providers to recognize that while youth involved in the child welfare system may be dealing with past and present experiences of violence and neglect, they also have well-developed strategies to resist, and strengths to build on (Kinewesquo & Bonnah, 2009; Smith & Eaton-Erickson, 2009).

Harm reduction includes policies, programs and practices with the goal of reducing the adverse health, social and economic consequences of the use of legal and illegal psychoactive substances without necessarily requiring abstinence. Harm reduction programs accept the reality that people use substances and that a drug-free society is an unlikely and unrealistic goal. The evidence supporting the effectiveness of harm reduction is significant (WHO, 2009; Canadian Nurses Association, 2011; Marlatt et al., 2012). In many places, a minority of adolescents may be using substances in heavy and harmful patterns, particularly as a means of escaping distress. These patterns have been difficult to change and harm reduction programs have emerged to address such issues.

Harm reduction initiatives are mainly low-threshold, meaning there are few requirements for accessing these services. These services are often used by adolescents who are marginalized from other health care services and can be a first step to gaining access to other services.

Key Finding: Leadership on youth substance use services is lacking and the direction of planning is in constant flux.

This review confirms that youth substance use services lack a clear strategic direction that addresses not only service delivery, but also key system supports such as workforce capacity building, effective policy and standards, robust quality assurance systems and collaboration with other system partners. This review also finds that governmental direction for substance use services is currently undergoing significant change, leading to uncertainty for both planners and service providers.

As noted in the Background section of this report, MoH is working on the implementation of a “Primary Care Home” (PCH) model defined as a “community-based network or group of full-service family practices formally linked with a team of health authority-delivered primary care services that are locally accessible for all health-related concerns” (MoH, 2016, p. 36). The MoH has created an MHSU “framework” to understand how a PCH will be linked to multiple mental health and substance use services currently provided across multiple sites including medical, psychological and social services. This framework acknowledges that the current approach to MHSU services is fragmented, that MHSU clients are often far too reliant on emergency department and acute care services to meet their needs, and that stigma directed against people with substance use and mental health problems continues to be a challenge. The data presented in this framework also notes that it is important to intervene early including in childhood and adolescence, to prevent MHSU problems from becoming worse. The framework notes that a formal medical diagnosis is not an indication of the severity of an MHSU and proposes that a system of care should be organized around the needs of the individual rather than around a diagnosis. For the Representative, this is good news, as many children and youth who come to the attention of this Office often have a raft of psychiatric diagnoses that do not always result in better care.

This framework is meant to help overcome the fragmentation of services experienced by many clients. It relies on the tiered continuum of services described previously in this report to understand the relationship between service types and individual needs. In the proposed MHSU framework, a person could obtain needed MHSU services through a PCH, and the PCH would provide coordination of care and care planning, two elements that are often missing currently. The framework also states that this system of care is “*not meant to operate independently of community supports*” (e.g. community-based services) and acknowledges that clients might want to first seek care through a low-barrier community-based service. Health authorities have already begun planning for the PCH model, and MoH expects they will have their plans in place by later in 2016.

The findings of this review show that not only are low-barrier community-based programs an asset in a system of care for youth substance use services, but that in many places in B.C. these services employ skilled individuals who are adept at engaging youth. Additionally, a large component of youth substance services from across all tiers are offered by contracted service providers. This means that considerable planning will need to go into ensuring these providers are fully integrated into this new model of care to preserve the advantages that these services currently offer. There are likely considerable benefits to reducing fragmentation of current MHSU services, and the proposed model in this framework is potentially a welcome improvement, but how this framework will be translated into action remains to be seen.

Other events may also introduce more changes to how MHSU services are organized. The B.C. Legislature’s Select Standing Committee on Children and Youth (SSCCY) released its final report on

child and youth mental health in B.C. in January 2016. This report recommends the implementation of a minister for mental health, but gives no indication of what role, if any, substance use services would have in these new arrangements. In addition, the B.C. government has established a Cabinet Working Group on Mental Health, chaired by the Deputy Premier. The mandate of this working group (supported by a secretariat) includes all mental health and substance use services across the lifespan and across the continuum of tiered services. It is unclear what the outcome of this initiative will be but it, too, could have major ramifications for how substance use and mental health services are organized, funded and delivered in B.C.

Finding: There is a lack of provincial leadership on policies, standards, workforce capacity building, and quality assurance processes

Lack of policies and standards

Policies and standards specific to youth substance use services are necessary to clarify what is expected of service providers. Standards provide a framework for accountability by establishing expectations and service indicators, and act as a vehicle for quality improvement. Monitoring the implementation of standards is also an important component of ensuring that services are meeting their goals (Addiction Services of Nova Scotia, 2013).

One of the few documents in B.C. that clarifies the expectations for youth substance use service providers is the MoH document *Service model and residential standards for youth residential substance use services* (B.C. MoH, 2011).

Another set of standards for youth withdrawal management services has been created at MoH, but has yet to be implemented. The lack of comprehensive standards for community-based services contrasts sharply with jurisdictions such as Nova Scotia, where a set of *System Level Standards for Community-Based Addiction Services* has been implemented (Addiction Services of Nova Scotia, 2013). These standards set expectations for program documentation, evaluation, monitoring, quality improvement, intake and assessment, as well as specific expectations for community-based adolescent services.

Promising Practices

Workforce Capacity Building – Core Addictions Practice

An example of workforce development is the Core Addictions Practice (CAP) program. CAP is a short training program that provides substance use service providers with an essential conceptual framework and foundational knowledge to provide communities with substance use services that are current and evidence-informed. CAP incorporates learning focused on engagement practices, foundational clinical skills, working from a strengths-based perspective, and addressing myths and stereotypes about substance use and substance use services. Fraser Health makes this training available to a range of service providers including mental health professionals, social workers and police officers. Island Health makes CAP available to allied professionals, including women's transition services, school staff, public health and other youth-serving agencies. The CAP course originated as a result of a partnership in 2009 between three health authorities: Fraser Health, Interior Health, and Vancouver Island Health. CAP course materials were updated in 2013 and are available to all health authorities. At present, no organization has responsibility for CAP, although discussions are underway with MoH to determine provincial stewardship for this training. CAP was previously supported by the federal Drug Treatment Funding Program.

At the health authority level in B.C., there are also few publicly available policies that guide youth substance use services. Notable exceptions include a set of policies for substance use services in Fraser Health and a policy on *Family Involvement with Mental Health and Addiction Services* in Vancouver Coastal Health.

Lack of quality assurance systems

Quality assurance focuses on gathering and assessing a range of information on programs and services with the goal of identifying where improvements are needed. Proper quality assurance includes:

- gathering and assessing data on who is using services, how well they are meeting goals and how satisfied they are with services
- setting evidence-based standards and monitoring adherence to these standards, including accreditation processes
- ensuring client and stakeholder feedback is gathered and used to assess the effectiveness of services (WHO, 2006).

Data collection in both youth and adult substance use services is particularly problematic in B.C. (Centre for Addictions and Mental Health, 2011). Although the data on clients in the MHSU systems can be accessed through physician billing, acute care (e.g. hospitals), and emergency departments, data on clients who use services provided by contractors is largely unavailable at the provincial level. MoH has mandated health authorities to collect data on their in-house services by using the provincially defined Minimum Reporting Requirements. In turn, health authorities have developed compatible systems to collect this data. These systems, however, are unavailable to contracted service providers due to privacy concerns.

Some health authorities use their own formal and informal methods for collecting data from contractors, but these systems do not allow for the collection and comparison of data at the provincial level. Aggregate or overall data on service utilization and client outcomes is also not readily available in some health authorities, making it difficult to assess the effectiveness of services and determine if they are reaching the intended groups of youth. There is also no public reporting that provides an overview of how these services are used and how well health authorities are doing at meeting their own goals.

