

“This isn’t gonna fix your child,” Experiences of parents using involuntary stabilization for a child’s substance use

by

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## **Abstract**

**Background:** Evidenced-informed strategies are urgently needed to support families who are struggling with a youth's substance use disorder. One strategy used in several Canadian provinces is involuntary stabilization programs, which involve the apprehension and confinement of youth whose substance use has resulted in serious harm to themselves or others, and who have declined voluntary treatment. In Alberta, the Protection of Children Abusing Drugs (PChAD) act allows for the confinement of minors for up to 15 days for detoxification, assessment, and discharge planning. Involuntary stabilization programs are controversial. Proponents argue that involuntary stabilization enables parents to rescue youth who are at risk of imminent serious harm and lack the mental capacity to make decisions. However, there is little evidence that compulsory treatment can improve outcomes for substance use in youth or adults. Further, there are serious concerns that involuntary stabilization may cause harm among opioid-dependent by increasing their risk of overdose. Indeed, it is well-documented among adults that rapid withdrawal from opioids poses a significant risk of experiencing an overdose due to loss of opioid tolerance. Finally, some parents who have used involuntary stabilization report that it “backfired” because it angered or distressed the youth and damaged the parent-child relationship.

Although secure programs for substance use have existed in Canada since 2006, little is known about the experiences of parents using these programs. This qualitative study was designed to explore parents' experiences with the PChAD program and their perceptions of how PChAD impacted their child. By illuminating parent experiences with PChAD, this study contributes knowledge about the possible benefits and drawbacks of involuntary stabilization and offers insights as to how these programs might better support families.

**Methodology:** Semi-structured individual interviews were conducted with 15 parents who used PChAD between 2008 and 2018. Interview transcripts were analyzed using Interpretive Phenomenological Analysis.

**Results:** During the application for a PChAD order, parents found the court hearings intimidating, overwhelming, and humiliating, and wanted more support to help them navigate this process. When their child was confined, parents were often frustrated that they were not more involved in their child's care and felt they did not receive enough guidance or planning for after discharge. Most parents thought the program had little lasting impact on their child's substance use. While some parents were relieved to simply have their child temporarily safe, others were disappointed because they had hoped PChAD would either improve their child's substance use or motivate them to seek further treatment. Parents thought that service providers should help parents develop realistic expectations about what involuntary stabilization can accomplish.

Some parents were frustrated that their child was discharged back into their care without any plan for continuous support or follow-up. They thought that even if their child was unwilling to attend voluntary treatment or reduce their substance use, they still needed guidance, education, and support to care for their child. Many parents thought longer involuntary programs were needed to address their child's addiction and mental health programs. Parents also identified several risks of using PChAD. They were concerned that police apprehension and confinement traumatized their child and damaged their relationship. Some parents found that their child subsequently worked harder to hide their drug use and avoid their parents because they were afraid of being re-apprehended. Other parents perceived that their child's substance use escalated following PChAD because they had met other peers who had a negative influence and offered

greater opportunities to access substances. Finally, several parents were concerned about the negative impact of detoxification on youth who are opioid dependant.

**Conclusions:** By describing parent experiences with the PChAD program, this study provides insight into how involuntary stabilization programs and other services can better serve families. Efforts are needed to increase parent involvement in involuntary stabilization, provide more comprehensive discharge planning, and offer ongoing support and guidance. Additionally, parents who are considering using involuntary stabilization need guidance to understand the possible benefits and drawbacks so that they can make informed decisions. Prior to using involuntary stabilization, parents should understand that involuntary stabilization may have little long-term impact on their child's substance use. Finally, policy makers should consider the risks associated with involuntary stabilization when implementing these programs and seek ways to mitigate possible harms. Future research is needed to demonstrate the outcomes of involuntary stabilization programs and explore youth experiences and perspectives.

## **Preface**

This this is an original work by Daniel O'Brien. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "Experiences of parents using secure care for a child's substance use," No. Pro00100552, April 19<sup>th</sup>, 2020. No part of this thesis has been previously published.

I conceived of this study, generated the data through participant interviews, analyzed the data, and wrote all sections of the thesis. Dr. Rebecca Hudson Breen was the supervisory author and contributed to the overall conception of the study as well as decisions regarding methodology selection and analytic approach. Dr. Rebecca Hudson Breen also contributed substantial feedback for the analysis and the writing of the thesis.

## **Dedication**

I would like to dedicate this thesis to my mother, Rachel O'Brien, who passed away as I was writing. My mom believed in using her career to contribute to society and help others, and she instilled these values in me.

## **Acknowledgements**

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Most importantly, I would like to sincerely thank all the parents who agreed to participate in this study and share their stories with me. I was honored to learn from your expertise and experiences.

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**Abbreviations**

AHS- Alberta Health Services

MSTH- Moms Stop The Harm

OAT- Opioid Agonist Treatment

OCYA- Office of the Child and Youth Advocate

OUD- Opioids Use Disorder

PEP- Parents Empowering Parents

PChAD- Protections of Children Abusing Drugs

## **Chapter 1: Introduction and background**

### **Thesis overview**

In this thesis, I explore the experiences and perspectives of parents who used the Protection of Children who Use Drugs (PChAD) program in Alberta. PChAD is an involuntary stabilization program in which parents can apply for a court order to have their child apprehended and confined in a protective safehouse for up to 10 days, with a possible 5-day extension. The purpose of PChAD is to provide detoxification, assessment, and discharge planning. As will be discussed, involuntary stabilization programs have been the subject of recent controversy in Canada. Proponents for involuntary stabilization argue that it enables parents to rescue youth who are at risk of serious harm and lack the mental capacity to make treatment decisions (Hamilton et al., 2020; Warshawski et al., 2019). However, critics of involuntary stabilization programs argue that they may unjustifiably override youth autonomy and can do more harm than good in the long-term (Chau et al., 2021; DeBeck et al., 2019; Goodyear et al., 2021; Pilarinos et al., 2018).

Presently, there is little peer-reviewed research examining whether forcing youth to undergo time-limited stabilization and detoxification can improve outcomes for substance use (Chau et al., 2021; Goodyear et al., 2021; Jain et al., 2018; Pilarinos et al., 2018). Further, the experiences of parents who have used these programs in the hopes of helping their children have not been described in detail. In this thesis, I aim to add to the scarce literature on involuntary stabilization by describing a range of possible experiences and perceived outcomes with PChAD. Additionally, I aim to develop insights regarding how involuntary stabilization programs as well as the health system more broadly can better support parents who are struggling to care for a youth who is using substances problematically.

This thesis will often take a public health orientation that focuses on issues of policy, health system design, and social justice. My tendency to take a public health perspective arises from my own background in public health research. However, this thesis research will also be relevant to the profession of counselling psychology in several respects. First, involuntary stabilization programs in Alberta involve mental health and addictions counsellors in several

capacities. Parents must meet with Alberta Health Services (AHS) counsellors before applying for a PChAD order to help them decide whether involuntary stabilization is appropriate for their needs. Mental health and addiction counsellors also work within involuntary stabilization programs to provide individual and family counselling. More broadly, any counselling psychologist that works with youth with mental health and substance use problem may need to provide guidance to parents on how to best care for their child. Thus, counsellors and psychologists working in this area need to be aware of the range of services available for youth and the potential benefits and drawbacks of using involuntary stabilization programs as compared to other approaches.

Additionally, I believe a public health approach to studying involuntary stabilization programs and youth substance use is consistent with the social justice orientation of the Counselling Psychology profession (Kennedy & Arthur, 2014; Sinacore et al., 2011). Specifically, Counselling Psychologists in Canada have stressed the importance of recognizing how oppression and social, cultural, political, and economic inequities adversely impact the mental health of individuals and communities (Sinacore et al., 2011). Accordingly, Canadian counselling psychologists are encouraged to advocate for their clients and work towards social change (Sinacore et al., 2011). This focus of counselling psychology on social-structural context is consistent with the public health orientation of addressing the social determinants of health inequalities (Marmot, 2005). Indeed, many of the ways in which counselling psychologists have been called upon to promote social change resemble public health practice, including advocacy, outreach, prevention, consultation, and political action (Sinacore et al., 2011).

On the specific issue of involuntary stabilization programs, counselling psychologists should be concerned about whether these programs are used in ways that are consistent with our social justice values. For instance, it would be problematic to routinely use intrusive interventions such as involuntary stabilization if access to voluntary services and supports is inadequate (Chau et al., 2021; B. A. Clark et al., 2019; DeBeck et al., 2019; Goodyear et al., 2021). From a social justice perspective, we should allocate resources to ensure all youth have access to a comprehensive continuum of voluntary services, rather than use highly coercive interventions with youth who face barriers to treatment (B. A. Clark et al., 2019). Moreover, social justice requires us to address social determinants of health linked to high-risk substance

use, such as poverty, unstable housing, and racism, and to provide equitable access of services to underserved communities (B. A. Clark et al., 2019)

In the first chapter of this thesis, I begin by providing background information on substance use harms among youth in Canada and the challenges of treating substance use disorders in young people. This is followed by a broad overview of the spectrum of interventions used to treat substance use disorders among youth, including a description of the involuntary stabilization program used in Alberta. Next, I provide a more in-depth review of the literature relevant to involuntary stabilization, which includes research on civil commitment, compulsory treatment, and legal social controls (i.e., drug courts). I also describe the limited research that has been conducted on involuntary stabilization through government evaluations and reports. Finally, I provide more details about the purpose of this study and how it will contribute to the literature on involuntary stabilization.

Chapter 2 will describe how I used the qualitative methodology of Interpretative Phenomenological Analysis to describe parent experiences with PChAD. I also discuss how I position myself within in this research and provide a brief description of each of the parent that I interviewed for the study. In chapter 3, I describe the research findings, using quotes from each participant to support my interpretation of the parents' experiences. In chapter 4, I further discuss and interpret the research findings, contextualizing them with the relevant literature. Finally, in chapter 5, I summarize the main findings and discuss implications for improving involuntary stabilization programs and other services for parents who are struggling to care for child who uses substances.

### **Substance use harms among Canadian youth**

Although substance use is not problematic for all adolescents, for some it can lead to various social and health consequences (PHAC, 2018; Turpel-Lafond, 2016). In general, the earlier youth begin using substances and the more frequent and heavier their use, the higher the risk for experiencing health and social harms (Fischer et al., 2017). For instance, heavy and long-term use may exacerbate pre-existing mental health issues such as depression and anxiety (Turpel-Lafond, 2016). Substance use can also impair social functioning through both episodic bingeing and long-term use (Turpel-Lafond, 2016). These impairments could include poor

decision making, disrupted academic performance, conflict with peers, family, or other adults, violence, and problems with law enforcement (Turpel-Lafond, 2016). For a minority of youth, persistent substance use may eventually lead to the development of a substance use disorder (Turpel-Lafond, 2016).

Different substances carry varying levels of risk. For instance, long-term alcohol use among youth can result in increased risk of chronic diseases (PHAC, 2018; Turpel-Lafond, 2016). Episodes of excess drinking can also increase the risk of various direct harms, including injury, alcohol toxicity, vehicle crashes, memory loss, and suicide or self-harm (PHAC, 2016; Turpel-Lafond, 2016). Early use of cannabis, mainly before the age of 16, can increase the risk of developing psychosis or cannabis use disorder (Fischer et al., 2017). Additionally, some studies have linked cannabis use in early adolescence to cognitive impairments in learning, attention, and memory, although more research is required in this area (Gabrys & Porath, 2019)

In recent years, accidental overdose related to opioids has become a serious concern for youth and young adults as a result of the national overdose crisis (PHAC, 2018). For instance, from 2016 to September 2020 there were 19,355 opioid related deaths, of which approximately 390 (2%) were under 19 years and approximately 3,900 (20%) were between 20-29 years (Government of Canada, 2021). In Alberta specifically, there were 376 opioid-related deaths among youth under 25 years old from 2016 to 2020 (Graff, 2021). In general, British Columbia and Alberta have been the most heavily impacted provinces by the overdose crisis since 2016, although overdose rates have recently increased in Ontario and other regions (Government of Canada, 2021). In 2020, 85% of opioid overdose deaths occurred in BC, Alberta, and Ontario (Government of Canada, 2021).

The main driver of these deaths are fentanyl and fentanyl analogues that are illegally manufactured (Government of Canada, 2021). These substances have become highly prevalent in the illegal market and are increasingly being combined with other controlled substances, which increases the toxicity and unpredictability of the illegal opioid supply (Belzak & Halverson, 2018; Fairbairn et al., 2017). People who use drugs who are exposed to erratic variations in drug potency are at greater risk for opioid overdose (Fairbairn et al., 2017). In 2020, fentanyl and fentanyl analogues were linked to 86% of opioid toxicity deaths between in 2020 (January to September) (Government of Canada, 2021). Fentanyl and its analogues have also been detected

in stimulants such as cocaine and methamphetamine, which means that people who use stimulants may unknowingly be at risk for opioid overdose (Belzak & Halverson, 2018).

The burden of substance-use related harms in Canada are especially high among populations of street involved youth who use drugs (Kirst & Erickson, 2013; PHAC, 2006). “Street-involved” youth refers to young people who live or work on the street (Kirst & Erickson, 2013; PHAC, 2006). Street-involved youth live within social-structural contexts characterized by poverty, unstable housing, and social exclusion (Kirst & Erickson, 2013; PHAC, 2006). Many street involved youth have left home to escape from family conflict, violence, and abuse, or to gain greater independence (Rosenthal et al., 2006; Winland, 2013). Other youth may have been forced out because of a history of family conflict or problems with school and the law (Kurtz et al., 2000). Whatever the reasons, these youth often become increasingly detached from their families and schools, and marginalized from mainstream society in general (Haley & Roy, 1999).

Street involved youth may use various survival and illegal income generation strategies in the absence of employment opportunities or other formal sources of income (Ferguson et al., 2012; PHAC, 2006; Thompson et al., 2015). These may include staying with friends, panhandling, survival sex work (i.e. participating in sexual acts in exchange for money, food, shelter, or drugs), and criminal activities such as selling stolen goods or dealing drugs (Ferguson et al., 2012; Haley & Roy, 1999; PHAC, 2006). Youth who engage in these survival strategies are at high risk of physical assault and sexual victimization (Tyler & Beal, 2010), as well as interactions with police, arrest, and incarceration (Omura et al., 2014).

Street involved youth are more likely than youth in stable housing to have substance use problems, with longer periods of unstable housing increasing the risk of substance use disorder (Kirst & Erickson, 2013; PHAC, 2006). Youth may use substances for a variety of reasons, including for recreation and pleasure, or to cope with the unpredictability and stress associated with surviving on the street (Kirst & Erickson, 2013). Other youth may use substances to cope with trauma and mental illness (Thompson et al., 2015). Indeed, childhood trauma, or adverse child experiences, are common experience among street-involved youth and a major risk factor for developing a substance use disorder in adolescence (Jongbloed et al., 2017; Maté, 2012). For instance, in one nationally representative Canadian survey from 2012, individuals who reported either physical abuse, sexual abuse, or exposure to intimate partner violence were about 2.5 times more likely to report developing an alcohol use disorder and 3 times more likely to develop another

substance use disorder (Afifi et al., 2014). Similarly, co-occurring mental health issues are common among this population, with some studies showing that 30-60% of street youth have met criteria for a substance use disorder and mental health problem (Kirst & Erickson, 2013; Whitbeck et al., 2004). In one study of youth who experienced a substance use-related injury or death, common co-occurring mental health disorders include depression (43%), anxiety disorder (35%), ADHD (29%), PTSD (14%), psychosis (8%), and personality disorders (8%) (Representative for Children and Youth, 2018).

A high proportion of street-involved youth in Canada will eventually transition to injection drug use, with estimates ranging from 20-40% in major urban centers (Bayoumi & Strike, 2012; Debeck et al., 2013; PHAC, 2006; Roy et al., 2000). Consequently, overdose is a leading cause of death among street-involved youth, and infections from HIV and Hepatitis C are common (B. D. L. Marshall et al., 2009, 2010; Roy et al., 2000, 2001, 2004). As a consequence of both overdose and suicide, street-involved youth are burdened with excess mortality (Roy et al., 2004). In one cohort study in Montreal, street-involved youth had a mortality rate 11 times the general population (Roy et al., 2004).

In the context of intergenerational traumas and adverse social determinants of health, Indigenous youth in Canada use substances at higher rates and experience a high burden of related mortality and morbidity compared to non-Indigenous populations (Firestone et al., 2015). Indeed, Indigenous leaders in Canada have spoken out in concern that their young people are dying prematurely, especially among those who are unstably housed or street-involved (Christian & Spittal, 2008). For instance, the Vancouver Injection Drug Use Cohort recruits individuals who use injection drugs in Vancouver's Downtown Eastside neighborhood (C. L. Miller et al., 2006). Among cohort participants under the age of 24, Indigenous youth made up approximately 30% of the cohort and were more likely to be positive for HIV or Hepatitis C compared to non-Indigenous young people (C. L. Miller et al., 2006). Another BC cohort called "the cedar project" investigated overdose mortality among young Indigenous people who use injection and non-injection drugs in Vancouver and Prince George, BC (Jongbloed et al., 2017). This study found that young Indigenous youth were dying of overdose at a rate that was 13 times greater than the rest of the Canadian Population and 8 times greater than the Indigenous population in Canada (Jongbloed et al., 2017).

## Challenges in treating youth Substance Use Disorder

Youth with a substance use disorder have several unique needs and can be challenging to engage in treatment (BCCSU, 2018; Passetti et al., 2016). Compared to adults, youth with substance use disorders are less likely to seek treatment on their own (Winters et al., 2014). Additionally, adolescents who receive treatment often have poor rates of retention and abstinence, with relapse rates as high as 60% during the year after treatment (Chung & Maisto, 2006; Passetti et al., 2016; Williams et al., 2000). Indeed, many youth cycle between periods of substance use and abstinence (Passetti et al., 2016).

Adolescents' lower likelihood of seeking and engaging with treatment may be related to a variety of factors, including mental health co-morbidities, less perceived risks, normalized drug use among peers, and a lack of maturity that contributes to poor problem recognition (Winters et al., 2014; Wu et al., 2011). Youth may also have low motivation to engage in treatment because they have a shorter history of substance use and are therefore less likely to have experienced negative psychosocial and health consequences of their substance use (Battjes et al., 2003; Breda & Heflinger, 2004). Moreover, they often enter treatment due to external pressures such as parental or legal coercion rather than internal motivation (Battjes et al., 2003). There are a variety of different trajectories among youth with substance use disorders. While many will eventually recover naturally or through treatment, others will struggle with long-term substance use disorder and chronic relapse (Passetti et al., 2016).

The vulnerability of youth to persistent substance use is often attributed to developmental and neurobiological differences between adolescents and adults. Adolescence is marked by significant developmental change, in which a sense of identity is established, acceptance by peers is greatly valued, and independence from parents is sought (Sanders, 2013). Additionally, brain regions governing reward incentives and sensation-seeking are relatively more developed in adolescence than regions regulating impulse control, decision-making, and planning (Rutherford et al., 2010). In particular, the prefrontal cortex, which is involved in self-regulation and impulse control, typically does not fully develop until the mid to late twenties (Rutherford et al., 2010). This developmental pattern may contribute to an initial curiosity to use substances as

well as a higher risk of continuing use despite negative consequences (Rutherford et al., 2010; Winters et al., 2014).

While lack of maturity and problem recognition represent individual-level barriers to engaging youth in treatment, youth who use substances may also face numerous social and structural barriers (DeBeck et al., 2016; Hadland et al., 2009; Milloy et al., 2010). These barriers especially impact street involved youth who use substances (Barker et al., 2015). In one study of street-involved youth in Vancouver, 26% of youth reported being unable to access treatment, with homeless youth more likely to report difficulties (Phillips et al., 2014). Structural barriers associated with unstable housing include having no transportation, no consistent residence for reliable contact, and no phone (Phillips et al., 2014). These issues can be especially problematic when individuals are waitlisted for treatment (Phillips et al., 2014). Additionally, youth who use drugs often avoid abstinence-based detox and drug treatment programs that have restrictive policies, such as expulsion for drug use, missing curfews, meeting attendance, and noise complaints (J. Boyd et al., 2017; Turpel-Lafond, 2016). Finally, youth may also have difficulty accessing services due to age restrictions, lack of knowledge, and an overall scarcity of services (Turpel-Lafond, 2016)

Social barriers faced by street-involved youth include having difficulty establishing and maintaining trust with authority figures and institutions (Hudson et al., 2010; Krüsi et al., 2010; Slesnick et al., 2008). This distrust may be related to prior institutional trauma among street-involved youth, given the high rates of previous government care and incarceration in this population (Barker et al., 2014; Omura et al., 2014). Street-involved youth may have also been previously victimized or exploited by their caregivers, which can contribute to mistrust of adults in general (Feldmann & Middleman, 2003). Other social barriers include real or perceived discrimination from service providers, fear of police or other government agency involvement, and the stigma attached to substance use (Barker et al., 2015; Garrett et al., 2008; Hudson et al., 2010; Krüsi et al., 2010; Reid & Klee, 1999; Turpel-Lafond, 2016; Wu et al., 2011). To address these barriers, evidence-based guidelines recommend several strategies and principles to engage and retain youth in treatment for substance use (BCCSU, 2018; Winters et al., 2014).

### **Treatment of youth substance use**

*Full spectrum of services should be available*

Similar to adults, it is important to offer youth a full range of evidence-based treatments (BCCSU, 2018). Both pharmacological and psychosocial interventions should be offered to youth, although provision of medications should not be dependent on participation in psychosocial treatment (BCCSU, 2018). Pharmacological interventions are particularly important for youth with Opioid Use Disorder, because Opioid Agonist Treatments (OAT) such as methadone and buprenorphine are recommended as the preferred first-line treatment for both youth and adults where possible (BCCSU, 2018; CRISM, 2017). In studies that have specifically examined youth with Opioid Use Disorder (OUD), timely treatment with OAT is associated with greater retention in care compared to behavioral treatments alone (Hadland et al., 2018).

One barrier faced by youth who use opioids is that there is often very poor access to medications for OUD (Alinsky et al., 2020). Youth are significantly less likely to receive medications for OUD compared to adults, likely because of poor availability of pediatric prescribers, clinician discomfort with prescribing these medications to youth, and the stigma attached to these medications (Bagley et al., 2017; Hadland et al., 2017; Rosenblatt et al., 2015). Often, youth will only receive medications for OUD as a last resort after non-pharmacological interventions such as psychotherapy have been tried (Bagley et al., 2017; Feder et al., 2017).

This is problematic, because there is a strong body of evidence showing that OAT is the most effective interventions for OUD (CRISM, 2017). These medications act on the mu opioid receptor to prevent withdrawal symptoms, reduce cravings, and block the euphoric effect of other opioid substances (CRISM, 2017). OAT is effective at retaining individuals with OUD in treatment, reducing illegal opioid use, reducing mortality, and reducing HIV and hepatitis C infections among injection drug users (CRISM, 2017). OAT is superior at treating OUD compared to either withdrawal management or psychological treatment alone in terms of treatment retention and reduction in non-medical opioid use, as evidenced by a 2016 meta-analysis of six randomized control trials (CRISM, 2017). More recently, a large US cohort study with over 40,000 individuals aged 16 or older with OUD showed that treatment with buprenorphine or methadone was associated with a 76% reduction in overdose at 3 months and 59% reduction at one year compared to no treatment (Wakeman et al., 2020). In contrast, inpatient detoxification or residential service, intensive behavioral therapy (outpatient or partial

hospitalization), and non-intensive behavior therapy (outpatient counselling) were not associated with reduced overdose at follow-up (Wakeman et al., 2020).

While pharmacological treatments are the preferred first line treatment for OUD, a range of psychosocial interventions have also shown to be effective in treating youth substance use disorders in general (Tanner-Smith et al., 2013). These include Cognitive Behavioral Therapy, motivational enhancement, family therapy, psychoeducation, and group counselling (Tanner-Smith et al., 2013). A comparative meta-analysis of these modalities in outpatient settings showed that all treatment approaches resulted in significant reductions in substance use compared to no treatment (Tanner-Smith et al., 2013). However, programs that used Family-based approaches were more beneficial in treating adolescent substance use relative to individual modalities (Tanner-Smith et al., 2013). These approaches seek to address family risk factors for substance use problems including poor problem solving skills, lack of family cohesion, and poor communication (BCCSU, 2018). Treatments that used motivational enhancement techniques also tended to yield beneficial effects compared to other approaches (Tanner-Smith et al., 2013).

