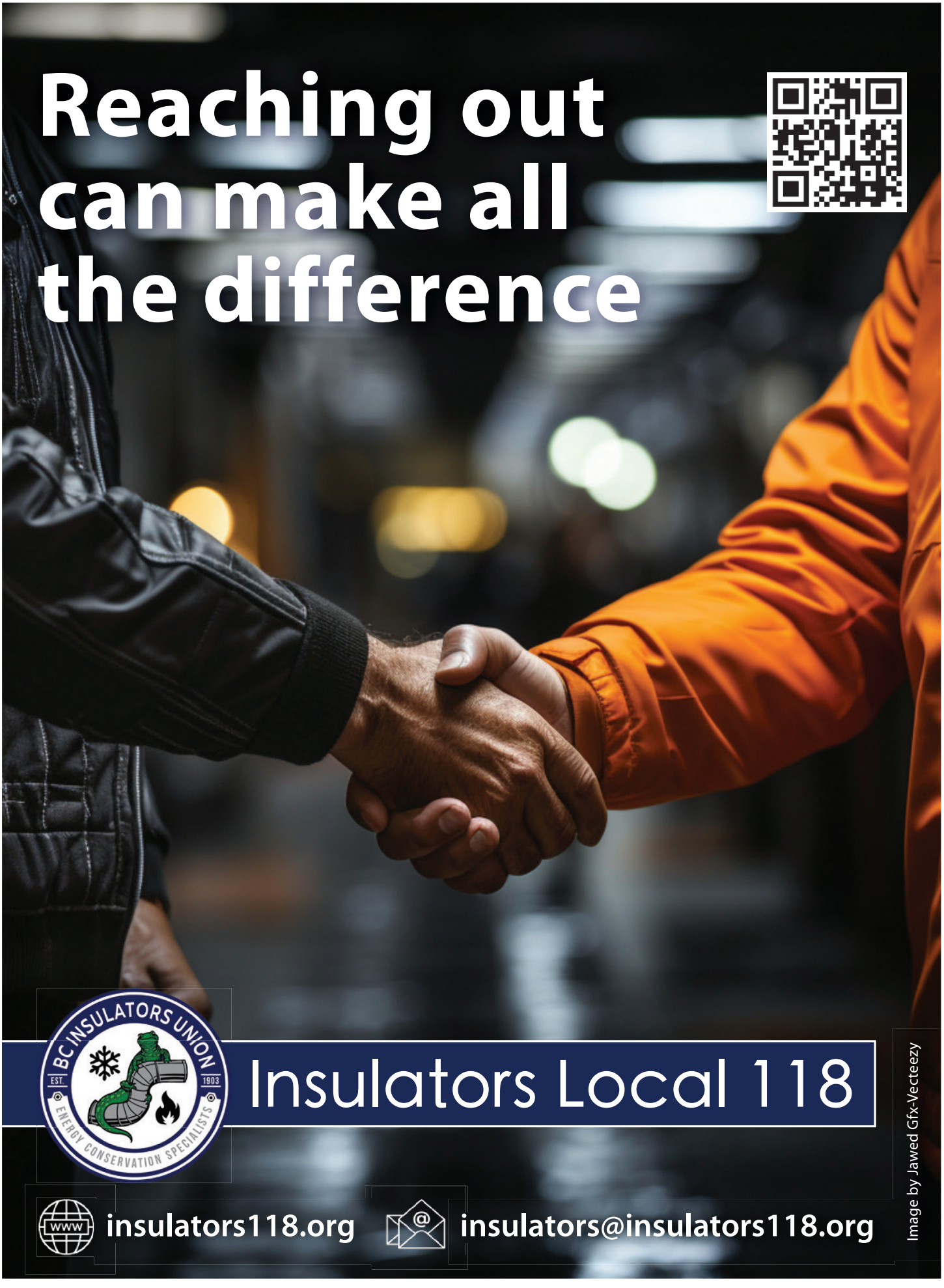
35th ANNIVERSARY
Since 1988
35 years of continuous publication

Family Drug & Alcohol Abuse MANUAL


Reaching out
can make all
the difference
BC INSULATORS UNION
EST.
1903
ENERGY CONSERVATION SPECIALISTS
Insulators Local 118
WWW
insulators118.org
@
insulators@insulators118.org
Image by Jawed Gfx-Vecteezy

The ***Family Drug & Alcohol Abuse Manual*** is of value to anyone concerned with alcohol and drug problems. The main theme is the relationship between these substances and the family. The geographical focus is the Province of British Columbia.

TABLE OF CONTENTS

WHERE TO GET HELP

Directory of Substance Abuse Services

This manual is made available only through the kind support of the businesses that advertise herein. A special THANK YOU goes out to all the businesses included in this manual. The ***Family Drug & Alcohol Abuse Manual*** is one of a series of educational manuals and trade magazines published by ALEXANDER MARKETING.

For information, please write to:
#101-6526 -135th Street, Surrey, BC V3W 8M1
Tel: 604-598-0502 • Fax: 604-598-0504 • Email: info@drugimpaired.org
Web: www.drugimpaired.org

FRAFCA

FRASER REGION ABORIGINAL FRIENDSHIP CENTRE ASSOCIATION

"Our Mission is to support the activities that promote the health and well being of Aboriginal People and to promote the resurgence of resident Aboriginal culture, language and teachings, particularly those of local residency.

DID YOU KNOW...

15600	There are over 15600 Indigenous people in Surrey, the 2nd largest Urban Indigenous population in BC
40%	40% of Indigenous people in Surrey are homeowners.
52%	52% of Indigenous people in Surrey have postsecondary certificate, diploma or degree
7.7%/year	Indigenous population in Surrey is growing at 7% per year

Tel: 604-595-1170
Fax: 604-595-1176
Eml: reception@frafca.org
Web: www.frafca.org
Add: #A101-10095 Whalley Boulevard
Surrey, BC V3T 4G1

INTRODUCTION

The following statistic, repeated over and over again by **law enforcement,** provides a clear indication of the devastation wrought by **substance abuse.**

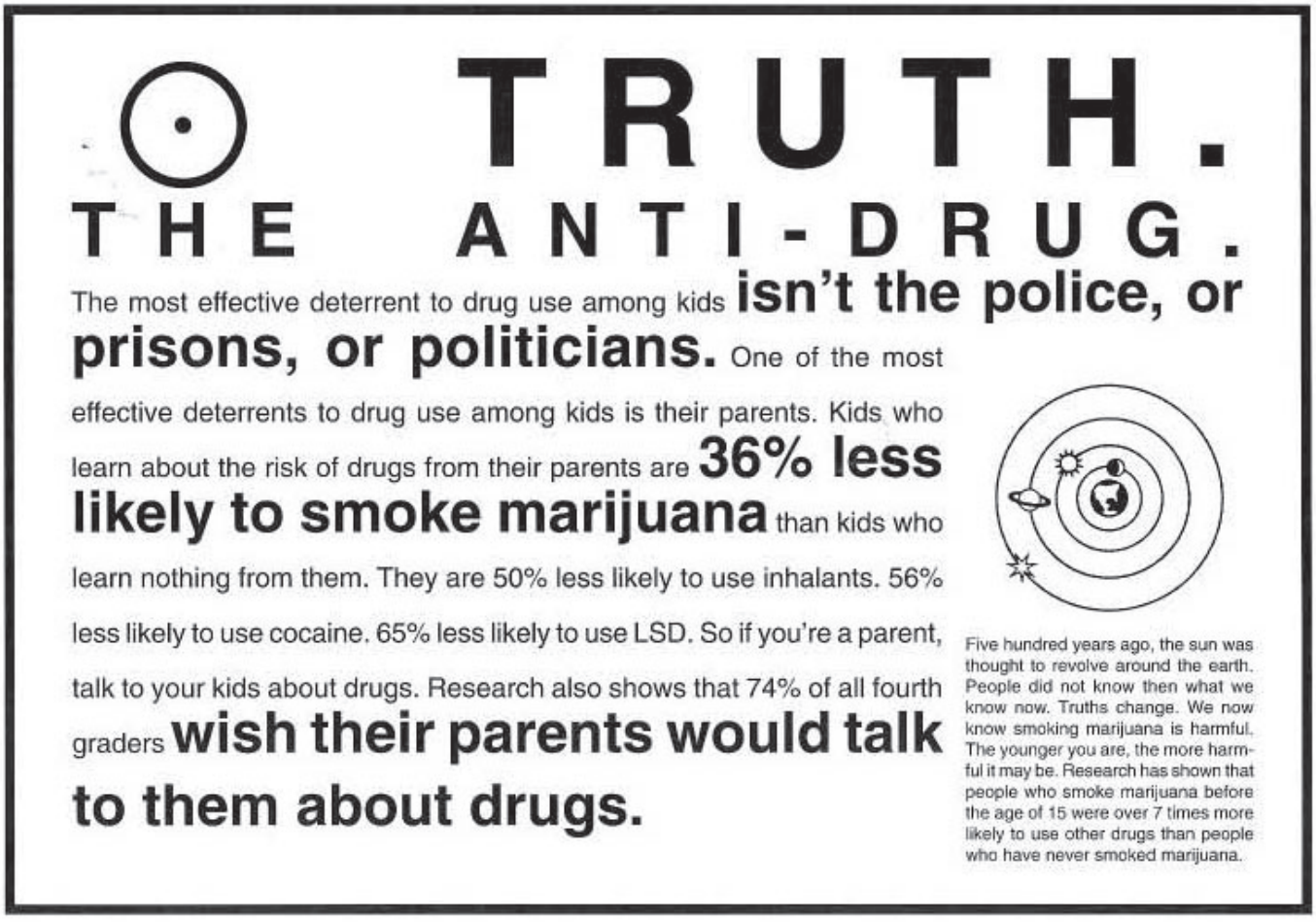
"90% of all crime is drug- and alcohol-related."

The emotional and financial costs, as well as the terrible personal tragedies that result directly from misuse and abuse of drugs and alcohol, are evident from every media source and experienced in virtually every family, school, workplace and community. There are no quick fixes and no easy answers.

The ***FAMILY DRUG & ALCOHOL ABUSE MANUAL*** is produced as a public service and community resource guide to help in the treatment, intervention and prevention of drug and alcohol abuse.

Special thanks must be given to the business owners and their employees, associations, unions and their members who have so generously contributed to the production and free distribution of this manual by advertising in its pages.

There is tremendous hope and strength to be realized in the commitment shown by these businesses to support this effort. The courage to fight drug and alcohol abuse is alive and well!



Narcotics

The term "Narcotic," derived from the Greek word for *stupor*, originally referred to a variety of substances that dulled the senses and relieved pain. Today, the term is used in a number of ways. Some individuals define narcotics as those substances that bind at opiate receptors (cellular membrane proteins activated by substances, like heroin of morphine), while others refer to any illicit substance as a narcotic. In a legal context, narcotic refers to opium and opium derivatives, and their semi-synthetic substitutes. Cocaine and coca leaves, which are also classified as "narcotics," neither bind at opiate receptors nor produce morphine-like effects; they are discussed in the section on stimulants. For the purposes of this discussion, the term "narcotic" refers to drugs that produce morphine-like effects.

Narcotics are used therapeutically to treat pain, suppress cough, alleviate diarrhea, and induce anesthesia. Narcotics are administered in a variety of ways. Some are taken orally, transdermally (skin patches), intranasally, or injected. They are also available in suppositories and, more recently, in "troches," a form of narcotics that can be sucked like candy. As drugs of abuse, they are often smoked, sniffed or injected. Drug effects depend heavily on the dose, route of administration, and previous exposure to the drug. Aside from their medical use, narcotics produce a general sense of well-being by reducing tension, anxiety and aggression. These effects are helpful in a therapeutic setting, but contribute to their abuse.

Narcotic use is associated with a variety of unwanted effects, including drowsiness, an inability to concentrate, apathy, lessened physical activity, constriction of the pupils, dilation of the subcutaneous blood vessels (causing flushing of the face and neck), constipation, nausea, vomiting and, most significantly, respiratory depression. As the dose is increased, the subjective, analgesic (pain relief), and toxic effect become more pronounced. Except in cases of acute intoxication, there is no loss of motor coordination or slurred speech as occurs with many depressants.

Among the hazards of illicit drug use is the ever-increasing risk of infection, disease and overdose. Medical complications common among narcotic abusers arise primarily from adulterants found in street drugs and in the non-sterile practices of injecting. Skin, lung and brain abscesses, endocarditis (inflammation of the lining of the heart), hepatitis and AIDS are commonly found among narcotic abusers. While pharmaceutical products have a known concentration and purity, clandestinely produced street drugs have unknown compositions. Since there is no simple way to de-

termine the purity of a drug that is sold on the street, the effects of illicit narcotic use are unpredictable and can be fatal. Physical signs of narcotic overdose include constricted (pinpoint) pupils, cold and clammy skin, confusion, convulsions, severe drowsiness, and respiratory depression (slow or troubled breathing). Most narcotic deaths are a result of respiratory depression.

With repeated use of narcotics, tolerance and dependence develop. The development of tolerance is characterized by a shortened duration and a decreased intensity of analgesia, euphoria and sedation, and this creates the need to consume progressively larger doses to attain the desired effect. Tolerant users can consume doses far in excess of the dose with which they initially started.

Chronic narcotic use is associated with physical dependence and a withdrawal of abstinence syndrome when drug use is discontinued. In general, shorter-acting narcotics tend to produce shorter, more intense withdrawal symptoms, while longer-acting narcotics produce a withdrawal syndrome that is protracted but less severe. Although unpleasant, withdrawal from narcotics is rarely life-threatening. The withdrawal symptoms associated with heroin/morphine addiction are usually experienced shortly before the time of the next scheduled dose. Early symptoms include watery eyes, runny nose, yawning and sweating. Restlessness, irritability, loss of appetite, nausea, tremors and drug craving appear as the syndrome progresses. Severe depression and vomiting are common. The heart rate and blood pressure are elevated. Chills, alternating with flushing and excessive sweating, are also symptoms. Pains in the bones and muscles of the back and extremities occur, as do muscle spasms. At any point during this process, a suitable narcotic can be administered to dramatically reverse the withdrawal symptoms. Without intervention, the syndrome will run its course, and most of the overt physical symptoms will disappear within 7 to 10 days.

The psychological dependence associated with narcotic addiction is complex and protracted. Long after the physical need for the drug has passed, the addict may continue to think and talk about the use of drugs, and feel strange or overwhelmed coping with daily activities without being under the influence of drugs. There is a high probability that relapse will occur after narcotic withdrawal when neither the physical environment nor the behavioural motivators that contributed to the abuse have been altered.

There are two major patterns of narcotic abuse or dependence seen in the United States. One involves individuals whose drug use was initiated within the context of medical treatment, and who escalate their dose by obtaining the drug through fraudulent prescriptions and "doctor shopping," or by branching out to illicit drugs. The other pattern of abuse is initiated outside the therapeutic setting, with experimental or recreational use of narcotics. The majority of individuals in this category may abuse narcotics sporadically for months or even years. Although they may not become addicts, the social, medical and legal consequences of their behaviour are very serious. Some experienced users will escalate their narcotic use and will eventually become dependent both physically and psychologically. The younger an individual is when drug use is initiated, the more likely the drug use will progress to dependence and addiction.

Narcotics of Natural Origin

The poppy plant, *Papaver somniferum*, is the source of non-synthetic narcotics. It was grown in the Mediterranean region as early as 5000 B.C., and has since been cultivated in a number of countries throughout the world. The milky fluid that seeps from incisions in the unripe seed pod of this poppy has, since ancient times, been scraped by hand and air-dried to produce what is known as opium. A more modern method of harvesting is by the industrial poppy straw process of extracting alkaloids from the mature, dried plant. The extract may be in liquid, solid or powder form, although most poppy straw concentrate available commercially is a fine brownish powder. More than 50 tons of opium or equivalents in poppy straw concentrate are legally imported into Canada annually for legitimate medical use.

Nitazenes

Nitazenes (ny-TAH-zeenz) are opioids that can be more toxic than fentanyl. They were first found in Canada's unregulated drug supply in 2019, and in BC in 2021. Nitazenes are not approved for clinical use.

Synthetic nitazene opioids are being "cut" (mixed) into BC's unregulated supply. In 2024, and increase in the presence of nitazenes has been found in opioids expected to be oxycodone (OxyContin), hydromophone (Dilaudid), hydrocodone and Percocet:

- N-desethyl etonitazene (considered up to 10 times more toxic than fentanyl)
- Protonitazepyne (considered more than 20 times more toxic than fentanyl)

Be aware:

- Nitazene opioids can increase the risk of overdose, especially for individuals who have lower opioid tolerances or for people who do not use fentanyl.
- Nitazenes are often present with other depressant substances, such as benzodiazepine-related drugs and veterinary tranquilizers. This increases the risk of slow, irregular, or stopped breathing, and decreases in blood pressure and heart rate.
- Naloxone should be used in a suspected overdose and may temporarily reverse the effects of nitazene opioids. Continue to follow the 5 steps to respond to an opioid overdose.

The 5 Steps to Respond to an Opioid Overdose:

What to do in case of overdose

COVID-19 Pandemic recommendations when responding to an overdose.

Remember to put on the non-latex gloves that come in your naloxone kit before you respond.

1. Shout the person's name and shake their shoulders.
2. Call 9-1-1 right away if unresponsive.
3. Give naloxone

- Spray: insert nozzle into nostril, then press plunger down firmly to give the dose (only spray plunger once in the nostril)

Or

- Injectable: Inject 1 vial or ampoule into arm or leg

4. Perform chest compressions only (not rescue breaths)
5. Is it working? If no improvement after 2-3 minutes, repeat steps 3 and 4.

Opium

There were no legal restrictions on the importation or use of opium until the early 1900s. In the Canada, the unrestricted availability of opium, the influx of opium-smoking immigrants from East Asia, and the invention of the hypodermic needle contributed to the more severe variety of compulsive drug abuse seen at the turn of the 20th century. In those days, medicines often contained opium without any warning label. Today there are provincial, federal and international laws governing the production and distribution of narcotic substances. Although opium is used in the form of paregoric to treat diarrhea, most opium imported into Canada is broken down into its alkaloid constituents. These alkaloids are divided into two distinct chemical classes: phenanthrenes and isoquinolines. The principal phenanthrenes are morphine, codeine and thebaine, while the isoquinolines have no significant central nervous system effects and are not regulated.

Morphine

Morphine is the principal constituent of opium and ranges in concentration from 4 to 20 percent. Commercial opium is standardized to contain 10 percent morphine. In Canada, a small percentage of the morphine obtained from opium is

used directly (about 2 tons); the remaining is converted to codeine and other derivatives (about 10 tons). Morphine is one of the most effective drugs known for the relief of severe pain and remains the standard against which new analgesics are measured. Like most narcotics, the use of morphine has increased significantly in recent years. Since 1998, there has been about a two-fold increase in the use of morphine products in Canada.

Morphine is marketed under generic and brand name products, including MS-Contin, Oramorph SR, MSIR, Roxanol, Kadian and RMS. Morphine is used parenterally (by injection) for preoperative sedation as a supplement to anesthesia, and for analgesia. It is the drug of choice for relieving the pain of myocardial infarction and for its cardiovascular effects in the treatment of acute pulmonary edema. Traditionally, morphine was almost exclusively used by injection. Today, morphine is marketed in a variety of forms, including oral solutions, immediate and sustained-release tablets and capsules, suppositories and preparations. In addition, the availability of high-concentration morphine preparations partially reflects the use of this substance for chronic pain management in opiate-tolerant patients.

Codeine

Codeine is the most widely used, naturally occurring narcotic in medical treatment in the world. This alkaloid is found in opium in concentrations ranging from 0.7 to 2.5 percent. However, most codeine used in Canada is produced from morphine. Codeine is also the starting material for the production of two other narcotics, dihydrocodeine and hydrocodone. Codeine is medically prescribed for the relief of moderate pain and cough suppression. Compared to morphine, codeine produces less analgesic, sedation and respiratory depressions, and is usually taken orally. It is made into tablets either alone or in combination with aspirin or acetaminophen. As a cough suppressant, codeine is found in a number of liquid preparations. Codeine is also used to a lesser extent as an injectable solution for the treatment of pain. Codeine products are diverted from legitimate sources and encountered on the illicit market.

Thebaine

Thebaine, a minor constituent of opium, is controlled under international law. Although chemically similar to both morphine and codeine, thebaine produces stimulatory rather than depressant effects. Thebaine is not used therapeutically, but is converted into a variety of substances, including oxycodone, nalbuphine, naloxone, naltrexone and buprenorphine.

Semi-Synthetic Narcotics

The following narcotics are among the more significant substances that have been derived from morphine, codeine and the thebaine contained in opium..

Heroin

First synthesized from morphine in 1874, heroin was not used extensively in medicine until the early 1900s. Commercial production of the new pain remedy was first started in 1898. It initially received widespread acceptance from the medical profession, and physicians remained unaware of its addiction potential for years. The first comprehensive control of heroin occurred with the *Harrison Narcotic Act* of 1914. Today, heroin is an illicit substance having no medical utility in Canada.

Four foreign source areas produce the heroin available in Canada: South America (Columbia), Mexico, Southeast Asia (principally Burma), and Southwest Asia (principally Afghanistan). However, South America and Mexico supply most of the illicit heroin marketed in Canada. South American heroin is a high-purity powder primarily distributed to metropolitan areas on the East Coast. Heroin powder may vary in color from white to dark brown because of impurities left from the manufacturing process or the presence of additives. Mexican heroin, known as "black tar," is primarily available in Western Canada. The colour and consistency of black tar heroin result from the crude processing methods used to illicitly manufacture heroin in Mexico. Black tar heroin may be sticky (like roofing tar) or hard (like coal), and its colour may vary from dark brown to black. Pure heroin is rarely sold on the street, and the retail purity of heroin for major metropolitan areas nationally has averaged about 40.7 percent recently. A "bad" (slang for a small unit of heroin sold on the street) currently contains about 30–50 milligrams of powder, only a portion of which is heroin. The remainder could be sugar, starch, acetaminophen, procaine, benzocaine or quinine, or any of numerous cutting agents for heroin. Traditionally, the purity of heroin in a bag ranged from about 10–70 percent. Black tar heroin is often sold in chunks weighing about an ounce. Its purity is generally less than South American heroin and it's most frequently smoked, or dissolved, diluted and injected. In the

past, heroin in Canada was almost always injected, because this is the most practical and efficient way to administer low-purity heroin. However, the recent availability of higher-purity heroin at relatively low cost has meant that a larger percentage of today's users are either snorting or smoking heroin instead of injecting it. This trend was first captured in the 1999 National Household Survey on Drug Abuse, which revealed that 60–70 percent of people who used heroin for the first time from 1996 to 1998 never injected it. This trend has continued. Snorting or smoking heroin is more appealing to new users because it both the fear of acquiring syringe-borne diseases, e.g., HIV and hepatitis, as well as the social stigma attached to intravenous heroin use. Many new users of heroin mistakenly believe that smoking or snorting heroin is a safe technique for avoiding addiction. However, both the smoking and the snorting of heroin are directly linked to high incidences of dependence and addiction.

According to the 2003 National Survey on Drug Use and Health, during the latter half of the 1990s heroin initiation rates rose to a level not reached since the 1970s. In 1974, there were an estimated 24,000 heroin initiates. Between 1988 and 1994, the annual number of new users ranged from 2,800 and 8,000. Between 1995 and 2001, the number of new heroin users was consistently greater than 10,000. Overall, approximately 370,000 Canadians report having used heroin at least once in their lifetime.

Hydromorphone

Hydromorphone (Dilaudid) is marketed in tablets (2, 4, and 8 mg), suppositories, oral solutions and injectable formulations. Its analgesic potency is from two to eight times that of morphine, but it is shorter acting and produces more sedation that morphine. Much sought after by narcotic addicts, hydromorphone is usually obtained by the abuser through fraudulent prescriptions or theft. The tablets are often dissolved and injected as substitute for heroin.

Oxycodone

Oxycodone is synthesized from thebaine. Like morphine and hydromorphone, oxycodone is used as and analgesic. It is effective orally and is marketed alone in 10, 20, 40, 80, and 160 mg controlled-release tablets (OxyContin), or 5 mg immediate release Capsules (OxyIR), or in combination products with aspirin (Percodan) or acetaminophen (Percocet) for the relief of pain. Oxycodone is abused orally, or the tablets are crushed and sniffed, or dissolved in water and injected. The use of oxycodone has increased significantly. In 1993, about 0.35 tons of oxycodone were manufactured for sale in Canada. In 2003, some 4 tons were manufactured.

Historically, oxycodone products have been popular drugs of abuse among the narcotic-abusing population. In recent years, concern has grown among federal, provincial and local officials about the dramatic increase in the illicit availability and abuse of OxyContin products. These products contain large amounts of oxycodone (10 to 160 mg) in a formulation intended for slow release over about a 12-hour period.

Abusers have learned that this slow-release mechanism can be easily circumvented by crushing the tablet and swallowing, snorting or injecting the drug product for a more rapid and intense high. The criminal activity associated with illicitly obtaining and distributing this drug, as well as serious consequences of illicit use — including addiction and fatal overdose deaths — are of epidemic proportions in some areas of Canada. In September 2004, the FDA approved the use of Palladone (hydromorphone hydrochloride) for the management of persistent pain. This extended-release formulation could have the same risk of abuse as OxyContin.

Hydrocodone

Hydrocodone is structurally related to codeine but is more closely related to morphine in its pharmacological profile. As a drug of abuse, it is equivalent to morphine with respect to subjective effects, opiate signs and symptoms, and "liking" scores. Hydrocodone is an effective cough suppressant and analgesic. It is most frequently prescribed in a combination with acetaminophen (i.e., Vicoden, Lortab), but is also marketed in products with aspirin (Lortab ASA), ibuprofen (Vicoprofen) and antihistamines (Hycomine). All products currently marketed in Canada primarily intended for pain management or antitussive medications are often marketed in liquid formulations. These products are currently under review at the federal level to determine if an increase in regulatory control is warranted.

Hydrocodone products are the most frequently prescribed pharmaceutical opiates in Canada, with over 10 million prescriptions dispensed in 2003–2004. Despite their obvious utility in medical practice, hydrocodone products are among the most popular pharmaceutical drugs associated with drug diversion, trafficking, abuse and addiction. Hydrocodone is the most frequently encountered opiate

pharmaceutical in submissions of drug evidence to federal, provincial and local forensic laboratories. Law enforcement has documented the diversion of millions of dosage units of hydrocodone by theft, doctor shopping, fraudulent prescriptions, bogus "call-in" prescriptions, and diversion by registrants and Internet fraud.

Hydrocodone products are associated with significant drug abuse. Hydrocodone was ranked sixth among controlled substances in the 2002 Drug Abuse Warning Network (DAWN) emergency department (ED) data. Poison control data, DAWN medical examiner (ME) data, and other ME data indicate that hydrocodone deaths are numerous, widespread and increasing in number. In addition, the hydrocodone acetaminophen combinations (accounting for about 80 percent of all hydrocodone prescriptions) carry significant public health risk when taken in excess.

Synthetic Narcotics

In contrast to the pharmaceutical products derived from opium, synthetic narcotics are produced entirely within the laboratory. The continuing search for products that retain the analgesic properties of morphine without the consequent dangers of tolerance and dependence has yet to yield a product that is not susceptible to abuse. A number of clandestinely produced drugs, as well as drugs that have accepted medical uses, fall within this category.

Meperidine

Introduced as an analgesic in the 1930s, meperidine produces effects that are similar, but not identical, to morphine (shorter duration of action and reduced antitussive and antidiarrheal actions). Currently it is used for pre-anesthesia and the relief of moderate to severe pain, particularly in obstetrics and post-operative situations. Meperidine is available in tablets, syrups and injectable forms under generic and brand names (Demerol, Mepergan, etc.). Several analogues of meperidine have been produced clandestinely. During the clandestine synthesis of the analogue MPPP, a neurotoxic by-product (MPTP) was produced. A number of individuals who consumed the MMMP-MPTP preparation developed and irreversible Parkinson's-like syndrome. It was later found that MPTP destroys the same neurons as those damaged in Parkinson's disease.

Narcotics Treatment Drugs

Methadone

German scientists synthesized methadone during the Second World War because of a shortage of morphine. Although chemically unlike morphine or heroin, methadone produces many of the same effects. It was introduced into Canada in 1947 as an analgesic (Dolophine). Today, methadone is used primarily for the treatment of narcotic addiction, although a growing number of prescriptions are being written for chronic pain management. It is available in oral solutions, tablets and injectable formulations.

Methadone's effects can last up to 24 hours, thereby permitting once-a-day oral administration in heroin detoxification and maintenance programs. High-dose methadone can block the effects of heroin, thereby discouraging the continued use of heroin by addicts in treatment. Chronic administration of methadone results in the development of tolerance and dependence. The withdrawal syndrome develops more slowly and is less severe, but more prolonged than that associated with heroin withdrawal. Ironically, methadone used to control narcotic addiction is encountered on the illicit market. Recent increases in the use of methadone for pain management have been associated with increasing numbers of overdose deaths.

LAAM

Closely related to methadone, the synthetic compound levo alphacetylmethadol, or LAAM (ORLMM), has an even longer duration of action (from 48 to 72 hours) than methadone, permitting a reduction in frequency of use. In 1994, it was approved as a treatment drug for narcotic addiction. Both methadone and LAAM have high abuse potential. Their acceptability as narcotic treatment drugs is predicated upon their ability to substitute for heroin, their long duration of action, and their mode of oral administration. Recent data regarding cardiovascular toxicity of LAAM has limited the use of this drug as a first-line therapy for addiction treatment.

Buprenorphine

This drug is a semi-synthetic narcotic derived from thebaine. Buprenorphine was initially marketed in Canada as an analgesic (Buprenex). In 2002, two new products (Subox-

one and Subutex) were approved for treatment of narcotic addiction. Like methadone and LAAM, buprenorphine is potent (30–50 times the analgesic potency of morphine), has a long duration and action, and does not need to be injected. Unlike the other treatment drugs, buprenorphine produces far less respiratory depression and is thought to be safer in overdose.

Dextropropoxyphene

A close relative of methadone, dextropropoxyphene was first marketed in 1957 under the trade name Darvon. Oral analgesic potency is one-half to one-third that of codeine, with 65 mg approximately equivalent to about 600 mg of aspirin. Dextropropoxyphene is prescribed for relief of mild to moderate pain. More than 15 tons of dextropropoxyphene are produced in the United States annually, and more than 100,000 prescriptions were written in Canada last year for the product. This narcotic is associated with a number of toxic side effects and is among the top ten drugs reported by medical examiners in drug-abuse deaths.

Fentanyl

First synthesized in Belgium in the late 1950s, fentanyl, with an analgesic potency of about 80 times that of morphine, was introduced into medical practice in the 1960s as an intravenous anesthetic under the trade name Sublimaze. Thereafter, two other fentanyl analogues were introduced: alfenanil (Alfenta), an ultra-short-acting (5–10 minutes) analgesic, and sufentanil (Sufenta, an exceptionally potent analgensic (5–10 times more potent than fentanyl) for use in heart surgery. Today, fentanyls are extensively used for anesthesia and analgesia. Duragesic, for example, is a fentanyl transdermal patch used in chronic pain management, and Actiq is a solid formulation of fentanyl citrate on a stick that dissolves slowly in the mouth for transmucosal absorption. Actiq is intended for opiate-tolerant individuals and is effective in treating breakthrough pain in cancer patients. Carfentanil (Wildnil) is an analogue of fentanyl with an analgesic potency 10,000 times that of morphine; it is used in veterinary practice to immobilize certain large animals.

Illicit use of pharmaceutical fentanyl's first appeared in the mid-1970s in the medical community and continues to be a problem in Canada. To date, more than a dozen different analogues of fentanyl have been produced clandestinely and identified within Canadian drug traffic. The biological effects of the fentanyls are indistinguishable from those of heroin, with the exception that the fentanyls may be hundreds of times more potent. Fentanyls are most commonly used by intravenous administration, but, like heroin, they may be smoked or snorted.

Nitazenes

Nitazenes (ny-TAH-zeenz) are opioids that can be more toxic than fentanyl. They were first found in Canada's unregulated drug supply in 2019, and in BC in 2021. Nitazenes are not approved for clinical use.

Synthetic nitazene opioids are being "cut" (mixed) into BC's unregulated supply. In 2024, and increase in the presence of nitazenes has been found in opioids expected to be oxycodone (OxyContin), hydromophone (Dilaudid), hydrocodone and Percocet:

- N-desethyl etonitazene (considered up to 10 times more toxic than fentanyl)
- Protonitazepyne (considered more than 20 times more toxic than fentanyl)

Be aware:

- Nitazene opioids can increase the risk of overdose, especially for individuals who have lower opioid tolerances or for people who do not use fentanyl.
- Nitazenes are often present with other depressant substances, such as benzodiazepine-related drugs and veterinary tranquilizers. This increases the risk of slow, irregular, or stopped breathing, and decreases in blood pressure and heart rate.
- Naloxone should be used in a suspected overdose and may temporarily reverse the effects of nitazene opioids. Continue to follow the 5 steps to respond to an opioid overdose.

The 5 Steps to Respond to an Opioid Overdose:

What to do in case of overdose
COVID-19 Pandemic recommendations when responding to an overdose.

Remember to put on the non-latex gloves that come in your naloxone kit before you respond.

1. Shout the person's name and shake their shoulders.
2. Call 9-1-1 right away if unresponsive.
3. Give naloxone

- Spray: insert nozzle into nostril, then press plunger down firmly to give the dose (only spray plunger once in the nostril)

Or

- Injectable: Inject 1 vial or ampoule into arm or leg

4. Perform chest compressions only (not rescue breaths)
5. Is it working? If no improvement after 2-3 minutes, repeat steps 3 and 4.

Pentazocine

The effort to find an effective analgesic with less dependence-producing consequences led to the development of pentazocine (Talwin). Introduced as an analgesic in 1967, it was frequently encountered in the illicit trade, usually in combination with tripelennamine. This product contains a quantity of antagonist (naloxone) sufficient to counteract the morphine-like effects of pentazocine if the tablets are dissolved and injected.

Butorphanol

While butorphanol can be made from thebaine, it is usually manufactured synthetically. It was initially available in injectable formulations for human (Stadol) and veterinary (Torbugesic and Torbutrol) use. More recently, a nasal spray (Stadol NS) became available, and significant diversion and abuse of this product led to the 1997 control of butorphanol. Butorphanol is a clear example of a drug gaining favour as a drug of abuse only after it became available in a form that facilitated greater ease of administration (nasal spray versus injection).

Stimulants

Stimulants, sometimes referred to as "uppers," reverse the effects of fatigue on both mental and physical tasks. Two commonly used stimulants are nicotine, which is found in tobacco products, and caffeine, an active ingredient in coffee, tea, some soft drinks and many non-prescription medicines. Used in moderation, these substances tend to relieve malaise and increase alertness. Although the use of these products has been an accepted part of Canadian culture, the recognition of their adverse effects has resulted in a proliferation of caffeine-free products and efforts to discourage cigarette smoking.

A number of stimulants, however, are under regulatory control. Some of these controlled substances are available be prescription for legitimate medical use in the treatment of obesity, narcolepsy and attention deficit disorders. As drugs of abuse, stimulants are frequently taken to produce a sense of exhilaration, enhance self-esteem, improve mental and physical performance, increase activity, reduce appetite, produce prolonged wakefulness and "get high." They are among the most potent agents of reward and reinforcement that underlie the problem of dependence.

Stimulants are diverted from legitimate channels and clandestinely manufactured exclusively for the illicit market. They are taken orally, sniffed, smoked and injected. Smoking, snorting or injecting stimulants produces a sudden sensation known as a "rush" or a "flash." Abuse is often associated with a pattern of binge use — sporadically consuming of large doses of stimulants over a short period of time. Heavy users may inject themselves every few hours, continuing until they have depleted their drug supply or reached a point of delirium, psychosis and physical exhaustion. During this period of heavy use, all other interests become secondary to re-creating the initial euphoric rush. Tolerance can develop rapidly, and both physical and psychological dependence occur. Abrupt cessation, even after a brief two- or three-day binge, is commonly followed by depression, anxiety, drug craving and extreme fatigue known as a "crash."

Therapeutic levels of stimulants can produce exhilaration, extended wakefulness and loss of appetite. These effects are greatly intensified when large doses of stimulants are taken. Physical side effects, including dizziness, tremor, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting and abdominal cramps, may occur as a result of taking too large a dose at one time or taking large doses over an extended period of time. Psychological effects include agitation, hostility, panic, aggression, and suicidal or homicidal tendencies. Paranoia, sometimes accompanied by both auditory and visual hallucinations, may also occur. Overdose is often associated with high fever, convulsions and cardiovascular collapse. Since accidental death is due partially to the effects of stimulants on the body's cardiovascular and temperature-regulating systems, physical exertion increases the hazards of stimulant use.

Cocaine

Cocaine, the most potent stimulant of natural origin, is extracted from the leaves of the coca plant (*Erythroxylum coca*) that is indigenous to the Andean highlands of South America. Natives in this region chew and brew coca leaves into a tea for refreshment and to relieve fatigue, similar to the customs of chewing tobacco and drinking coffee and tea.

Pure cocaine was first isolated in the 1880s and used as a local anesthetic in eye surgery. It was particularly useful in surgery of the nose and throat because of its ability to provide anesthesia, as well as to constrict blood vessels and limit bleeding. Many of its therapeutic applications are now obsolete due to the development of safer drugs.

Illicit cocaine is usually distributed as a white crystalline powder or as an off-white chunky material. The powder, usually cocaine hydrochloride, is often diluted with a variety of substances, the most common being sugars such as lactose, inositol and mannitol, and local anesthetics such as lidocaine. The adulteration increases the volume, multiplying profits. Cocaine hydrochloride is generally snorted or dissolved in water and injected. It is rarely smoked because it is heat-labile (destroyed by high temperatures).

"Crack," the chunk or "rock" form of cocaine, is a ready-to-use freebase. On the illicit market, it is sold in small, inexpensive dosage units that are smoked. Smoking delivers large quantities of cocaine to the lungs, producing effects comparable to intravenous injection. Drug effects are felt almost immediately, are very intense, and are over quickly. Once introduced in the mid-1980s, crack abuse spread rapidly and made the cocaine experience available to anyone with $10 and access to a dealer. In addition to other toxicities associated with cocaine abuse, cocaine smokers suffer from acute respiratory problems, including cough, shortness of breath, and severe chest pains with lung trauma and bleeding. It is noteworthy that the emergence of crack was accomplished by a dramatic increase in drug abuse problems and drug-related violence.

The intensity of the psychological effects of cocaine, as with most psychoactive drugs, depends on the dose and rate of entry to the brain. Cocaine reaches the brain through the snorting method in three to five minutes. Intravenous injection of cocaine produces a rush in 15–30 seconds, and smoking produces an almost immediate, intense experience. The euphoric effects of cocaine are almost indistinguishable from those of amphetamine, although they do not last as long. These intense effects can be followed by a dysphoric crash. To avoid the fatigue and the depression of coming down, frequent and repeated doses are taken. Excessive doses of cocaine may lead to seizures and death from respiratory failure, stroke or heart failure. There is no specific antidote for cocaine overdose.

Cocaine is the second most commonly used illicit drug (following marijuana) in Canada. More than three million Canadians (14.7%) aged 12 or older have used cocaine at least once in their lifetime. There are no drugs approved for replacement-pharmacotherapy (drugs taken on a chronic basis as a substitute for the abused drug, like methadone for heroin addiction). Cocaine addiction treatment relies heavily on psychotherapy and drugs like antidepressants to relieve some of the effects of cocaine abuse.

Amphetamines

Amphetamine, dextroamphetamine, methamphetamine, and their various salts, are collectively referred to as *amphetamines*. In fact, their chemical properties and actions are so similar that even experienced users have difficulty knowing which drug they have taken.

Amphetamine was first marketed in the 1930s as Benzedrine in an over-the-counter inhaler to treat nasal congestion. By 1937, amphetamine was available by prescription in tablet form for use in the treatment of the sleeping disorder narcolepsy and the behavioural syndrome called "minimal brain dysfunction" — today called attention deficit hyperactivity disorder (ADHD). During World War II, amphetamine was used widely to keep the fighting men going, and both dextroamphetamine (Dexedrine) and methamphetamine (Methedrine) were readily available.

As the use of amphetamines spread, so did their abuse. In the 1960s, amphetamines became a perceived remedy for helping truckers to complete their long routes without falling asleep, for weight control, for helping athletes to perform better and train longer, and for treating mild depression. Intravenous amphetamines, primarily methamphetamine, were abused by a subculture known as "speed freaks." With

experience, it became evident that the dangers of abuse of these drugs outweighed most of their therapeutic uses.

Increased control measures were initiated in 1965 with amendments to the federal food and drug laws to curb the black market in amphetamines. Many pharmaceutical amphetamine products were removed from the market — including all injectable formulations — and doctors prescribed the remaining formulations less freely. Recent increases in medical use of these drugs can be attributed to their use in the treatment of ADHD. The amphetamine products presently marketed include generic and brand name amphetamine (Adderall, Dexedrine, Dextrostat) and brand name methamphetamine (Desoxyn). Amphetamines are all controlled.

To meet the ever-increasing black market demand for amphetamines, clandestine laboratory production has mushroomed. Today, most amphetamines distributed in the black market are produced in clandestine laboratories. Methamphetamine laboratories are by far the most frequently encountered clandestine laboratories in Canada. The ease of clandestine synthesis, combined with the tremendous profits, have resulted in significant availability of illicit methamphetamine, especially on the west coast, where abuse of this drug has increased dramatically in recent years. Large amounts of the illicit methamphetamine are also illicitly smuggled into Canada from the United States and Mexico. Amphetamines are generally taken orally or injected. However, the addition of "ice," the slang name for crystallized methamphetamine hydrochloride, has promoted smoking as another mode of administration. Just as "crack" is smokable cocaine, "ice" is smokable methamphetamine. Methamphetamine, in all its forms, is highly addictive and toxic.

The effects of amphetamines, especially methamphetamine, are similar to cocaine, but their onset is slower and their duration longer. In contrast to cocaine, which is removed quickly from the brain and is almost completely metabolized, methamphetamine remains in the central nervous system longer; in addition, a larger percentage of the drug remains unchanged in the body, producing prolonged stimulant effects. Chronic abuse produces a psychosis that resembles schizophrenia and is characterized by paranoia, picking at the skin, preoccupation with one's own thoughts, and auditory and visual hallucinations. These psychotic symptoms can persist for months and even years after use of these drugs has ceased, and may be related to their neurotoxic effects. Violent and erratic behaviour is frequently seen among chronic abusers of amphetamines (especially methamphetamines).

Methcathinone

Methcathinone, known on the streets as "Cat," is a structural analogue of methamphetamine and cathinone. Clandestinely manufactured, methcathinone is almost exclusively sold in the stable and highly water-soluble hydrochloride salt form. It is most commonly snorted, although it can be taken orally by mixing it with a beverage or diluted in water and injected intravenously. Methcathinone has an abuse potential equivalent to methamphetamine and produces amphetamine-like effects.

Methylphenidate

Methylphenidate, has high potential for abuse and produces many of the same effects as cocaine and amphetamines. Abuse of this substance has been documented among narcotics addicts, who dissolve the tablets in water and inject the mixture. Complications arising from this practice are common due to the insoluble fillers used in the tablets. When injected, these materials block small blood vessels, causing serious damage to the lungs and retina of the eye. Binge use, psychotic episodes, cardiovascular complications, and severe psychological addiction have all been associated with methylphenidate abuse.

Methylphenidate is used legitimately in the treatment of excessive daytime sleepiness associated with narcolepsy, as is the newly marketed stimulant, modafinil (Provigil). However, the primary legitimate medical use of methylphenidate (Ritalin, Methylin, Concerta) is to treat attention deficit hyperactivity disorder (ADHD) in children. The increased use of this substance for the treatment of ADHD has paralleled an increase in its abuse among adolescents and young adults, who crush these tablets and snort the powder to get high. Abusers have little difficulty obtaining methylphenidate from classmates or friends who have had it prescribed.

Anorectic Drugs

A number of drugs have been developed and marketed to replace amphetamines as appetite suppressants. These anorectic drugs include benzphetamine (Didrex), diethylpro-

prion (Tanuate, Tepanil), mazindol (Sanorex, Maxanor). Phendimetrazine (Bontril, Prelu-27), and phentermine (Lonamin, Fastin, Anipex). These substance produce some amphetamine-like effects.

Khat

For centuries, khat, the fresh young leaves of the Catha edulis shrub, has been consumed where the plant is cultivated, primarily East Africa and the Arabian Peninsula. There, chewing khat predates the use of coffee and is used in a similar social context. Chewed in moderation, khat alleviates fatigue and reduces appetite. Compulsive use may result in manic behaviour with grandiose delusions or in a paranoid type of illness, sometimes accompanied by hallucinations. Khat has been smuggled into the Canada and other countries for use by emigrants. It contains a number of chemicals, among which are two controlled substances, cathinone and cathine. As the leaves mature or dry, cathinone is converted to cathine, significantly reducing its stimulatory properties.

Depressants

Historically, people of almost every culture have used chemical agents to induce sleep, relieve stress and allay anxiety. While alcohol is one of the oldest and most universal agents used for these purposes, hundreds of substances have been developed that produce central nervous system depression. These drugs have been referred to as downers, sedatives, hypnotics, minor tranquillizers, anxiolytics and anti-anxiety medications. Unlike most other classes of drugs of abuse, depressants are rarely produced in clandestine laboratories. Generally, legitimate pharmaceutical products are diverted to the illicit market. A notable exception to this is a relatively recent drug of abuse, gamma hydroxybutyric acid (GHB).

Barbiturates were very popular in the first half of the twentieth century. In moderate amounts, these drugs produce a state of intoxication that is remarkably similar to alcohol intoxication. Symptoms include slurred speech, loss of motor coordination and impaired judgment. Depending on the dose, frequency and duration of use, one can rapidly develop tolerance, as well as physical and psychological dependence, on barbiturates. With the development of tolerance, the margin of safety between the effective dose and the lethal dose becomes very narrow. That is, in order to obtain the same level of intoxication, the tolerant abuser may raise his or her dose to a level that may result in coma or death. Although many individuals have taken barbiturates therapeutically without harm, concern about the addiction potential of barbiturates and the ever-increasing number of fatalities associated with them has led to the development of alternative medications. Today, less than 10 percent of all depressant prescriptions in Canada are for barbiturates.

Benzodiazepines were first marketed in the 1960s. Touted as much safer depressants with far less addiction potential than barbiturates, today these drugs account for about one out of every five prescriptions for controlled substances. Although benzodiazepines produce significantly less respiratory depression than barbiturates, it is now recognized that benzodiazepines share many of the undesirable side effects of barbiturates. A number of toxic central nervous system effects are seen with chronic high-dose benzodiazepine therapy, including headaches, irritability, confusion, memory impairment and depression. The risk of over-sedation, dizziness and confusion increases substantially with higher doses of benzodiazepines. Prolonged use can lead to physical dependence even at doses recommended for medical treatment. Unlike barbiturates, large doses of benzodiazepines are rarely fatal unless combined with other drugs or alcohol. Although primary abuse of benzodiazepines is well documented, abuse of these drugs usually occurs as part of a pattern of multiple drug abuse. For example, heroin or cocaine abusers will use benzodiazepines and other depressants to augment their "high" or alter the side effects associated with over-stimulation or narcotic withdrawal.

There are marked similarities among the withdrawal symptoms seen with most drugs classified as depressants. In the mildest form, the withdrawal syndrome may produce insomnia and anxiety, usually the same symptoms that initiated the drug use. With a greater level of dependence, tremors and weakness are also present, and in its most severe from, the withdrawal syndrome can cause seizures and delirium. Unlike the withdrawal syndrome seen with most other drugs of abuse, withdrawal from depressants can be life threatening.

Barbiturates

Barbiturates were first introduced for medical use in the early 1900s. More than 2,500 barbiturates have been synthesized, and, at the height of their popularity, some 50 were marketed for human use. Today, about a dozen are in medical use. Barbiturates produce a wide spectrum of

central nervous system depression, from mild sedation to coma, and have been used as sedatives, hypnotics, anesthetics and anti-convulsants. The primary differences among many of these products are how fast they produce an effect and how long those effects last. Barbiturates are classified as ultrashort, short, intermediate and long-lasting.

The ultrashort-acting barbiturates produce anesthesia within about one minute after intravenous administration. Those in current medical use are methohexita (Brevital), thiamyl (Surital) and thiopental (Pentothal). Barbiturate abusers prefer the short-acting and intermediate-acting barbiturates, among which are amobarbital (Amytal), pentobarbital (Nembutal), secobarbital (Seconal) and Tuinal (an amobarbital/secobarbital combination product). Other short- and intermediate-acting barbiturates include butalbital (Fiorina), butabarbital (Butisol), talbutal (Lotusate) and aprobarbital (Alurate). After oral administration, the onset of action is from 15 to 40 minutes, and the effects last up to six hours. These drugs are used primarily for insomnia and preoperative sedation. Veterinarians use pentobarbital for anesthesia and euthanasia.