The lack of data collection undermines the ability of health authorities to know who is using their services, and how satisfied clients are with services. In turn, lack of data on these issues makes it difficult to know how well services are meeting their expectations and where adjustments need to be made. Lack of data collection also makes it challenging to continue to justify budget expenditures on these important services. Given that a large majority of youth services are offered by contractors, this lack of data collection means that youth services can lack visibility at the health authority and provincial levels.

Another key ingredient for planning is a needs-based analysis that can provide comprehensive, systems-level information to inform the allocation of services by type and according to population and sub-population needs. Given that health authorities have integrated mental health and substance use services, a needs-based analysis must also be able to inform planning for services for youth with both mental health and substance use challenges. In B.C., funding for programs is typically informed by budgets from previous years, resulting in gaps in services that are perpetuated into the future (Rush et al., 2012; Rush et al., ND). The MoH has reportedly conducted a needs-based analysis of substance use services. The findings of this analysis have not been made public and it is not clear if youth needs were clearly identified and disaggregated from adult needs

Lack of Support for Workforce Capacity Building

There is little provincial support for workforce capacity development, including the development of the knowledge, skills and values for working with youth who have substance use problems. Respondents emphasized, in particular, that significant efforts are needed to ensure that evidence-based clinical competencies appropriate for youth, including skills in youth engagement, are mandated throughout the province.⁹ They also emphasized the need for programs such as the Core Addictions Practice (see text box on p. 42) training

Promising Practices

Workforce Development and Knowledge Exchange

Robust systems for exchanging knowledge between people who work with youth is key to the development of effective services.

An example of knowledge exchange in B.C. is the funding provided for Addiction Knowledge Exchange (AKE) Leaders through the federal Drug Treatment Funding Program (Government of Canada, 2015). In 2009, an AKE Leader position became available to all health authorities in B.C. Priority knowledge exchange areas include workforce development, trauma-informed practice, expanding Aboriginal partnerships and stigma prevention and reduction. Health authority respondents noted that this program has funded web-based efforts at clinical training for the regions which have been particularly helpful, but which are also dependent on one-time funding from the federal Drug Treatment Funding Program (Collins & Kristy, 2013). The federal Drug Treatment Funding Program completed its cycle of funding in B.C. on March 31, 2016.

⁹ For materials that support the workforce development see: Canadian Centre on Substance Abuse (2015). The B.C. MoH standards for youth residential treatment services (2011) mandates agencies to abide by the competencies defined by the CCSA.

to be offered more broadly. Training programs are also needed to address any lingering discrimination by professionals against youth who use substances.

Finding: There is a lack of attention to substance use services by health authorities

This review confirms that the majority of health authorities have not paid sufficient attention to substance use services. While the integration of substance use and mental health services has benefits, this integration has resulted in two challenges – substance use service budgets being absorbed into mental health services and the de-prioritization of clinical and other expertise on substance use. In fact, respondents in this review were very concerned that when it comes to addressing the need for greater attention to mental health services, consideration of substance use services is often dropped from this discussion by both planners and clinicians.

These problems are compounded by the lack of attention given to community-based services in health authority budget-setting processes. These have been on-going challenges at the health authority level since the integration of substance use and mental health began in B.C. more than a decade ago (ASAP-BC, 2010). Respondents to the survey for this report also said that decisions about budgets and service-delivery options are increasingly being made by mental health managers who do not have a clinical or policy background in substance use.

Case Study: Donald

A 15-year-old boy, Donald, has suffered a long history of abuse and neglect and his family has been investigated numerous times by MCFD. By his teens, he has regularly moved between family members located in two geographically separate locations in B.C. Donald lost his mother when he was young and, before that, he and his mom moved around a lot. By age 12, he was living with his father and step-mother, but that relationship had become increasingly conflictual and Donald moved to another location to live with his mother's relatives. There were problems with the transfer of his MCFD Child Services file between the two locations and, as a result, a full recording of his history was not available to his current social workers. By age 15, Donald was found intoxicated in public on several occasions and was referred to a variety of substance use counsellors and to mental health programs. Unfortunately, he does not remain engaged with these services because of the high turnover of counsellors and a lack of coordinated services. This lack of reliable and coordinated services has contributed to his understandable resistance to "re-telling" his story so many times and, in turn, contributes to his lack of interest in seeking further services. He continues to drink heavily into his late teens.

This loss of clinical and policy leadership has meant that the continued development of substance use services has either stalled or become overwhelmed by mental health priorities in many areas of the province. As one respondent summed it up: *“Somebody needs to be at the table to protect [substance use] service provision.”*

The lack of attention to substance use services is evident in health authority strategic planning documents. The annual health authority service plans contain little information about the overall direction for mental health and substance use services, with even less attention paid to youth services. With the exception of Fraser Health, there is also a lack of publicly available strategic planning documents for mental health and substance use services that lay out specific and concrete key goals and milestones for achievement of these goals. Only Fraser Health has issued a planning document specific to its MHSU services, *Mental Health and Substance Use: Strategic and Operational Priorities, 2015-2020* that sets out specific expectations for the future of community-based, acute, tertiary and other services.

Without these documents it is almost impossible to assess what specific commitments the province or the health authorities have made to the development of a system of care for youth with substance use problems, nor can this review assess health authority plans for service provision in the future. The absence of publicly available strategy documents also confirms respondents’ concerns that substance use does not have a high enough profile in health authority planning.

Finding: Lack of collaboration among health and other system partners continues to be a challenge in B.C. and creates barriers for youth

The first indications that a youth has challenges with substance use are likely to be evident in schools or during visits to family physicians, drop-in clinics or hospital emergency departments. This reality makes these sites ideal for the identification of existing and emerging problems and for connecting youth to other supports. But interviews with health authorities and data collected from the surveys reveals that collaboration between these systems continues to be a challenge. A 2014 RCY survey of health authority partnership agreements between health and other system partners (e.g. schools, policing, Emergency Rooms, and primary care) found the following:

- Four of five health authorities have formalized arrangements with schools to conduct initiatives to raise awareness of substance use issues (e.g. school presentations, school-based programs), although the scope of these initiatives varies considerably between health authorities
- Partnership arrangements are limited between health authorities and others such as policing and primary care

Service Providers’ Voices

“Our community would be better served if we had more connection to the Emergency Department such that youth who go to the ED for overdoses could be connected directly to our outreach counsellors.”

Service Providers’ Voices

“Our experience is that youth substance use services are more accessible than youth mental health services.”

“We definitely need more access and partnerships with mental health for youth. Many youth are showing up with mental health issues in conjunction with substance use issues and there are no resources to refer them to.”

Analysis and Findings

- Only one health authority reported that it had a formalized arrangement with police to handle referrals to substance use services
- Transitions between Emergency Departments and community-based substance use services were of particular concern to both health authority and survey respondents.

While some community-based services reported that they currently work with local schools to identify youth who need assistance with substance use problems, many others reported that they are plagued by a lack of resources to offer these services. Without these connections, opportunities to identify substance use problems before they become more intransigent can be lost.

Despite these challenges, there have been significant efforts across the province to overcome the lack of collaboration between services. The Fraser Health authority, for example, developed stronger relationships with hospital emergency departments, local police detachments and other community partners to meet the needs of intoxicated clients. Another example is the Child & Youth Mental Health & Substance Use Collaborative, an initiative of Doctors of B.C. and MoH.