#### *Treatment approaches should be tailored to individual patients*

It is important to recognize that a “one size fits all” approach will not meet the diversity of patients, and that treatment should be matched to each patient’s needs and circumstances. Youth should have access to a varying intensity of treatment approaches, including outpatient, inpatient, residential programs, and mental health and psychiatric care (BCCSU, 2018). At the least intensive end of the continuum, early identification and brief intervention services can target youth who are consuming substances at levels that place them at risk for developing a substance use disorder, but who may not perceive their drug use as a problem (Winters et al., 2014). These interventions aim to help youth recognize and address the negative consequences of their substance use, often using a combination of Cognitive Behavioral Therapy and motivational enhancement therapy (Winters et al., 2014). In a systematic review of brief interventions for problematic alcohol use, these interventions were associated with significant reductions in alcohol use compared to controls up to one year after receipt, despite involving less than 5 hours of contact (Tanner-Smith & Lipsey, 2015).

More intensive services program should be available for youth with more severe problems with substance use or mental health issues (Winters et al., 2014). Outpatient therapy may include community-based individual, group, or family-based modalities (Winters et al., 2014). The intensity of outpatient care may range from a few hours each week, to day programs that consist of 4-6 hours of programming per day for 5 days a week (Winters et al., 2014). Even more intensive interventions include residential or inpatient treatment (Winters et al., 2014). Residential programs may last up to a year and are generally meant for adolescents who have severe substance use disorder as well as complex mental health problems or family conflict (Winters et al., 2014). Finally, the most intensive services include medically managed withdrawal or inpatient detoxification services (Winters et al., 2014). These services are necessary for youth who need full-time medical supervision, typically for a limited amount of time (Winters et al., 2014).

Best practice guidelines recommend that substance use disorder care should be continuous, with treatment intensity continually matched to patient needs (BCCSU, 2018). This may involve movement between treatment options and along a continuum of care through a “stepped approach” (BCCSU, 2018). For example, residential treatment programs should be followed up with ongoing outpatient services (BCCSU, 2018). Another consideration for tailoring services to individuals is ensuring that co-occurring mental health problem are simultaneously addressed (BCCSU, 2018). It is recommended that all youth with a substance use disorder be assessed for co-occurring disorders, and that integrated substance use and mental health treatment be offered if necessary (BCCSU, 2018).

#### *Youth specific considerations*

Previous studies have shown that adolescents are less likely to access services that are oriented towards adults (BCCSU, 2018). Thus, services targeting youth should strive to be relevant, interesting, and accessible to better engage youth (BCCSU, 2018). Strategies to make services acceptable to youth include inclusion of family members and providing opportunities to build close relationships with staff (BCCSU, 2018). Additionally, including peer support staff can also increase youth engagement, such as by helping youth who may feel ambivalent about trusting adult service providers feel for comfortable (BCCSU, 2018). Peer support staff with

lived experience with substance may provide hope by offering an example of the benefits of substance use treatment (BCCSU, 2018). As with all medical care, youth confidentiality should be maintained unless the youth provides consent to share their medical information with their parents (BCCSU, 2018). Communicating that treatment is confidential is especially important during the first encounter with a young person in order to build trust, while also informing them of the legal limits of confidentiality (BCCSU, 2018).

### *Trauma-informed care*

Principles of trauma informed care should be used, such as emphasizing safety and trustworthiness, choice, collaboration, strengths-based approaches, and relationship building (BCCSU, 2018). In line with these principles, care should respect the patient's autonomy and individuality to the extent that this is possible (BCCSU, 2018). Whenever possible, providers are encouraged to work collaboratively with patients and their families to develop a personalized plan for recovery, with an understanding that recovery looks different for each person (BCCSU, 2018). Relapses are frequent among youth and should be understood as part of the path to recovery, rather than behavioral problems warranting punishment (BCCSU, 2018).

From a trauma-informed perspective, youth with a history of traumatic experiences are unlikely to be frightened or deterred from problematic behaviors by threats of punishment, which are common in traditional systems of care (Smyth, 2017b). For example, group or foster homes may use a "three-strikes" approach to behavior in which they are threatened with discharge from the placement if they have multiple behavioral incidents (Smyth, 2017b). Similarly, traditional abstinence-based, twelve-step style treatment programs may have rigid rules that result in discharge if client does not remain abstain from drugs or experiences a relapse (J. Boyd et al., 2017). Rather than from learning from punishment, youth who have experienced trauma often interpret it as further rejection, which serves to alienate them and can undermine therapeutic relationships (Smyth, 2017b). Punishment can also trigger feelings of failure and shame, and for some youth may lead to aggressive emotional responses and behavioral escalations (Smyth, 2017b). Services that shift away from controlling and punitive approaches to more relational-based practice may avoid power struggles and build a sense of equality, safety, and respect

(Smyth, 2017b). This can result in youth staying longer in placements, buying into programs, and making better connections with staff (Smyth, 2017b).

### *Family Involvement*

Involving the family members, with the consent of the youth, can be critical in obtaining successful outcomes (BCCSU, 2018). This may include family counselling with the youth, and actively involving family in all phases of treatment (Turpel-Lafond, 2016). Family should be involved in planning for youth services because it may be important to address family dynamics and needs of the family members (Turpel-Lafond, 2016). Parents and family can also provide logistical support to ensure the youth attends appointments and takes medications as prescribed (BCCSU, 2018).

Parents should be supported with sufficient education and training (BCCSU, 2018). This can occur even when youth are not ready for services (Turpel-Lafond, 2016). Supports for family may include counselling, parent support and education groups, and referrals to other agencies and services (Turpel-Lafond, 2016).

### *Harm reduction*

In general, harm reduction refers to policies, programs, and practices that aim to reduce the health and social consequences of substance use without necessarily requiring abstinence (BCCSU, 2018; Representative for Children and Youth, 2018). Harm reduction interventions include supervised consumption services, needle distribution programs, and take-home naloxone programs (BCCSU, 2018). With youth, harm reduction may also include education about safer drug use practices (Representative for Children and Youth, 2018). Including these interventions in the continuum of care is critical for promoting the health and safety of youth who are not willing or able to achieve abstinence, especially in the current context of heightened overdose risk (BCCSU, 2018). There is a well-established literature showing that harm reduction interventions are effective at reducing overdose deaths and HIV and Hepatitis C transmission (CRISM, 2017).

Importantly, harm reduction initiatives are low-threshold, meaning there are few barriers or requirements for accessing these services (Turpel-Lafond, 2016). Therefore, these services are often used by street involved youth and can facilitate access to other health and social services (Turpel-Lafond, 2016). Harm reduction approaches may resonate particularly well with street involved youth who are distrusting of adult service providers (Turpel-Lafond, 2016). By using a non-judgemental and non-coercive approach to providing services, harm reduction services allow opportunities to develop positive relationships and trust with youth, which can eventually result in an openness to change (Representative for Children and Youth, 2018).

For instance, in one qualitative study with street involved youth who inject drugs in Vancouver, youth perceived services such as drop-in centers, shelters, and detox facilities, as more acceptable if they did not have restrictive rules regarding abstinence (J. Boyd et al., 2017). Instead of rigidly enforcing abstinence, these harm reduction-oriented services encouraged youth to inject more safely through education and providing sterile equipment (J. Boyd et al., 2017). They were also supportive of youth decisions to take a short break from injecting, and offered connection to more intensive residential services if youth decided to reduce their substance use more permanently (J. Boyd et al., 2017). These services were viewed as more relaxed and respectful, which was more conducive to establishing meaningful relationships with staff (J. Boyd et al., 2017). This is important, because social support can help some youth transition away from injection drug use (J. Boyd et al., 2017). These services were also perceived to be valuable resources for accessing basic needs, such as housing, work, clothing, showers, and food (J. Boyd et al., 2017). These results are consistent with previous quantitative evaluations of supervised consumption services, which have been shown to increase uptake into detoxification and methadone services among people who inject drugs (Wood et al., 2007).

The representative for children and youth in British Columbia conducted a comprehensive consultation with youth who use drugs in an effort to develop a continuum of services that youth find acceptable and beneficial (Representative for Children and Youth, 2018). For youth who choose to use substance, having safe places to go where someone could monitor and help them if needed was viewed as important (Representative for Children and Youth, 2018). Some youth were unable to access existing supervised consumption services because of age restrictions, or they felt uncomfortable because these services are mostly used by adults (Representative for Children and Youth, 2018). Others had difficulties accessing harm

reduction supplies, such as clean syringes, pipes, and take-home naloxone kits (Representative for Children and Youth, 2018). In light of these findings, the representative recommended the development and implementation of a full spectrum of youth-specific harm reduction services embedded within a system of wraparound services and supports (Representative for Children and Youth, 2018).

### *Housing*

Another important way to reduce substance use related harms among street involved youth who use substances is safe, low threshold housing (Turpel-Lafond, 2016). Supported residential services can provide a stable environment for youth who are awaiting services or accessing community-based services (Turpel-Lafond, 2016). Access to safe housing is not only an issue of human rights, it is also a critical means of reducing the harms associated with substance use (J. Boyd et al., 2017; Cheng et al., 2014; Pauly et al., 2013; Zerger, 2012). Among both youth and adults, the risks associated with injection drug use are exacerbated by homelessness (J. Boyd et al., 2016; Coady et al., 2007; Rachlis et al., 2009). For instance, street involved youth may use drugs as a survival strategy to suppress hunger or to stay alert and protect themselves (Bungay et al., 2006). Additionally, being homeless can impede efforts to reduce drug use, use more safely, and access and stay in treatment (J. Boyd et al., 2017; Cheng et al., 2014; Pauly et al., 2013; Zerger, 2012).

Housing first programs are harm reduction strategies that prioritize placing people in low-barrier housing options that are not contingent on abstinence or willingness to participate in treatment (Pauly et al., 2013). This strategy stands in contrast to traditional programs which require clients to be motivated to participate in treatment, stay sober, or acquire basic living skills before being housed (Pauly et al., 2013). There is a large body of literature showing that housing first strategies improve housing stability among adults, while decreasing unnecessary hospitalizations and services costs and improving quality of life (Baxter et al., 2019; Pauly et al., 2013). For some, housing first may also lead to improved mental health outcomes and stabilizing of substance use disorders, although additional supports may also be necessary (Gaetz, 2014; Kirst et al., 2015). Among youth, housing first strategies have also been shown to improve

housing stability, although there are few studies that have examined substance use and mental health outcomes (Wang et al., 2019).

Frameworks for housing approaches with youth involve various models for different client needs and circumstances (Gaetz, 2014). For instance, some models may offer supports that aim at returning youth home to their parents (Gaetz, 2014). Other models may provide permanent supportive housing with integrated services for individuals with complex and co-occurring issues (Gaetz, 2014). In general, a housing first approach for youth involves choice and self-determination, in which youth have choices in terms of what services they receive and when they start participating (Gaetz, 2014). For youth who use substances, there should be no requirement of abstinence and harm reduction services should be available on demand (Gaetz, 2014; Pauly et al., 2013). For the long-term sustainability of this model, young people should be encouraged to participate in education and employment training when appropriate (Gaetz, 2014).

### *Involuntary stabilization programs*

Another intervention used in Canada for youth with substance use problems is involuntary stabilization programs, which are also sometimes called “secure care” programs. While these programs vary in each province, they generally involve the short-term apprehension and confinement of youth whose substance use is deemed to pose an immediate and serious risk of physical or psychological harm (Charles, 2016). Currently, short-term, involuntary stabilization legislation designed specifically for substance use-related arms exists in Alberta, Saskatchewan, and Manitoba (Charles, 2016). Other provinces, including Ontario, Quebec, New Brunswick, and Nova Scotia, have secure care programs that apply to “mental disorders” or behavioral and emotional disorders” more broadly (Charles, 2016).

Involuntary stabilization programs are meant to be used as a last-resort mechanism to address crisis situations, and typically provide interventions related to stabilization, assessment, and detoxification (Charles, 2016). This involuntary “time out” from the immediate crisis is meant to provide a window of time during which youth can connect with their caregivers and professionals, and have their health needs attended to (Charles, 2016). Involuntary stabilization also provides parents and professionals with period of recovery in which they can rest assured

knowing that the youth under their care is temporarily safe (Charles, 2016). Typically, involuntary stabilization is used as tool to engage youth in health and social services when they have previously resisted services (Pilarinos et al., 2018). It is hoped that a youth will recover from the immediate crisis, regain decision-making capacities, and subsequently connect with voluntary resources (Charles, 2016; Smyth, 2017a).

### *Protection of Children Abusing Drugs (PChAD)*

In Alberta, the Protection of Children Abusing Drugs (PChAD) act allows for the apprehension and involuntary care of youth under 18 years of age whose substance use has resulted in “significant physical, psychological, or social harm to themselves, or physical harm to others, and who are refusing voluntary addiction treatment services” (Alberta Health Services, 2009). The PChAD act allows parents to apply for a court order to confine their children for up to 10 days in a protective safe house, where they will receive services related to detoxification, assessment, and discharge planning (Alberta Health Services, 2009). Parents may also apply for a five-day extension of the program if needed (Alberta Health Services, 2009). Parents may choose to either transport their children to the protect safe house themselves, or have police apprehend youth and transport them (Alberta Health Services, 2009).

There are multiple steps required to obtain a PChAD order. First, parents must first attend a PChAD pre-application information session with an Alberta Health Services (AHS) addiction and mental health counsellor (Alberta Health Services, 2021). This AHS counsellor meets with parents or guardians to educate them about the program and help parents decide whether to use it (Alberta Health Services, 2021). If parents decide to go forward with PChAD, the AHS counsellor will provide a confirmation of attendance letter, which is needed apply for a PChAD protection order with the provincial courts (Alberta Health Services, 2021). After the application is filed, parents receive a court date for some time in the next few days. In court, parents must present evidence to a judge that PChAD is necessary (Alberta Health Services, 2021). This could include testimony regarding how their child’s substance use is impacting various life areas, including education, employment, physical health, relationships, or physical health. Pictures and physical evidence can also be presented (Alberta Health Services, 2021). If the PChAD order is granted, parents must call PChAD to book a bed in a protective safe house, for which there may

be a waitlist (Alberta Health Services, 2021). Finally, Parents must contact the police to apprehend and transport the child to the protective safehouse. Parents can also transport their child themselves if they are able (Alberta Health Services, 2021). There are protective safehouses in Edmonton, Calgary, Red Deer, and Grande Prairie, and Picture Butte (Alberta Health Services, 2021).

Once in the protective safehouse, children are closely monitored by safe house staff through in-person checks and video surveillance (Alberta Health Services, 2021). The youth is assessed throughout the PChAD stay by an AHS mental health and addiction counsellor (Alberta Health Services, 2021). This ongoing assessment involves individual counselling, the use of standardized assessment tools, group counselling, and direct observation (Alberta Health Services, 2021). The child's AHS counsellor also meets with the child's parents, either in person or over the phone (Alberta Health Services, 2021). In this session, the counsellor may provide information that is contained in the assessment report (Alberta Health Services, 2021). However, the PChAD program maintains the child's right confidentiality, in accordance with Alberta's Health Information Act (Alberta Health Services, 2021). Therefore, assessment information is only provided to the parents with the child's consent (Alberta Health Services, 2021).

Several other services are provided in the protective safehouse. Youth may attend psychoeducational groups, and participate in discharge and treatment planning (Alberta Health Services, 2021). If parents choose, they may also participate in family counselling (Alberta Health Services, 2021). Finally, youth have access to indoor and outdoor recreational activities such as a gym, exercise equipment, and a sensory room, although the availability of these activities varies between locations (Alberta Health Services, 2021). Notably, the protective safehouse does not currently provide access to addiction medicine consultations or psychiatric services (Alberta Health Services, 2021).

When a youth is confined in the protective safehouse, they have the right to appeal the order at anytime (Alberta Health Services, 2021). If they request a review, a hearing must take place within the next two days, at which time the youth is given the opportunity to tell the judge why they feel the PChAD order is not appropriate (Alberta Health Services, 2021). The child may appear in court via a videoconferencing system or in person, and they may have their lawyer present (Alberta Health Services, 2021). Parents are also asked to attend this hearing, and may be asked to again present evidence as to why the protection order is necessary. Once the order has

been reviewed by a judge, it may be confirmed or terminated, or there may be a change in the length of the order (Alberta Health Services, 2021). If parents choose to extend the order for five days, they must once again attend a court hearing to present evidence as to why this is necessary (Alberta Health Services, 2021).

### *Proposed involuntary stabilization model in British Columbia*

Involuntary stabilization programs have been the subject of recent controversy in British Columbia because of proposed legislation that would allow hospitals to involuntarily detain youth for stabilization following an overdose for up to a week (DeBeck et al., 2019; Goodyear et al., 2021; Hamilton et al., 2020; Pilarinos et al., 2018; Warshawski et al., 2019). Currently, British Columbia does not have involuntary stabilization programs, but it does involuntarily admit many youth with mental health and substance use disorders through the current Mental Health Act (Charlesworth, 2021). Proponents of involuntary stabilization argue that it enables parents to rescue youth who are at risk of imminent serious harm and lack the mental capacity to make decisions (Hamilton et al., 2020; Warshawski et al., 2019). However, critics of involuntary stabilization programs argue that they may do more harm than good in the long-term (DeBeck et al., 2019; Goodyear et al., 2021; Pilarinos et al., 2018).

Currently, there is little peer-reviewed research that has examined whether forcing youth to undergo time-limited stabilization and detoxification can improve outcomes for substance use (Goodyear et al., 2021; Jain et al., 2018; Pilarinos et al., 2018). Thus, many of the concerns raised about involuntary stabilization are based on literature related to similar interventions such as compulsory and coerced treatment for substance use (Pilarinos et al., 2018). However, while involuntary stabilization programs have not received much attention in peer-reviewed academic literature, Alberta Health Services (AHS) conducted an evaluation of PChAD services in 2007-2008 which showed some positive program outcomes and areas for improvement (Alberta Health Services, 2009). Similarly, an investigative report was conducted by the Office of the Child and Youth Advocate in Alberta in 2018 into the opioid-related deaths of 12 youths, several of whom had used the PChAD program (Graff, 2018). The report identified several challenges for parents and youth who used PChAD and recommended that the program be reviewed (Graff, 2018). In the following sections, I will provide an overview of each of these

relevant sources of information, with a focus on the evidence for the use of coercion as well as the possible harms of these approaches.

## **Review of evidence relevant to involuntary stabilization**

### *Civil commitment legislation and Compulsory treatment*

In some jurisdictions, civil commitment legislation can be used to involuntarily hospitalize adults who use substances (Jain et al., 2018; Reitan, 2013). While legislation varies greatly, some jurisdictions use short-term civil commitment as a tool to facilitate uptake into longer term voluntary treatment in a way that is similar to involuntary stabilization programs in Canada (Jain et al., 2018; Reitan, 2013). However, there is currently little evidence that short-term civil commitment can lead to sustained recognition of treatment needs, engagement in care, or improved decision making (Jain et al., 2018).

For instance, one study in Switzerland examined the trajectory of patients who use substance who were involuntarily admitted into a psychiatric hospital due to intoxication or other behavioral disturbances (Habermeyer et al., 2018). The study found that once involuntarily admitted patients regained their decision-making capacity and had their involuntarily status changed to voluntary, the median length of voluntary stay was less than a day (Habermeyer et al., 2018). Indeed, the rate of patients who terminated treatment against recommendations was twice as high as those admitted voluntarily (Habermeyer et al., 2018). The authors concluded that involuntary hospitalization rarely contributes to sustained treatment of Substance Use Disorders (Habermeyer et al., 2018).

In the Swedish compulsory care system, individuals who are initially admitted involuntarily into secure facilities meet with workers who aim to motivate them to enter voluntary treatment in the community (Padyab et al., 2015; Reitan, 2016). As individuals move into the addiction treatment system in the community, drop-out from treatment is common (Padyab et al., 2015). In one study, approximately 60% of individuals dropped out of treatment, with risk of drop-out especially high among younger individuals (Padyab et al., 2015). Further, drop-out was associated with higher risk of future compulsory care and overdose mortality

(Padyab et al., 2015). Thus, while short-term civil commitment may have helped some individuals, most resumed substance soon after moving into community treatment (Padyab et al., 2015). Similarly, another study of the Swedish compulsory care system examined 106 patients who were assessed for civil commitment, and compared those who were assessed in areas of the country with high levels and low rates of involuntary commitment (Lindahl et al., 2010). The study found that at two years follow-up, there was no difference in substance use outcomes between individuals living in areas that had high rates of civil commitment and those with lower rates (Lindahl et al., 2010). Thus, the routine use involuntary commitment was not significantly associated with improved long-term substance use outcomes (Lindahl et al., 2010).

In the United states, civil commitment procedures vary greatly in each state (Christopher et al., 2015; Jain et al., 2018). In Minnesota, psychiatrists can petition the courts to allow for the involuntary hospitalization of individuals who are “chemically dependent” (Lamoureux et al., 2017). In one small study, involuntary commitment was pursued for 28 patients, of whom only seven were involuntarily admitted for an average of two weeks, with 6 of those who were committed relapsing almost immediately after discharge (Lamoureux et al., 2017).

In Massachusetts, short-term civil commitment has been increasingly used for individuals who use opioids in response to the overdose crisis, and can be invoked by an individual’s family, friends, or physician (Christopher et al., 2018; Evans et al., 2020). One study in this state sought to describe patient experience by surveying 292 patients who use opioids who had been involuntarily committed (Christopher et al., 2018). The study found that approximately 25% had been previously committed at least once, typically between 21 to 30 days (Christopher et al., 2018). Among those who were previously committed, about 30% reported being motivated for treatment at the beginning of confinement, which increased to 45% by the end (Christopher et al., 2018). Attitudes toward the confinement also significantly improved for some patients during prior commitment episodes (Christopher et al., 2018). The median time to relapse for these patients was about two weeks, with positive attitudes and motivations predicting longer time to relapse (Christopher et al., 2018). Thus, while short-term civil commitment may improve treatment motivation for some patients, those who remain unmotivated tend to resume substance use sooner after the period of confinement ends (Christopher et al., 2018). However, it is not possible from this study to assess whether civil commitment improved substance use outcomes

in general among patients who experienced civil commitment, because only outcomes among individuals who were subsequently re-admitted were examined (Christopher et al., 2018).

Several jurisdictions have introduced even longer-term compulsory treatment programs for youth and adults with substance use disorder, with lengths ranging from three weeks to 18 months (Werb et al., 2016). A 2015 systematic review summarized studies of compulsory or involuntary drug treatment programs that exist in the United States, China, Thailand, and Sweden (Werb et al., 2016). The compulsory programs were located in a variety of different settings, including community-based treatment, prisons, and residential facilities (Werb et al., 2016). The review found that most studies have not detected any positive impacts of compulsory treatment on drug use or crime, and two studies have found negative impacts on criminal recidivism (Werb et al., 2016). Only one study reported a small effect of reduced criminal recidivism at two years after release for compulsory treatment, and another found lower drug use within one week (Werb et al., 2016). The authors concluded that there is little evidence that compulsory drug treatment is effective in promoting abstinence or reducing criminal recidivism (Werb et al., 2016).

More recently, several studies have found that compulsory treatment may destabilize adults who use drugs and increase the risk of non-fatal overdose (Pasareanu et al., 2016, Rafful et al., 2018). For instance, a Norwegian study compared substance use outcomes between adults receiving compulsory treatment and those receiving treatment voluntarily (Pasareanu et al., 2016). While this study found that some patients receiving compulsory treatment had reduced their substance use 6 months post-treatment, the compulsory patients had higher rates of relapse and overdose compared to the voluntary patients (Pasareanu et al., 2016). Specifically, 22% of the compulsory patients experienced a non-fatal overdose, compared to only 1% in the voluntary group (Pasareanu et al., 2016). There is also evidence that involuntary drug treatment can increase risk of overdose compared to individuals receiving no treatment (Rafful et al., 2018). In one Mexican study, researchers followed a cohort of adults who inject drugs to identify characteristics and experiences associated with non-fatal overdoses (Rafful et al., 2018). The study found that abstinence-based involuntary drug treatment was associated with greater non-fatal overdose risks, which the authors attributed to loss of opioid tolerance following a period of abstinence (Rafful et al., 2018). Thus, forcing individuals to receive abstinence-based treatment may cause more harm than good given that many individuals who receive treatment will

continue to use substances and are often at greater vulnerability for overdose (Rafful et al., 2018).

Overall, the existing evidence does not support the assumption that either short-term civil commitment or longer-term compulsory treatment can improve outcomes for substance use (Jain et al., 2018; Werb et al., 2016). Moreover, there is some preliminary evidence among adults that forcing individuals into abstinence-based treatment may destabilize individuals and increase their risk of overdose (Pasareanu et al., 2016, Rafful et al., 2018). Finally, these interventions are controversial because they represent a violation of the human rights principles of informed consent and right to refuse treatment (Chase, 2020; Hall et al., 2012; Lunze et al., 2016).