Long-lasting barbiturates include Phenobarbital (Luminal) and mephobarbital (Mebaral). The effects of these drugs are realized in about an hour and last for approximately 12 hours, and are used primarily for daytime sedation and the treatment of seizure disorders.

Benzodiazepines

The Benzodiazepine family of depressants is used therapeutically to produce sedation, include sleep, relieve anxiety and muscle spasms, and prevent seizures. In general, benzodiazepines act as hypnotics in high doses, as anxiolytics in moderate doses, and as sedatives in low doses. Of the drugs marketed in the Canada that affect central nervous system function, benzodiazepines are among the most widely prescribed medications. Fifteen members of this group are presently marketed in the Canada, and about twenty additional benzodiazepines are marketed in other countries.

Short-acting benzodiazepines are generally used for patients with sleep-onset insomnia (difficulty falling asleep) without daytime anxiety. Shorter-acting benzodiazepines used to manage insomnia include estazolam (ProSom), flurazepam (Dalmane), temazepam (Restoril) and triazolam (Halcion). Midazolam (Versed), a short-acting benzodiazepine, is utilized for sedation, or for treating anxiety and amnesia in critical-care settings and prior to anesthesia. It is available in Canada as an injectable preparation and a syrup (primarily for pediatric patients).

Benzodiazepines with a longer duration of action are utilized to treat insomnia in patients with daytime anxiety. These benzodiazepines include alprazolam (Xanax), chlordiazepoxide (Librium), clorazepate (Tranxene), diazepam (Valium), halazepam (Paxipam), lorzepam (Ativan), oxazepam (Serax), prazepam (Centrax) and quazepam (Doral). Clonazepam (Klonopin), diazepam and clorazepate are also used as anti-convulsants.

Benzodiazepines are classified. Repeated use of large doses or, in some cases, daily use of therapeutic doses of benzodiazepines is associated with amnesia, hostility, irritability, and vivid or disturbing dreams, as well as tolerance and physical dependence. The withdrawal syndrome is similar to that of alcohol and may require hospitalization. Abrupt cessation of benzodiazepines is not recommended, and tapering down the dose eliminates many of the unpleasant symptoms.

Given the millions of prescriptions written for benzodiazepines, relatively few individuals increase their dose on their own initiative or engage in drug-seeking behaviour. Those individuals who do abuse benzodiazepines often maintain their drug supply by getting prescriptions from several doctors, forging prescriptions, or buying diverted pharmaceutical products on the illicit market. Abuse is frequently associated with adolescents and young adults, who take benzodiazepines to obtain a "high." This intoxicated state results in reduced inhibition and impaired judgment. Concurrent use of alcohol or other depressant with benzodiazepines can be life-threatening. Abuse of benzodiazepines is particularly high among heroin and cocaine abusers. A large percentage of people entering treatment for narcotic or cocaine addiction also report abusing benzodiazepines. Alprazolam and diazepam are the two most frequently encountered benzodiazepines on the illicit market.

Flunitrazepam

Flunitrazepam (Rohypnol) is a benzodiazepine that is not manufactured or legally marketed in Canada, but is smuggled in by traffickers. In the mid-1990s, flunitrazepam was extensively trafficked in Florida and Texas. Known as "rophies," "roofies," and "roach," flunitrazepam gained popularity among younger individuals as a "party" drug. In this context, flunitrazepam is placed in the alcoholic drink of

an unsuspecting victim to incapacitate them and prevent resistance from sexual assault. The victim is frequently unaware of what has happened to them and often does not report the incident to authorities. A number of actions by the manufacturer of this drug and by government agencies have resulted in reducing the availability and abuse of flunitrazepam in Canada.

Gamma Hydroxybutyric Acid (GHB) In recent years, gamma hydroxybutric acid (GHB) has emerged as a significant drug of abuse throughout Canada. Abusers of this drug fall into three major groups: (1) users take GHB for its intoxicant or euphoriant effects; (2) bodybuilders who abuse GHB for its alleged utility as an anabolic agent or as a sleep aid; and (3) individuals who use GHB as a weapon for sexual assault. These categories are not mutually exclusive, and an abuser may use the drug illicitly to produce several effects.

GHB is frequently taken with alcohol or other drugs that heighten its effects, and is often found at bars, nightclubs, rave parties and gyms. Teenagers and young adults who frequent these establishments are the primary users. Like flunitrazepam, GHB is often referred to as a "date rape" drug. GHB involvement in rape cases is likely to be unreported or unsubstantiated because GHB is quickly eliminated from the body, making detection in body fluids unlikely. Its fast onset of depressant effects may leave the victim with little memory of the details of the attack.

GHB produces a wide range of central nervous system effects, including dose-dependent drowsiness, dizziness, nausea, amnesia, visual hallucinations, hypotension, bradycardia, severe respiratory depression and coma. The use of alcohol in combination with GHB greatly enhances its depressant effects. Overdose frequently requires emergency room care, and many GHB-related fatalities have been reported.

Gamma butyrolactone (GBL) and 1,4-butanediol are GHB analogues that can be used as substitutes for GHB. When ingested, these analogues are converted to GHB and produce identical effects. GBL is also used in the clandestine production of GHB as an immediate precursor. Both GBL and 1,4-butanediol have been sold at health food stores and on various Internet sites.

The abuse of GHB began to seriously escalate in the mid-1990s. For example, in 1994 there were 55 emergency department episodes involving GHB reported in the Drug Abuse Warning Network (DAWN) system. By 2002, there were just over 3,330 emergency-room episodes. DAWN data also indicates that most users were male, less than 25 years of age, and taking the drug orally for recreational use.

Paraldehyde

Paraldehyde (Paral) is a depressant used most frequently in hospital settings to treat delirium tremens associated with alcohol withdrawal. Many individuals who become addicted to paraldehyde have been initially exposed during treatment for alcoholism and, despite the disagreeable odour and taste, come to prefer it to alcohol. This drug in not used by injection because of tissue damage, and, taken orally, it can be irritating to the throat and stomach. One of the signs of paraldehyde use is a strong, characteristic smell to the breath.

Chloral Hydrate

The oldest of the hypnotic sleep-inducing depressants, chloral hydrate was first synthesized in 1832. Marketed as syrups or soft gelatin capsules, chloral hydrate takes effect in a relatively short time (30 minutes) and will induce sleep in about an hour. A solution of chloral hydrate and alcohol constituted the infamous "knockout drops" or "Mickey Finn." At therapeutic doses, chloral hydrate has little effect on respiration and blood pressure; however, a toxic dose produces severe respiratory depression and very low blood pressure. Chronic use is associated with liver damage and a severe withdrawal syndrome. Although some physicians consider chloral hydrate to be the drug of choice for sedation of children before diagnostic, dental or medical procedures, its general use as a hypnotic has declined.

Glutethemide and Methaqualone

Glutethemide (Doriden) was introduced in 1954 and methaqualone (Quaalude, Sopor) in 1965 as safe barbiturate substitutes. Experience demonstrated, however, that their addiction liability and the severity of withdrawal symptoms were similar to those of barbiturates. By 1972, "luding out" — taking methaqualone with wine — was a popular college pastime. Excessive use leads to tolerance, dependence and withdrawal symptoms similar to those of barbiturates. In Canada, the marketing of Methaqualone pharmaceutical products stopped in 1984.

Meprobamate

Meprobamate was introduced as an anti-anxiety agent in 1955 and is prescribed primarily to treat anxiety, tension and associated muscle spasms. More than four tons are distributed annually in Canada under generic and brand names such as Miltown and Equanil. This drug's onset and duration of action are similar to intermediate-acting barbiturates; however, therapeutic doses of meprobamate produce less sedation and toxicity than barbiturates. Excessive use can result in psychological and physical dependence. Carisoprodol (Soma), a skeletal muscle relaxant, is metabolized to meprobamate. This conversion may account for some of the properties associated with carisoprodol and likely contributes to its abuse.

Newly Marketed Depressants

Zolpidem (Ambien) and zaleplon (Sonata) are two relatively new, benzodiazepine-like CNS depressants that have been approved for the short-term treatment of insomnia. Both of these drugs share many of the same properties as the benzodiazepines.

Cannabis

Cannabis sativa L., the cannabis plant, grows wild throughout most of the tropic and temperate regions of the world. Prior to the advent of synthetic fibres, the cannabis plant was cultivated for the tough fibre of its stem. In Canada, cannabis is legitimately grown only for scientific research.

Cannabis contains chemicals called cannabinoids that are unique to the cannabis plant. Among the cannabinoids synthesized by the plant are cannabinol, cannabidiol, cannabinolidic acids, cannabigerol, cannabichromene, and several isomers of tetrahydrocannabinol. One of these, delta-9- tetrahydrocannabinol (THC), is believed to be responsible for most of the characteristic psychoactive effects of cannabis. Research has resulted in development and marketing of the dronabinol (synthetic THC) product, Marinol, for the control of nausea and vomiting caused by chemotherapeutic agents used in the treatment of cancer and to stimulate appetite in AIDS patients.

Cannabis products are usually smoked. Their effects are felt within minutes, reach their peak in 10–30 minutes, and may linger for two or three hours. The effects experienced often depend upon the experience and expectations of the individual user, as well as the activity of the drug itself. Low doses tend to induce a sense of well-being and a dreamy state of relaxation that may be accompanied by a more vivid sense of sight, smell, taste and hearing, as well as by subtle alterations in thought formation and expression. This state of intoxication may not be noticeable to an observer. However, driving, occupational or household accidents may result from a distortion of time and space relationships, and impaired motor coordination. Stronger doses intensify reactions. The individual may experience shifting sensory imagery, rapidly fluctuating emotions, fragmentary thoughts with disturbing associations, and altered sense of self-identity, impaired memory, and a dulling of attention despite an illusion of heightened insight. High doses may result in image distortion, a loss of personal identity, fantasie, and hallucinations.

Three drugs come from cannabis — marijuana, hashish and hashish oil — and are distributed throughout Canada's illicit market. Today, cannabis is illicitly cultivated, both indoors and out, to maximize its THC content, thereby producing the greatest possible psychoactive effect.

Marijuana

Marijuana is the most frequently encountered illicit drug worldwide. In Canada, 57 percent of adults aged 19 to 28 have reported using marijuana in their lifetime. Among younger Canadians, 17.5 percent of eighth graders and 46.1 percent of twelfth graders had used marijuana in their lifetime. The commonly used term "marijuana," refers to the leaves and flowering tops of the cannabis plant that are dried to produce a tobacco-like substance. Marijuana varies significantly in its potency, depending on the source and selections of plant materials used. The form of marijuana known as sinsemilla (Spanish, sin semilla: without seed), derived from the unpollinated female cannabis plant, is preferred for its high THC content. Marijuana is usually smoked in the form of loosely rolled cigarettes called joints, in bongs, or in hollowed-out commercial cigars called blunts. Joints and blunts may be laced with a number of adulterants, including phencyclidine (PCP), substantially altering the effects and toxicity of these products. Street names for marijuana include pot, grass, weed, Mary Jane and reefer. Although marijuana grown in the United States

was once considered inferior because of a low concentration of THC, advancements in plant selection and cultivation have resulted in higher THC-containing domestic marijuana. In 1974, the average THC content of illicit marijuana was less than one percent. Today most commercial-grade marijuana from Mexico/Columbia and domestic outdoor cultivated marijuana has an average THC content of about 4–6 percent. Between 1998 and 2002, the NIDA-sponsored Marijuana Potency Monitoring System (MPMP) analyzed 4,603 domestic samples. Of those samples, 379 tested over 15 percent THC, 69 tested between 20 and 25 percent THC, and 4 tested over 25 percent THC.

Marijuana contains known toxins and cancer-causing chemicals. Marijuana users experience the same health problems as tobacco smokers, e.g., bronchitis, emphysema and bronchial asthma. Some of the effects of marijuana use also include increased heart rate, dryness of the mouth, reddening of the eyes, impaired motor skills and concentration, and hunger with an increased desire for sweets. Extended use increases risk to the lungs and reproductive system, as well as suppression of the immune system. Occasionally, hallucinations, fantasies and paranoia are reported. Long-term chronic marijuana use is associated with Amotivational Syndrome characterized by apathy; impairment of judgment, memory and concentration; and loss of interest in personal appearance and pursuit of goals.

Hashish

Hashish consists of the THC-rich resinous material of the cannabis plant that is collected, dried and then compressed into a variety of forms, e.g., balls, cakes or cookie-like sheets. Pieces are then broken off, placed in pipes, and smoked. The Middle East, North Africa and Pakistan/Afghanistan are the main sources of hashish. The THC content of hashish that reaches Canada, where demand is limited, averaged about five percent in the 1990s.

Hashish Oil

The term "hash oil" is used by illicit drug users and dealers, but is a misnomer in suggesting any resemblance to hashish. Hashish oil is produced by extracting the cannabinoids from plant material with solvent. The colour and odour of the resulting extract will vary, depending on the type of solvent used. Current samples of hash oil — a viscous liquid ranging from amber to dark brown in colour — average about 15 percent THC. In terms of its psychoactive effect, a drop of two of this liquid on a cigarette is equal to a single "joint" of marijuana.

Hallucinogens

Hallucinogens are among the oldest known group of drugs used for their ability to alter human perception and mood. For centuries, many of the naturally occurring hallucinogens found in plants and fungi have been used for a variety of shamanistic practices. In more recent years, a number of synthetic hallucinogens have been produced, some of which are much more potent than their naturally occurring counterparts.

The biochemical, pharmacological and physiological basis for hallucinogenic activity is not well understood. Even the name for this class of drugs is not ideal, since hallucinogens do not always produce hallucinations.

However, taken in non-toxic dosages, these substances produce changes in perception, thought and mood. Physiological effects include elevated heart rate, increased blood pressure and dilated pupils. Sensory effects include perceptual distortions that vary with dose, setting and mood. Psychic effects include disorders of thought associated with time and space. Time may appear to stand still and forms and colours seem to change and take on new significance. This experience may be either pleasurable or extremely frightening. It needs to be stressed that the effects of hallucinogens are unpredictable each time they are used.

Weeks or even months after some hallucinogens have been taken, the user may experience flashbacks — fragmentary recurrences of certain aspects of the drug experience in the absence of actually taking the drug. The occurrence of a flashback is unpredictable, but is likely to occur more frequently in younger individuals. With time, these episodes diminish and become less intense.

The abuse of hallucinogens in Canada received much public attention in the 1960s and 1970s. A subsequent decline in their use in the 1980s may be attributed to real or perceived hazards associated with taking these drugs.

However, a resurgence of the use of hallucinogens is cause for concern. According to the 2003 Monitoring the Future Study, 10.6 percent of twelfth graders reported hallucinogen use in their lifetime. Hallucinogenic mushrooms, LSD and MDMA are popular among junior and senior high school students who use hallucinogens.

There is a considerable body of literature that links the use of some of the hallucinogenic substances to neuronal damage in animals, and recent data support that some hallucinogens are neurotoxic to humans. However, the most common danger of hallucinogen use is impaired judgment that often leads to rash decisions and accidents.

LSD

Lysergic acid diethylamide (LSD) is the most potent hallucinogen known to science, as well as the most highly studied. LSD was originally synthesized in 1938 by Dr. Albert Hoffman. However, its hallucinogenic effects were unknown until 1943, when Hoffman accidentally consumed some LSD. It was later found that an oral dose of as little as 0.000025 grams (or 25 micrograms, equal in weight to a couple grains of salt) is capable of producing rich and vivid hallucinations. Because of its structural similarity to a chemical present in the brain and its similarity in effects to certain aspects of psychosis, LSD was used as a research tool to study mental illness. LSD abuse was popularized in the 1960s by individuals like Timothy Leary, who encouraged students in America to "turn on, tune in, and drop out." LSD use has varied over the years, but it still remains a significant drug of abuse. In 2003, the lifetime prevalence of LSD use for eighth and twelfth graders was 2.1 and 5.9 percent, respectively.

The average effective oral dose is from 20–80 micrograms, with the effects of higher doses lasting for 10–12 hours. LSD is usually sold in the form of impregnated paper (blotter acid), typically imprinted with colourful graphic designs. It has also been encountered in tablets (microdots), thin squares of gelatin (window panes), in sugar cubes and, though rarely, in liquid form.

Physical reactions may include dilated pupils, lowered body temperature, nausea, "goose bumps," profuse perspiration, increased blood sugar, and rapid heart rate. During the first hour after ingestion, the user may experience visual changes with extreme changes in mood. In the hallucinatory state, the LSD user may suffer impaired depth and time perception, accompanied by distorted perception of the size and shape of objects, movements, colour, sound, touch and the user's own body image. During this period, the ability to perceive objects through the senses is distorted: a user may describe "hearing colours" and "seeing sounds." The ability to make sensible judgments and see common dangers is impaired, making the user susceptible to personal injury. After an LSD "trip," the user may suffer acute anxiety or depression for a variable period of time. Flashbacks have been reported days of even months after taking the last dose.

Psilocybin & Psilocybin and Other Tryptamines

A number of hallucinogenic substances are classified chemically as tryptamines. Most of these are found in nature but many, if not all, can be produced synthetically. Psilocybin and psilocin (4-hydroxy-N,N-dimethyltryptamine) are obtained from certain mushrooms indigenous to tropical and subtropical regions of South America, Mexico and the United States. As pure chemicals at doses of 10–20 mg, these hallucinogens produce muscle relaxation, dilation of pupils, vivid visual and auditory distortions, and emotional disturbances. However, the effects produced by consuming preparations of dried or brewed mushrooms are far less predictable, and largely depend on the particular mushrooms used and the age/preservation of the extract. There are many species of "magic" mushrooms that contain varying amounts of other chemicals. As a consequence, the hallucinogenic activity, as well as the extent of toxicity produced by various plant samples, are often unknown.

Dimethyltryptamine (DMT)

N,N-Dimethyltruptamine has a long history of use and is found in a variety of plants and seeds. It can also be produced synthetically. It is ineffective when taken orally, unless combined with another drug that inhibits its metabolism. Generally, it is sniffed, smoked or injected. The effective hallucinogenic dose in humans is about 50–100 mg and lasts for around 45–60 minutes. Because the effects last only about an hour, the experience has been referred to as a "businessman's trip."

A number of other hallucinogens have very similar structures and properties to those of DMT.

Diethyltryptamine (DET) N,N-Diethyltryptamine, for example, is an analogue of DMT and produces the same pharmacological effects but is somewhat less potent than DMT. Bufotenine is a substance found in certain mushrooms, seeds and skin glands of Bufo toads. In general, most bufotenine preparations from natural sources are extremely toxic. N,N-Diiopropyl1- 5-methoxytryptamine (referred to as Foxy-Methoxy) is an orally active tryptamine recently encountered in Canada.

Peyote and Mescaline

Peyote is a small, spineless cactus, Lophophora williamsii, whose principal active ingredient is the hallucinogen mescaline (3, 4, 5 trimethoxyphenethylamine). From earliest recorded time, peyote has been used by natives in northern Mexico and the southwestern United States as part of their religious rites.

The top of the cactus above ground — also referred to as the *crown* — consists of disc-shaped buttons that are cut from the roots and dried. These buttons are generally chewed or soaked in water to produce an intoxicating liquid. The hallucinogenic dose of mescaline is about 0.3–0.5 grams and lasts about 12 hours. While peyote produced rich visual hallucinations that were important to the native American peyote users, the full spectrum of effects served as a chemically induced model of mental illness. Mescaline can be extracted from peyote or produced synthetically.

Most chemical variations of mescaline and amphetamine have been synthesized for their "feel good" effects. 4-Methyl-2,5-dimethoxyamphetamine (DOM) was introduced into the Canadian drug scene in the late 1960s and was nicknamed STP — an acronym for "serenity, tranquility and peace." Other illicitly produced analogues include 4-bromo- 2.5-dimethoxyamphetamine (2C-B of Nexus). In 2000, para-methoxyamphetamine (PMA) and paramethoxymethamphetamine (PMMA) were indentified in tablets sold as ecstasy. PMA, which first appeared on the illicit market briefly in the early 1970s, is associated with a number of deaths in Canada, the U.S. and Europe.

New Hallucinogens

A number of phenethylamine and tryptamine analogues have been encountered on the illicit market. Those recently placed under federal control include 2C-T-7 (dimethoxy-4-(n)-propylthiophenethylamine), permanently placed in Schedule 1 in March 2004, and 5-methoxy-diisopropyltyptamine) and AMT (alphamethyltryptamine), placed in Schedule 1 on an emergency basis in April 2003. In addition, a number of other analogues are being encountered. These include DIPT (N,N-diisopropyltrypttamine), DPT (N,N-dipropyltryptamine), 5-MeO-AMT (e-methylisopropyltryptamine), MIPT (N,Nmethylisopropyltryptamine) and 5-MeO-MIPT (5-Methoxy, N,N-methylisorporyltryptamine), to name a few. While these drugs are not specifically listed under the CSA, individuals trafficking in these substances can be prosecuted under the Analogue Statute of the CSA. The ever-increasing numbers of these types of hallucinogens being encountered by law enforcement is a testament to the effects of individuals to engage in profitable drug enterprises while trying to avoid criminal prosecution.

MDMA (Ecstasy) and Other Phenethylamines

3,4-Methylenedioxumethamphetamine (MDMA, Ecstasy) was first synthesized in 1912 but remained in relative obscurity for many years. In the 1980s, MDMA gained popularity as a drug of abuse, resulting in its final placement in Schedule 1 of the CSA. Today, MDMA is extremely popular. In 2000, it was estimated that 200,000 tablets were smuggled into Canada every week.

MDMA produces both amphetamine-like stimulation and mild mescaline-like hallucinations. It is touted as a "feel good" drug with an undeserved reputation for safety. MDMA produces euphoria, increased energy, increased sensual arousal and enhanced tactile sensations. However, it also produces nerve cell damage that can result in psychiatric disturbances and long-term cognitive impairments. The user will often experience increased muscle tension, tremors, blurred vision and hyperthermia. The increase in body temperature can result in organ failure and death.

MDMA is usually distributed in tablet form and taken orally at doses ranging from 50–200 mg. Individual tablets are often imprinted with graphic designs or commercial

logos, and typically contain 80–100 mg of MDMA. After oral administration, effects are felt within 30–45 minutes, peak at 60–90 minutes, and last for 4–6 hours. Analysis of seized MDMA tablets indicates that about 80 percent of all samples actually contain MDMA-positive samples also contain MDA (3,4-methylenedioxyamphetamine) and MDAE (3,4-methylenedioxyethylamphetamine), while another 10 percent contain amphetamine, methamphetamine or both. Fraudulent MDMA tablets frequently contain combinations of ephedrine, dextromethorphan, and caffeine or newer piperazine compounds.

Hundreds of compounds can be produced by making slight modifications to the phenethylamine molecule. Some of these analogues are pharmacologically active and differ from one another in potency, speed of onset, duration of action and capacity to modify mood, with or without producing overt hallucinations. The drugs are usually taken orally, sometimes snorted and (rarely) injected. Because they are produced in clandestine laboratories, they are seldom pure and the amount in a capsule or tablet is likely to vary considerably.

Initiation of ecstasy use increased in Canada from 1993 until 2001, when it peaked at 550,000 million new users. In 2002, the number declined to 320,000. Two-thirds (66 percent) of new ecstasy users in 2002 were 18 or older, and 50 percent were male.

Phencyclidine and Related Drugs

In the 1950s, phencyclidine (PCP) was investigated as an anesthetic but, due to the side effects of confusion and delirium, its development for human use was discontinued. It became commercially available for use as a veterinary anesthetic in the 1960s under the trade name Sernylan. In 1978, due to considerable abuse, the manufacture of phencyclidine as Sernylan was discontinued. Today, virtually all of the phencyclidine encountered on the illicit market in Canada is produced in clandestine laboratories.

PCP is marketed illicitly under a number of other names, including Angel Dust, Supergrass, Killer Weed, Embalming Fluid and Rocket Fuel, reflecting the range of its bizarre and volatile effects. In its pure form, it is a white crystalline powder that dissolves readily in water.

However, most PCP on the illicit market contains a number of contaminants as a result of makeshift manufacturing, causing the colour to range from tan to brown and the consistency from powder to a gummy mass. Although sold in tablet and capsules as well as powder and liquid form, it is commonly applied to a leafy material, such as parsley, mint, oregano or marijuana, and smoked.

The drug's effects are as varied as its appearance. A moderate amount of PCP often causes the user to feel detached, distant and estranged from his surroundings. Numbness, slurred speech and loss of coordination may be accompanied by a sense of strength and invulnerability. A blank stare, rapid and involuntary eye movements, and an exaggerated gait are among the more observable effects. Auditory hallucinations, image distortion, severe mood disorders, and amnesia may also occur. In some users, PCP may cause acute anxiety and a feeling of impending doom, and in others, paranoia and violent hostility; in some, it may produce a psychosis indistinguishable from schizophrenia. PCP use is associated with a number of risks, and many believe it to be one of the most dangerous drugs of abuse.

Modification of the manufacturing process may yield chemically related analogues capable of producing psychic effects similar to PCP. Four of these substances — N-ethyl-l-phenylcyclohexylamine of PCE, 1-(phenylcyclohexyl) pyrrolidine or PCPy,1- [1-(2-thienyl)cyclohexyl] piperdine or TCP, and 1-p1- (2-thienyl)cyclohexyl]pyrrolidine or TCPy — have been encountered on the illicit market and placed in Schedule 1 of the CSA. Telazol, a Schedule 111 veterinary anesthetic containing tiletamine (a PCP analogue), in combination with zolazepam, (a benzodiazepine), is sporadically encountered as a drug of abuse.

Ketamine

Ketamine is a rapidly acting general anesthetic. Its pharmacological profile is essentially the same as phencyclidine. Like PCP, ketamine is referred to as a dissociative anesthetic because patients feel detached or disconnected from their pain and environment when anesthetized with this drug. Unlike most anesthetics, ketamine produces only mild respiratory depression and appears to stimulate, not depress, the cardiovascular system. In addition, ketamine has both analgesic and amnesic properties and is associated with less

confusion, irrationality and violent behaviour than PCP. Use of ketamine as a general anesthetic for humans has been limited due to adverse effects, including delirium and hallucinations. Today, it is used primarily in veterinary medicine, but has some utility for emergency surgery in humans.

Although ketamine has been marketed in Canada for many years, it was only recently associated with significant diversion and abuse, and was placed in Schedule 111 of the CSA in 1999. Known in the drug culture as "Special K" or "Super K," ketamine has become a staple at dance parties or "raves." Ketamine is supplied to the illicit market by the diversion of legitimate pharmaceuticals (Ketaset, Ketalar). It is usually distributed as a powder obtained by removing the liquid from the pharmaceutical products. As a drug of abuse, ketamine can be administered orally, snorted or injected. It is also sprinkled on marijuana or tobacco, and smoked. After oral or intranasal administration, effects are evident in about 10–15 minutes and are over in about an hour.

After intravenous use, effects begin almost immediately and reach peak effects within minutes. Ketamine can act as a depressant or a psychedelic. Low doses produce vertigo, ataxia, slurred speech, slow reaction time and euphoria. Intermediate doses produce disorganized thinking, altered body image, and a feeling of unreality with vivid visual hallucinations. High doses produce analgesia, amnesia and coma.

Inhalants

Inhalants are a diverse group of substances that include volatile solvents, gases and nitrites that are sniffed, snorted, huffed or bagged to produce intoxicating effects similar to alcohol. These substances are found in common household products such as glues, lighter fluid, cleaning fluids and paint products. Inhalant abuse is the deliberate inhaling or sniffing of these substances to get high, and it is estimated that about 1,000 substances are misused in this manner. The easy accessibility, low cost, legal status, and ease of transport and concealment make inhalants one of the first substances abused by children.

The highest incidence of use is among 10- to 12-year-old children, with rates of use declining with age. Parents worry about alcohol, tobacco and drug use, but may be unaware of the hazards associated with products found within their own homes. Knowing what these products are and how they might be harmful, and recognizing the signs and symptoms of their use as inhalants, can help a parent prevent their abuse.

For example, volatile solvents are found in a number of everyday products. Some of these products include nail polish remover, lighter fluid, gasoline, paint and paint thinner, rubber glue, waxes and varnishes. Chemicals found in these products include toluene, benzene, methanol, methylene chloride, acetone, methyl ethyl ketone, methyl butyl ketone, trichloroethylene and trichlorethane. The gas used as a propellant in canned whipped cream and in small lavender metallic containers called "whippets" (used to make whipped cream) is nitrous oxide or "laughing gas" — the same gas used by dentists for anesthesia. Tiny cloth-covered ampules, called poppers or snappers, contain amyl nitrite, a medication used to dilate blood vessels. Butyl nitrite, sold as tape head cleaner and referred to as "rush," "locker room" or "climax," is often sniffed or huffed to get high.

Inhalants may be sniffed directly from an open container or huffed from a rag soaked in the substance and held to the face. Alternatively, the open container or soaked rag can be placed in a bag where the vapours can concentrate before being inhaled. Some chemicals are painted on the hands and fingernails or placed on shirt sleeves or wrist bands to enable the abuser to continually inhale the fumes without being detected by a teacher or other adult. Although inhalant abusers may prefer one particular substances due to its taste or odour, a variety of substances may be used because of similar effects, availability and cost. Once the substance is inhaled, the extensive capillary surface of the lungs allows rapid absorption of the substance, and blood levels peak rapidly. Entry into the brain is fast, and the intoxicating effects are short-lived but intense.

Inhalants depress the central nervous system, producing decreased respiration and blood pressure. Users report distortion in perceptions of time and space. Many users experience headaches, nausea, slurred speech and loss of motor coordination. Mental effects may include fear, anxiety or depression. A rash around the nose and mouth may be seen, and the abuser may start wheezing. An odour of paint or organic solvents on clothes, skin and breath is sometimes a sign of inhalant abuse. Other indicators of inhalant abuse include slurred speech or staggering gait, red/glassy/watery eyes, and excitability or unpredictable behaviour.

The chronic use of inhalants has been associated with a number of serious health problems. Sniffing glue and paint thinner causes kidney abnormalities, while sniffing the solvents toluene and trichloroethylene causes liver damage. Memory impairment, attention deficit and diminished non-verbal intelligence have been related to the abuse of inhalants. Deaths resulting from heart failure, asphyxiation and aspiration have occurred.

Steroids

When athletes gather, the issue of performance-enhancing drugs, especially anabolic steroids, once again gains international attention. These drugs are used by high school, college, professional and elite amateur athletes in a variety of sports (weight lifting, track and field, swimming, cycling and others) to obtain a competitive advantage. Body builders and fitness buffs take anabolic steroids to improve their physical appearance, and individuals in occupations requiring enhanced physical strength (e.g., body guards, night club bouncers, construction workers) are also known to use these drugs.

Anabolic steroids are defined as any drug or hormonal substance chemically and pharmacologically related to testosterone (other than estrogens, progestins and corticosteroids) that promotes muscle growth. Once viewed as a problem associated only with professional and elite amateur athletes, various reports indicate that anabolic steroid abuse has increased significantly among adolescents. According to the 2003 Monitoring the Future Study, 2.5 percent of eighth graders, 3.0 percent of tenth graders, and 3.5 percent of twelfth graders reported using steroids at least once in their lifetime.

Most illicit anabolic steroids are sold at gyms and competitions, and through mail-order operations. For the most part, these substances are smuggled into Canada from a range of countries. The illicit market includes various preparations intended for human and veterinary use, as well as bogus and counterfeit products. The most commonly encountered anabolic steroids on the illicit market include testosterone, nandrolone, methenolone, stanozolol and methandrostenolone. Other steroids seen include boldenone, fluoxymesterone, methendriol, methyltestosterone, oxandrolone, oxymetholone and trenbolone.

A limited number of anabolic steroids have been approved for medical and veterinary use. The primary legitimate use of these drugs in humans is for the replacement of inadequate levels of testosterone resulting from a reduction or absence of functioning testes. Other indications include anemia and breast cancer. Experimentally, anabolic steroids have been used to treat a number of disorders, including AIDS wasting, erectile dysfunction and osteoporosis. In veterinary practice, anabolic steroids are used to promote feed efficiency and to improve weight gain, vigour and hair coat. They are also used in veterinary practice to treat anemia and counteract tissue breakdown during illness and trauma.

When used in combination with exercise training and a high-protein diet, anabolic steroids can promote increased size and strength of muscles, improve endurance, and decrease recovery time between workouts. They are taken orally or by intramuscular injection. Users concerned about drug tolerance often take steroids on a schedule called a cycle. A cycle is a period of 6–14 weeks of steroid use, followed by a period of abstinence or reduction in use. Additionally, users tend to "stack" the drugs, using multiple drugs concurrently. Although the benefits of these practices are unsubstantiated, most users feel that cycling and stacking enhances the efficiency of the drugs and limits their side effects.

Another mode of steroid use is called "pyramiding." With this method, users slowly escalate steroid use (increasing the number of drugs used at one time and/or the dose and frequency of one or more steroids), reach a peak amount at mid-cycle, and gradually taper the dose toward the end of the cycle. The escalation of steroid use can vary with different types of training. Body builders and weight lifters tent to escalate their dose to a much higher level than do long-distance runners and swimmers.

The long-term adverse health effects of anabolic steroid use are not definitely known. There is, however, rising concern about possible serious health problems associated with the abuse of these agents, including cardiovascular damage, cerebrovascular toxicity and liver damage.

Physical side effects include elevated blood pressure and cholesterol levels, severe acne, premature balding, reduced sexual function and testicular atrophy. In males, abnormal breast development (gynecomastia) can occur. In females, anabolic steroids have a masculinizing effect, resulting in more body hair, a deeper voice, smaller breasts and fewer menstrual cycles. Several of these effects are irreversible. In adolescents, abuse of these agents may prematurely stop the

lengthening of bones, resulting in stunted growth. For some individuals, the use of anabolic steroids may be associated with psychotic reactions, manic episodes, feelings of anger or hostility, aggression, and violent behaviour.

A variety of non-steroid drugs are commonly found within the illicit anabolic steroid market. These substances are used primarily for one or more of the following reasons: 1) to serve as an alternative to anabolic steroids; 2) to alleviate short-term adverse effects associated with anabolic steroids; they include clenbuterol, human growth hormone, insulin, insulin-like growth factor and GHB. Drugs used to prevent or treat adverse effects of anabolic steroid use include tamoxifen, diuretics and human chorionic gonadotropin. Diuretics, probenocid and epitestosterone may be used to mask anabolic steroid use. Over the last few years, a number of precursors to either testosterone or nandrolone have been marketed as dietary supplements in Canada. Some of these substances include androstenedione, androstenediol, norandrostenedione, norandrostenediol and dehydroepiandrosterone (DHEA).

Chapter 1

ALCOHOL AND DRUGS: CANADIAN POLICY DEVELOPMENT

Background/Introduction

Many Canadian organizations in a wide variety of industry sectors are concerned about alcohol and drug use patterns and the need to take appropriate steps to deal with employees who may be impaired on the job. Many have provided assistance programs to help those with current or emerging alcohol or drug problems. Some have work rules around alcohol and drug use, while others may have some reference to "fitness for duty" requirements in a Health and Safety policy. However, many employers are recognizing that this may not be enough to minimize safety risk and associated liabilities. They are implementing comprehensive policies and supplementing their approach with alcohol and drug testing under certain circumstances.

There have not been a significant number of surveys on drug use patterns in Canada; however, we do have some data that suggest that, among the general population, overall substance use is at levels that lead to unacceptable impacts on health and safety, resulting in high social and financial cost to Canadians. The Canadian Alcohol and Drug Use Monitoring Survey 2012 provides the most recent survey information on alcohol and drug use patterns for Canadian adults (aged 15 and older). The following highlights are of interest:

- Alcohol is by far the most prevalent substance used by Canadian adults; the most recent national survey found the following:
  - 78.4% of Canadian adults reported being current drinkers (past year);
  - males are more likely than females to be current drinkers, to exceed the low-risk drinking guidelines, and report harms from drinking; and
  - reported current use in BC is slightly lower than national patterns (78.1%).
- Marijuana continues to be the illicit drug of choice. The same survey found the following:
  - 10.2% of Canadians report being current marijuana users (up from 9.1% in 2011);
  - males (13.7%) remain more likely than females (7.0%) to be current users;
  - 20.3% of those aged 15–24 report being current users, as do those 8.4% of those 25+;
  - 11.3% of Canadians reported using any drug (including pharmaceuticals) to get high in the past year, with males more likely (15.2%) than females (7.7%);
  - 38.7% of current users reported harm to self as a result of use; and
  - reported current cannabis use in BC is the highest in Canada at 13.8%, and reported use of any drug was the highest at 14.9%.

To put the Canadian situation into perspective, the International Narcotics Control Board's 2011 report (March 2012) confirmed that prescription drug abuse is a significant problem in the U.S., Canada and Mexico. The amount of cocaine entering Canada from the U.S. annually has more than doubled in the last five years. Most of the cannabis produced in Canada is consumed within the country, although some is sent to the United States.

Canada remains a significant manufacturer of ecstasy (which, although primarily intended for domestic use, is increasingly being trafficked to the United States, as well as expanding markets such as Australia, Japan and New Zealand); the market is now expanding to Asia, the Caribbean and Mexico.

Alcohol and Drug Policies and Testing Programs: Recent Trends

A significant number of employers, primarily with operations considered to be "safety-sensitive," are introducing alcohol and drug policies focused on fitness for work and minimizing risk of accidents and injuries. Court and arbitration decisions have confirmed that employers do not need "proof" of a problem before taking proactive steps in this area to ensure workplace and public safety.

Unlike the United States and some of the European countries, the Canadian government has decided not to issue regulations requiring policies and testing in certain industry sectors, nor

has it provided guidance on how to deal appropriately with workplace drug use. As a result, there is no guidance on appropriate policies/programs, nor any Canadian standards or procedures for the testing process. Based on a number of rulings and human rights commission policies, there has been guidance available on the need for assessment and appropriate accommodation for individuals who have a diagnosed dependency, although a finite point to "undue hardship" remains unclear. Much of the direction of Canadian policies and testing programs is drawn from interpretation of a variety of legal decisions issued over the last 10–15 years.

Policy Development — Canadian Direction: The primary impetus for programs in Canada came initially in the transportation and oil and gas sectors. In the mid-1990s, cross-border truck and bus drivers were regulated by the U.S. government in the absence of Canadian regulatory direction. Companies were obliged to have comprehensive alcohol and drug testing programs (including pre-employment and random testing) in place as a condition of operating in the United States. Most felt obliged, for health and safety reasons, to extend their policies to all employees (although not the random testing requirement).

A key human rights decision (Autocar Connaisseur), as well as changes in the position of various human rights commissions in this area, are causing some companies to rethink maintaining this differentiation. In particular, the most recent policy of the Federal Human Rights Commission has allowed for testing as a condition of qualification for a safety-sensitive position, as part of a reasonable cause or post-incident investigation, in a post-treatment situation to support continue recovery, and as a condition of continued employment after a policy violation. The Commission policy also allows for random alcohol and drug testing for truck and bus drivers whether regulated by the U.S. government or not. It also notes that a case could be made for random testing of other safety-sensitive positions as long as a bona fide occupational requirement can be established.

Parallel to this activity in transportation, after the Exxon Valdez incident off the coast of Alaska in the late 1980s, many companies in the oil and gas sector began to introduce comprehensive policies, with testing triggered in a number of circumstances. The Exxon subsidiary in Canada (Imperial Oil) also introduced random testing, but it was not widely embraced by other Canadian companies in this sector. Most of them had programs in place by the mid 1990s and many have reviewed

and updated these programs in recent years as the legal situation around testing has become clearer.

They have also extended their requirements to contract workers. In Northern Alberta, the Construction Owner's Association of Alberta, in conjunction with contractors and unions, created a "Model" to help guide contractors in setting their own policies in this area. It sets out core standards around fitness for work, and alcohol and other drug use and possession, as well as provisions for reasonable cause and post-incident testing, and is supported through education, training, and an opportunity for members in contravention of the rules to get assistance for a problem and be reassigned to the site. Reference to site access and random testing is in the most recent version of the Model. Further revisions were underway in 2014.

As more and more of the site owners have required site-access testing before a contract worker can begin a job, sites in northern Alberta have been experiencing delays in getting people on the job. As a result, an additional program was developed called the Rapid Site Access Program (RSAP). It does not take the place of the Model, but supplements it. It is a voluntary program through which a worker can pass a drug test and be put in a random "pool" through which he or she can be tested at any time. Owners that have accepted the program will waive the site-access requirement provided the worker's status remains "active." Should someone refuse or fail a test, they are sent for an assessment to determine whether there is a dependency; the worker would be expected to comply with any recommended treatment, and would be subject to a monitoring program for a specific period of time on returning to active status. In addition, a pilot program that would implement random testing on a more extensive basis is expected to be implemented on a number of these northern Alberta sites once further clarity is received from the courts on the conditions under which it can be introduced (the Drug and Alcohol Risk Reduction Pilot Project or DARRPP).

A similar direction has been taken in the B.C. and Saskatchewan construction industries. In order to minimize safety risk and liabilities, Canadian employers in many other industry sectors are implementing alcohol and drug policies that establish appropriate standards around possession and use, offer education, training and access to assistance, provide methods to investigate policy violations, and set out consequences for violation. They also set out minimum requirements that con-

tractors must meet when doing their work. One investigative tool to which many are now turning for detection and deterrence is alcohol and drug testing. The most active areas are in higher-risk industries, including forestry, mining, manufacturing and warehousing, other transportation (not affected by the cross-border requirements), utilities, construction, policing, municipal transit, etc. Some municipalities and health care facilities are taking steps to address the issue as well.

Policy Development — Process: There are a number of key areas that policies must address, and several difficult decisions that need to be made. The first step is to establish a background to the specific policy decisions that follow. There are some valid reasons for taking a "two-step" process. The courts/arbitrators/human rights tribunals have found that the reasons for establishing the policy — the thought patterns that go behind it — are just as important as the policy components themselves.

The policy should meet the standard set out by the Supreme Court to establish a bona fide occupational requirement for introducing the policy, as well as for introducing certain requirements (e.g., testing) or having higher standards for safety-sensitive or other designated positions or designated locations. The process should involve consultation with representatives from key parts of the organization, and ensure that the policy ultimately implemented results from an assessment of the organization's specific requirements and responds to those requirements. This would include the following:

- identifying all current practices, policies and services, including provisions in OH & S manuals, the collective agreement, employee benefit programs, etc.;
- ensuring the policy builds from this base;
- identifying gaps or missing pieces;
- determining what can be improved and ensuring the policy addresses this;
- assessing the degree of risk in the operations, identifying any past problems or incidents;
- looking at external factors, including recent legal decisions, trends and practices of others in the industry, general information on use patterns, impacts and effective solutions;

- identifying likely stakeholder expectations and how conflicting expectations will be handled; and
- setting out overall objectives for the program (which will be a foundation for its implementation).

Policy Components: Various adjudicators have indicated that simply putting in place a policy copied from a U.S. parent or someone else in the industry will not meet the Supreme Court test. There is no "typical" policy or program; if the steps above are followed, each program will reflect the unique corporate culture and values of the company, the fundamental aspects of the business it is in, the regulatory environment within which it must operate, and, most important, the specific program needs. However, there are a number of key areas that policies must address, and several difficult decisions that need to be tackled. And it should be clear throughout the following sections that assistance for those who may have a problem is an important part of a balanced approach.

Canadian companies cannot simply implement a testing program or policy. Testing may play a role as an investigation tool or deterrence tool, but must be part of a broader approach that includes the following:

1. Awareness and education programs, both at policy introduction and ongoing;
2. Access to assistance, through an internal or contracted employee assistance program or, as appropriate, community resources;
3. Training for supervisors in their role under the policy, including both performance management for early identification of potential problems, and appropriate steps to take to investigate a possible policy violation; and
4. A variety of tools to investigate if someone may be in violation of the policy.

Each of these components should be included in any company program. The policy statement itself should:

- be written in a user-friendly way and broadly communicated to all employees;
- provide clear direction on the objective and application (who is covered and under what circumstances);
- outline the applicable rules and responsibilities, including any higher standards for risk- or safety-sensitive positions;
- clarify avenues to access assistance, reinforce the importance of obtaining assistance for a problem before it impacts the workplace, and outline conditions for returning to duty, including aftercare provisions on a case-by-case basis;
- set out the procedures that will be followed to investigate a possible policy violation, (e.g., investigation and escort procedures if someone is unfit for work, accident investigation, impaired driving situations, searches, alcohol and drug testing); and
- set out consequences for a policy violation and any conditions for continued employment, including provisions for a Substance Abuse Professional assessment to determine whether the individual has a problem in need of accommodation.

In order to be effective, it must be carefully communicated so everyone knows what is expected of them and where to get assistance if they require it. Someone must be in charge of the overall program — usually called the Program Administrator — to ensure that consistent communications, education and training all take place, and who will contract for necessary external resources, including testing services, Employee Assistance Program or other counselling services, and Substance Abuse Professionals to provide specific assessments in a post-violation situation or if an employee requests help for a problem through the company.

Trends in Accommodation: Federal and provincial human rights legislation prohibits discrimination on the basis of a disability. Current or former dependence on alcohol or drugs is considered a disability under the federal act, and has been interpreted in the same manner at the provincial level. Issues around reasonable accommodation, and establishing a bona fide occupational requirement (bfor) for treating someone differently need to be addressed.

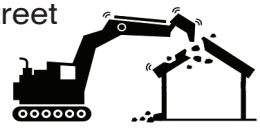
Prevention initiatives, including access to assessment, assistance, treatment and follow-up services, as well as modifying hours or duties in certain circumstances, would all contribute to accommodation responsibilities. Employee Assistance Programs (EAP), either internally provided or externally con-

tracted, are an employee benefit in many larger organizations. With more and more companies of all sizes putting in place policies in recent years, there has been recognition of the need to provide broad-brush, confidential assistance programs for employees (and often for family members).

Most EAPs provide access to services provided by a variety of professionals, including psychologists, social workers and addiction specialists. Although not limited to addictions, these professionals can be one of the most effective tools in dealing with alcohol and other drug problems in the workplace. An effective EAP provides confidential assistance with problems that interfere with an employee's ability to function on the job efficiently and safely, through prevention, identification, assessment and referral, as well as follow-up services. EAP services are normally accessed on a voluntary basis, although suggested referrals during the performance management process may also be triggered.

Although there have been professionals working in the field of substance abuse for many years, the concept of a "Substance Abuse Professional," or SAP, has taken on a new meaning when it comes to workplace policies in recent years. SAP services are entirely separate and different from the counselling services provided by an EAP. A SAP referral is normally triggered under a company's alcohol and drug policy when an employee violates stated rules regarding alcohol or drug use (e.g., use on the job, a positive test result, etc.) and becomes subject to discipline. The SAP must have knowledge of and clinical experience in the diagnosis and treatment of alcohol- and drug-related disorders. Due to human rights obligations to accommodate an individual with a drug or alcohol dependency, the SAP's role is to:

- assess whether the individual has a dependency;
- make recommendations regarding education and/or treatment as appropriate;
- confirm that the recommended program is or was being followed; and
- recommend a return-to-duty monitoring program to support someone's continued recovery and return to work (this often includes unannounced testing, particularly in higher-risk situations).



A more recent trend is to not wait for a policy violation to trigger a SAP referral. Predicated on a greater obligation to address potential safety risk, employers are increasingly making directed referrals for a SAP assessment in a performance management situation in which the employee specifically says they may have a problem with alcohol or drugs. In this case, and especially in situations in which the individual's work is risk- or safety-sensitive, employers cannot ignore the situation. This is an opportunity to trigger an assessment and assistance for the problem. Failure to do so could present a safety risk to the individual and those with whom they work.

The key to this is understanding that the SAP's responsibilities are separate and distinct from the counselling services provided through the EAP. Note that some programs refer to a Substance Abuse Expert (SAE), but the responsibilities and expectations of service should be the same. Finally, there is a direct conflict of interest if the organization providing the SAP assessment also profits from providing a treatment program or a testing program; one would have to question the objectiveness of an assessment when financial considerations are in play. Employers contracting for SAP services should ensure that this conflict of interest does not exist.

Medical Marijuana: Health Canada no longer issues licences for individuals to possess or produce marijuana for medical purposes. Instead, they are regulating a commercial market of licensed producers responsible for the production and distribution for medical purposes. Patients do not obtain a prescription, but instead they receive documentation from a licensed medical practitioner that allows them to purchase it directly from a licensed producer. In a March 31, 2014 release, Health Canada stated, "Marijuana is not an approved drug or medicine in Canada and has not gone through the necessary rigorous scientific trials for efficacy or safety. Health Canada does not endorse the use of marijuana, but the courts have required reasonable access to a legal source of marijuana for medical purposes." Health Canada also quoted experts outlining the significant side effects associated with use, not only with respect to negative health impacts, but also with respect to the skills needed to operate any vehicle or perform a task.

Employers should:

- ensure that their alcohol and drug policy is absolutely clear about a prohibition around the use of illicit drugs and alcohol in conjunction with work;
- set out the requirement for responsible use of medications, and the requirement to use a safe alternative wherever available; and
- expect employees to consult with their physician or pharmacist regarding the side effects of any medications being used, and require them to advise the company of any need for modified work.