The Collaborative began in 2013 in Interior Health and now includes participation from Vancouver Coastal Health, Island Health, Northern Health and Fraser Health, along with MCFD. The Collaborative has sponsored more than 65 Local Action teams comprised of professionals, parents and youth who develop action plans specific to the issues in their local areas. The Collaborative also sponsors a series of *Systems Barrier Working Groups* addressing topics such as emergency department protocols, information sharing, transitions (youth to adult), physician recruitment and retention, and evaluation and measurement. One of the projects initiated by the Collaborative is a new protocol to help youth transition from emergency departments to community-based services (B.C. Ministry of Health et al., 2015). The completion of the protocol along with its implementation at a range of hospital sites is still in process as of January 2016 (Shared Care: Partners for Patients, 2015).

Finding: The provincial division of responsibility for substance use services and mental health services creates numerous challenges and means that youth who need both substance use and mental health supports must navigate separate systems of care.

Survey data indicated that the capacity of youth substance use programs to offer mental health supports varies considerably between program providers. Many providers can offer informal supports to youth who are struggling with mild mental health challenges, but where youth are struggling with moderate to severe mental health problems, specialized mental health services will likely be required.

Service Providers' Voices

"Improve the connection between child and youth mental health and substance use services ... that they sit alone, must be navigated separately, rarely share information between systems ... and CYMH (Child and Youth Mental Health Services) waitlists are abysmal at best."

Although MoH provides funding to the health authorities for substance use services and for tertiary and acute mental health services for children and youth, it does not fund community-based mental health services for children and youth. These services are funded by MCFD through CYMH and most of these services are offered by MCFD or its contractors.¹⁰ Respondents for this review heartily agreed that the challenges resulting from this division of responsibility include:

- challenges to the provision of coordinated mental health and substance use care that make it difficult for youth to move easily from substance use to mental health supports or to receive those supports concurrently in the same service
- challenges with information sharing that inhibit case management
- referral of CYMH clients with concurrent mental health and substance use concerns to health authority services
- continued challenges with waitlisted and overburdened CYMH services

The organization of substance use and mental health services for youth has been a recurring concern in reports released by the Representative. The Representative concurs with the recent recommendation of the B.C. Legislature's Select Standing Committee on Children and Youth that mental health services for youth should have a higher priority in government and dedicated cabinet-level leadership, but would like that priority and leadership to also include substance use services for youth as a fully fledged partner in any MHSU configuration of services or organizations..

The Representative's 2013 report on child and youth mental health services in B.C. recommended the implementation of a Minister of State for Mental Health to ensure that these services receive the attention they so desperately need (*Still Waiting*, Representative for Children and Youth, 2013). Regardless of where the responsibility for mental health and substance use resides in government, the overarching goal should be strengthening provincial leadership for both so that the substance use and mental health needs of children, youth and their families are met in a seamless and timely manner.

¹⁰ Challenges with accessing and coordination of services provided by CYMH and the acute and tertiary components of the youth mental health system have been documented in a previous report issued by the Representative. See: Representative for Children and Youth. (2013). *Still Waiting: First-hand experiences with youth mental health services in B.C.* Exceptions include VCH where services have been contracted to the health authority, the community services agency Intersect in Prince George, and three specialized youth concurrent disorders therapists co-funded by Fraser Health and MCFD.

Conclusion

It is abundantly evident that substance use issues can have a significant impact on youth health. Addressing these potentially negative effects is a crucial component of the right to the best possible health care guaranteed by the *UNCRC* (Article 24). Additionally, when appropriate substance use supports are offered, the financial benefit to society is many times the cost of services (U.K. Drug Policy Commission, 2012; NASADAD, 2013).

This review found that B.C. does not have a complete system of substance use services for youth that covers the full spectrum of needs, from prevention, to assessment, to specialized substance use services. These challenges often leave youth and their families confused, frustrated and without help.

The province also lacks comprehensive leadership for a truly whole-system approach to youth substance use, leadership that would ensure not just adequate service delivery, but would commit government to overcoming a serious lack of leadership on quality assurance, standards and workforce capacity development.

Despite these limitations, this review found that many workers and some local leaders are dedicated “champions” who work to address the needs of youth by embodying the qualities that characterize the best of youth engagement practices, including openness and a non-judgmental approach. Where services work well together, it is because these leaders have put considerable time into developing relationships between service providers, offering training for all workers and developing quality improvement practices that keep youth needs at the centre of service design. Unfortunately, not every region in the province has these champions and services have suffered as a result. Clearly, a system cannot simply rely on such champions, who may move to other positions or retire. It is only through strong leadership and vision that the appropriate set of services is available – not through luck, but through design.

There is a considerable way to go to meet the needs of B.C.’s diverse youth population. In particular, services for Aboriginal youth are underdeveloped, although promising options are emerging from the work of the FNHA. This review demonstrates that some types of services for some of the most vulnerable youth in B.C. are not available in a timely manner, sometimes resulting in increased drug use and more risky drug use behaviours.

Lingering and deep-seated discrimination against youth who use substances has also hampered the development of suitable services. Old-fashioned notions of “rehab” are promoted through a steady diet of television programs and movies that advance the view that confrontation and residential treatment services are the only and best option for anyone who uses alcohol and other drugs. In fact, what this review reveals is that while residential treatment services are a necessary component of a system of services, community-based services that offer outreach and face-to-face supports such as counselling can often meet the needs of youth. However, community-based services sometimes go unappreciated by health authorities, even when these services can help prevent more expensive hospitalizations by providing timely supports before things become more dire.

Pathways to care for youth are fraught with information gaps and failures to communicate between system partners. Too often, discrimination and lack of understanding about substance use means that youth shy away from asking for help. Additionally, adults sometimes do not know about the valuable services available in their communities. But even when everything goes well, youth still face the reality that community-based services are under-resourced to meet their needs.

To ensure that youth can access substance use services in a timely manner, the province must lead a renewed cross-ministry effort that ensures all systems that touch the lives of youth are able to help them get supports early.

In addition, the voices of youth are not sufficiently incorporated into the planning and implementation of youth substance use services. The *UNCRC* guarantees all youth a voice in the decisions that matter most. This means that adults must take the time to ask youth for their input into service design and delivery. The *UNCRC* also guarantees that children and youth should be free from discrimination based on culture and ethnicity and it guarantees children and youth the right to the best possible health care. Neither of these rights is safeguarded by the current system of services for youth with substance use problems, either because of a lack of services generally, or a lack of services that are appropriate to the needs of some groups of youth, including Aboriginal, LGBT2Q+ and immigrant and refugee youth.

There is major work to be undertaken in B.C. to pull together a true system of substance use services that meets the needs of diverse groups of youth. This work will not be easy, but B.C. has excellent resources in the form of on-going research and people who can help build this system.

For change to occur, the province must show concrete and meaningful leadership by ensuring that programs and services are guided by standards and clinical expertise, and that there is adequate and earmarked funding. Programs and services must address youth needs for low-barrier community-based options, located close to home. These types of services can also be cost-effective compared to more expensive options such as residential care. For the sake of B.C.'s youth, government must go beyond high-level commitments and make specific and concrete plans to meet the clinical and age-specific needs of diverse groups of youth.

Recommendations

Recommendation 1

That government create a single point of leadership and accountability for youth substance use and child and youth mental health services, and services for youth with concurrent mental health and substance use challenges, that includes executive management and policy and other support staff. The mandate of this single point of leadership should include the full spectrum of services and system supports for children and youth. It is the responsibility of government to determine the best course of action for achieving this recommendation.

This one point of accountability should be responsible for the remaining recommendations in this report.

Details:

This single point of leadership and accountability can be accomplished in a number of ways including any of the following:

- Creating a minister or a minister of state
- Assigning responsibility for coordination to a specially designated deputy minister
- Assigning full responsibility for leadership, strategic planning and service delivery to an agency of the Provincial Health Services Authority.

Recommendation 2

That government develop and implement a five-year strategic plan for the comprehensive system of services described in recommendation No. 1 that is fully resourced through additional funding. This five-year strategic plan should be developed with the engagement and input of youth, their families, health authorities and other service partners, including contracted youth substance use service providers.

