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

SEPTEMBER 2023

Provincial Health Services Authority

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Table of Contents

Acknowledgments and Commitments

Land Acknowledgment

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

Commitment to Eradicating Indigenous Specific Racism

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

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

A commitment to gender-inclusive language

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

Acknowledging our Partners

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

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

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

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

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Disclaimer

Child Health BC develops evidence-based clinical support documents that include recommendations for the care of children and youth across British Columbia. These documents are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. These documents are for guidance only and are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of a clinical problem. Healthcare professionals should continue to use their own judgment and consider context, resources, and other relevant factors. Neither Provincial Health Services Authority nor Child Health BC assume any responsibility or liability from reliance on or use of the documents.

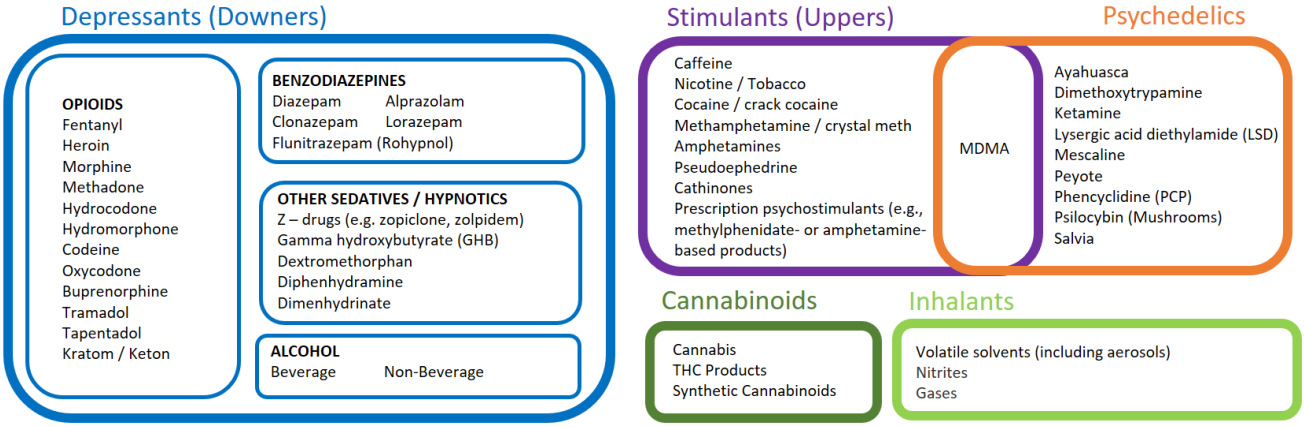
This document replaces the Child Health BC Provincial Substance Intoxication and Withdrawal Guideline for Children & Youth in the Emergency/Urgent Care Settings (Ages 0 days of age to 19 years of age less a day) published in September 2018.

Scope

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

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

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



Purpose

To promote best and wise practices [2] for assessment, screening, and initiation of treatment and discharge planning for substance intoxication and acute withdrawal for children and youth presenting to acute care settings across BC.

[1] "**Acute withdrawal"** is defined as a "group of symptoms of variable clustering and severity occurring after persistent (can be as little as a few days) use of that substance." (16)

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

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

Guiding Principles

Child and Youth Centered Care

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

Family/Caregiver Support

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

Strengths Based Approach

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

Anti-Racism

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

Anti-Indigenous Racism

In the context of the colonial history of Canada, we acknowledge the historic and ongoing Indigenous-specific racism in the health care system. Indigenous-specific racism is the unique nature of stereotyping, bias, and prejudice about Indigenous peoples in Canada (First Nations, Metis, and Inuit) [3] that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous peoples that perpetuates power imbalances, systemic discrimination, and inequitable outcomes stemming from the colonial policies and practices. All non-Indigenous clinicians and staff should undertake Indigenous cultural safety training and anti-Indigenous racism response training specifically focused on ending Indigenous specific racism and improving their ability to establish positive partnerships with Indigenous children, youth, and families seeking care.

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

***Learning Links**:*
In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care
San'yas Anti-Racism Indigenous Cultural Safety Training Program

Cultural Safety and Humility

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

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

***Learning Link:** Creating a Climate for Change - First Nations Health Authority*

Rights of Indigenous Peoples

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

***Learning Link:** BC Declaration on the Rights of Indigenous Peoples (BC DRIPA)*

Trauma and Violence Informed Care

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

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

***Learning Link:** Trauma & Violence-Informed Care for Health & Social Service Providers*

Stigma Free Care

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

***Learning Link**: Canadian Centre on Substance Use and Addiction Resources on Stigma*

Recovery and Wellness Oriented

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

Harm Reduction

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

Child Rights Approach

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

***Learning Link**: Convention on the Rights of the Child in child-friendly language*

1.0 Background

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

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

Children/youth who use substances may have experienced inequitable care. Many youth who use substances have expressed not feeling safe interacting with healthcare providers and accessing healthcare (1). Negative stereotyping and profiling leads to discriminatory behaviour by healthcare providers and poorer quality of care. As a consequence of historical and ongoing white supremacy [4], racism, discrimination, colonialism and social and economic inequality, Indigenous youth with substance use concerns are disproportionately impacted (2,3). Through engagement, relationship building, anti-racist, and non-judgemental approaches to care, we can all contribute to more positive experiences for children/youth and their chosen support(s). When children/youth feel supported, safe, and physically comfortable, it can mitigate risks such as: choosing to leave before hospital/administrative discharge, vulnerability for toxicity events (overdoses), discomfort and stress, decreased participation in care, and/or lack of engagement with treatment services.

A presentation to hospital is an opportunity to screen for substance use related concerns, and provide early intervention for the risks associated with substance use, including withdrawal syndromes. Youth

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

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

2.0 Engagement

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

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

- Relational practice is foundational to engagement.
- Health care providers should ensure they have completed the Indigenous Cultural Safety and Cultural Humility education required and/or recommended by their health authority (In Plain Sight Recommendation #20, TRC Call to Action #23); understand implicit biases and intersectionality; and have self-reflected on their personal values, assumptions, and belief structures.
- Healthcare providers should check in with themselves and consider their own assumptions about child/youth substance use and their overall position of power and privilege.
- Utilizing engagement strategies throughout all encounters with children/youth and their chosen supports is a key component of quality care and improves safety and comfort for all.

  Learning Link: Tips for engaging children and youth in acute care settings
- When working with children/youth who use substances it is important to be open and curious and use respectful, non-judgmental, non-stigmatizing, developmentally appropriate, and gender inclusive language.
- Use language the child/youth is most comfortable with and let them guide the conversation.
  - Clinicians can open the conversation by asking the child/youth's name and pronouns. To support relationship building, if you use the wrong name or pronouns acknowledge your mistake and use correct name/pronouns moving forward.
  - Use the child/youth's name whenever possible rather than "a person who" or a "child/youth who…" but continue to use people-first and non-stigmatizing language (i.e., "(name) uses opioids" vs "(name) is an opioid user").
  - Instead of using the medical term for a substance the child/youth may prefer a street name (e.g., weed in place of cannabis).

    Learning Link: Refer to **Appendix A** for common street names for substances.
  - Use strengths-based language. Focus care planning on the child/youth's own goals with respect to substance use, recovery and/or harm reduction.

- Ask child/youth if they would like access to cultural support/resources. For self-identifying Indigenous children/youth, ask if they would like to be connected with cultural wellness supports such as Indigenous patient navigators, liaisons, Elders, or traditional healers, recognizing their inherent right to traditional medicines and health practices (UNDRIP Article 24; TRC Call to Action #22). Individualized cultural supports and resources should be offered as early as possible to support children/youth and their families during their visit and through transitions in care.

3.0 Informed Consent, Confidentiality, and Information Sharing

3.1 Informed Consent

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

Learning Link: Consent to Healthcare: Procedure for Minors and Mature Minors

- Health care providers must seek informed consent before providing treatment.
- The Infants Act applies to anyone under the age of 19. Section 17 of the Infants Act provides that if certain requirements are met, a minor may provide consent to medical treatment.

  Learning Link: *Legislative Guidance on Consent of "Minors" Infants Act*
- Health care providers are ethically obligated to involve children/youth in transparent discussions involving their health and treatment at every stage of decision making.
- In emergent situations[5] where the child/youth and/or guardian is not able to provide informed consent, health care providers have a duty to provide necessary treatment to preserve life until informed consent can be obtained (i.e., when the child/youth regains consciousness and is assessed for capacity to provide informed consent, or the minor's legal guardian can be contacted).
    - A minor may give consent to, or decline healthcare, if a health care provider is satisfied that the minor has capacity to consent, and the decision is deemed in their best interest. Capacity is demonstrated if the minor: understands the need for the proposed treatment/ intervention; understands what the health care involves; shows appreciation of the benefits and risks of receiving or not receiving health care; applies values to the decision; and makes a decision that is consistent with these values and consistent over time. If the provider has any doubt as to whether the proposed health care is in a minor's best interests, obtain a second opinion, as necessary.
        - "Best Interests" means that the health care is, in the Most Responsible Practitioner's (MRP) clinical judgment, medically advisable, and would benefit the patient when balancing potential benefits and harms.
        - Determination of "Best Interests" is also informed by child/youth wishes and is respectful of their culture and belief systems; considering relationships with chosen supports and the importance on their mental, emotional, physical, and spiritual well-being.