Employers may find out about authorization to "use" directly from the employee or through a drug test. They will then need to determine if they can allow the employee to safely continue working in their regular job, or whether alternative work can be accommodated and for how long. In the case of medical marijuana use, it may well be that the authorizing physician offers no cautions, even for those operating vehicles and equipment; this is why a second, more knowledgeable medical opinion may be required from a doctor with an occupational health background (not simply the doctor who authorized the use). Legal advice may be needed regarding whether accommodation is possible and what that should look like. Employers have a duty to accommodate a medical condition up to undue hardship, but the question remains whether they have a duty to accommodate the choice of medication when use of marijuana presents a safety risk and there are alternative medications that can be used. There have been no legal cases impacting the workplace to date, so further direction is needed from arbitrators and human rights panels.

Testing Programs: As noted, Canadian companies have taken the initiative to put in place comprehensive policies with a priority on workplace safety, including assessment and assistance provisions. For the most part, the testing procedures that have been adopted mirror those developed in the U.S. governing Canadian cross-border drivers. Canadian laboratories have been accredited directly by the U.S. Department of Health and Human Services to provide sample analysis services at a very high standard.

The following trends have been seen in recent years:

- Canadian companies are increasingly including alcohol and drug testing as one component of their company

policies, particularly in what would be considered risk- or safety-sensitive industries or activities. Historically, the standard practice has been as follows:

- to collect a urine sample for analysis in a certified laboratory with the core testing panel of marijuana, opiates, amphetamines (including methamphetamine and ecstasy), phencyclidine (PCP) and cocaine, although protocols can be set up to test for other drugs as required under the circumstances (e.g., for a follow-up testing program on direction from the SAP/SAE or treatment centre in special client circumstances, or where there are significant problems with additional drugs in a community).
- to use a calibrated breath analyzer for alcohol testing, although a saliva test (to "screen" out negatives) and a second urine collection for lab analysis has been used in remote locations if a breath machine is not readily available. This back-up option should be used with caution. Careful steps are needed in the collection stage, and conversion of results is needed to blood-equivalent levels.

• Because of the demands of the regulated motor carriers for qualified testing services,

- a comprehensive network of trained collection facilities was established across Canada to meet "'cross-border" motor carrier needs; collection capability has expanded further, as there is more demand throughout the country.
- there is currently one Canadian lab certified to provide fully accurate testing services for Canadian companies (located in London, Ontario). The company has also introduced an approved screening lab in Edmonton.
- a number of Canadian occupational health physicians have had the appropriate training to be certified as Medical Review Officers — an essential part of any workplace testing program.

  As such, an infrastructure has been established, and companies exploring the option of including testing under their policies can be assured of reliable and accurate results (provided they used qualified and expe-

rienced service providers). Normally this is managed by a third party administrator who provides all of the necessary services under one package. This is a case of "buyer beware," though. Unfortunately, product manufacturers with quick and cheap solutions, unqualified collectors, doctors claiming to be qualified Medical Review Officers (MROs), and non-certified labs have shown up and started promoting their services. In the absence of any government standards, employers have been at the mercy of product promoters; without asking the right questions, some have ended up with highly ineffective programs, or programs that would not be defensible if challenged.

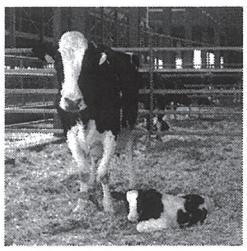
- Other technologies have also been in development.
  - "0n site" or "point of collection" urine drug testing screens are increasingly being used for reasonable cause and post-incident testing, particularly where there are concerns about turnaround times because of distance from the lab. The process is the same as would be followed for standard lab urinalysis, except that the first-stage immunoassay screen is performed at the collection site. It is essential that these test kits also have the capability to test for adulterants at the time the "screen" test is taken, or else they will present a "false negative" result that would not go on to a lab for confirmation testing. Any "non-negative" result must be confirmed in a certified laboratory with qualified independent MRO review of positive lab results.
  - oral fluid (saliva) samples are being used in many locations to test for drug presence, and this technology will increasingly be looked at as a less invasive alternative in the coming years. The newest version can also test for alcohol levels. The sample must be collected, sealed and forwarded to a laboratory for analysis using the same procedures for urinalysis. There are no accurate "quick" saliva tests available at this time despite what the marketers are saying — they are not yet specific enough to accurately identify use of a number of the drugs being tested at designated cut-off levels. The result is that drug users will have negative test results at site and thus their sample would never go to the lab. However, it is expected that the accuracy of these devices will improve over time.
  - Many Canadian employers are also recognizing the significant problems with Oxycontin (prescribed pain killers), which is increasingly being used illegally. Testing for these synthetic opiates is often added to the opiate group, but must be specifically requested in the testing program.
- **Adulteration?** There are hundreds of products available in North America to help individuals who want to "beat" the drug test. These are available through magazines, head shops, novelty shops, dietary supplement retailers and websites. The products include dilution products, cleansing products, adulteration additives, and substituted urine (devices, reservoir, catheter). Some products are effective and detectable, while others are not yet detectable or disappear on their own. Some are not effective, but are still marketed and sold as being able to "beat a test."

Because of the proliferation of products, if an employer decides to begin testing, the company must ensure adulterant checks are part of the program, and any confirmed adulteration of a sample is considered a "refusal to test" with appropriate consequences.

Legal Developments

Canadian employers face a variety of potential legal issues that may be related to alcohol and drugs and are best addressed through consistent implementation of a clear and reasonable policy. This can include addressing the liabilities associated with the actions of impaired employees at work, due diligence responsibility around workplace safety, actions in response to possession or trafficking of illicit drugs, and the duty to accommodate those with a chemical dependency in accordance with human rights provisions.

In fact, a recent court decision confirmed that "human rights legislation fits within the entire legal framework within which enterprises must function … and … that framework includes other standards that also reflect deep values of the community such as those established by workers' compensation legislation prohibiting an employer from placing an employee in a situation of undue risk, and the standards of the law of negligence." The court stated that this fuller legal framework must be con-



sidered when a company's occupational requirements are being assessed. The key responsibilities follow.

- **Occupational Health and Safety Legislation** places the onus on employers to ensure the health, safety and welfare of employees; employers must prove diligence in minimizing or eliminating all potential safety risks, including those associated with independent contractors. Organizations can be liable for any negligent or wrongful acts committed by an employee acting within the scope or course of employment, which could include negligence in allowing an alcohol- or drug-impaired employee on the worksite or on a public highway once declared unfit to work, and negligence when returning someone to a risk-sensitive job after treatment or after a policy violation where sufficient monitoring mechanisms are not in place and a substance-related incident results. The company policy should have provisions to address these responsibilities.

  The courts have clarified that occupational health and safety responsibilities can extend to contracted workers and sub-contractors. As a result, increasingly companies are not only introducing policies for employees, but they are also introducing requirements for contractors (generally by issuing a "Statement of Expectations for Contractors").

- Reinforcing these safety obligations, Canada's Criminal Code has been amended to set rules for attributing to organizations, including corporations, criminal liability for the acts of their representatives.

  There is a legal duty for all persons directing work to take reasonable steps to ensure the safety of workers and the public. In essence, criminal negligence is established in case in which the organization or individual, in doing anything or in omitting to do anything that is its/his/her legal duty to do, shows wanton or reckless disregard for the lives or safety of others. There have been no cases at this point, but it is expected that this legislation will impact how organizations deal with substance-abuse issues.

- **Driver Liability** makes the owner of a vehicle accountable for any injuries or damages caused by a person driving the vehicle with the owner's consent. This is why companies must be clear that the rules around alcohol and drug use apply when someone is operating a company vehicle and/

or operating a vehicle on behalf of the company. It is also why policies set out the requirement to report receiving an impaired driving charge or licence suspension (provincial or territorial law) in these situations, as they have lost their licence for a specified period of time after being identified as a safety risk by the police.

- **Hosting Liabilities** associated with the provision of alcohol to others or hosting alcohol-related events can include the provider of the alcohol, the occupier of the premises in which the problem occurred, and the sponsor of the event. If they are in any way implicated in an event involving alcohol use, the company can be held responsible for injuries the person who drank may receive, and for any third party they may injure. This is why Canadian companies must have clear rules around when alcohol can be used, as well as procedures for social and business hosting where alcohol use may be involved. This includes procedures to minimize the possibility that someone may leave in an intoxicated state that could result in injury to themselves or a third party.

- **Federal and Provincial Human Rights Legislation** prohibits discrimination on the basis of a disability. Current or former dependence on drugs or alcohol is considered a disability under the federal Act, and has been interpreted in the same manner at the provincial level. Issues around reasonable accommodation, and establishing a bona fide occupational requirement (bfor) for treating someone differently need to be addressed. Prevention initiatives, including access to assessment, assistance, treatment and follow-up services, as well as modifying hours or duties in certain circumstances, would all represent accommodation responsibilities.

- **Legal direction on Testing** is becoming clearer on a number of fronts. There are at present no provincial or federal laws that would specifically prohibit drug testing, and there have been no Supreme Court decisions in this area. However, a number of recent decisions provide some guidance on where the law may stand on this issue. An interesting twist in the last few years has made legal interpretation a bit more complicated. The human rights laws apply to all individuals, and decisions would accept testing in a number of situations, with the key limitation being the requirement for applicant and random testing

acceptable only for safety-sensitive positions for which a bona fide occupational requirement can be established. However, a number of arbitrators have concluded that there may need to be higher standards to meet in a unionized setting, leading the way to limiting reasonable cause and post-incident testing to safety-sensitive positions or safety-sensitive work environments.

Although each case has its own unique aspects, it appears the trend has been to find testing acceptable:

- as part of an investigation in an unfit for duty (reasonable cause) situation in which there is evidence that alcohol or drug use may be a contributing factor.
- as part of a full investigation into an accident/incident situation, without reasonable cause, provided testing is only for those whose acts or omissions contributed to the situation.
- as part of a monitoring program after treatment to support continued recovery, normally on the advice of a substance-abuse professional or treatment program.
- as a condition of return to duty after a policy violation and on an ongoing, follow-up basis.
- as a condition of "certification" or qualification to a higher-risk position for new hires and existing employees transferring to the position.
- on a random basis for alcohol in higher-risk (safety-sensitive) positions with the qualification noted below.

In a previously referenced ruling, the Federal Human Rights Tribunal upheld drug testing on a pre-employment and random basis for safety-sensitive positions in the motor coach industry. The Tribunal also ruled that any individual who tests positive and has an alcohol or drug dependency must be provided with assistance and accommodation. This means employers must have a process in place to ensure that professional assessment is done. The Federal Human Rights Commission's new policy resulted from this decision and would allow for random testing for other, federally regulated safety-sensitive positions for which justification can be established (i.e., testing meets a bona fide occupational requirement for the position).

In other industries, however, random testing is still being challenged, and a few key decisions have been issued that better clarify an employer's options in this area. There is no question random testing would have to be limited to the highest-risk "safety-sensitive" positions in any operation, and even then random drug testing may not be upheld beyond the federally regulated sector, or, if upheld, may be limited to using the newer oral fluid testing technology. However, it appears the law is taking a different perspective in a unionized setting.

A series of labour arbitration rulings have stated that to introduce random testing in a unionized setting in Canada, employers either have to have prior union agreement, or evidence of an "out of control" drug culture. In an Irving Pulp and Paper case, the New Brunswick Court of Appeal overturned this requirement, saying proof of an extensive problem is not necessary; the particular hearing dealt with random alcohol testing, but, in an earlier ruling, the Court of Queen's Bench commented that it could see the same situation for random drug testing. The union in this case was granted leave to appeal to the Supreme Court of Canada, which in turn issued a decision confirming that, in order for random alcohol testing to be acceptable, there must be a demonstrated problem with alcohol use or evi-

dence of an alcohol problem in the workplace. An arbitration case involving Suncor attempted to demonstrate a problem sufficiently serious to justify the introduction of random testing, but the grievance by Unifor against Suncor's new requirement was upheld in March 2014. The company is appealing this ruling to the courts.

CONCLUSION

Many Canadian employers have concluded that one of the most effective ways to prevent workplace alcohol and drug problems, and to effectively investigate and take corrective action, is by first establishing a clear and comprehensive workplace policy. Each company must decide what will work best in their own environment, as there is no model policy. Each program should be tailored to meet the specific needs of each workplace, and should be seen as a reasonable and responsible response to those stated needs. The result should be an appropriate balance between health/safety (due diligence) and respect for individual rights/privacy.

This means finding a balance between measures to control or deter use (clear standards, investigation tools and consequences/discipline) and prevention measures (education, training and employee assistance). Alcohol and drug testing has been introduced in a significant number of workplaces in Canada, particularly in higher-risk sectors, but these programs are defensible only if they are part of a more comprehensive approach and the highest standards are used for the testing process.

References:

1 Cannabis, cocaine/crack, meth/crystal meth,ecstasy, hallucinogens, salvia, inhalants, heroin;abuse of pain relievers, stimulants; sedatives to get high

i. More information on Canadian policy and testing issues can be found at http://www.butlerconsultants.com/barb.html

ii. 2012 Canadian Alcohol and Drug Use Monitoring Survey, Health Canadahttp://www.hc-sc.gc.ca/hc-ps/drugs-drogues/cadums-esccad-eng.php

iii. The Canadian Model is being updated in 2014; the current version can be found at http://www.coaa.ab.ca/safety/CanadianModel.aspx

iv. Rapid Site Access Program is found at http://www.clra.org/p/rsap/36

v. More information on DARRPP is found at http://www.darrpp.ca/

vi. SCC file No. 26274, September 9, 1999 (Meiorin) accessible at: http://scc.lexum.umontreal.ca/en/1999/1999scr3-3/1999scr3-3.html.

These tests were confirmed in British Columbia superintendent of Motor Vehicles v. British Columbia Council of Human Rights, SCC file NO. 26481, December 16, 1999 (Grismer) at: http://scc.lexum.umontreal.ca/en/1999/1999scr3-868/1999scr3-868.html

vii. Oak Bay Marina Ltd (Painter's Lodge) and B.C.Human Rights Tribunal and Robert Gordy, B.C. Courtof Appeal, September 2002 accessible at: http://www.lancasterhouse.com/decisions/2002/sept/bcca-gordy.htm

viii. Salvatore Milazzo and Canadian HumanRights Commission, and Autocar Connaisseur Inc.(Coach Canada), Federal Human Rights Tribunal, November 6, 2003. Decision can be accessed at: http://chrt-tcdp.gc.ca/NS/decisions/index-eng.asp?filter=year&yr=2003&SortedByLetter

ix. Canadian Human Rights Commission Policyon Alcohol and Drug Testing, October 2009 can be viewed at: http://www.chrc-ccdp.ca/eng/content/policyalcohol-and-drug-testing

x. Communications, Energy and Paperworkers Union of Canada Local 30 v. Irving Pulp & PaperLtd., 2013 SCC34, June 2013 can be viewed at: http://scc.lexum.org/decisia-scc-csc/scc-csc/scccsc/en/item/13106/index.do?r=AAAAAQAVSXJ2aW5nIFB1bHAgYW5kIFBhcGVyAAAAAAAAAAQ

xi. The Suncor arbitration decision and dissent can be viewed at: http://www.coaa.ab.ca/sa

Chapter 2

Smoking and Health

Taken from ***Fit For Life II, LIVING HEALTH,*** *written by Harvey and Marilyn Diamond and published by Warner Books, Inc., 1271 Avenue of the Americas, New York, NY 10020 USA.*

There is no way to discuss the importance of air and your lungs without discussing the vile, stinking, filthy, offensive, hurtful, anti-life, anti-natural habit of smoking — as emotionally, creatively, intellectually and spiritually injurious as it is physically. There are not enough nasty words in the English language to characterize this putrid, depraved habit appropriately. Strong language? Not to me. There is no language too strong to condemn this habit of self-destruction, suffering and premature death. How has something so inherently bad, so horrendously harmful, so completely and totally devoid of any value whatsoever become such a common addiction for so many millions of people? This is a human tragedy of monumental proportions. How sad that such a deadly practice should be so pervasive among the populations of the world. Are people so disgusted with themselves that they would deliberately destroy their own bodies?

Our Creator saw fit to bestow the precious gift of life. Is it an appropriate showing of gratitude to inflict such hellish ravages on that gift? A thousand people die of tobacco-related illnesses every day in the United States alone. That is more than seven times as many people as die in motor vehicle crashes. More people die every year because of tobacco than the total number of Americans killed in the First World War, the Second World War and the Vietnam War… *combined!* I don't know about you, but that shocks me to the core. Worldwide, 2–2.5 million people die each year; that's more than 6,000 people a day! In an editorial in its journal in 1986, the American Medical Association opened a scathing attack on tobacco companies, calling them "vultures," seeking to create addicts hooked on their products. The American Lung Association calls them "merchants of death." If spreading this addiction is the goal of these "vultures," they should be very proud of themselves. Former President Jimmy Carter, referring to cigarettes as the *greatest menace* to public health, stated, "I think there is a deliberate commitment on the part of the tobacco industry to cause death for profit."*

There are now some 54 *million* smokers in the United States, some 75 percent of whom are considered to be addicted to this vile narcotic.** Of course, when people hear the word "addicted," they tend to think of heroin or alcohol or some other dangerous drug. According to Dr. William Poland, the director of the National Institute on Drug Abuse, *tobacco has far worse addictive potential than alcohol or heroin*. In fact, he says that tobacco may be as much as eight times deadlier than excessive use of alcohol and is far more resistant to successful treatment than heroin addiction (which is also less likely to be fatal than tobacco use). Dr. Poland has called for recognition of tobacco use as far deadlier than *any other* dangerous drug.

Heaven only knows to what extent disease and ill health can be attributed to smoking. But what *is* known reads like a horror story — a horrible horror story: cancer, heart disease, emphysema, bronchitis, spontaneous abortions, fetal death, birth defects, ulcers, damage to DNA, high blood sugar, high blood pressure, infertility in women, impotence in men, dried-up testicles, pathological increase in the heart rate and subsequent damage to the heart, constriction and even total collapse of blood vessels, numbness of hands and arms, marked increase in stomach acidity, crippling of the taste buds, and massive destruction of vital cells from the lips to the lungs. Tobacco smoke is much hotter than hot food. It wipes out cells and taste buds wholesale. Ever notice how much salt and pepper smokers use? It's because they can't taste their food. These condiments further irritate the lining of the mouth, lips, tongue, gums, cheeks, throat. *The latest findings suggest that smoking may even contribute to Alzheimer's disease in people as young as forty-eight. Sound inviting?*

The tobacco companies pull in more than $20 billion per year selling a product that causes incalculable pain, suffering, anguish and death. No wonder the AMA calls the industry "vultures." And to think that less than seventy-five years ago many physicians did not consider smoking harmful. Note this statement made by a Brooklyn medical doctor in 1913: "The history of human experience as well as exhaustive investigations conducted by men highly trained

in scientific research point to the fact that the moderate use of smoking tobacco is not harmful to either the body or the mind." Compare this to the open-eyed realism of Dr. Russell T. Trall, a medical doctor turned natural hygienist, who, recognizing the extreme danger of tobacco, dedicated the entirety of one of the books he wrote to assailing its use (this was in 1857).

Cigarette smoke contains more than 3,000 chemical substances, and a few of them deserve mentioning:

- **ACROLEIN** — toxic, colorless liquid with irritating cancerous vapors.
- **CARBON MONOXIDE** — highly toxic, flammable gas used in the manufacture of numerous chemical products. Inhalation of carbon monoxide interferes with the transportation of oxygen from the lungs to the tissues (where it is required).
- **NICOTINE** — poisonous alkaloid that is the chief addictive substance in tobacco. It is also used as an insecticide and to kill parasitic worms in animals. One pack of cigarettes per day, inhaled, gives you enough nicotine to kill you outright if you were to receive it all in one dose.
- **AMMONIA** — gaseous alkaline compound of nitrogen and hydrogen used as a coolant in refrigerating and air conditioning equipment, and in explosives, artificial fertilizers and disinfectants.
- **FORMIC ACID** — pungent liquid gas used in processing textiles and leather. Exposure to the acid irritates the mucous membranes and causes blistering.
- **HYDROGEN CYANIDE** — An extremely poisonous liquid used in many chemical processes, including fumigation, and in the case-hardening of iron and steel. Hydrogen cyanide gas is used as the lethal agent in capital punishment.
- **NITROUS OXIDE** — group of irritating and sometimes poisonous gases that combine with hydrocarbons to produce smog. Nitrogen dioxide can weaken bodily tissues and increase susceptibility to respiratory ailments.
- **FORMALDEHYDE** — pungent gas used primarily as a disinfectant and preservative. It is extremely irritating to the mucous membranes.
- **PHENOL** — caustic, poisonous acidic compound present in coal and wood tar and used in disinfectants.

- **ACETALDEHYDE** — highly toxic, flammable liquid that irritates the eyes and mucous membranes and accelerates the action of the heart. Prolonged exposure causes blood pressure to rise and causes proliferation of white and red blood cells.
- **HYDROGEN SULFIDE** — poisonous gas produced naturally from putrefying matter and used extensively in chemical laboratories.
- **PYRIDYNE** — flammable liquid used in pharmaceuticals, water repellents, bactericides and herbicides.
- **METHYL CHLORIDE** — toxic gas used in the production of rubber and paint remover and as an anti-knock agent in gasoline.
- **ACETONITRILE** — toxic compound found in coal tar and molasses residue and used in the production of plastics, rubber, acrylic fiber, insecticides and perfumes.
- **PROPIONALDEHYDE** — colorless liquid with a suffocating odor, used as a chemical disinfectant and preservative as well as in plastic and rubber.
- **METHANOL** — poisonous liquid alcohol used in automotive antifreezes, rocket fuels, synthetic dye stuffs, resins, drugs and perfumes.

AND…let's not forget arsenic!

All these chemicals create untold dangers in the body. Dr. Paul Erlich, Professor of Biological Science at Stanford University, has stated that almost half a million tests would have to be conducted just to determine the effect of any two chemicals in conjunction with each other in the body.*** Technology capable of determining the harm of sixteen at one time doesn't exist.

Ever notice some of the ads the tobacco industry uses to hook more women into smoking? It's always a picture of some super-chic, ultra-svelte beauty having the absolute time of her life. (For obvious reasons, they won't show a picture of someone in the middle of a coughing spasm hacking up a chunk of diseased lung.) Ever notice that the ads *never* show the evil weed on her lips? She's always holding it ever so delicately, as if it were some cherished possession. Know why? Because the sight of a cigarette dangling off a woman's lip is so offensive that the advertising rule is *not to show it*. For some reason, however, to show it dangling off a man's

lips is supposed to be "macho" — that is, until he's had his voicebox removed and has to talk through a tube stuck in his throat.

One sight never ceases to amaze me; it's usually in an airport. I see a very well dressed, beautifully turned-out woman, impeccably stylish, with hair and makeup done flawlessly — obviously a lot of time and effort put into looking just so — and you know those standing ashtrays that are all over airports? They're about two feet high, round, about ten inches across, with a big hole in the top in which to deposit ashes and butts. Remember the smell when you get close enough? Right. We're talking about one of the foulest stenches possible — something like a dead goat that has been decomposing for a couple of weeks. This exquisitely turned-out woman goes over to one of these things and pulls it over to her so she can flick the ashes from the cigarette she just lit up. So pretty on the *outside*, with not even one hair in her eyebrow turning in the wrong direction, and she voluntarily drags one of these foul, stinking containers full of filth over to her. It is like stopping on the highway to pick up a dead skunk that has been run over and then stuffing it down your shirt. Hours spent being sure the exterior is perfect while assaulting the inside with cancerous poisons. I have seen this scene played out hundreds of times, but each time I cannot help but experience disbelief and sadness at the situation.

I find it hard to swallow that the Department of Health and Human Services spends millions of dollars in taxes each year in an effort to combat smoking, while another arm of the same government, the Department of Agriculture, spends hundreds of millions of dollars of our tax monies to subsidize the industry. Think about that. Out of one side of the government's mouth it's, "Better stop smoking; you're going to die of cancer," and out of the other side of the mouth it's, "Here, let me pay you to grow tobacco." Does this strike you as strange? Do you know that if a farmer's crop cannot be sold on the market at a fixed price, a federally supervised corporation buys the tobacco with money borrowed from the government, then holds on to it to sell later when the price is better? You can be dead-set against smoking, but your tax money can be used to subsidize the tobacco you deplore. Charming.

Sidestream Smoke

I know there will be people reading this who will say, "Hey, if I want to smoke, it's *my* business." True enough. You can also stick a knife in your chest, set your hair on fire, or jump off a cliff. And, as foolhardy as those actions would be, at least they would not hurt anyone else. This brings up what I find to be the most outrageously objectionable issue about smoking: secondhand, or *sidestream*, smoke — the smoke that winds up in the lungs of an innocent bystander.

People may have the inalienable right to poison themselves, but they certainly have *no* right to poison you or your child. If you were in a store shopping and someone came up and slapped your kid across the face, what would you do? You could have that person arrested. But let that same person blow malodorous, filthy smoke from his or her cancerous lungs into your child's face and lungs and you're supposed to "realize that smokers have rights, too." Well, that's a real interesting concept: because people have the insane, perverted habit of poisoning themselves, they expect the same segment of the population to stand idly by while they impose their perversion on others.

Let's take it a step further. Does the person who loves to get drunk have the right to run down a kid on a bike? Does a gun enthusiast have the right to shoot someone in the head?

You may say, "Wait a minute, you're getting a little carried away." Am I? Let me tell you about sidestream smoke.

I did not have a great deal of information about sidestream smoke when I began research for this book, although my common sense and natural aversion to it told me what to suspect. I contacted Action on Smoking and Health (ASH) in Washington, D.C., a highly visible, highly respected organization started twenty years ago by a distinguished body of physicians, attorneys and other prominent citizens to use the law to fight back against the might of the tobacco companies. I called and asked for whatever they could send me on sidestream smoke.

What I received stunned me. I knew that sidestream smoke was harmful, but I never realized just how harmful. Over the last fifteen years there have been literally thousands of studies on sidestream smoke, and they are reported in the most prestigious medical journals in the world, including the *Journal of the American Medical Association, The New England Journal of Medicine, Lancet, British Medical Journal*, and many others. The results are depressingly discouraging. The unquestionable, irrefutable fact is that tobacco smoke exposes non-smokers to potent, killing carcinogens. The question is not whether sidestream smoke poses a cancer risk to nonsmokers, it's the magnitude of the risk.

Consider this the next time someone exercises his or her "rights" and causes a plume of smoke to waft into your face: three of the most poisonous elements in smoke are tar, nicotine and carbon monoxide. Carbon monoxide is the most deadly of them. Sidestream smoke has been shown to contain twice the tar, twice the nicotine, and five times as much carbon monoxide as mainstream smoke. Plus! In an article in the *Los Angeles Times* dated August 15, 1986, there was reference to a new study finding: people sitting in a room filled with cigarette smoke retain the dangerous chemicals (end product of nicotine) they inhale more than twice as long as people doing the smoking. Marvelous! So perhaps the next time you're in a restaurant eating a nice meal (or trying to) and the people next to you exercise their "rights," bear in mind that they are inflicting on your lungs probably the most potent pollutant in the environment.

One fourteen-year study in Japan showed that wives of smokers have a much higher risk of developing lung cancer than the wives of non-smokers. This was attributed to sidestream smoke. One Environmental Protection Agency report based on a dozen studies from several countries and reported in major medical journals concludes that as many as 5,000 non-smokers may die each year from lung cancer caused solely by breathing other people's tobacco smoke. Any allergist at a major hospital will tell you about people among the estimated 30–40 million Americans who have conditions such as asthma, hay fever or sinusitis, and can be sensitive to the point that exposure to tobacco smoke in everyday situations makes them so ill they require medical attention and sometimes hospitalization.

To me, the most despicable, unforgivable outrage is the damage that sidestream smoke inflicts on children. In a study of the correlation between respiratory infection in children and the smoking habits of their families, it was shown that the percentage of children with these diseases rose in direct relation to the level of family members that

smoked. The incidence of pneumonia and bronchitis in infants examined over the first three years of life showed a definite relationship between these diseases and parents' smoking habits. It was lowest when both parents were non-smokers, highest when both smoked, and lay between these two levels when only one parent smoked. Within the first year of life, exposure to cigarette smoke generated by parents' smoking doubles the risk for the infant of an attack of pneumonia or bronchitis.

Do you have children? Do you smoke? Do them a favour: step outside! Medical literature reports numerous studies performed to discover what effect passive smoking has on the development of the most innocent non-smoker of all, the fetus. It is not good. Aside from depriving the fetus of air (which is tantamount to strangling it!), smoking can reduce birth weight by up to 10 percent below normal. Lack of oxygen in the developing fetus causes brain damage.****

References:

* *Los Angeles Times*, September 30, 1986.

** Until its latest issue, *Taber's Medical Dictionary* consistently described tobacco as a narcotic.

*** *Los Angeles Times*, June 2, 1978.

**** If interested in receiving any of the information I have discussed or some of the studies, contact ASH, 2013 H Street, N.W., Washington, DC 20006; Tel: 202-659-4310.

For prevention and treatment information, and resources, please refer to the "DIRECTORY OF SUBSTANCE ABUSE SERVICES" at the back of the manual.

Chapter 3

Primary Prevention

It is a tragic fact that a growing number of primary school-aged children are using and abusing alcohol and drugs. Education about drugs and awareness of the signs of drug use can help in keeping your own children from becoming another statistic. The most startling of these: only 50% of children who become addicts (drugs or alcohol) before 18 years of age will live to see their 30th birthday.

Parents appear to be woefully oblivious to the possibility that their own children may be drug users. According to a recent Lewis Harris poll, parents are far off when questioned:

- 36% of parents thought their children had taken a drink, while in fact 66% of their children reported that they had;
- 14% of parents thought their children had tried cigarettes while 41% actually *had* smoked; and
- 5% of parents thought their children had tried illicit drugs; 17% of the children noted that they had.

A few other statistics that can make parents get seriously interested in this problem: 6 out of every 10 primary school students have tried alcohol before grade 9, and 40% of those indulged to the point of drunkenness; 1 of every 4 primary students has used illicit drug(s); approximately 50% of all teenage homicides (including vehicular homicide) are associated with alcohol or other drugs.

Warnings on the dangers of drug use appear to stimulate interest in drugs rather than steer kids away from them.

Not only are young people using illegal drugs and alcohol, but they are also beginning smoking cigarettes in record numbers. According to the U.S. Centre for Disease Control, a survey of smokers demonstrated that 1.2 million Americans under age 18 took up daily smoking in 1996 compared to 708,000 new smokers in 1988 — an increase of 73%. These new smokers credited tobacco companies' persuasion techniques aimed at children (specifically, giveaways and depictions of cartoon characters in advertisements). Celebrities and cartoon characters pictured with cigarettes in the media were also cited as motivators to smoke. According to medical data, a person who starts smoking before the age of 14 is fifteen times more likely to develop lung cancer later in life than a non-smoker.

Rather than being a hopeless scenario, heading off primary and teenaged drug use seems to have an inoculation effect. A teenager who does not start smoking by grade 9 is not likely to start later.

While some drug-control programs take a simplistic approach such as "just say no to drugs," it is clear this type of approach is not effective in dealing with the problem. Motivators to use drugs and alcohol can include the following:

- forceful peer pressure;
- availability of drugs and alcohol at home;
- observation of parents or older siblings using drugs and alcohol;
- promotion of drug use through films and other media;
- desire to escape a stressful environment at school and home;
- thrill-seeking;
- the party motivation; and
- offers to make or share money from drug sales.

The emphasis in many effective drug and alcohol programs in primary schools is shifting toward why and how to say no to drugs — in effect, training students in the reasoning behind saying no in response to the pressure to do drugs. Becoming aware of the way advertising slants the message toward young audiences can help targets to dodge the bullet.

To approach the subject of drug use, parents and other adult advisors need to be discerning about their audience. Are these children who have not used drugs; have they tried drugs; or are they habitual users? In addressing a young audience before their first drug use, they can be told the following:

- physical addictions develop more quickly in children than in adults;
- because of their growing bodies, drugs are more damaging at their young age;

- if they start smoking before the age of 18, 25% of them will still be smoking 20 years later. If they don't smoke in their youth, they will almost surely not be addicted smokers later in life; and
- trying a drug once is not "free." You do not know whether you will become addicted until you are exposed by using.

Most primary and young teenaged children who have not tried drugs will do so to satisfy their curiosity and to stimulate a mood shift. The common drugs featured in early drug experiments are alcohol, tobacco, marijuana and inhalants. These first tentative experiences with drugs usually take place at parties, in groups of their peers, and on weekends. The substances are usually supplied by others,whether they are the child's friends or others in the group.

Because the child having his first drug experience has developed no tolerance, the substances can have a much more profound effect than they would on habitual users — hence the expression "cheap drunk." He may be surprised at how inexpensive it is at first to have a fun time with drugs. As the person uses more frequently, his tolerance builds and he needs more of the drug to produce the same effect.

Unfortunately, when children are at the stage at which they are simply trying different drugs, it is difficult for parents and other adults to detect that such experimentation is taking place. Behavioural changes in the child are minimal and virtually invisible. The child may feel that he has gotten away with his small transgression and no one will be the wiser — and that may remain true if his drug experience ends at the point where he has tried it once. Unfortunately and statistically, that is unlikely. A child who has tried drugs will generally take his explorations further.

The next stage of drug experimentation generally takes the form of moving beyond bingeing in social settings (parties and other youth activities). Drugs gradually move into the child's daily life. It is at this point when the child is not practiced at hiding his habit or lying about it that parents have the greatest opportunity to detect it and intervene. Not only will the child continue to use the drugs he has already tried — likely cigarettes and/or alcohol that are known "gateway drugs" — but he will also begin to introduce more variety into his habit. He may begin to smoke marijuana to relax, or to take amphetamines to recover from hangovers.

A child in this advancing stage of habituating to drugs may begin pilfering drugs from the parent's medicine cabinet and leave other clues. Again, it's at this point that a parent has another marked opportunity to get help for the child. Other behavioural changes will give pointers to the alert adult. These pointers can include:

- loss of motivation;
- lying about times and places he has been and who's been with;
- drop in performance in academics or sports;
- truancy from school;
- sudden disinterest in hobbies or extracurricular activities;
- decreased attention span;
- memory loss;
- change in social group;
- suddenly dropping old friends;
- mood swings (manipulative behaviour); and
- lack of dexterity/agility.

While most experimentation is done in a social setting, a growing habit is often developed in solitude. The child will begin to buy his own drugs and use them on his own. This means that he will spend more time alone and his need for ready cash will increase. He may begin to steal from family, friends or others at school.

It is very often difficult to convince a young drug user at this stage that his new habit is harmful to him. He is likely to feel elated that he is able to control the use of his drugs and still get that high that everyone seems to be looking for. Although he has a mild distress when he is coming off the drugs, his ability to attain the altered state very inexpensively still prevails.

A further development of the young user's habituation to drugs is when he becomes so absorbed in exploring the altered state that he prefers it to being straight. Relatively few young people reach this level with their habit. In fact, only 5% of high school students get to a stage where they are using alcohol or marijuana every day.

However, although few do get this far with drugs, 5% of high school students still represents a large number. That 5% works out to 50 people with a serious drug habit in a school of 1,000 children. This is the beginning of hard core drug use. It's that time in a user's life when he decides how he is going to support his habit — whether through robbery, prostitution or other criminal behaviors. Having 50 such children in a school can be extremely disruptive and dangerous to the other students.

At this level of the serious user, the child begins to mix and match his drugs to get more of a lift; this is when habituation has undermined the lift he had been getting from single drugs. Now is the time when drugs laced with various poisons become desirable. Alcohol, tobacco and marijuana are not enough, nor are the cadged prescription drugs from mom's medicine cabinet. Cocaine, crack, PCP, LSD, opium (opiates), and a whole alphabet of designer drugs become attractive.

While a habituated user is buying his own drugs, he is offered other drugs that are described as giving more of a rush. Of course, he would like to get higher for less money; that is his goal.

Danger signs of this level of drug use would be apparent to the observant adult, including the following:

- non-drug using friends are summarily dropped;
- art, clothing and other identification with drug culture are obvious;
- lying occurs at all times for apparently no reason;
- police are frequently involved with student and parents;
- school failures or dropping out occur;
- there is an inability to keep commitments, jobs and appointments;
- unhealthy appearance prevails: coughing, weight loss;
- suicidal and paranoid indications;
- escalating conflict with family and social group; and
- increasing self-centredness.

A further step in the progress of the user's habit is in a physical need to have the drugs to maintain a normal outward appearance. A child who has reached this stage is dangerously ill, and is a threat to his own life and to those around him. As his tolerance to the drugs has increased, he has continued to build his dosage. Eventually, the dosage is so high that the user is maintaining a delicate balance between getting high and death. The most obvious outward symptom of this stage is overdosing on drugs. Such overdoses are frequent and frightening to those around the user and, without help, will ultimately lead to the death of the drug user.

To set up a drug-free environment in which the child feels he can safely ask for help, the parent should NOT:

- make alcohol and drug use a significant part of his *own* lifestyle;
- provide alcohol or cigarettes for underaged guests or children;
- attempt a confrontation of the child when either child or parent has been using drugs or alcohol;
- adopt a blaming attitude for the child's drug use;
- abdicate responsibility for the child;
- expect the school or police to provide the boundaries for the child;
- try to address the problem once and then never try again;
- label your child as hopeless;

Parents and other concerned adults who want to help a child to avoid involvement in drugs should:

- first build a strong, tight relationship within the family group;
- find hobbies and activities that you can do as a group;
- encourage and support the child's positive interests and hobbies;
- set clear boundaries and guidelines for the child to follow;
- discuss and develop within the family an attitude against drugs;
- be a positive role model. Don't expect the child to do as you say, not as you do;
- educate themselves about drugs and the signs of drug addiction;
- become aware of the warning signs of drug use;
- be actively involved in the child's school and social activities;
- know the child's friends and their parents;
- develop an ongoing relationship with the child's teacher and other adult advisors;
- ensure that the child feels comfortable bringing friends home; and
- listen to the child rather than preaching.

References:

Meehan, Bob, *Beyond The Yellow Brick Road, Our Children And Drugs,* Contemporary Books, Inc., 1984.

Goldstein, Arnold P., Reagles, Kenneth W., and Amann, Lester L., *Refusal Skills, Preventing Drug Use In Adolescents,* Research Press, 1990.

Dimoff, Timothy and Carper, Steve, *How to Tell if Your Kids are Using Drugs*, Facts on File, 1992.

For prevention and treatment information, and resources, please refer to the "DIRECTORY OF SUBSTANCE ABUSE SERVICES" at the back of the manual.

Chapter 4

Drug-Impaired Driving

Research Studies Examine Prevalence of Drug-Impaired Driving, its Relation to Vehicle Crashes, and Improving Drug Identification, and Evaluation

Ottawa, August 25, 2010 — As drug-impaired driving becomes an issue of greater public concern, enforcement efforts based on solid research and evidence are becoming increasingly necessary. To this end, senior researchers from the Canadian Centre on Substance Abuse (CCSA) presented leading research on drugs and driving at the International Council on Alcohol, Drugs and Traffic Safety (ICADTS), held August 22–26 in Oslo, Norway.

The three different studies presented by CCSA indicate that drug use among drivers is as common as alcohol use, that a significant number of fatal car crashes involve the use of drugs by drivers, and that there are opportunities to streamline and improve the effectiveness of the system used to identify drug impairment among drivers.

Drug use is just as common as alcohol use among drivers, with 10.4 percent of drivers testing positive for drug use and 8.1 percent testing positive for alcohol, according to the Alcohol and Drug Use Among Drivers: British Columbia Roadside Survey 2008. Presented by Douglas J. Beirness, CCSA Senior Research and Policy Analyst and Advisor, the survey was the first to simultaneously collect data on both drug and alcohol use among drivers. A second in-depth roadside survey on impaired driving was conducted in June 2010.

"The rate of driving after drug use is more prevalent than originally thought, and the 2008 and 2010 surveys provide us with a baseline assessment to evaluate any changes introduced to deal with the problem" said Beirness. "Illegal, prescription and some over-the-counter drugs can have serious effects on a variety of mental and motor abilities. As many of these abilities are critical to the safe operation of a motor vehicle, there is a real need for an impaired driving awareness campaign that is inclusive of both alcohol and drugs."

Additional research presented by Beirness, "A Comparison of Drug and Alcohol-involved Motor Vehicle Driver Fatalities," examined more than 14,000 driver fatalities in Canada during 2000–2006. Researchers found that 33 percent of drivers tested positive for at least one drug and 38 percent tested positive for alcohol. The most common drugs found in the blood of fatally injured drivers are depressants, stimulants and cannabis.

The results also reveal that fatal crashes involving drugs differ substantially from those involving alcohol. (For example, whereas alcohol-involved fatal crashes tend to occur on weekends and late at night, drug-related fatal crashes are more likely to occur during daylight hours throughout the week.) The research provides new evidence-based information to shape the development of prevention efforts and road safety. It could also allow enforcement officers to better identify drug-involved crashes, and follow a course of action to investigate and prosecute those responsible.

In response to the increased concern from public health and road safety officials, the federal government passed Bill C-2 that empowers Canadian police who suspect a driver of being impaired by any drug — illegal, prescription or over-the-counter — to conduct a Standardized Field Sobriety Test. If the driver is impaired, they must submit to a mandatory Drug Evaluation and Classification (DEC) assessment — a standardized 12-step process that requires them to provide a bodily fluid sample.

The DEC assessment is conducted by Drug Recognition Experts (DREs) — police officers who have undergone intensive and specialized training. Research conducted by CSA has demonstrated that DREs are 95 percent accurate in identifying the categories of drugs responsible for the impairment.

An extensive procedure that takes approximately 45 minutes to complete, the DEC assessment requires a DRE to analyze more than 100 pieces of information, including observations documented on divided-attention tests and various clinical indicators such as body temperature, pulse rate and the condition of the eyes.

In an effort to simplify the process, Dr. Amy Porath-Waller, CCSA Senior Research and Policy Advisor, presented research that analyzed DEC cases to identify whether a core set of signs and symptoms could be used to predict the categories of drugs used by suspected drug-impaired drivers.

The study, "Simplifying the Process for Identifying Drugs by Drug Recognition Experts," confirmed that DREs could focus on a limited set of clinical indicators without significantly compromising the accuracy of their drug evaluations. Indicators related to the eyes were found to be particularly informative."

"Simplifying the process of drug evaluation may lead to increasing the effectiveness and efficiency of the DEC program and improving the enforcement of drug-impaired driving" said Dr. Porath-Waller. "The information on these clinical indicators in conjunction with what the DRE observes will contribute to an accurate assessment of drug impairment."

Enforcement is only one component of an overall strategy to tackle the persistent and growing problem of drug-impaired driving. Although there is much to be learned from years of experience in the area of drinking and driving, societal attempts to control drugged driving must recognize the substantial differences that exist and develop an innovative approach to deal with this issue. We also need a national drug-impaired driving awareness campaign that is supported by a specific and targeted enforcement strategy using latest evidence-based drug identification and assessment approaches.

About CCSA: With a legislated mandate to reduce alcohol-/other drug-related harms, the Canadian Centre on Substance Abuse (CSSA) provides leadership on national priorities, fosters knowledge translation within the field, and creates sustainable partnerships that maximize collective efforts. CCSA receives funding support from Health Canada.

For more information contact:

Yasmina Pepa, Communications Advisor, CCSA
Tel.: (613) 235-4048 ext. 276
Mobile: (613) 866-3303
Email: ypepa@ccsa.ca

DRUG-IMPAIRED DRIVING

Introduction

Every year more than a million people in the world are killed in traffic crashes, and many millions more are in-

jured. Besides the heavy and tragic burden on those directly affected, there is an enormous economic impact, costing countries between 1 percent and 4 percent of their GNP. Driving is a very complex task, requiring the cooperation of several different cognitive and psychomotorfunctions at once. Crashes can be the consequence of many different factors, which can be classified into three categories: the road, the vehicle and the driver. A crash is rarely attributable to only one factor, meaning that it is very difficult to determine precisely to what percentage of crashes alcohol or drugs have contributed.

Influence of Drugs on Performance

The effects of drugs on performance can be studied by means of experimental studies, in which different doses of a certain drug are administered to volunteers, and the effects on performance are measured and compared to a placebo or a positive control. The performance of the volunteers can be evaluated by means of tests that assess the different psychomotor and cognitive functions, by means of tests in a driving simulator, or by "real" driving tests [1-3].

Alcohol

Alcohol is a central nervous system depressant. Many studies have already been performed to determine the effects of acute alcohol ingestion on cognitive functions and driving performance. These studies found that numerous driving-related skills are degraded beginning at low blood alcohol concentrations (BACs). Several skills have been shown to decrease with increasing BAC, such as prolongation of reaction time performances and lowering of coordination performance [4-5]. (For further information, see also Alcohol.)

Cannabis

A cannabis user feels euphoria, relaxation and increased social interaction, with frequent laughing, and experiences changes in perception (visual, audible, sensory or time perception). The users are aware of the effects of the drug, and this awareness increases with higher doses. Cannabis acutely reduces some cognitive and psychomotor skills such as learning, equilibrium, coordination, tracking ability, memory, perception, motor impulsivity and vigilance, and these effects are mostly dose-dependent [6,7].

Cannabis can also have an effect on behaviour. The influence of cannabis on human risk-taking is unclear. The results of experiments in laboratory settings are contradictory, while in some driving studies (with rather low doses), users are aware of the impairment and often compensate their driving style by driving more slowly, overtaking less, or keeping longer distances from other vehicles. Nevertheless, the driver is still unable to completely compensate for the loss of capability in some psychomotorskills [8].

Some deleterious effects of cannabis appear to be additive or even synergistic with those of alcohol, and the combination of both substances results in a prolongation as well as enhancement of their effects. Driving studies revealed that drivers under the influence of both alcohol and cannabis were less attentive to traffic approaching from the side streets, while the use of either cannabis or alcohol (at low doses) had no effect [9], and the combination of cannabis and alcohol generated an additional decrement in control of lateral deviation on top of the decrement caused by either cannabis or alcohol [10]. The detrimental effects of other drugs such as cocaine can also be reinforced by additional intake of cannabis [11]. (For further information, see also Cannabis.)

Amphetamines

Amphetamine causes a strong central stimulation and euphoria. The user thinks he can do everything and will take more risks. In addition, amphetamine widens the pupils (mydriasis) and reduces sleepiness, leading to insomnia, but, after some time (hours or days, depending on the pattern of use), the subject is exhausted and falls asleep (crash phase). Amphetamine can improve some cognitive functions, such as divided attention performance and verbal interaction [12]. However, tests in driving simulators reveal that the intake of amphetamine causes a decrease in overall simulated driving by inducing problems such as incorrect signalling, failing to stop at a red light, and slowing reaction times. The decrease in simulated driving ability is only observed during the daytime, which is consistent with the tunnel vision associated with amphetamine consumption [12, 13]. It is also important to note that the doses of amphetamine administered in these experimental studies were very

low (10–30 mg), and thus not representative of the doses that are generally taken by abusers (100–1000mg/day) [1].

Studies investigating the effect of amphetamine in sleep-deprived persons revealed a positive effect on psychomotor functions [14, 15]. The effects of amphetamine on cognitive functions in sleep-deprived persons are less obvious. Both positive and negative effects, as well as no effects, have been assessed [12, 14].

Methamphetamine-like amphetamine is a central nervous system stimulant that may cause restlessness, euphoria, dizziness, dysphoria, tremor and insomnia.

Ecstasy (methylenedioxymeth(yl) amphetamine, MDMA, XTC) is a, "designer" amphetamine, indicating that it is synthesized to resemble the effects of amphetamine. It causes a weaker stimulation of the central nervous system than amphetamine, but it can also cause sensory disturbances, nausea, dizziness, ataxia, muscular rigidity, sweating, restlessness and tremor.

Ecstasy acutely causes decreases in attention, short and long-term memory, verbal memory, visuo-spatial skills, executive functioning, and prediction of object movement under divided attention [16-18]. It also leads to improved psychomotor performance on a battery of tests, such as movement speed and tracking performance in a single, as well as in a divided attention task [16]. Tests in driving simulators, however, revealed that the intake of ecstasy can decrease performance by increasing speed and speed variation, and inducing problems in care following, while come tasks are not influenced (reaction time, lateral control), and may ever be improved (e.g., lateral control) [17, 19].

Other psychoactive substances such as alcohol can reinforce the deleterious effects of ecstasy, and cause some additional negative effects [20]. On the other hand, the use of ecstasy can diminish some, but not all, detrimental effects of alcohol, while other negative effects of alcohol can be reinforced [17]. During the crash phase following the use of amphetamines, the subject feels very tired, unable to combat sleep, and depressed. This phase can last for several days [21]. (For further information, also see Amphetamines.)

Cocaine

Cocaine is extensively metabolized to a variety of compounds. The major metabolites are benzoylecgonine, ecgonine and ecgonine methyl ester, and they are often targeted in analyses.

The desired effects of cocaine are similar to those of amphetamines, but the onset is slower and the duration is longer. The use of cocaine can partially reverse performance decrements in sleep-deprived persons [22]. In rested persons, some studies found no effect from the use of cocaine on psychomotor cognitive skills [23], while other studies assessed an improvement in psychomoto performance (decreased reaction time), attention and learning [24].