Details:

The strategic plan should include:

- An initial needs-based assessment of youth substance use services across B.C., followed by allocation of resources to substance use services that are appropriate for meeting the identified service needs of youth and their families.
- Specific attention paid to the service-delivery needs of Aboriginal youth and families.
- The creation and maintenance of a comprehensive system of substance use services that consistently meet the needs of youth and their families in communities across the province. A comprehensive system includes both specialized residential and community-based youth substance use services, harm reduction services and supports for families or caregivers, as well as prevention and early intervention supports. This plan should include models of service delivery appropriate to both rural and urban areas of B.C.
- The creation of a comprehensive framework of policies and standards to ensure consistent, quality services across B.C. that are accessible and friendly to youth, responsive to specific youth populations as described in this report and supportive of families of youth with substance use problems.
- The creation and monitoring of a framework, including any required policies and protocols to support inter-agency and inter-professional coordination and collaboration. This framework should be centred on meeting the needs of youth with substance use problems and their families. This framework should also address linkages between substance use services and:
 - MCFD Child and Youth Mental Health services
 - School-based settings
 - Primary care
 - Hospital emergency departments
 - MCFD child protection and guardianship services
 - Aboriginal child and family services
- Identification of workforce capacity building initiatives that support youth substance use services and clinicians
- Quality assurance mechanisms, including the generation and use of data and other information on service utilization, progress toward goals and outcomes, and client satisfaction.

Recommendation 3

That the appropriate ministries and the health authorities, in consultation with other stakeholders, undertake broad-based educational activities aimed at both professionals and the public with the goal of eliminating stigma and discrimination toward youth with substance use problems.

Acronyms

BCMHSU	B.C. Mental Health and Substance Use Services
CYMH	Child and Youth Mental Health Services
FNHA	First Nations Health Authority
MCFD	Ministry of Children and Family Development
MHSU	Mental Health and Substance Use
MoH	Ministry of Health
NNADAP	National Native Alcohol Drug Abuse Program
NTS	National Treatment Strategy
NTSWG	National Treatment Strategy Working Group
PCH	Primary Care Home
PHSA	Provincial Health Services Authority
SSCCY	Select Standing Committee on Children and Youth
UNCRC	United Nations Convention on the Rights of the Child
UNYA	Urban Native Youth Association
VCH	Vancouver Coastal Health

Glossary

After Care Services: offered after inpatient or outpatient services have been completed, in order to assist the client with transitioning back into their normal routines, and may include counselling or abstinence support.

Binge Drinking: consuming a large number of alcoholic drinks over a short period of time (generally defined as more than five drinks in 2 hours for men, and more than four drinks in 2 hours for women).

Clinical Outreach: services provided by a clinician in settings such as homes, schools and community organizations that are outside of the traditional office environment.

Community-Based Services: specialized services that are delivered in the community rather than in hospital or in residential facilities.

Concurrent Disorder: any co-occurring mental health and substance use disorders.

Day Treatment Program: an intensive community-based program that provides daily services, usually in a group setting, to youth with serious substance use problems. Services are provided along with other supports that usually include alternative education.

Harm Reduction Initiatives: Harm reduction includes policies, programs and practices with a goal of reducing the adverse health, social and economic consequences of the use of legal and illegal psychoactive substances without necessarily requiring abstinence. Harm reduction programs accept the reality that people use substances and that a drug-free society is an unlikely and unrealistic goal.

LGBT2Q+: individuals who identify as one of the following: Lesbian, Gay, Bisexual, Transgendered, Two-Spirited, Queer or Questioning. The plus sign acknowledges the evolving nature of sexual and gender identities.

Medical Home: first defined in 1967 by the American Pediatric Association as a place where patients can access continuous and supportive care without financial or social restrictions. More recently conceived as a patient-centred setting where patients can expect holistic care from their primary physician and can be connected to other providers if necessary, and where quality improvement and patient safety are seen as essential to better health outcomes.

Mental Health: a state of well-being in which the individual realizes his or her own abilities, copes with the normal stresses of life, works productively and contributes to his or her community. Good mental health is much more than the absence of mental illness – it enables people to experience life as meaningful and to be creative, productive members of society.

Mental Health Problem: a cluster of symptoms that causes distress and disrupts one's ability to function in important aspects of life. Mental health problems include those that may not meet the criteria for diagnosis as mental illnesses as well as those that do.

Needs-Based Planning Model and Analysis: a needs-based planning model involves estimating the actual need for services in any given population. This model entails not just determining how many people need services, but what types of services they actually need.

Outpatient Services: traditionally, services delivered by hospitals where patients visit without receiving acute care from an emergency room or being admitted to in-patient services. Some acute hospital-based levels of care, such as acute home-based services, are now delivered through outreach to youth in home and community settings.

Primary Health Care: a system that provides first contact access for each new health need, long-term person-focused care, comprehensive care for most health needs, and coordinated care when it must be sought elsewhere.

Self-Care: the act of caring for one's self and the care of family and friends. Self-care takes many forms, such as managing stress, cultivating healthy relationships and keeping physically active. Other forms of self-care include seeking help when needed, engaging in planning for services and participating in supports and services.

Step Up/Step Down Care: a form of intensive intermediate health care that is less intensive than hospital care but more supportive than many types of community health care. An individual with declining health can 'step-up' into a highly supportive environment in the community to prevent his or her health from deteriorating further and prevent the need for hospitalization. People who have received and no longer require hospitalization can 'step down' to enable a gradual and supported return to the community, reducing the likelihood of re-admission to hospital.

Stigma: beliefs and attitudes that lead to the negative stereotyping of people with certain attributes, circumstances or experiences and to prejudice against them and their families.

Street-Involved Youth: youth who are involved with a street lifestyle that may include being homeless, panhandling, or engaging in high-risk activities such as criminal behaviour, using or selling drugs, or the sex trade.

Substance Use Disorder: where the sustained use of one or more substances (legal or illegal) leads to a clinically significant level of impairment or dependence.

Tier 1 Services (National Treatment Strategy): initiatives that encourage general wellness and focus on prevention strategies for the population as a whole, such as health promotion, self-care and aftercare programs.

Tier 2 Services (National Treatment Strategy): early intervention or self-management programs for individuals who are at risk of developing substance use or mental health problems. Options may include brief intervention programs, initiatives for early identification of mental health and substance use issues, or referrals to other health professionals.

Tier 3 Services (National Treatment Strategy): intended for individuals who have acknowledged problems with substance use or mental health issues. These include outreach, harm reduction, community-based counselling and withdrawal management.

Tier 4 Services (National Treatment Strategy): include specialized care options such as outpatient counselling, supportive residential programs and day treatments and are intended to assist people who are in need of more intensive forms of care or require targeted treatment options to address specific problems.

Glossary

Tier 5 Services (National Treatment Strategy): include services that link people with highly complex concurrent substance use and mental health problems to the full range of needed assessment, treatment and support services; intensive treatment services in correctional facilities; residential or hospital-based services (e.g., residential programs for the treatment of concurrent disorders, hospital-based medical withdrawal management services).

Withdrawal Management: inpatient, in-home or day program detox services that allow for safe and supervised physical withdrawal from drugs and alcohol. Programs are usually residential and can run from one day in length (sobering/assessment centres) to extended stays of one month or more.

Appendix 1: List of Advisory Group Members

- Dan Reist, Assistant Director, Knowledge Exchange, Centre for Addictions Research of BC, University of Victoria
- Brian Rush, Professor Emeritus, Centre for Addiction and Mental Health, University of Toronto
- Jennifer Vornbrock, former Vice President, Knowledge and Innovation, Mental Health Commission of Canada

Appendix 2: Organization of Youth Substance Use Services in B.C.