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

    - For an Indigenous minor, "Best Interests" also includes maintaining the Indigenous minor's connection to their community, and to learning and practicing Indigenous traditions, customs, and language. This is in alignment with the rights of Indigenous children as described in the United Nations Declaration on the Rights of Indigenous People (UNDRIP) (4) and in the Principles of Reconciliation prefacing the Truth and Reconciliation Commission (TRC) (5).
- If a minor is deemed incapable of providing informed consent, the legal guardian is responsible for decision making in these circumstances, independent of the child/youth's agreement. The health care provider must make every reasonable effort to obtain informed consent from the minor's legal guardian. This should not delay treatment in emergency circumstances where there is a duty to preserve life. An explanation with rationale for the treatment should be provided as soon as possible after the event.
- A minor's capacity to consent should be reassessed for subsequent healthcare decisions as capacity may shift over time and is decision specific.
- In non-emergent situations, where a minor, or the guardian(s) of a minor, does not consent to health care and, two medical practitioners are of the view that the health care is necessary to preserve the child/youth's life or to prevent serious or permanent impairment to their health, the child/youth is considered to be in need of protection and the duty to report process should be followed as per below.
    - When there is reason to believe a child/youth is in need of protection, there is a duty to report the matter under the authority of Section 14 of the BC *Child, Family and Community Service Act*. Contact the Ministry of Children and Family Development (MCFD) (**1-800-663-9122**) to make a report. If you are aware that an Indigenous child and family service law applies to the child/youth you can make the report to the applicable Indigenous authority providing services under that law. If you are unsure whether an Indigenous child and family service law applies to a child/youth or how to make a report under it, the report should be made to MCFD. Providers should also refer to their Health Authority's Child Protection policy.
    - A child/youth does not need to be in the care of MCFD or an applicable Indigenous authority to obtain a Court Order authorizing the required care. The Director may apply for a court order authorizing the health care to be provided to the minor. Refer to Section 29 of the BC *Child, Family and Community Service Act*.

3.2 Confidentiality and Information Sharing

- Children and youth have the right to confidentiality, and we need to respect a child/youths' wishes in relation to who is given information about their situation.
- Sharing information with chosen supports may be helpful in supporting treatment goals when done respectfully in partnership with the child/youth and with their consent.
- Personal health information can be shared with healthcare providers who form a patient's circle of care (e.g., specialists, lab technologists) for the purposes of ongoing care and treatment. For more information refer to Doctors of BC Privacy and Security in the BC Health Care System Today.

- Disclosure without the consent of a capable minor is a breach of confidentiality. Disclosures may be considered when: 1) it is necessary for urgent medical treatment of the individual and consent cannot be obtained in a timely way; 2) compelling circumstances exist that affect the health or safety of any individual; 3) there is a need to contact a relative or friend of an injured, ill, or deceased individual; and/or 4) there is a duty to report the matter under the authority of Section 14 of the BC *Child, Family and Community Service Act* or applicable Indigenous child and family service law.
    - Refer to the *Freedom of Information and Protection of Privacy Act* *section 33(3)(a) and (c)* and section 18(1)(b), (k), and (l) of the *Personal Information Protection Act*.
    - Healthcare providers should not assume that personal health information must be disclosed based on a mere request by a law enforcement authority. For more information refer to the College of Physicians and Surgeons of BC Disclosure of Patient Information to Law Enforcement Authorities.
- Having a conversation about confidentiality and information sharing with a child/youth supports relationship building, trust, and youth centered care that is collaborative and reflective of a child/youth's priorities and needs.
- Confidentiality and the limits of confidentiality should be discussed with children and youth. It should be noted that breaking a child/youth's confidentiality may erode their trust in the healthcare system and lead them to disengage from potentially lifesaving care in the future.
- If there are emergencies in which healthcare providers consider contacting parents/guardians against a child/youth's wishes, they should:
    - Discuss with the child or youth the emergency circumstances in which they are obligated to inform parents/guardian.
    - Be clear about the level of risk to the child or youth (or others) they are seeking to prevent.
    - Discuss the child or youth's reasons for keeping information private to discover if there are better and safer ways to decrease this risk.
    - See **Appendix B** for information sharing decision support tool.

    Learning Link: *Best Practice Guide on information disclosure for youth with mental health and substance use concerns*

4.0 General Assessment, Treatment, and Consultations

Children/youth presenting intoxicated or in acute withdrawal require a comprehensive physical assessment, mental status assessment, suicidality and self-harm screening, patient history, substance use screening, and psychosocial assessment (6). Collateral information can support the assessment. During assessment and treatment provide environmental supports and calming interventions such as minimizing stimuli (e.g., quiet, reduced lighting) and offering for a support person to be present whenever possible. Close monitoring and frequent reassessment are required due to increased risk for medical and psychiatric complications in children and youth. Substance specific guidance is provided in **Appendix D.**

4.1 General Assessment and Treatment

- Complete primary assessment and immediate interventions for stabilization (Airway, Breathing, Circulation, Disability, Exposure).

- The physical exam should assess for signs of toxidromes[6]. See **Appendix D Assessment & Treatment Recommendations by Substance.**
- In patients with profoundly decreased level of consciousness or respiratory depression refractory to initial antidotes, consider mixed substance ingestion.

- Complete secondary assessment including but not limited to a full set of vital signs (including blood pressure and temperature), Pediatric Early Warning Score (PEWS), neurological status (Glasgow coma scale), and mental status exam.
  - Temperature should be assessed due to risk of hypo- or hyperthermia dependent on substance taken and/or prolonged environmental exposure (7,8).
  - Rule out possible medical or biological reasons for the presentation. Medical conditions may have symptoms that could be confused with substance intoxication or withdrawal. Examples include head injury, acute infection, chronic neurological disease (encephalopathy, epilepsy), electrolyte imbalance, cerebrovascular accident, hypoglycemia, metabolic disease (diabetes mellitus, adrenal gland involvement, thyroid disease), psychosis, severe liver disease, or cardiac conditions (rhythm disorders, congenital or acquired cardiopathy).
  - Assess for concurrent acute conditions such as head injury, recent sexual or physical abuse, pregnancy, skin integrity (cellulitis, phlebitis, abscesses, irritation, or rashes), and dehydration and/or impacts of malnourishment.
  - Ask about what substance(s) they used, frequency, quantity, route of use and when they last used and assess for withdrawal symptoms. Ask about previous medical complications of use, such as overdose or complicated withdrawal.
    - For examples of substance specific tools for assessing withdrawal see **Appendix D**.
    - Note: The child/youth may have ingested more than one substance or be unaware of other substances that may have been ingested. You may not be able to determine what substance(s) and/or how much was used.
    - Collateral information can support the assessment including the review of PharmaNet for history/current list of medication(s) used.
  - Assess specifically for suicidality and self-harm related to substance use.
- Order point of care glucose and serum toxicology (ethanol, acetaminophen, or salicylates).
- Depending on clinical circumstances, consider: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and intracranial imaging,
- Consider urine drug test (UDT).
  - The results of these tests can inform assessment of risk and are useful for ongoing treatment planning and interventions post-acute stabilization, including withdrawal management. It also supports harm reduction education with the child/youth by providing feedback about their substance use and a potentially toxic substance supply.

[6] **"Toxidrome"** A toxidrome (toxic syndrome) is characterised by a classic constellation of symptoms and signs due to toxic effects of chemicals in the body. Toxidrome recognition is important for rapid detection of the suspected cause and helps focus the differential diagnosis to those few chemicals which have similar toxic effects (11)

- Results may not identify all types of substances or distinguish between members within a single class of medications. Conventional UDTs may not detect synthetic or semi-synthetic substances (8). It is important to understand the limitations and know what other medication(s) the child or youth may have been prescribed (e.g., psychostimulants, benzodiazepines).
- See **Appendix C** for information on interpreting UDTs.

- Provide environmental supports and calming interventions such as minimizing stimuli (e.g., quiet, reduced lighting) and offering a chosen support person to be present whenever possible to prevent agitation (see CHBC Least restraint Hierarchy of Safety). Prompt treatment of increased agitation and/or changes in mental status may decrease safety risk to self-and/or others. Refer to CHBC Chemical Restraint Algorithm for treatment of increased agitation.
- Children/youth who appear to have stabilized after being intoxicated should be further assessed for any possibility of withdrawal. Early identification and treatment for withdrawal can prevent potentially life-threatening complications, reduce agitation, and support acceptance of ongoing assessment and treatment planning. It may also reduce rates of patient-initiated discharge and associated risks.
- Reassess and consider escalating to higher level of care as required per Canadian Triage Acuity Score (CTAS), PEWS, and/or health authority guideline/standards.

4.2 Consultations

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

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

5.0 Assessment and Treatment Recommendations by Substance

Medical stabilization is the priority for children and youth presenting to hospitals intoxicated or experiencing acute withdrawal symptoms. Antidote administration (where appropriate), observation, and supportive symptom management are the most common interventions described in literature (8,9) and

existing guidelines (10–16). Detailed guidance on assessment and treatment recommendations by substance is outlined in **Appendix D**.