Cocaine can partially diminish performance decrements caused by alcohol consumption. The use of a combination of alcohol and cocaine decreased psychomotor impairment and improves performance on cognitive tests when compared to the use of alcohol alone. Cocaine also decreases the subjective feeling of drunkenness cause by alcohol [11, 25]. Detrimental effects of other drugs such as cannabis can be reinforced by cocaine [11].

A depressive phase follows the use of cocaine, with the subject feeling very tired, depressed, nervous and unable to combat sleep [1]. (For further information, see also Cocaine.)

Heroin

The user generally feels intense euphoria ("rush") accompanied by a warm flushing of the skin, dry mouth, and heavy extremities, and alternates between a wakeful and drowsy state. Few experimental studies have investigated the acute effects of heroin on humans. Several studies confirmed the acute effect of heroin on subjective sedation and miosis [26, 27]. One study found a trend toward a decreased performance on the circular lights task, which measures psychomotor performance [28]. In another study, the administration of heroin impaired performance on the reaction time task [26]. However, the doses used in these experimental studies ranged from 2 to 20 mg, while average daily doses of heroin in a chronic, tolerant user range from 300 to 500 mg [1] (For further information, see also Opioids.)

Epidemiology and Risks

Prevalence of Drugs in the General Driving Population or in a Subset of Drivers

The prevalence of drugs in the general driving population can be estimated by means of roadside surveys, in which samples of randomly stopped drivers are analyzed. Results of roadside surveys have shown that about 1–2 percent of drivers stopped during roadside surveys test positive for drugs in saliva. Higher prevalence rates were found in studies using urine as sample (6–12 percent) or in studies in which samples were collected only during weekend nights (6–15 percent) [29].

In some studies, samples of a subset of drivers are analyzed. Such studies have shown that drugs are prevalent in 19–50 percent of drivers injured by a traffic crash, 6–35 percent of drivers killed by a traffic crash and 55–99 percent of drivers suspected of driving under the influence of drugs (DUID) [29]. These figures can vary strongly, because the methodology used in the different studies can differ in the type of drugs included in the analysis, and the kind (and sensitivity) of analysis method used.

The most prevalent drug in most of these studies is cannabis. Other important drugs are amphetamines, benzodiazepines and opiates.

Besides analyzing biological samples of drivers, the prevalence of DUID can also be assessed by interviewing persons. A disadvantage of this method is the possibility of underestimation of the prevalence. Such interviews have shown that about 3.6 percent of the general population, 15 percent of the young people, and 85 percent of drug users state never to have driven after having used drugs [29]. In the United States in 2005, an estimated 10.5 million persons aged 12 or older reported having driven under the influence of an illicit drug in the past year [31].

Risks Associated with DUID

By comparing the prevalence of a certain drug in the general driving population to the prevalence in drivers who were involved in a traffic accident, some studies tried to estimate

the accident risk. Several studies have already shown that an increasing BAC is associated with other psychoactive substances. The "impaired motorists, methods of roadside testing and assessment for licensing" (IMMORTAL) study in the Netherlands revealed that drivers under the influence of benzodiazepines alone have a relative risk for an accident that is three times greater than the risk of a drug-free driver. The highest risk was associated with the use of drugs in combination with alcohol, namely 179 times higher [34]. A study that was performed in Canada, for example, showed that the influence of cocaine, benzodiazepines and cannabis is respectively 5, 2.5 and 2.2 times higher than that of a person who has not consumed these drugs [33].

Some studies have made a more thorough analysis than calculating the risk of being involved in a traffic crash, and have estimated the risk of being responsible for a traffic crash while DUID. The results of these types of studies indicate that increasing BACs are associated with increasing risks of being responsible for an accident [35]. They also show that driving under the influence of cannabis increases the risk of being responsible for a crash. The risk of being responsible for a crash even increases with increasing cannabis concentration in the blood, indicating a causal relationship between cannabis and crashes. The risk of being responsible for a fatal accident when driving under the influence of cannabis and alcohol is approximately equal to the multiplication of the risks when driving under the influence of cannabis and alcohol alone [35]. Responsibility analyses have also shown that benzodiazepines and cocaine are associated with increased risks of being responsible for an accident, and that the risk is higher for a combination of alcohol and benzodiazepines than for benzodiazepines alone [36, 37].

Legislation

Each developed country has its specific legislation to deal with DUID. There is a lack of uniformity in the way in which nations approach the drugged driving problem. Generally, there exist two major types of DUID legislation, namely "impairment" legislation and "per se" legislation [38].

Impairment Legislation

In impairment legislation, the prosecution must demonstrate that the driver was impaired, not fit to drive, or "under the influence" depending on how the law is interpreted. The analysis of drugs in bodily fluids only provides corroborating evidence about the cause of the impairment. This kind of legislation is subjective and requires the assessment by a medical doctor or a specially trained police officer. As a consequence, many of the countries with this kind of legislation experience difficulties obtaining convictions. Examples of countries with "impairment" legislation are Norway and the United Kingdom.

"Per se" Legislation

A "per se" law prohibits driving if drugs are present in blood, serum, plasma or oral fluid above a certain threshold. Since the prosecution does not have to prove that the driver was impaired, this kind of legislation facilitates the enforcement process. The threshold concentrations (or cut-offs) used are analytical detection limits, meaning that any detectable concentration of a drug constitutes an offense. Therefore, these laws are sometimes called zero-tolerance laws. Presently, Germany, Belgium, Sweden, France, Finland, Luxembourg, Switzerland, Denmark, a number of Australian states, and 14 U.S. states have introduced "per se" legislation in addition to "impairment" legislation.

There is no consensus on the analytical cutoffs between the various countries. This lack of consensus can be attributed partially to the use of different biological matrices (serum in Germany, plasma in Belgium, and whole blood in Australia, France, Sweden and Switzerland) and to the different consequences of a positive result: for example, in Belgium there is a penal sanction that follows a positive result, while in Germany there is an administrative sanction. The effectiveness of "per se" legislation in increasing the number of prosecutions has already been demonstrated in some countries. For example, in Finland there was a slow increase in the number of samples that were investigated until 2002. However, since the introduction of "per se" legislation in 2003, there has been a cumulative monthly increase in the number of samples [39].

In Sweden, immediately after the zero-limit law came into force, the number of cases of DUID submitted by the police

for toxicological analysis increased sharply and was 10 times higher in 2005 than before the new legislation. Nevertheless, it was found that Sweden's zero-concentration limit has done nothing to reduce DUID or deter the typical offender, because recidivism is high in this population of individuals (40–50 percent). Many traffic delinquents in Sweden are criminal elements in society, with previous convictions for drunk and/or drugged driving, as well as other offenses. The spectrum of drugs identified in blood samples from DUID suspects has not changed much since the zero-limit law was introduced [40].

Detection of Drugs in Drivers

Roadside Detection

For many years, police officers involved in road safety have expressed the need for a rapid and reliable roadside screening test for drugs similar to an alcohol breathalyzer. This would help them to determine which drivers have to provide a blood sample, or to take immediate administrative measures like confiscating the driver's licence or impounding the vehicle. Since illegal drugs are not released in measurable amounts in the breath, roadside drug testing must be based on other specimens (see Oral Fluid Toxicology).

Roadside detection tests are mostly immunoassays read visually or by a small electronic reader. At first, urine was used for roadside drug testing because of the high drug concentrations. Unfortunately, for some substances such as cannabis, the metabolites can be detected for a long time after chronic use. Consequently, the presence of drugs in urine does not necessarily indicate impairment. Another disadvantage of urine is the necessity of sufficient privacy during the sample collection. Nevertheless, roadside urine screening in Belgium has significantly decreased the number of unnecessary confirmatory blood analyses for DUID [41].

In recent years, the interest in the use of oral fluid as biological matrix has increased significantly, as this matrix displays some particularly interesting properties. First of all, oral fluid can be obtained easily by non-medical personnel in a relatively non-invasive and observable way. There is also some correlation with impairment. The results of the European project roadside testing assessment (ROSITA) indicated that, for most drugs of abuse, the correlation with blood is better for oral fluid than the urine. Nevertheless, the results of ROSITA and the follow-up project ROSITA 2 indicated that none of the currently available onsite oral fluid testing devices is reliable enough to be recommended for roadside screening for drivers [42]. However, the experience in the state of Victoria in Australia shows that random roadside oral fluid testing of drivers for methamphetamine, ecstasy and cannabis has a deterrent effect: the level of awareness of drivers of random oral fluid testing increased from 78 percent to 92 percent; 33 percent of illicit drug users stated that the drug tests had influenced them (primarily to avoid taking drugs when they are going to drive); and driving while under the influence of drugs dropped in the after period from 45 percent to 35 percent (Swann, P. 5-12-2005. Baltimore, Maryland, USA. Rosita 2 meeting. Person Meeting Communication). On the other hand, the oral cavity can be contaminated by intranasal and smoked drug use, leading to extremely high concentrations in oral fluid. It is also difficult to obtain sufficient sample volume for the analysis, and the concentrations of 9-tetahydrocannabinol (THC) and benzodiazepines in this matrix are low [43].

Evidentiary Analysis

Blood is considered the best matrix for confirmation analysis, because the presence of drugs in blood corresponds best with recent use and impairment. In many countries with "per se" legislation, the only legally allowed evidence for DUID is confirmation of the presence of drugs in the blood. A review on drugs of abuse monitoring in blood for control of DUID was recently published [44]. The most widely used method is gas chromatography coupled to mass spectrometry (GS-MS) because of its sensitivity and specificity. However, the procedure is labour-intensive and time-consuming, as solid phase extraction and derivatization are necessary for sample preparation. In addition, there are different drug classes. Liquid chromatography (tandem) mass spectrometry (LC-MS) procedures have been introduced for different classes of drugs for confirmatory analyses for screening and confirmation in one step. Several laboratories are developing methods that detect a large series of different drugs in one procedure in a small sample volume [45].

Another biological specimen that is used for evidentiary analysis in the context of DUID is hair. In Germany, Italy and other countries, hair analysis is used for licence grant-

ing to drug-dependent persons. The hair samples are first screened by immunoassay and positives are confirmed by high pressure liquid chromatography (HPLC), capillary electrophoresis (CE), GC-MS, or LC-MS. The major practical advantage of hair testing compared with urine and blood testing for drugs is its larger detection window — weeks to months — depending on the length of hair shaft analyzed. Other advantages of hair are its stability and ease-of-transportation. A disadvantage of the use of hair as biological matrix is the possible contamination by exposure to drugs in the air, and the absence of correlation with recent use because of the delayed appearance of drugs in hair [46-48]. (For further information, see also Hair: Toxicology.)

Conclusion

There is an increasing knowledge regarding the influence of drugs on performance and the prevalence of drugs other than alcohol in road traffic. Experimental studies show clearly that many drugs can have a detrimental effect on driving performance. These negative effects are often even more pronounced when drugs are combined with alcohol. Results of epidemiological studies confirm the detrimental effects of drugs on driving performance. These studies show that DUID is associated with increased crash risks and increased risks of being responsible for a traffic crash. They also show that these risks increase when drugs are taken in combination with alcohol, as compared to when drugs are taken alone.

Regarding DUID there is a clear move toward "per se" legislation, although some countries at this time have decided to stay with impairment legislation, and some have both (e.g., Australia, Germany, etc.). The detection by the police of drivers under the influence of drugs can be done by means of screening tests. In recent years, the interest in oral fluid screening tests has grown significantly. Studies however have shown that none of the currently available on-site devices are reliable when used alone. More recent methods developed for confirmation analysis use HPLC with tandem mass spectrometry.

It is possible that future developments could lead to on-site screening of capillary blood obtained by a finger prick and confirmation of the presence/absence of drugs by analyzing dried blood spots. Possible advantages of this approach would be the easy transportation (no need for refrigeration or shipping in dry ice), and stability of parent substances at ambient temperature, and less risk of loss of sample (e.g., breakage of glass tube of blood) or of infection.

References:

1 Couper, F.J. & Logan, B. K. (2004). *Drugs and Human Performance Fact Sheets*. DOT HS 809 725, NHTSA, pp. 1-100.

2 Baselt, R.C. (2001). Drug Effects on Psychomotor Performance, Biomedical Publications, Foster City.

3 Raes, E. & Verstraete, A.G. (in press) *Influence of Drugs on Performance. Workplace Drug Testing*. 1st Edition, Pharmaceutical Press, London.

4 Liguori, A., D'Agostino Jr., R.B., Dworkin, S.I., Edwards, D. & Robinson, J.H. (1999). "Alcohol effects on mood, equilibrium, and simulated driving," *Alcoholism: Clinical and Experimental Research* 23(5), 815-821.

5 Grant, S.A., Millar, K. & Kenny, G.N.C. (2000). "Blood alcohol concentration and psychomotor effects," *British Journal of Anaesthesia* 85(3), 401- 406

6 Menetrey, A., Augsburger, M., Favrat, B., Pin, M.A., Rothuizen, L.E., Appenzeller, M., Buclin, T., Mangin, P. & Giroud, C. (2005). "Assessment of driving capability re-

lation to blood cannabinoids levels following oral administration of 20mg dronabinol or of a cannabis decoction made of 20 or 60 mg Delta9- THC," *Journal of Analytical Toxicology* 29(5), 327- 338.

7 Ramackers, J.G., Kauert, G., van Ruitenback, P., Theunissen, E.L., Schneider, E. & Moeller, M.R. (2006). "High-Potency marijuana impairs executive function and inhibitory motor control," *Neuropsychopharmacology* 31(10), 2296-2303.

8 Sexton, B.F., Turnbridge, R., Brook-carter, N., Jackson, P.G. & Wright, K. (2000). *The Influence of Cannabis on Driving*. TRL 477, Road Safety Division, Department of the Environment, Transport and the Regions, pp. 1-106.

9 Lamers, C.T. & Ramackers, J.G. (2001). "Visual search and urban driving under the influence of marijuana and alcohol," *Hum Psychopharmacol* 16(5), 393-401.

10 Sexton, B.F., Turnbridge, R.J., Board, A., Jackson, P.G., Wright, K., Stark, M.M. & Engehart, K. (2002). TRL 543, *The Influence of Cannabis and Alcohol on Driving, Road Safety Division, Department of the Environment, Transport and the Regions.*

11 Foltin, R.W., Fischman, M.W., Pippen, P.A. & Kelly, T.H. (1993). Behavioral-effects of cocaine alone and in combination with ethanol or marijuana in humans, Drug and Alcohol Dependence 32(2), 93- 106.

12 Mills, K.C., Spruill, S.E., Kanne, R.W., Parkman, K.M. & Zhang, Y. (2001). "The influence of stimulants, sedatives, and fatigue on tunnel vision: risk factors for driving and piloting," *Human Factors* 43(2), 310-327.

13 Silber, B.Y., Papafotiou, K., Croft, R.J., Ogden, E., Swann, P. & Stough, C. (2005). "The effects of dexamphetamine on simulated driving performance," *Psychopharmacology* 179(3), 536-543.

14 Wesensten, N.J., Killgore, W.D.S. & Balkin, T.J. (2005). "Performance and alertness effects of caffeine, dextroamphetamine, and modafinil during sleep deprivation," *Journal of Sleep Research* 14(3), 255-266.

15 Caldwell, J.A. & Caldwell, J.L. (1997). "An in-flight investigation of the efficacy of dextroamphetamine of sustaining helicopter pilot performance," *Aviation Space and Environmental Medicine* 68(12), 1073-1080.

16 Lamers, C.T.J., Ramaekers, J.G., Muntjewerff, N.D., Sikkema, K.L., Samyn, N., Read, N.L., Brookhuis, K.A. & Reidel, W.J. (2003). "Dissociable effects of a single dose of ecstasy (MDMA) on psychomotor skills and attentional performance," *Journal of Psychopharmacology* 17(4), 379-387.

17 Ramaekers, J.G., Kuypers, K.P.C., Wood, C.M., Hockey, G.R.J., Jamson, S., Jamson, H. & Birch, E. (2004). IMMORTAL Deliverable D-R4.4: *Experimental Studies on the Effects of Licit and Illicit Drugs on Driving Performance, Psychomotor Skills and Cognitive Function.*

18 Smith, R.M., Tivarus, M., Campbell, H.L., Hillier, A. & Beversdorf, D.Q. (2006). "Apparent transient effects of recent 'ecstasy' use on cognitive performance and extrapyramidal signs in human subjects," *Cognitive and Behavioral Neurology* 19(3), 157-164.

19 Laurell, H. & Schlyter, F. (eds) (2000). *A Driving Simulator Study on the Effects of MDMA (Ecstasy) on Driving Performance and Traffic Safety,* The International Council on Alcohol, Drugs and Traffic Safety (ICADTS), Stockholm.

20 Brookhuis, K.A., de Waard, D. & Samyn, N. (2004). "Effects of MDMA (ecstasy), and multiple drugs use on (simulated) driving performance and traffic safety," *Psychopharmacology* 173(3-4), 440- 445.

21 Verheyden, S.L., Henry, J.A. & Curran, H.V. (2003). "Acute, sub-acute, and long-term subjective consequences of "ecstasy" (MDMA) consumption in 430 regular users," *Human Psychopharmacology: Clinical and Experimental* 18(7), 511-516.

22 Fischman, M.W. & Schuster, C.R. (1980). "Cocaine effects in sleep-deprived humans," *Psychopharmacology* (Berlin) 72(1), 1-8.

23 Hopper, J.W., Karlsgodt, K.H., Adler, C.M., Macklin, E.A., Lukas, S.E. & Elman, I. (2004). "Effects of acute cortisol and cocaine administration on attention, recall and recognition task performance in individuals with cocaine dependence," *Human Psychopharmacology: Clinical and Experimental* 19(7), 511-516.

24 Johnson, B., Overton, D., Wells, L., Kenny, P., Abramson, D., Dhother, S., Chen, Y.R. & Bornick, P. (1998). "Effects of acute intravenous cocaine on cardiovascular function, human learning, and performance in cocaine addicts," *Psychiatry Research* 77(1), 35-42.

25 Farre, M., Delatorre, R., Llorente, M., Lamas, X., Ugen, B., Segura, J. & Cami, J. (1993). "Alcohol and cocaine interactions in humans," *The Journal of Pharmacology and Experimental Therapeutics* 266(3), 1364-1373.

26 Jenkins, A.J., Keenan, R.M., Henningfield, J.E. & Cone, E.J. (1994). "Pharmacokinetics and pharmacodynamics of smoked heroin," *Journal of Analytical Toxicology* 18(6), 317-330.

27 Martin, W.R. & Fraser, H.F. (1961). "A comparative study of physiological and subjective effects of heroin and morphine administered intravenously in postaddicts," *The Journal of Pharmacology and Experimental Therapeutics* 133, 388-399.

28 Cone, E.J., Holicky, B.A., Grant, T.M., Darwin, W.D. & Goldberger, B.A. (1993). "Pharmacokinetics and pharmacodynamics of intranasal, 'snorted' heroin," *Journal of Analytical Toxicology* 17(6), 327- 337.

29 Scheers, M., Verstraete, A.G., Adriaensen, M., Raes, E. & Tang, M. (2006). *Rijden Onder invloed van Psychoactieve Stoffen: Literaruurstudie en Evaluatie van Het Handhavingsbeleid*, Academia Press, Ghent, p. 291.

30 Verstraete, A.G. (2004). "Detection times of drugs of abuse in blood, urine, and oral fluid," *Therapeutic Drug Monitoring* 26(2), 200-205.

31 SAMSHA,- Office of Applied Studies (OAS) (2005). Data of the 2005 National Survey on Drug Use and Health, http://www. drugabusestatistics.samhsa.gov/latest. htm#Prev.

32 Kloeden, C.N. & McLean, A.J. (eds) (1995). "Grand Rapids Effects Revisited: Accidents, Alcohol, and Risk," The International Council on Alcohol, Drugs and Traffic Safety (ICADTS), Adelaide.

33 Mayhew, D. & Dussault, C. (eds) (2002). "The Contribution of Alcohol and other Drugs Among Fatally Injured Drivers in Quebec: Some Preliminary Results," The International Council on Alcohol, Drugs and Traffic Safety (ICADTS), Montreal.

34 Assum, T., Mathijssen, M.P.M., Houwing, S., Buttress, S.C., Sexton, B., Turnbridge, R.J. & Oliver, J. (2005). IMMORTAL Deliverable D-R4.2: The Prevalence of Driving and Relative Risk Estimations. A study conducted in the Netherlands, Norway.

35 Laumon, B., Gadegbeku, B., Martin, J.L. & Biecheler, M.B. (2005). "Cannabis intoxication and fatal road crashes in France: population based casecontrol study," *British Medical Journal* 331(7529), 1371-1376.

36 Soderstrom, C.A., Dischinger, P.C., Kufera, J.A., Ho, S.M. & Shepard, A. (2005). "Crash culpability relative to age and sex for injured drivers using alcohol, marijuana, or cocaine," *Annual Proceedings Association for the Advancement of Automotive Medicine* 49, 315-330.

37 Longo, M.C., Hunter, C.E., Lokan, R.J., White, J.M. 7 White, M.A. (2000). "The prevalence of alcohol, cannabinoids, benzodiazapines, and stimulants amongst injured drivers and their role in driver culpability: Part II: the relationship between drug prevalence and drug concentration, and driver culpability," *Accident Analysis and Prevention* 32(5), 623-632.

38 Walsh, J.M., De Gier, J.J., Christopherson, A.S. & Verstraete, A.G. (2004). "Drugs and driving," *Traffic Injury Prevention* 5, 241-253.

39 Lillsunde, P., Gunnar, T. & Seppa, H. (2005). Rosita 2 in Finland. Rosita 2 Meeting. 5-12-2005, Baltimore.

40 Jones, A.W. (2005). "Driving under the influence of drugs in Sweden with zero concentration limits in blood for controlled substances," *Traffic Injury Prevention* 6(4), 317-322.

41 Raes, E. & Verstraete, A.G. (2005). "Usefulness of roadside urine drug screening in drivers suspected of driving under the influence of drugs (DUID)," *Journal of Analytical Toxicology* 29(7), 632-636.

42 Verstraete, A.G. & Raes, E. (eds) (2006). Rosita-2 Project: Final Report, Academia Press, Ghent, p. 257.

43 Drummer, O.H. (2006). "Drug testing in oral fluid," *Clinical Biochemistry Reviews* 27, 147-159.

44 Moeller, M.R. & Kraemer, T. (2002). "Drugs of abuse monitoring in blood for control of driving under the influence of drugs," *Therapeutic Drug Monitoring* 24(2), 210-221.

45 Oiestad, E.L., Johansen, U. & Christopherson, A.S. (2007). "Drug screening of preserved oral fluid by liquid chromatography-tandem mass spectrometry," *Clinical Chemistry* 53(2), 300-309.

46 Nakashima, K. (2005). "High-performance liquid chromatographic analysis of drugs of abuse in biological samples," *Journal of Health Science* 51(3), 272-277.

47 Kintz, P., Villain, M., Ciriminele, V., Janey, C. & Ludes, B. (2003). Decret n 2003-293 du 31 mars 2003. "Restitution de permis de conduire a partir d'analyses de cheveux," *Annales de Toxicologie Analytique* 15(2), 117-122

Chapter 5

Prayer & Your Higher Power

Drugs, Alcohol and the Higher Power

If you are going to get off drugs and alcohol, you need help. The number of people who do it completely alone is almost nil. Without a program to help you, there is almost no chance you can do it.

Why can't you do it alone? Because your habit is bigger than you are — it is all around you, in every aspect of your life. Using your drug of choice pervades your social life, your family and probably your work as well.

To combat a problem that big, most rehabilitation programs are based on the realization that you need help from others — from some power greater than yourself. The most successful alcohol and drug rehabilitation programs have grown out of the Alcoholics Anonymous (AA) movement. Within AA, this helper is called the "higher power."

Twelve Steps Focus on a Higher Power

According to the Alcoholics Anonymous world website, "The majority of AA members believe that they have found the solution to their drinking problem not through individual willpower, but through a power greater than themselves. However, everyone defines this power as he or she wishes. Many people call it God, others think it is the AA group, still others don't believe in it at all."

AA considers itself a fellowship of men and women who have lost the ability to control their drinking. Losing control means they have found themselves in various kinds of trouble as a result of drinking.

As in Alcoholics Anonymous, an offshoot group, Narcotics Anonymous (NA) also believes that one of the keys to its success is the therapeutic value of addicts working with other addicts. In meetings, each member shares personal experience with others seeking help, not as professionals but simply as people who have been there themselves and found a solution. Narcotics Anonymous has no professional therapists, no residential facilities and no clinics. NA provides no

vocational, legal, financial, psychiatric or medical services. The closest thing to an "NA counsellor" is the sponsor, an experienced member who gives informal assistance to a newer member.

Within these recovery groups, the individual's attempt to create a satisfying way of life without drugs or alcohol involves not only quitting the habit, but also group and individual prayer that supports their clean and sober lifestyle.

The Twelve Steps of Alcoholics Anonymous

The success of the AA program seems to be due at least in part to the fact that an alcoholic who no longer drinks has a higher success rate in helping other uncontrolled drinkers. The AA program focuses on recovered alcoholics passing along the stories of their own problem drinking.

The heart of this program of personal recovery is the famous Twelve Steps. These steps have been used by millions of recovering alcoholics (and drug addicts). The Twelve Steps are as follows:

1. We admitted we were powerless over alcohol — that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God (higher power) as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God (higher power), to ourselves and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God (higher power) remove all these defects of character.
7. We humbly asked Him (higher power) to remove our shortcomings.

8. We made a list of all persons we had harmed, and ssbecame willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and, when we were wrong, promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God (higher power) as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Newcomers are not asked to accept or follow these Twelve Steps in their entirety if they feel unwilling or unable to do so. They will usually be asked to keep an open mind, to attend meetings at which recovered alcoholics describe their personal experiences in achieving sobriety, and to read AA literature describing and interpreting the AA program.

According to Dr. Bob (Bob Smith), a co-founder of the AA movement with Bill W., when asked how the program works, "There are two or three things that flashed into my mind on which it would be fitting to lay a little emphasis. One is the simplicity of our program. Let's not louse it all up with Freudian complexes and things that are interesting to the scientific mind but have very little to do with our actual AA work."

In his comments specific to the Twelve Steps, Dr. Bob said, "Our Twelve Steps, when simmered down to the last, resolve themselves into the words 'love' and 'service.'"

AA members will usually emphasize to newcomers that only problem drinkers themselves, individually, can determine whether or not they are in fact alcoholics. At the same time, it will be pointed out that all available medical testimony indicates that alcoholism is a progressive illness, that it cannot be cured in the ordinary sense of the term, but that it can be arrested through total abstinence from alcohol in any form.

The Six Steps — A Short Form

Creative short cuts are sometimes helpful in remembering key concepts. Some of the members of twelve-step pro-

grams (AA, NA, ACOA, CODA, Gamblers Anonymous, Al-Anon and others) have boiled down the twelve steps to six:

1. We admit we are licked and cannot get well on our own.
2. We get honest with ourselves.
3. We talk it out with somebody else.
4. We try to make amends to people we have harmed.
5. We pray to whatever greater Power we think there is, even as an experiment, or think of our AA group as our "higher power."
6. We try to give of ourselves for our own sake and without stint to other alcoholics, with no thought of reward.

Narcotics Anonymous Twelve Steps

The core of the Narcotics Anonymous recovery program is a series of personal activities known as the Twelve Steps, adapted from Alcoholics Anonymous. These "steps" include admitting there is a problem, seeking help, undertaking self-appraisal and confidential self-disclosure, making amends where harm has been done, and working with other drug addicts who want to recover.

Central to the NA program is an emphasis on what is referred to as a "spiritual awakening," emphasizing its practical value, not its philosophical or metaphysical import. This has posed little difficulty when translated across cultural boundaries. Narcotics Anonymous as a program is non-religious and encourages each member to cultivate an individual understanding, religious or not, of this "spiritual awakening."

One Prayer at a Time

The active addict or alcoholic only wants to be finished with the misery of his lifestyle. He wants to be out of pain. The idea of getting relief from a "higher power" through prayer and meditation is a stretch for most who are beginning the recovery process. However, stories of spiritual transformation in recovery groups are not only common, they are essential to the sobriety of the addict.

Seeing the Light

How does such a spiritual awakening or transformation happen? One of the most famous stories of such an awakening is that of Bill Wilson (Bill W.), founder of Alcoholics Anonymous.

His account in the *Big Blue Book* of AA recounts how in 1934 he was admitted for the fourth time to a sanitarium, sedated, and started on the routine belladonna rehab treatment. During those first stages of his "dry out," Bill was visited by Ebby, a man who told him an inspiring story. Ebby had recently been able to stop drinking by surrendering his life to God, having recognized that he couldn't run it himself. After having being brutally honest with himself and making amends to his friends, he began to help others stop drinking too. Eventually these realizations led Ebby to prayer. This practice of asking a higher power for assistance gave him even more relief.

When Bill expressed his reluctance to believe in God or to pray, Ebby suggested that Bill should choose his own conception of God. According to Bill, as he thought over what Ebby had told him, "It melted the icy intellectual mountain in whose shadow I had lived and shivered many years. It was only a matter of being willing to believe in a Power greater than myself. Nothing more was required of me to make my beginning."

Resistance Becomes Revelation

Bill reacted with excitement to Ebby's story, but within a few minutes his mood shifted rapidly from elation to rebellion, then to depression and finally to desperation. At that point, Bill W. prayed for help.

What happened next is the stuff of legend. There isn't an AA member anywhere who hasn't heard the story. Most of them have one very much like it.

During his prayer, Bill W. spontaneously said, "I'll do anything, anything for release."

To quote from the *Big Blue Book*, "The effect was electric. There was a sense of victory, followed by such a peace and serenity as I had never known. There was utter confidence. I felt lifted up, as though the great clean wind of a mountain top blew through and through. God comes to most men gradually, but His impact on me was sudden and profound." He cried out, "If there be a God, let Him show Himself!" He told Lois [his wife] how the room blazed with light, how he was filled with a "joy beyond description."

Transformation For its Own Sake

Today, doctors and therapists try to analyze and decode these transformative experiences Bill W. and so many other AA members have had. According to one doctor who specializes in treating both alcoholics and drug addicts, Bill's surge of spiritual fervour could have been a hallucination — a reaction to the sobering-up drugs he had been given in the sanitarium. Or, it could have been the kind of ecstatic experience mystics have reported throughout history.

"The cause is ultimately not important. What's important is what you then do with that experience…. When you talk to cocaine users — especially people doing crack — they report a kind of oceanic rush. What they then do is go and get more crack [so they can have that experience again]. It's how you use the experience that matters. For some people, it leads to an opening up — an awareness of a different sort, often of your own potential."

Higher Power Confronts Everyone

In the *Big Blue Book*, Bill goes on to address what the "god stuff " means to Agnostics in the program. "It means, of course, that we are going to talk about God. Here difficulty arises with agnostics. Many times we talk to a new man and watch his hope rise as we discuss his alcoholic problems and explain our fellowship. But his face falls when we speak of spiritual matters, especially when we mention God."

Bill W. goes on, "We know how he feels. We have shared his honest doubt and prejudice. Some of us have been violently anti-religious. Much to our relief, we discovered we did not need to consider another's conception of God. Our own conception, however inadequate, was sufficient to make the approach and effect a contact with Him."

Spiritual Practice is Prayer Plus Action

Although there is much emphasis on prayer in the AA program and other forms of recovery, spiritual practice is much more than that. Much of religion seems to isolate people in an escapist spiral that works out to "just me in the prayer closet." However, in the recovery movement, the focus is on reaching out, not closing in.

A minister from the Lutheran fold said, "Our purpose on this earth is primarily to reach out to others. It is the only way we have to know God. My personal belief is that we have to get involved with each other. It's what's left out of so much organized religion. In that caring dimension, the church hasn't done as well as I think AA has."

A meaningful contact with others and an appreciation of our participation as individuals and groups is key in our humanity. Whether we play together or pray together, being with other people who share a common bond is a big part of the healing and recovery from drugs and alcohol.

Forms of Prayer

The way most people begin their spiritual practice is with a prayer. A simple prayer works best. Often it's something as small and neat as, "God, help me."

There are many ways to pray — to communicate with the higher power. Usually people start their spiritual work by praying, and later add meditating as a further practice. If you are wondering what the difference is between the two, prayer is talking to God, while meditation is listening to God.

Personal Prayer

When you are first in recovery, or are hoping to start recovering, you talk spontaneously to your higher power a lot. Usually you are asking for personal things, bargaining. Your prayer might go something like this: "God, I promise if you help me kick this habit [drinking or drugging], I'll start going to AA, I'll be nicer to my kids, and I'll get a job." As you can see, this is a personal sort of prayer.

When you become fully involved in your recovery program, you start to be concerned about people other than yourself. The twelfth step (see The Twelve Steps) encourages you to take your story to others who suffer from the disease from which you are healing. When you get to the stage at which you are sponsoring others, you might be including them in your prayers. That would be asking for the higher power to help them, and to help you be a better sponsor while strengthening your own recovery.

It's hard to explain how important spirituality becomes to people who had no interest in such things before they entered recovery. Prayer and meditation or other spiritual work becomes the way they deal with problems, pain and other difficulties. It's not about being an escapist. Spirituality adds meaning and purpose in going through the everyday round, in putting up with the usual ups and downs, rejections and changes.

One AA member said, "To me, spirituality is the living out — the putting into practice — of our greatest responsibility. That responsibility is to love. At their best, the members of AA are trying to live up to that responsibility. They are also living out my definition of grace: being loved when we don't deserve it."

Forms of Prayer

The way most people begin their spiritual practice is with a prayer. A simple prayer works best. Often it's something as small and neat as, "God, help me."

There are many ways to pray — to communicate with the higher power. Usually people start their spiritual work by praying, and later add meditating as a further practice. If you are wondering what the difference is between the two, prayer is talking to God, while meditation is listening to God.

Personal Prayer

When you are first in recovery, or are hoping to start recovering, you talk spontaneously to your higher power a lot. Usually you are asking for personal things, bargaining. Your prayer might go something like this: "God, I promise if you help me kick this habit [drinking or drugging], I'll start going to AA, I'll be nicer to my kids, and I'll get a job." As you can see, this is a personal sort of prayer.

When you become fully involved in your recovery program, you start to be concerned about people other than yourself. The twelfth step (see The Twelve Steps) encourages you to take your story to others who suffer from the disease from which you are healing. When you get to the stage at which you are sponsoring others, you might be including them in your prayers. That would be asking for the higher power to help them, and to help you be a better sponsor while strengthening your own recovery.

Written Prayers Get You Started

It's a good habit to use a written prayer each day to get you started in your spiritual practice. Among AA members, the *Serenity Prayer* is a focus during each meeting. Other people

like the *23rd Psalm*, *The Lord's Prayer* (see end of this chapter for the complete text) to help them get into the mood for personal prayer.

One disadvantage of the ritual type of prayer, one that is said frequently by individuals and groups of people, is that you can forget you are praying. That's a problem. To avoid a loss of meaning in the prayer, try to focus deeply on each phrase of the prayer. Take the *Serenity Prayer*, for instance. Think about what it means to have the wisdom to know the difference between things you can change and things you can't.

- Do you know anyone who has that wisdom?
- Where do you think they learned that?
- Can you develop that wisdom yourself?
- *The Lord's Prayer* is another prayer in which people get lost in the ritual and forget they are talking to their higher power or God. Ask yourself these questions:
  - Where is the Valley of the Shadow of Death?
  - What does it look like?
  - Have you ever been there?
  - How did you get out?
  - Who helped you? Was it God?
  - Did you fear evil or did you have the help and guidance of the higher power?

Daily Cycle Prayers

There are certain times of the day that trigger prayer. Morning is a time to set the tone for the day ahead. No one gives you an opportunity to take a stress-relief moment. After work is a time for shifting gears and changing focus to yourself, relationship or friends. Bedtime is when you review what you did through the day and ask for help to do it even better tomorrow. An example of a daily cycle prayer would be this evening prayer from Marianne Williamson's *Illuminata*:

"Dear God, I surrender to You the day now over. May only the love remain. Take all else into the fire of Your transformative power. Release me, release others, from any effects of my wrongmindedness. As I now give to You who I am, what I did, who I loved, who I failed to love, please make all things right. Take all things. May I continue to grow in Your light and love. Tomorrow, may I be better. Amen."

Prayers can be either spontaneous or written. They can come from a book, from a friend, or you can compose them yourself. One person in recovery found his favourite prayer as he was walking in a cemetery one evening. It was inscribed on a tombstone.

Prayers For Stress

You can write out a prayer that is meaningful to you and use it regularly in stressful situations. Maybe there is a time in the day that is particularly difficult in your recovery. For instance, many people find it hardest to stay sober either right after work or after dinner. They start feeling edgy and tense. They just need to do something, and they want to drink or go get drugs. That's when the special stress prayer can be helpful. In especially tough moments, many people talk in a conversational style to a departed relative, saint or guardian angel.

Non-Christian Prayer Forms

Christian prayers aren't the only game in town. Many non-Christians recover through twelve-step programs. Recognition of a higher power isn't exclusively for Christians. Buddhists pray to be useful in helping others to achieve a release from suffering, becoming a "Bodhisattva." Here is The Bodhisattva's Prayer: "For as long as space endures, And for as long as sentient beings remain, Until then may I too abide, To dispel the misery of the world." Among aboriginal people, prayer often finds a centre in the natural world. Asking to gain greater harmony with the heart of nature is one way to regain personal balance. One such prayer from the Chinook tribe is as follows: "May all things move and be moved in me, And know and be known in me, May all creation, Dance for joy within me."

Visualization Puts You in the Picture

Whether you are using a spontaneous prayer or a written one, seeing yourself in the picture can make the idea of the prayer real for you. If you are asking to understand how to be healthy and free of drugs, picturing yourself as a strong, vital person can help make that a reality. In the mental picture, "look" around yourself and see what features of a healthy life you put into the scene with you. Ask yourself these questions:

- Who is there with you?
- What are you wearing?
- If you are eating or drinking something, what is it?
- What is the healthy "you" saying to the current "you"?

Chanting and Mantras

When you are starting to develop a relationship with your higher power, you want to keep it as simple as possible. Spontaneous, personal prayers might be one way to maintain that simplicity. Another way would be to use a simple chant or mantra.

A mantra is a few syllables that are repeated over and over again. The words used are usually sacred, often one of the many names of God from various cultures or religions. These are a few of the better-known mantras:

- Rama;
- Om;
- Hail Mary, full of grace; and
- Om mani padme hum.

You might have heard that mantras are used in meditation. People often do use a mantra to focus the mind during meditation, but mantras can be used for much more than that.

Try this: when you are beginning your spiritual practice session, repeat a mantra several times quietly or silently in your mind. Breathe deeply and do it again. Then start your normal prayer. Experimentation may reveal that you feel much clearer in your prayers after repeating a mantra.

Prayer is the Way Out of Misery

Whatever kind of prayer or meditation you do, it's the key ingredient in your release from the disease of addiction. If you don't subscribe to a religion, think of it this way: you don't have to be religious to be spiritual.

Go to any group of recovering addicts or alcoholics. Ask them what one thing has made their recovery possible. Every single one of them will tell you that they were getting sicker and more miserable until the moment that they turned their life over to a power greater than themselves.

It's spirituality and prayer that makes recovery possible. Even if you don't believe it will work, give it a try. Say a little prayer for you. A miracle is waiting to happen!

Appendix 1

The Serenity Prayer

God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference. Living one day at a time, Enjoying one moment at a time, Accepting hardship as the pathway to peace. Taking, as He did, this sinful world as it is, not as I would have it. Trusting that He will make all things right if I surrender to His will. That

I may be reasonably happy in this life, And supremely happy with Him forever in the next. Amen.

Appendix 2

23rd Psalm — The Lord's Prayer

The Lord is my Shepherd: I shall not want. He maketh me to lie down in green pastures; He leadeth me beside the still waters. He restoreth my soul; He leadeth me in the paths of righteousness for His Name's sake. Yea, though I walk through the valley of the shadow of death I will fear no evil for Thou art with me: Thy rod and Thy staff they comfort me. Thou preparest a table before me in the presence of mine enemies; Thou anointest my head with oil; my cup runneth over. Surely goodness and mercy shall follow me all the days of my life: and I will dwell in the House of the Lord forever.

Appendix 3

SOS Sobriety

SOS sobriety is sure to be controversial. It analyzes the limitations of Alcoholics Anonymous while describing the methods of alcohol and drug abstention advocated by James Christopher, founder of Secular Organizations for Sobriety (or "Save Our Selves"), the world's largest non-twelve-step addiction recovery program.

After answering basic questions about the nature and purpose of SOS, the success of the "sobriety priority" approach is documented through two scientific studies. Included are moving, in-depth individual recovery stories, interviews with addiction experts and legal professionals, and a critique of "controlled drinking" programs and the insistence of AA and the liquor industry that alcoholism is a problem of behaviour rather than one rooted in physiology and genetics.

James Christopher is author of *Unhooked: Staying Sober and Drug Free and How to Stay Sober: Recovery Without Religion*. He is also editor of *The SOS Newsletter*.

Additional Reading on Recovery from Drugs & Alcohol in the Family

Becker, Robert, *Addicted to Misery*

Bradshaw, John, *Healing the Shame That Binds You*

Brinkley, Dannion, *Saved By The Light*

Carter-Scott, Cherie, *Negaholics — How To Overcome Negativity*

Cary, Sylvia, 10+ — *Women with Long-Term Sobriety Talk*

Cruse, J., *Painful Affairs, Looking for Love Through Addiction*

Cruse & Wegscheider, *Choicemaking for Co-Das, ACOA's & Spirituality Seekers*

Gray, John, *What You Feel, You Can Heal*

Jampolsky, Gerry, *Love is Letting Go of Fear* and *Goodbye to Guilt*

LeBoutiller, *Little Miss Perfect — ACOA*

Lee, John, *Flying Boy, Healing the Wounded Man*

Levine, Stephen, *Guided Meditations, Explorations and Healings*

Mastrich & Virnes, *ACOA's Guide to Raising Healthy Children*

Miller, Joy, *My Holding You Up is Holding Me Back*

Napier, Nancy, *Recreating Yourself* (self-hypnosis)

Olitzky & Copans, *12 Jewish Steps*

Prather, Hugh and Gayle, *A Book for Couples*

Redfield, James, *Celestine Prophecy*

Schlessinger, Dr. Laura, *Ten Stupid Things Women Do to Mess Up Their Lives*

Recovery on the World Wide Web

Alcoholics Anonymous websites:

http://www.aa.org/econtent.html
http://www.aa.org/em24doc1.html

Serenity Prayer home page:

http://Open-Mind.org/Serenity.htm

Narcotics Anonymous home page:

http://www.wsoinc.com/

Resources:

Batchelor, Martine, *Walking on Lotus Flowers, Buddhist Women Living, Loving and Meditating,* Thorsons, 1996

Christopher, James, *SOS Sobriety, The Proven Alternative to 12-Step Programs,* Prometheus Books, 1992

Cooper, David A., *The Heart of Stillness, The Elements of Spiritual Practice,* Bell Tower, 1992

Crisman, William H., *The Opposite of Everything is True, Reflections on Denial in Alcoholic Families,* William Morrow and Company, 1991

Dossey, Larry, M.D., *Prayer is Good Medicine,* Harper San Francisco, 1996

Goldstein, Joseph, and Kornfield, Jack, *Seeking the Heart of Wisdom, The Path of Insight Meditation*, Shambhala, 1987

Groves, Dawn, *Meditation for Busy People, 60 Seconds to Serenity,*

New World Library, 1993

Moore, Thomas, *Care of the Soul, A Guide for Cultivating Depth and Sacredness in Everyday Life,* Harper Collins, 1992

O'Reilly, Edmund B., *Sobering Tales, Narratives of Alcoholism and Recovery,* University of Massachusetts, 1997

Roberts, Elizabeth, and Amidon, Elias, *Earth Prayers from Around the World,* Harper San Francisco, 1991

Robertson, Nan, *Getting Better, Inside Alcoholics Anonymous,* William Morrow and Company, 1988

Williamson, Marianne, *Illuminata, Thoughts, Prayers, Rites of Passage,* Random House, 1994

For prevention and treatment information, and resources, please refer to the "DIRECTORY OF SUBSTANCE ABUSE SERVICES" at the back of the manual.

Chapter 6

Social Host Liability

by Shelley Timms

During the holidays you want to invite a few friends over for dinner and have a couple of drinks, or you want to have a party for whatever reason. As the host, should you be worried?

As a social host, you should be concerned about your guests consuming too much alcohol for a variety of reasons, the most important one being, of course, their safety. Most motor vehicle crashes involving alcohol result in death or serious injury such as brain injury or spinal cord injury, as well as emotional trauma. Very rarely are the injuries minor. Your guest could also choke on vomit, fall down, or be involved in an assault, among other things.

You may be sued if you were aware that your guest was intoxicated and you did nothing to prevent that person from driving or causing injuries to themselves or others.

Most of the successful alcohol liability cases have been against commercial hosts such as bars, restaurants and any entity that serves alcohol for profit. Liability and responsibility for service have been extended to employers and to those who supply alcohol to minors. There hasn't been a successful case against a social host. However, this doesn't mean it won't happen, and it is worth knowing what is expected of commercial hosts to assist social hosts in protecting themselves from liability and, more importantly, their guests and others from tragic consequences related to over-service and excessive consumption of alcohol.

Commercial Host Liability

The courts have stated that in order for there to be a finding of liability against a host, there must be the following:

- a special relationship;
- duty of care;
- ability to forsee; and
- an obligation to monitor and supervise.

The Supreme Court of Canada decided in 1972 that there was a "special relationship" between a bar and its patron because the bar "invites" the patron to use its premises to buy and drink alcohol. There is a duty or responsibility on the bar to ensure that there is no "foreseeable" harm that occurs to the patron because of what the bar does (serving alcohol to a patron when he is visibly intoxicated and then ejecting him) and what it fails to do (take preventative steps — offer a ride or call a taxi or police).

The commercial host also has an obligation to determine the patron's condition and not serve alcohol to someone who is visibly intoxicated.

A duty of care is extended to the commercial host because alcohol is essentially the only "legal" intoxicating substance that can be sold with limited regulation, and the commercial host is making money as its patrons are becoming intoxicated and less able to make proper judgments. So, once a guest has had a few drinks, the host then has a positive duty to be sure that he does not cause harm to him/herself or others.

The next stage is that the consequences must be "foreseeable." This does not require a crystal ball, but a small level of common sense. If a guest is visibly drunk or the host knows that the guest has consumed several drinks, then, if the guest drives, it is foreseeable that the guest will cause a crash. It is also foreseeable that a drunk driver will crash into another vehicle or pedestrian. Essentially, the courts have decided that the cost of doing business of selling alcohol is preventing intoxicated guests from driving. It is also foreseeable that the guest might injure him/herself in other ways; however, there must be something to cause the host to realize that this is a possibility, such as the person is very angry or stumbling on the premises.

The courts have said that the commercial host has an obligation to take preventative action such as calling a taxi, obtaining the guest's car keys, and offering accommodation. If these fail, the tavern must call the police.

Beyond Commercial Host

Once tavern liability became established, it was only a matter of time before other "hosts" were sued when their guests drank too much and then caused injury.

In one case, a supervisor provided alcohol to his crew while they were working on a trade show. One employee drank at least eight beers while on the job, went to a bar after work, and then had a 45-minute drive home. He fell asleep, crashed his car and is now in a wheelchair for life. The court held that the relationship between employer and employee was even more special than that of bar and patron. The employer had an obligation to provide a safe workplace, to monitor the consumption of beer — especially if the supervisor knew the employees were driving — and then prevent the employees from driving. It was foreseeable that providing alcohol would put the employee at risk when it was known that he would be driving.

Non-profit and charitable organizations can be at risk for liability during special events that serve alcohol. Most provinces require a special-occasion permit, and the same obligations that belong to a tavern will belong to the group with this permit. The problem is that many of these organizations do not have an alcohol policy, or staff training in service of alcohol and dealing with intoxicated guests. A British Columbia service organization ran a beer garden for a town's special event and was liable for failing to set up appropriate security to prevent pranks by guests from getting out of hand. A number of guests ran up a pole to "moon" the group. The third attempt resulted in the person falling on top of another person sitting below the pole. As this was the third attempt, the organization was aware of the problem — it had become foreseeable — and it had a duty of care to stop further attempts.

The closest case to a social host situation involved a 24-year-old supplying alcohol to an 18-year-old by buying him two bottles of rum. The 18-year-old drank a good portion of both bottles, and eventually ran a red light in his car, crashing into another vehicle, killing himself and another person, and causing severe injuries to a third person. Liability was found to be 5 percent against the 24-year-old for supplying the alcohol and, while this may seem like a low percentage, the total damages were $8.7 million.

But What About the Social Host?

First, who is a social host? A definition could include anyone who:

- is not selling or supplying alcohol for profit;
- is not an employer, nor could be defined as having a "unique relationship" with the guests; or
- is serving alcohol or condoning the service/consumption of alcohol on premises over which he or she has control.

Further, the issue of BYOB (Bring Your Own Bottle/Booze) adds a unique flavour to the concept, as it implies that the social host does not necessarily have to provide the liquor, but merely condone its use on the premises.