Health Authority	Responsible Administrative Unit	Organization of Services	Services Delivered by
Vancouver Coastal	Mental Health and Substance Use	<ul style="list-style-type: none"> Services are organized geographically and include North Shore/Coast Garibaldi, Vancouver, and Richmond. Led by regional MHSU directors who report to a Chief Operating Officer for each region. 	<ul style="list-style-type: none"> Contract Affiliates Some direct service provision by the health authority.
Island Health	Mental Health and Substance Use	<ul style="list-style-type: none"> Services organized geographically: South Vancouver Island, Central Vancouver Island, North Vancouver Island. Overall direction provided by a Manager of Child, Youth and Family Mental Health and Substance Use Services who reports to the Director of Child, Youth & Family Mental Health and Substance Use Services. 	<ul style="list-style-type: none"> Contract Affiliates Some services delivered directly.
Interior Health	Community Integration, Mental Health and Substance Use Services	<ul style="list-style-type: none"> Services organized geographically: East Kootenay, Kootenay Boundary, Okanagan, Thompson Cariboo Shuswap. Oversight by regional MHSU Managers and MHSU Practice Leads. 	<ul style="list-style-type: none"> Contract Affiliates Some services delivered directly.
Fraser Health	Mental Health and Substance Use	<ul style="list-style-type: none"> MHSU services are managed regionally by four managers. 	<ul style="list-style-type: none"> Contract Affiliates Some services delivered directly.
Northern Health	Mental Health and Substance Use	<ul style="list-style-type: none"> Services are organized geographically: Northwest, Northern Interior, Northeast. Services managed by regional MHSU managers who report to a regional Chief Operating Officer. 	<ul style="list-style-type: none"> Services delivered by the health authority. Some services delivered by Friendship Centres.

Appendix 3: Youth Substance Use Services in B.C. by Health Authority and Service Type

Interior Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Golden Family Services, Golden (Contractor)	12 to 18	None reported	<ul style="list-style-type: none"> • Outreach services 	Part-time youth outreach worker
ARC Community Intervention and Treatment Services, Central Okanagan (Contractor)	12 to 19	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services • Other: school-based targeted intervention (assessments, referrals and case management) 	Yes
Freedom Quest Regional Youth Services, Castlegar, Slocan Valley, Trail, Salmon Arm (Contractor)	13 to 24	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services • Concurrent disorder services 	Yes
East Kootenay Addiction Services Society, Creston, Cranbrook, Kimberly, Invermere, Golden, Fernie, Sparwood, Elkford (TEAM program) (Contractor)	Flexible	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services • Concurrent disorder services 	Yes
Family Resource Centre Invermere (Contractor)	12 to 18	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services (as part of outreach program) 	Yes, by a part-time worker.
Interior Health – Kamloops, Hundred Mile House, Williams Lake, Vernon, North Okanagan, Kelowna, South Okanagan, Creston (Direct) Concurrent Disorder therapist available in Kamloops, Castlegar, Cranbrook (Interior Health funded)	12 to 24 Under age 19 but can include up to 25 where appropriate	None reported	<ul style="list-style-type: none"> • Drop-in • Outreach • Counselling services 	Services for youth also available at other Interior Health sites when specific substance use services are unavailable. Services for youth include dedicated workers ranging from 4 to 1 full-time equivalent per location.

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Interior Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
SD#22 Vernon (Contractor)	Flexible	None reported for drop-in / outreach	<ul style="list-style-type: none"> • Drop-in • Outreach • Other: education, screening, counselling to students and families in schools 	Yes
Kamloops Society for Alcohol and Drug Services (Phoenix Centre) (Contractor)	<19	None reported	<ul style="list-style-type: none"> • Raven Program • Outreach • Outpatient services • Family supports 	Yes
Whitevalley Community Resource Centre, Lumby, Cherryville, Mable Lake, Lavington (Contractor)	Flexible	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services 	No; combined adult/ youth program.
Pathways Addiction Resource Centre, Penticton, Summerland (Contractor)	Flexible	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services • Other: youth education suspension series 	Yes
Withdrawal Management Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Kamloops Society for Alcohol and Drug Services (Phoenix Centre) (Contractor)	<19	None reported	<ul style="list-style-type: none"> • Phoenix detox (2 beds for youth) 	Yes
Axis Family Resources Williams Lake (Contractor)	13 to 24	Dependent on current capacity that changes over time	<ul style="list-style-type: none"> • 2 withdrawal management beds in family-based homes 	Under age 25
Interior Health Cranbrook (Direct)	Under 19	Dependent on current capacity that changes over time	<ul style="list-style-type: none"> • 1 bed 	One bed is youth specific but there are other beds available on site for different purposes and ages.

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Interior Health				
Day Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Axis Family Resources (Thompson Cariboo communities) (Contractor)	13 to 24 Under age 19 but can include up to age 25 where appropriate	None reported	<ul style="list-style-type: none"> • Short term safe housing • 2 beds (supportive housing) • Mobile day treatment in 11 communities 	Yes
Freedom Quest Regional Youth Services, Castlegar, Slocan Valley, Trail, Salmon (Contractor)	13 to 24 Mostly under age 19 but can include up to age 24 where appropriate	None reported	<ul style="list-style-type: none"> • Day treatment program 	Yes
Interior Health Aboriginal Services	Age Mandate	Wait Time	Services Provided	Youth Specific?
Conayt Friendship Society Merritt and Nicola Valley (Contractor)	Over age 14		<ul style="list-style-type: none"> • MHSU counselling, referrals and case management 	
Nenqayni Wellness Centre Society, Cariboo, Chilcotin, five communities (Contractor)	Over age 10		<ul style="list-style-type: none"> • MHSU counselling 	
Kamloops Aboriginal Friendship Society (Contractor)	Over age 14		<ul style="list-style-type: none"> • Substance use case management, crisis intervention and counselling 	
First Nations Friendship Centre, Vernon (Contractor)	Over age 16		<ul style="list-style-type: none"> • MHSU counselling and referrals 	
Ki-Low-Na Kelowna (Contractor)	All ages		<ul style="list-style-type: none"> • MHSU counselling, case management, referrals 	
Metis Community Resources of B.C., Kelowna (Contractor)	All ages		<ul style="list-style-type: none"> • Trauma counselling 	
Okanagan Nation Alliance Okanagan area	13 to 18		<ul style="list-style-type: none"> • MHSU prevention and early intervention 	
Circle of Indigenous Nations Society, Kootenay Boundary (Contractor)	Over age 15		<ul style="list-style-type: none"> • MHSU counselling, substance use groups and referrals 	
Ktunaxa Nation Council Society, Cranbrook and area (Contractor)	All ages		<ul style="list-style-type: none"> • MHSU counselling, substance use referrals and crisis intervention 	

Northern Health				
Community Based Services	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Northern Health – Prince George (Direct)	12 to 18/ Flexible	None reported	<ul style="list-style-type: none"> Youth community out-patient service (counselling) 	Yes. Provides outreach to youth with both mental health and substance use issues through assessment, individual and group therapy, case management, life skills training, recreational activities, and family support.
Northern Health, Terrace (Direct)	12 to 18	None reported	<ul style="list-style-type: none"> Youth community out-patient service (counselling) 	Yes. Provides outreach to youth with both mental health and substance use issues through assessment, individual and group therapy, case management, life skills training, recreational activities, and family support.
Northern Health – Atlin, Burns Lake, Chetwynd, Dawson Creek, Dease Lake, Fort Nelson, Fort St. James, Fraser Lake, Haida Gwaii, Hazelton, Houston, Kitimat, MacKenzie, McBride, Prince Rupert, Quesnel, Smithers, Stewart, Tumbler Ridge, Valemont, Vanderhoof (Direct)	12 to 18	1 week	<ul style="list-style-type: none"> Services to youth offered through MHSU offices by MHSU teams that serve both youth and adults 	No. No dedicated youth clinicians outside of Prince George and Terrace.
Prince George Native Friendship Centre (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	Yes; one counsellor focuses on youth.
Nawican Friendship Centre, Dawson Creek (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Quesnel Tillicum Society (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Dze L K'ant Friendship Centre, Smithers (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Fort St. John Friendship Society (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Fort Nelson Aboriginal Friendship Centre (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Friendship House Association of Prince Rupert (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.
Kermode Friendship Centre, Terrace (Contractor)			<ul style="list-style-type: none"> Substance use counselling services 	No; one counsellor for youth and adults.