6.0 Screening, Brief Intervention, Referrals, Harm Reduction and Discharge Planning

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

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

6.1 Screening

- When the child/youth can safely participate, all children and youth presenting to acute care settings for substance intoxication or withdrawal concerns should be screened for substance use disorders (12,17). The CRAFFT 2.1+N or S2BI are validated options for substance use screening that are child/youth specific (18–20).
    - Having this conversation with the child/youth privately may facilitate open and honest disclosures. If parent/caregiver or other chosen support is present, ask to give privacy for a moment and then explain to child/youth that you will be taking a substance use history and ask if they prefer for parent/caregiver or chosen support to be present or not.
- Take a detailed substance use history, using an open and non-judgmental approach. Offer an explanation as to why it is important to their ongoing care and how the information is going to be used. Ask about age of first use, what substance(s) they use, frequency, quantity, route of use, when they last used, and assess stage of change to support harm reduction and treatment planning with the child/youth.
    - The stage of change model describes the stages people go through when changing their behaviour: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, maintenance, and/or re-occurrence (21).
    - Identifying the individual's stage of change can help pair specific treatment recommendations with their own identified goals. Motivational interviewing techniques can be utilized to help guide the individual along the stages of change.
        - ***Learning Link:*** *The Stages of Change Model - YouTube*

- All children and youth presenting with intoxication and withdrawal should have an assessment completed to screen for co-occurring psychosocial and mental health concerns. Examples of tools to support assessment include HEARTSMAP (22), HEADSSS, HEADS-ED (23,24), and the DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Child Age 11-17. Psychiatry consultation may also be required, following your health authority process.
- Thank the child/youth for sharing information with you and ask if they have any questions.

6.2 Brief Intervention

Brief intervention is used to raise child/youth awareness of the benefits and concerns surrounding substance use, elicit internal motivation for change, and help set behavior-change goals, ideally using a motivational interviewing approach (25–30).

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

6.3 Referral to Supports and Services and Creating the Discharge Plan

- Referral to supports and services is intended to facilitate access to and engagement in specialized services and coordinated care for a child/youth.
- Consider consultation or referral to an addiction provider if there is an identified risk for substance use disorder based on screening completed.
- Engage the child/youth and chosen support(s) (as appropriate) in setting goals for wellness and provide relevant resources and referrals.
    - Individualized, multi-dimensional approaches to treatment are valued by youth and allow them to work toward futures not defined by substance use and mental health crises.
    - To support developing a holistic care plan (e.g., mental, physical, spiritual, and emotional) explore supports that respects the individual's culture, customs, values, and beliefs (UNDRIP Article 24; TRC Call to Action #22; A Path Forward Strategic Action J3).
    - Youth may prefer treatment modalities that give them more control and subject them to less surveillance.
    - Pharmacotherapies should be presented as one piece of a larger plan that includes housing, employment, income, social, and cultural supports.
    - Medications for substance use disorders such as opioid agonist therapy (OAT), psychotropic medications, or nicotine replacement therapy (NRT) should be discussed with youth and should include discussion on what kind of medication would work best for them, potential timelines, and the possibility of tapering doses.
- Inform child/youth and chosen supports about the voluntary nature of community resources.
- Complete referrals to appropriate inpatient and/or outpatient community services.
- If safety concerns have been identified, complete a safety plan prior to discharge with the child/youth and chosen supports.

- Address any questions and education requirements including harm reduction.
- Ask youth if they have any other health questions or concerns (i.e., sexual health) and connect them to appropriate community resources.

6.4 Harm Reduction

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

- Ask child/youth what harm reduction strategies they currently use (if any)
- Encourage child/youth to use in a safe environment such as a supervised consumption service, overdose prevention site, or with trusted peers.
- Encourage child/youth not to use substances alone and if using alone to consider the Lifeguard Application's "Use Alone" timer that will send emergency services to a user's location if a person becomes unresponsive after consuming substances.
- Recommend they start by taking a small amount and wait to see how it affects them before using more e.g., "Start low and go slow."
- Recommend they only use one substance at a time. For more information on mixing medicine, alcohol and drugs share www.drugcocktails.ca .
- Recommend testing substances using fentanyl tests and/or drug-checking services to screen substances where available. See available drug checking locations.
- Review safer substance use practices, including where to access sterile supplies (e.g., syringes, pipes) and safer consumption services and overdose prevention sites.
- Offer a Take Home Naloxone Kit and training to all youth who use substances as they may also witness someone overdose due to the toxic illicit drug supply (31,32).
- Provide evidence-based information on substances (e.g., percentage of alcohol in beer versus hard liquor)

Indigenous harm reduction moves beyond a focus on individual safety and includes undoing the harms of colonialism that place Indigenous people at a higher risk of harm from substance use (33). A decolonized and Indigenized approach is strengths based, re-connects children and youth to culture, and focuses on building relationships with the interconnected natural, human, and spiritual worlds. This can include connecting children and youth to Elders, traditional healers, community, and traditional practices, such as opportunities to participate in ceremonies, Indigenous arts and crafts, storytelling, language revitalization, and traditional land-based activities (TRC Call to Action #22; A Path Forward Strategic Action J).

Learning Link: *Indigenous Harm Reduction*

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

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

6.5 Communicating the Discharge Plan

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

7.0 Resources

7.1 Provider Resources

Type of Resource	
General Resources	• Compass Mental Health • BC Centre On Substance Use • Child Health BC Mental Health and Substance Use Initiatives
Guidelines	• Child Health BC Least Restraint Guideline • Consent to Healthcare: Procedure for Minors and Mature Minors • Canada's Low Risk Drinking Guidelines • Canada's Lower Risk Cannabis Use Guidelines • BC Centre on Substance Use Opioid Use Disorder Youth Guidance
Education	• Substance Use / Concurrent Disorders Toolkit • Engagement and Relationship Building Learning Activities • Mental Health Screening and Assessment Learning Activities • Supporting Emotional Regulation Learning Activities • Trauma Informed Practice Guide • Trauma & Violence Informed Care Toolkit - Equip Healthcare
Indigenous Health	• United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) Report • Principles of Reconciliation

	• Truth and Reconciliation Commission of Canada: Calls to Action • In Plain Sight Report • Indigenous Harm Reduction (fnha.ca)
Working with Youth	• BCCSU Harm Reduction Calls to Action and Youth Voices on Treatment Report • Gender Inclusive Language
Harm Reduction	• Toward the Heart • Lifeguard App • Indigenous Harm Reduction (fnha.ca) • Overdose prevention and supervised consumption sites

7.2 Family & Youth Resources

Type of Resource	
Youth Focused Support and Information	• Foundry (Direct clinical support in addition to information) • Youth Mental Health and Wellbeing | Wellbeing.gov.bc.ca • Drug Cocktails • SMART Recovery Teen and Youth Support Program • Young People and AA • British Columbia Region of Narcotics Anonymous
Information and Supports for Families / Caregivers	• Kelty Mental Health • Family Smart • Wellbeing by the Ministry of Mental Health and Addictions • Here to Help : From Grief to Action Coping Kit • Addiction. The Next Step Toolkit • SMART Recovery Family and Friends • Alanon Family Groups • Naranon Family Groups
Alcohol and Drug Information Referral Service	• Contact ADIRS toll free at 1-800-663-1441
Harm Reduction	• Toward the Heart • Lifeguard App • Indigenous Harm Reduction (fnha.ca) • Overdose prevention and supervised consumption sites