The definition is not exhaustive. Two recent cases have come close to establishing social host liability. In one, parents of a teenager were sued when the teenager hosted a party of which the parents knew nothing because they were asleep. When the police were called, the teenager woke his mother to tell her but said everything was under control and the mother fell back to sleep. One of the guests crashed her car, injuring one of her passengers. In a pretrial matter, the judge suggested the fact that the parents had hosted previous parties in which there was underage drinking put them in a more vulnerable position. However, it was the fact that the teenager woke his mother, who then did not check on the situation, that made the parents very vulnerable to liability. The case settled before trial.

Another case involved a New Year's Eve party and a guest who left intoxicated and crashed into another car, killing one person and paralyzing another. The hosts knew the guest had a history of alcohol abuse and convictions for impaired driving. The guest was apparently visibly intoxicated when he left the party. Although the hosts were encouraging their friends to spend the night instead of driving, it was the view of the trial judge that they were relieved to see this one guest leave.

An analysis of negligence law suggested that there might be social host liability based on what the hosts knew about this guest. Further, the judge stated that the fact that it was a BYOB party only created a greater responsibility on the hosts to monitor their guests more closely, as they could not monitor the actual consumption of alcohol.

However, the trial judge said it was up to the provincial government to regulate social host responsibility and subtly suggested that the government should develop criteria to avoid the chaos in the courts. The case has been appealed to the Ontario Court of Appeal.

Social Host Through the Back Door

At least half the provinces have Occupiers' Liability legislation, which means that anyone who has control over premises (owners, renters, and special occasions) could be responsible for injuries (or worse) to people who are invited onto the premises. This includes being responsible for the condition of the premises; the conduct of the guests, and incidents coming from the activities allowed on the premises.

The legislation is assuming that there is a duty of care owed by the person in control of the premises to all those who are invited. There still needs to be the element of foreseeability and, as a result, there have been few successful cases because the courts have found the risk and resulting injury to be unforeseeable. Further, liability is limited to incidents that occur on the premises, and is not applicable to incidents occurring off the host's property.

Where Does This Leave the Social Host?

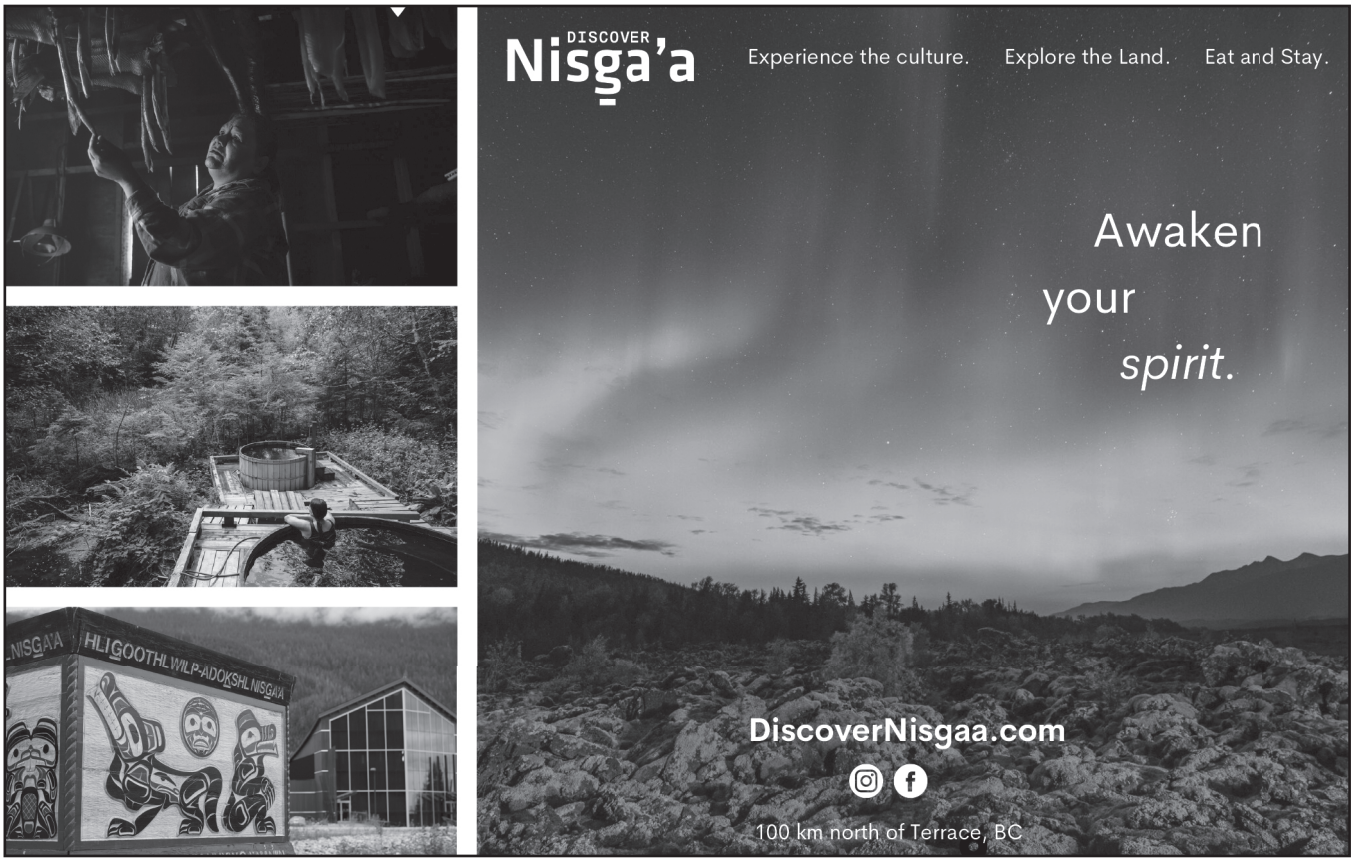
It is important for every social host to consider the consequences involved with the service of alcohol, because there will continue to be lawsuits. The social host could be found to have a duty of care to guests, and all those who are at risk, due to the intoxication of the guests in terms of events that could be foreseeable. Further, the host has a duty to monitor and supervise the service and consumption of alcohol during a party or event.

The best course is to take risk-management measures. The social host should check his or her insurance to determine if there is coverage for any incident that may occur on the property or as a result of actions from the property. When hosting a party, plan appropriately. This includes the following:

- either don't drink or limit your own consumption of alcohol in order to track that of your guests;
- know your guests — it is much easier to track the changes in behaviour of those you know;
- try to serve all drinks yourself and avoid self-serve bars, in order to track and monitor your guests' consumption. Consider hiring a bartender trained in alcohol service;
- have plenty of non-alcoholic choices;
- serve lots of food that has protein and fat — salt encourages more drinking and sugar does not mix well with alcohol;
- meet, greet and repeat — meet and greet all your guests as they arrive in order to determine if they have had anything alcoholic to drink before arriving. If the party is an open house or cocktail format, repeat the process as guests leave;
- if a guest is intoxicated, encourage him or her to give you their car keys if relevant. Buddy up with a friend to assist in persuading the intoxicated person to take a cab;
- keep the phone numbers of cab companies handy and tell the guest that a cab has been ordered — don't give them the option to refuse;
- if the guest is quite intoxicated, keep that person with you until they have sobered or can be left with a sober, responsible person;
- only time will sober up the person, not additional fluids or food. Offering a spare bed is a good recourse; and
- if the person refuses to give the car keys or spend the night at your house, call the police. It may seem drastic, but it could be a choice between that of an upset friend or far more tragic consequences.

Having a plan will allow you to prevent problems from happening or handle those that do occur in the least unpleasant way so that you can enjoy your own party.

For prevention and treatment information, and resources, please refer to the "DIRECTORY OF SUBSTANCE ABUSE SERVICES" at the back of the manual.



Chapter 7

Crystal Methamphetamine

What is Crystal Meth?

Crystal methamphetamine, also known as speed, methamphetamine, crank, crystal, tweak, meth, ice Tina and jib, is made from a substance called amphetamine. It is a synthetic stimulant that affects the central nervous system.

What Does Crystal Meth Do?

It speeds up the body's functioning by increasing the heart rate and pulse, increasing wakefulness, and intensifying concentration and thought processes. It elevates the mood and provides a high or a feeling of euphoria. It stimulates the part of the brain that is responsible for pleasure and reward, fine motor control, sex drive and increased energy levels. It can also cause increased irritability, restlessness, insomnia, anxiety, and panic. At high doses, it can induce a confused and disorganized behaviour, paranoia, hallucinations, increased aggressiveness and antisocial behaviours. Overdoses are relatively common. Symptoms include agitation, hostility, hallucinations, high temperature, convulsions, suicidal tendencies, circulatory and respiratory collapse, coma and possible death.

Who Uses Crystal Meth?

Crystal meth is popular with street youth, and in gay clubs and circuit parties, although its use is spreading into mainstream culture and clubs. It is becoming the drug of choice for teens.

Crystal meth's ability to keep users awake and feeling good for long periods of time have made it a popular drug in the dance club scene and in circuit parties. Cocktails of club drugs are popular. Crystal meth is often mixed with other drugs such as ecstasy. Club drugs consumers may even be inadvertently taking crystal meth, as ecstasy-like pills have been found to contain crystal meth.

Because of its potent effect on stamina and sex drive, the drug has become popular with gay and bisexual men who attend dance clubs and sex parties. Rituals of multi-partner barebacking have been developed around crystal meth. Crystal meth is often used with ketamine (known as Special K), a drug that loosens the sphincter, and with Viagra to overcome what is known as "crystal dick" — the impotence that often accompanies the use of crystal meth.

For a few decades now, men who have sex with men have been inundated with messages of safer sex, and there appears to be "condom fatigue" within that community. In addition, today's gay and bisexual men in their 20s and 30s have not witnessed their friends' and acquaintances' frequent deaths from AIDS-related illnesses as in the early days of AIDS, so they may not feel it is a serious threat. These factors, combined with deeper issues of built-up shame, insecurity, loneliness and alienation, render them particularly vulnerable to drugs such as crystal meth.

Men who are HIV-positive are drawn to crystal meth, as it helps them overcome fatigue, a low libido and depression, and gives them a sense of feeling desirable. For people who are HIV-positive, using crystal meth may decrease adherence to HIV medications. Interruptions in medication can provide an opportunity for the virus to become resistant to medication. The virus then becomes "treatment-resistant," and the spread of such a potent virus can lead to serious public health consequences. Since crystal meth also results in loss of appetite, users often skip meals. This can lead to vitamin depletion and weight loss. Sleep is also affected. All of these factors can contribute to a faster progression of HIV.

What is Crystal Meth Made of?

It is made of highly volatile, toxic substances melded in a variety of combinations that are never exactly the same. It can be produced very easily and cheaply by obtaining ingredients from local hardware stores and pharmacies, making the drug readily available. Ingredients include ephedrine (from over-the-counter cold medicine), ether, battery acid, insecticides, solvents and lye. There is no quality control on this product; the quality of the drug will vary depending on the supplier. There are a few precautions that can be taken to increase safety. It is a good idea to sample a small amount of the crystal meth first, especially if it came from a new supplier. Finding a regular supplier who is trustworthy can also minimize risks.

How is Crystal Meth Used?

Crystal meth can be swallowed, snorted, smoked or injected. Swallowing a capsule of tablet is the safest way to use crystal meth. It takes longer to take effect, from 15 to 30 minutes, as it has to pass through the stomach and liver before getting to the brain. **Snorting** crystal meth provides a faster high, within 3 to 5 minutes, as the drug is absorbed by the blood vessels in the nose. **Smoking** crystal meth has the quickest effect, within 7 to 10 seconds, as the vapors enter the lungs and are absorbed rapidly through the blood vessels lining the lungs; the drug then gets pumped throughout the body and brain. **Injecting** crystal meth is also quick and potent. It is important to inject crystal right into the veins. Injecting it into skin or muscle greatly increases the risk of abcesses and can cause damage to skin and muscles, as it is very difficult for these tissues to absorb the drug. Crystal meth can also be used as a suppository.

What Does Crystal Meth Look Like?

Crystal meth can appear as crystals, chunks, and fine to coarse powders, off-white to yellow in colour. It is supplied loose (in plastic or foil bags), or in capsules or tablets of various sizes and colours.

What are the Short-Term and Long-Term Effects of Crystal Meth?

Short-term Effects

Crystal meth increases attention, wakefulness and physical activity, and decreases appetite and fatigue. There is a brief, intense sensation or rush, followed by a long-lasting high or euphoria. It also brings about rapid breathing and heartbeat, high blood pressure, dilated pupils, and an elevated body temperature. It can cause stomach cramps, shaking and anxiety. The short-term effects of crystal meth appear soon after a single dose and disappear after a few hours or days. With larger doses, effects can include fever, sweating, headache, blurred vision and dizziness. The body temperature can elevate to dangerous and sometimes lethal levels that may cause convulsions.

Once the drug's effect disappears, known as the "crash," the user may experience symptoms such as fatigue, nightmares, insomnia, disorientation, confusion, increased appetite, severe depression and suicidal tendencies. The term "Suicide Tuesday" has been coined due to the number of weekend users who feel severe depression during the week — a few days after they have stopped using. To avoid the unpleasant effects of crashing, some people will take more of the drug. Paradoxically, the more one uses the drug, the harder one crashes.

To minimize the unpleasantness of crashing, it is advised to eat, sleep and drink plenty of water and juice, even if not hungry and especially if on a binge. Acupuncture may help to stabilize and balance the damage from overuse of crystal meth.

Overuse of crystal meth can bring on paranoia, short-term memory loss and extreme mood swings, and cause some damage to the immune system.

Overdoses are relatively common. Symptoms include agitation, hostility, hallucinations, high temperature, convulsions, suicidal tendencies, circulatory and respiratory collapse, coma and possible death. Overdoses can be avoided by sampling a small amount of the drug first, especially if injecting or when the drug is from a new supplier. Doing half a hit is also advised, especially if it has been a while and tolerance may be down. Injecting the hit extra slowly will

also help. Mixing crystal meth with other drugs increases the risk of overdose.

Long-Term Effects

Like some other drugs, the more one uses crystal meth, the more drug the body needs to get the desired effect as it develops a tolerance. Bingeing is common in users trying to sustain the desired effect. Tolerance happens more rapidly if crystal meth is smoked or injected. Prolonged use at high levels leads to tolerance and both psychological and physical dependence on the drug. Psychological dependence occurs when you feel you cannot function without it, and physical dependence occurs when your body has adapted to the presence of the drug and experiences withdrawal symptoms if its use is stopped.

Some people are able to keep their crystal meth use under control and use only in social settings, mostly on weekends. However, crystal meth is very easy to become addicted to when used over a period of time. It is very inexpensive (as little as $5 a day) and is deeply rooted in some social circles (in that social networks tend to support its use). When someone has difficulty functioning without crystal meth, it is a sign of trouble. There are several signs of addiction or dependence: compulsively seeking the drug and wanting to use; violent behaviour; anxiety; confusion; insomnia; psychotic features such as paranoia, hallucinations, mood disturbances or delusions (the most common one is a sensation of insects creeping on your skin); irregular heart beats; possible stroke; and suicidal thoughts. Withdrawal symptoms include anxiety, fatigue, rash, diarrhea, sweats, chills and fevers, severe depression, suicidal thoughts, paranoia, aggression and an intense craving for the drug. Treatment and support are necessary in this situation. Dealing with addiction requires a period of detoxification followed by rehabilitation to relearn how to live a sober life. Counselling is recommended to address deeper issues that may be leading one to take crystal meth. People who have become dependent on the drug often make many attempts to quit using before they are successful. It can also be difficult to maintain the same social network if trying to quit, as friends may be continuing to use the drug.

Effects on Others

Crystal meth use can also have effects on others around you. Children of crystal meth users are at risk of neglect and abuse. Using crystal meth during pregnancy can impair growth of the fetus, and cause premature birth, developmental disorders in newborns, and enduring cognitive deficits in children. Family and friends can also be affected, as crystal meth users have a tendency to pull away from their social network and isolate themselves when they are using excessively.

Is There a Link Between Crystal Meth and HIV?

Yes. One of the biggest health risks from using crystal meth is the increased chance of HIV infection through unprotected and uninhibited sex while under the influence. Crystal meth increases the sex drive and enhances the sexual experience, and also increases euphoria while reducing inhibitions. The liberating feeling that comes with crystal meth use means that safer sex is often discarded, while higher-risk sexual activity increases greatly.

Are There Other Health Risks Associated With Crystal Meth?

Yes. Along with an increased chance of HIV infection, there is also a risk of getting other sexually transmitted diseases (syphilis, gonorrhea, hepatitis A and B, herpes, chlamydia, and intestinal parasites such as Cryptosporidium) as a result of unprotected sex while under the influence.

In addition, some other blood-borne infectious diseases can be transmitted by using crystal meth, depending on how it is consumed. When smoking, pipes can get hot and cause damage and bleeding to the lips. If one shares a pipe, there is a chance that a small amount of blood from an infected person can remain on the pipe and get onto someone else's lips. The blood can get in contact with a small cut or sore on the lips, providing an opportunity for the transmission of hepatitis C. Similarly, the lining inside the nose can bleed onto a straw used for snorting. There is a chance that a small amount of blood from an infected person can remain on the straw. If one shares a straw to snort meth, that blood can find its way into the nose of another person and transmit hepatitis C. Unlike the HIV virus, the hepatitis virus sur-

vives well in dried blood exposed to air, therefore increasing the risk of transmission when sharing drug paraphernalia. Hepatitis C causes damage to the liver and is very difficult to treat. It is a major cause of cirrhosis of the liver, liver failure and liver cancer.

Sharing needles is a high-risk activity for spreading blood-borne diseases such as HIV and hepatitis C. This can be prevented by not sharing syringes and using a new, clean needle and syringe every time. Supplies of injecting drugs can be obtained from local needle-exchange program.

Where to Get Help For Addiction

In the box below is a directory of some of the resources available for information or help regarding crystal meth use. We encourage you to also consult your local yellow pages and look for "Addiction — Information and Treatment Centres." Treatment for addiction is covered under provincial health insurance.

To speak with someone about a situation, obtain information about drugs, or find out about counselling and support groups and treatment centres in your area, call the following numbers:

ALBERTA:	1-866-332-2322
BRITISH COLUMBIA:	(604) 660-9382 or 1-800-663-1441
CRYSTAL METH ANONYMOUS:	(604) 633-4242 (Vancouver)
MANITOBA:	(204) 944-6200
NEW BRUNSWICK:	(506) 452-5558 or in Moncton (506) 856-2333
NEWFOUNDLAND:	(709) 752-4919
NOVA SCOTIA:	(902) 424 5920
NORTHWEST TERRITORIES:	(867) 873-7049
NUNAVUT:	Baffin Region (867) 473-2659 Kitikmeot Region (867) 983-4075 Kivaliiq Region (867) 645 2171
ONTARIO:	1-800-565-8603
PRINCE EDWARD ISLAND:	Charlottetown — (902) 368-4120 Souris — (902) 687-7111 Montaque — (902) 838-0959 Summerside — (902) 888-8380
QUEBEC:	(514) 527-2626 or 1-800-265-2626
SASKATCHEWAN:	(306) 787-5826
YUKON:	(867) 667-5777

Chapter 8

Domestic Violence

There is no crime more pervasive in our society than drug- and alcohol-related domestic violence. The legal terms are corporal punishment, spousal or wife battery, and spousal abuse. Any way you describe it, domestic violence comes down to family members abusing their loved ones.

The abusers or abused can be any member of a residential living group or family, including wives, husbands, children, elderly parents, step relatives, in-laws, and members of the extended family such as uncles, aunts and cousins, dating partners (boyfriend/girlfriend), foster parents or siblings, and child care or elder care workers in the home. It can be initiated by more than one abuser or group of abusers in the home setting.

Statistically, 95 percent–98 percent of abusers are husbands, and their number one victims are wives. Women are nine times more likely to be assaulted in their own homes, by their husbands or boyfriends, than on the street. Of reported assaults on women, 20 percent resulted in serious injury. In hospital emergency rooms, 33 percent of women are there because of domestic violence. At least 25 percent of women in psychiatric care are suffering from domestic violence. Approximately 70 percent of child abuse is committed by the father.

What is Abuse?

What is considered abusive behaviour includes verbal, psychological and physical abuse. The abuser may terrorize, intimidate, hurt or victimize the other person. Rape and incest are two types of sexual abuse that are common in violent families. These abuses can also encompass emotional and spiritual abuses.

Abusers Want Control

The abuser's desired result is to control his victim. That control sometimes culminates in the death of the victim. Among female homicide victims, 31 percent are killed by their male partners. In one survey in the U.S., 35–45 percent of homicides were said to be the result of domestic violence. In another study, 60 percent of homicides of women were the result of battering by husbands or boyfriends.

Drug and alcohol abusers try to take control of their world. The worse their compulsion to the substance, the more the user tries to control everyone and everything around them. He will do that by manipulating, placating, coercing, seducing, threatening, intimidating and physically abusing. The more he tries to keep things in control, the greater his failure to do so. This ultimately leads to even more desperate, and potentially violent, attempts to control.

To a friend or family member witnessing the situation, it is frustrating, discouraging, frightening and depressing — like watching a man in quicksand struggling desperately to extricate himself until he finally goes under. In the case of addiction, abusers often take their loved ones down with them.

The urge to control seals the addict's fate. The more he tries to grab power, the less he has. Ironically, to overcome his obsession, the abuser needs to stop the struggle to control. In fact, many recovering people avoid relapse by reciting the *Serenity Prayer* when that urge to control or become abusive threatens.

Obsessive control and manipulation is an indicator of addiction that has taken over the person's life. The more abusive he is to those around him, the less control he has over himself and the drug and/or alcohol habit.

Same-sex relationships show a marked similarity to heterosexual dynamics. While there are cases of domestic violence in lesbian couples, it is less frequent than between homosexual men. The dysfunctional male need to dominate the partner still results in violence, even when both partners are men.

In all types of relationships, men choose to batter their spouses and/or children in an effort to resolve conflict and achieve dominance. They assume that such violent coercion is necessary to maintain their unequal position in the family group.

Recognizing Domestic Violence

Abusive relationships get worse with time, not better. Because many abused women feel that the abuse is somehow

their fault, they allow it to continue by not leaving or seeking help. However, victims of domestic violence must get help for themselves, for their families, and for the abuser.

Here is a brief list of abusive behaviours to watch for. See which ones you recognize in your own family:

- being sweet and then suddenly becoming angry or violent, often followed by declarations of love, gifts, and apologies;
- being jealous and possessive with no reason. Insisting that you to account for every moment you are away from him. Protesting "I can't live without you," "I'll kill myself if you leave," or "I'll kill you/him if I see you talking to him again";
- threatening violence, "Don't make me stop you," "If you don't/do [X], I'll never let you go again," "Be careful because I'll be waiting when you get home.";
- breaking, burning, throwing away, or selling things, especially your valued possessions or gifts to him from you;
- making intimidating gestures or threatening you with weapons that they plan to use against you "if you do that again." This can be done in a joke but it is, in fact, no joke;
- insulting or humiliating you in front of children, friends, peers at home, family groups, school events, or work-related social gatherings;
- extending the intimidation to other members of the family or friends not to tell what they know about the abuse you are suffering.;
- `restricting, preventing or prohibiting your children from seeing or communicating with their friends or other family members as a means of control; and
- draining family resources by drinking, drugging, gambling or spending on himself and his own interests so that there is inadequate funding for basic household expenses, such as rent, food, clothing, transportation.

Drugs and Alcohol Escalate the Abuse

How does drug and alcohol abuse relate to domestic violence? Mood-altering substances such as drugs and alcohol can lessen abusers' moral restrictions against expression of negative and violent urges. The O.J. Simpson defense — "you made me do it" — is often given by an abuser violently who is punishing his victim for imagined infractions of his control. Abusers will often use drugs or alcohol to release conscious control over his behaviours. The further excuse, "I didn't know what I was doing because I was under the influence of X [substance]" is then used. Drugs and/or alcohol are almost always present in domestic crimes resulting in injury or death of the victim.

As the abuser's habit becomes more severe, the addict loses all self-esteem. He softens the impact of his low self-image by using his drug of choice. When he is unable to get the drug, often he will fall back on a display of false pride, expounding on grandiose plans for the future and acting as if he is the centre of the universe.

The term for such behaviour is "all bluff and no stuff." Insecurity makes the addict supremely imaginative, offering overcharged solutions to minuscule dilemmas and fanciful visions of the future to his shellshocked family and co-workers. Unkeepable promises multiply as the abuser inflates his own ego to the magnitude of the Wizard of Oz. Fabrications, stories and lies support the thin illusion of the master plans he has woven.

When the abuser begins to believe himself, the sense of defeat becomes even greater when he does not achieve the success he visualized. His wide-eyed energy can fool others, especially those outside his immediate sphere of the people he regularly abuses and disappoints. He becomes a hollow shell, finally realizing that nothing he can do will fulfill the promises he has made. Eventually, even those in the outer circle, friends, co-workers and clients become angry when they realize his promises and plans are empty. They become angry and resentful at being taken for fools.

When confronted by his lack of ability to perform, the addict claims he has been set up by the people around him. He often turns back on his loved ones in a more violent abuse cycle. He projects his own character defects on others, accusing them of lying to him, leading him on, sneaking

around behind his back, trying to steal the rewards he deserves. His defense of himself is often vicious. His counter-attack for any criticism can be far beyond the scope of the original problem. He blames, and retaliates against, everyone around him for the problems. The ego display on the outside is a measure of the insecurity and moral degradation on the inside. False pride is an excellent test of an abuser with an out-of-control drug or alcohol dependency.

Manipulative Cons

Drug and alcohol abusers are continually developing stories to put off their inevitable failure. Some of the most common cons they use to flimflam those around them include the following:

- the cheque's in the mail;
- I'm late because [long, involved excuse] and I promise it won't happen again;
- when I called you, I couldn't leave a message because I hate machines (but you were not away from the phone);
- please forgive me for dumping my rage on you. I promise I won't do it again. It was a fluke;
- you don't want to buy that house [car/dress] do you? [controlling mind game];
- nothing's wrong. I'm not angry [grinding his teeth];
- I would never talk about you behind your back. Don't you trust me?;
- you know I was traumatized as a child and you are now doing to me exactly what my mother used to do;
- if you don't spend all your time with me, I will die of a broken heart;
- I wouldn't be here if I didn't love you. You are too needy if you want me to keep saying I love you all the time;
- I wish you were more like my ex-husband [ex-wife, boyfriend, etc.] when we make love. He/she really knew how to make me feel good;
- if you would only make more money [or lose weight or were prettier] I would be happy with you;
- I wouldn't ever drive when I'm drinking. How can you accuse me of that? [alcohol smell on his breath];
- you make me so crazy. I have to drink [or do drugs or have extramarital affairs] just to stay sane; or
- why do you make me hit you? If you would only try harder to be good then I wouldn't have to punish you and I could feel better about myself.

Effects on Others

The abuser's use of drugs becomes a measurable problem when he begins to expect others to take over his responsibilities. This is not a type of delegation; it's a cover-up for his problem, whereby he expects his victims to keep the secret of his shortcomings. When the abuser forces his loved ones to carry the ball in the house and in the family, time after time, that is a problem. His inability to handle his responsibilities around the home, to make his rent and car payments, or to remember errands or significant appointments and events, forces those around him to take on more than their share. Then, when they are overtaxed and begin

to lose their ability to function, the abuser punishes them for being unable to perform adequately.

Abuse runs in cycles. Over a period of time, the pressure builds like an electrical charge before a thunderstorm. The abuser then blows in a flash of discharged rage. Afterwards, it's like the storm never happened; the sunny behaviour is back. The abuser apologizes for his behaviour if there were witnesses to it, but will obliquely blame it on others (usually his wife). However, he is on good behaviour for a short time. He may make demonstrations of his love to the wife and family. He shows physical affection, becomes romantic, buys back his relationships with overly generous gifts. All the while, his rage is amassing behind the sunny mask. It only takes something small to set off the storm again.

The partners and children of abusers have learned to expect these cycles. In some families, the victims may unconsciously trigger the attacks just to get them over with. The longer it has been between attacks, the more severe this dynamic usually is. And, as the relationships progress over the years, the profundity of the physical, emotional and verbal battering increases.

Once the abuser has crossed a threshold to a more damaging abuse, it becomes easier and more "normal" for him to repeat that and to carry it farther. In fact, it is almost impossible for him to retreat or de-escalate the violence without losing face. The non-violent remedies for such family groups are nearly impossible to access without intervention. Even though a victim of psychological abuse may not be bleeding or visibly scarred, the damages sustained can be pervasive in his or her present and future life.

Domestic Violence Teaches Life Lessons

In a family that is conflicted by domestic violence and complicated by drug and alcohol issues children learn life patterns of self destruction. Here are a few of the message of the violent household:

1. Mom takes care of everyone but herself.
2. Women are responsible for keeping relationships going.
3. The purpose of marriage is to make men happy (not women).
4. Men are unable to control their feelings so they have to act out.
5. Make him think it's his idea so the abuser will go along with you.
6. Freedom means being able to smoke, drug and drink oneself to death.
7. Loved ones are supposed to hit, batter, shame or criticize each other.
8. If you want something, ask for the opposite. Your loved one will prevent you from getting what you want.
9. A man's home is his castle. He can do anything he wants in it and everybody else had better look out.
10. Don't disagree with the abuser; that will only make him angry and then he will be forced to punish you.
11. Merciless ridicule is a part of daily life.
12. It's normal to demonstrate or experience little care or concern for/from others.

13. Keep a "stiff upper lip" when you are hurt emotionally or physically.
14. Family loyalty: keeping the family secrets is more important than being honest.

A child who grows up in such an environment has been set up to fail in his adult life. Men from backgrounds such as this have over a 70 percent chance of physically or emotionally abusing his own wife and children.

For women, the chances are equally high that she will seek out a partner from a similar family who will later abuse her and her children. As victims grow to adulthood, they do not stop to question the control and manipulation that pervaded their families of origin. Even though they may rebel against their fathers, women from such families tend to marry into or create similar families for themselves.

Fathers serve as models of what men should be like. Growing up with an emotionally distant father, or one who is irresponsible, a perfectionist, demanding or psychologically cruel, sets women up to expect the same treatment from men as adults. They may feel more comfortable with that kind of man because they understand him and his motivations. They do not understand a sensitive, giving person because they don't know how to relate to openness and honesty. Nice guys do finish last with women from an abusive family background.

What Can Be Done?

Taking steps to end domestic violence can be frightening at first. However, it must be done before it ends in serious injury or death of the victims.

1. Call for help. Even if it feels like you are butting in. Call a counsellor or helping agency that can help break the cycle of abuse.
2. Modify the scene. Remove the combatants from the stage on which the violence is taking place. Either the abuser or the victims need to leave the home, either temporarily or permanently.
3. A meaningful timeout gives the abuser incentive to change his drug and alcohol habits and the behaviours that result. He must stop drinking and/or drugging. Usually the abuser will not make significant progress in changing his behaviour until he stops his addictions. Before both of those changes are made, he should not be allowed to return to the family.
4. Counselling for the abuser and the family needs to accompany the separation.
5. Any addictions among the victims also must be addressed.
6. Alternative housing for either the abuser or the victims can be found in community shelters. Approximately 40 percent of homeless families have been victims of domestic violence.
7. Children in the abusive family may need to be placed in foster care. Over 50 percent of children in foster care are victims of domestic violence.
8. Medical treatment must be obtained where it is necessary. Medical documentation of physical abuse may also be part of any legal proceedings against the abuser.

References:

Bean, Rich, and Crane, Karen, *The O.J. Syndrome, Confessions of an Abuser,* Blue Bird Publishing, 1995

Berry, Dawn Bradley, *Domestic Violence Sourcebook*, Lowell House, 1995

Deltufo, Alisa, *Domestic Violence for Beginners*, Writers and Readers Publishing Inc., 1995

Friel, John, and Friel, Linda, *An Adult Child's Guide To What's Normal,* Health Communications, Inc., 1990

Hester, Marianne, Kelly, Liz, and Radford, Jill, *Women, Violence, and Male Power,* Open University Presss , 1996

Isenberg, Sheila, *Women Who Love Men Who Kill,* Simon & Schuster, 1991

Centers for Disease Control and Prevention. Accessed 19 January 2015

Warner M, Chen LH, & Makuc DM (2009). Increase in fatal poisonings involving opioid analgesics in the United States, 1999-2006. NCHS data brief (22), 1-8 PMID:

Chapter 9

The Epidemic of Prescription Drug Abuse

Drug overdose death rates have never been higher. In the United States alone, 100 people die from drug overdoses every day, most of them caused by prescription drugs. The Centers for Disease Control and Prevention (CDC) have officially declared prescription drug abuse in the U.S. an epidemic. Prescription drug abuse is defined as taking a medicine in any way that is different from what the doctor originally prescribed, e.g., taking drugs prescribed for someone else, taking a larger dose, taking it in a different way than the drug is designed to be consumed (crushing tablets and then snorting or injecting them, for example), or using the medicine for another purpose, such as getting high. What makes these drugs appealing is the fact that they can have effects similar to illicit drugs when taken in higher quantities than prescribed or in the absence of symptoms.

Opioids

Although many types of prescription drugs are abused, prescription opioids take the lead. Chronic pain is frequently treated with prescription opioids, the clinical use of which nearly doubled from 2000 to 2010. This increase was accompanied by a rise in opioid abuse; it's estimated that over two million people in the U.S. currently abuse prescription opioids. Nearly 75% of prescription drug overdoses are caused by prescription opioid painkillers; these drugs are involved in more deaths than cocaine and heroin combined. In 2010, pharmaceutical drug overdoses were established as one of the leading causes of death in the U.S.; that year, drug overdoses were more lethal than firearms or motor vehicle accidents.

Opioids can create a feeling of euphoria, cause physical dependence, and lead to addiction. Furthermore, these drugs can have many other health effects. Opioids can cause drowsiness, constipation and impaired breathing. The latter effect makes opioids particularly dangerous, especially when snorted, injected or combined with other drugs or alcohol. Depressed respiration decreases brain oxygenation, a condition called hypoxia that can have short- and long-term effects, including coma and permanent brain damage. Long-term abuse of opioids can also cause deterioration of the brain's white matter, affecting behaviour, decision-making and responses to stress. The abuse of prescription painkillers leads to the need of larger doses to achieve an effect and reduce withdrawal symptoms, which in turn can cause breathing to slow down so much that it stops, resulting in a fatal overdose.

Opioids such as Oxycontin and Vicodin can have effects similar to heroin when taken in high doses or in ways other than prescribed. A progression from pain pills to heroin is quite common since the latter provides the same euphoric high but is cheaper and easier to obtain than prescription opioids. In fact, the Substance Abuse and Mental Health Services Administration (SAMSHA) cites an increase in heroin use of 75 percent between 2007 and 2011.

Other Drugs

Opioids are not the only class of prescription drugs being abused. Stimulants for treating Attention Deficit Hyperactivity Disorder (ADHD), such as Adderall, Concerta or Ritalin act on the same neurotransmitter systems as cocaine. Prescription central nervous system (CNS) depressants for relieving anxiety, such as Valium or Xanax, produce sedating or calming effects in the same way as the club drugs GHB and rohypnol. Over-the-counter (OTC) drugs are also abused — mostly cough and cold remedies containing dextromethorphan — as, when taken in very high doses, they act on the same receptors as PCP or ketamine and produce similar out-of-body experiences. When abused, these drugs cause an increase in dopamine in the brain that is perceived as pleasurable. Repeatedly seeking such pleasure can lead to addiction.

The health risks of these drugs are also abundant. Stimulants can have strong effects on the cardiovascular system, dangerously raise body temperature, and cause irregular heartbeat or even heart failure or seizures. High doses or repeated use of some stimulants can lead to hostility or paranoia. CNS depressants decrease brain activity, causing sleepiness and loss of coordination, and continued use can lead to withdrawal symptoms associated with physical dependence.

ADHD drugs may boost alertness and are often abused by students aiming to improve their performance. However, there is little evidence they improve cognitive functioning in the absence of a medical condition. Dextromethorphan can cause impaired motor function, numbness, nausea or vomiting, and increased heart rate and blood pressure. In extreme cases, hypoxic brain damage can occur due to the combination of dextromethorphan with decongestants present in the medication. Also, as with other drugs, abuse of prescription and OTC drugs can alter a person's judgment and decision-making, leading to dangerous behaviours.

All of these drugs have the potential for addiction and this risk is amplified when they are abused. Concerns about addiction and drug abuse are causing some primary care physicians to prescribe fewer opioids for chronic pain, according to a recent national survey on prescription drug abuse. However, an increase in the awareness of the epidemic of prescription drug abuse is still urgently needed so that adequate prevention measures are set in motion.

References:

Centers for Disease Control and Prevention (CDC) (2013). Vital signs: overdoses of prescription opioid pain relievers and other drugs among women–United States, 1999-2010. MMWR. Morbidity and mortality weekly report, 62 (26), 537-42 PMID: 23820967

DrugFacts: Prescription and Over-the-Counter Medications, NIH National Institute on Drug Abuse. Accessed 19 January 2015

Hwang CS, Turner LW, Kruszewski SP, Kolodny A, & Alexander GC (2014). Prescription Drug Abuse: A National Survey of Primary Care Physicians. JAMA internal medicine PMID: 25485657

Policy Impact: Prescription Painkiller Overdoses, Centers for Disease Control and Prevention. Accessed 19 January 2015

Prescription Drug Abuse Statistics, Center for Lawful Access and Abuse Deterrence. Accessed 19 January 2015. Prescription Drug Overdose in the United States: Fact Sheet,

Directory of Substance Abuse Services

PROVINCIAL TREATMENT & PREVENTION RESOURCES

ALCOHOL AND DRUG SERVICES — MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT

Alcohol and Drug Services (ADS) within the Ministry for Children and Family Development
Tel: (604) 660-9382
Victoria: (250) 387-6162
Elsewhere in BC: 1-800-663-2421
Email: services@gov.bc.ca

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

PROVINCIAL FAS RESOURCES

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Fetal Alcohol Spectrum Disorder
PO Box 9719 STN Prov Govt,
Victoria, BC V8W 9S1
Office: (250) 952-6044
Office: 1 877 387-7027
Email: mcf.childrenyouthspecialneeds@gov.bc.ca

Aurora Treatment Centre
BC Women's Health Centre
4500 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2032
Toll Free: 1 888 300-3088
Fax: (604) 875-2039
Website: www.bcwomens.ca

Inclusion Resource Network
BC Teachers' Federation
Website: www.bctf.bc.ca

YWCA Crabtree Corner FAS/NAS Prevention Project
533 East Hastings Street,
Vancouver, BC V6A 1P9
Tel: (604) 216-1652
May Kwan, Community Programs Manager
Email: mkwan@ywcavan.org

PROVINCIAL FIRST NATIONS SERVICES

Fraser Valley:
Seabird Island Band
2895 Chowat Road,
PO Box 650,
Agassiz, BC V0M 1A0
Tel: (604) 796-2177
Fax: (604) 796 3729
Website: www. seabirdisland.ca
Email: seabirdweb@seabirdisland.ca

Native Courtworker and Counselling Association of British Columbia
207 – 1999 Marine Drive,
North Vancouver, BC V7P 3J3
Toll-free: 1-877-811-1190
Tel: (604) 985-5355
Fax: (604) 985-8933
Email: nccabc@nccabc.net
Website: www.nccabc.ca

HIV/AIDS PROGRAM

Provincial Health Services Authority
Lynda Cranston, CEO, HIV/AIDS Program
c/o BCCDC, STI/HIV Prevention & Control
700 – 1380 Burrard St.,
Vancouver, BC V6Z 2H3
Tel: (604) 657-7400
Fax: (604) 708 2700
Email: lcranston@phsa.ca
Website: www.phsa.ca

PRIVATE TREATMENT SERVICES

British Columbia Psychological Association
#402 - 1177 Broadway W.,
Vancouver, BC V6H 1G3
Tel: (604) 730-0522
Website: www.psychologists.bc.ca

The British Columbia Association for Marriage and Family Therapy
PO Box 3958 Vancouver Main,
349 West Georgia St.
Vancouver, BC V6B 3Z4
Tel: 1 778 888-6844
Website: www.bcamft.bc.ca
Email: info@bcamft.bc.ca

British Columbia College Of Social Workers
1430 - 1200 West 73rd Avenue,
Vancouver, BC V6P 6G5
Tel: (604) 737 4916
Website: www.bccollegeofsocialworkers.ca
Email; info@bccsw.ca

EMPLOYEE ASSISTANCE PROGRAMS

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

Shepell : The EFAP Specialists
400 - 411 Dunsmuir Street,
Vancouver, BC V6Z 2K8
Toll-free: 1 866 833-7690
Tel: (604) 642-5200
Fax: (604) 632-9930
Website: www.shepell.com

PREVENTION PROGRAMS

Alcohol–Drug Education Service
#2550 Shaughnessy Street
Port Coquitlam, BC V3C 3G2
Tel: (604) 944-4155

YWCA Crabtree Corner FAS/NAS Prevention Project
533 East Hastings Street,
Vancouver, BC V6A 1P9
Tel: (604) 216-1652
May Kwan, Community Programs Manager
Email: mkwan@ywcavan.org

Royal Canadian Mounted Police Drugs and Organized Crime
Awareness Services (DOCAS)
Email: docas@rcmp.grc.bc.ca
Website: www.rcmp-grc.bc.ca

ROYAL CANADIAN MOUNTED POLICE DRUG AWARENESS PROGRAM

RCMP Drug Awareness Program
Vancouver, BC
Tel: (604) 264-3029
Website: www.rcmpda.com

FRASER VALLEY

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

COMMUNITY-BASED CRIME PREVENTION PROGRAMS

Chilliwack Crime Prevention & Operational Support Unit
45877 Wellington Avenue
Chilliwack, BC V2P 2C8
Tel: (604) 393-3000

Mission Crime Prevention Office
33131 First Avenue
Mission, BC V2V 1G5
Tel: (604) 820-2722

Hope Community Services
434 Wallace Street
Hope, BC V0X 1L0
Tel: (604) 869-2466
Website: www.dosomegood.ca
Email: mthornhill@dosomegood.ca

Pacific Community Resources Society - Fraser Regional Office
10328 Whalley Blvd
Surrey, BC V3T 4H4
Tel: (604) 951-4821
Fax: (604) 951-4808
Email: fraser@pcrs.ca
Website: www.pcrs.ca

Royal Canadian Mounted Police Drugs and Organized Crime Awareness Services
46326 Airport Road
Chilliwack, BC V2P 1A5
Tel: (604) 702-4000
Email: docas@rcmp.grc.bc.ca
Website: www.rcmp-grc.bc.ca

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

EMPLOYEE ASSISTANCE

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

FETAL ALCOHOL SYNDROME (FAS)

Pregnancy Outreach Program
Best for Babies
Abbotsford Communities Services
2420 Montrose Avenue,
Abbotsford, BC V2S 3S9
Tel: (604) 859-7681
Fax: (604) 859-6334
Email: info@abbotsfordaommunityaervices.com

Pregnancy Outreach Program
Better Beginnings
Hope Communities Services
434 Wallace Street,
Hope, BC V0X 1L0
Tel: (604) 869-2466
Fax: (604) 869-3317
Email: mbourquin@dosomegood.ca

Sara for Women
(previously Women's Resource Society of the Fraser Valley)
33070 – 5th Avenue,
Mission, BC V2V 4J3
Tel: (604) 820-8455
Fax: (604) 820-8495
Email: info@saraforwomen.ca
Website: www.saraforwomen.ca

HIV/AIDS

BC Centre for Disease Control
655 West 12th Avenue,
Vancouver, BC, V5Z 4R4
Tel: 604-707-2400
Fax: 603-707-2401
Email: admininfo@bccdc.ca
Website: www.bccdc.ca

Positive Living Fraser Valley Society
Unit #108A - 32883 South Fraser Way,
Abbotsford, BC V2T 2Z1
Tel: (604) 854-1101
Fax: (604) 854-1105
Email: info@plfv.org
Website: www.plfv.org

Chilliwack Addiction and Prevention Services – Fraser Health Authority
45921 Hocking Road,
Chilliwack, BC V2P 1B5
Tel: (604) 795-5449
Email: caps@pcrs.ca
Website: www.pcrs.ca

HOSPITALS

Abbosford Regional Hospital and Cancer Centre
32900 Marshall Road,
Abbotsford, BC V2S 0C2
Tel: (604) 851-4700
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Burnaby Hospital
3935 Kincaid Street,
Burnaby, BC V5G 2X6
Tel: (604) 434-4211
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Chilliwack General Hospital
45600 Menholm Road,
Chilliwack, BC V2P 1P7
Tel: (604) 795-4141
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Delta Hospital
5800 Mountain View Boulevard,
Delta, BC V4K 3V6
Tel: (604) 946-1121
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Eagle Ridge Hospital
475 Guilford Way,
Port Moody, BC V3H 3W9
Tel: (604) 461-2022
Fax: (604) 461-9972
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Fraser Canyon Hospital
1275 – 7th Avenue,
Hope, BC V0X 1L4
Tel: (604) 869-5656
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

ROYAL CANADIAN MOUNTED POLICE DRUG AWARENESS PROGRAM

RCMP Drug Awareness Program
Vancouver, BC
Tel: (604) 264-3029
Website: www.rcmpda.com

FRASER VALLEY

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

COMMUNITY-BASED CRIME PREVENTION PROGRAMS

Chilliwack Crime Prevention & Operational Support Unit
45877 Wellington Avenue
Chilliwack, BC V2P 2C8
Tel: (604) 393-3000

Mission Crime Prevention Office
33131 First Avenue
Mission, BC V2V 1G5
Tel: (604) 820-2722

Hope Community Services
434 Wallace Street
Hope, BC V0X 1L0
Tel: (604) 869-2466
Website: www.dosomegood.ca
Email: mthornhill@dosomegood.ca

Pacific Community Resources Society - Fraser Regional Office
10328 Whalley Blvd
Surrey, BC V3T 4H4
Tel: (604) 951-4821
Fax: (604) 951-4808
Email: fraser@pcrs.ca
Website: www.pcrs.ca

Royal Canadian Mounted Police Drugs and Organized Crime Awareness Services
46326 Airport Road
Chilliwack, BC V2P 1A5
Tel: (604) 702-4000
Email: docas@rcmp.grc.bc.ca
Website: www.rcmp-grc.bc.ca

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

EMPLOYEE ASSISTANCE

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

FETAL ALCOHOL SYNDROME (FAS)

Pregnancy Outreach Program
Best for Babies
Abbotsford Communities Services
2420 Montrose Avenue,
Abbotsford, BC V2S 3S9
Tel: (604) 859-7681
Fax: (604) 859-6334
Email: info@abbotsfordaommunityaervices.com

Pregnancy Outreach Program
Better Beginnings
Hope Communities Services
434 Wallace Street,
Hope, BC V0X 1L0
Tel: (604) 869-2466
Fax: (604) 869-3317
Email: mbourquin@dosomegood.ca

Sara for Women
(previously Women's Resource Society of the Fraser Valley)
33070 – 5th Avenue,
Mission, BC V2V 4J3
Tel: (604) 820-8455
Fax: (604) 820-8495
Email: info@saraforwomen.ca
Website: www.saraforwomen.ca

HIV/AIDS

BC Centre for Disease Control
655 West 12th Avenue,
Vancouver, BC, V5Z 4R4
Tel: 604-707-2400
Fax: 603-707-2401
Email: admininfo@bccdc.ca
Website: www.bccdc.ca

Positive Living Fraser Valley Society
Unit #108A - 32883 South Fraser Way,
Abbotsford, BC V2T 2Z1
Tel: (604) 854-1101
Fax: (604) 854-1105
Email: info@plfv.org
Website: www.plfv.org

Chilliwack Addiction and Prevention Services – Fraser Health Authority
45921 Hocking Road,
Chilliwack, BC V2P 1B5
Tel: (604) 795-5449
Email: caps@pcrs.ca
Website: www.pcrs.ca

HOSPITALS

Abbosford Regional Hospital and Cancer Centre
32900 Marshall Road,
Abbotsford, BC V2S 0C2
Tel: (604) 851-4700
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Burnaby Hospital
3935 Kincaid Street,
Burnaby, BC V5G 2X6
Tel: (604) 434-4211
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Chilliwack General Hospital
45600 Menholm Road,
Chilliwack, BC V2P 1P7
Tel: (604) 795-4141
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Delta Hospital
5800 Mountain View Boulevard,
Delta, BC V4K 3V6
Tel: (604) 946-1121
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Eagle Ridge Hospital
475 Guilford Way,
Port Moody, BC V3H 3W9
Tel: (604) 461-2022
Fax: (604) 461-9972
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Fraser Canyon Hospital
1275 – 7th Avenue,
Hope, BC V0X 1L4
Tel: (604) 869-5656
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Jim Pattison Outpatient Care and Surgery Centre
9750 – 140th Street,
Surrey, BC V3T 0G9
Tel: (604) 582-4550
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Langley Memorial Hospital
22051 Fraser Highway,
Langley, BC V3A 4H4
Tel: (604) 514-6000
Fax: (6040 534-8283
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Ridge Meadows Hospital
11666 Laity Street,
Maple Ridge, BC V2X 7G5
Tel: (604) 463-4111
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Mission Memorial Hospital
7324 Hurd Street,
Mission, BC V2V 3H5
Tel: (604) 826-6261
Fax: (604) 826-9513
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