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Northern Health				
Residential Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Nechako Treatment Centre, Prince George (Direct)	12 to 18	Yes, 1 day to 1 week	<ul style="list-style-type: none"> Residential treatment 7 beds Withdrawal management (1 bed in adult unit) 	Yes

Fraser Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Agassiz Harrison Community Services (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> Outreach Counselling services 	Generic counsellor that serves youth, adults, families.
Alouette Addiction Services – Maple Ridge, Pitt Meadows (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> Drop-in Outreach Counselling services Aftercare 	Includes a youth specific counsellor as well as a school-based prevention worker.
Abbotsford Community Services (Abbotsford Addiction Services) (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> Counselling services and referrals Prevention work in schools 	Youth specific counsellor and a school-based prevention worker.
Boys and Girls Club of South Coast BC – Odyssey I, Burnaby (Contractor)	12 to 20+	Yes – length unknown	<ul style="list-style-type: none"> Drop-in Outreach Counselling services Aftercare Other: Parent and family counselling and group (Parents Together) 	Yes
Burnaby Substance Use Services (Direct)	Up to 24 years of age	No wait time	<ul style="list-style-type: none"> Outreach Outpatient counselling (youth and families) 	Yes, for the Outreach Program.

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Fraser Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Deltassist Family and Community Services, North Delta, Ladner, Tsawwassen (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> • Drop-in • Outreach • Counselling services, aftercare • School education programs, school assessment and counselling services, groups requested by schools 	One dedicated youth addictions counsellor.
DiverseCity Surrey (Contractor)	Youth up to 24 years of age Adults 19+ Includes families with children under 12	<ul style="list-style-type: none"> • 4 to 5 weeks for groups • No waitlist for individual services 	<ul style="list-style-type: none"> • Outpatient counselling-screening, assessment, treatment planning and referral • Individual, group and family counselling • Case Management • Aftercare 	Services for Immigrant and refugee youth and families.
Fraser Health/MCFD – Concurrent Disorders Therapists (Direct)	Up to 24 years of age	Unknown		Yes
Fraser House Society, Mission (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> • Outreach • Counselling service • Aftercare • Other: Referrals, prevention services in schools and community, etc., and a parents' support group 	One dedicated youth addictions counsellor.

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Fraser Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Fraserside Community Services, New Westminster and surrounding area (Perspectives Youth & Family Outreach) (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> • Counselling service, for youth, parents/ guardians • Education, training and prevention services 	Yes. Offers a specialized substance use program for youth.
Hope and Area Transition Society (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> • Outreach • Counselling • School-based programming 	1 full-time youth substance use worker co-funded by MCFD and Fraser Health plus one full-time school-based prevention worker.
Langley Community Services (Contractor)	Flexible	None reported	<ul style="list-style-type: none"> • Counselling services 	One dedicated youth clinician.
Impact Society, Abbotsford and Mission (Contractor)	12 to 24	None reported	<ul style="list-style-type: none"> • Drop-in • Outreach • School-based counselling and group work 	Dedicated youth outpatient/outreach counselling service, work in schools and with youth in the community.
Mission Friendship Centre Society – Alcohol and Drug Outpatient Treatment Program (Contractor)	All ages	None reported	<ul style="list-style-type: none"> • Counselling 	Generic youth and adults counsellor serving both populations.
PCRS – Chilliwack Addiction and Prevention Services (CAPS) (Contractor)	<12 to 24	None reported	<ul style="list-style-type: none"> • Drop-in • Outreach • Counselling services • Prevention services – school-based K-7 	Yes. Dedicated youth clinicians.
PCRS – Prevention programs (Contractor)	<12 to 18	None reported	<ul style="list-style-type: none"> • Prevention services – school based K-7 for Fraser region 	Yes. Dedicated youth workers.
PCRS – ASTRA program, Aldergrove, Chilliwack, Delta, Langley, Maple Ridge, Pitt Meadows, Surrey, Tsawwassen, White Rock (Contractor)	13 to 24	None reported	<ul style="list-style-type: none"> • One-to-one outreach counselling and some group counselling • Referrals to detox 	Dedicated youth workers.

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Fraser Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
SHARE Family and Community Services – Tri Cities (Port Coquitlam, Coquitlam, Port Moody, Anmore, Belcarra) (Contractor)	12 to 20+	Counselling services – Yes depending upon risk level and age	<ul style="list-style-type: none"> • Counselling services • Parent support services • Aftercare: relapse prevention groups 	<p>Yes. Offers a specialized substance use program for youth.</p> <p>For youth 18 and under there is no wait after the intake appt. to receive service. For youth 19–24 years, there is a risk-based prioritization waitlist system in which youth with risk do not wait and youth who are not facing significant risk wait typically two to four weeks.</p>
Sources Community Resources Society, White Rock (Contractor)	12 to 20+	None reported	<ul style="list-style-type: none"> • Counselling services 	Dedicated youth counsellors.
Surrey Substance Use Services (Direct)	12 and older	<p>Group counselling – none</p> <p>Individual counselling – two weeks</p>	<ul style="list-style-type: none"> • Substance use counselling (individual, group, couple and family); • Referrals and education 	No designated counsellor offering youth specific services.
Withdrawal Management Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Creekside Withdrawal Management, Surrey (Direct)	14 to 18	Yes, 1–3 days or no days	<ul style="list-style-type: none"> • Withdrawal management services • Medically monitored • Average stay is 5–7 days but there is flexibility. Youth can stay up to 30 days during a secondary detox phase for the purpose of stabilization. 	Yes

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Fraser Health				
Riverstone Home/Mobile Detox Maple Ridge/Pitt Meadows to Boston Bar (Direct)	Services available to youth	No information	<ul style="list-style-type: none"> • Mobile and home based withdrawal management 	For adults and youth
Day Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
PCRS – ASTRA program, Aldergrove, Chilliwack, Delta, Langley, Maple Ridge, Pitt Meadows, Surrey, Tsawwassen, White Rock (Contractor)	13 to 24	No wait time	<ul style="list-style-type: none"> • Intensive day treatment 	Yes
Pacific Community Resource Society (PCRS), DEWY, Langley (Contractor)	12 to 20+	Yes, sometimes day treatment groups are not running	<ul style="list-style-type: none"> • Day treatment program • Aftercare 	Yes
Residential Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Last Door Recovery Society (Contractor)	14 to 18	Yes, but depends on bed availability	<ul style="list-style-type: none"> • Long-term supportive recovery for males • Aftercare • Fraser Health funds 4 beds in this program 	Yes