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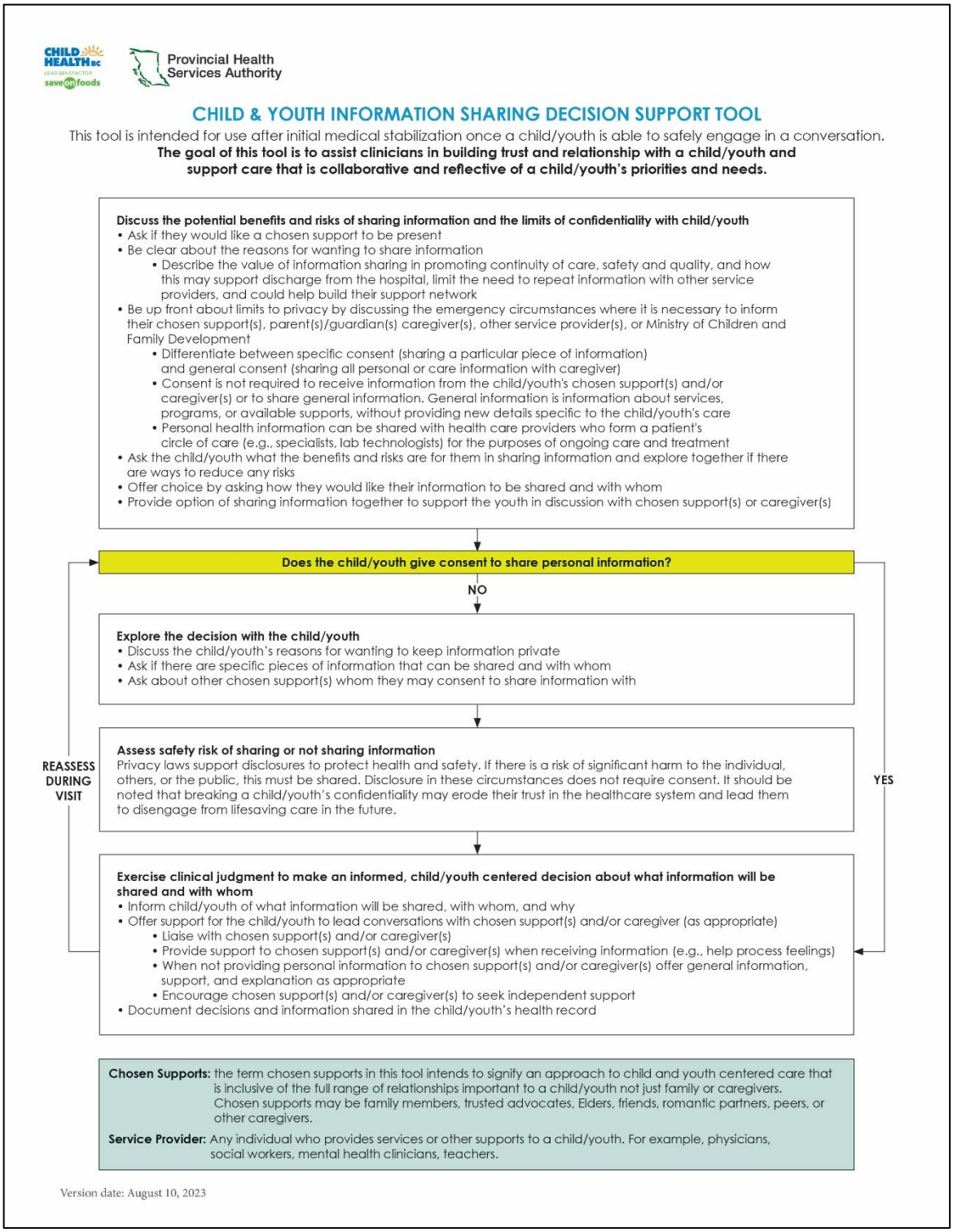
Appendices

Appendix A. Common Street Names for Substances

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

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

Appendix B. Child & Youth Information Sharing Decision Support Tool



Provincial Health Services Authority

CHILD & YOUTH INFORMATION SHARING DECISION SUPPORT TOOL

This tool is intended for use after initial medical stabilization once a child/youth is able to safely engage in a conversation.
The goal of this tool is to assist clinicians in building trust and relationship with a child/youth and support care that is collaborative and reflective of a child/youth's priorities and needs.

Discuss the potential benefits and risks of sharing information and the limits of confidentiality with child/youth
- Ask if they would like a chosen support to be present
- Be clear about the reasons for wanting to share information
  - Describe the value of information sharing in promoting continuity of care, safety and quality, and how this may support discharge from the hospital, limit the need to repeat information with other service providers, and could help build their support network
- Be up front about limits to privacy by discussing the emergency circumstances where it is necessary to inform their chosen support(s), parent(s)/guardian(s) caregiver(s), other service provider(s), or Ministry of Children and Family Development
  - Differentiate between specific consent (sharing a particular piece of information) and general consent (sharing all personal or care information with caregiver)
  - Consent is not required to receive information from the child/youth's chosen support(s) and/or caregiver(s) or to share general information. General information is information about services, programs, or available supports, without providing new details specific to the child/youth's care
  - Personal health information can be shared with health care providers who form a patient's circle of care (e.g., specialists, lab technologists) for the purposes of ongoing care and treatment
- Ask the child/youth what the benefits and risks are for them in sharing information and explore together if there are ways to reduce any risks
- Offer choice by asking how they would like their information to be shared and with whom
- Provide option of sharing information together to support the youth in discussion with chosen support(s) or caregiver(s)

Does the child/youth give consent to share personal information?

NO

Explore the decision with the child/youth
- Discuss the child/youth's reasons for wanting to keep information private
- Ask if there are specific pieces of information that can be shared and with whom
- Ask about other chosen support(s) whom they may consent to share information with

REASSESS DURING VISIT

Assess safety risk of sharing or not sharing information
Privacy laws support disclosures to protect health and safety. If there is a risk of significant harm to the individual, others, or the public, this must be shared. Disclosure in these circumstances does not require consent. It should be noted that breaking a child/youth's confidentiality may erode their trust in the healthcare system and lead them to disengage from lifesaving care in the future.

YES

Exercise clinical judgment to make an informed, child/youth centered decision about what information will be shared and with whom
- Inform child/youth of what information will be shared, with whom, and why
- Offer support for the child/youth to lead conversations with chosen support(s) and/or caregiver (as appropriate)
  - Liaise with chosen support(s) and/or caregiver(s)
  - Provide support to chosen support(s) and/or caregiver(s) when receiving information (e.g., help process feelings)
  - When not providing personal information to chosen support(s) and/or caregiver(s) offer general information, support, and explanation as appropriate
  - Encourage chosen support(s) and/or caregiver(s) to seek independent support
- Document decisions and information shared in the child/youth's health record

Chosen Supports: the term chosen supports in this tool intends to signify an approach to child and youth centered care that is inclusive of the full range of relationships important to a child/youth not just family or caregivers. Chosen supports may be family members, trusted advocates, Elders, friends, romantic partners, peers, or other caregivers.

Service Provider: Any individual who provides services or other supports to a child/youth. For example, physicians, social workers, mental health clinicians, teachers.

Version date: August 10, 2023

Appendix C. Interpreting Urine Drug Tests (UDT)

Why a UDT is Important

- In an emergent situation, the immediate value of a UDT may be limited. However, the results can be useful for ongoing treatment planning and interventions post-acute stabilization including withdrawal management.
- Some medications and illicit drugs are only present in urine for a brief time (34). Early collection (with child/youth consent) can be helpful for later treatment planning.
- UDT results can support harm reduction education with a child/youth by providing feedback about their substance use and potentially toxic substance supply. Youth may be surprised to learn that the substance they thought they were ingesting was something else.

Considerations for Interpreting UDT

- It is important to understand timelines for detection, what other medication(s) have been prescribed (e.g., psychostimulants, benzodiazepines), and risks of false positive or false negative results.
- Initial UDTs use immunoassay that are quick but less accurate. Immunoassays may not distinguish between or detect all members within a single class of medications and may not detect synthetic/ semi-synthetic substances.
- Urine collected can be used for confirmatory testing by liquid chromatography or gas chromatography–mass spectrometry (GCMS). This testing is highly sensitive and specific, but takes longer, and may need to be sent away.

The following tables adapted with permission from: *British Columbia Centre on Substance Use, BC Ministry of Health, and Ministry of Mental Health and Addictions. Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment — Breakout Resource. Published July 28, 2021. Available at: https://www.bccsu.ca/wp-content/uploads/2021/07/Urine-Drug-Testing-Breakout-Resource.pdf*

Timelines for detection of substances in urine drug test (35)

	Substance	Length of time substance detected in urine after ingestion
Depressants (Downers)	**Alcohol**	6-8 hours
	Opioids	
	Buprenorphine	up to 7 days
	Codeine	2-5 days
	Fentanyl – short term use	2-3 days(36)
	Fentanyl – chronic use[7]	Up to 4 weeks
	Heroin metabolite (6-MAM)	< 1 day
	Hydromorphone	Up to 3 days
	Methadone	≤ 6 days
	Morphine	2-5 days
	Oxycodone	2-4 days
	Benzodiazepines	
	Short acting (e.g., lorazepam)	1-2 days
	Long acting (e.g., diazepam)	Up to 30 days (regular use)
	Sedative Hypnotics	
	Gamma hydroxybutyrate / GHB	12 hours(37)
	Zolpidem	1-2 days(38)
Stimulants (Uppers)	Amphetamines	2-5 days
	Cocaine	2-3 days
	Methamphetamine	2-5 days
Psychedelics	Ketamine	Up to 14 days(39)
	LSD metabolites	Up to 4 days(40)
	Phencyclidine (PCP)	5-6 days(41)
Cannabinoids	Cannabis	Single use: 1-3 days Chronic use ≤ 30 days

[7] Fentanyl persists in urine for up to 4 weeks due to lipophilic properties, not due to duration of action (i.e., fentanyl is not a long acting opioid)

Possible causes of false positive and false negative results in urine drug testing (35)

Clinicians should not automatically assume a false-positive or false-negative result if the patient is prescribed one of the medications listed below. This cross-reactivity table does not provide definitive answers as to the reason for a positive or negative UDT result. Clinicians are advised to request confirmatory testing if there is an unexpected result.