Pacific Arch Hospital
15521 Russell Avenue,
White Rock, BC V4B 2R4
Tel: (604) 531-5512
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

OPIATE ADDICTION TREATMENT RESOURCES & METHODONE CLINICS

Abbotsford Health Centre
33634 Busby Rd.,
Abbotsford, BC V2S 1V2
Tel: (604) 870-9925
Email: abbyhc@telus.net

Emerald Clinic
33324 South Fraser Way, Suite #5.,
Abbotsford, BC V2S 2B4
Tel: (604) 853-4484

Cedarview Clinic
9380 College Street,
Chilliwack, BC V2P 4L6
Tel: (604) 792-1070
Toll-free: 1-877-792-1070

Mission Oaks Medical Centre
7303 Hurd Street,
Mission, BC V2V 3H6
Tel: (604) 826-7996

NEEDLE EXCHANGE

Abbotsford Public Health Unit
Fraser Health Authority (FHA)
104 – 34194 Marshall Road,
Abbotsford, BC V2S 2A3
Tel: (604) 864-3400

Agassiz Public Health Unit
Fraser Health Authority (FHA)
7243 Pioneer Avenue,
Agassiz, BC V0M 1A0
Tel: (604) 793-7160

Chilliwack Public Health Unit
Fraser Health Authority (FHA)
45470 Menholm Road,
Chilliwack, BC V2P 1M2
Tel: (604) 702-4900

Hope Public Health Unit
Fraser Health Authority (FHA)
444 Park Street,
Hope, BC V0X 1L0
Tel: (604) 860-7630

Mission Public Health Unit
Fraser Health Authority (FHA)
First Floor, 7298 Hurd Street
Hope, BC V2V 3H6
Tel: (604) 814-5500

MUTUAL SUPPORT GROUPS

Alano Club of Abbotsford
2584 Cyril Street,
Abbotsford, BC V2S 2G2
Tel: (604) 859-1601
Email: meetinglists@abbotsfordaa.org
Website: www.abbotsfordaa.org

Alano Club of Chilliwack
46035 Victoria Avenue,
Chilliwack, BC V2P 2T9
Tel: (604) 792-9099
Website: www.chilliwackaa.com

Alano Club of Mission
33229 N. Railway Avenue,
Mission, BC V2V 1E4
Tel: (604) 826-5744
Website: www.chilliwackaa.com

ALANON
Alanon Family Groups
All Saints Anglican Church (Tuesday 8:00 PM)
33077 Second Avenue,
Mission, BC V2V 1J4 (Basement entry)
Tel: (604) 814-0358
Email: ybonnert1@aol.com
Website: www.bcyukon-al-anon.org

Alcoholics Anonymous – Abbotsford
Unit #4 – 32465 South Fraser Way, Suite #125,
Abbotsford, BC V2T 0C7
Tel: (604) 615-2911 (24 hours)
Email: meetinglists@abbotsfordaa.org
Website: www.abbotsfordaa.org

Alcoholics Anonymous – Chilliwack
Serving:
Chilliwack • Agassiz • Boston Bar • Hope • Rosedale •Yarrow
Tel: (604) 819-2644 (24 hours)
Website: www.chilliwackaa.com

Narcotics Anonymous – Fraser Valley
Toll-free: 1 866 683-6819
Website: www.fraservalleyna.ca

SMART Recovery Face to Face Meetings
Alcohol & Drug Abuse Self-Help Network, Inc.
Tel: (604) 262-8334
Email: info@smartrecoverybc.com
Website: www.smartrecovery.org

OUTPATIENT TREATMENT

Chilliwack Addiction and Prevention Services – Fraser Health Authority
45921 Hocking Road,
Chilliwack, BC V2P 1B5
Tel: (604) 795-5449
Email: caps@pcrs.ca
Website: www.pcrs.ca

Stsailes Health & Family Services; Stsailes Indian Band
4690 Salish Way,
Agassiz, BC V0M 1A1
Tel: (604) 796-2116
Fax: (604) 796-3946
Acting Facility Supervisor:
Ms. Laura Wright
Tel: (604) 796-9832
Fax: (604) 796-3578
Email: lhawathet@stsailes.com
Website: www.stsailes.com

Fraser House Outpatient Clinic
33063 - 4th Avenue,
Mission, BC V2V 1S6
Tel: (604) 826-6810
Fax: (604) 826-1424
Email: admin_fraserhouse@shaw.ca
Website: www.fraserhouse.org/links

Hope Community Services
434 Wallace Street,
Hope, BC V0X 1L0
Tel: (604) 869-2466
Email: mthornhill@dosomegood.ca
Website: www.dosomegood.ca

Matsqui – Abbotsford Impact Society
Suite #101 - 32555 Simon Avenue,
Abbotsford, BC V2T 4Y2
Tel: (778) 347-8664
Fax: (604) 746-7399
Michele Christle: Administration
Email: michele@impactabby.com
Website: www.impactabby.com

Finlay Counselling & Mediation Services
203 – 26 Fourth Street,
New Westminster, BC V3L 5M4
Tel: (604) 522-9266
Fax: (604) 522-9267
Email: bobfinlay@shaw.ca
Website: www.finlaycounselling.ca

OUTPATIENT TREATMENT — DAY TREATMENT

Agassiz–Harrison Community Services
7086 Cheam Avenue,
Agassiz, BC V0M 1A0
Tel: (604) 796-2585
Fax: (604) 796-2517
Email: ahcs@shawlink.ca
Website: www.agassiz-harrisoncs.ca

Fraser House Outpatient Clinic
33063 - 4th Avenue,
Mission, BC V2V 1S6
Tel: (604) 826-6810
Fax: (604) 826-1424
Email: admin_fraserhouse@shaw.ca
Website: www.fraserhouse.org/links

Hope & Area Transition Society
400 Park Street,
Hope, BC V0X 1L0
Tel: (604) 869-5111
Fax: (604) 869-5123
Email: info@hopetransition.org
Website: www.hopetransition.org

Mission Friendship Centre
33150 A – First Avenue,
Mission, BC V2V 1G4
Tel: (604) 826-1281
Toll-free: 1-888-826-1281
Fax: (604) 826-4056
Email: info@mifcs.bc.ca
Website: www.mifcs.bc.ca

RESIDENTIAL TREATMENT

Adult and Teen Challenge BC – Abbotsford
PO Box 2095, STN A,
Abbotsford, BC V2T 3X8
Tel: (604) 575-3930
Toll-free: 1-888-575-3930
Fax: (604) 575-3903
Email: info@teenchallengebc.com
Website: www.teenchallengebc.com

Adult and Teen Challenge BC – Chilliwack
Chilliwack Men's Centre
4166 Eckert Street,
Chilliwack, BC V2R 5J6
Tel: (604) 575-3930
Fax: (604) 823-0139
Email: info@teenchallengebc.com
Website: www.teenchallengebc.com

Kinghaven Treatment Centre
31250 King Road,
Abbotsford, BC V2T 6C2
Tel: (604) 864-0039
Fax: (604) 864-9420
Email: admissions@kinghaven.ca
Website: www.kinghaven.ca

Lydia Home – Union Gospel Mission
Women-only facility located in Mission
33170 – 7th Avenue,
Mission, BC V2V 2E1
Tel: (604) 826-4868
Email: lydiahome@ugm.ca
Website: www.ugm.ca

Peardonville House Treatment Centre
825 Peardonville Road,
Abbotsford, BC V4X 2L8
Tel: (604) 856-3966
Fax: (604) 856-3120
Email: intake@peardonvillehouse.ca
Website: www.peardonvillehouse.ca

PSALM 23
Transition Society
31794 Peardonville Road,
Abbotsford, BC V2T 1L4
Tel: (604) 870-5616
Fax: (604) 870-5617
Email: psalm23society@shaw.ca
Website: www.psalm23society.com

SCHOOL-BASED PREVENTION PROGRAMS

Fraser House Society
School-Based Prevention
33063 - 4th Avenue,
Mission, BC V2V 1S6
Tel: (604) 826-6810
Fax: (604) 826-1424
Email: admin_fraserhouse@shaw.ca
Website: www.fraserhouse.org/links

SENIORS PROGRAMS

Seniors Liaison Program
Abbotsford Community Services
2420 Montrose Avenue,
Abbotsford, BC V2S 3S9
Tel: (604) 859-7681
Fax: (604) 859-56334
Email: aac@abbotsfordcommunityservices.com
Website: www.abbotsfordcommunityservices.com

SHORT-TERM CRISIS CENTRES

START team – Surrey –
Crisis Intervention for Children and Teens
Suite #101 – 32555 Simon Avenue,
Abbotsford, BC V2T 4Y2
Tel: 1 844 782-7811
Fax: (604) 776-2121
Website: www.fraserhealth.ca

WITHDRAWAL MANAGEMENT

Creekside Withdrawal Management Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

SURREY/DELTA/ LANGLEY/WHITE ROCK

AMSSA
(Affiliation of Multicultural Societies
And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

COMMUNITY-BASED PREVENTION PROGRAMS

LANGLY

Aldergrove Community Policing Office
26970 Fraser Hwy.,
Aldergrove, BC V4W 3L6
Tel: (604) 856-7386
Monday – Friday 8:30 AM to 4:00 PM

Brookswood Community Policing Office
Suite #102 – 4059 – 200th Street,
Aldergrove, BC V3A 1K8
Tel: (604) 530-3104
Monday – Friday 8:30 AM to 4:00 PM

Langley Community Policing Office
Suite #100 – 20408 Douglas Crescent,
Langley, BC V3A 4B4
Tel: (604) 514-2870

Walnut Grove Community Policing Office
Suite #108 – 8850 Walnut Grove Drive,
Langley, BC V1M 2C9
Tel: (604) 856-7386

Willowbrook Community Policing Office
Suite #140 – 20338 – 65th Avenue,
Langley, BC V2Y 2X3
Tel: (604) 534-1040

SURREY

Whalley – City Centre
District #1 RCMP Office
10720 King George Hwy.,
Surrey, BC V3T 2X3
Tel: (604) 502-6390

Cloverdale/Port Kells
District #4 RCMP Office
5723 – 176A Street,
Surrey, BC V3S 4H2
Tel: (604) 502-6266

Guildford - Fleetwood
District #2 RCMP Office
10395 – 48th Street,
Surrey, BC V3R 6S4
Tel: (604) 502-6500

Newton District #3 RCMP Office
7235 – 137th Street,
Surrey, BC V3W 1A4
Tel: (604) 502-6233

South Surrey District #5 RCMP Office
Suite #100 – 1815 -152nd Street,
Surrey, BC V4A 9Y9
Tel: (604) 599-7810

WHITE ROCK

White Rock Community Policing Office
15299 Pacific Avenue,
White Rock, BC V4B 1R1
Tel: (778) 593-3611

ATIRA Women's Resource Society
Suite #107 – 2430 King George Blvd.,
Surrey, BC V4P 1H5
Tel: (604) 681-4437
(and press 5 for Surrey)
Fax: (604) 525-1767
Email: info@atira.bc.ca
Website: www.atira.bc.ca

Deltassist Family & Community
Services Society
9097 – 120th Street,
Delta, BC V4C 6R7
Tel: (604) 594-3455
Email: inquiry@deltaassist.com
Website: www.deltaassist.com

Deltassist Family & Community
Services Society (Ladner/Tsawwassen)
Suite #202 – 5000 Bridge Street,
Delta, BC V4K 2K4
Tel: (604) 946-9526
Email: inquiry@deltaassist.com
Website: www.deltaassist.com

DIVERSEcity Community Services Society
13455 – 76TH Avenue,
Surrey, BC V3W 2W3
Tel: (604) 597-0205
Fax: (604) 597-4299
Email: info@dcrs.ca
Website: www.dcrs.ca

POPFASD, the Provincial Outreach
Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Options Community Services
9815 – 140th Street,
Carole Wahl Building,
Surrey, BC V3T 4M4
Tel: (604) 584-5811
Fax: (604) 584-7628
Janice Boyle
Director of Development
Email: janice.boyle@options.bc.ca
Website: www.options.bc.ca

Options Community Services
13520 – 78th Avenue,
Newton Office,
Surrey, BC V3W 8J6
Tel: (604) 596-4321
Fax: (604) 572-7413
Janice Boyle
Director of Development
Email: janice.boyle@options.bc.ca
Website: www.options.bc.ca

Pacific Community Resources:
Fraser Regional Office
10318 East Whalley Blvd.,
Surrey, BC V3T 4H4
Tel: (604) 951-4821
Fax: (604) 951-4808
Email: fraser@pcrs.ca
Website: www.pcrs.ca

DAY TREATMENT

Adolescent Day Treatment Program
Education Services School
14033 – 92nd Avenue,
Surrey, BC V3V 0B7
Tel: (604) 595-6436
Fax: (604) 595-6400

Night and Day Recovery
14688 – 106th Avenue,
Surrey, BC V53R 5Y1
Tel: (778) 317-4673
Email: info@nightanddayrecovery.ca
Website: www.nightanddayrecovery.ca

Sage Counselling and Addiction Services Inc.
Suite #303 – 4180 Lougheed Hwy.,
Burnaby, BC V5C 6A7
Tel: (604) 558-0090
Toll-free 1-888-589-7080
Fax: (604) 558-0092
Email: info@sagecounselling.com
Website: www.sagecounselling.com

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

DOMESTIC VIOLENCE

DOMESTIC ABUSE HELP LINE
Our Lady of Good Counsel Society
Suite #201 – 14045 – 104th Avenue,
Surrey, BC V3T 1X4
Crisis Help Lines
Tel: (604) 640-7549
Toll-free 1 888 333-7733
Email: directexec@domesticabuseservices.ca
Website: www.domesticabuseservices.ca

EMPLOYEE ASSISTANCE

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

Stroh Health Care Consulting Group - Responsible Driver Program
1215-C – 56th Street,
PO Box 18006,
Delta, BC V4L 2B0
Tel: (604) 948-4912
Toll Free: 1 800 948-4912
Tel: (604) 948-4913
Email: info@strohhealth.com
Website: www.strohhealth.com

FETAL ALCOHOL SYNDROME (FAS)

The Asante Centre
Suite #303 – 7337 – 137th Street,
Surrey, BC V3W 3C1
Tel: (778) 564-7101
Toll-free: 1-877-327-7101
Email: info@asantecentre.org
Website: www.asantecentre.org

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Options Community Services
9815 – 140th Street,
Carole Wahl Building,
Surrey, BC V3T 4M4
Tel: (604) 584-5811
Fax: (604) 584-7628
Janice Boyle
Director of Development
Email: janice.boyle@options.bc.ca
Website: www.options.bc.ca

MUTUAL SUPPORT GROUPS

AA Greater Vancouver Intergroup Society
(604) 434-3393 (24 Hours)
Email: staff@vancouveraa.ca
Website: www.vancouveraa.ca/meetings/

Narcotics Anonymous - British Columbia Region
Toll Free: 1 855 444-BCNA (2262)
Website: www.bcrna.bc.ca

OUTPATIENT TREATMENT

Sources Community Resource Centres – Peace Arch Resource Centre
882 Maple Street,
White Rock, BC V4B 3M2
Tel: (604) 531-6226
Fax: (604) 531-2316
Website: www.sourcesbc.ca
Email: info@sourcesbc.ca

Deltassist Family & Community
Services Society
9097 – 120th Street,
Delta, BC V4C 6R7
Tel: (604) 594-3455
Email: inquiry@deltaassist.com
Website: www.deltaassist.com

Pacific Community Resources – ASTRA Program
Suite #114 – 13479 – 76th Avenue,
Surrey, BC V3W 2W3
Tel: (604) 836-6241
Fax: (604) 951-4882
Email: bmajoor@pcrs.ca
Website: www.pcrs.ca/astra

Reconnect – Guildford Youth Resource Centre
205 – 14727 – 108th Avenue,
Surrey, BC V3R 1V9
Tel: (604) 587-8100
Email: gyrcreception@pcrs.ca
Website: www.pcrs.ca

Sage Counselling and Addiction Services Inc.
Suite #303 – 4180 Lougheed Hwy.,
Burnaby, BC V5C 6A7
Tel: (604) 558-0090
Toll-free 1-888-589-7080
Fax: (604) 558-0092
Email: info@sagecounselling.com
Website: www.sagecounselling.com

Options Community Services
9815 – 140th Street,
Carole Wahl Building,
Surrey, BC V3T 4M4
Tel: (604) 584-5811
Fax: (604) 584-7628
Janice Boyle
Director of Development
Email: janice.boyle@options.bc.ca
Website: www.options.bc.ca

Langley Community Services Society
5339 - 207th Street,
Langley, BC V3A 2E6
Tel: (604) 534-7921
Fax: (604) 534-3110
Email: info@lcss.ca
Website: www.lcss.ca

Pacific Community Resources - D. E. W. Y. Program
10328 Whalley Blvd.,
Surrey, BC V3T 4H4
Tel: (604) 951-4821
Email: dewyprogram@pcrs.ca
Website: www.pcrs.ca

Seniors Substance Awareness Program Russell Unit
15521 Russell Avenue,
White Rock, BC V4B 2R4
Tel: (604) 541-6844
Website: www.fraserhealth.ca

RESIDENTIAL SERVICE

Campbell Valley House of Hope Women's facility
460 – 216th Street
Langley, BC V2Z 1R5
Tel: (604) 530-6228
Email: houseofhope@wagnerhills.com
Website: www.wagnerhills.com

Cornerstone Manor Recovery Centre
10078 - 133rd Street
Surrey, BC V3T 3Y5
Tel: (604) 589-6060
Fax: (604) 589-6025

Daughters & Sisters (PLEA)
100 – 8431 – 160th Street
Surrey, BC V4N 0V6
Tel: (604) 543-7892
Fax: (604) 543-8392
Email: intake@plea.bc.ca
Website: www.plea.ca

Phoenix Drug and Alcohol Centre
13686 – 94A Avenue
Surrey, BC V3V 1M1
Tel: (604) 583-7166
Fax: (604) 581-1808
Website: www.phoenixsociety.com
Email: admin@phoenixsociety.com

John Volken Academy
6911 King George Blvd.,
Surrey, BC V3W 5A1
Tel: (604) 598-2050
Fax: (778) 591-6768
Website: www.volken.org

SCHOOL-BASED PREVENTION PROGRAMS

Deltassist Family & Community Services Society
9097 – 120th Street
Delta, BC V4C 6R7
Tel: (604) 594-3455
Email: inquiry@deltaassist.com
Website: www.deltaassist.com

Options Community Services
9815 – 140th Street,
Carole Wahl Building,
Surrey, BC V3T 4M4
Tel: (604) 584-5811
Fax: (604) 584-7628
Janice Boyle
Director of Development
Email: janice.boyle@options.bc.ca
Website: www.options.bc.ca

SENIORS PROGRAMS

Seniors Substance Awareness Program Russell Unit
15521 Russell Avenue,
White Rock, BC V4B 2R4
Tel: (604) 541-6844
Website: www.fraserhealth.ca

SHORT-TERM CRISIS CENTRES

START team – Surrey – Crisis Intervention for Children and Teens
9634 King George Blvd.,
Surrey, BC V3T 0G7
Tel: 1 844 782-7811
Fax: (604) 585-5560
Website: www.fraserhealth.ca

SUPPORTIVE RECOVERY SERVICES

Pacific Community Resources: Fraser Regional Office
10318 East Whalley Blvd.,
Surrey, BC V3T 4H4
Tel: (604) 951-4821
Fax: (604) 951-4808
Email: fraser@pcrs.ca
Website: www.pcrs.ca

YOUTH SERVICES

Boys and Girls Clubs of South Coast BC
3rd Floor – 11861 – 88th Avenue
Delta, BC V4C 3C6
Tel: (604) 591-9262
Email: info@bgcbc.ca
Website: www.bgcbc.ca

Guildford Youth Resource Centre
Suite #205– 14727 – 108th Avenue,
Surrey, BC V3R 1V9
Tel: (604) 587-8100
Email: nyrcreception@pcrs.ca
Website: www.pcrs.ca

Newton Youth Resource Centre
Suite #114 – 13479 – 76th Avenue,
Surrey, BC V3W 2W3
Tel: (604) 592-6200
Email: nyrcreception@pcrs.ca
Website: www.pcrs.ca

COQUITLAM/PORT COQUITLAM/PORT MOODY/MAPLE RIDGE

COMMUNITY-BASED PREVENTION PROGRAMS

AMSSA
(Affiliation of Multicultural Societies
And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

COQUITLAM

Burquitlam Community Police Office
560 Clarke Road,
Coquitlam, BC V3J 3X5
Tel: (604) 933-6833

Ridgeway Community Police Office
1059 Ridgeway Avenue,
Coquitlam, BC V3J 1S6
Tel: (604) 933-6888

PORT COQUITLAM

Coast Meridian Community Police Office
3312 Coast Meridian Street,
Port Coquitlam, BC V3B 3N6
Tel: (604) 927-5172

Mary Hill Community Police Office
2581 Mary Hill Road,
Port Coquitlam, BC V3C 2A8
Tel: (604) 927-2383

Access Youth Outreach Services
Box 6 - 2601 Lougheed Hwy.,
Coquitlam, BC V3C 4J2
Office: (604) 525-1888
Fax: (604) 525-1852
Youth Bus: (604) 781-6671
Email: reachout@accessyouth.org
Email: admin@accessyouth.org
Website: www.accessyouth.org

RCMP School Liaison
Cpl. Michael McLaughlin
2986 Guildford Way,
Coquitlam, BC V3B 7Y5
Tel: (604) 945-1580
Email: coquitlam_media@rcmp-grc.gc.ca
Website: www.coquitlam.rcpm.ca

DAY TREATMENT

InnerVisions Recovery Society
1937 Prairie Avenue,
Port Coquitlan, BC V3B 1V5
24-hour toll free phone line
Men: (604) 468-2032
TollFree: 1 877 939-1420
Women: (604) 466-4215
Toll Free: 1 866 466-4215
Email: helpme@innervisionsrecovery.com
Website: www.innervisionsrecovery.com

SHARE Family & Community Services Society
Suite #200 – 25 King Edward Street,
Coquitlan, BC V3K 4S8
Tel: (604) 540-9161
Fax: (604) 540-2290
Website: www.sharesociety.ca

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

EMPLOYEE & FAMILY ASSISTANCE PROGRAMS

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Email: help@efap.ca
Website: www.efap.ca

Finlay Counselling
& Mediation Services Ltd.
Suite #202 – 26 Fourth Street,
New Westminster, BC V3L 5M4
Tel: (604) 522-9266
Fax: (604) 522-9267
Email: bobfinlay@shaw.ca
Website: www.finlaycounselling.ca

FETAL ALCOHOL SYNDROME (FAS)

The Asante Centre
Suite #103 – 22356 McIntosh Avenue,
Maple Ridge, BC V2X 3C1
Tel: (604) 467-7101
Toll-free: 1-877-327-7101
Fax: (604) 467-7102
Email: info@asantecentre.org
Website: www.asantecentre.org

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

HOSPITALS

Eagle Ridge Hospital
475 Guildford Way,
Port Moody, BC V3H 3W9
Tel: (604) 461-2022
Tel: (604) 461-9972
Email: erh@fraserhealth.ca
Website: www.fraserhealth.ca

Community Maternity Hospital
205 Newport Drive,
Port Moody, BC V3H 5C9
Tel: (604) 949-7248
Email: cmh@fraserhealth.ca
Website: www.fraserhealth.ca

Forensic Psychiatric Hospital
70 Colony Farm Road,
Coquitlam, BC V3C 5X9
Tel: (604) 524-7700
Crisis Line: (604) 310-6789
Email: feedback@bcmhs.bc.ca
Website: www.bcmha.ca

METHADONE TREATMENT

Alouette Addictions Services
Suite #106 - 22838 Lougheed Highway,
Maple Ridge, BC V2X 2V6
Tel: (604) 467-5179
Fax: (604) 467-8592
Email: mail@allouetteaddictions.org
Website: www.alouetteaddictions.org

MUTUAL SUPPORT COMMUNITY PREVENTION

Narcotics Anonymous - British Columbia Region
Toll Free: 1 855 444-BCNA (2262)
Website: www.bcrna.bc.ca

One Way Club Society
22270 North Avenue,
Maple Ridge, BC V2X 2L5
Tel: (604) 463-6617
Website: www.vancouveraa.ca

OUTPATIENT TREATMENT

Alouette Addictions Services
Suite #106 - 22838 Lougheed Highway,
Maple Ridge, BC V2X 2V6
Tel: (604) 467-5179
Fax: (604) 467-8592
Email: mail@allouetteaddictions.org
Website: www.alouetteaddictions.org

Seniors Well Aware Program (SWAP)
Suite #306 – 321 – 6th Street,
New Westminster, BC V3L 3A7
Tel: (604) 524-8998
Fax: (604) 524-1184
Burnaby:
Tel: (604) 524-8994
Fax: (604) 524-8781
Email: info@swapbc.ca
Website: www.vrhb.bc.ca/swap/

SHARE Family & Community Services Society
Suite #200 – 25 King Edward Street,
Coquitlan, BC V3K 4S8
Tel: (604) 540-9161
Fax: (604) 540-2290
Website: www.sharesociety.ca

RESIDENTIAL TREATMENT

Maple Ridge Treatment Centre
22269 Callaghan Avenue,
Maple Ridge, BC V2X 2E2
Tel: (604) 467-3471
Toll-free: 1 877 678-6782
Fax: (604) 467-8833
Email: info@mrtc.bc.ca
Website: www.mrtc.bc.ca

SCHOOL-BASED PREVENTION PROGRAMS

Alouette Addictions Services
Suite #106 - 22838 Lougheed Highway,
Maple Ridge, BC V2X 2V6
Tel: (604) 467-5179
Fax: (604) 467-8592
Email: mail@allouetteaddictions.org
Website: www.alouetteaddictions.org

plea Community Services
3894 Commercial Street,
Vancouver, BC V5N 4G2
Tel: (604) 871-0450
Fax: (604) 524-1184:
Email: info@plea.ca
Website: www.plea.ca

SHARE Family & Community Services
Society
2nd Floor - 2615 Clarke Street,
Port Moody, BC V3C 6C7
Tel: (604) 936-3900
Fax: (604) 936-3955
Email: info25@sharesociety.ca
Website: www.sharesociety.ca

SHORT-TERM CRISIS CENTRES

START team – Port Moody – Crisis Intervention for Children and Teens
205 Newport Drive,
Port Moody, BC V3H 5C9
Tel: 1 844 782-7811
Fax: (604) 949-7766
Website: www.fraserhealth.ca

SUPPORTIVE RECOVERY SERVICES

Pacific Community Services Astra Program
202 – 9180 King George Hwy.,
Surrey, BC V3V 5V9
Tel: (604) 951-4867
Fax: (604) 951-4823
Website: www.pcrs.ca
Email: bear-creek@pcrs.ca

Lana House Society
407 Kelly Street,
New Westminster, BC V3L 3T7
Tel: (604) 290-6663

Westminster House
228 – 7th Street,
New Westminster, BC V3M 3K3
Tel: (604) 524-5633
Toll-free: 1-866-524-5633
Fax: (604) 524-4643
Email: info@westminsterhouse.ca
Website www.westminsterhouse.ca

WOMEN'S SHELTER

Battered Women's Support Services
CRISIS & INTAKE LINE
(604) 687-1867
Business Phone (604) 687-1868
Toll Free: 1-855-687-1868
Mailing Address: PO Box 21503
1424 Commercial Drive,
Vancouver, BC V5L 5G2
MY SISTER'S CLOSET
Phone: (604) 687-0770
1092 Seymour Street,
Vancouver, BC V6B 1B4
Email: information@bwss.org
Website: www.bwss.org

Ending Violence Association of Canada
Suite #1404 – 510 West Hastings Street,
Vancouver, BC V6B 1L8
Tel: (604) 633-2506
Fax: (604) 633-2507
Email: info@endingviolencecanada.org
Website: www.endingviolencecanada.org

Tri-City Transitions
Suite #402 – 2071 Kingsway Avenue,
Port Coquitlam, BC V3C 6N2
Crisis Line: (604) 492-1700
Crisis Toll Free: 1 800 563-0808
Tel: (604) 941-7111
Email: info@tricitytransitions.com
Website www.tricitytransitions.com

YOUTH SERVICES

Access Youth Outreach Services
Box 6 - 2601 Lougheed Hwy.,
Coquitlam, BC V3C 4J2
Office: (604) 525-1888
Fax: (604) 525-1852
Youth Bus: (604) 781-6671
Email: reachout@accessyouth.org
Email: admin@accessyouth.org
Website: www.accessyouth.org

VANCOUVER

COMMUNITY-BASED PREVENTION PROGRAMS

AMSSA
(Affiliation of Multicultural Societies
And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

Alcohol & Drug Information and Referral Service
Tel: Call 8-1-1
Email: @healthlinkbc@gov.bc.ca
Website: www.healthlinkbc.bc.ca

The Alcohol and Substance Use Helpline
Toll-free: 1-877-327-4636
Website: www.motherisk.org

ATIRA Women's Resource Society
Suite #201 – 190 Alexander Street,
Vancouver, BC V6A 1B5
Tel: (604) 681-4437
Fax: (604) 688-1799
Email: info@atira.bc.ca
Website: www.atira.bc.ca

Battered Women's Support Services
CRISIS & INTAKE LINE
(604) 687-1867
Business Phone (604) 687-1868
Toll Free: 1-855-687-1868
Mailing Address: PO Box 21503
1424 Commercial Drive,
Vancouver, BC V5L 5G2
MY SISTER'S CLOSET
Phone: (604) 687-0770
1092 Seymour Street,
Vancouver, BC V6B 1B4
Email: information@bwss.org
Website: www.bwss.org

Boys and Girls Clubs of South Coast BC
2875 St. George Street,
Vancouver, BC V5T 3R8
Tel: (604) 879-6554
Email: info@bgcbc.ca
Website: www.bgcbc.ca

Ending Violence Association of Canada
Suite #1404 – 510 West Hastings Street,
Vancouver, BC V6B 1L8
Tel: (604) 633-2506
Fax: (604) 633-2507
Email: info@endingviolencecanada.org
Website: www.endingviolencecanada.org

Choices
John Howard Society
763 Kingsway,
Vancouver, BC V5V 3C2
Tel: (604) 872-5651
Fax: (604) 872-8737
Email: info@jhslmbc.ca
Website: www.jhslmbc.ca

Grief To Action – When Addiction Hits Home
c/o St. Mary's Anglican Church
2490 West 37th Avenue,
Vancouver, BC V6M 1P5
Tel: (604) 261-4228
Website: www.formgrieftoaction.org

Vancouver Coastal Health – Youth Addiction
601 West Broadway, 11th Floor,
Vancouver, BC V5Z 4W2
Tel: (604) 736-2033
Toll Free: 1 866 884-0888
Website: www.vch.ca

Green Thumb Theatre for Young People
1885 Venables Street,
Vancouver, BC V5L 2H6
Tel: (604) 254-4055
Fax: (604) 251-7002
Email: info@greenthumb.bc.ca
Website: www.greenthumb.bc.ca

DOMESTIC ABUSE HELP LINE
Our Lady of Good Counsel Society
Suite #201 – 14045 – 104th Avenue,
Surrey, BC V3T 1X4
Crisis Help Lines
Tel: (604) 640-7549
Toll-free 1 888 333-7733
Email: directexec@domesticabuseservices.ca
Website: www.domesticabuseservices.ca

Problem Gambling Information and Referral Service
Information Services Vancouver
202 - 3102 Main Street
Vancouver, BC V5T 3G7
Tel: 1-888-795-6111

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Raincity Housing and Support Society
616 Powell Street
Vancouver, BC V6A 1H4
Tel: (604) 662-7023
Fax: (604) 254-3703
Email: info@raincityhousing.org
Website: www.raincityhousing.org

BC Mental Health & Substance Use Services
4949 Heather Street,
Vancouver, BC V5C 3L7
Crisis Line: (604) 310-6789
Tel: (604) 524-5570
Email: feedback@bcmhcs.bc.ca
Website: www.bcmhs.ca

WAVAW Rape Crisis Centre
2405 Pine Street,
PO Box 46851
Vancouver, BC V6J 5M4
Crisis Line (604) 255-6344 (24-hours)
Tel: (604) 255-6228
Toll Free: 1 877 392-7583
Email: admin@wava.ca
Website: www.wava.ca

BC Women's Hospital & Health Centre
4500 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2424
Toll Free: 1 888 300-3088
Email: PatientExperience@cw.bc.ca
Website: www.bcwomens.ca

YWCA Crabtree Corner FAS/NAS Prevention Project
533 East Hastings Street,
Vancouver, BC V6A 1P9
Tel: (604) 216-1652
May Kwan, Community Programs Manager
Email: mkwan@ywcavan.org

DAY TREATMENT

Watari Counselling & Support Services
Suite #200 – 678 Hastings Street East,
Vancouver, BC V6A 1R1
Tel: (604) 254-6995
Fax: (604) 254-6985
Email: info@watari.ca
Website: www.watari.ca

Options for Sexual Health
Suite #202 – 1193 Kingsway,
Vancouver, BC V5V 3C9
Tel: (604) 731-4252
Toll Free: 1 800 739-7367
Email: info@optbc.org
Website: www.optionsforsexualhealth.org

DAY TREATMENT RESIDENTIAL TREATMENT

Aurora Treatment Centre
BC Women's Health Centre
4500 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2032
Toll Free: 1 888 300-3088
Fax: (604) 875-2039
Website: www.bcwomens.ca

Watari Counselling & Support Services
Suite #200 – 678 Hastings Street East,
Vancouver, BC V6A 1R1
Tel: (604) 254-6995
Fax: (604) 254-6985
Email: info@watari.ca
Website: www.watari.ca

Women's Dew Program
Family Services of Greater Vancouver
202 – 1193 Kingsway
Vancouver, BC V5V 3C9
Tel: (604) 874-2938
Fax: (604) 874-9898
Website: www.fsgv.ca

Women's Dew Program
Family Services of Greater Vancouver
202 – 1193 Kingsway
Vancouver, BC V5V 3C9
Tel: (604) 874-2938
Fax: (604) 874-9898
Website: www.fsgv.ca

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

D'Talks – Youth Detox Line
Tel: (604) 658-1221
Toll-free: 1 866 658-1221

Daytox Vancouver
377 East 2nd Avenue,
Vancouver, BC V5T 1B9
Intake: 1 866 658-1221
Appointments: (604) 658-1278
Web: www.vch.ca

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

plea Community Services
3894 Commercial Street,
Vancouver, BC V5N 4G2
Tel: (604) 871-0450
Fax: (604) 524-1184:
Email: info@plea.ca
Website: www.plea.ca

Salvation Army Harbour Light - Detox
119 Cordova Street East,
Vancouver, BC V6A 1K8
Detox: (604) 646-6844
Office Tel: (604) 646-6800
Fax: (604) 646-6840
Website: www.harbourlightbc.com

Seniors Well Aware Program (SWAP)
3rd Floor, 1290 Hornby Street
Vancouver, BC V6Z 1W2
Tel: (604) 633-4230
Fax: (604) 633-4231
Email: swap@vrhb.bc.ca
Website: www.vcn.bc.ca/swap/

DUAL DIAGNOSIS TREATMENT CENTRES IN VANCOUVER

Together We Can – Addiction Recovery Centre
2831 Kingsway,
Vancouver, BC V5R 5H9
Tel: (604) 670-2923

Pacifica Treatment Centre Society
1755 East 11th Avenue,
Vancouver, BC V5N 1Y9
Tel: (604) 670-4238 (x228)

White Rock EHN Canada
Treatment Centre
2567 King George Blvd.,
Vancouver, BC V5R 5H9
Tel: (833) 561-7778

Last Door Recovery Centre
323 – 8th Street,
New Westminster, BC V3M 3R3
Tel: (604) 245-3459

EMPLOYEE ASSISTANCE PROGRAMS

Air Canada Employee Assistance – Western Region – Richmond BC
7980 River Road,
Richmond, BC V6X 1X7
Office Tel: (604) 448-0721
Toll Free: 1 844 297-6361
Fax: (604) 448-0710
Email: western@iam140.ca
Website: www.iam140.ca

Brown Crawshaw Inc.
BCI Consulting Inc.
Suite #2350 – 4720 Kingsway,
Burnaby, BC V5H 4N2
Tel: (604) 683-3255
Toll-free 1-800-668-2055
Fax: (604) 683-2383
Email: info@browncrawshaw.com
Website: www.browancrawshaw.com

Bitten, Chris (CEAP)
Registered Clinical Counsellor
Couples/Family/Individual
Specialist in Family Addictions
Employee Assistance Consulting
Suite #223 – 1628 West 1st Avenue,
Vancouver, BC V6J 1G1
Tel: (604) 687-8513
Email: cbitten@telus.net

Dental Profession Advisory Program – College of Dental Surgeons of BC
Dr. John Palmer, BDS, MC, RCC, Abbotsford
Tel: (604) 853-0089
Cell: (604) 308-5232
Toll-free: 1-800-661-9199
Confidential Email: dpap@telus.net
Dr. Toni Paroni, RDH, MA, RCC,
Vancouver,
Tel: (604) 737-0168
Toll-free: 1-888-669-9199
Confidential Email: tonip@telus.net

Family Services of Greater Vancouver – Employee Assistance Group
Suite #201 – 1638 East Broadway,
Vancouver, BC V5N 1W1
Tel: (604) 731-4951
Fax: (604) 733-7009
Website: www.fsgv.ca

Lawyers Assistance Program
415 - 1080 Mainland Street,
Vancouver, BC V6B 2T4
Tel: (604) 685-2171
Tol1 Free 1-888-685-2171
Email: info@lapbc.com
Website: www.lapbc.com

Teamsters, Local 155 Employee Assistance
490 Broadway East,
Vancouver, BC V5T 1X3
Tel: (604) 876-8898
Fax: (604) 873-1595
Email: team155@teamsters155.org
Website: www.teamsters155.org

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

Linda Robbins (R. Psych)
Suite #310 – 2902 West Broadway,
Vancouver, BC V6K 2G8
Tel: (604) 732-1891
Email: linda@lindarobbins.ca
Website: www.lindarobbins.ca

Family Services Employee Assistance Programs
Suite #301 – 1638 East Broadway
Vancouver, BC V5N 1W1
Tel: (604) 732-6933
Toll Free: 1 800 667-0993
Fax: (604) 739-4353
Email: acfseap@fsgva.ca
Website: www.fseap-bcproviders.com

Waterfront Industry E.A.P.
John Felicella - Coordinator
3665 Kingsway,
Vancouver, BC V5R 5W2
Tel: (604) 254-7911

Shepell : The EFAP Specialists
Suite #400 - 411 Dunsmuir Street,
Vancouver, BC V6Z 2K8
Toll-free: 1 866 833-7690
Tel: (604) 642-5200
Fax: (604) 632-9930
Website: www.shepell.com

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Pregnancy Outreach Program
Healthiest Babies Possible
Evergreen Community Health Centre
3425 Crowley Drive
Vancouver, BC V5R 6G3
Tel: (604) 872-2511

Sheway: Pregnancy Outreach Program
Suite #101 – 533 E. Hastings Street
Vancouver, BC V6A 1P9
Tel: (604) 216-1699
Fax: (604) 216-1698
Email: sheway.sheway@vch.ca
Website: www.sheway.vcn.bc.ca

YWCA Crabtree Corner FAS/NAS
Prevention Project
533 East Hastings Street,
Vancouver, BC V6A 1P9
Tel: (604) 216-1652
May Kwan, Community Programs Manager
Email: mkwan@ywcavan.org

HIV-AIDS

AIDS Vancouver – Since 1983
1101 Seymour St.,
Suite #235, 2nd Floor
Vancouver, BC, V6B 0R1
Tel: 604-893-2201
Email: contact@aidsvancouver.org
Website: www.aidsvancouver.org

BC Centre for Disease Control
655 West 12th Avenue,
Vancouver, BC, V5Z 4R4
Tel: 604-707-2400
Fax: 603-707-2401
Email: admininfo@bccdc.ca
Website: www.bccdc.ca

Provincial Health Services Authority
Lynda Cranston, CEO, HIV/AIDS Program
c/o BCCDC, STI/HIV Prevention & Control
700 – 1380 Burrard St.,
Vancouver, BC V6Z 2H3
Tel: (604) 657-7400
Fax: (604) 708 2700
Email: lcranston@phsa.ca
Website: www.phsa.ca

HOSPITAL-BASED PROGRAM PRIVATE COUNSELLING

Chemical Dependency
Providence Healthcare
St. Paul's Hospital
1081 Burrard Street,
Vancouver, BC V6Z 1Y6
Tel: (604) 682-2344
Emergency: (604) 806-8016
Website: www.providencehealthcare.org

HOSPITALS

Vancouver General Hospital – Jim Pattison Pavilion
899 West 12th Avenue,
Vancouver, BC V5Z 1M9
Tel: (604) 875-4111
Website: www.vch.ca

Mount Saint Joseph Hospital
3080 Prince Edward Street,
Vancouver, BC V5T 3N4
Tel: (604) 874-1141
Website: www.providencehealthcare.org

Saint Paul's Hospital
1081 Burrard Street,
Vancouver, BC V6Z 1Y6
Tel: (604) 682-2344
Website: www.providencehealthcare.org

BC Women's Hospital
4500 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2032
Toll Free: 1 888 300-3088
Fax: (604) 875-2039
Website: www.bcwomens.ca

BC Children's Hospital
4480 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2345
Toll-free (BC): 1 888 300-3088
Website: www.bcchildrens.ca

BC Children's Hospital
MRI Research Facility
4480 Oak Street,
Vancouver, BC V6H 0B3
Tel: (604) 875-2000
Email: cfrifadmin@bcchr.ca
Website: www.bcchr.ca

MUTUAL SUPPORT GROUPS

Adult Children of Alcoholics
(ACA)/Dysfunctional Families
Tel: (604) 878-8500 (24 hours)
Email: information@acawso.com
Website: www.adultchildren.org

Alanon/Alateen Central Services Office
101 - 3680 East Hastings Street,
Vancouver, BC V5K 2A9
Tel: (604) 688-1716
Email: afgcentraloffice@shaw.ca
Website: www.bcyukon-al-anon.org

Alano Club of Vancouver
1525 - 7th Avenue West,
Vancouver, BC V6J 1S1
Tel: (604) 736-5110
Email: vanalano@shaw.ca
Website: www.vancouverfoundation.ca/vanalano

Alcoholics Anonymous
Central Office
3457 Kingsway
Vancouver, BC V5R 5L5
Tel: (604) 434-3933 (24 Hours)
Fax: (604) 434-2553
Email: staff@vancouveraa.ca
Website: www.vancouveraa.ca

Cocaine Anonymous
Vancouver, BC
(24 hour) Help Line (604) 662-8500
Toll-free: 1-800-662-8300
Email: webservant@ca-bc.org
Website: www.ca-bc.org

Co-Dependents Anonymous (CoDa)
Tel: (604) 515-5585
Email: codaretreat@shaw.ca
Website: www.cdrs.ca

DAMS – Drug and Alcohol Meeting Support for Women
Inner city Women's Initiatives Society
Tel: (604) 687-5454
Email: info@innercitywomen.ca
Website: innercitywomen.ca

Three Bridges Substance Use Services
1128 Hornby Street,
Vancouver, BC V6Z 2L4
Tel: (604) 331-8900
Website: www.vch.ca

Gam-Anon/Gamblers Anonymous
Lower Mainland
Hotline: 1 855 222-5542 (24 hour)
Email: friend@gabc.ca
Website: www.gabc.ca/meetings

Nar-Anon/Narcotics Anonymous
Greater Vancouver
(24 hour) Help Line: (604) 878-8844
Email: bcnaranon@gmail.com

Self – Help Resource Association of BC
Self - Help Support Group
306 - 1212 West Broadway,
Vancouver, BC V6H 3V1
Tel: (604) 733-6186
Fax: (604) 730-1015
Website: www.cwhn.ca
Email: info@peernetbc.com

Vancouver Area Network of Drug Users (VANDU)
380 East Hastings Street,
Vancouver, BC V6A 1R1
Tel: (604) 683-6061
Website: www.vandu.org
Email: vandu@vandu.org

Vancouver Recovery Club
2775 Sophia Street,
Vancouver, BC V5T 3L1
Tel: (604) 708-9955
Fax: (604) 708-9957
Website: www.vancouverrecoveryclub.com
Email: info@vancouverrecoveryclub.com

OUTPATIENT TREATMENT

DEYAS - Downtown Eastside Youth Alternatives Society
541 East Broadway,
Vancouver, BC V5Z 1E6
Tel: (604) 685-6561 (Office)
Tel: (604) 657-6561 (Needle Exchange Van)
Fax: (604) 685-7117
Website: www.deyas.org

Directions Youth Haven
1138 Burrard Street,
Vancouver, BC V6Z 1Y7
Tel: 778 800-3300 (24 Hour)
Text: (604) 367-5204
Tel: (604) 675-2455 (Central Intake)
Email: directions@fsgv.ca
Website: www.directionsyouthservices.ca

Hey-Way'-Noqu' Healing
Circle for Addictions Society
2484 Renfrew Street,
Vancouver, BC V5M 3K2
Tel: (604) 874-1831
Fax: (604) 874-5235
Email: heywaynoqu-reception@telus.net
Website: www.heywaynoqu.org

Musqueam Indian Band
6735 Salish Drive,
Vancouver, BC V6N 4C4
Tel: (604) 263-3261
Fax: (604) 263-4212
Email: coreenpaul@musqueam.bc.ca
Website: www.musqueam.bc.ca

Native Courtworker and Counselling Association of BC
Suite #207 – 1999 Marine Drive,
North Vancouver, BC V7P 3J3
Tel: (604) 985-5355
Toll Free: 1 877 811-1190
Fax: (604) 985-8933
Email: nccabc@nccabc.net
Website: www.nccabc.ca

Nexus - Substance Abuse Services for Youth and Families
Boys and Girls Clubs of Greater Vancouver
550 Cambie Street,
Vancouver, BC V6B 2N7
Tel: (604) 660-5216
Website: www.youthinbc.com

Odyssey II
Boys and Girls Clubs of Greater Vancouver
2875 St. George Street,
Vancouver, BC V5T 3R8
Tel: (604) 879-8853
Website: www.youthinbc.com

Pacific Community Resources Society
Head Office
201 – 2830 Grandview Hwy.,
Vancouver, BC V5M 2C9
Tel: (604) 412-7950
Fax: (604) 412-7951
Email: mailbox@pcrs.ca
Website: www.pcrs.ca

Addiction Services - Evergreen
Community Health Centre
3425 Crowley Drive,
Vancouver, BC V5R 6G3
Tel: (604) 707-3620
Website: www.vch.ca

Three Bridges
Community Health Centre
1128 Hornby Street
Vancouver, BC V6Z 2L4
Tel: (604) 331-8900
Fax: (604) 714-3478
Email: prism@vch.ca
Website: www.vch.ca

Seniors Well Aware Program (SWAP)
3rd Floor – 1290 Hornby Street,
Vancouver, BC V6Z 1W2
Tel: (604) 633-4230
Fax: (604) 633-4231
Email: swap@vrhb.ca
Website: www.vrhb.bc.ca/swap/

Addictions Services
Pacific Spirit Health Centre
3rd Floor. – 2110 West 43rd Avenue,
Vancouver, BC V6M 2E1
Tel: (604) 261-6366
Fax: (604) 261-7220
Website: www.vch.ca

RESIDENTIAL TREATMENT

Aurora Treatment Centre
BC Women's Health Centre
4500 Oak Street,
Vancouver, BC V6H 3N1
Tel: (604) 875-2032
Toll Free: 1 888 300-3088
Fax: (604) 875-2039
Website: www.bcwomens.ca

Avalon Women's Centre
5957 West Boulevard,
Vancouver, BC V6M 3X1
Coordinator: Michelle Swan
Tel: (604) 263-7177
Website: www.avalonrecoverysociety.org

Central City Lodge
Addiction Recovery
415 West Pender Street,
Vancouver, BC V6B 1V2
Tel: (604) 681-9111
Email: info@cccares.org
Website: www.fromgrieftoaction.com

Circle of Eagles Lodge Society
1470 Broadway East,
Vancouver, BC V5N 1V6
Tel: (604) 874-9610
Fax: (604) 874-3858
Email: admin@circleofeagles.com
Website: www.circleofeagles.com

Harbour Light Treatment Centre
The Salvation Army – BC Division
119 East Cordova Street,
Vancouver, BC V6A 1K8
Tel: (604) 646-6800
Fax: (604) 682-1673
Website: www.harbourlightbc.com

plea Community Services
3894 Commercial Street,
Vancouver, BC V5N 4G2
Tel: (604) 871-0450
Fax: (604) 524-1184:
Email: info@plea.ca
Website: www.plea.ca

Pacifica Treatment Centre
1755 - 11th Avenue East
Vancouver, BC V5N 1Y9
Tel: (604) 872-5517
Toll-free: 1-866-537-5517
Fax: (604) 872-3554
Email: info@pacificatreatment.ca
Website: www.pacificatreatment.bc.ca