### *Legal social controls*

While compulsory treatment and civil commitment for substance use disorder is highly controversial due to ethical concerns and a lack of evidence (Chase, 2020; Chau et al., 2021; Hall et al., 2012; Lunze et al., 2016; Nicolini et al., 2018), there are a range of other social control tactics that are commonly used to coerce individuals to participate in treatment (Klag et al., 2005). Legal social controls typically involve providing individuals who are charged with a drug-related crime with the option of receiving drug treatment as an alternative criminal justice intervention (Werb et al., 2016). This approach is sometimes referred to as “quasi-compulsory care” or “legally mandated care” and commonly occurs in “drug courts” (Lunze et al., 2016; Werb et al., 2016). Internationally, there has been a trend since the 1990’s of countries moving away from civil commitment legislation and compulsory treatment towards the more frequent use of social controls through the criminal justice system (Israelsson & Gerdner, 2012). While legal social controls are distinct from involuntary stabilization programs, the literature on legal social controls have been used to question the effectiveness of involuntary stabilization because both represent coercive interventions that seek to facilitate uptake into treatment (Chau et al., 2021; Goodyear et al., 2021; Pilarinos et al., 2018).

Legal social controls (i.e. drug courts), typically involve court hearings in which judges sentence individuals to attend community based treatment services (Tanner-Smith et al., 2016). The judges may monitor individuals for an extended period of time (12-18 months) and apply incentives to reward abstinence and sanctions to punish those who continue to use substances or

do not attend treatment (Tanner-Smith et al., 2016). Individuals in drug courts are not forced into treatment per se, because they typically have the option of being processed through the traditional criminal justice system if they refuse treatment (Klag et al., 2005). Within this general framework, varying levels of coercion are possible (Parhar et al., 2008). The most coercive approaches involve incarcerating those who do not attend treatment, whereas less coercive approaches might involve other legal consequences such as being given another court date or increasing the length of parole (Parhar et al., 2008). In general, it is reasoned that legal social control will increase individuals' motivation to reduce their substance use (Klag et al., 2005).

The US National Institute on Drug Abuse (NIDA) endorses the use of legal social controls for youth because of evidence showing that "treatment can work even if it is mandated or entered into unwillingly" (Volkow, 2014). NIDA argues that both legal and family pressure can play an important role in getting youth to enter and remain in treatment because youth with a substance use disorder rarely seek treatment on their own (Volkow, 2014). A large body of literature in both youth and adults has compared legally mandated clients with voluntarily admitted clients (Klag et al., 2005). Most of these studies are non-randomized, observational studies that compare treatment outcomes between these groups (Klag et al., 2005). Consistent with the position of NIDA, many of these studies show similar rates of treatment retention, treatment engagement, and short-term treatment outcomes between and voluntary and legally mandated patients, including reductions in substance use and crime (Kelly et al., 2005; N. S. Miller & Flaherty, 2000; Perron & Bright, 2008; Schaub et al., 2010; Urbanoski, 2010).

However, several scholars have taken a much more critical stance towards legal social controls, arguing that the evidence base is largely mixed and inconclusive (Klag et al., 2005; Pilarinos et al., 2018; Urbanoski, 2010; T. C. Wild, 2006). For instance, one systematic review and meta-analysis showed that legally mandated patients generally had poorer recidivism compared to those accessing treatment voluntarily (Parhar et al., 2008). The review also found that among individuals in an institutional setting who were fully mandated to attend treatment (i.e. threatened with incarceration), the treatment had little effect (Parhar et al., 2008).

Additionally, the longer-term outcomes associated with treatment under social control are largely unknown, and some research suggests that the initial benefits of mandated treatment do not continue once legal pressure is lifted (Stevens et al., 2005; Urbanoski, 2010; Zhang et al., 2013). There is also evidence that the use of legal social control is associated with lower

motivation to change, less confidence in treatment, lower levels of treatment engagement, and a poor quality of therapeutic alliance (G. N. Marshall & Hser, 2002; Wolfe et al., 2013).

Other studies have compared outcomes between legally mandated patients and those processed by the traditional criminal justice system (Tanner-Smith et al., 2016). Among youth, a meta-analysis of studies examining juvenile drug courts did not detect any differences in drug use or criminal recidivism between youth who participated in drug courts and those who received traditional juvenile court processing (Tanner-Smith et al., 2016). This suggests that drug courts are no more effective than the traditional criminal justice system at treating youth with substance use disorders (Tanner-Smith et al., 2016). The authors noted one reason for this equivalence in outcomes may be that juvenile drug courts provide very similar services to youth as the traditional criminal justice system (Tanner-Smith et al., 2016).

One reason for the mixed and conflicting results of research on legal social controls is that some clients may not perceive legally mandated treatment as coercive, or as contributing significantly to their decision to attend treatment (Urbanoski, 2010). The converse of this is also true- many individuals who supposedly enter treatment voluntarily may actually perceive significant levels of informal coercion from friends and family (Urbanoski, 2010). Indeed, there is growing evidence that although legal mandates are associated with perceived coercion, there is not a directed one-to-one correspondence between them (C. Wild et al., 2006; T. C. Wild et al., 1998). This was illustrated in a study of patients referred for outpatient counselling, in which a third of legally mandated clients and two thirds of client who had been mandated by their employers to enter treatment did not perceive any coercion (T. C. Wild et al., 1998). In contrast, 37% of clients who claimed to be self-referred actually reported being coerced into treatment (T. C. Wild et al., 1998).

This is an important finding because increased perceptions of coercion are linked with lower levels of internal or autonomous motivation (C. Wild et al., 2006). In turn, lower levels of autonomous motivation predict low patient engagement and retention in treatment, and in some studies has been associated with poorer post-treatment outcomes (Leon et al., 1994; Ryan et al., 1995; Staines et al., 2003; Urbanoski, 2010; Zeldman et al., 2004). Therefore, clients who perceive themselves as being coerced may benefit little from legally mandated treatment in the long-term because it undermines their internal motivation to change.

While only a few studies have explored the interrelationships between perceived coercion, motivation, and treatment outcomes, these findings align with the broader literature on Self-Determination Theory (SDT), which has been developed with a large base of empirical support (C. Wild et al., 2006; T. C. Wild et al., 2016). According to SDT, motivation to engage in activities can range from being completely self-determined, to those that are completely initiated and controlled by external forces (Urbanoski & Wild, 2012). Further, SDT posits that people have fundamental psychological needs for autonomy, relatedness, and competence, and that social contexts which support these factors will promote interested engagement in activities and personal growth (Urbanoski & Wild, 2012). In contrast, perceptions of being coerced or controlled can undermine interest and engagement in treatment (Urbanoski & Wild, 2012).

In the context of addiction treatment, identified or internalized motivation is present when an individual personally identifies with the goals of treatment, commits to these goals, and perceives that they have chosen to seek help (Urbanoski & Wild, 2012). The higher an individual's identified motivation, the greater their level of interest, persistence, and engagement in treatment will be (Urbanoski & Wild, 2012). In contrast, individuals with high external motivations believe treatment is being sought because of external events or agents, such as the legal system or friends and family (Urbanoski & Wild, 2012). Similarly, individuals with introjected motivations may have feelings of shame or guilt driving their treatment decisions (Urbanoski & Wild, 2012). SDT predicts that external and introjected motivations will be associated with low cognitive engagement in treatment, such that clients simply “go through the motions” of treatment (Urbanoski & Wild, 2012). Additionally, if clients are primarily driven by external motivations, they may change their behaviors for only as long as the external contingencies are present (Urbanoski & Wild, 2012).

Wild & Urbanoski acknowledge that using legal social controls may be one way to expand treatment coverage, but that programs that foster perceptions of coercion should be avoided (Urbanoski, 2010; C. Wild et al., 2006). These authors suggest it may be possible to mitigate patient perceptions of coercion associated with social control measures by offering choice in treatment and fostering client autonomy (Urbanoski, 2010; C. Wild et al., 2006). Motivational interviewing techniques, which aim to enhance client motivation while respecting their autonomy, may also help to reduce perceptions of coercion (Urbanoski, 2010; C. Wild et al., 2006). Nevertheless, the authors argue that more evidence is needed to demonstrate the long-

term benefit of legal social controls in order to ethically justify the significant infringements of autonomy they entail (Urbanoski, 2010; C. Wild et al., 2006).

In the current debate regarding involuntary stabilization programs, opponents of involuntary stabilization have interpreted the mixed and conflicting literature on social control as evidence that coercive interventions may not be effective at reducing negative outcomes among youth (DeBeck et al., 2019). However, proponents of involuntary stabilization argue that much of the research on social control is irrelevant anyway because most studies compare legally mandated and voluntary treatment outcomes, whereas involuntary stabilization programs are only used for youth who are unwilling to attend voluntary addictions treatment (Hamilton et al., 2019; Warshawski et al., 2019). Therefore, if youth are unwilling to attend voluntary addictions services, involuntary stabilization may be the only option left to intervene and rescue them from imminent harms (Hamilton et al., 2019; Warshawski et al., 2019).

### *Criticisms of involuntary stabilization programs*

One the most consequential concerns raised about Canadian involuntary stabilization programs is that they focus on short-term detoxification, which can destabilize opioid-dependent individuals (Goodyear et al., 2021; Pilarinos et al., 2018). In general, rapid withdrawal (i.e. detoxification) alone is not a safe option for OUD treatment and is not recommended by clinical guidelines (CRISM, 2017). Clinical trials have shown that relapse rates after short-term withdrawal management can be as high as 53%-67% at one month and 61% to 89% at six months (CRISM, 2017). Because of these high relapse rates, individuals who have receive detox are at elevated risk of overdose death compared to those who receive no treatment (CRISM, 2017). This elevated risk occurs because people with OUD are more likely to overdose when they have lost tolerance to opioids (CRISM, 2017). Thus, involuntary stabilization programs can be dangerous for youth who use opioids unless they are transitioned to ongoing addiction treatment, such as long-term OAT (Pilarinos et al., 2018).

Other potential risks of involuntary stabilization programs have been identified by critics of the proposed model in British Columbia (Goodyear et al., 2021; Pilarinos et al., 2018). These opponents have argued that involuntary stabilization will be experienced by many youth as punitive, and will therefore increase mistrust and fear of services providers (Goodyear et al.,

2021; Pilarinos et al., 2018). This increased fear and mistrust may increase barriers to healthcare access (Goodyear et al., 2021; Pilarinos et al., 2018). For instance, because the proposed involuntary stabilization model in BC involves detaining youth who have received Emergency Department care for an overdose, youth may subsequently be more reluctant to call 911 in the case of an overdose out of fear of confinement (Goodyear et al., 2021; Pilarinos et al., 2018). Indeed, previous studies have shown that people who use drugs may be deterred from seeking emergency help following overdose because of fears of law enforcement (Karamouzian et al., 2019). Ultimately, delays to activate emergency services in the case of an overdose could lead to increased risk of death (Charlesworth, 2021).

Similarly, as a result of increased feelings mistrust towards service providers, youth who are detained may become less likely to engage in harm reduction and voluntary addiction treatment (Goodyear et al., 2021; Pilarinos et al., 2018). This may especially impact structurally vulnerable youth who already experience stigma and alienation, such as street involved youth, indigenous and other racialized youth, and LGBTQ2+ youth (Goodyear et al., 2021). Indigenous youth may also experience involuntary stabilization as another form of oppressive colonialism (Charlesworth, 2021; Goodyear et al., 2021). Finally, there are concerns that the proposed involuntary stabilization model in BC would increase the number of Indigenous youth entering care due to discriminatory attitudes among service providers that view Indigenous parents as less capable of caring for their children (Charlesworth, 2021).

## **Previous evaluations of PChAD**

### *Alberta Health Services evaluations*

Two evaluations were conducted by the Alberta government on the services provided through PChAD. The first evaluation in 2007 was followed by a more comprehensive report in 2008 (Alberta Alcohol and Drug Abuse Commission, 2007; Alberta Health Services, 2009). The 2008 evaluation reported that 429 clients were admitted to PChAD between January 1st 2008, and August 31<sup>st</sup> 2008 (Alberta Health Services, 2009). Of these clients, surveys were conducted upon discharge with 109 (25.4%) of youth, at one month follow-up with 56 (13%) of youth, and at three-month follow-up with 50 (11%) of youth (Alberta Health Services, 2009). Surveys were also completed with 158 parents at discharge from PChAD, 115 at one-months follow up, and at

three months with 83 of parents (Alberta Health Services, 2009). Only parents and youth that used PChAD between January and August 2008 were eligible to participate in the one month follow-up, and only those admitted between January 2008 and June 2008 were eligible to participate in the three month follow-up (Alberta Health Services, 2009). Given the low proportion of total PChAD participants that participated in the survey, the results need to be interpreted with caution. The evaluation also included focus groups with 15 parents, and individual interviews with 10 parents and 10 youth (Alberta Health Services, 2009).

The evaluation found that a high proportion of both parents and youth reported being satisfied with the services provided through PChAD (Alberta Health Services, 2009). Specifically, 98% of youth reported being very satisfied or somewhat satisfied at discharge and 100% reported satisfaction at both one- and three-month follow-up surveys (Alberta Health Services, 2009). Among parents, 88% of parents surveyed reported being somewhat or very satisfied at discharge, 80% at one month follow-up, and 94% at three-month follow-up respectively (Alberta Health Services, 2009). Clearly, overall program satisfaction was remarkably high among this limited sample of youth and adults surveyed (Alberta Health Services, 2009).

Additionally, a key finding of the evaluation was that about half (56%) of youth reported seeking some type of help or support services from some provider (Alberta Health Services, 2009). This rate was almost constant at one-month follow-up (54%) and decreased somewhat three months after discharge to 37% (Alberta Health Services, 2009). This is a positive finding, given that one of the main goals of the program is to connect youth with voluntary treatment services. However, this also means that about half of youth who used PChAD did not subsequently attend voluntary treatment services (Alberta Health Services, 2009). Similarly, the reported described how some youth who were interviewed refused to participate in treatment planning with youth workers because they were not interesting in changing their substance use behavior (Alberta Health Services, 2009).

While youth satisfaction with PChAD was high, it appears that PChAD had a limited impact on youth substance use behaviors. When youth were asked about substance use in follow-up surveys, 23% and 36% of youth reported not using any substances at one month and three month follow-up respectively (Alberta Health Services, 2009). Among youth who continued to use alcohol, tobacco, or cannabis after PChAD, an average of 26% said that they used less at one

month follow-up (Alberta Health Services, 2009). Thus, while PChAD may have caused some youth to change their substance use behaviors, the majority of youth surveyed continued to use substances at the same level or more one month after participating in PChAD (Alberta Health Services, 2009).

Despite the overall satisfaction with PChAD services, some parents and youth had negative experiences with the program. For instance, some parents reported that PChAD “backfired” because it angered or distressed the youth and damaged the parent-child relationship (Alberta Health Services, 2009; Fournier, 2018). Some youths were very angry with their parents for using PChAD services and continued to be angry when they are released back to their parents (Alberta Health Services, 2009). Moreover, some parents reported that they intended to use PChAD to punish their child to frighten them into changing their substance use behavior (Alberta Health Services, 2009). These parents typically felt that police apprehension and transportation of youth was a particularly good way to send their children a message (Alberta Health Services, 2009). It is possible that youth who perceive their parents’ intentions as punitive are more likely to be angered by PChAD, which could lead to exacerbating already strained relationships with the family. Finally, some youth chose to use their right to confidentiality by blocking any of their information from being disclosed to their parents, presumably because they did not trust them (Alberta Health Services, 2009). This was troubling for parents because it meant that they could not be involved in any treatment planning (Alberta Health Services, 2009).

The survey results from this evaluation need to be interpreted with caution. In addition to having a very low response rate, the surveys did not include a pre-post comparison. Therefore, it is not possible to know how service engagement changed from baseline. While 56% of youth were receiving some form of service after PChAD, it is possible that many of these youth were also involved with some form of services before PChAD as well. Additionally, there was no attempt to provide a control or comparator condition, so it is not possible to know whether the changes observed would have occurred without involuntary stabilization or with other less coercive approaches.

Finally, it is generally difficult to judge the rigor of this evaluation because their methods and results sections are missing many important details. For instance, it is reported that among youth who continued to use some substance after PChAD, an average of 26% of youth who used alcohol, tobacco, or cannabis said they used less one month after discharge, and an average of

23% of those who use alcohol, cannabis, or hallucinogens said they used less after three months. It is unclear how this “average proportion” was calculated, nor why the investigators chose to report the level of alcohol, tobacco, or cannabis use at one month follow up, and alcohol, cannabis, and hallucinogen use at three months follow up. This untransparent, selective, and inconsistent reporting reduces the trustworthiness of the findings. Additionally, the report does not provide any results related to the use of stimulants or opioids, which entail a higher risk of overdose and ought to be of greater concern than alcohol, cannabis, tobacco, or hallucinogen use.

### *Office of the Child and Youth Advocate Investigative Review*

The 2018 Office of the Child and Youth Advocate (OCYA) review investigated the deaths of 12 youth who had died of an opioid overdose and made several recommendations to the government to reform policies and practices (Graff, 2018). For each case, the reviewers conducted interviews with family and service providers (Graff, 2018). The report echoed some of the concerns raised about PChAD in the AHS evaluations (Graff, 2018). Specifically, parents expressed that the PChAD process, which requires them to apprehend and confine their child, damaged their already fragile relationship (Graff, 2018). Similarly, the report expressed concern that PChAD may place children who use opioids at a higher risk of overdose following the period of abstinence in confinement (Graff, 2018).

Additionally, Parents were concerned that youth in PChAD made harmful connections with peers that increased their risk-taking behaviors (Graff, 2018). Other parents were concerned that their child engaged minimally with services because they spent much of the time in PChAD physically withdrawing (Graff, 2018). In terms of the actual PChAD application process, some parents reported difficulty obtaining evidence required to apply for the PChAD order, and found that obtaining the five day extension was challenging (Graff, 2018). Parents also expressed feeling alone, ashamed, and intimidated by the application process (Graff, 2018). Once their child was in PChAD, parents found they did not get the information they needed which left them feeling disconnected from their child’s recovery (Graff, 2018). Finally, parents and professionals voiced that the program’s timeline did not meet their needs or provide the level of service that they required (Graff, 2018).

In response to recommendations to the OCYA, the Government of Alberta identified several ways it planned to update PChAD policies and procedures based on an internal review conducted by AHS in 2017 (Government of Alberta, 2018). These updates included:

- Developing policies and resources to support parents with court application and hearing processes
- Reviewing the parent testimonial procedures to reduce impact on families in court
- Working with the justice system to improve processes related to police apprehension, including more training for police
- Developing policies to improve information sharing with parents, including discharge recommendations for the youth
- Exploring policies and practices to address the needs of opioid dependent youth
- Improving policies and practices to facilitate seamless transitions to post-PChAD services

Finally, in a recent follow-up report, the OCYA stated that the challenges identified in the original investigative review remaining ongoing and continue to cause distress to families and parents (Graff, 2021). However, it was also reported that the Government of Alberta had conducted further internal reviews and had planned to enact several changes to address these concerns (Graff, 2021). This Government of Alberta review is not currently available to the public (A. Eaton-Erickson, personal communication, June 16, 2021).

## **Purpose of the study**

Although involuntary stabilization programs for substance use have existed in several provinces through Canada since 2006 (Charles, 2016), there is currently little evidence demonstrating their outcomes (Chau et al., 2021; Goodyear et al., 2021; Jain et al., 2018; Pilarinos et al., 2018). Specifically, very few studies have evaluated the extent to which involuntary stabilization is effective at helping youth recover their decision-making abilities, motivate uptake into voluntary treatment programs, or improving substance use outcomes (Chau et al., 2021; Jain et al., 2018). Early government evaluations of PChAD in Alberta demonstrated that the program can be helpful for at least some youth and parents (Alberta Health Services,

2009). However, these evaluations were not peer-reviewed and were limited by weak methodology. Additionally, in recent years the overdose crisis in Canada has led to an increased level of scrutiny of involuntary stabilization as a strategy to address substance use harms among youth. For instance, the proposed involuntary stabilization legislation in BC was paused because of backlash from academics and advocates, who have argued that involuntary stabilization has little empirical backing and may do more harm than good in the long run (Zeidler, 2020). Considering these trends, evidence is sorely needed to help inform decisions regarding the implementation and design of involuntary stabilization.

In Alberta, the OCYA conducted an investigative review which identified several areas of improvement for PChAD (Graff, 2018, 2021). In response, the Government of Alberta has conducted internal reviews of the program and had taken several steps to improve PChAD policies and procedures (Government of Alberta, 2018; Graff, 2021). While these are promising developments for the PChAD program, the experiences of parents who use involuntary stabilization programs have not yet been described in detail in either government reports or the existing academic literature and are poorly understood. This represents a significant knowledge gap because parents are a key stakeholder for involuntary stabilization programs. Indeed, Parents groups across Canada have advocated for the implementation of involuntary stabilization programs (Hamilton et al., 2020; Parents Empowering Parents, 2021), and in Alberta, parents are responsible for both initiating and coordinating the involuntary stabilization process (Alberta Health Services, 2021). This study was designed to address this knowledge gap and contribute to the sparse literature on involuntary stabilization programs by exploring the experiences of parents in Alberta who have used PChAD.

**The specific research objectives** of this study are to add to the literature on involuntary stabilization programs by **1)** exploring parent experiences with an involuntary stabilization program and **2)** exploring the perceived impact of involuntary stabilization on youth. Additionally, I endeavor to **3)** develop insights for improving involuntary stabilization programs and other services to better support families. This study aims to provide a rich, detailed, description of a range of possible parent experiences and outcomes that can result from involuntary stabilization. By illuminating parent experiences and perspectives with this program, I aim to develop timely knowledge that may help improve involuntary stabilization in the current context of heightened overdose risk. Further, based on parent's experiences and perceived

outcomes with involuntary stabilization, I endeavor to develop insights as to how services and supports in general may better serve parents who are struggling with similar problems. This is important, because involuntary stabilization represents only a small component of the spectrum of possible services for youth who use substances.

### **Central research questions**

- 1) How do parents in Alberta experience the PChAD program, including the application for the court-order, the apprehension of the child, the confinement period, and the discharge of the child back to the parents?
- 2) How do parents perceive and make sense of the impact of the PChAD program on their child?

## **Chapter 2: Methods**

### **Interpretative Phenomenological Analysis (IPA)**

I selected Interpretative Phenomenological Analysis (IPA) as a suitable methodology for my research questions. IPA is an approach to qualitative inquiry that aims to produce rich descriptions of what an experience is like from the unique point of view of participants (J. Smith et al., 2009). IPA involves the use of critical questioning to draw out interpretations and meaning from the participants, which are then analyzed and contextualized with relevant theoretical material by the researcher (J. Smith et al., 2009).

IPA is based on the theoretical principles of phenomenology, hermeneutics, and idiography (J. Smith et al., 2009). The first of these principles, phenomenology, involves systematically and attentively reflecting on and describing subjective experience (J. Smith et al., 2009). As described by J. Smith et al., (2009), phenomenology was developed by the philosopher Edmund Husserl, who argued that we should “go back to the things themselves.” By this, he meant focusing on the experiential content of consciousness and identifying its essential qualities or core structures. For Husserl, phenomenologists needed to avoid various obstacles to understanding things in themselves. These obstacles include our propensity for too quickly imposing our own meaning making categories on phenomena. His phenomenological method involved “bracketing out,” or setting aside the things we take for granted about the order of the

world so that we can better concentrate on our perceptions. Husserl emphasized that our consciousness is always focused on an object. This could be a physical object in the world, or an object in our mind such as a memory or imagination. For Husserl, a phenomenological attitude requires us to turn our gaze inward from objects in the world to our perception of those objects, and become self-conscious of processes such as thinking, wishing, seeing, and remembering.

As a primarily phenomenological approach, in IPA an individual's unique perceptions of objects and events is the focus, rather than the researcher's theoretical or scientific interpretations of the phenomenon of interest (J. Smith et al., 2009). Thus, during the interviewing and analysis IPA researchers should attentively focus on the participant's lived experience (J. Smith et al., 2009). This includes both immediate perceptions of objects and events, as well as high order meaning-making activities such as desiring, regretting, remembering and so on (J. Smith et al., 2009).

The hermeneutic aspect of IPA refers to interpretation and meaning making activities (J. Smith et al., 2009). According to hermeneutics, there is no such thing as uninterpreted phenomena because an individual's preconceptions and language mediates one's experience of the world (J. Smith et al., 2009). Therefore, in order to understand a participant's message, IPA researchers takes an active role in trying to make meaning of the participant's inner world (J. Smith et al., 2009). This represents a departure from the purely Husserlian phenomenological approach, which seeks to "bracket out" prior concerns (J. Smith et al., 2009). Instead, a hermeneutic approach involves acknowledging the active role the researcher plays in making sense of the participant's experience (J. Smith et al., 2009).