Vancouver Coastal Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Boys and Girls Club of South Coast BC – Nexus Program, Downtown Vancouver (Contractor)	24 and under	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services • Aftercare 	Yes
Boyd and Girls Club of South Coast BC – Odyssey II Program, Mt. Pleasant, Vancouver (Contractor)	24 and under	None reported	<ul style="list-style-type: none"> • Drop in • Outreach • Counselling • Aftercare • Other: Social recreation programs 	Yes
Family Services of Greater Vancouver (Directions Youth Services) (Contractor)	24 and under	None reported	<ul style="list-style-type: none"> • MCFD/Health hub: 24/7 drop-in services • Directions Youth Services Centre – counselling services • Outreach services • Extreme Weather Response shelter • Pre-employment programs 	Yes
Richmond Addiction Services Society (Contractor)	12 to 20+	None reported for drop-in, outreach, counselling Wait time up to 3 days for CATS program	<ul style="list-style-type: none"> • Drop-in, outreach, counselling services, Aftercare • Other: Constructive Alternative to Teen Suspension Program (CATS) 	Yes
VCH Powell River Mental Health & Addictions Services (Direct)	Flexible depending on program	None reported	<ul style="list-style-type: none"> • Drop-in, outreach, counselling services, Aftercare • Other: Support group and prevention activities 	Yes
VCH Sunshine Coast Mental Health and Addictions Services, Gibsons, Sechelt, Pender Harbour (Direct)	Flexible to 19	None reported	<ul style="list-style-type: none"> • Outreach to schools • Counselling services 	1 FTE for youth services.
VCH Sea to Sky Mental Health and Addiction Services (Direct) – Squamish, Whistler and Pemberton	Up to age 19, with flexibility based on developmental age	None reported	<ul style="list-style-type: none"> • Outreach to schools, counselling services 	0.8 FTE for youth services (co-funded 50/50 with school district).

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Vancouver Coastal Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
VCH Anne Vogel Primary Care Addiction Clinic, Richmond (Direct)	15 to 19+	None reported	<ul style="list-style-type: none"> • Methadone maintenance 	No but youth are seen here.
VCH Youth Addiction and Concurrent Disorder Counsellors, Vancouver (Direct): <ul style="list-style-type: none"> • Pacific Spirit Community Health Clinic (CHC) • Evergreen CHC • Raven’s Song CHC • Three Bridges, CHC • Robert & Lily Lee Family CHC 	13 to 24	None reported	<ul style="list-style-type: none"> • Counselling services for 13 to 24 year olds 	Yes
VCH SACY Leadership and Resiliency Program (Contractor)	School Age youth	Not applicable	<ul style="list-style-type: none"> • School-based early intervention services for elementary and early high school aged youth • Tertiary prevention programs 	Yes
SACY – School-Age Children and Youth – Substance use Prevention Initiative (Vancouver School Board/VCH) (Contractor)	School Age youth	Not applicable	<ul style="list-style-type: none"> • Youth prevention and engagement • STEP: SACY Teen Engagement Program – three-day structured education program for teens • Parent engagement • Curriculum and teacher training 	Yes
Urban Native Youth Association (Contractor)	Counselling 13 to 24 School program: 13 to 18	None reported	<ul style="list-style-type: none"> • Counselling services (2 full-time, 1 part-time) • School supports and programs • Family supports 	Yes

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Vancouver Coastal Health				
Community Based Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Watari Counselling and Support Services (Contractor)	12 to 24	Day treatment: none Counselling: up to one month	<ul style="list-style-type: none"> • Counselling services • Day treatment • Downtown Eastside team (outreach) • STAR grade 5 and 7 activity based and healthy choices school program • Care Coordination Table • TIP (Transition to Independence Program) – housing support for youth who are pregnant/parenting or struggling with finding market housing 	Yes
VCH 15th Street Youth Services (North shore) (Direct)	13 to 18	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services 	Yes
VCH Powell River Mental Health & Addictions Services (Direct)	Flexible depending on program	None reported	<ul style="list-style-type: none"> • Drop-in • Outreach • Counselling services • Aftercare • Other: Support groups and prevention activities 	Yes
VCH Sunshine Coast Mental Health and Addictions Services, Gibsons, Sechelt, Pender Harbour (Direct)	Flexible to 19	None reported	<ul style="list-style-type: none"> • Outreach to schools • Counselling services • 1 FTE for youth services 	Yes
VCH 15th Street Youth Services (North shore) (Direct)	13 to 18	None reported	<ul style="list-style-type: none"> • Outreach • Counselling services 	Yes

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Vancouver Coastal Health				
Withdrawal Management Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Family Services of Greater Vancouver (Directions Youth Services) (Contractor)	Detox: 16 to 21	None reported for withdrawal management	<ul style="list-style-type: none"> • Social detox with weekday onsite medical supports (RN and MD 5 days/week) • 10 beds 	Yes
PLEA Community Services (Contractor)	21 and under; priority given to youth 16 and under	Do not keep waitlist for withdrawal management – youth are referred elsewhere (e.g. Directions Detox)	<ul style="list-style-type: none"> • Non-medically supervised withdrawal management • Up to 10 days • Aftercare • Family care home model for supported recovery and detox • 3 beds 	Yes
Day Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Watari Counselling and Support Services (Contractor)	13 to 24	Day treatment: none	<ul style="list-style-type: none"> • Day treatment program 	Yes
Supported Recovery Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
PLEA Community Services (Contractor)	21 and under; priority given to youth 16 and under	Supported recovery has variable wait time – generally 1–2 weeks	<ul style="list-style-type: none"> • Supported recovery services • Family care home model for supported recovery • Up to 28 days in supported recovery • 4.25 beds 	Yes

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Vancouver Coastal Health				
Residential Treatment Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Pacific Youth and Family Services, Peak House, Vancouver (Contractor)	13 to 18	30 days on average	<ul style="list-style-type: none"> • Specialized residential treatment • 8 beds • 10 week program – 2 week orientation and assessment phase and 8 week treatment phase with possible extension if needed 	Yes
Urban Native Youth Association, Young Bears Lodge (Contractor)	13 to 18	Variable wait time – up to a month	<ul style="list-style-type: none"> • Residential treatment • 5 beds • Four month program with possible extension 	Yes

Island Health				
Community Based Services	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Alberni Valley Drug and Alcohol (Contractor)	13 to 19 with flexibility	2–3 days 2–3 weeks during busy times Busy times are: Mid May to end of June, Mid Sep to Mid Oct, Dec to the end of Jan	<ul style="list-style-type: none"> • Community-based counselling • Indicated Prevention and Early Intervention • Drop-in • Outreach 	Yes
Island Health Discovery Youth & Family Substance Use Services, Victoria, Duncan, Ladysmith, Nanaimo, Parksville/Qualicum, Ucluelet, Port Hardy (Direct)	12 to 19	Victoria: 5–10 days, 15–20 days* Duncan: 1–7 days, 1–2 wks* Ladysmith: 1–7 days Nanaimo: 1–7 days, 1–2 wks* Parksville: 1–7 days Ucluelet: Within 1 wk** Port Hardy: 7–10 days	<ul style="list-style-type: none"> • Youth and family counselling • Outreach services 	Yes * during busy seasons (June, Sep–Dec) Intake Counsellor is available for on-going support during wait times. ** wait time can be longer (up to 2 wks) in remote areas
Hornby and Denman Community Health Care Society (Contractor)	0 to 19 and parents/caregivers		<ul style="list-style-type: none"> • Drop-in • Outreach • Community-based counselling 	Yes
Salt Spring Island Community Services (Contractor)	12 to 20+	Counselling services: 4 weeks	<ul style="list-style-type: none"> • Youth outreach • Counselling services • Child and youth psychiatry • Community-based counselling • School-based counselling • Youth navigator/intake 	Yes