Peak House –
Pacific Youth & Family Services Society
2427 Turner Street,
Vancouver, BC V5K 2E7
Office Tel: (604) 253-2187
Intake Tel: (604) 253-6319
Fax: (604) 254-6985
Email: admin@peakhouse.ca
Intake Email: intake@peakhouse.ca
Website: www.peakhouse.ca

Together We Can
Drug and Alcohol Recovery and
Education Society
2831 Kingsway,
Vancouver, BC V5R 5H9
Tel: (604) 451-9854
Toll Free: 1 888 940-9854
Website: www.twcrecoverylife.org

Alcohol & Drug Recovery |
Union Gospel Mission
601 East Hastings Street,
Vancouver, BC V6A 1J7
Tel: (604) 253-3323
Email: contact@ugm.ca
Website: www.ugm.ca

The Vancouver Homestead
Women-only facility
975 West 57th Avenue,
Vancouver, BC V6P 6Y9
Office: (604) 266-9696
Website: www.salvationarmy.ca

SENIORS SERVICES

Older Adult Community
Mental Health Referral Line
Health Referral Line
Crisis Line: (604) 951-8855
Toll Free: 1 877 820-7444

Seniors Well Aware Program (SWAP)
3rd Floor – 1290 Hornby Street,
Vancouver, BC V6Z 1W2
Tel: (604) 633-4230
Fax: (604) 633-4231
Email: swap@vrhb.ca
Website: www.vrhb.bc.ca/swap/

SUPPORTIVE RECOVERY

Central City Lodge
415 Pender Street West,
Vancouver, BC V6B 1V2
Tel: (604) 681-9111
Fax: (604) 681-5546
Website: www.cccares.org

New Dawn Recovery Home-women
946 – 40th Avenue East,
Vancouver, BC V5W 1M3
Tel: (604) 325-0576
Fax: (604) 325-0563
Email: intake@chrysalissociety.com
Website: www.chrysalissociety.com

plea Community Services
3894 Commercial Street,
Vancouver, BC V5N 4G2
Tel: (604) 871-0450
Fax: (604) 524-1184:
Email: info@plea.ca
Website: www.plea.ca

Raincity Housing and Support Society
616 Powell Street,
Vancouver, BC V6A 1H4
Tel: (604) 662-7023
Fax: (604) 254-3703
Website: www.wava.ca
Email: info@raincityhousing.org
Website: www.raincityhousing.org

Sancta Maria House
2056 - 7th Avenue West,
Vancouver, BC V6J 1T2
Tel: (604) 731-5550

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

Union Gospel Mission Counselling Services
616 Cordova Street East
Vancouver, BC V6A 1L9
Tel: (604) 253-3323
Fax: (604) 253-3496
Website: www.ugm.bc.ca
Email: contact@ugm.bc.ca

Battered Women's Support Services
CRISIS & INTAKE LINE
(604) 687-1867
Business Phone (604) 687-1868
Toll Free: 1-855-687-1868
Mailing Address: PO Box 21503
1424 Commercial Drive,
Vancouver, BC V5L 5G2
MY SISTER'S CLOSET
Phone: (604) 687-0770
1092 Seymour Street,
Vancouver, BC V6B 1B4
Email: information@bwss.org
Website: www.bwss.org

YOUTH SERVICES

BC Society for Transition Houses
Suite #325 – 119 W. Pender Street,
Vancouver, BC V6B 1S5
Tel: (604) 669-6943
Toll Free: 1 800 661-1040
Fax: (604) 682-6962
Email: info@bcsth.ca
Website: www. bcsth.ca

Broadway Youth Resource Centre
2455 Fraser Street,
Vancouver, BC V5T 0E5
Tel: (604) 709-5720
Fax: (604) 709-5721
Email: byrc@pcrs.ca
Website: www.pcrs.ca

DEYAS - Downtown Eastside Youth
Alternatives Society
541 East Broadway,
Vancouver, BC V5Z 1E6
Tel: (604) 685-6561 (Office)
Tel: (604) 657-6561 (Needle Exchange Van)
Fax: (604) 685-7117
Website: www.deyas.org

Directions Youth Haven
1138 Burrard Street,
Vancouver, BC V6Z 1Y7
Tel: 778 800-3300 (24 Hour)
Text: (604) 367-5204
Tel: (604) 675-2455 (Central Intake)
Email: directions@fsgv.ca
Website: www.directionsyouthservices.ca

Peak House –
Pacific Youth & Family Services Society
2427 Turner Street,
Vancouver, BC V5K 2E7
Office Tel: (604) 253-2187
Intake Tel: (604) 253-6319
Fax: (604) 254-6985
Email: admin@peakhouse.ca
Intake Email: intake@peakhouse.ca
Website: www.peakhouse.ca

BURNABY/NEW WESTMINSTER

COMMUNITY-BASED PREVENTION PROGRAMS

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

Hastings Brentwood Community Police Office
104 – 4191 Hastings Street,
Burnaby, BC V5C 2J3
Tel: (604) 646-9533
Email: lyall.woznesensky@icbc.com

Lougheed Community Police Office
178 – 9855 Austin Road,
Burnaby, BC V3J 1N4
Tel: (604) 646-9559

Southeast Community Police Office
7191 Arcola Way,
Burnaby, BC V5E 0A6
Tel: (604) 646-9577

Southwest Community Police Office
4501 Kingsborough Street,
Burnaby, BC V5H 4V3
Tel: (604) 646-9595

New Westminster Community Policing Committee
555 Columbia Street,
New Westminster, BC V3L 1B2
Tel: (604) 525-55411

RCMP Youth Services
6355 Deer Lake Avenue,
Burnaby, BC V5G 2J2
Tel: (604) 646-9956
Fax: (604) 294-7807
Email: philip.dutton@burnaby.ca

Sport Medicine Council of BC
3713 Kensington Avenue,
Burnaby, BC V5B 0A7
Tel: (604) 294-3050
Email: info@sportmedbc.com
Website: www. sportmedbc.com

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

D'Talks – Youth Detox Line
Tel: (604) 658-1221
Toll-free: 1 866 658-1221

Daytox Vancouver
377 East 2nd Avenue,
Vancouver, BC V5T 1B9
Intake: 1 866 658-1221
Appointments: (604) 658-1278
Web: www.vch.ca

Seniors Well Aware Program (SWAP)
Home Detox-Burnaby/New Westminster
306 – 321 Sixth Street,
New Westminster, BC V3L 3A7
Tel: (604) 524-8998
Fax: (604) 524-1184
Email: swap@vrhb.ca
Website: www.vrhb.bc.ca/swap/

EMPLOYEE ASSISTANCE PROGRAMS

Finlay Counselling
& Mediation Services Ltd.
Suite #202 – 26 Fourth Street,
New Westminster, BC V3L 5M4
Tel: (604) 522-9266
Fax: (604) 522-9267
Email: bobfinlay@shaw.ca
Website: www.finlaycounselling.ca

Brown Crawshaw Inc.
BCI Consulting Inc.
Suite #2350 – 4720 Kingsway,
Burnaby, BC V5H 4N2
Tel: (604) 683-3255
Toll-free 1-800-668-2055
Fax: (604) 683-2383
Email: info@browncrawshaw.com
Website: www.browancrawshaw.com

Construction Industry Rehabilitation Plan
Suite #402 – 223 Nelson's Crescent,
New Westminster, BC V3L 0E4
Tel: (604) 521-8611
Toll-free: 1-888-521-8611
Email: info@constructionrehabplan.ca
Website: www.constructionrehabplan.ca

Denis E. Boyd and Associates Inc.
202 - 1046 Austin Avenue
Coquitlam, BC V3K 3P3
Tel: (604) 931-7211
Website: www.denisboyd.com

Interlock Employee & Family
Assistance Corporation of Canada
Suite #301 – 6190 Agronomy Road,
Vancouver, BC V6T 1Z3
Tel: (604) 822-9189
Fax: (604) 822-3689
Website: www.mitacs.ca

Lower Mainland Assessment &
Referral Service
204 – 5623 Imperial Street
Burnaby, BC V5J 1G1
Tel: (604) 437-4776

FAMILY ASSISTANCE PROGRAMS

Last Door Recovery Centre
323 – 8th Street,
New Westminster, BC V3M 3R3
Tel: (604) 245-3459

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach
Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Pregnancy Outreach Program
Burnaby Family Life
#204 – 7355 Canada Way
Burnaby, BC V3N 4Z6
Tel: (604) 659-2228
Fax: (604) 524-4153
Email: info@burnabyfamilylife.org
Website: www.burnabyfamilylife.org

HIV/AIDS

Burnaby Treatment Services
HIV/AIDS Program
40 Begbie Street,
New Westminster, BC V6M 3L9
Tel: (604) 526-2522
Email: info@purposessociety.org
Website: www.purposessociety.org

HOSPITALS

Burnaby General Hospital
3935 Kincaid Street,
Burnaby, BC V5G 2X6
Tel: (604) 434-4211

Royal Columbian Hospital
330 E. Columbia Street,
New Westminster, BC V3L 3W7
Tel: (604) 520-4253

METHADONE TREATMENT

Lower Mainland Drug Freedom, Inc.
25 Blackwood Street
New Westminster, BC V3L 2T3
Tel: (604) 520-1068
Fax: (604) 520-3435

MUTUAL SUPPORT GROUPS

Gam-Anon/Gamblers Anonymous
Lower Mainland
Hotline: 1 855 222-5542 (24 hour)
Email: friend@gabc.ca
Website: www.gabc.ca/meetings

MADD Metro Vancouver
14 – 12353 – 104th Avenue
Surrey, BC V3V 3H2
Toll Free: 1 800 665-6233 ext. 266
Fax: (604) 515-9213
Email: maddvancouver@gmail.com
Website: www.maddchapters.ca/vancouver

Nar-Anon/Narcotics Anonymous
Greater Vancouver
(24 hour) Help Line: (604) 878-8844
Email: bcnaranon@gmail.com

NEEDLE EXCHANGE PROGRAMS

New Westminster Needle Exchange
New Westminster Public Health Unit
218 – 610 Sixth Street
New Westminster, BC V3L 3C2
Tel: (604) 777-6740
Fax: (604) 525-0878

OUTPATIENT TREATMENT

Burnaby Centre for Mental
Health and Addiction
3405 Willingdon Avenue,
Burnaby, BC V5G 3H4
Tel: (604) 675-3950
Fax: (604) 675-3955
Email: feedback@bcmhs.bc.ca
Website: www.bcmhsus.ca

Lower Mainland Drug Freedom
25 Blackwood Street,
New Westminster, BC V3L 2T3
Tel: (604) 520-1068
Fax: (604) 520-3435
Email: info@methodonesuboxoneclinics.com
Website: www.suboxonemethadoneclinics.com

Odyssey 1 Substance Misuse Services
(Boys and Girls Clubs of South Coast BC)
Suite #2 - 518 S, Howard Avenue,
Burnaby, BC V3B 3R1
Tel: (604) 299-6377
Email: www.fromgrieftoaction.com

Perspectives Substance Use
Counselling for Adults
2nd Floor - 519 Seventh Street,
New Westminster, BC V3M 6A7
Tel: (604) 522-3722, Ext. 101
Fax: (604) 522-4031
Website: www.fraserside.bc.ca
Email: info@fraserside.bc.ca

SHARE Family and Community Services Society
#200 - 25 King Edward Street,
Coquitlam, BC V3K 4S8
Tel: (604) 540-9161
Fax: (604) 540-2290
Website: www.sharesociety.ca

RESIDENTIAL TREATMENT

Charlford House Society for Women
6845 Kitchener Street
Burnaby, BC V5B 2J8
Tel: (604) 420-4626
Administration: (604) 420-6601
Fax: (604) 420-4629
Email: info@charlfordhouse.ca
Website: www.charlfordhouse.ca

Lana House Society
407 Kelly Street
New Westminster, BC V3L 3T7
Tel: (604) 524-3969
Fax: (604) 524-3969
Cell: (604) 290-6663
Email: morin3969@home.com
Or Email: handlebar96@yahoo.com

Last Door Recovery Centre
323 – 8th Street,
New Westminster, BC V3M 3R3
Tel: (604) 245-3459
Creekside Withdrawal Management Centre

Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

RESIDENTIAL SUPPORTIVE RECOVERY

Lana House Society
407 Kelly Street,
New Westminster, BC V3L 3T7
Tel: (604) 290-6663
Fax: (604) 524-3969
Email: morin3969@home.com
Or Email: handlebar96@yahoo.com

Hope for Freedom Society
3237 Liverpool Street,
Port Coquitlam, BC V3B 3V5
Tel: (604) 464-0472
Fax: (604) 410-4103
Email: info@hopeforfreedom.org
Website: www.hopeforfreedom.org

SCHOOL-BASED PREVENTION PROGRAMS

Burnaby School District #41
5325 Kincaid Street,
Burnaby, BC V5G 1W2
Tel: (604) 296-6900
Email: inquiries@burnabyschools.ca
Website: www.burnabyschools.ca

New Westminster Chamber of Commerce
Suite #201 - 309 Sixth Street,
New Westminster, BC V3L 3A7
Tel: (604) 517-6247 (school board)
(604) 521-7781 (Chamber of Commerce)
Fax: (604) 517-6204
Email: administration@newwestchamber.com
Website: www. newwestchamber.com

SENIORS PROGRAMS

Seniors Well Aware Program (SWAP)
Suite #306 – 321 – 6th Street,
New Westminster, BC V3L 3A7
Tel: (604) 524-8998
Fax: (604) 524-1184
Burnaby:
Tel: (604) 524-8994
Fax: (604) 524-8781
Email: info@swapbc.ca
Website: www.vrhb.bc.ca/swap/

SUPPORTIVE RECOVERY SERVICES

Charlford House Society for Women
PO Box 44077,
Burnaby, BC V5B 4Y2
Tel: (604) 420-4626 (24 Hour)
Administration: (604) 420-6601
Fax: (604) 420-4629
Email: info@charlfordhouse.ca
Website: www.charlfordhouse.ca

Innervisions Recovery Society
1937 Prairie Avenue,
Port Coquitlam, BC V3B 1V5
Women's: Toll Free: 1 866 466-4215
Men's: Toll Free: 1 877 939-1420
Women's: (604) 466-4215
Men's: (604) 468-2032
Email: helpme@innervisionsrecovery.com
Website: www. innervisionsrecovery.com

Westminster House:
Alcohol & Drug Addiction Treatment for Women
228 – 7th Street
New Westminster, BC V3M 3K3
Tel: (604) 524-5633
Toll-free: 1-866-524-5633
Email: info@westminsterhouse.ca
Website: www.westminsterhouse.ca

Last Door Recovery Centre
323 – 8th Street,
New Westminster, BC V3M 3R3
Tel: (604) 245-3459

YOUTH SERVICES

Last Door Recovery Centre
323 – 8th Street,
New Westminster, BC V3M 3R3
Tel: (604) 245-3459

Odyssey 1 Substance Misuse Services
(Boys and Girls Clubs of South Coast BC)
Suite #2 - 518 S, Howard Avenue,
Burnaby, BC V3B 3R1
Tel: (604) 299-6377
Email: www.fromgrieftoaction.com

NORTH VANCOUVER/ WEST VANCOUVER/ SQUAMISH/WHISTLER/ PEMBERTON/POWELL RIVER

COMMUNITY-BASED PREVENTION PROGRAMS

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

District Community Policing Office
355 West Queens Road,
North Vancouver, BC V7N 4N5
Tel: (604) 990-2342
Fax: (604) 990-2409

City Community Policing Office
112 East 3rd Street,
North Vancouver, BC V7L 1E6
Tel: (604) 969-7464
Fax: (604) 969-7959

Hollyburn Family Services
210 – 255 W. 1st Street,
North Vanccouver, BC V7M 3G8
Tel: (604) 987-8211
Fax: (604) 987-8122
Email: info@hollyburn.ca
Website: www.hollyburn.ca
North Shore Crisis Services Society

SAGE House & Women's 24-Hour Support Line
North Vancouver, BC
Tel: (604) 987-3374
Fax: (604) 987-5396

Optima Humanus Inc.
Medical Centre
2078 Rivergrove Place,
North Vancouver, BC V7H 2L4
Tel: (604) 929-7336

Tla'Amin Health Addictions Program
4895 Salish Drive,
Powell River, BC V8A 0B6
Tel: (604) 483-3009
Toll Free: 1 866 209-6538
Fax: (604) 483-2466
Email: health@tn-bc.ca
Website: www.tlaaminhealth.com

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

D'Talks – Youth Detox Line
Tel: (604) 658-1221
Toll-free: 1 866 658-1221

EMPLOYEE & FAMILY ASSISTANCE PROGRAMS

Brown Crawshaw Inc.
BCI Consulting Inc.
Suite #2350 – 4720 Kingsway,
Burnaby, BC V5H 4N2
Tel: (604) 683-3255
Toll-free 1-800-668-2055
Fax: (604) 683-2383
Email: info@browncrawshaw.com
Website: www.browancrawshaw.com

EFAP Employee & Family Assistance
Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Email: help@efap.ca
Website: www.efap.ca

Finlay Counselling & Mediation Services Ltd.
Suite #202 – 26 Fourth Street,
New Westminster, BC V3L 5M4
Tel: (604) 522-9266
Fax: (604) 522-9267
Email: bobfinlay@shaw.ca
Website: www.finlaycounselling.ca

Family Services of the North Shore
Suite #203 – 1111 Lonsdale Avenue,
North Vancouver, BC V7M 2H4
Tel: (604) 988-5281
Website: www.familyservices.bc.ca

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Babies Open New Doors (BOND)
Powell River Employment Program (PREP)
4727 Marine Avenue,
Powell River, BC V8A 2L2
Tel: (604) 485-2604
Fax: 1 888 822-3914
Email: bondprogram@prepsociety.org
Website: www.prepsociety.org

Sea to Sky Community Services (SSCS) Society
Pregnancy Support Services (Parenting Education and Support)
38024 Fourth Avenue,
Squamish, BC V8B 0A7
Tel: (604) 892-5796
Toll Free: 1 877 892-2022
Fax: 604-892-2267
Email: community@sscs.ca
Website: www.sscs.ca

HOSPITALS

Lions Gate Hospital
231 - 15th Street East,
Vancouver, BC V7L 2L7
Tel: (604) 988-3131
Fax: (604) 984-5838
Email: info@lghfoundation.com
Website: www.lghfoundation.com

MUTUAL SUPPORT GROUPS

Alano Club of the North Shore
176 - 2nd Street East,
North Vancouver, BC V7L 1C3
Tel: (604) 987-4141
Website: www.northshorealano.com

Alano Club of Powell River
5903 Arbutus Avenue,
Powell River, BC V8A 4S2
Tel: 604-483-3800

Alanon/Alateen Central Services Office
101 - 3680 East Hastings Street,
Vancouver, BC V5K 2A9
Tel: (604) 688-1716
Email: afgcentraloffice@shaw.ca
Website: www.bcyukon-al-anon.org

Alcoholics Anonymous
Central Office
3457 Kingsway
Vancouver, BC V5R 5L5
Tel: (604) 434-3933 (24 Hours)
Fax: (604) 434-2553
Email: staff@vancouveraa.ca
Website: www.vancouveraa.ca

Avalon Women's Recovery Society
Suite #300 – 132 East 14th Street,
North Vancouver, BC V7T 2N3
Tel: (604) 913-0477
Website: www.avalonrecoverysociety.org

Cocaine Anonymous –Squamish
Toll Free: 1 866 662-8300 (24 Hours)
Tel: (604) 662-8500
Email: meetings@ca-bc.org
Website: www.ca-bc.org

Gam-Anon/Gamblers Anonymous
Lower Mainland
Hotline: 1 855 222-5542 (24 hour)
Email: friend@gabc.ca
Website: www.gabc.ca/meetings

Nar-Anon/Narcotics Anonymous
Greater Vancouver
(24 hour) Help Line: (604) 878-8844
Email: bcnaranon@gmail.com

NEEDLE EXCHANGE

Harm Reduction and Needle Exchange
Vancouver Coastal Health (VCH)
6th Floor – 132 West Esplanade Avenue,
North Vancouver, BC V7M 1A2
Tel: (604) 983-6700
Fax: (604) 983-6883
Website: www.vch.ca

OUTPATIENT TREATMENT

Native Courtworker and Counselling Association of British Columbia
Suite #207 – 1999 Marine Drive,
North Vancouver, BC V7P 3N5
Tel: (604) 985-5355
Fax: (604) 985-8933
Email: nccabc@nccabc.net
Website: www.nccabc.ca

Sea to Sky Community Services (SSCS) Society
Pregnancy Support Services (Parenting Education and Support)
38024 Fourth Avenue,
Squamish, BC V8B 0A7
Tel: (604) 892-5796
Toll Free: 1 877 892-2022
Fax: 604-892-2267
Email: community@sscs.ca
Website: www.sscs.ca

Squamish Nation Alcohol and Drug Yuustway Health Sevices
1221 Billy Road
Squamish, BC V0N 3G0
Tel: (604) 892-5975
Fax: (604) 892-3478
Website: www.squamish.net

West Coast Alternatives Services
Suite #117 – 3721 Delbrook Avenue
North Vancouver, BC V7N 3Z4
Tel: (604) 984-0255
Fax: (604) 984-0799
Website: www.drugrehab.ca

RESIDENTIAL TREATMENT

Avalon Women's Recovery Society
Suite #300 – 132 East 14th Street,
North Vancouver, BC V7T 2N3
Tel: (604) 913-0477
Website: www.avalonrecoverysociety.org

Revera Hollyburn House
2095 Marine Drive,
West Vancouver, BC V7V 4V5
Tel: (604) 922-7616

Sunshine Coast Health Centre
2174 Fleury Road,
Powell River, BC V8A 0H8
Toll Free: 1 866 487-9050
Fax: (604) 487-9012
Email: info@schc.ca
Website: www.schc.ca

SCHOOL-BASED PREVENTION PROGRAMS

Sea to Sky Community Services (SSCS) Society
School-Based Alcohol and Drug Prevention Program
(Addiction Services)
38024 Fourth Avenue,
Squamish, BC V8B 0A7
Tel: (604) 892-5796
Toll Free: 1 877 892-2022
Fax: 604-892-2267
Email: community@sscs.ca
Website: www.sscs.ca

RICHMOND

COMMUNITY-BASED PREVENTION PROGRAMS

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

City Centre Community Police Office
Suite #140 – 5671 – No. 3 Road,
Richmond, BC V6X 2C7
Tel: (604) 207-4761
Fax: (604) 270-9372

South Arm Community Police Station
8880 Williams Road,
Richmond, BC V7A 1G6
Tel: (604) 713-2300

Steveston Community Police Station
4371 Moncton Street,
Richmond, BC V7E 3A8
Tel: (604) 713-2323

Vancouver Richmond Mental Health Network
Suite #207 – 1300 Richards Street,
Vancouver, BC V6B 3G6
Tel: (604) 733-5570
Fax: (604) 733-9556
Email: office@wcmhn.org
Website: www.vrmhs.tripod.com

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Creekside Withdrawal Management Centre
Maple Cottage Detoxification Centre
13740 – 94A Avenue,
Surrey, BC V3V 1N1
Intake: (604) 587-3755
Daytox: (604) 585-5610
Fax: (604) 587-3795
Email: feedback@fraserhealth.ca
Website: www.fraserhealth.ca

D'Talks – Youth Detox Line
Tel: (604) 658-1221
Toll-free: 1 866 658-1221

Richmond Addiction Services Society
Suite#105 – 8080 Anderson Road,
Richmond, BC V6Y 0J5
Tel: (604) 270-9220
Fax: (604) 270-9245
Website: www. richmondaddiction.ca
Email: info@richmondaddiction.ca

EMPLOYEE ASSISTANCE PROGRAMS

Brown Crawshaw Inc.
BCI Consulting Inc.
Suite #2350 – 4720 Kingsway,
Burnaby, BC V5H 4N2
Tel: (604) 683-3255
Toll-free 1-800-668-2055
Fax: (604) 683-2383
Email: info@browncrawshaw.com
Website: www.browancrawshaw.com

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Email: help@efap.ca
Website: www.efap.ca

Finlay Counselling & Mediation Services Ltd.
Suite #202 – 26 Fourth Street,
New Westminster, BC V3L 5M4
Tel: (604) 522-9266
Fax: (604) 522-9267
Email: bobfinlay@shaw.ca
Website: www.finlaycounselling.ca

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

MUTUAL SUPPORT GROUPS

Narcotics Anonymous
Tel: (604) 873-1018 (24 hours)

Richmond Addiction Services
170 – 5720 Minoru Boulevard
Richmond, BC V6X 2A9
Tel: (604) 270-9220
Fax: (604) 270-9245
Website: www. richmondaddiction.ca
Email: info@richmondaddiction.ca

OUTPATIENT TREATMENT

Richmond Addiction Services Society
Suite#105 – 8080 Anderson Road,
Richmond, BC V6Y 0J5
Tel: (604) 270-9220
Fax: (604) 270-9245
Website: www. richmondaddiction.ca
Email: info@richmondaddiction.ca

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

RESIDENTIAL TREATMENT

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

SCHOOL-BASED PREVENTION PROGRAMS

Richmond Addiction Services Society
Suite#105 – 8080 Anderson Road,
Richmond, BC V6Y 0J5
Tel: (604) 270-9220
Fax: (604) 270-9245
Website: www. richmondaddiction.ca
Email: info@richmondaddiction.ca

Turning Point Recovery Society
Admin: (604) 303-6844
Vancouver,
(604) 875-1710
Fax: (604) 874-5752
Richmond Men's,
(604) 303-6717
Fax: (604) 303-7646
Richmond Women's,
(604) 284-5354
Fax: (604) 284-5421
North Shore Women's,
(604) 971-0111
Fax: (604) 973-0151
North Shore Men's,
(604) 988-4317
Fax: (604) 988-2618
Website: www.turningpointrecovery.com

VANCOUVER ISLAND (MID AND UPPER ISLAND)

PROVINCIAL GOVERNMENT SERVICES

AMSSA
(Affiliation of Multicultural Societies And Services Agencies of BC)
4445 Norfolk Street,
Burnaby, BC V5G 0A7
Tel: (604) 718-2780
Toll Free: 1 888 355-5560
Fax: (604) 298-0747
Email: amssa@amssa.org
Website: www.amssa.org

COMMUNITY-BASED PREVENTION PROGRAMS

Community Police & Services
18 Victoria Cres.,
Nanaimo, BC V9R 5B8
Tel: (250) 753-3777

Community Police Station
546 Centre Street,
Nanaimo, BC V9R 4Z3
Tel: (250) 753-3368

Cedar Community Police Station
1830 Cedar Road,
Nanaimo, BC V9R 1H9
Tel: (250) 722-3486

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

Ann Elmore Transition House Detox Program
Campbell River and North Island Transition Society (CRNITS)
#101 – 1116 Dogwood Street,
Campbell River, BC V9W 3A2
Crisis Line: (250) 286-3666
Toll-free: 1 800 667-2188
Fax: (250) 287-1139
Email: campbellriverdistrict@divisionsbc.ca
Website: www.campbellriver.fetchbc.ca

Clearview Centre
Resources for Safety & Wellbeing
967 Haliburton Street,
Nanaimo, BC V9R 6N4
Tel: (250) 753-9968
Fax: (250) 754-9305
Email: clearviewdetox@shaw.ca
Website: www.clearviewcentre.org

Comox Valley Transition Society
625 England Avenue,
Courtenay, BC V9N 2N5
Tel: (250) 897-0511
Email: cvts@shaw.ca
Website: www.cvts.ca

Mental Health & Substance Use Services
Withdrawal & Detox Services
Suite #203 – 2000 Island Highway North
Nanaimo, BC V9S 5W3
Tel: (250) 739-5710
Fax: (250) 755-3310
Email: info@viha.ca
Website: www.islandhealth.ca

St. Joseph's General Hospital
Withdrawal Management
2137 Comox Avenue,
Comox, BC V9M 1P2
Tel: (250) 339-1573 or
Tel: (250) 339-1495
Website: www.sjghcomox.ca

Upper Island Counselling Services
280B Anderson Road,
Comox, BC V9M 1Y2
Tel: (250) 287-2266
Toll Free: 1 866 789-2266
Fax: (250) 287-3380
Email: info@uics.ca
Website: www.uics.ca

Specialized Youth
Detox (SYD)
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: syd@vyes.ca

Smart Recovery Parksville Meeting Society of Organized Services
245 Hirst Avenue West,
Parksville, BC V9P 1K3
Tel: (250) 752-1052
or (250) 752-5847
Email: info@smartrecoverybc.com
Website: www.smartrecoverybc.com

EMPLOYEE ASSISTANCE PROGRAMS

EFAP Employee & Family Assistance Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

Shepell : The EFAP Specialists
400 - 411 Dunsmuir Street,
Vancouver, BC V6Z 2K8
Toll-free: 1 866 833-7690
Tel: (604) 642-5200
Fax: (604) 632-9930
Website: www.shepell.com

Vancouver Island Counselling
#305 – 394 Duncan Street,
Duncan, BC V9L 3W4
Tel: (250) 746-6900
Nanaimo: (250) 754-8222
Email: counselors@islandefap.org
Website: www.vancouverislandcounselling.com

Interlock Employee and Family
Assistance Vancouver Office
Suite #301 – 6190 Agronomy Road,
Vancouver, BC V6T 1Z3
Tel: (604) 822-9189
Fax: (604) 822-3689
Website: www.mitacs.ca
Lee Marshall & Associates
35A Commercial Street,
Nanaimo, BC V9R 5L3
Tel: (250) 754-7703
Fax: (250) 754-7494
Email: marshallcounselling@shaw.ca
Website: www.marshallcounselling.ca

Lee Marshall, and Associates
149 Wallace Street
Nanaimo, BC V9R 5B2
Tel: (250) 754-7703
Fax: (250) 754-7494
Website: www.leemarshall.org

North Island Assessment and Referral Service
PO Box 1450
5A - 1705 Campbell Way
Port McNeill, BC V0N 2R0
Tel: (250) 956-3144
Fax: (250) 956-3146
Email: hopeful@island.net

Port Alberni Assessment and Resource Service Society
201 - 4988 Argyle Street
Port Alberni, BC V9Y 1V7
Tel: (250) 724-2443
Fax: (250) 724-3440
Email: paars@alberni.net

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Baby's Best Chance
Campbell River Family Services Society
487 - 10th Avenue,
Campbell River, BC V9W 4E4
Tel: (250) 287-2421
Fax: (250) 287-4268
Email: family.services@crfs.ca
Website: www.crfamilyservices.ca

Building Better Babies
Tillicum Lelum Aboriginal Friendship Centre
602 Haliburton Street,
Nanaimo, BC V9R 6N4
Tel: (250) 753-6578 or
Tel: (250) 753-8291
Fax: (250) 754-1390
Website: www.tillicumlelum.ca
Email: healthcentre@tillicumlelum.ca

Healthy Babies
Comox Valley Family Services
1415 Cliffe Avenue,
Courtney, BC V9N 2K6
Tel: (250) 338-7575
Fax: (250) 338-2343
Email: info@cvfsa.org
Website: comoxvalleyfamilyservices.com

HOSPITAL-BASED PROGRAMS

Chemical Dependency Resource Program
Nanaimo Regional General Hospital
1200 Dufferin Crescent
Nanaimo, BC V9S 2B7
Tel: (250) 755-7691
Toll Free: (250) 947-8214

CR Hospital Substance Abuse Program
Campbell River and District General Hospital
375 Second Avenue
Campbell River, BC V9W 3V1
Tel: (250) 286-7027 or
Tel: (250) 287-7111
Fax: (250) 286-7087

Cowichan District Hospital
3045 Gibbins Road,
Duncan, BC V9L 1E5
Tel: (250) 737-2030
Website: www.islandhealth.ca

North Island Hospital
Campbell River & District
375 – 2nd Avenue
Campbell River, BC V9W 3V1
Tel: (250) 286-7100

METHADONE TREATMENT

Outreach Services Clinic
603 Gorge Road East,
Victoria, BC V8T 2W7
Tel: (250) 480-1232
Toll-free: 1-877-480-1232
Fax: (250) 480-1231
Website: www.outreachservicesclinic.com

NEEDLE EXCHANGE PROGRAMS

Nanaimo and Area Resource Services for Families (NARSF Programs)
Suite #201 – 170 Wallace Street
Nanaimo, BC V9R 5B1
Tel: (250) 753-2773
Fax: (250) 754-1605
Email: www.admin@narsf.org
Website: www.narsf.org

OUTPATIENT TREATMENT

Addiction Services
Campbell River Mental Health
207 - 1040 Shopper Row,
Campbell River, BC V9W 2C6
Tel: (250) 850-5800
Crisis Line: 1 888 494-3888
Fax: (250) 286-6679

Salt Spring Island Community Services
Society
268 Fulford – Ganges Road
Salt Spring Island, BC V8K 2K6
Tel: (250) 537-9971
Fax: (250) 537-9974
Website: www.saltspringcommunityservices.ca

Ahousat Holistic Recovery Centre Society
458 Ahousat Reserve
Ahousat, BC V0R 1A0
Tel: (250) 670-9558
Fax: (250) 670-9554
Email: ahousat1@telus.net
Website: www.ahousat.ca

Alcohol and Drug Outpatient Services
Community Health Connections
Cowichan District Hospital
3045 Gibbins Road,
Duncan, BC V9L 1E5
Tel: (250) 737-2030
Website: www.islandhealth.ca

Alcohol and Drug Services
Ministry for Children and Family Development
2455 Mansfield Drive,
Courtenay, BC V9N 2M2
Tel: (250) 334-5820

Referrals Mount Waddington
Mental Health & Substance Use
7070 Shorncliffe Avenue,
PO Box 1290
Port Hardy, BC V0N 2P0
Tel: (250) 902-6051
Fax: (250) 902-6052
Website: www.islandhealth.ca

Klahoose First Nation
PO Box 09
1790 Tork Road,
Squirrel Cove, BC V0P 1K0
Tel: (250) 935-6536 (Band Office)
Fax: (250) 935-6997
Website: www.klahoose.org

Kwakiutl Distict Council
Health Centre
1400 A Drake Road,
Campbell River, BC V9W 7K6
Tel: (250) 286-9766
Toll Free: 1 866 286-9766
Fax: (250) 286-9713
Email: kim.roberts@kdchealth.com
Website: www.kdchealth.com

Ts'ewulhtun Health Centre
5768 Allenby Road,
Duncan, BC V9L 5J1
Tel: (250) 746-6184
Fax: (250) 748-8815
Email: health@cowichantribes.com
Website: www.cowichantribes.com

Namgis Health Centre
48 School Road,
Alert Bay, BC V0N 1A0
Tel: (250) 974-5522
Fax: (250) 974-5900
Email: info@namgis.bc.ca
Website: www.namgis.bc.ca

Vancouver Island Older Adult Mental Health and Addiction Service
1952 Bay Street,
Victoria, BC V8R 1J8
Tel: (250) 370-8514
Website: www.psychiatry.ubc.ca

John Howard Society
of The North Island
1455 Cliffe Avenue,
Courtenay, BC V9N 2K6
Tel: (250) 338-7341
Fax; (250) 338-6568
Email: mail@jhsni.bc.ca
Website: www.jhsni.bc.ca

Penelakut Health Unit
Clam Bay Road North,
Chemainus, BC V0R 1K0
Tel: (250) 246-9885 or
Website: www.islandhealth.ca

Port Alberni – Adult
Substance Abuse Service Team
4780 Roger Street,
Port Alberni, BC V9Y 3Z2
Tel: (250) 731-1311
Fax: (250) 731-1312
Website: www.islandhealth.ca

Port Alberni Friendship Centre
3555 – 4th Avenue,
Port Alberni, BC V9Y 4H3
Tel: (250) 723-8281
Fax: (250) 723-1877
Website: www.pafriendshipcenter.com

Problem Gambling Program
John Howard Society
1585 Bowen Rd.,
Nanaimo, BC V8T 4Y4
Tel: (250) 754-1266
Website: www.canadadrugrehab.bc.ca

Snuneymuxw First Nation
Alcohol and Drug Abuse Program
668 Centre Street,
Nanaimo, BC V9R 4Z4
Tel: (250) 740 2337
Crisis Line: (250) 802-7122
Email: health@snuneymuxw.ca
Website: www.snuneymuxw.ca

Tahsis Health Centre
1085 Maquinna Drive,
PO Box 399
Tahsis, BC V0P 1X0
Tel: (250) 934-6322
Fax: (250) 934-6404
Website: www.islandhealth.ca

Tillicum Lelum Friendship Centre
602 Haliburton Street,
Nanaimo, BC V9R 4W5
Tel: (250) 753-6578 or
Website: www.tillicumlelum.ca

RESIDENTIAL TREATMENT

Edgewood Treatment Centre
2121 Boxwood Road,
Nanaimo, BC V9S 4L2
Toll-free: 1-800-683-0111
Fax: (250) 751-2758
Email: info@edgewood.ca
Website: www.edgewoodhealthnetwork.com

Kakawis Family Development Centre
Meares Island
PO Box 17,
Tofino, BC V0R 2Z0
Tel: (250) 725-3951
Fax: (250) 725-4285
Email: kakwis@tofino-bc.com

Namgis Health Centre
48 School Road,
Alert Bay, BC V0N 1A0
Tel: (250) 974-5522
Fax: (250) 974-5900
Email: info@namgis.bc.ca
Website: www.namgis.bc.ca

Tsow-Tun Le Lum Society
Substance Abuse and
Trauma Treatment Centre
699 Capilano Road,
Lantzville, BC V0R 2H0
Tel: (250) 390-3123
Fax: (250) 390-3119
Email: info@tsowtunlelum.org
Website: www.tsowtunlelum.org

SUPPORTIVE RECOVERY SERVICES

Second Chance Recovery Society
North Island Supportive Recovery Society
647 Birch Street,
PO Box 996, Station A,
Campbell River, BC V9W 6Y4
Tel: (250) 830-1103
Fax: (250) 830-1175
Email: second.chance.recovery@gmail.com
Website: www.nisrs.org

SURFSIDE RECOVERY HOUSE

Vancouver Island
Therapeutic Community
2386 Rosstown Road,
Nanaimo, BC V9T 3R7
Tel: (250) 758-5611 (24 hours)
Tel:/Fax: (250) 758-2253
Email: nanaimosurfside@shaw.ca
Website: www.surfsiderecovery.com

YOUTH PROGRAMS

Island Health, Discovery Youth & Family Substance Use Services
206 – 96 Cavan Street,
Nanaimo, BC V9R 2V1
Tel: (250) 739-5790
Fax: (250) 740-2672
Email: discovery@viha.ca
Website: www.viha.ca

Specialized Youth Detox (SYD)
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: syd@vyes.ca

Youth Alcohol & Drug
Salt Spring Island Community Services Society
268 Fulford – Ganges Road,
Salt Spring Island, BC V8K 2K6
Tel: (250) 537-9971
Fax: (250) 537-9974
Email: connect@ssics.ca
Website: www.saltspringcommunityservices.ca

Discovery Youth and Family Addictions Services
96 Cavan Street
Nanaimo, BC V9R 2V1
Tel: (250) 739-5790

Youth Addictions Services
Salt Spring Island Community Services Society
268 Fulford – Ganges Road
Salt Spring Island, BC V8K 2K6
Tel: (250) 537-9971
Fax: (250) 537-9974
Email: connect@ssics.ca
Website: www.saltspringcommunityservices.ca

VANCOUVER ISLAND (SOUTH ISLAND)

COMMUNITY-BASED PREVENTION PROGRAMS

North Island Alcohol and Drug Education & Information Society (NADIS)
910C Island Highway,
Campbell River, BC V9W 2C3
Tel; (250) 287-4771
Fax: (250) 286-1936
Email: nadis@crcn.net

Port Alberni Mental Health
& Additions
4780 Roger Street,
Port Alberni, BC V9Y 3Z2
Tel: (250) 724-3554

Duncan Health Unit/
Margaret Moss Health Unit
675 Canada Avenue,
Duncan, BC V9L 1T9
Tel; (250) 709-3050
Fax: (250) 709-3055
Website: www.islandhealth.ca

MUTUAL SUPPORT GROUPS

Al-Anon/Alateen – Nanaimo
Tel: (250) 754-3909 (24 hours)
(meetings information)

Alano Club of Campbell River
Suite #301 - 10th Avenue,
Campbell River, BC V9W 4E4
Tel: (250) 287-2911

Alano Club of Courtenay
543 – 6th Street,
Courtney, BC V9N 1M5
Tel: (250) 338-0041

Alano Club of Duncan
107 Evans Street,
Duncan, BC V9L 1P5
Tel: (250) 748-0724

Alano Club of Nanaimo
245 Fraser Street,
Nanaimo, BC V9R 5B5
Tel: (250) 754 4541

Alano Club of Port Alberni
3028-2nd Avenue,
Port Alberni, BC V9Y 1Y9
Tel: (250) 724-3911

Alcoholics Anonymous – Campbell River
Tel: (250) 287-4313 (24 hours)
(meetings & information)

Alcoholics Anonymous – Nanaimo
Suuite #212 – 285 Prideaux Street,
Nanaimo, BC V9R 2N2
Tel: (250) 753-7513 (24 hours)

Klahoose Healing Circle
Klahoose First Nation
PO Box 9, Squirrel Cove,
Mansons Landing, BC V0P 1T0
Tel: (250) 935-6536
Fax: (2500 935-6997
Website: www.bcafn.ca

Nar-Anon/Narcotics Anonymous
Greater Vancouver
(24 hour) Help Line: (604) 878-8844
Email: bcnaranon@gmail.com

Vancouver Island North and
Powell River Area of Narcotics Anonymous
PO Box 3362,
Courtenay, BC V9N 5N5
Toll Free: 1 844 484-6772
Email: webbw664@gmail.com
Website: www.vinprana.ca/meetings/

SCHOOL-BASED PREVENTION PROGRAMS

John Howard Society Of The North Island
Youth Forensic Psychiatic Services
1455 Cliffe Avenue,
Courtenay, BC V9N 4K6
Tel: (250) 338-7341
Fax: (250) 338-6568
Email: mail@jhsni.bc.ca
Website: www.jhsni.bc.ca

Island Health, Discovery Youth & Family
Substance Use Services
206 – 96 Cavan Street,
Nanaimo, BC V9R 2V1
Tel: (250) 739-5790
Fax: (250) 740-2672
Email: discovery@viha.ca
Website: www.viha.ca

YOUTH PROGRAMS

Island Health,
Discovery Youth & Family
Substance Use Services
206 – 96 Cavan Street,
Nanaimo, BC V9R 2V1
Tel: (250) 739-5790
Fax: (250) 740-2672
Email: discovery@viha.ca
Website: www.viha.ca

Step Stones Program
1665 Grant Street,
Nanaimo, BC V9T 2Z8
Tel: (250) 739-5749
Email: marybeth.wells@edengardens.ca
Website: www.edengardens.ca

Specialized Youth Detox (SYD)
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: syd@vyes.ca

VICTORIA/SOUTH ISLAND

PROVINCIAL GOVERNMENT SERVICES

Ministry of Children & Family
Development Contacts
PO Box 9724 Stn Prov Govt,
Victoria, BC V8W 9S2
Toll Free: 1 877 387-7027
Tel: (250) 356-1639
Fax: (250) 356-3007

COMMUNITY-BASED PREVENTION PROGRAMS

BC Aboriginal Network on Disability
Society (BCANDS)
1179 Kosapsum Crescent
Victoria, BC V9A 7K7
Tel: (250) 381-7303 or
Toll-free: 1-800-815-5511
Fax: (250) 381-7312
Email: jeanwylie@bcands.bc.ca
Website: www.bcands.bc.ca

Dallas Services Society
304 - 1095 McKenzie Avenue,
Victoria, BC V8P 2L5
Tel: (250) 727-3544
Fax; (250) 727-2205

Kids' Options
Quadra Village Community Centre
901 Kings Road,
Victoria, BC V8P 1W5
Toll Free: 1 800 866-6868
Tel: (250) 388-7696
Website: www.ypsn.ca

First Nations in BC
Knowledge Network
Tseycum First Nation
1210 Totem Lane,
North Saanich, BC V8L 5S4
Tel: (250) 656-0858
Toll Free: 1 877 656-0858
Fax: (250) 656-0868
Website: www.tseycum.ca
Website: www.fnbc.info

Victoria Native Friendship Centre
231 Regina Avenue,
Victoria, BC V8Z 1J6
Tel: (250) 384-3211
Fax: (250) 384-1586
Website: www.vnfc.ca

DETOXIFICATION (WITHDRAWAL MANAGEMENT)

BC Mental Health & Addictions
1119 Pembrooke Street,
Victoria, BC V8T 1J5
Tel: (250) 519-3485

Specialized Youth Detox (SYD)
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: syd@vyes.ca

EMPOYEE ASSISTANCE PROGRAMS

EFAP Employee & Family Assistance
Program BC
514 – 750 West Broadway,
Vancouver, BC V5Z 1H4
Tel: (604) 872-4929
Toll-free 1-800-505-4929
Fax: (604) 872-7430
Website: www.efap.ca
Email: help@efap.ca

Shepell : The EFAP Specialists
400 - 411 Dunsmuir Street,
Vancouver, BC V6Z 2K8
Toll-free: 1 866 833-7690
Tel: (604) 642-5200
Fax: (604) 632-9930
Website: www.shepell.com

Pacific Centre Family
Services Association
3221 Heatherbell Road,
Victoria, BC V9C 1T3
Tel: (250) 478-8357
Toll Free: 1 866 478-8357
Fax: (250) 478-3699
Email: pacificcentre@pcfsa.org
Website: www.pacificcentrefamilyservices.org

Pacific Centre Family Services Association
3221 Heatherbell Road
Victoria, BC V9C 1Y8
Tel: (250) 478-8357
Fax: (250) 478-3699
Email: pcfsa@coastnet.com

Doctors of BC
Suite #115 – 1665 West Broadway
Vancouver, BC V6J 5A4
Tel: (604) 736-5551 or
Toll Free: 1 800 665-2262
Email: benefits@doctorsofbc.ca
Website: www.doctorsofbc.ca

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Best Babies Programs
Access Midwifery & Family Care
Suite #208 – 2951 Tillicum Road,
Victoria, BC V9A 2A6
Tel: (250) 380-6329
Fax: (250) 380-6436
Email: info@accessmidwifery.ca
Website: www.accessmidwifery.ca

METHADONE TREATMENT

Outreach Services Clinic
603 Gorge Road East,
Victoria, BC V8T 2W7
Tel: (250) 480-1232
Toll-free: 1-877-480-1232
Fax: (250) 480-1231
Website: www.outreachservicesclinic.com

MUTUAL SUPPORT GROUPS

Adult Children of Alcoholics (ACA)
Victoria, BC
Website: www.adultchildren.org/meeting-search/

Alano Club (Victoria)
1402 Broad Street,
Victoria, BC V8W 2B1
Tel: (250) 383-9151 or
Tel: (250) 383-7803

Al-Anon/Alateen – Victoria
2020 Douglas Street,
Victoria, BC V8T 4L1
Tel: (250) 383-4020 (24 hours)

Alcoholics Anonymous – Victoria
AA Central Office
Suite #8 – 2020 Douglas Street,
Victoria, BC V8T 4L1
Tel: (250) 383-7744 (24 hours) or
Tel: (250) 383-0415 (Business)
Fax: (250) 383-0417
Email: vicintgpco@shaw.ca
Website: www.aavictoria.ca

Parents Together
Boys and Girls Clubs Services of Greater Victoria
1240 Yates Street,
Victoria, BC V8V 3N3
Tel: (250) 474-6468 (Parent line) or
Tel: (250) 384-9133 (Office)
Fax: (250) 474-6629
Email: parentstog@bgcvic.org

NEEDLE EXCHANGE PROGRAMS

Street Outreach Nurse Program
Island Health
1947 Cook Street,
Victoria, BC V8T 3P7
Tel: (250) 361-7056
Tel: (250) 388-2225 (Office)
Fax: (250) 388-2228
Website: www.islandhealth.ca

AIDS Vancouver Island-Victoria
1601 Blanshard Street,
Victoria, BC V8W 2J5
Tel: (250) 384-2366
Toll Free: 1 800 665-2437
Fax: (250) 380-9411
Email: info@avi.org
Website: www.avi.org/victoria

NON-RESIDENTIAL TREATMENT

Full Circle Women's Day Program
Dallas Services Society
304 - 1095 McKenzie Avenue,
Victoria, BC V8P 2L5
Tel: (250) 727-3544
Fax; (250) 727-2205

OUTPATIENT TREATMENT

Ahousat Holistic Recovery Centre Society
458 Ahousat Reserve
Ahousat, BC V0R 1A0
Tel: (250) 670-9558
Fax: (250) 670-9554
Email: ahousat1@telus.net
Website: www.ahousat.ca

Salt Spring Island
Community Services Society
268 Fulford-Ganges Road,
Salt Spring Island, BC V8K 2K6
Tel: (250) 537-9971
Fax: (250) 537-9974
Email: www.saltspringcommunityservices.ca

Tsartlip Band Health Centre
Unit #3 Boat Ramp Road,
Brentwood Bay, BC V8M 1N9
Tel: (250) 652-4473
Toll Free: 1 800 681-2349
Fax: (250) 652-4525
Website: www.tsartlip.com