An important concept in hermeneutics that is central to IPA is the hermeneutic circle (J. Smith et al., 2009). This refers to the dynamic process by which researchers move repeatedly between the part and the whole to make sense of the participant's experience (J. Smith et al., 2009). For instance, a single phrase uttered by a participant may only make sense within the context of a whole interview (J. Smith et al., 2009). At the same time, the meaning of a phrase depends on the cumulative meaning of individual words (J. Smith et al., 2009). At a higher level, the meaning an individual interview will be understood within the context of the overall research project (J. Smith et al., 2009). Another important feature of IPA is called the "double hermeneutic." This refers to the two interpretive processes occurring - first the participant makes

meaning of their experience, and then the researcher strives to make sense of the participant's meaning making (J. Smith et al., 2009).

Essentially, IPA combines both phenomenological and hermeneutical approaches so that it is both descriptive and interpretive of the participants experiences (J. Smith et al., 2009). On the one hand IPA studies seek to empathically adopt the participants perspective and attend as close as possible to the participants' experience (J. Smith et al., 2009). However, IPA researchers acknowledge that our experience of another's experience is mediated by our preconceptions (J. Smith et al., 2009). Additionally, during the analysis IPA researchers take an explicitly interpretative stance by questioning the participant's account of their experience (J. Smith et al., 2009). This may include interpretations that go beyond the explicit claims of the participants in order to provide further illumination or insight (J. Smith et al., 2009). However, the interpretation should still be primarily based on readings from within the text the participant has produced (J. Smith et al., 2009). Thus, it would be inappropriate to import a theoretical framework from outside the text, such as by conducting a psychoanalytic interpretation (J. Smith et al., 2009).

Finally, IPA is idiographic in its approach. This refers to the in-depth examination of individual perspectives of participants before making generalizations (J. Smith et al., 2009). IPA studies first focus on individual participants by conducting a detailed exploration of each specific case (J. Smith et al., 2009). To study a group of individuals, important themes are generated in the analysis and illustrated using the narratives of specific individuals (J. Smith et al., 2009). Finally, IPA studies may examine similarities and differences in individual narratives (J. Smith et al., 2009).

IPA methodology is consistent with the main purpose of this study, which is to describe the experiences of parents before, during, and after the youth received services through the PChAD program. I primarily sought to take a phenomenological approach to understanding these unique experiences and explore the perceived impacts of the program on the overall physical, social, and psychological well-being of the youth. In addition to describing these experiences, I sought to interpret the meaning of the parent's perspectives. For example, parents tended to describe their experiences and perceptions using the language and concepts of addiction they had been taught or had absorbed from common discourse in society. Because I am aware of the different ways that addictive behaviors are commonly understood, I was able to identify these

concepts when they emerged and use them to better understand the participants account of their own experience. Specifically, some parent described how they hoped PChAD would give their child a “wake up call” or cause them to “hit bottom.” This description mobilized the narrative that “tough love” is needed to address substance use because individuals must experience the full consequences of their addiction so they will be motivated to change (i.e. people need to hit rock bottom). By identifying this narrative within the text, I was able to gain greater insight into how parents were making sense of their experiences.

Lastly, the idiographic approach that characterizes IPA was appropriate for this study because I planned to conduct an in-depth exploration of each parent and produce a rich description of their experience and context. Subsequently, I identified similarities and differences between the parents’ experiences and perceptions. In general, I sought to describe a range of different experiences, including those who had both positive and negative overall perceptions of the program. While this study does not purport to describe all possible experiences with PChAD, the sample of parents did capture a broad range of experiences.

### **Positionality**

My position in this research has been shaped by my previous job as a youth worker. In this position, I worked with several high-risk youth who used substances. In my work at this agency, we took a pragmatic harm reduction approach by acknowledging that it is not feasible to eliminate all risks for some youth, and that attempting to control youth can be counterproductive. For example, if we attempted to contain a youth within her foster house, the youth might leave their placement and subsequently be reluctant to return if they perceived the house as overly controlling. Instead, we conducted safety plans in which we would request that youth tell us where they are going and check in periodically. By respecting the youth’s autonomy, we were also able to draw youth in and develop a therapeutic relationship. One benefit of this approach is that if the youth needed help, they be more likely reach out instead of avoiding us.

One youth with whom I worked closely was apprehended and confined through PChAD multiple times. As her youth worker, I went to visit her in the protective safehouse shortly after she was apprehended. I observed that she very angry and distressed at being confined and

unmotivated to engage with treatment. The intervention seemed to have little impact, because she soon resumed her previous level of substance use after she was released. In general, these experiences prompted my interest in involuntary stabilization because I was skeptical of their long-term effectiveness. As a result of youth work experiences, I generally take a critical stance to any coercive approaches to addressing substance use harms among youth.

Instead of supporting coercive interventions, I now embrace the philosophical tenets of harm reduction, which I believe are consistent with counselling psychology values. For instance, harm reduction philosophy entails a shift away from controlling and punitive approaches to more relational-based practice, in which service providers avoid power struggles and build a sense of equality, safety, and respect (Smyth, 2017b). For youth, this can facilitate better connections with staff, a greater willingness to collaborate, and staying longer in placements (Smyth, 2017b). Harm reduction also embraces client self-determination, such that all work with clients is conducted collaboratively and is informed by the client's needs, wants, and perspectives (Bigler, 2005). This is consistent with the counselling psychology commitment to client-centered care, in which counsellors seek to establish shared goals and change tasks with clients in an effort to develop a therapeutic alliance. Harm reduction and counselling psychology also share the humanistic valuing of individual dignity and worth (Bigler, 2005). That is, the valuing of individual dignity is placed above moral judgements of risky or socially deviant behavior (Bigler, 2005). From this perspective, people should not be left to suffer simply because the harms they are experiencing are a consequence of their own behavior or addiction (Bigler, 2005). Similarly, harm reduction is a strengths-based approach because it gives attention to an individual's abilities and assets rather than focussing on pathology (Bigler, 2005). Specifically, harm reduction emphasizes individuals' survival skills and resourcefulness, recognizes their expertise in their own lives, and recognizes that individuals can enact positive incremental changes even in the context of high-risk behaviors and circumstances (Bigler, 2005).

Another aspect of my experience that has shaped my views of substance use is my previous research through my master's in public health. Through this program, I worked as a research assistant with the Inner-City Health and Wellness program at the Royal Alexandra hospital, which takes a harm reduction approach to promoting the health and well-being of people who use drugs. Through my scholarship in this area, I began to reconceptualize substance use-

related harms as primarily related to structural issues and social determinants of health rather than individual agency. For instance, I learned how the criminalization of drugs is rooted in racism and colonialism and has historically caused much more harm than good (S. Boyd et al., 2016). Currently, I am involved with advocacy work through the Canadian Students for Sensible Drug Policy, which is an organization that promotes progressive drug policy reforms including decriminalization, expanded harm reduction, and the provision of pharmaceutical alternatives to the toxic drug supply.

## **Data collection**

### *Sample*

Parents who previously used PChAD were recruited for semi-structured interviews. To recruit participants, I contacted the Alberta-based parent organizations “Moms Stop the Harm,” and “Parents Empowering Parents.” These organizations both offer support to parents who are either currently experiencing a child’s substance use disorder or have lost a child to overdose. I asked representatives from these organizations to distribute my study recruitment flyer through their social media accounts (i.e. Facebook) and email lists. A member of Moms Stop The Harm agreed to distribute my study flyer over social media, which led to the recruitment of 9 participants. Additionally, the representative I contacted from Parents Empowering Parents connected me with one parent who agreed to participate. I recruited further participants through snowball sampling (i.e. participants referring other participants). In particular, the fifth parent I interviewed shared my study advertisement in a Facebook group made up of parents who had previously used a private residential treatment program that provides abstinence-based care based on a traditional 12-step approach. This led to the recruitment of five more parents who had used PChAD.

In total, I recruited 15 parents. IPA studies often have smaller sample sizes (6-8 participants) because the objective of IPA is to give a comprehensive and in-depth description of an individual’s experience (Pietkiewicz & Smith, 2014). However, I recruited slightly more participants because I sought to capture a greater range of experiences.

The parents I recruited held a range of perspectives on addiction treatment that reflect the different organizations from which they were recruited. For instance, Moms Stop the Harm advocates for expanding harm reduction services and making progressive drug policy changes, including decriminalization and providing people who use drugs with pharmaceutical-grade alternatives to the toxic illegal drug supply (Moms Stop the Harm, 2021). In July 2020, one of the co-founders of Moms Stop the Harm wrote an open letter strongly objecting to the proposed involuntary stabilization program in British Columbia (Moms Stop The Harm, 2020). The letter argued that involuntary stabilization was a counterproductive approach, and that involuntary addiction treatment was not supported by research (Moms Stop The Harm, 2020). Another Moms Stop the Harm member wrote a blog post titled “The Trouble with PChAD” in which she raised many of the same concerns about involuntary stabilization programs (Welz, 2020).

In contrast, Parents Empowering Parents is more supportive of involuntary stabilization programs. The organization was an instrumental advocate in the development of the PChAD legislation in the mid- 2000’s, and offers guidance to parents who are considering using the program (Parents Empowering Parents, 2021). Similarly, the parents recruited from the private, abstinence-based residential treatment program were generally less supportive of harm reduction approaches. In general, these parents were more supportive of involuntary stabilization because they had learned that youth must remain abstinent to recover and should therefore be kept in drug-free environments. Overall, the parents in this study were recruited from organizations with a range of perspectives related to involuntary stabilization programs and the use of coercion for youth who use substances.

Table 1. shows the characteristics of the participants. In total, there were 15 parents of 14 different youth, because two parents of the same child were interviewed. The participants consisted of 12 (80%) mothers and 3 (20%) fathers and the children included 9 (64%) sons and 5 (34%) daughters. Some parents used PChAD multiple times, with 16 being the maximum uses of PChAD, although the majority (75%) used the program 2 times or less. The median age of the children at the time of the first PChAD was 15, with a minimum of 13 and a maximum of 17. Four of the children have since died from an overdose and eight continue to struggle with substance use in some capacity. In contrast, two children entered a long-term residential treatment program and have since stopping using substance problematically. In one of these cases, the child entered treatment immediately after using PChAD.

Table 1 lists the substances that parents thought their child were using, as well as the co-morbid mental health issues. I did not ask the parents specifically about what mental health issues they had, but this information often came up when I asked parents to describe the specific circumstances that led them to use PChAD. If parents did not mention which substances their child was using, I specifically asked for this information.

Several parents used secure care programs other than PChAD that are not specific to youth who use substances. For instance, 4 (29%) parents also used the PSECA program (Protection of Sexually Exploited Children), which allows for up to 47 days of confinement for children under 18 who are “sexually exploited through their involvement in prostitution” (Government of Alberta Children and Youth Services, 2014). Further, 2 (14%) parents had their children involuntarily confined for the purpose of stabilization and assessment through the Child, Youth, and Family Enhancement Act (Government of Alberta, 2000). Through this legislation, children that are involved with Children’s Services and are under 16 years old can be apprehended and confined for secure services for up to 30 consecutive days (Government of Alberta, 2000). They must be in the custody of a director, or the subject of a supervision order, temporary guardianship order, permanent guardianship agreement/order, or a family enhancement agreement (Government of Alberta, 2000). Children may be secured if: 1) they present an immediate danger to themselves or others 2) it is necessary to confine the youth for stabilization and assessment, and 3) less intrusive measures are not adequate to reduce the danger (Government of Alberta, 2000).

**Table 1. Characteristics of parent participants and their children**

<b>Participant Characteristics</b>	<b>No. (%) (n=14)</b>
Parent gender (n=15)*	
Father	3 (20%)
Mother	12 (80%)
Child gender	
Son	9 (64%)
Daughter	5 (34%)
Number of times PChAD used	
Median, range	1 (1-16)
Interquartile range	(1-2)
Year that PChAD was last used	
Median, range	2015 (2007-2018)
Interquartile range	(2013.5-2017)
Child's age at first PChAD	
Median, range	15 (13-17)
Interquartile range	(15-16.75)
Child has since passed away from an overdose	4 (29%)
Child continues to struggle with substance use	8 (57%)
Child entered treatment and is no longer using substances	2 (14%)
PChAD protective safehouse site used§	
Edmonton	6 (43%)
Calgary	6 (43%)
Red deer	3 (21%)
Other involuntary measures used§	
Child, Youth, and Family Enhancement Act secure services†	2 (14%)
Protection of Sexually Exploited Children (PSECA)	4 (29%)
Involuntary detention through Mental Health Act	2 (14%)
Substances parents thought child was using§	
Adderall	1 (7%)
Alcohol	3 (21%)

Benadryl	1 (7%)
Cannabis	9 (64%)
Cocaine	7 (50%)
Fentanyl	2 (14%)
Heroin	5 (36%)
Inhalants	1 (7%)
Methamphetamine	6 (43%)
MDMA	2 (14%)
Unspecified opioids	2 (14%)

#### Mental health and behavior problems described by parents§

Anger issues	1 (7%)
Attention Deficit Hyperactivity Disorder	5 (36%)
Anxiety	3 (21%)
Bipolar disorder	1 (7%)
Fetal Alcohol Spectrum Disorder	1 (7%)
Post-traumatic Stress Disorder	1 (7%)
Oppositional Defiance Disorder	2 (14%)
Psychosis	1 (7%)
Self-harm	2 (14%)
Trauma	2 (14%)
Violence	2 (14%)

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\* There were 15 parents of 14 children in this study

§May apply in multiple cases so percentages will not equal 100%

#### Semi-structured interview

Data was generated using semi-structured interviews either over the phone or zoom video conferencing. Interviews lasted 60 to 90 minutes and consisted of open-ended questions. This flexible approach allowed the participants and I to explore unexpected issues as they emerged . Appendix A shows the interview protocol. The interview protocol was developed by Daniel and reviewed by Dr. Hudson Breen.

My rationale for asking the **question 1**, “what circumstances led you to use the PChAD program” was to establish context for understanding the parents’ experiences and how they perceived the outcome of the program. **Question 2** “tell me about your experience with each step of the program, starting with this application” was related to my central research question of exploring parent experiences with PChAD. I was careful to prompt the parent to describe each phase of the program, including the pre-application counselling session, the court application process, the experience of having their child in PChAD, their involvement with their child’s care in PChAD, and their experience when their child was discharged from the program.

**Question 3** “tell me about how the program impacted the well-being of your child” was directly related to the how the parents perceived the impact of the program (research question 2). I prompted parents to take about how they thought PChAD impacted the parent-child relationship, as well as what they thought the positive and negative outcomes of the program were. After the first three interviews, I began asking **question 4**: “what were your initial hopes and expectations for were using PChAD, and how did your experience match these expectations?” I began to ask this question because it became apparent to me that parents’ perceptions of the outcome of PChAD were shaped by their initial expectations and reasons for using the program. I subsequently conducted two follow-up interviews with parents from earlier interviews because I wanted to clarify this question.

Finally, **question 5** involved directly asking participants what they would like to see change about the PChAD program. This was followed by a prompt asking parents what other service besides PChAD may have helped during this period. These questions were related to my research objective of creating recommendations and insights regarding how PChAD and other services can better support families.

My interviewing approach was influenced by my training as a counselling psychologist. I sought to develop rapport and trust with participants by listen actively and conveying empathy. I also frequently sought clarifications and asked open-ended questions that were not leading.

## **Data analysis**

The interviews were audio recorded and transcribed using speech to text software. I then reviewed the resulting transcripts to correct errors.

Data analysis was conducted using NVIVO software. The first stage of data analysis involved creating notes on the transcriptions using the annotation feature in NVIVO. These initial notes were made based on the content of the participant responses as well as my initial interpretations (J. Smith et al., 2009). After making detailed notes, I began constructing themes and sub-themes using the “nodes” feature in NVIVO. Specifically, I formulated a concise phrase that conceptualized a component of the psychological phenomenon based on my initial notes, while still being grounded the participant’s account (J. Smith et al., 2009). Next, I grouped themes together into clusters or “superordinate themes” based on conceptual similarities, and concisely labelling each (J. Smith et al., 2009).

After analyzing the first five interviews, I used the themes for each participant to create an initial overall structure of themes and superordinate themes. I did this by printing the themes from each participant on small pieces of paper so that I could easily move them into clusters based on conceptual similarities. Through this process I initially generated a structure with nine superordinate themes. Dr. Hudson Breen reviewed this structure and provided feedback, which led me to reduce the structure to four superordinate themes.

I continued to analyze the remaining ten transcripts in the same way, giving each interview thorough attention in line with the idiographic approach of IPA. After creating themes for each of these interviews, I then incorporated these themes into the overall theme structure I had created with the first five interviews. This sometimes involved adding in new themes to the overall structure and reorganizing as new ideas emerged. After I had analyzed every interview, I reviewed each theme and superordinate theme in NVIVO and ensured the quotes supporting each theme were appropriate. This was a creative process that involved substantial reorganization of the theme structure. To finalize the theme structure, I created a document that described each theme and listed the key ideas in each. I also enumerated the number of participants for whom each idea emerged and listed the relevant quotations from the interviews. I shared this theme structure with Dr. Hudson Breen for review. Finally, I created a narrative account in which each theme is described and exemplified with quotes from the interviews (Pietkiewicz & Smith, 2014).

### **Introducing the participants**

The following section is meant to provide context about the circumstances that led to each parent using PChAD and their reasons for using it. I will also describe the outcome of the program and how each parent generally perceived this outcome. Please note that all participants have been given pseudonyms and key details have been changed to maintain anonymity.

### *Daisy*

Daisy described her son as struggling with mental health and addiction throughout his life. She describes him as being very violent and angry, and that it was “impossible to get help.” Her son was expelled from high school when drugs were found in his possession. Daisy tried to persuade him to attend voluntary treatment, but he did not think his drug use was a problem. Daisy used PChAD once and was disappointed with the outcome because her son “went and smoked drugs the minute he got out.” Her son was angry about being PChAD’d and Daisy noted that it had strained their relationship. In the early days Daisy knew her son was using cannabis and experimenting with pills. After PChAD, he went through a long phase with cocaine and eventually starting using opioids. Daisy’s son passed away from a fentanyl overdose in his 20’s.

### *Rose*

Rose had a very close relationship with her daughter growing up. However, in high school Rose described how everything went “off the rails really fast.” Rose’s daughter began struggling with mental health issues and engaged in self harm (cutting). At one point, she was caught smoking cannabis at school and was suspended for several weeks. Rose took her daughter to an addiction counsellor, but the counsellor didn’t think Rose’s daughter had a substance use disorder at this time. Rose felt like her daughter had two personalities. Sometimes they had great talks, spent quality time together, and felt very close. At other times they fought, her daughter would leave the house for long periods of time. Near the end of high school, Rose’s daughter told her she was not coming home at all and would be staying with her boyfriend. They had little contact during this time and when they did talk, her daughter seemed very aggressive and confrontational. For several months, Rose grieved the loss of their once close relationship.

Eventually, Rose heard from her daughter was using and selling cannabis and cocaine. Rose was disturbed by this and decided to use PChAD because she was concerned for her daughter’s safety. Rose also wanted to intervene while she still could because her daughter was

almost 18. In PChAD, Rose was happy to visit and connect with her daughter after being separated for so long. For a while, Rose was hopeful because it seemed like her daughter was back to being her typical “open-hearted” and “chit chatty” self. However, the conversations eventually went “off the rails” again. Her daughter became aggressive and decided to go with her boyfriend following PChAD, and Rose did not hear from her again for several months. Rose feels PChAD has negatively impacted their relationship and placed a wall between them. Rose hoped her daughter benefited from the drug education she received in PChAD, but she isn’t sure whether it had a positive impact.

### *Lily*

Lily described her daughter’s childhood as very happy, with plenty of quality time spent with family. However, after a traumatic experience, Lily said that her daughter began to self-medicate with cannabis and alcohol. Eventually, she started to take pills and move on to injecting illegal street drugs. As her daughter’s substance use escalated, she dropped out of school because she couldn’t concentrate. This led to arguments, and her daughter eventually left the family home. For several months, Lily had little connection with her daughter and tried frantically to locate her.

Lily finally located her daughter when she became involved with the criminal justice system. At this time, a police officer suggested that Lily apply for a PChAD order. Lily successfully obtained a PChAD order, but then had to wait for a good opportunity to use it because she lost connection with her daughter again. The opportunity arose later when her daughter needed medical attention. Lily brought her daughter to the hospital, and then returned home once her medical needs had been treated. That night, Lily finally activated the PChAD order and had the police apprehend her daughter from their home.

After the 10-day period of confinement ended, Lily said her daughter was discharged back into her care without a plan in place. The same night, Lily’s daughter left home with another youth she had met in the protective safehouse. Lily’s daughter continued to use substances and was frequently involved with the criminal justice system. Lily was also concerned she was being sexually exploited. Lily eventually applied for a second PChAD order,

and used it after her daughter was arrested. Again, Lily described how her daughter was discharged back into her care and left home almost immediately.

Lily described her experience using PChAD as a “disaster” because her daughter was very angry and uncooperative. Lily thought the process of calling the police to apprehend her daughter destroyed all trust between them. Lily’s daughter died of an overdose after using PChAD the second time. Lily subsequently learned that detoxification can be dangerous for a youth who uses opioids and now regrets using PChAD. Lily feels using PChAD was the “worse thing that we could possibly do.” However, she says she was desperate at the time and PChAD was the only thing available.

### *Cassandra*

Cassandra’s son struggled with mental health problems from a young age. Cassandra’s son started leaving home and using substances as a young teenager. She wasn’t sure what he was using, but thought it was probably meth. He would often be gone for months, sleeping rough around the city. He had frequent interactions with the RCMP, who would often pick him up and drop him off with at home with her. Cassandra says she tried many times to get him help but was unsuccessful. She said she had tried everything, including AA and mental health services. She even “kid napped” him several times by pulling him off the streets herself. She went to social services looking for help, but said that they could not help her because she did not “beat” her son. Cassandra said she felt helpless because no one was able to help her.

Cassandra used PChAD once, and was initially hopeful that it would help her son reduce his substance use. She said the family counselling in PChAD was positive because it helped them communicate openly for one of the first times. However, she was disappointed when her son resumed using shortly after being discharged. She also said that he subsequently “got smarter” and worked harder to elude her. Her son is now in his 20’s and continues to cycle between periods of substance use and abstinence. At the end of our interview, Cassandra asked me if I could refer her to a service where she could “get help dealing with an addict.”

### *Emily*

Emily first suspected her son might have a substance use problem when she found an empty vial in his bedroom. She initially tried to get her son to talk to her about what was going on. However, they had an argument and her son ended up leaving the home for over a week. Eventually, it became apparent that he had been struggling with drugs. They would later find out that he was using MDMA, hallucinogens, and cocaine. His substance use was causing numerous problems, such as disrupted school performance and not participating in activities he used to enjoy. According to Emily, he was also stealing, lying, not coming home, and spending time with a different peer group.

Emily obtained many PChAD orders, but only actually used the program twice. When asked what she hoped to achieve by using PChAD, she simply said she wanted to “fix my kid,” either by connecting him to other resources or giving him an awakening. However, Emily was very disappointed with PChAD because after the program ended, her son left home the next day to go use substances after being discharged. He was very angry at being PChAD’d, and was not grateful for the effort to keep him safe. Eventually, Emily was able to get her son into a long-term, abstinence-based private residential program for youth. The program seemed to work well for Emily’s son, and he has been abstinent for the last several years.

### *Amy*

When Amy’s son was 16, she was initially aware he was dabbling in drugs, but didn’t know the extent of it until much later. Her son used heroin and methamphetamines, and struggled with multiple mental health disorders including bipolar disorder, Attention Deficit Disorder, and Oppositional Defiance Disorder. Amy described the experience of having her son living with her as being very chaotic due to his substance use and behavioral problems. Eventually, Amy could no longer have him in the house and forced him to leave. At this point, Amy’s son was mainly living in an Emergency Shelter and on the streets.

Amy used the PChAD program three different times. During PChAD, Amy was relieved to know her son was safe. She said it meant a lot to her because it gave her a sense of control that she didn’t normally have. However, Amy didn’t think the program was long enough to have a lasting impact. The first time she used PChAD, her son relapsed very quickly afterwards. On one occasion, Amy arranged for her son to attend a voluntary residential treatment program after

PChAD. Unfortunately, Amy said that abstinence-based treatments never worked for her son, and he very quickly dropped out of the program. Amy's son continues to struggle with substance use disorder and Amy lives with the constant fear that he is going to overdose and die. Looking back on the time in which she used PChAD, she realizes that this period was only the beginning of his long journey with substances. Amy remains cautiously hopeful and awaits the day when her son will reach out for her help.