Opioids	**False-negative results**	False-negative results can occur when immunoassays do not reliably detect the following semi-synthetic or synthetic opioids:		
		Oxycodone Hydromorphone	Buprenorphine Fentanyl	Methadone Meperidine
	False-positive results	Cross-reactivity and false-positive results can occur with compounds that have a similar chemical and physical structure.		
		Substances		**Cross reacts with:**
		Fluoroquinolones Poppy seeds Dextromethorphan Diphenhydramine Quinine Rifampin		Morphine Codeine Heroin metabolite
		Trazodone Risperidone Paliperidone		Fentanyl
		Quetiapine Verapamil		Methadone metabolite
Benzodiazepines	**False-negative results**	Some benzodiazepines have distinct metabolic pathways and may not adequately cross-react on immunoassays (resulting in false negative). "Z-drugs" are not detected in benzodiazepine immunoassay panels.		
		Lorazepam Clonazepam	Alprazolam Zopiclone	Zolpidem
	False-positive results	Cross-reactivity and false-positive results can occur with compounds that have a similar chemical and physical structure.		
		Sertraline	Oxaprozin	
Amphetamines	**False-negative results**	Not applicable		
	False-positive results	Amphetamines have the highest degree of cross-reactivity of any substance and thus the highest rate of false-positive results		
		Substances		
		Amantadine Aripiprazole Bupropion Chlorpromazine Clobenzorex Desipramine Ephedrine	Fenproporex Fluoxetine L-Methamphetamine Labetalol Methylphenidate Phentermine Phenylephrine	Phenylpropanolamine Promethazine Pseudoephedrine Ranitidine Thioridazine Trazodone Venlafaxine
		Lactate dehydrogenase and lactate, in patients with lactic acidosis		
Cannabinoids	**False-negative results**	Synthetic cannabinoids very unlikely to cross-react. Typically present at very low concentrations.		
		Nabilone		
	False-positive results	Cross-reactivity and false-positive results can occur with compounds that contain THC or cannabidiol, or compounds that have similar chemical/physical structure.		
		Sativex Dronabinol	Efavirenz NSAIDs	Proton pump inhibitors Baby soap[8] or shampoo

[8] Topical use of commercial baby soaps may cause false positive results.

Appendix D. Assessment and Treatment Recommendations by Substance

This resource provides guidance on assessment and initiation of treatment for children/youth 10 to 18.99 years old presenting intoxicated or undergoing acute withdrawal. Information may be relevant for other ages based on clinical judgement. This table is intended to be used in conjunction with the full guideline.

- **Consult BC Drug and Poison Information Centre 24/7 (1-800-567-8911) for treatment/toxicity information on intentional overdoses or unintentional exposures**
- The Addiction Medicine Clinician Support Line (1-778-945-7619) is available **24/7** for questions regarding treatment of substance use concerns

SUBSTANCE	Vitals, Signs & Symptoms	Complications	Treatment Recommendations

Undifferentiated (INTOXICATION)	Complete vitals, Pediatric Early Warning Score, neurological status (Glasgow coma scale), and mental status exam.
	Other considerations:
	• Temperature should be assessed due to risk of hypo- or hyperthermia dependent on substance taken and/or prolonged environmental exposure
	• Assess pupils
		Dependent on substance(s) ingested	**Investigations & Monitoring**
			• Complete primary assessment and immediate interventions for stabilization (ABCs)
			• For profoundly decreased LOC or respiratory depression refractory to initial antidotes, consider mixed substance ingestion
			• Rule out possible medical / biological reasons for presentation and assess for concurrent acute conditions
			• Order point of care glucose and serum toxicology (ethanol, acetaminophen, or salicylates)
			• Consider urine drug test
			• Depending on clinical circumstances, consider: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and intracranial imaging
			• Gather collateral information
			• Reassess and consider escalating to higher level of care as required
			
			Medications
			• If heavily sedated/obtunded with vital sign instability consider naloxone. Naloxone should only be used with signs of opioid overdose (respiratory rate < 10/minute, SpO2 < 92% on room air, or fentanyl induced chest wall rigidity). Otherwise, use watch and wait approach
			  ○ A smaller dose of naloxone is preferred initially to avoid inducing severe withdrawal syndrome, unless there is acute concern for airway compromise
			  ○ Refer to Emergency Care BC Opioid Overdose Management Guideline for additional guidance
			  ○ Note: may remain over-sedated due to combination of substances (e.g., opioids and benzodiazepines) stimulant withdrawal, or other patient factors
			• Refer to CHBC Chemical Restraint Algorithm for increased agitation
			
			Supportive Care
			• Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements
			• Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Alcohol (ethanol) (INTOXICATION)	- / ↓	↓	↓	↓	• CNS depression • Respiratory depression • Hypoglycemia • Hypovolemia • Hypothermia • Loss of consciousness	**Investigations & Monitoring** • Clinical signs are not specific or sensitive indicators of blood alcohol concentration (42). Alcohol levels in children/youth may be underestimated based on clinical appearance alone (29) • Monitor for CNS and respiratory depression (9) • Point of care blood glucose, blood ethanol concentration, serum electrolytes/osmolality, anion gap, osmolal gap, venous blood gas (43,44) • Consider liver function and enzyme tests • Temperature maintenance • Consider CT if decreased level of consciousness **Medications** • **Antidote** – nil • IV fluids (crystalloid) if needed due to vomiting (7) • Antiemetics may be used to reduce nausea and vomiting to prevent gastric content aspiration (9) • Consider thiamine IV or PO if heavy alcohol use or poor nutrition intake • Refer to CHBC Chemical Restraint Algorithm for increased agitation **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Confusion • Altered LOC **Other signs/symptoms** • Alcohol odor or halitosis • Slurred speech • Lack of coordination • Poor concentration • Dizziness • Unsteady gait • Hyporeflexia • Vomiting • Hematemesis • Gastritis • Hypotension					

<table>
<tr><th>SUBSTANCE</th><th>Vitals, Signs & Symptoms</th><th>Complications</th><th>Treatment Recommendations</th></tr>
<tr>
<td>Alcohol (WITHDRAWAL)</td>
<td>
<table>
<tr><th>Temp</th><th>HR</th><th>BP</th><th>Resp Rate</th></tr>
<tr><td>-/↑</td><td>↑</td><td>↑</td><td>↑</td></tr>
</table>
Mental Status
• Agitation
• Anxiety
• Confusion
• Transient hallucinations, auditory visual, tactile disturbances

Other signs/symptoms
• Autonomic hyperactivity
• Sweating
• Nausea, vomiting, diarrhea
• Tremor
• Tactile disturbances
• Headache
</td>
<td>• Seizures</td>
<td>
Investigations & Monitoring
• Use CIWA- Ar: Clinical Institute Withdrawal Assessment for Alcohol Revised to guide based on severity of withdrawal
• Refer to MSTEP guide for information on progression of withdrawal symptoms (pg. 15)
• Consider monitoring for refeeding syndrome if heavy alcohol use or poor nutrition intake.

Medications
• Consider thiamine IV or PO if heavy alcohol use or poor nutrition intake
• Consider benzodiazepines (severe withdrawal) in consultation with an Addiction Medicine specialist
• Refer to page 58 & 77 of the BCCSU High Risk Drinking and Alcohol Use Disorder Guideline for guidance on withdrawal management and pharmacotherapy options for youth
• Refer to CHBC Chemical Restraint Algorithm for increased agitation

Supportive Care
• Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements
• Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
</td>
</tr>
</table>

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Benzodiazepines, Sedative hypnotics (INTOXICATION)	- / ↓	↓	↓	↓	• CNS & respiratory depression • If deeply sedated/obtunded, consider mixed substance ingestion	**Investigations & Monitoring** • Point of care glucose, serum toxicology (ethanol, acetaminophen, or salicylates) • Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and/or intracranial imaging • Consider urine drug test (UDT). Certain benzodiazepines may not be detected in UDT. See Appendix C **Medications** • Activated charcoal is not recommended due to risk of aspiration and lack of benefit • If respiratory depression, a concomitant opioid overdose may be present, and it is reasonable to administer appropriate doses of parenteral naloxone • **Antidote** – Flumazenil administration is generally **NOT** recommended. Flumazenil can precipitate seizures in patients on chronic benzodiazepine therapy, other anti-convulsant, or in co-ingestions with other agents that lower seizure threshold. Only consider using flumazenil if it is a confirmed, single-substance benzodiazepine ingestion producing hypoventilation or over-sedation with the inability to protect airway. **Consult BC Drug and Poison Information Centre 1-800-567-8911.** **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Confusion • Lethargy • Altered LOC **Other signs/symptoms** • Slurred speech • Poor concentration • Dizziness • Ataxia (lack of coordination / unsteady gait) • Decreased muscle tone • Hyporeflexia • Vomiting • Paradoxical reaction					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Benzodiazepines, Sedative hypnotics (WITHDRAWAL)	-/↑	↑	↑	↑	• Seizures	**Investigations & Monitoring** • Inpatient management may be required • Implement ongoing monitoring for signs and symptoms, consider using CIWA-B: Clinical Institute Withdrawal Assessment for Benzodiazepines or CIWA- Ar: Clinical Institute Withdrawal Assessment for Alcohol Revised • Withdrawal timelines differ between types of benzodiazepines and with duration of use. Concentrations of benzodiazepines within the illicit drug supply can be high enough to cause withdrawal. Urine drug test (UDT) may be used for confirmatory testing to identify and alert team to possible withdrawal. Certain benzodiazepines may not be detected in UDT (see Appendix C) **Medications** • If considering a benzodiazepine taper, consult Addiction Medicine specialist to weigh risks and benefits and consider admission **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Agitation • Anxiety • Confusion • Hallucinations (auditory, tactile, visual) • Paranoia **Other signs/symptoms** • Psychomotor agitation • Sensory hypersensitivity • Insomnia • Sweating • Abdominal cramping, nausea, vomiting, diarrhea • Lack of appetite • Tremor • Headache					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Gamma-hydroxybutyrate (GHB) (INTOXICATION)	- / ↓	↓	↓	↓	• CNS & respiratory depression, which can be very rapid, especially when combined with other sedating drugs (GHB | CAMH) • Seizures	**Investigations & Monitoring** • Order point of care glucose, serum toxicology (ethanol) • Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and/or intracranial imaging • Monitor for CNS & respiratory depression • If drug-facilitated sexual assault is suspected, offer sexual assault assessment **Medications** • **Antidote-** nil (no clinically proven reversal agents/antidotes for GHB toxicity exist) • Refer to CHBC Chemical Restraint Algorithm for increased agitation **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Fluctuations in mental status • Euphoria (lower doses) • Confusion • Disinhibition • Drowsiness/dizziness • Impaired memory • Sedation **Other signs/symptoms** • Nausea and vomiting (with higher dose) • Bradycardia • Myoclonic jerks					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Gamma-hydroxybutyrate (GHB) (45,46) **(WITHDRAWAL)**	↑	↑	↑	-	• Delirium • Rhabdomyolysis • Seizures Note: Withdrawal presents similar to alcohol and benzodiazepine withdrawal but given its short half-life can progress rapidly and be severe (e.g., seizures) in someone with dependence.	**Investigations & Monitoring** • Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and/or intracranial imaging • Inpatient admission may be required **Medications** • Treatment of GHB withdrawal is primarily supportive with administration of sedatives and requires monitoring for respiratory depression. Consult Addiction Medicine • Selection of medications is dependent on severity and presence of delirium. For detailed guidance refer to Up to Date Guidance on GHB Withdrawal **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Anxiety • Agitation • Paranoia • Hallucinations • Labile mood **Other signs/symptoms** • Tremors • Insomnia • Sweating • Nausea and vomiting					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		