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Island Health				
Community Based Services	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Sooke Family Resource Society (Contractor)	12 to 20+	Counselling services: 90–120 days Waitlist times have expanded considerably (from 10 days to 90–120 days). We contact everyone one on the waitlist within 72 hours and then monthly to ensure they are still in need of services	<ul style="list-style-type: none"> • Outreach • Counselling 	Yes
The John Howard Society of North Island, Comox Valley (Contractor)	12 to Flexible	Counselling services: 2–4 weeks	<ul style="list-style-type: none"> • Drop-in • Outreach • Counselling services (Courtenay, Campbell River, Gold River) • Indicated Prevention and Early Intervention (Courtenay) 	Yes
Victoria Youth Clinic (Contractor)	13 to 19	None reported	<ul style="list-style-type: none"> • Youth counselling • Outreach support • Medical clinic 	Yes
School District # 72 (Contractor)	13 to 18	none	<ul style="list-style-type: none"> • School-based Indicated Prevention and Early Intervention 	Yes
Withdrawal Management Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Boys & Girls Club Services of Greater Victoria (Contractor)	13 to 19	none	<ul style="list-style-type: none"> • Withdrawal management – combined with supported recovery • Aftercare 	Yes

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Island Health				
Withdrawal Management Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Nanaimo and Area Resource Services for Families (Contractor)	13 to 19	Generally 2–3 days Wait times generally dependent on type of placement and care home availability as some have scheduled time off periods.	In a family care home model: <ul style="list-style-type: none"> • Non-medical withdrawal management • Supported residential (6 beds) 	Yes
The John Howard Society of North Island, Campbell River (180 Degrees Program) (Contractor)	13 to Flexible	Depends on care home availability 1 week to 2 months	In a family care home model: <ul style="list-style-type: none"> • Non-medical withdrawal management • Supported residential (3 beds) 	Yes
Youth Empowerment Society, Victoria (Contractor)	13 to 18	Yes. 0.5 to 1 day	<ul style="list-style-type: none"> • Withdrawal management • Will provide support until the youth is able to access services. A medical screen is required • 5 beds 	Yes
Supported Recovery Services	Age Mandates	Wait Time	Services Provided	Youth Specific?
Hope House, Male only (Contractor)	13 to 19 with flexibility	1–2 days 2–3 weeks during busy periods	<ul style="list-style-type: none"> • Supported residential drug and alcohol recovery and treatment program • Outreach services for those awaiting residential services • Aftercare for residents and families • Clinical individual and group counselling provided on a daily basis 	Yes

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Island Health				
Safe Housing and More	Age Mandates	Wait Time	Services Provided	Youth Specific?
Tillicum Aboriginal Friendship Centre – Youth Safe House (Contractor)	13 to 18	Approx. 2 days Do not keep a waitlist, youth are asked to call back daily. Last year, working at half-capacity, refused over 200 requests for beds and the wait was up to two weeks. This year, operating at full capacity. The monthly average would be around 2–3 phone calls for space when there was none.	<ul style="list-style-type: none"> • Short term youth shelter 	Yes
Herway Home Victoria (Direct)	Any age, no restrictions (child bearing years)	None	<ul style="list-style-type: none"> • Herway Home has 4.5 direct staff and in-kind support provided by a Public Health Nurse (3-4 days/week); GP/nurse practitioner half day per week; dental hygienist and dietician once a month. • Herway Home contracts with the Boys and Girls Club of Greater Victoria to provide suites to clients aged 16-24 in a Care Home Parenting program. Supports in this program include housing, outreach support, life skills and parenting skills support. 	All services are tailored to individual need including age and developmental stage.

First Nations Health Authority				
Services Offered	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Nenqayni Wellness Centre Williams Lake Youth inhalant program for girls	13 to 18		<ul style="list-style-type: none"> Inhalant use program for young women/girls 10 beds Residential, up to four months Accepts referrals from across Canada 	Yes Former NNADAP operated program.
Nenqayni Wellness Centre Williams Lake	All ages of family members		<ul style="list-style-type: none"> Family alcohol and drug program 4 family beds (16 beds) Residential 8 week program 	Family specific; some intakes include single mothers with children, and couples with children.
Kackaamin Family Development Centre Port Alberni	All ages of family members		<ul style="list-style-type: none"> Family alcohol and drug program 6 week program 	Family specific; one adult must have identified challenges with substances.

MCFD Funded Youth Justice Substance Use Residential Services				
Services Offered	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Waypoint Addiction Treatment for Boys, Surrey (Contractor)	12 to 18		<ul style="list-style-type: none"> 7 beds for boys 	Youth Justice Funded (MCFD)
Daughters and Sisters Treatment Program for Girls (Contractor)	12 to 18		<ul style="list-style-type: none"> 7 beds for girls 	Youth Justice Funded (MCFD)
Osprey Place (Kamloops Society for Alcohol & Drug Services/Elizabeth Fry Society) (Contractor)	12 to 16		<ul style="list-style-type: none"> Residential Treatment (care home/day treatment model) 	Youth Justice Funded (MCFD)
'Am'ut, Elizabeth Fry Society of Greater Vancouver (Contractor)	12 to 18		<ul style="list-style-type: none"> Residential treatment, 6 beds 	Youth Justice Funded (MCFD)

PHSA Mental Health and Substance Use				
Services Offered	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Youth Concurrent Disorders Program (Direct)	12 to 24	Average annual wait time is 28 days	<ul style="list-style-type: none"> • Consultation, psychiatric assessment, limited treatment • Outpatient program 	Yes

Providence Health				
Services Offered	Age Mandates	Wait Time?	Services Provided?	Youth Specific?
Providence Inner City Youth Team	16 to 24	No information	<ul style="list-style-type: none"> • Counsellors for MHSU at Granville Youth Centre 	Yes. Youth intensive case management team with capacity to support 120 youth with mental illness and concurrent substance use. Works with multiple community partners in Vancouver, including housing providers.
Granville Youth Centre Operated by St. Paul's	12 to 24	No information	<ul style="list-style-type: none"> • Granville Youth Centre – primary care, MHSU intensive case management, income assistance, life skills, clinical groups, recreational groups 	Yes
Renfrew House	16 to 24	No information	<ul style="list-style-type: none"> • Housing program • Comprehensive mental health and addictions services available 	Homeless or precariously housed youth
BC Integrated Youth Services Initiative Funded by the Province and Donors from Foundations	12 to 24	Not applicable	<ul style="list-style-type: none"> • Proposal to create a youth hub of services in each health authority • Similar services to the Granville youth Centre • One-stop storefronts for youth-friendly services 	Request for Expressions of Interest has been issued to run a centre in each of the five health authorities, based on the Granville Youth Centre model.

Appendix 4: Summary of Questions Asked in Survey to Service Providers

- Section 1: Information about your organization
- Section 2: Types of services offered by your organization
- Section 3: Service/Program Information
 - Name of program/Health Service Delivery Area/town
 - Urban/rural/remote
 - Hours of operation/mode of service delivery (e.g. one-to-one, group)
- Section 4: Program Eligibility Criteria
 - Gender/services for specific populations of youth
 - Age mandates/most common age accessing program
 - Substances addressed by program
 - Wait time for entry/average number of days of wait time
 - How youth are referred to program
 - Is withdrawal from all substances required for entry/continued participation?
 - Does the program do screening, assessment, develop treatment plans?
- Section 5: Linkages with other services
 - Does the program offer mental health services?
 - Does the program offer:
 - Basic needs – food
 - Shelter
 - Transportation costs
 - Life skills
 - Substance use doctor/nurse
 - Education/information about drugs and alcohol
 - Services to support step up/step down care
 - Supports to family/caregivers
 - Case management
 - System navigators
 - Does the program help link youth to other services such as child care, etc.?
- Section 6: Data collection
 - Does the program collect data on:
 - Client demographics
 - Service utilization
 - Client satisfaction
 - Client progress toward goals

Appendix 5: Summary of Questions Asked in Survey to Health Authorities

- Section 1: Identification of Health Authority
- Section 2: What policies/standards exist for youth substance use services?
- Section 3: Questions about linkages between service providers and system partners
- Section 4: Questions about problem screening and assessment
- Section 5: Questions about quality assurance processes and information management

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