### *Tracey*

Tracey described her son as being a “nerd.” He loved science, and was on the honor roll. He also struggled with mental health issues from a young age, including suicide ideation and attempts, self-harm, ADHD, anxiety, and psychosis. In his teens, he began using substances as a way of self-medicating and eventually began injecting heroin and methamphetamine. Tracey described how she “fought” with system to try to get a diagnosis and get support. She recalled that the professionals she met with didn't seem to take her sons problems seriously enough, which she felt resulted in missed opportunities to intervene early. She described how he had multiple Emergency Department visits for mental health crises and at once point was involuntarily admitted to the psychiatric ward for a few weeks. However, he did not get the help he needed, and his addiction and mental health eventually spiraled to the point where he was very high risk. Tracey's son died eventually died in his teens due to a drug overdose.

The first time Tracey obtained a PChAD order, she did so because she wanted to use it as leverage to coerce her son to attend a voluntary addiction and mental health program. Her son did attend the program, but his functioning continued to deteriorate. Eventually, Tracey used PChAD because her son continued to use substances problematically and would not stay in voluntary abstinence-based addiction treatment. However, Tracey's son was only in PChAD briefly before he was transferred to PSECA, which is a secure care program for sexually exploited youth that can last up to 47 days. After this program, Tracy entered into a voluntary custody agreement with children's services, which enabled her son to be secured through the Child, Youth, and Family Enhancement Act for up to 30-days. Tracey said that her son was secured through this legislation multiple times throughout the next few years. However, Tracey felt these 30-day placements were not long enough to have a lasting impact on her son's mental

health and substance use problems. The final program Tracey's son was placed in was a residential program that did not have locked doors. While in this program, Tracey's son often left for days or weeks to use substances. Tracey attributed his tendency to leave any unlocked placement to his lack of impulse control. During one of these periods of absence, her son overdosed and died

### *Evelyn*

Evelyn said her daughter's behavior had become erratic and it was difficult to have her in the home. Eventually, Evelyn discovered her daughter was using cannabis and suspected that she may be using other substances. These suspicions were confirmed by drug tests when she attended a voluntary mental health and addiction treatment center. During this time, her daughter cycled between periods of abstinence and substance use. When she wasn't using, Evelyn described her daughter as being a "dry drunk," which she explained is a term from Narcotics Anonymous that refers to an individual's who is "withdrawing from drugs and miserable as hell." Eventually, Evelyn's behavior became too difficult to handle in the home, and Evelyn said she "fought" for her daughter to be placed in a group home. Evelyn also said her daughter would sometimes leave her placements and "live on the streets."

Evelyn used PChAD for her daughter three times. She said that by using PChAD, she hoped something would "click" and that her daughter would realize she didn't want drugs in her life. Evelyn was very thankful for PChAD because it gave her a break from the non-stop stress. She was relieved to know where her daughter was, and felt like PChAD was necessary to save her life. However, she didn't think PChAD was long enough to have any lasting impact unless there was a program in place for her afterwards. On one occasion after using PChAD, Evelyn's daughter was transferred to PSECA because she was being sexually exploited. However, as soon as she was able to leave PSECA, Evelyn's daughter resumed using substances. Evelyn believed that using PChAD and PSECA destroyed her daughter's trust in them and prompted her to avoid them.

At one point, Evelyn said she let her daughter go for a long period of time, during which she was mainly living on the streets. Eventually, Evelyn used PChAD again and this time arranged for her to enter a long-term, abstinence-based residential program for youth with severe

substance use disorders. The program worked for Evelyn's daughter, and she has now been in recovery for several years.

### *James*

James adopted his daughter as a newborn. Growing up, his daughter struggled with what they suspected were FASD and ADHD. As a young teenager, James described how she began "acting out," such as by sneaking out at night and running away. James said that his daughter's substance use escalated very quickly from cannabis to methamphetamine. When she would come home to detox, James said she could be quite violent. Throughout the years, James struggled to get his daughter to participate in voluntary treatment programs. Eventually, they were able to have her assessed and diagnosed with FASD. She continued to go through cycles of binge use and withdrawal for several years. James was fearful for his daughter's safety, and recalled a few near miss incidents in which his daughter overdosed on opioids. He was also concerned that his daughter was being exploited by drug dealers to run drug transactions.

James used PChAD for his daughter over 10 times throughout her adolescence. James believed that PChAD was not a fix, but appreciated that it gave his daughter a safe place to detox and offer various referrals. He notes that his daughter was also connected with a counsellor whom she had a good relationship with. On one occasion, James arranged for her to attend a voluntary abstinence-based program. However, she was discharged prematurely for behavioral problems. In general, James isn't sure that PChAD accomplished much for his daughter in the long-term. She is now almost an adult and continues to cycle between substance use and abstinence, and still struggles with executive functioning and decision making.

### *Diane*

Diane described how her son began using substances at a young age to help cope with the effects of a traumatic experience. He initially just used cannabis and alcohol, but eventually started using cocaine and other drugs. Diane described her son has having an excessive, "all or none" type personality. Diane used PChAD twice. The first time, she thought she would try it to see if it made a difference. She hoped it might be enough to motivate him to change his life. She

said the program obviously didn't help because his mental health and substance use continued to deteriorate. She eventually used PChAD a second time because she once again thought his drug use had "gotten out of hand."

Unfortunately, Diane believed that the experience of being apprehended by police and confined may have re-traumatized her son. Diane's son was very angry with her, and told her "this isn't gonna help mom." Diane agreed that PChAD had little impact because it doesn't deal with the "root causes" of addiction, such as grief and trauma. Diane thought the only positive outcome of PChAD was that it kept temporarily safe. After the second time Diane used PChAD, her son was involuntarily admitted to the psychiatric unit of the local hospital. However, his substance use has continued to be a problem. Eventually, Diane could not longer have her son in her home, and he became homeless. At this point, his drug use escalated, and he began using meth and fentanyl. During this time, Diane mentioned that harm reduction programs helped her son stay safe while he was using. Currently, Diane has a deal with her son in which he may only return home if he finishes a voluntary treatment program.

### *Tina*

Tina used PChAD for her son only once. She was concerned that he was skipping school, not coming home at night, and running away. Despite her best efforts, she was unable to persuade him to enter voluntary treatment. She explained that she used the program as a "last ditch effort" to try to get him some help before he turned 18.

Tina described how her son was shocked when the police apprehended him from the family home. He was angered and resentful at being PChAD'd, and Tina feels he has never fully forgiven. Following PChAD, her son went to go live with another family member, who Tina believed was not a good influence given their own struggles with substance use. Tina described how her son continued to cycle between periods of abstinence and substance use. He often struggled to hold down a steady job because of his continued use, and even lost the place he was staying at. Tina's son never did come back to live with her, in part because she was concerned about safety and didn't feel she could trust him. Tina thought the impact of PChAD was mainly negative because he refused to engage in any kind of treatment and blocked her from accessing

any of his information. This made Tina feel like she had done something wrong, even though she was just trying the best she could to help her son.

*Jon*

Jon's son was diagnosed with ADHD and ODD. Jon believes his son started using alcohol and cannabis at a young age to help cope with his mental health issues. Later, he began to use illegal drugs such as cocaine and MDMA. Jon described how his son's behavioral issues became increasingly challenging to deal with during this time. Specifically, his son could become verbally and physically abusive, which led to fighting and physical confrontations. Jon also described how his son stole things, broke into houses, and struggled with school. Jon said he tried to place his son into a day program for youth with mental health issues, but that this didn't go over well. He described trying many different services over the years but believed nothing was in place to provide consistent support for them.

Eventually, Jon's son's behavioral issues became so challenging that his mom put up a boundary that he could not be in her house. Jon's son then went to live with his friend who was his connection to illegal drugs. At this point, Jon used PChAD once because he wanted to remove his son this environment because he believed it was very unhealthy. Additionally, Jon described himself as being at "his wit's end" on how to deal with his son's behaviors. He recalled how his son was very angry when he was PChAD'd. However, they had already had so many conflicts that more anger wasn't a large concern for Jon. Jon described how his son was discharged from PChAD without a plan for continued treatment, and soon returned to use drugs at his friend's house. Later, Jon arranged for his son to attend a private, long-term residential treatment program based on the twelve-step model. Jon said that his son completed the program, but didn't believe in the 12 steps and demonstrated limited engagement. His son is now living on his own and says that he is not drinking or smoking and is trying to get his life on track. However, Jon suspects that his son will continue to struggle with substance use

*Claire & Dereck*

I interviewed Claire and Dereck separately about their experience using PChAD once for their son. Claire provided a detailed description of the circumstances that led them to use PChAD, but she was less familiar with the PChAD program itself and suggested I talk to Dereck to learn more. She explained that Derek was very knowledgeable about the PChAD program and “the system” in general.

Dereck described how their son had a stable upbringing. He said he was smart, had an outgoing personality, and was very popular among his peers. He also tended to be a risk taker and “loved getting into trouble.” He started using cannabis at a young age. While Dereck and Claire were concerned, they didn’t think it was a serious addiction problem. However, their son developed some mental health issues after their separation. He also started misusing his ADHD medications by crushing and snorting them. Eventually, he would start to use any substance he could obtain, including methamphetamine, cocaine, cannabis, and inhalants (i.e., commuter cleaners, gasoline). Claire said that when their son hit high school, his drug use became out of control. She said he would frequently not attend class, and would only go to school to buy and use substances. Dereck was also concerned that his physical health was being impacted because he had lost a significant amount of weight.

Claire and Dereck attempted many interventions over the years. They tried to put him in a voluntary detox programs and day treatment programs, but found these were ineffective. Their final effort before PChAD involved placing him in voluntary residential mental health program, which he left after only few days. Claire said he ran away from the facility, stole some over the pharmaceutical medications, and overdosed. Once their son had recovered from the overdose, the mental health program he left refused to take him back because he was considered too high risk for their mandate. As a result, Claire and Dereck felt their only option was PChAD.

Dereck was aware that PChAD often has a limited impact because it is not designed to provide treatment. However, he and Claire still believed it was worth using to keep their son safe temporarily. Indeed, both parents believed that if they didn’t use PChAD, their son might die of an overdose very soon. Additionally, they were also struggling to deal with his behaviors, as he would sometimes become violent, aggressive, and confrontational. Claire and Dereck both described how their son was angered by being PChAD’d, but that they were very relieved to have him safe temporarily. They said the PChAD program itself had a limited impact because he

used immediately after he was discharged. Despite this limitation, it did give them the opportunity to plan for their son to enter a long-term, private, residential treatment program for youth with severe substance use disorders. They were able to transport him to this treatment center a few days after he was discharged from PChAD. While Claire and Dereck had good experiences with this residential treatment program, their son continued to struggle with substance use. Specifically, Claire described how he ran away from the residential treatment program a few times and relapsed. Even when he finally completed the program, he again relapsed and had to return to the center for more treatment. Claire says that he is now back home with them, and continues to cycle between periods of abstinence and substance use.

### *Jamie*

Jamie's described her daughter as struggling with mental health issues, including low self-worth. She believes her daughter eventually started using substances to cope. However, Jamie had found it very difficult to find services that could provide adequate diagnosis and treatment. Jamie first heard of PChAD when it was suggested by a police officer who had come to the family home. The police had come when Jamie called 911 because of a physical confrontation she had had with her daughter. Specifically, her daughter had tried to sneak out at night, and she had physically tried to prevent her from leaving. On the advice of the police officer, Jamie applied for a PChAD order, hoping that she could use it to deter her daughter from continuing to use substances. At this point, she was concerned her daughter had been using MDMA and cocaine and she wanted to "head it off" before her substance use got any worse. However, Jamie did not end up using this PChAD order.

Eventually, Jamie obtained another PChAD order and used it because her daughter refused to come home from a friend's house where she had been staying, and Jamie wanted to remove her from this environment. While Jamie appreciated having her daughter safe temporarily, she was ultimately disappointed with PChAD and thought it was too short to have a lasting impact. In fact, Jamie said that her daughter's substance use escalated after she used PChAD because she met other peers who she could use drugs with. Jamie also thought her daughter became "sneakier" after PChAD and worked harder to hide her drug use. Following

PChAD, Jamie also used secure care services through PSECA and children's services. However, when her daughter was eventually discharged from these programs, she soon resumed her substance use. Moreover, after PSECA Jamie said her daughter was introduced to methamphetamine by a girl she had met in the program. Jamie described the "last stop" for her daughter as being a private, long-term residential treatment program for youth with severe substance use disorders. Although Jamie had a positive experience with this treatment center, her daughter overdosed and died after completing it.

### **Personal reflections on interviewing and analysis**

Overall, I was very moved by the stories these parents shared with me. I felt honored that parents shared very intimate details of their hopes, disappointments, grief, and struggles. I did my best to hold space for the parents, and ended up leaning on my counselling skills such as using reflections to convey empathy.

One issue that that I found challenging with this research was that my philosophical position towards substance use was sometimes very different from the parents. For instance, some parents viewed abstinence-based interventions as the only appropriate option to address substance use and often advocated for longer-term involuntary treatment, which is a recommendation I disagreed with on both empirical and ethical grounds. As an IPA analyst, I sought to describe these perspectives phenomenologically while offering my interpretive comments to illuminate the perspective. Specifically, I sought to understand the reason why parents thought involuntary care was needed. However, in the discussion I contextualized the parents' perspectives by explaining that compulsory treatment is highly controversial from a human rights perspective and there is little evidence that is effective.

Similarly, some parents described parenting strategies that I thought were counterproductive based on my experience as a youth worker. For instance, some parents described trying to physically prevent kids from leaving the house or attempting to forcibly remove them from where they were staying. When a questionable parenting practice emerged, I interpreted this as further evidence that parents were desperate to help their children but sometimes were ill-equipped to deal with their child's complex behavioral needs. Thus, I concluded that parents needed much greater levels of support, guidance, and education. In

general, I was very troubled by how parent felt lost, helpless, and unsupported as their child's behavior and substance use problems escalated. I remembered back to when I was a youth worker with several high-risk youth in government care, and how we had a team of professionals who would meet with us to offer guidance and expert strategies. In some meetings, we had social workers, psychiatrists, counsellors, and probation officers. While there were no magic solutions, it felt good to know that we had a full support team to rely on. In an ideal system, I think that parents who are dealing with their own high-risk children would receive a similar level of coordinated professional support and guidance.

### **Chapter 3: Findings**

#### **Superordinate Theme 1: Parents struggling to help child**

Prior to using PChAD, parents struggled to help their child because they lacked guidance on how to deal with their child's complex behavioral and mental health challenges. They had difficulty finding and accessing appropriate services, which left them feeling lost, helpless, and desperate. Eventually, these feelings of desperation led them to try using PChAD to find help for their child. However, many parents continued to struggle with the PChAD application. They often feeling intimidated, ashamed, and unsupported as they explained to the judge why they thought PChAD was necessary. Some parents also struggled with the execution of the PChAD order, which requires parents to coordinate with the police to locate and apprehend their child.

##### *Theme 1: Struggling to find help*

In general, parents struggled to find the right services for their Child. They felt that they had little guidance with this process and had to navigate the complex system on their own. Jamie felt the constant searching for services was time consuming and exacerbated the stress of managing her daughter's complex needs and other parenting responsibilities.

“I was Googling. I was searching. I was calling. I was doing everything. So now not only are you dealing with a child who's an addict, who's a child and you have other kids and other things going on, and at the time I'm working full time. Plus, I have to figure out what the next step is for my child who is struggling. It was a really stressful time.”

(Jamie)

Many parents have little knowledge of mental health and addictions, so it is challenging to find what services match their child's needs. The high number of disconnected services means that parents must spend considerable time and effort learning what is available and calling various services providers. Tracy felt overwhelmed with the high number of programs she had to search through. She was often frustrated because she was redirected to different services multiple times.

“Parents don't have a clue. And there's so much out there that it's so hard reading through the mental health system. It's a nightmare. Everywhere you go, you get a stack of pamphlets. A stack of phone numbers and it becomes overwhelming. Usually when you phone one it's like, nope, this is where you need to call, and then it's like nope” (Tracy)

Several parents had an especially difficult time finding services for youth with co-occurring addiction and mental health issues. Service providers typically had a mandate for either addiction or mental health issues, but rarely both. Parents felt it would be much easier to get help if providers “treated the person as a whole” in one place instead of having this dichotomy.

“Any sort of addiction service, they're too segregated right? So, if you're suffering from mental health you go over here and wait six months to get in, addiction you go over here and you wait six months and they don't collaborate, like you can't get them treated at the same place. And they go hand-in-hand... I think it needs to be a holistic approach where you're dealing with the individual as a whole, not well, this is just his addiction.” (Daisy)

As their child's problems escalated, parents became more and more desperate to find help. Parents described reaching out to many different providers for assistance, including hospital physicians, social services, and police. These parents felt that no one was able to provide support that matched their needs, which left them feeling lost and helpless. When Lily took her daughter into the emergency department to have an infection related to injection drug use treated, she pleaded with a physician to admit her daughter to the psychiatric ward. The physician could

not admit her child involuntarily or share information about her daughter for confidentiality reasons. For Lily, this was one case among many in which a service provider was unable to provide any help or guidance.

“I had no support from the doctor there. No support from the medi-center doctors, zero support from the system. I had called many, many social services organisations, Alberta health services to try and help me, AADAC [Alberta Alcohol and Drug Commission] to try and help me. You know, the only thing AADAC was able to do was make family counselling available to us, which we did a couple of times, but she never showed. So that didn't help us either. And so, I was like completely lost with zero help at all.” (Lily)

Similarly, Cassandra felt like she had tried everything to help her child. She explained that she had gone to “social services” and asked to have her child taken into care, but was told this was not appropriate for her situation. Cassandra had also requested to health providers that her son receive “mandated” treatment, which is what she believed was needed at time. Cassandra was again told that this was not possible, but was not provided guidance to the appropriate services for her needs. As with other parents, she was frequently left feeling disappointed and helpless because she did not know what could be done to help her child. “It was always said, you know, we can't, you know, we can't lock up the kid. We can't this. We can't that, you know. I was just, I guess, helplessness, you know?” (Cassandra)

### *Theme 2: Parents used PChAD out of desperation*

For most parents, the decision to use PChAD was driven by a sense of desperation, which resulted from several different factors. Parents reported having conflicts and confrontations with their child, and finding their complex behavioral and mental health problems increasingly difficult to manage on their own. Often the voluntary treatments that they had tried did not work for their child, or their child was unwilling to attend abstinence-based voluntary treatment. As they became more desperate to help their child, some parents were willing to try any program that was available to them. Daisy described feeling like she was “grasping at straws” trying to find any program that might help. She feels that parents may think PChAD is effective because it is available, even though it is not a perfect solution and may have little impact.

“You have to realize a family's mindset at the time if you're going to go through all those hoops. Your child needs help. And, you're at that point grasping at straws. And, so maybe

this [PChAD] isn't the perfect thing, but you think oh, it just might help. But I really don't think it does. And, so even if it's, I guess my point is it's available, so families might think that it will help.” (Daisy)

Parents’ sense of desperation was largely driven by their fear and concern for the child’s well-being. Many perceived their child as being at high risk of overdose death given the toxic illegal drug supply in Alberta. Upon discovering PChAD, some parents decided it was worth trying because it was an option that was offered in a time of desperation. For Diane, the fact that PChAD was offered by the government led her to believe it might help, which gave her a sense of hope.

“It was something that was offered to me, in a desperate situation, and it, and it felt like hope, it felt like, okay, I have this, the government is giving me permission to do a PChAD against his will. And let's, let's try this. Let's, because as a parent, you're desperate. You're desperate in those times. You want your child to not damage their brain, their lives, you know, death, whatever. And at that time, you know, he was using meth or fentanyl, you know nowadays, it's like life or death. But it, it was something that was offered to try.” (Diane)

For some parents, the risk of overdose was perceived as so imminent that PChAD was worth using to just keep their child safe temporarily while they figure out a more long-term solution. These parents felt PChAD was the only option to rescue their child at this time given that their child would not consent to the voluntary services they had previously tried to persuade him to participate in.

“And he [my partner] said, all I can think of right now is PChAD. I don't know what we're going to do after but it buys us 10 to 14 days of knowing he's not going to die. And at that point in time, we were just desperate and terrified and knowing that his using, just was escalating to ridiculous levels and any anything we had tried had failed, because you need his consent, right?” (Claire)

Parents were also worried for their child’s safety because they had left home for extended periods while they were using substances. During these periods, some parents did not know their child’s location and had little connection or communication with their child. Lili described

frantically trying to locate her daughter when she left home through any means necessary, including using phone records to track her location. She was only able to connect with her daughter when she became involved in the criminal justice system.

“We had literally no connection with her at all. I didn't know where she was living. All I had, you know, to connect with her was her cell phone, which, you know, was in my name. And so I could check calls she made to and from where she was calling. But I really couldn't pinpoint her location. And so, we spent a frantic probably six months before, we finally connected with her. And the only reason we finally did connect with her was she was in a hit and run.” (Lily)

Other parents were concerned that their child was spending time in unsafe environments such as “drug houses” where they associated with adults who used drugs.

“He was small and in the most dangerous part of town. And he would talk about being outside, I forget the name of it, it's some bar that's... you know, a scary place. And he also would use with a friend who lived across the street from a trap house, and they found themselves in that trap house, we thought it was once, but he was probably in there quite regularly.” (Dereck)

Many parents were concerned by how substance use was negatively impacting their child's academic, recreational, and social functioning. Tina was concerned that her son was frequently going missing and his academic functioning was being impacted. She resorted to PChAD because she felt like she was running out of time to intervene while he was still a minor.

“He was skipping school and you know involved in drugs, and I needed another way to, a last ditch effort to, try to get him some help. He was 17, so I kind of felt like I was running out of time before he turned into an adult... He was skipping school, not coming home at night, running away. Just general chaos. Not being a healthy teenager.” (Tina)

Finally, several parents wanted to remove their children from situations in which they were being exploited by adults. Some were concerned that their children were being sexually exploited, such as by adults who offered drugs or money for sex. Indeed, four parents in this study also sought services from the PSECA (Protection for Sexually Exploited Children), which is a program in Alberta that allows for up to 47 days of confinement of children under 18 who

are “sexually exploited through their involvement in prostitution” (table 1). For some parents, sexual exploitation was part of the motivation to use PChAD as well.

“There was a lot of other stuff going on with him, too. He was being groomed by a sixty-five-year-old man that he met online who was, buying him drugs, sending him upwards of a thousand dollars a week in cash. All kinds of things like that were going on.” (Tracy)

In another case, James was concerned his young daughter was being exploited into working for a drug dealer.

“We didn't know where she was and she was in a drug house in west Edmonton, and she was selling and using, at 13. And, you know, I asked her about that, because we were really careful with money. We would get were gift cards, just limited amounts. And she said hey, you know, I ran drugs from a car to a mall and made three hundred bucks in one night. You know, at thirteen.” (James)

### *Theme 3: Parents struggled with PChAD order application*

Parents reported struggling with several different aspects of obtaining and executing the PChAD order. Some parents felt that this overall process was unnecessarily onerous, especially during a time of crisis. Several parents complained that the process required them to make one in-person visit for the pre-application information session, followed by at least two more visits to the courts. This was difficult for parents who worked full-time or lived in a rural area. Emily acknowledged that it was necessary to ensure parents are using the program appropriately. However, she also thought that PChAD should be easier to access given the urgency of the situation many parents face.

“It just seemed like a waste of time. Like, I don't know what, like if a lot of parents make this shit up and just use it as a control move on their kid. Because I get taking away someone's rights is a serious thing. But I feel like, especially if you're kids using opiates, this is just something that doesn't need to happen. I don't know if it's still the process now, but it just seemed there were so- then we had to go to court, that he had to get a date, then he had to come back. It just seems really insensitive to families.” (Emily)

Other parents spoke positively of their experience with the preapplication information session. Several parents appreciated being able to share their story with a supportive and encouraging counsellor, who then helped them prepare the necessary paperwork. “Everybody there, that part of the program, they were so nice... They were very encouraging and very helpful with the paperwork. And that was very positive. The paperwork was pretty straightforward.” (Amy)

Many parents struggled with defending their PChAD application in court in front of a judge. Parents experienced this process as humiliating because they had to describe intimate details of their family issues in front of a courtroom full of strangers. Parents reported that they felt judged as parents because of the stigma associated with substance use problems. Some parents also felt defensive or disrespected because the judge was questioning whether they really needed PChAD. All this was the case for Lily, who described feeling judged for her parenting abilities and stigmatized like a criminal. The humiliation she experienced in court compounded the feelings of shame she already had from having to use PChAD.

**“Lily:** The worst part of it was the feeling that the judge was actually judging me, and asking me questions like, well, how do you know that she's, you know, using drugs? And how do you, why do you feel that you need to use this protection order? I thought that's spending the two hours with the, you know, uh addiction services counsellor at the time. Giving them all that information would have warranted enough for me to get in front of a judge and have some sympathy, and be treated like a human being, instead of, of a criminal. Because I felt like the judge was pretty much, you know, treating me as like, you know, innocent until proven guilty, like I had to prove myself. As to why I wanted this protection order against my child.