Opioids (INTOXICATION)	↓	↓	↓	↓	• CNS & respiratory depression (47)
					• Severe bradycardia (47,48)
					• Bowel perforation (chronic use)
						Investigations & Monitoring
						• Order point of care glucose, serum toxicology (ethanol, acetaminophen, or salicylates)
						• Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections, ECG, and/or intracranial imaging
						• Consider chest x-ray, in patients with persistent respiratory findings
						• Urine drug test (UDT) (32)
						• Monitor for CNS & respiratory depression and support airway as required
						• Inpatient admission may be required
						
						Medications
						• **Antidote -** Naloxone
						  ○ Naloxone should only be used with signs of opioid overdose (respiratory rate < 10/minute, SpO2 < 92% on room air, or fentanyl induced chest wall rigidity). Otherwise, use watch and wait approach
						  ○ A smaller dose of naloxone is preferred initially to avoid inducing severe withdrawal syndrome, unless there is acute concern for airway compromise
						  ○ Refer to Emergency Care BC Opioid Overdose Management Guideline for additional guidance
						  ○ Note: may remain over-sedated due to combination of substances (e.g., opioids and benzodiazepines) stimulant withdrawal, or other patient factors
						
						Supportive Care
						• Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements
						• Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous

	Pupils - Constricted (pinpoint) • Pinpoint pupils may not be present with polysubstance toxicity **Mental Status** • Drowsiness and decreased level of consciousness • Impairment in attention / memory **Other signs/symptoms** • Hyporeflexia • Muscle rigidity (fentanyl) • Myoclonic jerks • Pruritus • Slurred speech • Decreased bowel sounds • Constipation • Urinary Retention					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Opioids (WITHDRAWAL)	-/↑	↑	↑	↑		**Investigations & Monitoring** • Implement ongoing monitoring for signs and symptoms of withdrawal using Clinical Opioid Withdrawal Scale (COWS) or Subjective Opiate Withdrawal Scale (SOWS) • Urine drug test to inform withdrawal management **Medications** • Consult/refer to addiction provider if there is an identified risk for opioid use disorder to discuss if Opioid Agonist Treatment (OAT) is appropriate. For detailed guidance on treatment of opioid use disorder in youth refer to: BCCSU Opioid Use Disorder—Youth Supplement • Buprenorphine-naloxone is preferred if youth is interested and has an opioid use disorder. • May also consider short acting opioid medications or non-opioid adjuncts (e.g., clonidine) • For more detailed guidance on treating opioid withdrawal refer to: Opioid withdrawal in adolescents - UpToDate • Withdrawal management alone is not recommended, due to high rates of non-completion, relapse, and toxicity events **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Anxiety • Agitation **Other signs/symptoms** • Autonomic hyperactivity • Restlessness • Insomnia • Yawning • Lacrimation /rhinorrhea (tearing / runny nose) • Sweating • Muscle spasms, cramps, and aches • Joint stiffness • Nausea / vomiting (may cause hypotension due to volume loss) • Diarrhea • Increased bowel sounds • Fever/chills • Piloerection (goosebumps)					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Stimulants (i.e., cocaine, crack, amphetamines, methamphetamines) (INTOXICATION) ***For MDMA see MDMA specific section of table***	↑	↑	↑	↑	• Severe hyperthermia • Central & peripheral sympathomimetic effects • Vasoconstriction • Chest pain or cardiac arrhythmias • Rhabdomyolysis • Seizures • Intracranial hemorrhage • Cerebral edema • Amphetamines, methamphetamines, cocaine, and MDMA all have risk of serotonin toxicity (serotonin syndrome), which if untreated can lead to multi-organ failure and death • Synthetic cathinones (bath salts) act similarly and have risk of serotonin syndrome • Severe delirium • Psychosis	**Investigations & Monitoring** • 12 lead ECG Continuous cardiac monitoring • Monitor temperature due to risk of hyperthermia and initiate cooling measures • Monitor muscle tone and mental status • Order point of care glucose • Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections • Consider intracranial imaging if any concern of vascular dissection • Assess and monitor for psychosis. If a patient presents with symptoms of psychosis, psychiatry should be consulted **Medications** • **Antidote –** nil • Benzodiazepines are recommended to treat restlessness, agitation, hypertension, cardiovascular symptoms, and/or serotonin toxicity • Consult with BC Drug and Poison Information Centre (1-800-567-8911) for other treatment options regarding serotonin toxicity • Differentiating primary psychosis from stimulant induced psychosis in acute care may be difficult. May need to consult psychiatry to be able to rule out primary psychotic disorder from substance induced psychosis. Treatment with benzodiazepines and antipsychotics depends on severity of symptoms • Refer to CHBC Chemical Restraint Algorithm for increased agitation • For more detailed guidance on treating stimulant use disorder refer to: BCCSU Stimulant Use Disorder Practice Update **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Agitation • Confusion • Paranoia • Hallucinations / delusions • Sedation **Other signs/symptoms** • Sweating/chills • Tachycardia • Hypertension • Nausea / vomiting • Muscle weakness • Abnormal movements • Skin-picking					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Stimulants (i.e., cocaine, crack, amphetamines, methamphetamines) (WITHDRAWAL)	-	-	-	-	• Persistent psychiatric symptoms (due to stimulant use not specifically resulting from withdrawal) (49)	**Investigations & Monitoring** • Monitor mental status for complications such as psychosis, depression, and anxiety **Medications** • Refer to CHBC Chemical Restraint Algorithm for increased agitation • Symptomatic medications may be offered for aches, anxiety, and other symptoms • Consult addiction medicine • For more information on treating stimulant disorder refer to BCCSU Practice Update on Stimulant Use Disorder **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Sedated, with normal vitals usually • Dysphoric mood • Agitation • Irritability • Depression **Other signs/symptoms** • Fatigue • Vivid / unpleasant dreams • Insomnia or hypersomnia • Increased appetite • Psychomotor retardation or agitation • Muscle aches					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Nicotine (INTOXICATION)	↑	↑	↑	↑	Complications with large doses: • CVS: Cardiac dysrhythmias including atrial or ventricular fibrillation. Initial hypertension may progress to hypotension • Respiratory – may progress to dyspnea and respiratory depression • Neurologic – lethargy, drowsiness, muscle paralysis, stupor, coma, seizures • Musculoskeletal: fasciculations progressing to weakness, decreased deep tendon reflexes, paralysis	*Acute nicotine toxicity more likely to occur with accidental ingestion* (50). *Consult BC Drug and Poison Information Centre **24/7** at 1-800-567-8911.* **Investigations & Monitoring** • Look for and remove nicotine patches and discontinue nicotine replacement therapy • ECG: initially and repeat at 4 hours until normal **Medications** • **Antidote –** nil • Activated charcoal very rarely indicated. Discuss with toxicologist (14) • Following stabilization consider the possible impacts of withdrawal **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements
	Mental Status • Agitation • Confusion • Anxiety **Other signs/symptoms** • Tremor • Diaphoresis • Nausea, vomiting, abdominal pain, and/or diarrhea • Tachycardia • Hypertension • Shortness of breath, wheeze, Bronchoconstriction • Bronchorrhea • Headache					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Nicotine (WITHDRAWAL)	-	-	-	-		**Investigations & Monitoring** • Assess level of nicotine use (mg per day from cigarettes or vaping) • Encourage self-report of nicotine withdrawal (e.g., urge to smoke) and continue to monitor for withdrawal symptoms **Medications** • Provide nicotine replacement therapy (NRT) as appropriate **Supportive Care** • Consider providing brief advice about quitting. Refer to Quit Now • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Low mood **Other signs/symptoms** • Irritability, anger, difficulty concentrating, restlessness • Increased appetite, nausea • Constipation • Insomnia, nightmares					

<table>
<tr><th rowspan="2">SUBSTANCE</th><th colspan="4">Vitals, Signs & Symptoms</th><th rowspan="2">Complications</th><th rowspan="2">Treatment Recommendations</th></tr>
<tr><th>Temp</th><th>HR</th><th>BP</th><th>Resp Rate</th></tr>
<tr><td>MDMA (INTOXICATION)</td><td colspan="4">↑ ↑ ↑ ↑

Mental Status
• Euphoria
• Changes to sensory perception

Other signs/symptoms
• Hyperthermia
• Hypertension
• Tachycardia
• Sweating
• Excessive thirst and fluid intake
• Hyponatremia
• Muscle tension
• Bruxism
• Insomnia</td><td>• Hyperthermia
• Hyponatremia
• May result in serotonin syndrome
• Some case reports of cerebral edema and liver failure (8)
• Multi-organ failure</td><td>Investigations & Monitoring
• 12 lead ECG Continuous cardiac monitoring
• Monitor temperature and initiate cooling measures for hyperthermia
• Order point of care glucose
• Depending on clinical circumstances, consider the following investigations: serum pregnancy test, venous blood gas, lactate, urea and electrolytes/osmolality, anion gap, osmolal gap, creatinine, and creatine kinase, CBC, liver enzymes, blood cultures, testing for sexually transmitted and blood borne infections
• Consider intracranial imaging if any concern regarding vascular dissection

Medications
• Antidote – nil
• Benzodiazepines are recommended to treat restlessness, agitation, hypertension, cardiovascular symptoms, and/or serotonin toxicity
• Consult with BC Drug and Poison Information Centre (1-800-567-8911) for other treatment options regarding serotonin toxicity
• Fluid replacement may be necessary for water-electrolyte imbalances (9)
• Refer to CHBC Chemical Restraint Algorithm for increased agitation

Supportive Care
• Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements
• Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous</td></tr>
</table>

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Psychedelics (INTOXICATION)	↑	↑	↑	-	• Central & peripheral anti-cholinergic toxidrome • Persistent psychosis	**Investigations & Monitoring** • Assess and monitor for substance-induced psychosis. May need to consult psychiatry to rule out primary psychotic disorder from substance induced psychosis **Medications** • **Antidote –** nil • Benzodiazepines are recommended to treat restlessness, agitation, hypertension, cardiovascular symptoms, and/or serotonin toxicity in discussion with toxicologist • Refer to CHBC Chemical Restraint Algorithm for increased agitation **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Euphoria • Hallucinations / Perceptual distortions • Synesthesia • Agitation • Delirium **Other signs/symptoms** • Nystagmus (rapid, repetitive eye movement) • Tachycardia • Dry flushed skin					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Cannabinoids (INTOXICATION) (51–53)	- / ↑	↑	↑	↑	• CNS depression • Hyperthermia is an adverse effect of **synthetic** cannabinoids and cannot be corrected with antipyretics (8) • Cannabinoid Hyperemesis Syndrome (CHS) should be considered if cyclic vomiting and abdominal pain is present in the absence of an alternative diagnosis (51,54) Severity of CHS varies from mild dehydration to dehydration related acute kidney injury (53)	**Investigations & Monitoring** • If nausea, vomiting or concerns of CHS consider serum pregnancy test • Assess and monitor for substance-induced psychosis. May need to consult psychiatry to rule out primary psychotic disorder from substance induced psychosis • Treat hyperthermia with cooling measures **Medications** • **Antidote –** nil • Acute anxiety may be treated with diazepam or lorazepam • Oral or IV (crystalloid) rehydration may be considered based on severity and tolerance • Antiemetics may be trialed for nausea • Activated charcoal NOT recommended **Cannabinoid Hyperemesis Syndrome (CHS)** (chronic use) • IV fluids (crystalloid) • Hot showers have evidence for treating CHS if available • For persistent vomiting, consider trial of ondansetron, topical capsaicin, +/- other antiemetics • If IV fluids and initial antiemetics are not successful, consider haloperidol in consultation with addiction medicine. Caution: high incidence of extrapyramidal symptoms or dystonic reactions in children and adolescents • Consider admission to hospital • Provide counselling about cannabis cessation as only long-term treatment for CHS **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Sedation • Euphoria & disinhibition • Anxiety • Panic attacks • Delirium • Psychosis (chronic use) **Other signs/symptoms** • Myoclonic jerking • Nausea • Hypertension • Worsening asthma symptoms • Conjunctival injection • Dry mouth • Increased appetite • Nystagmus (rapid, repetitive eye movement) • Ataxia and slurred speech					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Cannabinoids (WITHDRAWAL)	-	- / ↑	- / ↑	-		**Investigations & Monitoring** • Monitor for worsening anxiety and dissociation and consider consultation with psychiatry **Medications** • Consider medication to help with sleep related disturbances • Pharmacotherapy for withdrawal may be considered in consultation with addiction medicine • Refer to CHBC Chemical Restraint Algorithm for increased agitation **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural support if child/youth self-identifies as Indigenous
	Mental Status • Agitation and irritability • Depressed Mood • Anxiety **Other signs/symptoms** • Restlessness • Cravings • Decreased appetite • Insomnia • Night sweats and vivid dreams • Sweating • Tremors • Headache • Abdominal pain • Fevers and chills					

SUBSTANCE	Vitals, Signs & Symptoms				Complications	Treatment Recommendations
	Temp	HR	BP	Resp Rate		
Inhalants (INTOXICATION)	-	↑	-	-	• Sustained 'high', encephalopathy • Seizures • Methemoglobinemia • Cardiac arrhythmia & sudden sniffing death syndrome (SSDS) • Tachydysrhythmias and QT prolongation • Dyspnea from aspiration and pneumonitis • Some inhalants may cause metabolic acidosis	**Investigations & Monitoring** • ECG to evaluate dysrhythmias or QT prolongation (15) • Chest x-ray if respiratory symptoms/signs • Venous blood gas to check acid/base status, urea, and electrolytes **Medications** • Treatment may require correction of hypokalemia and maintenance of potassium and magnesium in the upper range of normal if prolonged QT (15) • Inhalant use may increase susceptibility of the heart to catecholamines. Excess catecholamine exposure, such as epinephrine, may result in dysrhythmias (VT, VF) and cardiac arrest (55). Consultation with BC Drug and Poison Information Centre (1-800-567-8911) is recommended for prevention and management of cardiac dysrhythmias in the context of inhalant toxicity. • Refer to CHBC Chemical Restraint Algorithm for increased agitation • Limited evidence on physical or psychological dependence necessitating pharmacotherapy for withdrawal management **Supportive Care** • Provide environmental supports and minimize stimuli as appropriate and informed by the CHBC Least Restraint Hierarchy of Safety and the patient's level of stability and monitoring requirements • Offer to connect with Indigenous cultural supports if child/youth self-identifies as Indigenous
	Mental Status • Varying levels of CNS depression • Hallucinations • Impulsive behavior • Disinhibition **Other signs/symptoms** • Slurred speech • Headache • Dizziness • Ataxia • Palpitations					

Appendix E. Provincial Working Group and Sub-Working Group Members and Contributing Partners

Provincial Working Group Members

Partner	Name	Role
Fraser Health	Bill Bousquet	Indigenous Cultural Advisor
	Melissa Brown	Pediatric Inpatient Clinical Nurse Specialist
	Allison Fillion	Clinical Nurse Educator, Child, Youth & Young Adult, Mental Health & Substance Use Services
	Elspeth Humphreys	Manager of Operations, Youth Concurrent Disorders, Eating Disorders and Youth Substance Use
	Mike Kenyon	Clinical Director, Mental Health and Substance Use Services
	Dr. John Koehn	Addiction Medicine Acute Lead
	Shannon Laflamme	Manager, Indigenous Health - Mental Health & Substance Use
	Melissa Manchester	Clinical Nurse Educator, Pediatric Emergency Department, Surrey Memorial Hospital
	Dr. John Otasowie	Child and Youth Division Lead
	Edric Paw Cho Sing	Pediatric Pharmacist
	Alyssa Pelletier	Lead, Indigenous Health, Mental Health & Substance Use
	Paula Sandhu	Manager, Clinical Operations, Child, Youth & Young Adult, Mental Health & Substance Use
	Janelle Tarnow	Regional Clinical Nurse Educator, Emergency Network
	Dr. Sharon Vipler	Medical Director/Regional Department Head, Addiction Medicine and Substance Use Services
	Jordan White	Indigenous Youth Mental Health Coordinator, Indigenous Health, Mental Health Substance Use
First Nations Health Authority	Emma Garrod	Clinical Nurse Specialist – Substance Use and Harm Reduction
	Cynthia Russell	Clinical Nurse Specialist – Mental Health
Interior Health	Laura Beresford	Clinical Pharmacy Specialist, Pediatrics & Neonatology
	Ron Davies	Project Lead - Suicide Initiatives in the Emergency Departments, Transformational Lead Alcohol Use Disorder in the Emergency Departments, Emergency Services Network
	Lisa Hobenshield	Transformational Lead Emergency Services
	Amanda Lavigne	Clinical Nurse Specialist, Substance Use Team, Mental Health Substance Use Network
	Amy Luff	Regional Emergency Department Educator
	Audrey Ward	Practice Lead, Aboriginal Wellness Team
	Melissa White	Lead, Youth Substance Use Services, Mental Health Substance Use Network
Island Health	Dr. Sandy Barlow	Addictions and Family Medicine Physician, Addictions Medicine Consult Service Nanaimo Regional General Hospital, Nanaimo School Based Wellness Centre and Snaw-Naw-As First Nation Health Centre
	Ashlynn Berg	Registered Nurse, Emergency Department, Victoria General Hospital
	Kyle Collins	Child and Adolescent Pharmacist
	Grace Court	Registered Nurse, Emergency Department, Victoria General Hospital
	Sarah Heighington	Regional Pediatric Program Lead
	Shauna Kazeil	Manager, Child & Youth Mental Health and Substance Use
	Jennifer Mackenzie	Regional Mental Health & Substance Use Nurse Clinician - Youth Substance Use Services
	Christina Malo	Registered Nurse, Emergency Department, Victoria General Hospital