**Interviewer:** You had to defend your case.

**Lily:** Yes, and that was brutal. I mean, it was more than brutal. I can't even explain what it was because, you know, you're feeling really down about having to make this decision in the first place. And then you have to go up in front of the judge, swear on the Bible, in front of all of these people that you don't know, and virtually air your dirty laundry.”

Similarly, parents often described feeling very alone and unprepared for the court process. Some parents wished that they had some sort of advocate or support to help them manage the court process. Jon described how he felt there was a disconnect between himself and the judge. Whereas Jon was in an emotionally vulnerable state in which he was seeking support for a health and social issue, the Judge's role was to provide a dispassionate interpretation of the law.

“I wish perhaps that we had some kind of support in place. Someone from, Alberta Health Services. That knew how it worked. That would be there with us. Perhaps a lawyer? I don't know. That would have just been able to emotionally prepare us for being there. How the process would work... because it's like, there's nothing. It's the judge, and the judge isn't there to be emotional, or care or anything. They're just from a legal perspective. And so there's no bridge, I guess, you know, between where we're at and where the judges at. There's nothing in between that brings us together.” (Jon)

There were a few notable exceptions to these negative PChAD application experiences. A few parents successfully managed the court process on their own and thought the court was responsive to their needs. In one case, Cassandra described how the judge respectfully cleared the courtroom so that she could speak privately.

“I went in and handwrote, I guess I don't know the document or whatever that goes into the judge. And handed it over to them and they took it into the judge. And, and honestly, the judge is a family court judge, I believe. He even stopped the court proceedings and cleared the courtroom and brought me in by myself, and granted it. So I was pretty impressed at that time. I was surprised, honestly, that it went as well as it did.”  
(Cassandra)

Once the PChAD order was granted, some parents had difficulty executing the order. For some parents, a PChAD bed was not immediately available and they were concerned that one may not become available before the PChAD order expired. For parents who didn't know the location of their children, it was stressful to have to locate them within the time window that the PChAD order was valid.

“It's stressful because you do get the order and we've never been turned down. But that doesn't mean a thing, right? Because if I'm trying to remember, you only had the order for a certain amount of days, right? Like 30. I'm trying to remember how long it's valid for. So you have to go find the kid, right?” (Evelyn)

Finally, several parents reported that when they called the police to have them apprehend the child, the police were uninformed about the PCHAD program or were reluctant to conduct the apprehension. These parents were frustrated that they had to inform the police that it was their role to execute the apprehension and felt like they had to convince them to do their jobs. Amy expressed that she would have liked to have more support communicating with the police.

“It would have been nice to have a little more support in that end, because the police, in my experience, they just acted like it was like, we gotta go to do this. Like it was an inconvenience for them, absolutely would be how I would explain it. It was it was never a welcome job for them to do, ever. And that was the worst part of it.” (Amy)

## **Superordinate theme 2: Parent involvement is critical**

Parents expressed that their child's substance use was a family issue and that the parents needed to be involved in treatment. At the start of the process, parents needed help understanding PChAD services and what they could realistically expect. When their child was in PChAD, parents appreciated the opportunity to have visits and family counselling sessions with their child. However, in other cases parents felt isolated from their child's care because their child was not willing to cooperate with them and they felt like the PCHAD staff did not adequately communicate to them what had happened. The PChAD confidentiality policy meant that youth could choose to withhold their personal information from parents. For some parents this was frustrating because they felt they did not have sufficient information to plan their child's care moving forward. Similarly, many parents were very disappointed that PChAD staff did not offer more guidance in developing a plan for their child's care after PChAD. Parents stated that even if youth were unwilling to pursue further voluntary treatment, they needed guidance on how to best care for them moving forward.

*Theme 4: Parent expectations need clarifying*

Parents expressed needing a clear explanation about what services PChAD provides and what outcomes they should expect. James used PChAD multiple times, and appreciated that both the pre-application counsellor and a judge frankly explained that PChAD was not a long-term solution to his daughter's substance use disorder. Initially he wasn't sure what to expect, so he was grateful that his expectations about what PChAD could accomplish were realistically adjusted.

“We didn't know what to expect. But she [the pre-application counsellor] said, “you know, she's just going to detox and we're really not going to be able to do very much. And then we're going make some referrals at the end.” And I'm really glad that she told us that because, you know, I think a lot of parents think this is a fix...

One of the judges and I've forgotten his name and I saw quite a few, was pretty good and laid it out and, he said, “you understand, you know, this isn't gonna fix your child.””  
(James)

In contrast, some parents went into PChAD unclear about what services PChAD provided. These parents were frustrated and disappointed when their child simply received detoxification rather than more comprehensive addiction treatment.

“I guess I didn't really think it was just like a detox or whatever. I'm not even sure what I thought it was. I thought it would help my son's addiction. I thought it would lead to better supports that I wasn't able to access otherwise. Yeah, and I'm not sure, like in hindsight, it almost sounds like it was just a place to detox or something like that.”  
(Daisy)

Parent expectations of PChAD varied in other important ways. Some desperate parents simply wanted to keep their child safe temporarily while they planned their next steps, but did not necessarily expect a significant long-term impact. Other parents hoped PChAD would motivate their child to subsequently enter voluntary treatment. For instance, Diane hoped that being apprehended by police and confined in the protective safehouse would be a “wake up call” that

would motivate her son to change his behavior. This approach aligns with the widespread belief that people who use drugs need to “hit bottom” before they can change.

“You know, it's always, you know, is this going to be what it's going to take to wake them up? Is this going to be the rock bottom? Being arrested and, taken away from your family, is this, is this going to be a wake up call? Some, it works for, some it doesn't. So, yeah, of course, you know, we're always, yeah, is this going to, are they going to turn their life around and they're going to be a new kid?” (Diane)

Some parents had heard that multiple PChADs may be necessary. Tracy had been told that if parents are persistent and PChAD their children multiple times, the youth would eventually grow tired of being PChAD'd and agree to seek voluntary abstinence-based treatment.

“Somebody explained to me in the beginning. That PChAD is never going to work the first time. But what they hope is that the first time your kids just going to leave mad, the second time they're going to be like, oh, you know, mom and dad are serious. The next time they might actually calm down enough while they're there to listen to what's being told to them. You know, four or five times they might be like, hey, I'm tired of coming back here, so I'll agree to go do something else.” (Tracy)

Most parents considered PChAD a program to be used as a last resort when other measure had failed. However, a few parents obtained a PChAD order more pre-emptively in hopes that the threat of apprehension and confinement would change their child's behavior. For instance, Jamie obtained a PChAD order to try to deter her daughter from continuing to use substances, even though the judge expressed some disapproval about this usage.

“I was trying to convey [to the judge] that we wanted to have the PChAD order in place in case we needed it. And his response was, well, this isn't something that you just kind of post on your fridge and have it as a deterrent to your child, you know, doing whatever. And I said, why not? If that works, why wouldn't you support that?” (Jamie)

Similarly, at the advice of an addiction counsellor, Tracy once obtained a PChAD order to coerce her son to attend voluntary treatment. In the end she did not actually need to use it.

“He wasn't willing to get help at that point. So at that point, I did get a PChAD order to use as leverage, basically. That either I'm going to PChAD you or you sign up for these weekly appointments. I did that at the advice of the addiction centre.” (Tracy)

*Theme 5: Parents want to be involved in child's care*

As a part of the PChAD program, parents may choose to participate in the treatment process after waiting a few days for youth to stabilize. In general, most parents wanted to connect with their child during PChAD and feel involved with their care. They often felt very grateful and relieved to have the chance to visit their child and reconnect with them after a long period in which they may not have seen or heard from them. Some found the family counselling sessions especially helpful for facilitating communication about their child's struggles. These parents thought that family counselling was one of the most important aspects of PChAD and should be required for all parents when possible.

Rose felt like her daughter was acting more like herself and was willing to have conversations, which meant that the family counselling was productive during PChAD

“During that 10 days, we talked a lot every single day. And I went and visited her once for sure, maybe twice. And she was yeah, completely open hearted and chit chatty and, she talked about her life and then she was also telling me how she was enjoying helping the other kids in the program. She's back to her sort of way...

We did that counselling thing. I went in there. And, I can't remember all the details of the conversation but it felt really good. Like she was really open. She wasn't sitting there like a stone. It just never really has been that way. She was very chatty.” (Rose)

However, several other parents found that their child was unwilling to cooperate with them and was resistant to any kind of counselling because they were angry about having been apprehended and confined.

“They tried to have a family counselling session, but the first one they did, she wasn't, she didn't want to do it. The second one we did meet on the Saturday before she was

dismissed on the Sunday. It didn't go well. She was very angry with us. And, so that didn't go well.” (Lily)

Several parents also appreciated communication from PChAD staff because it made them feel included with their child’s care. They were grateful when staff provided general updates about their children, especially at the beginning of the PChAD while they were asked to wait a few days before visiting their child. Cassandra appreciated updates even if staff couldn’t provide specific details because of the confidentiality policy.

“They would speak to me and let me know, you know, that he was okay or whatever during the time I wasn't allowed to communicate with him. You know, so it wasn't dropping him off and, you know, we'll see you whenever. They spoke to me, they didn't, I remember they wouldn't release any information unless he said it was okay... It was very confidential, which I thought was good. Because, you know, probably a lot of them don't want their parents to know stuff that they've done. And that's okay.” (Cassandra)

However, other parents expressed frustration with poor communication from PChAD staff and the youth confidentiality policy. Several parents said they didn’t know their child’s location or what services they were receiving. This lack of updates and information left parents feeling removed from their child’s care. Parents felt especially disconnected if their child chose not to share more specific information with them.

“You don't know where they're taking them, you know communication wasn't great. And then like I said there's that confidentiality it just, I felt like, he's my child I should have been part of the treatment right... I felt horrible. We found out after a while where the location was that he was being sent. I think he phoned us once. We were able to go down and visit him once. But they didn't really tell us what they were doing with him and then he was not collaborative as well.” (Daisy)

#### *Theme 6: Parents need greater support with discharge planning*

Most parents in this study were dissatisfied with the level of service they received for planning their child’s care after PChAD. Parents expressed that there should be some sort of program that

comes after PChAD because it didn't make sense for PChAD to simply send the child home with them without any follow-up or support services.

“It's a 10 day take them off the streets thing. And then what? There's nothing mandatory after. There's nothing. There's no continuous. They, they don't call a check on you. It's just it's nothing... you know, what options are available to them? I don't think there's a lot of youth programs like there are adult programs. So, then that child comes back home and now the parent is having to deal with what? You know? Something needs to be there to support them” (Rose)

Parents felt that they were mainly responsible for finding appropriate services for their child. However, many found navigating the myriad mental health and addiction services was challenging at the best of times, and even more difficult while their child was in PChAD because they were stressed and overwhelmed.

“Any kind of advocating to put her into a different program had to come from us. It was never the, the program. Saying, Oh, I think, you know, this is a really good fit. I mean, they would mention things, but for us, it wasn't that they would do it. We would have to do it, right? Yeah, so when you're like, stressed out to the max, that's hard.” (Tracy)

Some parents were frustrated that they were expected to find program options for their child, because the whole reason they had used PChAD in the first place was because they felt they were out of options. Jon described that he was already at his “wit's end” when he used PChAD because all the services he had tried previously hadn't worked. He needed more help trying to find services that could meet his son's needs.

“I wish there was more support after the PChAD expired. So, perhaps you know, the PChAD process can be connected to some kind of a program that helped. Because I mean obviously, they got to think, when you're at the PChAD point. In my head, you're at your wits end. And there wasn't really anything in place after that, through the system that helped us get further help for [my son].” (Jon)

Some parents mentioned that it was difficult to plan their child's care because of the PChAD confidentiality policy, which allows children to withhold personal information from their parents. Consequently, these parents felt they didn't have enough information to know what kind

of treatment or programs were appropriate for their child. Lily described how PChAD provided her daughter with a report with recommendations, but because these recommendations were not shared with her, she did not know what to do to help her daughter.

“They gave her a report, with some things that she needed to follow. But that report was not made available to us. It was only made available to her because of confidentiality reasons. And then she was to provide us with, that report to her parents. So, again, you know, we're kind of left in the dark without any clear direction or clear instructions as to how we can help her. What we can do to help her?” (Lily)

Several parents mentioned that even if their child was unwilling to attend a voluntary abstinence-based treatment program, they still need guidance on how to best support them moving forward. These parents thought PChAD should offer services options that would potentially be acceptable for youth who are not ready to stop using substances. For Amy, it was important to have her son's mental health addressed even if he was still using substances, because his substance use was related to mental health issues.

“I think where it could improve is... more options and resources when during those 10 days that, you know, okay, well, maybe we there's no treatment center. He's not ready for treatment. Okay, this is plan B. Like what about having mental health assessments done, that kind of stuff? Because mental health does not come into play until I demanded it. Many years later, right? And that's a huge part of the issue here” (Amy)

A few parents also mentioned that access to services such as housing or harm reduction was important if youth continued to use substances. For example, because it was no longer tenable for Diane's son to live with her, they accessed housing that offered harm reduction services for youth. The Supervised Consumption Service in Calgary was also a valuable support for Diane's son.

“He does have housing. And again, it took me a long time to find this resource, harm reduction housing in Calgary. He has a place there, they're bachelor suites? And it is staffed and they have saved his life, every time he overdoses on fentanyl, they have administered naloxone and saved him. He has used the safe consumption site at the

Sheldon Schumir. They've saved his life as well several times. And so that has been a valuable resource. It's keeping him alive.” (Diane)

*Theme 7: Parents need ongoing guidance, education, and support*

Parents described needing more education about substances and addiction. Many describe how they knew very little around the time that they use PChAD and have since learned a lot of critical information they wish they had known earlier. In particular, most parents said they needed practical guidance, such as how to set boundaries, how to effectively handle conflict, whether to give their child money, and how to generally care for a youth who is struggling with mental health and addiction.

After she used PChAD, Tracy did attend a series of five weekly drug education classes provided by AHS that mainly taught parents about various classes of drugs and their effects. While she thought these were helpful, she described needing more practical knowledge such as how to set boundaries and parenting strategies to manage her son’s chaotic behavior. Tracy expressed that it was difficult to find parenting information herself during this time when she was overwhelmed with stress.

“I think maybe offering some more. More like boundaries and parents, how to handle your kids. How to handle the chaos... I think so many parents and I know myself, I didn't know a lot about addiction at all. At the time, my life was upside down. Like, you're in chaos if you're at that point where you're PChADing your kid. You are. You're just stressed beyond, you know, like that you can barely think. Life is not probably good at home. Obviously, there's information out there I could Google and figure out, OK, what how do I need to be with him? How do I set boundaries?” (Tracy)

Likewise, Amy believes that it is important to educate parents on how to care for their child over the long-term. Amy thinks that parents should be taught to manage a child’s substance use disorder like other chronic health conditions such as asthma or diabetes. As an example, she thinks parents should know that long-term Opioid Agonist Treatment is necessary for many individuals with Opioid Use Disorder.

“He wasn't ready to get help, you know, he's twenty five and most days now he's still not ready to get help right? so, I mean, the reality is not everybody's going to just use and [then], you know, get better. They're going to either have to go on Suboxone or something or, you know. And whatever it may be for them. And like, we need to start educating parents. Like treating it like when, for example, when my son as an asthmatic, when he was a baby, I had to go through a course that.” (Amy)

Parents also said that they needed this guidance and support to continue beyond PChAD. In general, parents were often frustrated that there was no follow up or continuity of support for them after PChAD. In some cases, parents who received initial safety planning in PChAD said it was not long before they needed further guidance because their circumstances changed or their child's problems escalated.

“That was another issue right after PChAD. I mean, they try to set you up with the plan, the safety plan. But if your child escalates their substance use. What's the next step? Right. Like... OK, we did our ten days. We're good. Your child's stable. No, not even close. So after 10 days, she wasn't stable, whatever that means, and you were left looking for other programs.” (Jamie)

Several parents suggested that having a consistent counsellor or caseworker to provide ongoing guidance and connection to services would have been helpful. James suggested an advocate should follow-up with parents who have used PChAD to facilitate connections to further supports if needed. He thought this would be especially beneficial for parents who don't have the resources or education to search for appropriate services themselves.

“If there was an advocate, an AHS or some other advocate, it could be a volunteer group or whatever, that would just say, okay, so you've gone through this process, first time your kid's in PChAD. Phone call [the] parents and say, look, I want to work through this process with you, okay. I want to be your advocate. I want to be there to support. Just that one contact that could point them at all and encourage them. That would be really helpful... Some parents have very few resources and limited education. They just don't know.” (James)

Additionally, parents described how they needed help coping with the stress and chaos of dealing with their child's substance use during this time. Often, their stress was exacerbated by feelings of guilt and isolation related to the stigma of drug use and addiction. For many parents, parent support groups were extremely valuable for learning to cope with these circumstances and to receive ongoing guidance and emotional support. Several parents strongly recommended that PChAD staff connect all parents who use PChAD to parent support groups.

For instance, because Tina initially felt alone in her struggle, she appreciated finding a sense of community and belonging among parents dealing with similar issues. She remarked that these parent support groups were unfortunately very difficult for her to find initially.

“I did the AADAC parent route, and I've been going to counseling for years on how to deal with this. I did, did the Al-Anon thing, I've gone to AA meetings. I guess what it comes down to is community. And having support, from like minded people, from community. Once you can find them, that was my greatest challenge when my son was younger is I did not know where to find these people.” (Tina)

Similarly, Claire was very grateful for Twelve-Step group therapy for parents because they taught her practical parenting and coping strategies. These groups also helped alleviate her sense of guilt and responsibility for her son's substance use disorder.

“So we learned a lot. And I get it now. I get it a lot more than I did when I was just fearful and scrambling at the outset. That's what my piece is and what I need to do for me and how I can't control them. I can't cure him. I didn't cause it. All of these things... I think it saved all of our lives. To be quite honest. What I learned and gained from cause the parents have to do twelve steps. Well, Al-anon and figuring out how everything plays together and my role and how to take care of me and the disease like it was our first time, wide-eyed. I had so much to learn and grow. And yeah, pretty grateful.” (Claire)

### **Superordinate theme 3: PChAD had little lasting impact**

Almost all parents agreed that PChAD had little impact on their child other than keeping them safe for 10-days. Some parents were very grateful that PChAD kept their child for 10 days

because it gave them a reprieve to know their child was safe as well as an opportunity to make a plan for their child's care. Other parents stated that giving parents a break should not be the goal of PChAD and that the program wasn't worth using unless it helped the child beyond the 10-day period. Several parents expressed wanting PChAD to do more than just temporary stabilization and detoxification. For instance, some thought that PCHAD should incorporate more therapeutic interventions. Others thought long-term involuntary programming was necessary and ethically justified.

*Theme 8: PChAD had little impact on youth's substance use*

Almost all parents in this study agreed that PCHAD had little impact on their child's substance use besides keeping them alive for 10 to 15 days. Indeed, many parents reported that their child left home and resumed using substances shortly after leaving PChAD. Emily was angry and disappointed that her son had resumed using substances so quickly.

“He was gone the next day. He left, came back, high as, everything could be high. It was a joke. The only thing I felt I could say was, well, I kept him alive for 10 more days.”  
(Emily).

Parents had various perceptions about why PChAD had little impact beyond the 10-day program. Several parents thought that PChAD provided little therapeutic intervention and simply held their children for 10-days.

“So far as the program went, I don't even actually see much as a programme so much as the detention centre really. Yeah, they go and they have this mandatory class in there but the rest it's time to just sit around playing video games.” (Rose)

Many parents also felt that PCHAD could not realistically impact their child's addiction or motivation to change in such a short period. Some parents thought that because youth spent much of the time in PChAD withdrawing from drugs, there was often limited time to engage them in any kind of counselling or treatment. Others felt that because addiction is such a complex phenomenon that is often related to trauma and mental illness, a 10-15 day program could have little impact unless there was another program afterwards. James's daughter had been

adopted and struggled with several mental health issues, including a sense of rejection that came with growing up as an Indigenous youth in a white settler community. For James, these issues were clearly too complex to be addressed in PChAD.

“She has lots of First Nations friends in the north, since she was really young and, but still that sense of identity, feeling rejected. Along with the mental health, fetal alcohol, and then all of the markers that would identify her as being high risk for addictions, right? So she has you know, she was born with a lot of challenges. And you know, I talked to other parents, too, and you know, not unusual for adoptive kids. Certainly, lots of fetal alcohol there, mental health issues. And so the reality is for PChAD to be a fix-it's not, when it's so complicated.” (James)

Some parent described how their child was just not yet ready or willing to reduce their substance use. This was often evident because youth were angry with parents and resistant to attempts to control their behavior. Diane's son was angry at being confined and uncooperative with parents when they visited him in PChAD.

“We did, we were able to go visit. But he was, you know, why did you do this to me? Why did you do this? This isn't gonna help Mom. And then of course when he comes home he's just mad. So he just starts using again.” (Diane)

Similarly, other parents perceived that when they went to meet with their child and PChAD staff, their youth was simply “saying what everyone wanted to hear” but was not genuinely motivated to reduce their substance use. This was the case for Cassandra, whose initial optimism quickly turned to disappointment when things returned to normal for her son after PChAD.

“Originally, I was really comfortable with it. You know, when I went and, you know, I guess he blows smoke up everybody's ass and tells them, you know, what they want to hear and, you know, comes home in a couple days. Things are all right, and then it's all back to normal right? Or what his normal is. But yeah when I had originally picked him up, I guess I had a lot of false hope” (Cassandra)

The objective of PChAD is not to provide treatment per se, but to stabilize the youth so that they can be discharged into a system of voluntary treatment. Several parents in this study described how PChAD did provide an opportunity to plan for their child to attend a voluntary treatment

program. However, even when parents managed to connect their children with voluntary programs, there was still no guarantee that their child would be willing or able to remain abstinent. In some cases, the youth was only at the beginning of a long-term journey in which substance use in which abstinence-based approaches did not work for them. For instance, voluntary residential treatment was never a workable solution for Amy's son.

“The second time [using PChAD] I made arrangements or second and third times he went into some sort of treatment for youth after, but, you know, it never lasted for him. It never. You know, as soon as he could get out or it was, he was gone.” (Amy)

*Theme 9: parents relieved to have child safe temporarily*

Many parents expressed that PChAD provided a period of relief in which they at least knew their child would be kept safe. These parents were grateful that PChAD gave them a break from the constant stress and provided an opportunity to figure out the next steps for how to help their child. For some parents, it was worth using PChAD to keep their child temporarily safe even though it may have been a negative experience for their child and the long-term impact was limited.

“And I am so grateful because honestly, I know it wasn't positive for him. It wasn't positive [for our] relationship. It wasn't rehab. It wasn't anything. But it gave us the space we needed to figure out our plan and kept him alive.” (Claire)

Similarly, some parents were also thankful that PChAD also forced their child to “take a break” from using drugs and have their physical health needs addressed.

“By the end of the 10 days, I think she, you know, she didn't look very good either. Like she looked a little better [by the end of PChAD]. Like I could tell that she had a little bit of rest, maybe” (Jamie)

However, other parents thought that having a temporary reprieve was not worth the risks of PChAD, and that PChAD was only worth using if it actually helped their child beyond the 10-15

day program. Lily felt that the only true relief would be if her daughter was healthy and connected with family again, rather than just being confined temporarily.

“It should not be a reprieve. A reprieve should be that your child is healthy. And a member of your family again... I will say that having her there actually, you know, gave me some solace in the fact that I knew that she was in a quote unquote, "safe place." But that's not the reason for the PChAD. And that's not why I did it. I did so that I could try and get her some help.” (Lily)

#### *Theme 10: Parents want involuntary treatment*

Parents wanted PChAD to be longer and offer more therapeutic interventions. In general, many parents reasoned that addiction was the result of mental illness and other underlying issues such as grief and trauma, and that PChAD currently does nothing to address these “root causes.” Therefore, some parents thought that PChAD should be longer so that there would be time to engage youth in more therapeutic interventions. “I just think it needs to be, a longer program where they start actually looking at some of the reasons behind why these kids are where they're at.” (Jamie)

Most parents agreed that 10 days was too short to make any real progress in addressing a child’s mental health or addictions. However, there were varying ideas about how long it needed to be. Some parents suggested PChAD only needed to be slightly longer, such as two weeks to a month. “I don't think that ten days ever could be enough to help these kids. I think a month and you're getting somewhere and then you better have a good aftercare plan, is just my opinion.” (Amy)

However, several parents felt strongly that even longer-term involuntary treatment options, such as 6 to 12 months, were necessary and ethically justifiable. In general, these parents believed that youth who use substances do not have the mental capacity to make treatment decisions in their own best interest. This lack of capacity was believed to result from the impairing effects of a substance use disorder, the developing adolescent brain, and mental health issues.

“His impulse control was not good, so and then you put the drug cravings in there and everything else. And the teenage stupidity. That was always my argument, that you're letting a kid with an underdeveloped brain, drug addiction and mental illness you know, make life altering decisions.” (Tracy)

In Tracy's case, she had also accessed 30-day secure care services through the Child, Youth, and Family enhancement act in Alberta, which allows children under 16 years to be secured if they are the subject of a guardianship order through Children's services or if the parents enter into a voluntary family enhancement agreement. Tracy thought that even a 30-day secure care order was not long enough to stabilize her son on medications and teach him alternative coping strategies that would presumably have allowed him to abstain from substance use. She suggested that 6-months might be a more realistic timeframe for this process.

“By the time he detoxed and slept and ate and you know, got back to feeling somewhat normal, getting back on his meds, with some of those meds take up to six weeks to fully take effect. So as he's trying to get that all stabilised, then he's supposed to learn coping skills and everything else so that when he gets out, he can control himself and not run away. So 30 days is just not long enough for him ever. The professionals knew it, we knew it. Children's Services did not ever want to secure him... I feel like the only way we could have got him proper help is if we could have secured him for, say, six months, like for a period of time long enough to get him to a point where he was thinking clearly and could make rational decisions.” (Tracy)

#### **Superordinate theme 4: PChAD has risks**

These themes describe several ways in which parents perceived PChAD negatively impacted their child. Some parents were aware of these risks ahead of time because they had been warned by counsellors or social workers, while others had to learn through experience.

##### *Theme 11: Youth may make negative social connections*

Many parents identified that a significant risk of using PChAD is that youth may connect with that will have a negative influence on them. Parents described how meeting other youth in

PChAD gave their child a place to go when they left home and more opportunities to use substances. In several cases, parents believed that their child's substance use escalated after PChAD because youth they met provided them with a way to access drugs or introduced them to new types of drugs. These risks seemed to be well-known among service providers. Although James had been reassured that this was not supposed to happen, he felt that it was an inevitable risk that was difficult to prevent.

“The challenge with [the PChAD] program is they meet other people. And they are all very similar. And, you know, they're not supposed to connect, but they all do. And so we found that she developed a network of people, mostly in West Edmonton, where she would go and use with and couch surf and be gone.” (James)

In Evelyn's case, she received advice from her daughter's group home staff that using PChAD was not worth the risk of making negative social connections. These service providers recommended that youth should be encouraged to be at home instead of the PChAD protective safehouse.

”Social services, we had a guardianship with them, like we were still her parents, but she lived in places. And they were very much against her going to PChAD because of the type of people that were there. So there was that, feeling going in, and that fear, that she's going to meet worse people there... their whole entire thing was that she should just be at home.” (Evelyn)

### *Theme 12: Parents concerned about dangers of detox*

Several parents expressed concern about the physical impact of “detox” on their children. These parents had learned that rapid detox from opioids could increase the risk of overdose following PChAD if youth resumed using opioid due to loss of tolerance. Lily describes how she was initially unaware that detox can increase risk of overdose and feels angry that she was not informed earlier. She believes that PChAD may have contributed to her daughter's overdose death, which occurred a few months after using PChAD. This possibility is a source of profound regret and sadness for Lily.

“I really did not know what detox meant. Because it was foreign to me. I didn't know the process of addiction. I didn't know, you know... that detox is an actually, a very dangerous, depending on the type of drug that the person is detoxing from can be very dangerous procedure. So I was completely unaware of that. So I essentially went into this with, kind of, I mean, I know I have to take responsibility and I do that. I have to do that every day because, I mean, I lost my daughter. But, at the time, given what I knew um, and what it was informed to me, it wasn't a good decision to make. And, you know, I have to live with that for the rest of my life.” (Lily)

*Theme 13: Anger, trauma, and damaged relationships*

Several of the police apprehensions occurred at the family home and were witnessed by the parent. In some cases, the child experienced the apprehension as shocking, confusing, and traumatizing. Even though parents believed they were using PChAD to help their child, seeing their child apprehended was still very upsetting for them. Diane clearly remembers the sense of fear, hurt, and betrayal that her son seemed to experience when the RCMP arrived at their home.

“I can to this day, picture the look on his face when he realized the RCMP pulled up to arrest him. He was like, you know, they go into that fight or flight, right? And, he's not understanding. He's like, what's happening, why is this, why is my mom doing this? Why? Why is this policeman taking me into the RCMP vehicle? So, yeah that's traumatizing, sure... he's my son, right? And to see that, the hurt that he felt, that I did this. Kind of like a betrayal, maybe.” (Diane)

Many parents said their child was subsequently angry or resentful with them for having them apprehended and confined. Some parents felt the anger and distress caused by PChAD impacted the youth's relationship with their parent's. Specifically, some youth subsequently did not trust their parents, worked harder to avoid them, and tended to hide their drug use more. This is understandable behavior from the perspective of the youth, because at any point the parents could obtain another PChAD order and have them apprehended if they returned home or if their parents discovered where they were staying.

Evelyn described experiencing some moral distress because she had to lie to her daughter to locate her so that the police could apprehend her. She described how one consequence of using PChAD and other secure care programs was that her daughter subsequently refused to come home to visit out of fear of being apprehended and confined again.

“You want to talk about justification behavior, you're basically trying to find them, you're searching for them on social media. You're lying to them. And I know, my daughter is still hates me. Part of her gets angry that I lied to her. So I could, the police could find her. So that part's not great... She has huge resentments about me tricking her. And for the longest time after that, and it's not just PChAD. But, you know, PSECA and everything else. Is that she, she had zero trust for us. So, even something genuine like meeting us for dinner, she didn't want to do, right? Because she just figured that we're just going to lock her up.” (Evelyn)

In addition to distrusting their parents, some youth were perceived to have become more distrustful of adults in general after being PChAD'd. For example, Jamie mentioned that “They still come away with a little bit of distrust. Well, I say a little or a lot. I don't know. But distrust in adults in general.”

While most youth were angry with their parents, some parents did not think that PChAD significantly worsened their relationship given that it had already deteriorated. For instance, Jon wasn't overly concern about his son's resentful attitude because their relationship had already been so strained.

“But at this point, I mean, the relationship between himself and myself and his mom was just not good to begin with. So it really, didn't faze me very well. It didn't faze me in terms of like I was, I wasn't surprised by his attitude” (Jon)

Finally, several parents described how the PChAD appeal process was especially problematic for their relationship with their child. All youth have the right to appeal the PChAD order in court, which involves both parents and youth testifying in front of a judge. Some parents were also required to cross-examine their child directly. For Tina, this confrontational situation further strained the relationship with her son.

“He had the opportunity, I think he had 24, 48 hours or something like that, to protest the order. So the next thing I knew. I can't remember if it was the day or, they, that next day or the day after...he's appealing this order. So I'm literally standing in court testifying against my son, for me to keep the order in place. And for him, he wants to appeal the order and have it rescinded.... So that was stressful and not exactly great for, the relationship either.” (Tina)

#### **Chapter 4: Discussion**

In this study, I explored parent experiences with all aspects of the program (research question 1), and parent perspectives on the impact on of the program (research question 2). By illuminating parents lived experience with PChAD, I sought to add to the scare literature on involuntary stabilization and generate insights regarding how these programs and other services can better support families.

In this discussion, I will provide a synthesis and interpretation of the findings to these research questions, while contextualizing them within the relevant literature. In the first section, I will discuss parent experiences before, during, and after using PChAD, with a focus on how on these experiences were shaped by a need for greater support and guidance. In the following two section, I will discuss the parents' perceived benefits and risks of the PChAD program, respectively. This involves a discussion of how parents' perceived benefits and usefulness of the program were shaped by their initial expectations. In the final section, I will discuss parents' sometimes conflicting perspectives on what is needed to better help child and youth who use substances, and how these views can be understood within the more general tension that exists between involuntary care and harm reduction approaches to substance use.

##### *Parents struggled and needed greater support*

Prior to accessing PChAD, parents struggled to find services that matched their child's needs. Many parents weren't even sure what to expect from PChAD, but were simply trying to use any available program that might help them. This sense of desperation and of “grasping at straws” was understandable because they were very concerned about their child's safety and

well-being. Previous attempts to involve the child in voluntary treatment hadn't worked because the child was unwilling to participate, and parents found it increasingly stressful to care for their child's complex behavior and mental health needs.

The feelings of stress, chaos, and desperation resonant with descriptions from previous studies (Choate, 2015; J. M. Smith & Estefan, 2014). For instance, in one other study, parents of adolescents with substance use problems reported significant conflict and confrontation with their child (Choate, 2015). Some parents described that their child became like a different person, with behavior that was increasing difficult to manage (Choate, 2015). Fear of a child's death was a common concern, as were feelings of despair that the behaviors will never get better (Choate, 2015). Eventually, some parents were left feeling exhausted because they had done all they could think of to address the problem and felt out of options (Choate, 2015).

In addition to the challenge of dealing with their child's behavior, the parents in this study also struggling to navigate the overwhelming number of programs and services available, and found it especially difficult to find programs that addressed both addiction and mental health concerns. Some parents began to reach out to service providers such as police, physicians, or social services, who were unable to provide the types of services the parents wanted. Parents were often left feeling lost and helpless as a result of always being told what couldn't be done, and were looking for more guidance on what they should do to care for their child.

The parents' challenges with finding appropriate services are consistent with systemic issues identified by the Office of the Child and Youth Advocate in Alberta (Graff, 2018). The 2018 investigative review described that there are limited services for the treatment of youth with substance use problems and mental illness, and even fewer resources for youth with co-occurring substance use problems and cognitive or intellectual disabilities (Graff, 2018). The report described how many parents seek help from various services including the police, hospitals, and community agencies, but that often they are unable to help because the youth does not fit their mandate (Graff, 2018).

To address these issues, the report called for the creation of easily accessible, integrated services that coordinate transitions between treatment levels of varying intensity (Graff, 2018). The Representative for Children and Youth in BC identified similar systemic issues in their province, and suggested that youth and families need a one-stop source that lists all services to make it easier navigate the numerous programs and services (Turpel-Lafond, 2016).

Additionally, the BC report recommended that health partners such as schools, primary care physicians, and emergency physicians, need greater awareness of available services in their regions (Turpel-Lafond, 2016). According to best practice documents, people should be able to enter the system of care through multiple doors, and the coordination of care should be the responsibility of the system, not individual youths or parents (Turpel-Lafond, 2016).

This best-practice ideal, in which it is “the system’s” responsibility to coordinate the care of the child, was far from realized for the parents in this study. The parents in this study felt burdened with case management work. They recalled constantly searching for services and calling around to inquire about whether services were available and appropriate for their child’s needs. Even when parents were involved with PChAD, many were dissatisfied with level of service they received in planning for discharge. Parents recalled that program options were suggested by the PChAD staff, but that it was still their responsibility to coordinate the transition of care. This was very difficult to manage for some parents during a time of high stress and crisis. Some parents were frustrated because they felt they had exhausted all their options, but were now being asked to find options themselves.

Previous authors have commented that family members are often left to fill gaps in the continuum of care for Substance Use Disorders (Ventura & Bagley, 2017). For example, untrained family members must often provide critical transitional care when individuals with a substance use disorder are discharged into their care without follow-up, or are waiting to move from one level of care to the next (Ventura & Bagley, 2017). In this study, parents were responsible for ensuring the continuity of service delivery for their children. In an effort to better support parents, Alberta Health has stated it aims to improve transitions in care following PChAD (Government of Alberta, 2018). However, ensuring seamless transitions may be difficult while gaps and barriers to substance use interventions continue to exist throughout the broader health system (Graff, 2021).

Parents were even more frustrated with the discharge planning process if the child chose not to share the results of the PChAD assessment report with them. This situation left parents feeling disconnected from their child’s care and ill-prepared to take care of their child after the program ended. Other studies have described similar conflicts arising when clinicians maintain youth confidentiality (Choate, 2015). Parents are sometimes frustrated when professionals hold back information about their child’s situation because it prevents them from understanding the

youth's issues and effectively responding (Choate, 2015). This situation can leave parents feeling disempowered because the counsellor is perceived as being allied with the youth and as enabling secret keeping (Choate, 2015). This sentiment was also identified in the focus groups conducted as a part of the 2009 AHS evaluation of PChAD (Alberta Health Services, 2009). Specifically, the parents expressed that because they had the right to force their child into PChAD, they should also have the right to the information during the assessment (Alberta Health Services, 2009). In an effort to address these concerns, the Government of Alberta has stated that it is developing an "information sharing for Guardians" policy to improve information sharing with parents, including discharge recommendations (Government of Alberta, 2018).

Best practice guidelines for treating youth with substance use disorders state that youth confidentiality should be maintained unless the youth gives consent to share their medical information with their parents (BCCSU, 2018). This is because maintaining confidentiality, within legal limits, is necessary to building trust with a young person (BCCSU, 2018). However, parents can still be supported with education and training when youth are not ready for services (Turpel-Lafond, 2016). Supports for family may include counselling, parent support and education groups, and referrals to other agencies and services (Turpel-Lafond, 2016).

Unfortunately, many parents in this study did not receive the guidance, education, and support they needed immediately following PChAD. These parents were frustrated when their child was discharged into their care without a plan for follow-up or some other program to enter. Some parents suggested that it would be helpful if a case manager or advocate followed up with parents to see if they needed any support. Parents mentioned that support should ideally be ongoing so that parents can receive further guidance as their circumstances change, such as if their child's substance use problems worsen. Parents also reported needing more practical education or coaching on how to care for their child and manage their behaviors. One parent expressed wishing that she had a class on how to provide care for a child with a chronic substance use disorder, similar to how she had a class on caring for a child with asthma.

Prior studies have similarly described how parents face an array of practical problems and dilemmas related to parenting a child with substance use problems (J. M. Smith & Estefan, 2014). In general, parents often struggle to set limits on their child behavior, and may go through a series of trials and errors of parenting techniques in the hopes of finding something that works (Usher et al., 2007). Many parents also have to deal with conflicts over money and possessions,

such as deciding how to respond if their child steals from the family or requests money (Orford et al., 2010). Further, parents may have to deal with verbal and physical abuse and aggression (Jackson et al., 2007; Usher et al., 2007). In such cases, parents often feel torn between wanting to support for their child and ensuring a stable and safe environment for the other children (Jackson et al., 2007). Decisions about whether to force the child to leave the home are extremely difficult, and parents may disagree on what approach is most appropriate (Butler & Bauld, 2005). Indeed, parents may attempt various coping strategies, including putting up with the behaviours, attempting to be assertive and stand up to the child, or withdrawing from the problems (Orford et al., 2010).

The stress of dealing with a child who is struggling with a substance use disorder can exact a heavy physical and mental toll on parents (Ventura & Bagley, 2017). Affected family members are at higher risk for developing chronic physical conditions and mental health disorders and have higher healthcare needs compared than family members of similar individuals without a substance use disorder (Ray et al., 2009). Further, the health of affected family members is associated with the severity if their child's substance use disorder (Weisner et al., 2010). Many parents also describe living with blame and shame because they are perceived by society as being responsible for their adolescent child becoming involved with drugs (Usher et al., 2007). This shame and stigma can leave parents, and especially mothers, feeling shunned by society and reluctant to seek out services (J. M. Smith & Estefan, 2014; Usher et al., 2007).

However, with the appropriate interventions and supports, parents can often be taught the necessary skills to help both themselves and their child with a substance use disorder (Ventura & Bagley, 2017). For instance, evidence-based interventions have been developed to teach family members non-confrontational communication and counselling skills to deal with their love one at home (Meyers et al., 1998). Such interventions can increase the engagement of the loved one in treatment, reduce their substance use, and improve the parent's mental health (Meyers et al., 1998, 2002; W. R. Miller et al., 1999). Additionally, evidence-based psychosocial interventions have been developed to reduced stress-related symptoms and improve coping among parents and other family members affected by substance use problems (Copello et al., 2009).

Several parents in this study reported access a variety of supports, including mutual parent support groups and more formalized interventions from professionals. These parents described how learning practical parenting and coping strategies helped them manage the chaos

and stress in their lives. Additionally, finding a sense of community and belonging helped alleviate their sense of guilt and isolation. However, some parents reported difficulty finding these services, and strongly recommended that PChAD help parents connect with services and supports that serve family members.

Many parents in this study also struggled with the PChAD application process in ways that have been previously described (Alberta Health Services, 2009; Graff, 2018). For instance, the Office of the Child and Youth Advocate report described how some parents do not understand how to provide evidence to the judge to obtain the PChAD order, or how to apply for the five-day extension period (Graff, 2018). Further, some parents feel alone, ashamed, and intimidated by the process (Graff, 2018). The parents in this study shared these concerns, and identified the process of defending the PChAD order to the judge as being particularly emotionally difficult. Specifically, parents felt judged and ashamed as parents for having to use the program, and humiliated at having to describe intimate details of their life in front of other families in the courtroom. Similarly, some parents felt defensive and disrespected when the judge was trying to ascertain whether the protection order was warranted, which involved asking parents questions about why they thought PChAD was necessary. This dispassionate assessment from the judge stood in stark contrast to the session with the pre-application counsellor, who was perceived as supportive and encouraging.

Several parents wished they would have had a support worker, advocate, or lawyer to help them manage their case and prepare for court. A similar suggestion was made in the focus groups in the earlier AHS evaluation (Alberta Health Services, 2009). Specifically, parents had said that access to PChAD would be easier if they had an advocate who could explain the process, tell them what to expect, and be available either in person or over the phone to answer questions (Alberta Health Services, 2009).

Once parents had obtained the PChAD order, there were still several challenges in executing the apprehension. Parents sometimes had difficulty locating their child, and sometimes a bed wasn't immediately available. This caused delays, which could be stressful because the parents had to execute the PChAD order before it expired. Additionally, several parents had difficulty with police, who were sometimes uninformed about PChAD or reluctant to conduct the apprehension. Some parents were frustrated because they felt like they had to convince the police to do their job. These parents wished there could have been more support for them to coordinate

this process. This concern also emerged in the AHS focus groups (Alberta Health Services, 2009). The report stated that not all police were aware of PChAD or knew how to locate the protective safehouses (Alberta Health Services, 2009). Police sometimes denied parents transportation because of limited resources or because they didn't know this role was in their jurisdiction (Alberta Health Services, 2009).

Finally, some parents were frustrated if their child appealed the PChAD order, in-part because this led to a confrontational court hearing that further strained their relationship. For some parents, the confrontation was very direct because parents were asked to cross-examine their child. Concerns about the review process were common among focus group participants from the AHS evaluation in 2009 (Alberta Health Services, 2009). Many were upset with review process because it often left them feeling like "the bad guy," even though they were just trying to do what they thought was best for their child (Alberta Health Services, 2009). Some parents were not fully aware their child had this right, and were left feeling unprepared and unsupported (Alberta Health Services, 2009). Some of the parents felt disadvantaged in this process because the youth had the support of lawyers to argue their case for them, and parents may lack complete knowledge of their child's drug use (Alberta Health Services, 2009).

The report describes how 139 (34%) of youth who were "PChAD'd" in the first 8 months of 2008 chose to appeal the protection order (Alberta Health Services, 2009). Of these, 82 (59%) were successful in overturning the order (Alberta Health Services, 2009). In these cases, parents felt they were left in a worse position than when they started (Alberta Health Services, 2009).

In recent years, the Government of Alberta has taken steps to improve several aspects of the PChAD application process that the parents have identified as problematic (Government of Alberta, 2018). For instance, to improve parent understanding about PChAD and court processes, Alberta Health developed more program information materials such as brochures and information cards (Government of Alberta, 2018). Alberta Health also stated it was developing policies and resources to better help parents manage the court application process and hearing orders when a child applies for a review order (Government of Alberta, 2018). Finally, Alberta Health stated it intends to collaborate with the Justice and Solicitor General to review practices for parent testimonials in court, and to improve the process related to apprehension of children by police (Government of Alberta, 2018). Continued evaluations could help determine whether these policy changes are improving parent experiences with the PChAD program.

### *Perceived benefits of involuntary stabilization*

Most of the parents in this study thought that PChAD had little impact on their child's substance use besides temporarily stopping it for 10 to 15 days. However, parents varied in the extent to which they felt this temporary pause was worthwhile given their circumstances. Some parents were grateful for the reprieve because it gave them peace of mind knowing their child was safe and it gave them a chance to develop a treatment plan. Some parents also appreciated that it forced their child to take a break from using substances and have their physical needs attended to. However, other parents were disappointed that PChAD did little to curb their child's substance use, and thought that PChAD wasn't worth using unless it had an impact that lasted beyond the period of confinement.

The finding that some parents were grateful for temporarily pausing the immediate danger to their child is consistent with the perspectives of family members and clinicians who have used civil commitment legislations for adults using opioids in Massachusetts (Evans et al., 2020). In this prior work, participants overwhelmingly indicated that the primary benefit of using civil commitment was its ability to save lives in the short-term (Evans et al., 2020). This immediate removal from life-threatening situations was viewed as necessary in cases when the patient was "out of control," such as when they had repeatedly overdosed in a short period, were experiencing a mental health crisis, or had supposedly lost the ability to make good decisions as a result of their addiction (Evans et al., 2020).

In the current study, parents' perceptions of whether the program outcome was positive was shaped by their initial expectations. Several parents had been warned by a judge or counsellor that PChAD would not "fix" their child and understood that PChAD was designed for detoxification and stabilization, rather than comprehensive treatment. Because these parents had a realistic understanding of the services, they were less prone to disappointment if the program had limited impact beyond keeping their child temporarily safe and offering options for treatment programs. Other parents did not seem to fully understand the nature of the services provided, and were dissatisfied that their child received "just detox" or was "just sitting around playing video games" instead of receiving more comprehensive addiction treatment. Similarly,

some had hoped that PChAD would motivate their child to reduce their substance use or enter voluntary abstinence-based treatment.

The finding that parents' expectations for the program varied is consistent with findings from the 2009 AHS evaluation of PChAD, in which there were several dominant motivations for using the program, including: 1) educating youth about alcohol and drugs, 2) providing respite from the family, removing the child from negative influences, and providing a safe place to detoxify, and 3) gaining control over the youth or stimulating a change in decision making (Alberta Health Services, 2009). The parents who sought to gain control of the youth wanted to show their child how seriously they felt about their transgressions, or to frighten or punish their child into making different choices (Alberta Health Services, 2009). For some, involving police in apprehending and transporting the youth was thought to be an effective means of accomplishing this (Alberta Health Services, 2009). The report notes that motivations of punishment and control do not align with the primary purpose of PChAD, which is to provide an opportunity for detoxification and an assessment of the child's physical, behavioral, and emotional concerns and develop a discharge treatment plan (Alberta Health Services, 2009). As a result of the discrepancy between parent motivations and the program's intentions, the report recommended that the purpose of PChAD needs to be better communicated to parents (Alberta Health Services, 2009).

While none of the parents in the current study reported using PChAD to "punish" their child, some had hoped that involuntary stabilization could stimulate a change in decision making by giving a "wake up call." This hope is consistent with the widespread belief in "tough love" approaches to youth substance use, in which confrontational interventions are thought to hasten the moment when people with a substance use disorder will "hit bottom" and initiate recovery (C. Clark, 2012; White & Miller, 2007). In this way, parents were not looking to punish youth per se, but to motivate them to initiate recovery. Police apprehension and confinement were viewed as a potential means to achieve this goal, with multiple PChADs sometimes necessary to eventually increase the youth's motivation.

Similarly, patients and clinicians involved with civil commitment programs in Massachusetts described how they hoped short-term confinement would be a turning-point event for their loved ones who use opioids, in which they would start thinking clearly, gain hope, make a fresh start, recover decision making ability, and become motivated to engage in treatment

(Evans et al., 2020). Consistent with these hopes and expectations, there were at least some patients in Massachusetts who thought civil commitment increased their motivation to change (Christopher et al., 2018; Evans et al., 2020). However, clinicians perceived that using civil commitment rarely works out this way (Evans et al., 2020). Moreover, there is currently little evidence that short-term, involuntary stabilization is effective at motivating youth to decrease their substance use or enter and engaged with voluntary treatment compared to other approaches (Chau et al., 2021; Evans et al., 2020; Goodyear et al., 2021; Jain et al., 2018; Pilarinos et al., 2018).

A few parents in this study also reported using PChAD in-part to gain control over their child in ways that do not fit with the stated purpose of the program. For example, Tracy described how a counsellor from an addiction treatment center advised her to get a PChAD order to use as leverage to coerce her son to attend voluntary treatment, and Jamie obtained a PChAD order to try to deter her daughter from continuing to use substances. Similarly, some family members in the Massachusetts study reported using civil commitment as “leverage” to gain control of their loved ones (Evans et al., 2020). Thus, while punishment and gaining control over youth are not intended purposes of PChAD, some parents use it as a tool for coercion to motivate their child to change.