	Sandra Mcleod	Clinical Nurse Educator, Emergency Department, Victoria General Hospital
	Dr. Danika Milne	Family Physician, Victoria Youth Clinic
	Janine Stokoe	Registered Nurse, Pediatrics, Nanaimo Regional General Hospital
	Tara Wiersma	Clinical Nurse Lead, Emergency Department, Nanaimo Regional General Hospital
Northern Health	Megan Crawford	Regional Liaison, Child Youth Mental Health & Substance Use Regional Support Team
	Connie Cunningham	Northeast Lead, Indigenous Community Engagement & Education
	Michelle Lamoureux	Clinical Nurse Educator, Early Psychosis Intervention Program
	Nick Rempel	Strategic Lead, Regional Substance Use
	Martha Ridsdale	Substance Use Resource Nurse
	Dr. Patrick Rowe	Regional Medical Lead Emergency Services
Vancouver Coastal/ Providence	Janice Castillo	Clinical Nurse Educator, Emergency Department and Short Stay Pediatric Unit, Richmond General Hospital
	Dominic Chan	Manager, Mental Health & Addiction Services
	Mari Chua	Indigenous Nurse Educator
	Carole Gill	Patient Care Coordinator, Carlile Youth Concurrent Disorder Center
	Piotr Majkowski	Regional Mental Health & Substance Use Lead
Provincial Health Services Authority	Robyn Dignan	Indigenous Discharge Liaison, Indigenous Health, BC Children's Hospital
	Ruby Dodd	Clinical Resource Nurse, Emergency Department, BC Children's Hospital
	Dean Elbe	Clinical Pharmacy Specialist, Child and Adolescent Mental Health, BC Children's Hospital
	Shannon Fjeldstad	Provincial Lead – Health Systems Planning, Child Health BC
	Dr. Martha Ignaszewski	Clinical Lead, Substance Use Response and Facilitation Service, BC Children's Hospital
	Erica Koopmans	Regional Coordinator – Northern Health, Child Health BC
	Keara Manrique	Clinical Resource Nurse, BC Children's Hospital
	Catherine Marshall	Regional Coordinator – Vancouver Coastal/ Providence, Child Health BC
	Stephanie McMaster	Psychiatric Nurse Clinician, Emergency Department – CAPE – LINK, BC Children's Hospital
	Dr. Eva Moore	Clinical Associate Professor, Division of Adolescent Health and Medicine, Department of Pediatrics, University of British Columbia, BC Children's Hospital
	Dr. Jennifer Russel	Child and Adolescent Psychiatrist, Compass Mental Health
	Drew Ryan	Nurse Clinician, Compass Mental Health
	Kendra Sih	Clinical Pharmacy Specialist, Pediatric Emergency Medicine, BC Children's Hospital
	Jennifer Toomey	Nurse Clinician, Substance Use Response and Facilitation Service, BC Children's Hospital
	Dr. Dzung X. Vo	Head, Division of Adolescent Health and Medicine, Department of Pediatrics, BC Children's Hospital
BC Centre on Substance Use	Danya Fast	Research Scientist & Assistant Professor, Department of Medicine (Division of Social Medicine), University of British Columbia
Foundry	Rick Dubras	Leader, Implementation and Integration
	Julie Zimmerman	Provincial Director, Primary Care & Virtual Care
Ministry of Mental Health & Addictions	Siv Buchmuller	Senior Policy Analyst

Provincial Sub-working Group on Informed Consent, Confidentiality & Information Sharing

Partner	Name	Role
BC Centre on Substance Use	Danya Fast	Research Scientist
Interior Health	Melissa White	Lead, Youth Substance Use Services, Mental Health and Substance Use Network
Island Health	Sarah Heighington	Regional Pediatric Program Lead
Ministry of Mental Health and Addictions	Siv Buchmuller	Senior Policy Analyst
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	Dr. Eva Moore	Adolescent Medicine Pediatrician, BC Children's Hospital
	J.R. Quin Sheppard	Associate Legal Counsel
	Alice Virani	Executive Director, Ethics & Spiritual Care
	Dr. Dzung X. Vo	Head, Division of Adolescent Health and Medicine, Department of Pediatrics, BC Children's Hospital
	Ella Young	Risk Director, BC Children's & Women's Hospital, Risk Management

Provincial Sub-working Group on Indigenous Health & Wise Practices

Partner	Name	Role
Carrier Sekani Family Services	Tracey Day	Family Nurse Practitioner, Clinical Director, Substance Use and Addiction Services
First Nations Health Authority	Emma Garrod	Clinical Nurse Specialist, Substance Use and Harm Reduction
Foundry	Rick Dubras	Leader, Implementation and Integration
Fraser Health	Bill Bousquet	Indigenous Cultural Advisor
Metis Nations BC	Jillian Jones	Director, Mental Health & Harm Reduction
	Mike Mercier	Provincial Harm Reduction Manager
Northern Health	Connie Cunningham	Northeast Lead for Indigenous Community Engagement & Education
Provincial Health Services Authority	Robyn Dignan	Indigenous Discharge Liaison, Indigenous Health
Vancouver Coastal Health	Janice Castillo	Clinical Nurse Educator, Richmond General Hospital Emergency Department and Short Stay Pediatric Unit

Provincial Sub-working Group on Substance Specific Guidance

Partner	Name	Role
BC Centre on Substance Use	Dr. James Wang	Pediatrician & Addiction Medicine Fellow
Fraser Health	Dr. Melissa Allan	Emergency Physician, Burnaby Hospital
	Dr. David Deng	Emergency Physician & Addiction Medicine Fellow
Interior Health	Laura Beresford	Clinical Pharmacy Specialist, Pediatrics
	Dr. James Heilman	Emergency Physician, East Kootenay Regional Hospital
	Lisa Hobenshield	Transformational Lead Emergency Services
	Amanda Lavigne	Substance Use Clinical Nurse Specialist
	Dr. David Stoll	Family Physician, Penticton Regional Hospital & Martin Street Outreach Centre
Island Health	Ashlynn Berg	Registered Nurse, Emergency Department, Victoria General Hospital
	Kyle Collins	Child and Adolescent Pharmacist
	Christina Malo	Registered Nurse, Emergency Department, Victoria General Hospital

Northern Health	Martha Ridsdale	Substance Use Resource Nurse
Provincial Health Services Authority	Dr. Martha Ignaszewski	Psychiatrist, Clinical Lead of Substance Use Response and Facilitation Service, BC Children's Hospital
	Dr. Anas Manouzi	Emergency Physician, BC Children's Hospital
	Catherine Marshall	Child Health BC Regional Coordinator – Vancouver Coastal / Providence
Vancouver Coastal & Providence	Dr. Cheryl Gascoyne	Addiction Medicine, St Paul's Hospital and BC Women's and Children Hospital

Additional Contributing Partners to Guideline Development

Partner	Name	Role
Youth Partners	BC Centre on Substance Use Youth Health Advisory Council	
BC Centre on Substance Use	Dr. Paxton Bach	Co-Medical Director
	Christina Chant	Director, Education and Clinical Activities
	Ashley Goodman	Director, Indigenous Initiatives
	Trevor Goodyear	Registered Nurse & PhD Candidate, School of Nursing, University of British Columbia
	Josey Ross	Associate Director, Education and Clinical Activities
BC Drug and Poison Information Centre	Dr. Jesse Godwin	Physician Lead, BC Drug and Poison Information Centre
	Dr. Roy Purssell	Physician Lead, BC Drug and Poison Information Centre
Fraser Health	Melissa Lee	Regional Clinical Nurse Educator - Pediatrics, Emergency Network
Interior Health	Lesley Coates	Regional Harm Reduction Coordinator
Northern Health	Brianne Boyd	Youth Regional Liaison, Nechako Youth Treatment
Vancouver Coastal	Dr. Jessica Moe	Assistant Professor, UBC Department of Emergency Medicine, Emergency Physician Vancouver General Hospital & BC Children's Hospital