While no parents reported that PChAD reduced their child’s substance use, several mentioned that they appreciated being able to connect with their child through visits and family counselling. Some also had successful family counselling sessions in which they were able to engage in open communication with their child. However, other youth were unwilling to participate in family counselling because they were still angry and resentful at being confined. The different reactions of youth to involuntary stabilization fit with prior research with coerced addiction treatment. Specifically, individuals can vary significantly in terms of how much coercion they perceive, as well as how these perceptions impact their motivation to engage in treatment (T. C. Wild, 2006; T. C. Wild et al., 1998). In general, individuals who perceive the intervention as more coercive tend to have lower engagement in treatment (C. Wild et al., 2006).

### *Perceived risks of involuntary stabilization*

The parents in this study raised many of the same risks and concerns about involuntary stabilization have been previously identified (Alberta Health Services, 2009; Goodyear et al., 2021; Graff, 2018; Pilarinos et al., 2018). For instance, the parents in this study identified trauma, anger, and damaged relationships as a significant concern. Feelings of mental distress, betrayal, and resentment were especially apparent when youth were apprehended from their home in front of their parents. Many parents described how youth subsequently worked harder to elude them, hide their drug use, and avoid coming home. These concerns are consistent with previous evaluations of PChAD, in which some parents described the program as “backfiring” because their youth remained angry with the parents upon being released (Alberta Health Services, 2009). Similarly, critics of the proposed involuntary stabilization model in BC have raised concerns about increased alienation from service providers and adults in general (Charlesworth, 2021; Goodyear et al., 2021; Pilarinos et al., 2018).

These concerns are also consistent with those described by adult patients who experienced civil commitment for their opioid use in Massachusetts (Evans et al., 2020). Patients often perceived civil commitment as being more like “jail” than treatment (Evans et al., 2020). They described the process of being apprehended by police and confined as being, punitive, degrading, humiliating, fearful, isolating, and stigmatizing (Evans et al., 2020). Some thought the experience ultimately did more harm than good because it angered them and deterred recovery rather than helping them find reasons to change (Evans et al., 2020). It is important to note that these perceptions of being “jailed” may have been more pronounced in Massachusetts because civil commitment in this state often involves confinement in actual jails or repurposed prisons, whereas PChAD uses protective safehouses (Evans et al., 2020). Nevertheless, some Massachusetts patients described similar feelings of betrayal and resentment towards their family (Evans et al., 2020). They felt the experience divided their family and caused them to be less likely to reach out for help in the future (Evans et al., 2020). These attitudes were particularly apparent among patients who thought the intervention was unnecessary, or that their family had not duly considered alternatives to civil commitment (Evans et al., 2020).

The risk of pushing youth away from their parents or caregivers is concerning, because family support plays a central role in youths’ engagement in addictions treatment and long-term recovery (Fagan, 2006; J. M. Smith & Estefan, 2014; Ventura & Bagley, 2017). While family dynamics can contribute to the development of substance use disorders, they can also provide

protective and recovery factors, such as parental warmth and appropriate monitoring and control that is neither too authoritarian, nor too lenient (Fagan, 2006). Indeed, family-based models that provide counselling, communication, and parenting skills are recognized as one of the most effective interventions for treating youth substance use disorders (Tanner-Smith et al., 2013; Ventura & Bagley, 2017; Winters et al., 2014). Thus, undermining the youth's relationship with their caregivers may be counterproductive for their long-term recovery. However, for several parents the relationship their child was already very fragile, and the risk of further straining was perceived as being outweighed by the more immediate need to remove the youth from a dangerous environment.

Another risk of using PChAD is that youth may connect with peers that will have a negative influence on them, such as by providing them with greater access to substances or a place stay when they left home. This risk seemed to be well known among some services providers, as some parents had been warned about it beforehand. Iatrogenic effects from negative "peer contagion" have long been a concern within residential care and group treatment settings for youth (Gifford-Smith et al., 2005; Weiss et al., 2005). In general, there is strong evidence that negative peer influence occurs in naturally occurring peer groups outside of services programs or treatment (Gifford-Smith et al., 2005). Exposure to deviant peers has been linked to a wide range of problem behaviors among youth, including drug use, covert antisocial behaviors such as lying and cheating, and violence offenses (Gifford-Smith et al., 2005). According to one theory, this negative peer influence occurs through "deviance training," in which deviant peers may positively reinforce each other's antisocial behavior, increasing the likelihood of further delinquent acts (Weiss et al., 2005).

While negative peer influence has not been studied in the context of involuntary stabilization, these programs share features with other contexts in which negative peer influence has been demonstrated, such as juvenile detentions programs and residential care settings (Gifford-Smith et al., 2005). In young offender programs, there is considerable evidence to suggest that the detention of youth with high exposure to deviant peers and minimal adult interaction is ineffective at reducing the rate of recidivism, and in some cases may exacerbate it (Gifford-Smith et al., 2005). Similarly, in a residential care setting, a recent study showed evidence for negative peer influence on problem behaviors, although this only occurred in months where over half of the youth in care had behavioral or emotional problems (Huefner et

al., 2018). The involuntary stabilization program in Alberta (PChAD) is similar to juvenile detention and residential care settings because it involves the aggregation of youth together with a large amount of unstructured activity time. The presence of unstructured activity or leisure time with other youth with problematic or deviant behaviors is theorized to be one factor that contributes to a higher risk of negative peer influence (Gifford-Smith et al., 2005; Mahoney et al., 2001).

The last form of risk of PChAD identified by parents was the danger of detoxification for youth with opioid disorders. Some parents had little knowledge about opioid use disorder and expressed concern that PChAD may have increased the risk of overdose for their child. Indeed, withdrawal management, or detoxification, is not recommended for individuals with Opioid Use Disorder unless they are connected to longer term addiction care because of the increased risk of overdose due to lost tolerance (CRISM, 2017). This concern has been recently raised by the Office of the Child and Youth Advocate in Alberta, the Representative for Children and Youth in BC, and numerous other academics and advocates critical of involuntary stabilization and short-term civil commitment, in both Canada and the United States (Charlesworth, 2021; DeBeck et al., 2019; Evans et al., 2020; Goodyear et al., 2021; Graff, 2018; Jain et al., 2018; Pilarinos et al., 2018). In response to these concerns, the Government of Alberta has stated it intends to explore ways of addressing the needs of opioid dependent youth (Government of Alberta, 2018; Graff, 2021).

### *Perspective on involuntary care and harm reduction*

There was a tension in this study between parents who advocated for longer involuntary treatment options and parents who were willing to take harm reduction approaches. When asked what they would like to change about the PChAD program, many parents stated that they wanted the program to be longer. These parents reasoned that a longer involuntary program could offer more therapeutic interventions and address the underlying “root causes” of substance use, such as trauma and mental illness. The parents’ suggestions about how long they thought involuntary treatment should be varied. Some suggested that involuntary programs should last a few weeks to a month. However, some parents had used the 30-day secure care service available through children’s services and had found that this length was still too short to change the youth’s

substance use behavior. Indeed, several parents advocated for long-term involuntary residential treatment, such as 6 months to a year. These parents believed that long-term involuntary measures were necessary and ethically justifiable because the youth's decision-making capacity had been compromised because of their substance use, mental illness, and immature development.

It is not uncommon for parents to advocate for the involuntary treatment of their loved ones (Hall et al., 2014; Ventura & Bagley, 2017). For instance, in one support group for family members in Massachusetts, over a third of family members had applied for an individual to receive treatment through the involuntary commitment legislation in that state (Bagley et al., 2015). While it may be understandable that parents would like to eliminate all drug-related risks, there is little evidence to support the use of compulsory treatment for individuals with a substance use disorder (Hall et al., 2014; Werb et al., 2016).

A systematic review of studies with both adults and youth found that most studies do not detect any positive impacts of compulsory treatment on drug use or crime, and two studies have found negative impacts on criminal recidivism (Werb et al., 2016). Overall, the review concluded that the existing evidence does not support the assumption that compulsory treatment can improve outcomes for substance use (Werb et al., 2016). More recently, several studies have found poorer outcomes among adults receiving compulsory treatment in Norway compared to those receiving treatment voluntarily (Pasareanu et al., 2016, 2017). While these studies found that some patients receiving compulsory treatment had reduced their substance use 6 months post-treatment, the compulsory patients had higher rates of relapse and overdose compared to the voluntary patients (Pasareanu et al., 2016). Further, patients receiving compulsory treatment showed no improvements in their levels of mental distress 6 months after involuntary treatment (Pasareanu et al., 2017). Involuntary drug treatment may also destabilize people who use drugs and increase risk of overdose (Rafful et al., 2018). In one study in Mexico, abstinence-based involuntary drug treatment was associated with greater non-fatal overdose risk among a cohort of adults who use drugs (Rafful et al., 2018).

In addition to lacking evidence, compulsory treatment raises ethical and human rights concerns because it violates the principles of informed consent and right to refuse treatment (Hall et al., 2012; Lunze et al., 2016; Werb et al., 2016). In Canada, child and youth representative organizations have called on governments and service providers to ensure young people are

involved in decision-making about their care (Graff, 2018; Turpel-Lafond, 2016). This is in line with the United Nations Convention on the Rights of the Child (article 12), which states the young people have the right to have their voices heard and their opinions taken seriously when decisions are made about them (Charlesworth, 2021; Graff, 2018). Also relevant is article 37, which states that depriving a child of their liberty through arrest, detention, or imprisonment, should only be used as a measure of last resort and for the shortest appropriate period (Charlesworth, 2021).

Given the lack of evidence and ethical concerns associated with involuntary approaches to youth substance use, numerous advocates and academics have instead called on governments in Canada to invest in the voluntary treatment system instead of introducing new forms of involuntary treatment (Charlesworth, 2021; Chau et al., 2021; Goodyear et al., 2021; Pilarinos et al., 2018). For instance, the representative of children and youth in BC has expressed that it would be inappropriate to introduce involuntary stabilization legislation for children and youth when there is currently inadequate investment in a spectrum of robust voluntary substance use services (Charlesworth, 2021). Similarly, in a recent study that explored attitudes about involuntary care among people who use drugs, many viewed involuntary care as inappropriate and inequitable when the current system of voluntary care was inaccessible for so many (Chau et al., 2021). The participants advised that the government should focus on improving voluntary services, including improving access to pharmacotherapy, psychosocial supports, and detox services (Chau et al., 2021). This resonates with the report from the Office of the Child and Youth Advocate in Alberta, which recommended ensuring that voluntary services are easily accessible and available, adapted to youth needs, and integrated so that transitions are seamless, while also ensuring youth have a say in their treatment (Graff, 2018).

While ensuring accessibility to voluntary treatment is critical, many youth may not be willing or able to participate in abstinence-based treatment, or may continue to cycle between periods of substance use and abstinence (Passetti et al., 2016). Therefore, it is important to include harm reduction interventions as part of the continuum of care for youth who use substances to help keep them safe until they are ready to engage in longer-term voluntary treatment (BCCSU, 2018; Turpel-Lafond, 2016). There is often a reluctance to embrace harm reduction strategies for youth because they focus on safety while using substances rather than stopping use altogether (Graff, 2018; Smyth, 2017a). However, harm reduction interventions

such as supervised consumption services, take-home naloxone, and needle distribution have been shown to reducing mortality and blood-borne infections (Abdul-Quader et al., 2013; Irvine et al., 2019; Potier et al., 2014). Harm reduction strategies such as supervised Consumption Services can also help youth build positive connections with staff and can facilitate uptake into voluntary services (Jade Boyd et al., 2017; Hadland et al., 2014; Wood et al., 2007). Additionally, supportive housing models for youth have been developed to improve housing stability among street-involved youth, promote quality of life, and help stabilize mental health and addictions (Gaetz, 2014; Pauly et al., 2013). These models can be integrated with harm reduction and wrap around supports (Fast & Cunningham, 2018; Gaetz, 2014).

Consultations with youth who use drugs in BC have revealed that youth want greater access to youth-specific harm reduction interventions and safe spaces such as drop-in centers, in addition to greater access to voluntary treatment (Representative for Children and Youth, 2018). Youth also identified issues related to housing placements, such as needing group and foster placements that can offer support and harm reduction if youth are using substances (Representative for Children and Youth, 2018). These youth expressed that it was important for them to be able to reach out to residential care staff for information and help without having to fear getting kicked out of their placement or other consequences (Representative for Children and Youth, 2018). More generally, having adult supports that are caring, stable, and non-judgemental was viewed as very important for encouraging safer use, especially among youth who may be lacking positive family relationships (Representative for Children and Youth, 2018).

Several of the parents in this study described how they were glad their child had access to a variety of harm reduction interventions, including supervised consumption services and housing programs with integrated harm reduction. Some parents also expressed needing guidance on how to care for their child even if they are unwilling to reduce their substance use at the time. This signalled a willingness to embrace the harm reduction principle of meeting the child where they are at (Bigler, 2005). That is, even if youth are not willing to abstain from all substance use after PChAD, some parents were still willing to help them access services that would promote their well-being, such as mental health counseling or access to housing. For some parents, a long period of time had passed since they used PChAD, and they had now come to a more realistic understanding that abstinence-based approaches were not workable for their child.

## Limitations

I interviewed 15 different parents for this study. Small sample sizes are typical in qualitative research because it is meant to provide a depth of information rather than to produce findings that can be generalized. This is consistent with the objectives of this study, in which I sought to describe a range of experiences and perspectives related to involuntary stabilization programs. While I do not purport to have described all possible experiences with PChAD, I believe I have captured a wide range of perspectives given the diversity of ideological positions in the sample.

However, there are some important experiences and perspectives that are not captured in this study. First, there were no indigenous parents recruited in this study. It is possible that indigenous parents would have a unique perspective on the use of involuntary stabilization given the history of oppressive colonial practices in Canada that have separated Indigenous children from their parents. Additionally, this study is missing perspectives from guardians other than parents who may apply for a PChAD order, such as case workers with children's services. In cases where youth have been apprehended, it would be the caseworker's responsibility to apply for a PChAD order. The 2009 AHS evaluation of PChAD showed that almost half of parents included had some involvement with Children's services before accessing PChAD (Alberta Health Services, 2009). These parents likely worked with caseworkers who routinely use PChAD and may have valuable experiences and perspectives on the program.

This study also did not examine youth experiences with the program. Youth experiences with substance use programs are important to explore in order to develop interventions that are perceived as acceptable and beneficial. Further, it could be valuable to explore PChAD staff experiences with the program. This would help gain a more fulsome understanding of the various issues that parents in this study raised, such as their dissatisfaction with the level of service provided for discharge planning. PChAD staff may also have valuable expertise on the range of outcomes that occur with involuntary stabilization given that they observe a high volume of youth going through the program.

Finally, the parents in study used PChAD for the first time between 2008 and 2018, with the median year of 2015. I decided to include parents who used PChAD many years ago because these parents would have the benefit of hindsight and could speak to how PChAD impacted their child in the long-term. However, some of the parents who used PChAD further in the past may have had greater difficulties recalling their experiences accurately. Additionally, the experiences of these parents would not have reflected the Government of Alberta's efforts since 2017 to improve aspects of the PChAD application process (Government of Alberta, 2018). Nevertheless, exploring their experiences can still provide valuable insights into the benefits and drawbacks of involuntary stabilization programs in general, even if specific details of the PChAD program has changed in recent years.

### **Directions for future research**

If involuntary stabilization programs are going to be included within the spectrum of services for youth who use substances, more research is necessary to establish evidence for the outcomes of involuntary stabilization. Specifically, research should evaluate the extent to which involuntary stabilization achieves its objectives of facilitating recognition of treatment need, promoting engagement in care, and improving decision making. From an ethical perspective, because involuntary stabilization is an intrusive intervention that overrides youth autonomy, we have a duty to ensure that the intervention is working as intended (B. A. Clark et al., 2019). Moreover, we must ensure that involuntary stabilization is not causing more harm than it seeks to prevent (B. A. Clark et al., 2019). Ideally, future research on involuntary stabilization will reveal for whom it may be helpful and how to mitigate potential unintended negative consequences (B. A. Clark et al., 2019).

### **Chapter 5: Conclusions and implications**

This study described parent experiences and perspectives about PChAD, which is an involuntary stabilization program in Alberta for youth who uses substances. Through this program, parents can apply to have their child apprehended and confined in a protective safehouse for 10-15 days if their child is deemed at risk of serious physical or psychological

harm because of their substance use. The purpose of the program is to provide detoxification, assessment, and treatment planning. To my knowledge, this study is the first in the academic literature to describe parent experiences with involuntary stabilization programs for children who use substances. By describing parent experiences with this program, this study has identified several unmet service needs that have important implications for policy and practice. Efforts to address parent unmet needs are needed both within PChAD and the broader health system.

*Implication 1: Parents need greater guidance, education, and support*

- Efforts are needed to help parents connect with services that are appropriate for their child's needs and readiness to change. Parents need guidance connecting with services even if their child is unwilling to attend voluntary abstinence-based treatments.
- Parents need greater support coordinating transitions in care after involuntary stabilization. Parents may feel stressed and burdened if the responsibility to ensure continuity of care is left to them.
- Parents should be connected to support programs after involuntary stabilization. Parents may benefit from programs that provide mutual parent support, teach practical parenting skills, provide drug education, or help parents cope with the stress.
- Parents need ongoing support and guidance. Following involuntary stabilization, parents need continued guidance to deal with changing circumstances, such as their child's potentially escalating substance use or mental health problems. Parents suggested that have a case manager or advocate to help guide their decisions and access services would be helpful.
- Parents want to be involved in their child's care during involuntary stabilization, but this may be difficult when youth chooses not to share information. Parent feelings of disconnection may be ameliorated by information sharing from staff to the extent that this is possible.

The parents in this study described needing more guidance to access services that matched their child's needs. Prior to using PChAD, parents struggled to find appropriate

services, especially if their child had co-occurring substance use and mental health disorders. As parents became increasingly distressed for their child's safety and well-being, many tried reaching out to a variety of professionals for support, including police, physicians, and social services. However, many did not receive the guidance they needed, which led to a sense of helplessness and desperation. These experiences suggest that more efforts are needed to help parents connect with services that are appropriate for their child's needs.

Even once they were in PChAD, many parents were dissatisfied with the level of support and guidance they received with planning their child's care. Parents described being given treatment options, but still feeling burdened by having to coordinate their child's transition of care on their own. Some parents were upset that their child had simply been discharged back into their care after PChAD without a plan for ongoing support or follow-up. Several parents mentioned that they needed guidance on how to care for their child even if the youth was unwilling to attend voluntary abstinence-based treatment. One suggestion was to provide parents with an ongoing advocate or case manager to help navigate the overwhelming number of services available.

Parents were especially frustrated in situations where their child chose not to share the results of the PChAD assessment. In these cases, parents felt disconnected from their child's care, and didn't feel they had sufficient information to care for their child going forward. While maintaining confidentiality is considered best practice when treating adolescents so that trust can be built, this does not preclude connecting parents with supports such as counselling, parent support and education groups, and referrals to other agencies and services. Many parents reported needing education and coaching on how to manage their child's problematic behaviors. Eventually, some parents found supports that were helpful, such as parent mutual support groups, or group therapy sessions for family members affected by a loved one's substance use. However, parents noted that these services had been difficult for them to connect with, and recommended that PChAD prioritize connecting parents to the appropriate supports.

Finally, during PChAD some parents complained that they felt disconnected from their child's care, especially if their child chose to withhold information or did not cooperate with family counselling. PChAD staff may help parents feel involved in their child's care with greater communication, to the extent that they are able given the limits of confidentiality. For instance,

parents in this study appreciated receiving updates about their child's condition and information about what services they were receiving.

*Implication 2: Parents need support making informed decisions*

- Parents need help to anticipate the most likely outcome of involuntary stabilization and adjust their expectations accordingly. Involuntary stabilization may have little lasting impact on the youth beyond the immediate benefit of keeping them temporarily safe.
- Service providers should ensure parents understand the services provided during involuntary stabilization.
- Service providers can explore the parent's goals for using involuntary stabilization to ensure that it aligns with the objectives of the program.
- Service providers should help parents understand the various risks of using involuntary stabilization, including negative peer influence, increased risk of overdose due to loss of opioid tolerance, and the potential for anger, trauma, and damaged parent-child relationship.
- Service providers can help parents weigh the risks of using the program with the expected benefits, and can explore alternative options to using involuntary stabilization

Most parents in this study thought involuntary stabilization had little impact on their child's substance use, beyond pausing everything for 10-15 days. Some parents were still very grateful for this outcome because they were relieved knowing their child was safe temporarily. It also gave them an opportunity to develop a plan for their child's care. However, some parents felt disappointed that involuntary stabilization did not reduce their child's substance use, and did not think that it was worth using unless the benefits extended beyond the period of confinement.

These perceptions were shaped partially by the parent's prior expectations. Several parents had appreciated when service providers informed them that PChAD was not designed to provide comprehensive addiction treatment and may therefore have a limited impact on their child's substance. To prevent parent disappointment, service providers should help parents develop realistic expectations about the outcome of the program based on the child's history and

the nature of their substance use. Service providers can also ensure that parents understand that the scope of involuntary stabilization services are limited to detoxification and stabilization. These steps are necessary to ensure parents can make an informed decision about whether to use involuntary stabilization.

Similarly, service providers should clarify the purpose of involuntary stabilization with parents. Some parents may apply for PChAD for reasons that do not align with the program's stated purpose, such as using the threat of involuntary stabilization to deter their child from continuing to use substances, or to use as leverage to coerce their child into another voluntary treatment program. If service providers and policy makers deem these inappropriate uses of involuntary stabilization, then this should be communicated with parents and an alternative plan should be developed.

Parents also identified several risks of using PChAD that are consistent with prior concerns raised about involuntary stabilization program. These include the risk that youth will be angered and traumatized by police apprehension and confinement, which risks damaging the parent-child relationship. Parents were also concerned about the impact of negative peer influences within involuntary stabilization, which some parents thought exacerbated their child's substance use. Finally, several parents whose children used opioids were concerned that involuntarily stabilization could increase the risk of overdose due to loss of tolerance, but had not been aware of this risk at the time. Parents should be informed of these risks when deciding to use involuntary stabilization so they can decide whether the potential harms outweigh the expected benefits.

*Implication 3: Policy makers should address risks of involuntary stabilization*

- Policy makers should seek to mitigate the risks of involuntary stabilization identified by the parents in this study. These risks should be weighed against the expected benefits of involuntary stabilization when considering their implementation.

Most of the risks of involuntary stabilization described in this study have been previously identified (Alberta Health Services, 2009; Charlesworth, 2021; Evans et al., 2020; Goodyear et

al., 2021; Graff, 2018; Pilarinos et al., 2018). The risk of increased overdose following rapid detoxification from opioids is a particular concerning risk given the current high risk of overdose associated with illegal opioid use. This risk could be mitigated by offering evidence-based OAT such as buprenorphine. However, the possibility of increased risk cannot be completely eliminated because not all youth with Opioid Use Disorder will want to use these medications. Other risks of involuntary stabilization may be challenging to mitigate because they are inherent to the coercive nature of the intervention. These include angering or traumatizing youth, damaging parent-child relationships, and fostering mistrust of “the system.” These risks may be counterproductive for the youth’s long-term recovery and must be weighed against the more immediate benefits of temporarily removing them from dangerous situations.

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## Appendices

### Appendix A – Interview Protocol

Interviewer will thank participant for volunteering to participate in the research. Project will be described, including purpose of study, sources of data being collected. Informed consent form will be reviewed, emphasizing voluntary nature of participation, what will be done to protect confidentiality and anonymity, how data security will be maintained, how long participation will take, right to withdraw at any time, and potential participation in snowball sampling. Researcher will answer any questions the participant might have.

Participant will be asked to sign informed consent.

Interviewer will turn on digital recording device.

Questions & possible prompts:

1. Please describe the circumstances that initially led you to use the PChAD program?
  - a. What substance was your child consuming?
  
2. Tell me about your experience with all aspects of the program, starting with the application process
  - a. Tell me about your experience while your child was receiving services in PChAD
  - b. What happened after your child was discharged from PChAD
  - c. How involved were you in the process of your child receiving services through PChAD?
  
3. How do you think using the PChAD program impacted the well-being of your child?
  - a. What impact did the PChAD program have on your relationship with your child?
  - b. What were the positive outcomes? What were the negative outcomes?

4. What were your initial hopes and expectations when you used the program
  - a. How did your experience match those expectations?
  
5. What would you want to change about the PChAD program?
  - a. What other supports or programs do you think would have been helpful?
  
6. Is there anything you think I should know that I didn't ask?