Dallas Services Society
304 - 1095 McKenzie Avenue,
Victoria, BC V8P 2L5
Tel: (250) 727-3544
Fax; (250) 727-2205

Getting Off Alcohol and Substances (GOALS)
Victoria Youth Empowerment Society
533 Yates Street
Victoria, BC V8W 1K7
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: office_manager@vyes.ca
Website: www.vyes.ca

Tsawout First Nation
Health Services
7728 Tetayut Road,
Saanichton, BC V8M 2E4
Tel: (250) 652-1149
Fax: (250) 652-8886

Older Adult Mental Health & Addiction Outpatient Services
2828 Nanaimo Street,
Victoria, BC V8T 4W9
Tel: (250) 953-3966
Fax: (250) 356-9342
Website: www.viha.ca

Outreach Alcohol and Drug Services
Victoria Cool Aid Society
Suite #101 – 749 Pandora Avenue,
Victoria, BC V8W 1N9
Tel: (250) 383-1977
Fax: (250) 383-1639
Email: society@coolaid.org
Website: www.coolaid.org

Pacific Centre Family Services Association
3221 Heatherbell Road,
Victoria, BC V9C 1T3
Tel: (250) 478-8357
Toll Free: 1 866 478-8357
Fax: (250) 478-3699
Email: pacificcentre@pcfsa.org
Website: www.pacificcentrefamilyservices.org

Mental Health & Addictions
VIHA
2nd Floor - 1250 Quadra Street,
Victoria, BC V8W 2K7
Tel: (250) 519-3554
Fax: (250) 519-3545
Website: www.viha.ca/mhas

Senior Outreach Team
Vancouver Island
Health Authority
2828 Nanaimo, Street
Victoria, BC V8T 4W9
Tel: (250) 519-3556
Fax: (250) 519-3567
Website: www.viha.ca/mhas

Victoria Native Friendship Centre
231 Regina Avenue,
Victoria, BC V8Z 1J6
Tel: (250) 384-3211
Fax: (250) 384-1586
Website: www.vnfa.ca

Youth Alcohol & Drug Outreach
YM – YWCA of Greater Victoria
880 Courtney Street,
Victoria, BC V8W 1C4
Tel: (250) 386-7511
Fax: (250) 380-1933
Website: www.victoriay.com

Community Medical Detox
Victoria – Eric Martin Pavilion
2334 Trent Street,
Victoria, BC V8S 4Z3
Tel: (250) 519-7708
Crisis Line: 1 888 494-3888
Website: www.islandhealth.ca

Specialized Youth
Detox (SYD)
Tel: (250) 383-3514
Fax: (250) 383-3812
Email: syd@vyes.ca

RESIDENTIAL TREATMENT

Senior Outreach Team
Vancouver Island
Health Authority
2828 Nanaimo, Street
Victoria, BC V8T 4W9
Tel: (250) 519-3556
Fax: (250) 519-3567
Website: www.viha.ca/mhas

Victoria Life Enrichment Society
Suite #404 – Elk Lake Drive,
Victoria, BC V8Z 0B4
Tel: (250) 652-5100

SUPPORTIVE RECOVERY SERVICES

Outreach Alcohol and Drug Services
Victoria Cool Aid Society
Suite #101 – 749 Pandora Avenue,
Victoria, BC V8W 1N9
Tel: (250) 383-1977
Fax: (250) 383-1639
Email: society@coolaid.org
Website: www.coolaid.org

YOUTH PROGRAMS

Dallas Services Society
304 - 1095 McKenzie Avenue,
Victoria, BC V8P 2L5
Tel: (250) 727-3544
Fax; (250) 727-2205

Youth Supportive Recovery Care Homes
Boys & Girls Club Services of Greater Victoria
Suite #310 – 1195 Esquimalt Road,
Victoria, BC V9A 3N6
Tel: (250) 384-9133
Fax: (250) 384-9136
Email: info@bgcvic.org
Website: www.bgcvic.org

NORTHERN BRITISH COLUMBIA

ALCOHOL AND DRUG SERVICES — MINISTRY FOR CHILDREN & FAMILY DEVELOPMENT

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Detox Centre / Renner House
Axis Family Resources
Williams Lake, BC V2G 2A1
Tel: (250) 392-1800
Fax: (250) 398-2841

Northern Health
Suite #600 - 299 Victoria Street,
Prince George, BC V2L 5B8
Tel: (250) 565-2649
Toll Free: 1 866 565-2999
Fax: (250) 565-2640
Website: www.northernhealth.ca

Soda Creek First Nation
3405 Mountain House Road,
Williams Lake, BC V2G 5L5
Tel: (250) 989-2323
Fax: (250) 989-2300
Website: www.xatsull.com

Interior Health – Public Health
Williams Lake Mental Health Centre
540 Borland Street,
Williams Lake, BC V2G 1R9
Tel: (250) 392-1483
Fax: 250) 392-1484
Website: www.interiorhealth.ca

Social Work Services –
South Cariboo Health Centre
555 D Cedar Avenue,
100 Mile House, BC V0K 2E0
Tel: (250) 395-7676
Fax: (250) 395-7675
Website: www.interiorhealth.ca

EMPLOYEE ASSISTANCE PROGRAMS — DETOX

Prince George Detox/Assessment Unit
(Prince George - Addiction Services)
University Hospital of Northern
British Columbia (UHNBC)
1475 Edmonton Street,
Prince George, BC V2M 1S2
Tel: (250) 565-2000
Fax: (250) 565-2343
Website: www.northernhealth.ca

FETAL ALCOHOL SYNDROME (FAS) RESOURCES

POPFASD, the Provincial Outreach
Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Baby's Best Chance Dawson Creek
Nawican Friendship Centre
1320 – 102nd Avenue,
Dawson Creek, BC V1G 2C6
Tel: (250) 782-8448
Fax: (250) 785-4659
Website: www.optionsforsexualhealth.org

Cariboo Family Connections
Cariboo Family Enrichment Centre
215 Fourth Street
Mailing address: PO Box 2427
100 Mile House, BC V0K 2E0
Tel: 250-395-5155
Fax: 250-395-1811

Building Healthier Babies
Terrace Child Development Centre
4665 SW Park Avenue,
Terrace, BC V8G 1V9
Tel: (250) 635-1830
Fax: (250) 635-1501
Email: b.b@telus.net
Website: www.terracechilldevelopmentcentre.ca

Cariboo Family Enrichment Centre
Unit #1 – 486 Birch Avenue,
100 Mile House, BC V0K 2E0
Tel: (250) 395-5155
Fax: (250) 395-1811
Email: cfec@cariboofamily.org
Website: www.cariboofamily.org

Cariboo Friendship Society
Pregnancy Outreach Program
99 South Third Avenue,
Williams Lake, BC V2G 1J1
Tel: (250) 398-6831
Fax: (250) 398-6115
Email: admin@cfswl.ca
Website: www.cariboofriendshipsociety.ca

POPFASD, the Provincial Outreach
Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive,
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Friendship House Association
of Prince Rupert Pregnancy Outreach Program
744 Fraser Street,
Prince Rupert, BC V8J 1P9
Tel: (250) 627-1717
Fax: (250) 627-7533
Email: reception@friendshiphouse.ca
Website: www.bcaafc.com

Healthy Babies Program
Wet'suwet'en First Nation
Suite #1 - 205 Beaver Road,
Smithers, BC V0J 2N1
Tel: (250) 847-3613
Fax: (250) 847-5381

Healthy Babies Program
Kitimat Child Development Centre
1515 Kingfisher Avenue,
Kitimat, BC V8C 1S5
Tel: (250) 632-3144
Fax: (250) 632-3120
Email: info@kitimatcdc.ca
Website: www.kitimacdc.ca

Grace Lynn Family Centre
Medical & Health
2510 Highway 62,
Hazelton, BC V0J 1Y1
Tel: (250) 842-4608
Fax: (250) 842-4633

HIV/AIDS

Outreach Prince Rupert
Mental Health & Addiction Services
Suite #300 - 3rd Avenue West,
Prince Rupert, BC V8J 1L4
Tel: (250) 622-6380
Fax: (250) 622-6391
Website: www.northernhealth.ca

Positive Living North
3862 - F Broadway Avenue,
PO Box 4368
Smithers, BC V0J 2N0
Tel: (250) 877-0042
Tol1 Free: 1 866 877-0042
Website: www.positivelivingnorth.org

OUTPATIENT TREATMENT

Bella Coola Community Support Society
1028 Elcho Street,
PO Box 22,
Bella Coola, BC V0T 1C0
Tel: (250) 799-5588
Fax: (250) 799-5791
Website: www.bccss.net

Dawson Creek Adult
Mental Health & Addictions
1001 – 110th Avenue,
Dawson Creek, BC V1G 4X3
Tel: (250) 719-6500
Fax: (250) 719-6513
Website: www.northernhealth.ca

Dze L K'ant Friendship Centre Society
Alcohol and Drug Program
1188 Main Street,
PO Box 2920,
Smithers, BC V0J 2N0
Tel: (250) 847-5211
Fax: (250) 847-5144
Email: info@dzelkant.com
Website: www.dzelkant.com

Esk'etemc First Nations Health Service
1004 Esk'et Drive,
PO Box 157,
Alkali Lake, BC V0L 1B0
Tel: (250) 440-5611
Fax: (250) 440-5614
Email: adminassistant@esketemc.ca
Website: www.esketemc.ca

Fort St. John Keeginaw
Friendship Centre - FSJ
10208 – 95th Avenue,
Fort St. John, BC V1J 1J2
Tel: 250-785-3411
Email: friendship@bluenova.ca
Website: www.bcaafc.com

Namgis Health Centre
48 School Road,
Alert Bay, BC V0N 1A0
Tel: (250) 974-5522
Fax: (250) 974-5900
Email: info@namgis.bc.ca
Website: www.namgis.bc.ca

Nenqayni Treatment Centre
PO Box 2529
Williams Lake, BC V2G 4P2
Tel: 250 989-0301
Fax: 250 989-0307
E-mail: Nenqayni@wlake.com

North Wind Healing Centre
5524 Graham Road,
Farmington, BC V0C 1N0
Tel: (250) 843-6977
Toll Free: 1 888 698-4333
Fax: (250) 843-6978
E-mail: t8heal@pris.bc.ca
Website: www.northwindwellnesscentre.ca

Ulkatcho Indian Band
Addiction Services Ulkatcho Council
PO Box 3430,
Anahim Lake, BC V0L 1C0
Tel: (250) 742-2090
Fax: (250) 742-3411
Website: www.carrierchilcotin.org

Yellowhead Community Services
612 Park Drive,
Clearwater, BC V0E 1N1
Tel: (250) 674-2600
Fax: (250) 674-2676
Email: info@yellowheadcs.ca
Webmail: www.yellowheadcs.ca

OUTPATIENT TREATMENT — DAY TREATMENT

Alcohol and Drug Program
Nawican Friendship Centre
1320 - 102nd Avenue,
Dawson Creek, BC V1G 2C5
Tel: (250) 782-5502
Fax: (250) 782-5514
Website: www.nlc.bc.ca

Fort St. John Keeginaw
Friendship Centre - FSJ
10208 – 95th Avenue,
Fort St. John, BC V1J 1J2
Tel: 250-785-3411
Email: friendship@bluenova.ca
Website: www.bcaafc.com

Gitxsan Alcohol & Drug Counselling
Gitxsan Health Society
PO Box 223,
Hazelton, BC V0J 1Y0
Tel: (250) 842-5165
Fax: (250) 842-2186
Website: www.gitxsanhealth.com

Mental Health & Substance Use
Services – Gateway Crisis Unit
3rd Floor – 517 North 6th Avenue,
Williams Lake, BC V2G 2P3
Tel: (250) 392-8261
Fax: (250) 392-8262
Website: www.interiorhealth.ca

Nenqayni Treatment Centre
Family Alcohol & Drug
PO Box 2529,
Williams Lake, BC V2G 4P2
Tel: (250) 989-0301 Ext. 206
Toll Free: 1 888 668-4245
Fax: (250) 989-0307
E-mail: jevens@nenqayni.com
Website: www.nenqayni.com

Northern Health
Suite #600 - 299 Victoria Street,
Prince George, BC V2L 5B8
Tel: (250) 565-2649
Toll Free: 1 866 565-2999
Fax: (250) 565-2640
Website: www.northernhealth.ca

Quesnel Tillicum Society
Native Friendship Centre
319 North Fraser Drive,
Quesnel, BC V2J 1Y9
Tel: (250) 992-8347
Fax: (250) 992-5708
Email: tony.goulet@qnfc.bc.ca
Website: www.quesnet-friendship.org

Saint Patrick's House Society
1735 Yew Street,
Prince George, BC V2L 2X3
Tel: (250) 564-5530
Fax: (250) 564-2932

Soda Creek First Nation
3405 Mountain House Road,
Williams Lake, BC V2G 5L5
Tel: (250) 989-2323
Fax: (250) 989-2300
Website: www.xatsull.com

Southside Health and Wellness Centre
27920 Wellness Way,
Burns Lake, BC V0J 1E4
Tel: (250) 694-3270
Fax: (250) 694-3290
Email: southsidewellness@hotmail.com
Website: www.southsidewellness.ca

Three Sisters Haven Society
(People's Haven Society)
PO Box 59,
Telegraph Creek, BC V0J 2W0
Tel: (250) 771-5575
Toll Free: 1 888 414-2836
Website: www.bwss.org

RESIDENTIAL TREATMENT

Carrier Sekani Family Services
987 – 4th Avenue
Prince George, BC V2L 3H7
Tel: (250) 562-3591
Toll Free: 1 800 889-6855
Fax: (250) 562-2272
Website: www.csfs.org

Prince George Detox/Assessment Unit
(Prince George - Addiction Services)
University Hospital of Northern
British Columbia (UHNBC)
1475 Edmonton Street,
Prince George, BC V2M 1S2
Tel: (250) 565-2000
Fax: (250) 565-2343
Website: www.northernhealth.ca

Nenqayni Treatment Centre
Family Alcohol & Drug
PO Box 2529,
Williams Lake, BC V2G 4P2
Tel: (250) 989-0301 Ext. 206
Toll Free: 1 888 668-4245
Fax: (250) 989-0307
E-mail: jevens@nenqayni.com
Website: www.nenqayni.com

North Wind Healing Centre
5524 Graham Road,
Farmington, BC V0C 1N0
Tel: (250) 843-6977
Toll Free: 1 888 698-4333
Fax: (250) 843-6978
E-mail: t8heal@pris.bc.ca
Website: www.northwindwellnesscentre.ca

Vanderhoof Addiction Recovery Program
240 West Stewart Street,
Vanderhoof, BC V0J 3A0
Phone: (250) 567-2900
Toll Free: 1 866 567-2333
Fax: (250) 567-2975
Email: arp@csfs.org
Website: www.csfs.org

SUPPORTIVE RECOVERY

Canim Lake Band
Alcohol and Drug Abuse Program
PO Box 1030,
100 Mile House, BC V0K 2E0
Tel: (250) 397-2717
Fax: (250) 397-4155
Email: reception@canimlakeband.com
Website: www.canimlakeband.com

Haisla Nation
Support & Recovery Centre
500 Gitksan Avenue,
Kitamaat Village, BC V0T 2B0
Tel: (250) 639-9817
Website: www.haisla.ca

Simpcw Health Programs
Simpcw First Nation
PO Box 220,
Barriere, BC V0E 1E0
Tel: (250) 672-9995
Toll Free: 1 800 678-1129
Fax: (250) 672-5858
Email: Health.Clerk@simpcw.com
Website: www.simpcw.com

MUTUAL SUPPORT GROUPS

Al-Anon – 100 Mile House
100 Mile House, BC
Linda: (250) 395-4646
Vicky: (250) 395-4744
Website: www.bcyukon-al-anon.org

Lakes District
Counselling Services Society
132 – B Francois Lake Drive,
Burns Lake, BC V0J 1E0
Tel: (250) 692-7577
Fax: (250) 692-3935
Email: Kelly.turford@ld-cs.ca
Website: www.lakesdistrictcommunityservices.ca

Alcoholics Anonymous (AA)
BC/Yukon AA
Find A Meeting Near You
Tel: (604) 435-2181
Website: www.bcyukonaa.org

Narcotics Anonymous BC
Find A Meeting Near You
Toll Free: 1 888 543-2499
Website: www.bcrna.ca

Cocaine Anonymous BC
Find A Meeting Near You
Toll Free: 1 866 662-8300
Website: www.ca-bc.org/meetings.html

COMMUNITY-BASED PREVENTION PROGRAMS

Northern Health
Suite #600 - 299 Victoria Street,
Prince George, BC V2L 5B8
Tel: (250) 565-2649
Toll Free: 1 866 565-2999
Fax: (250) 565-2640
Website: www.northernhealth.ca

Tl'etinqox-t'in Health Services
PO Box 168,
Alexis Creek, BC V0L 1A0
Tel: (250) 394-4212
Toll Free: 1 888 224-3322
Fax: (250) 394-4275
Website: www.tletinqox.ca

Saulteau First Nations
PO Box 1020
Chetwynd, BC V0C 1J0
Admin: (250) 788-3955
Fax: (250) 788-7251
Email: reception@saulteau.com
Website: www.saulteau.com

Bonaparte Indian Band
Drug & Alcohol Program
2689A Sage Hill Road,
Cache Creek, BC V0K 1H0
Tel: (250) 457-9624
Toll Free: 1 877 457-4944
Fax: (250) 457-9550
Email: wellness@bonaparteindianband.com
Website: www.bonaparteindianband.com

Hazelton Community Health
Northern Health Authority
2510 Highway 62
Hazelton, BC V0J 1Y0
Tel: (250) 842-4640
Fax: (250) 842-4642
Website: www.northernhealth.ca

Quesnel Mental Health
& Addiction Services
GR Baker Memorial Hospital
543 Front Street,
Quesnel, BC V2J 2K7
Tel: (250) 992-5600
Fax: (250) 992-5652
Website: www.northernhealth.ca

Dawson Creek Adult
Mental Health & Addictions
1001 – 110th Avenue
Dawson Creek, BC V1G 4X3
Tel: (250) 719-6500
Fax: (250) 719-6513
Website: www.northernhealth.ca

Friendship House Association
of Prince Rupert
744 Fraser Street,
Prince Rupert, BC V8J 1P9
Tel: (250) 627-1717
Fax: (250) 627-7533
Email: reception@friendshiphouse.ca
Website: www.friendshiphouse.ca
Website: www.bcaafc.com

Xaxli'p Indian Band
Fountain Valley Road,
PO Box 2168,
Lillooet, BC V0K 1V0
Tel: (250) 256-4800
Toll Free: 1 888 321-2711
Fax: 250-256-0085
Email: healthmanager@xaxlip.ca
Website: www.xaxlip.ca

Gitanmaax Band Council
4240 Field Street,
PO Box 440,
Hazelton, BC V0J 1Y0
Tel: (250) 842-5297
Fax: (250) 842-6364
Email: info@gitanmaax.com
Website: www.gitanmaax.com

Gitwangak Band Council
Mental Health Counsellor
149 Bridge Street,
PO Box 550,
Kitwanga, BC V0J 2A0
Tel: (250) 849-5555
Fax: (250) 849-5531
Website: www.fnbc.info

Haisla Nation
Support & Recovery Centre
500 Gitksan Avenue,
Kitamaat Village, BC V0T 2B0
Tel: (250) 639-9817
Website: www.haisla.ca

Iskut Band Office
Health
PO Box 30,
Iskut, BC V0J 1K0
Contact: Peggy Abou
Tel: (250) 234-3511
Tel: (250) 234-3331 (Band Office)
Fax: (250) 234-3200
Email: info@iskut.org
Website: www.iskut.org

Nisga'a Valley
Health Authority
4920 Tait Avenue,
PO Box 234,
Gitlaxt'aamiks, BC V0J 1A0
Tel: (250) 633-5000
Toll Free: 1 888 233-2212
Fax: (250) 633-2512
Website: www.nisgaahealth.bc.ca

Kermode Friendship Society
Drugs & Alcohol
3313 Kalum Street,
Terrace, BC V8G 2N7
Tel: (250) 635-7670
Fax: (250) 635-7650
Website: www.kermodefriendship.ca

Kispiox Band Council
Drugs & Alcohol
1336 Kispiox Valley Road,
Kispiox, BC V0J 1Y4
Tel: (250) 842-6314
Toll Free: 1 877 842-5911
Fax: (250) 842-5604
Email: reception@kispioxband.ca
Website: www.kispioxband.com

Kitsumkalum Band Council
Drugs & Alcohol
3514 West Kalum Road,
PO Box 544,
Terrace, BC V8G 4B5
Tel:(250) 635-6177
Toll Free: 1 877 635-6177
Fax: (250) 635-4622
Email: kitsumkalum@citywest.ca
Website: www.kitsumkalum.com

Lax Kw'alaams Band
Health Centre
1602 Legaic Street,
Lax Kw'alaams, BC V0V 1H0
Tel: (250) 625-3331
Fax: (250) 625-3624
Email: reception@laxband.com
Website: www.laxkwalaams.ca

Lillooet Friendship Centre Society
Addiction Services
357 Main Street PO Box 2170
Lillooet, BC V0K 1V0
Tel: (250) 256-4146
Fax: (250) 256-7928
Email: info@lfcs.ca
Website: www.lfcs.ca

Lower Post First Nation
Addition Services
PO Box 10,
Building 29,
Lower Post, BC V0C 1W0
Tel: (250) 779-3161
Fax: (250) 779-3371
Website: www.fnbc.info

Lower Post First Nation
Addition Services
PO Box 10,
Building 29,
Lower Post, BC V0C 1W0
Tel: (250) 779-3161
Fax: (250) 779-3371
Website: www.fnbc.info

Mackenzie Counselling Services Society
500 Mackenzie Blvd.,
PO Box 790,
Mackenzie, BC V0J 2C0
Tel: (250) 997-6595
Fax: (250) 997-3903
Email: reception@mackenziecounselling.ca
Website: www.mackenziecounselling.ca

McLeod Lake Indian Band
Health
61 Tse'khene Drive,
General Delivery,
McLeod Lake, BC V0J 2G0
Tel: (250) 750-4415
Toll Free: 1 888 822-1143
Fax: (250) 750-4420
Website: www.mlib.ca

Prince George Detox
Addiction Services
Northern Health Authority
1308 Alward Street,
Prince George, BC V2M 7B1
Tel: (250) 565-2387
Fax: (250) 565-2106
Website: www.northernhealth.ca

Prince George Native
Friendship Centre
(PGNFC)
Native Healing Centre
1600 - 3rd Avenue,
Prince George, BC V2L 3G6
Tel: (250) 564-3568
Fax: (250) 563-0924
Email: info@pgnfc.com
Website: www.pgnfc.com

Prince Rupert Mental Health
& Addiction Services (PRMHADS)
300 – 3rd Avenue West,
Prince Rupert, BC V8J 1L4
Tel: (250) 622-6310
Fax: (250) 622-6391
Website: www.northernhealth.ca

Stewart Health Centre
Northern Health Authority
904 Brightwell Street,
PO Box 8,
Stewart, BC V0T 1W0
Tel: (250) 636-2221
Fax: (250) 636-2715
Website: www.northernhealth.ca

Takla Lake First Nations
Nursing Station
Takla Landing, BC V0J 2T0
Tel: (250) 996-7877
Toll Free: 1 877 794-7877
Fax: (250) 996-7874
Email: social@taklafn.ca
Website: www.taklafn.ca

Terrace & District
Community Services Society
Suite #200 – 3219 Eby Street,
Terrace, BC V8G 4R3
Tel: (250) 635-3178
Email: info@tdcss.ca
Website: www.tdcss.ca

Tl'azt'en Nation
Drug & Alcohol
PO Box 670
Fort St. James, BC V0J 1P0
A-A Hotline: (250) 564-7550
Crisis Line: 1 888 562-1214 (24 Hour)
Website: www.tlaztennation.ca

Tansi Friendship Centre Society
5301 South Access Road,
PO Box 418,
Chetwynd, BC V0C 1J0
Tel: (250) 788-2996
Fax: (250) 788-2353
Email: reception@tansifcs.com
Website: www.tansifcs.com

Stellat'en First Nation
Health Centre
PO Box 2055,
Fraser Lake, BC V0J 1S0
Tel: (250) 699-8922
Fax: (250) 699-7704
Website: www.stellaten.ca

Big Water Society
Healthy Families
PO Box 324
Atlin, BC V0W 1A0
Tel: (250) 651-2189
Fax: (250) 651-2460
Email: bwsociety@bigwatersociety.org
Website: www.bigwatersociety.org

Heiltsuk Health Centre
212 Wabalisla Street,
PO Box 819,
Bella Bella, BC V0T 1Z0
Tel: (250) 957-2308
Fax: (250) 957-2311
Email: medricr@heiltsukhealth.com
Website: www.heiltsukhealth.com

Lake Babine Nation
Health Services
Woyenne Health Centre
225 Sus Avenue,
PO Box 297,
Burns Lake, BC V0J 1E0
Tel: (250) 692-4720
Toll Free: 1 888 692-3214
Fax: (250) 692-4792
Email: receptionist@lakebabine.com
Website: www.lakebabine.com

Quesnel Addiction Services
GR Baker Hospital
543 Front Street,
Quesnel, BC V2J 2K7

Tel: (250) 985-5600
Fax: (250) 992-5652
Website: northernhealth.ca

Robson Valley Mental Health & Addiction Program
McBride & District Hospital
1136 5th Avenue
PO Box 669
McBride, BC V0J 2E0
Tel: (250) 569-2251
Fax: (250) 569-2230
Website: www.northerhealth.ca

Carrier Sekani Family Services
987 – 4th Avenue
Prince George, BC V2L 3H7
Tel: (250) 562-3591
Toll Free: 1 800 889-6855
Fax: (250) 562-2272
Website: www.csfs.org

Tahltan Band Council
Health
PO Box 46,
Telegraph Creek, BC V0J 2W0
Tel: (250) 235-3151
Fax: (250) 235-3244
Email: info@palebluedot.ca
Website: www.tahltan.ca

Nation T'itq'et First Nations
59 Retasket Drive,
PO Box 615
Lillooet, BC V0K 1V0
Tel: (250) 256-4118
Fax: (250) 256-4544
Email: phatpat10@gmail.com
Website: www.titqet.org

Ts'kw'aylaxw First Nation
Health
35100 Hwy. 99 North,
PO Box 609,
Lillooet, BC V0K 1V0
Tel: (250) 256-4204
Toll Free: 1 800 669-1955
Fax: (250) 256-4058
Email: reception@tskwaylaxw.com
Website: www.tskwaylaxw.com

Vanderhoof Alcohol and Drug Services
Fort Alcohol and Drug Services Society
192 West Stewart Street,
Mailing address: PO Box 688,
Vanderhoof, BC V0J 3A0
Tel: 250-567-2107
Fax: 250-567-2780
Website: www.hwy16.com/vads

Wet'suwet'en First Nation
Health
PO Box 760,
Burns Lake, BC V0J 1E0
Tel: (250) 698-7307
Fax: (250) 698-7480
Email: info@wetsuwetenfirstnation.com
Webstie: www.wetsuwetenfirstnation.com

Williams Lake Mental Health Centre
540 Borland Street,
Williams Lake, BC V2G 1R9
Tel: (250) 392-1483
Fax: 250) 392-1484
Website: www.interiorhealth.ca

SCHOOL-BASED PREVENTION PROGRAMS

Big Water Society
Healthy Families
PO Box 324
Atlin, BC V0W 1A0
Tel: (250) 651-2189
Fax: (250) 651-2460
Email: bwsociety@bigwatersociety.org
Website: www.bigwatersociety.org

Williams Lake Mental Health Centre
540 Borland Street,
Williams Lake, BC V2G 1R9
Tel: (250) 392-1483
Fax: (250) 392-1484
Website: www.interiorhealth.ca

SUPPORTIVE RECOVERY RESIDENTIAL SERVICE

Cariboo Friendship Society
Supportive Recovery Services
99 South 3rd Avenue
Williams Lake, BC V2G 1J1
Tel: (250) 398-6831
Fax: (250) 398-6115
Website: www.caribooofriendshpsociety.ca

WOMENS' EMERGENCY SHORT-TERM HOUSING

Amata Transition House Society
PO Box 4076,
Quesnel, BC V2J 3J2
Tel: (250) 249-0060
Email: dorosh@quesnelbc.com
Website: www.bcsth.ca

Williams Lake Mental Health
Centre & Addictions Services
540 Borland Street,
Williams Lake, BC V2G 1R9
Tel: (250) 392-1483
Fax: (250) 392-1484
Website: www.interiorhealth.ca

Phoenix House Program
Phoenix Transition Society
1770 - 11th Avenue,
Prince George, BC V2L 3S8
Tel: (250) 563-7305
Fax: (250) 563-2792

North Coast Transition Society
Canadian Women's Health Network
PO Box 907,
Prince Rupert, BC V8J 4B7
Tel: (250) 627-8959
Fax: (250) 624-3919
Email: nctspr@gmail.com
Website: www.cwhn.ca

YOUTH ADDICTIONS SERVICES

ATLAS Youth Facility
Terrace & District
Community Services Society
Suite #200 – 3219 Eby Street,
Terrace, BC V8G 4R3
Tel: (250) 635-3178
Email: info@tdcss.ca
Website: www.tdcss.ca

Dze L K'ant Friendship
Centre Society
1188 Main Street,
PO Box 2920
Smithers, BC V0J 2N0
Tel: (250) 847-5211
Fax: (250) 847-5144
Email: info@dzelkant.com
Website: www.dzelkant.com

Axis Family Resources Ltd.
321 North 2nd Avenue,
Williams Lake, BC V2G 2A1
Tel: (250) 392-1000
Toll Free: 1 877 392-1003
Fax: (250) 392-1003
Email: info@axis.bc.ca
Website: www.axis.bc.ca

Prince George Detox
Addiction Services
Northern Health Authority
1308 Alward Street,
Prince George, BC V2M 7B1
Tel: (250) 565-2387
Fax: (250) 565-2106
Website: www.northernhealth.ca

Quesnel Addiction Services
GR Baker Hospital
543 Front Street,
Quesnel, BC V2J 2K7
Tel: (250) 985-5600
Fax: (250) 992-5652
Website: northernhealth.ca

Youth Around Prince (YAP)
Resource Centre
1160 – 7th Avenue,
Prince George, BC V2L 5G6
Tel: (250) 645-4010
Fax: (250) 565-4209
Email: youth@nbcy.org
Website: www.youtharoundprince.org

Nenqayni Treatment Centre
Youth & Family Inhalant
PO Box 2529,
Williams Lake, BC V2G 4P2
Tel: (250) 989-0301 Ext. 206
Toll Free: 1 888 668-4245
Fax: (250) 989-0307
E-mail: jevens@nenqayni.com
Website: www.nenqayni.com

SOUTHERN INTERIOR

ALCOHOL AND DRUG SERVICES — MINISTRY FOR CHILDREN & FAMILY DEVELOPMENT

North Okanagan Friendship Centre Society
2904 29th Avenue,
Vernon, BC V1T 1Y8
Tel: (250) 542-1247
Fax: (250) 542-3707
Email: ed@fnfc.ca

DETOX

Trail – Addiction Service
Kootenay Boundary Regional Hospital
1200 Hospital Bench,
Trail, BC V1R 4M1
Tel: (250) 368-3311
Fax: (250) 364-3422
Website: www.interiorhealth.ca

Penticton – Addiction Service
Penticton Regional Hospital
550 Carmi Avenue,
Penticton, BC V2A 3G6
Tel: (250) 492-4000
Fax: (250) 492-9068
Website: www.interiorhealth.ca
Crossroads Treatment Centre Society
123 Franklyn Road,
Kelowna, BC V1X 6A9
Tel: (250) 860-4001
Toll Free: 1 866 860-4001
Fax: (250) 860-2605
Email: info@xrdstc.net
Website: www.crossroadstc.ca

East Kootenay Addiction Services Society
East Kootenay Regional Hospital
13 – 24th Avenue North,
Cranbrook, BC V1C 3H9
Tel: (250) 426-5281
Toll Free: 1 866 288-8082
Fax: (250) 426-5285
Website: www.interiorhealth.ca

Okanagan Families Society
260 Harvey Avenue,
Kelowna, BC V1Y 7S5
Tel: (250) 869-0585
Fax: 250-763-4910

The Bridge Youth & Family Services Society - Kelowna
1829 Chandler Street,
Kelowna, BC V1Y 3Z2
Tel: (250) 763-0456
Email: info@thebridgeservices.ca
Website: www.thebridgeservices.ca

EMERGENCY — ACUTE INTERVENTION FACILITIES

Boundary Mental Health
& Substance Use Services
Interior Health Authority
7441 – 2nd Street,
Grand Forks, BC V0H 1H0
Tel: (250) 442-0330
Fax: (250) 442-0334
Website: www.interiorhealth.ca

John Howard Society
of The North Okanagan
2307 – 43rd Street,
Vernon, BC V1T 6K7
Tel: (250) 542-3555
Fax: (250) 542-3213
Website: www.johnhowardbc.ca

FETAL ALCOHOL SYNDROME (FAS)

POPFASD, the Provincial Outreach Program for Fetal Alcohol Spectrum Disorder
3400 Westwood Drive
Prince George, BC V2N 1S1
Tel: (250) 564-6574 ext. 2020
Mr. Stacey Wakabayashi
Senior Teacher Consultant
Tel: (250) 564-6574 ext. 2019
Email: swakabayshi@sd57.bc.ca
Website: www.fasdoutreach.ca

Baby's Head Start
Interior Community Services
396 Tranquille Road,
Kamloops, BC V2B 3G7
Tel: (250) 554-3134
Fax: (250) 554-1833
Website: www.interiorcommunityservices.bc.ca

Boundary Mental Health
& Substance Use Services
Interior Health Authority
7441 – 2nd Street,
Grand Forks, BC V0H 1H0
Tel: (250) 442-0330
Fax: (250) 442-0334
Website: www.interiorhealth.ca

Kootenay Kids Society
312 Silica Street,
Nelson, BC V1L 4M5
Tel: (250) 352-6678 (Ext. 227)
Website: www.frpbc.ca

Pregnancy Outreach Program
First Nations Friendship Centre
2902 – 29th Avenue,
Vernon, BC V1T 1Y7
Tel: (250) 542-5448
Fax: (250) 542-3707
Email: prenatal@fnfc.ca

HIV/AIDS

AIDS Network Kootenay
Outreach and Support Society (ANKORS)
101 Baker Street,
Nelson, BC V1L 4H1
Tel: (250) 505-5506
Email: information@ankors.bc.ca
Website: www.ankors.bc.ca

OUTPATIENT TREATMENT

North Kootenay Lake
Community Services Society
336 - B Avenue,
PO Box 546,
Kaslo, BC V0G 1M0
Tel: (250) 353-7691
Website: www.nklcss.org

Arrow & Slocan Lakes
Community Services
205 – 6th Avenue,
Nakusp, BC V0G 1R0
Tel: (250) 265-3674
Website: www.aslcs.com

Arrow & Slocan Lakes
Community Services
205 – 6th Avenue NW,
Nakusp, BC V0G 1R0
Tel: (250) 265-3674
Fax: (250) 265-3378

East Kootenay Addiction Services Society
East Kootenay Regional Hospital
13 – 24th Avenue North,
Cranbrook, BC V1C 3H9
Tel: (250) 426-5281
Toll Free: 1 866 288-8082
Fax: (250) 426-5285
Website: www.interiorhealth.ca

North Okanagan Friendship Centre Society
2904 29th Avenue,
Vernon, BC V1T 1Y8
Tel: (250) 542-1247
Fax: (250) 542-3707
Email: ed@fnfc.ca

Kamloops Aborignal
Friendship Society
119 Palm Street,
Kamloops, BC V2B 8J7
Tel: (250) 376-1296
Fax: (250) 376-2275
Website: www.krafs.ca

Ki-Low-Na Friendship Society
442 Leon Avenue,
Kelowna, BC V1Y 6J3
Tel: (250) 763-4905
Website: www.kfs.bc.ca

Ktunaxa/Kinbasket Wellness Centre Society
7825 Mission Road,
Cranbrook, BC V1C 7E5
Tel: (250) 489-2464
Toll Free: 1 800 480-2464
Fax: (250) 489-5760
Email: jnicholas@ktunaxa.org
Website: www.ktunaxa.org

Round Lake Alcohol & Drug
Treatment Society
200 Emery Louis Road,
Armstrong, BC V0E 1B5
Tel: (250) 546-3077
Toll Free: 1 888 554-9944
Email: rltc@roundlake.bc.ca
Website: www.roundlaketreatmentcentre.ca

Wilp Si'Satxw Community
Healing Centre
Cedarvale – Kitwanga Road,
PO Box 429,
Kitwanga, BC V0J 2A0
Tel: (250) 849-5211
Fax: (250) 849-5374
Email: intake@wilpchc.ca
Website: www.wilpchc.ca

Yellowhead Community Services
612 Park Drive,
Clearwater, BC V0E 1N1
Tel: (250) 674-2600
Fax: (250) 674-2676
Email: info@yellowheadcs.ca
Website: www.yellowheadcs.ca

North Okanagan Youth & Family
Services Society (NOYFSS)
3100 – 32nd Avenue,
Vernon, BC V1T 2L9
Tel: (250) 545-3572
Fax: (250) 545-1510
Website: www.noyfss.org

Invermere Family
Resource Centre
1317 – 7th Avenue,
Invermere, BC V0A 1K0
Tel: (250) 342-4242
Website: www.familyresourcecentre.ca

METHADONE TREATMENT

East Kootenay Addiction Services Society
East Kootenay Regional Hospital
13 – 24th Avenue North,
Cranbrook, BC V1C 3H9
Tel: (250) 426-5281
Toll Free: 1 866 288-8082
Fax: (250) 426-5285
Website: www.interiorhealth.ca

OUTPATIENT TREATMENT — DAY TREATMENT

ARC Programs Ltd.
513 Bernard Avenue,
Kelowna, BC V1Y 6N9
Tel: (250) 763-2977
Fax: (250) 763-6060
Email: arcprograms@arcprograms.com
Website: www.arcprograms.com

Arrow & Slocan Lakes
Community Services
205 – 6th Avenue NW,
Nakusp, BC V0G 1R0
Tel: (250) 265-3674
Fax: (250) 265-3378

Crossroads Treatment
Centre Society
123 Franklyn Road,
Kelowna, BC V1X 6A9
Tel: (250) 860-4001
Toll Free: 1 866 860-4001
Fax: (250) 860-2605
Email: info@xrdstc.net
Website: www.crossroadstc.ca

Family Resource Centre
Society for the North Okanagan
Suite #201 – 3402 – 27th Avenue,
Vernon, BC V1T 1S1
Tel: (250) 545-3390
Email: info@vernonfrc.ca
Webmail: www.vernonfrc.ca

Kamloops Public Health Unit
519 Columbia Street,
Kamloops, BC V2C 2T8
Tel: (250) 851-7300
Toll Free: 1 866 847-4372
Fax: (250) 851-7301
Website: www.interiorhealth.ca

Kamloops Mental Health Centre
(Kamloops – Mental Health Services)
Interior Health Authority
519 Columbia Street
Kamloops, BC V2C 2T8
Tel: 250-851-7450
After hours (4:30 pm to 1 am): 250-377-0088
Fax: 250-851-7471

Ki-Low-Na Friendship Society
442 Leon Avenue,
Kelowna, BC V1Y 6J3
Tel: (250) 763-4905
Website: www.kfs.bc.ca

The Mustard Seed
New Life Community
Kamloops Outreach Centre
181 West Victoria Street,
Kamloops, BC V2C 5L7
Tel: (250) 434-9898
Email: info@nowlifekamloops.ca
Website: www.newlifekamloops.ca

North Kootenay Lake
Community Services Society
336 - B Avenue,
PO Box 546,
Kaslo, BC V0G 1M0
Tel: (250) 353-7691
Website: www.nklcss.org

Osprey Place
Phoenix Centre Programming
922 – 3rd Avenue,
Kamloops, BC V2C 6W5
Tel: (250) 374-4634
Toll Free: 1 877 318-1177
Fax: (250) 374-4621
Email: ksad@phoenixcentre.org
Website: www.phoenixcentre.org

Pathways Addictions
Resource Centre
Suite #1 - 996 Main Street,
Penticton, BC V2A 5E4
Tel: (250) 492-0400
Email: info@pathwaysaddictions.ca
Website: www.pathwaysaddictions.ca

Vernon Treatment Centre
Shuswap–Okanagan Treatment
Centre Society
Suite #3 – 2810 – 48th Avenue,
Vernon, BC V1T 3R4
Tel: (250) 542-6151
Fax: (250) 542-6891

RESIDENTIAL TREATMENT

Freedom's Door Addiction
Recovery Program for Men
1279 Centennial Crescent,
Kelowna, BC V1Y 6K3
Tel: (250) 717-0435 (24 Hour)
Office: (250) 717-0472
Fax: (250) 717-0495
Email: info@freedomsdoorkelowna.com
Website: www.freedomsdoorkelowna.com

Sage House Centre
101 Columbia Street,
Kamloops, BC V2C 2S7
Tel: (250) 374-6551
Toll Free: 1 866 414-1206
Fax: (250) 374-2399
Website: www.sagehealthcentre.ca

Round Lake
Alcohol & Drug Treatment Society
200 Emery Louis Road,
Armstrong, BC V0E 1B5
Tel: (250) 546-3077
Toll Free: 1 888 554-9944
Email: rltc@roundlake.bc.ca
Website: www.roundlaketreatmentcentre.ca

MUTUAL SUPPORT GROUPS

Alcoholics Anonymous (AA)
BC/Yukon AA
Find A Meeting Near You
Tel: (604) 435-2181
Website: www.bcyukonaa.org

Narcotics Anonymous BC
Find A Meeting Near You
Toll Free: 1 888 543-2499
Website: www.bcrna.ca

Cocaine Anonymous BC
Find A Meeting Near You
Toll Free: 1 866 662-8300
Website: www.ca-bc.org/meetings.html

COMMUNITY-BASED PREVENTION PROGRAMS

Sexqeltqin Health Centre
Adams Lake Indian Band
Sexqeltqin Health Centre
PO Box 1009,
Chase, BC V0E 1M0
Tel: (250) 679-7726
Toll Free: (250) 679-8841
Tel: (250) 679-2234
Website: www.adamslakeband.org

Boundary Mental Health
& Substance Use Services
Interior Health Authority
7441 – 2nd Street,
Grand Forks, BC V0H 1H0
Tel: (250) 442-0330
Fax: (250) 442-0334
Website: www.interiorhealth.ca

Castlegar Mental Health
Interior Health Authority
707 – 10th Street,
Castlegar, BC V1N 2H7
Tel: (250) 304-1846
Fax: (250) 304-1240
Website: www.interiorhealth.ca

Kelowna Addiction Services
Kelowna General Hospital
2268 Pandosy Street,
Kelowna, BC V1Y 1T2
Tel: (250) 862-4000
Toll Free: 1 888 877-4442
Fax: (250) 862-4020
Website: www.interiorhealth.ca

Desert Sun Counselling
& Resource Centre
762 Fairview Road,
PO Box 1890,
Oliver, BC V0H 1T0
Tel: (250) 498-2538
Fax: (250) 498-6088
Website: www.desertsuncounselling.ca

East Kootenay Addiction Services Society
East Kootenay Regional Hospital
13 – 24th Avenue North,
Cranbrook, BC V1C 3H9
Tel: (250) 426-5281
Toll Free: 1 866 288-8082
Fax: (250) 426-5285
Website: www.interiorhealth.ca

Enderby Community Health Centre
Addiction Services
707 – 3rd Avenue
Enderby, BC V0E 1V0
Tel: (250) 838-2450
Fax: (250) 838-6005
Website: www.interiorhealth.ca

Golden Family Centre
421 – 9th Avenue North,
PO Box 415,
Golden, BC V0A 1H0
Tel: (250) 344-2000
Email: gfc@goldenfamilycentre.bc.ca
Website: www.goldenfamilycentre.bc.ca

Kamloops Aborignal
Friendship Society
119 Palm Street,
Kamloops, BC V2B 8J7
Tel: (250) 376-1296
Fax: (250) 376-2275
Website: www.krafs.ca

Kalano Club of Kelowna
2108 Vasile Road,
Kelowna, BC V1Y 6H5
Tel: (250) 762-4999
Email: kalano@shaw.ca
Website: www.kalanoclub.wordpress.com

Princeton/ Keremeos
Mental Health & Substance Use Services
700 – 3rd Street,
Keremeos, BC V0X 1N3
Tel: (250) 499-3029
Toll Free: 1 800 663-7867
Fax: (250) 499-3027
Website: www.interiorhealth.ca

Logan Lake Mental Health & Substance Use
5 Beryl Drive,
Logan Lake, BC V0K 1W0
Tel: (250) 523-9414 (Ext. 6)
Website: www.interiorhealth.ca

Lower Nicola Indian
Band Health Centre
181 Nawishaskin Lane,
Merritt, BC V1K 0A7
Tel: (250) 378-5157
Fax: (250) 378-6188

Nelson Mental Health &
Addictions Services
333 Victoria Street,
Nelson, BC V1L 4K3
Tel: (250) 505-7248
Website: www.interiorhealth.ca

Nisga'a Valley
Health Authority
4920 Tait Avenue,
PO Box 234,
Gitlaxt'aamiks, BC V0J 1A0
Tel: (250) 633-5000
Toll Free: 1 888 233-2212
Fax: (250) 633-2512
Website: www.nisgaahealth.bc.ca

Armstrong Boys & Girls Clubs
3459 Pleasant Valley Road,
Armstrong, BC V0E 1B0
Tel: (250) 546-9900
Fax: (250) 546-3468
Email: Armstrong@obgc.ca
Website: www.boysandgirlsclubs.ca

Okanagan Indian Band
Health Department
12420 Westside Road,
Vernon, BC V1H 2A4
Tel: (250) 542-4328
Toll Free: 1 866 542-4328
Fax: (250) 542-4990
Email: okibadmin@okanagan.org
Website: www.okib.ca

Pleasant Valley Health
Centre Addictions Services
3800 Patten Drive,
Armstrong, BC V0E 1B2
Tel: (250) 546-4700
Fax: (250) 546-8834
Website: www.interiorhealth.ca

Revelstoke Mental Health
& Substance Use Services
Queen Victoria Hospital
1200 Newlands Road,
Revelstoke, BC V0E 2S0
Tel: (250) 837-2131
Website: www.interiorhealth.ca

Robson Valley Mental Health and
Addiction Program
Valemount Health Centre
1445 5th Avenue,
Valemount, BC V0E 2Z0
Tel: (250) 566-9138
Fax: (250) 566-4319
Website: www.northernhealth.ca

Salmo Community Resources Society
Adult Mental Health & Addictions Services
311 Railway Avenue,
PO Box 39,
Salmo, BC V0G 1Z0
Tel: (250) 357-2277
Fax: (250) 357-2385
Email: info@scrs.ca
Website: www.scrs.ca

Vernon Mental Health
& Addiction Services
1440 14th Avenue,
Vernon, BC V1B 2T1
Tel: (250) 549-5737
Website: www.interiorhealth.ca

West Kootenay/Boundary
AIDS Network (ANKORS)
101 Baker Street,
Nelson, BC V1L 4H1
Tel: (250) 505-5506
Email: information@ankors.bc.ca
Website: www.ankors.bc.ca

Whitevalley Community Resource Centre
2114 Shuswap Avenue,
Lumby, BC V0E 2G0
Tel: (250) 547-8866
Fax: (250) 547-6285
Email: info@whitevalley.ca
Website: www.whitevalley.ca

SCHOOL-BASED PREVENTION PROGRAMS

ARC Programs Ltd.
513 Bernard Avenue,
Kelowna, BC V1Y 6N9
Tel: (250) 763-2977
Fax: (250) 763-6060
Email: arcprograms@arcprograms.com
Website: www.arcprograms.com

YOUTH ADDICTIONS SERVICES

ARC Programs Ltd.
513 Bernard Avenue,
Kelowna, BC V1Y 6N9
Tel: (250) 763-2977
Fax: (250) 763-6060
Email: arcprograms@arcprograms.com
Website: www.arcprograms.com

Invermere Family Resource Centre
1317 – 7th Avenue,
Invermere, BC V0A 1K0
Tel: (250) 342-4242
Website: www.familyresourcecentre.ca

Pathways Addictions Resource Centre
Suite #1 - 996 Main Street,
Penticton, BC V2A 5E4
Tel: (250) 492-0400
Email: info@pathwaysaddictions.ca
Website: www.pathwaysaddictions.ca

Shuswap Family Centre
681 Marine Park Drive NE,
Salmon Arm, BC V1E 2W7
Tel: (250) 832-2170
Fax: (250) 833-0137
Email: sfrrcinfo@familyresource.bc.ca
Website: www.familyresource.bc.ca

Princeton/ Keremeos Mental Health & Substance Use Services
700 – 3rd Street,
Keremeos, BC V0X 1N3
Tel: (250) 499-3029
Toll Free: 1 800 663-7867
Fax: (250) 499-3027
Website: www.interiorhealth.ca

Freedom Quest Regional Youth Services
349 Columbia Avenue,
Castlegar, BC V1N 1G6
Tel: (250) 304-2676
Toll Free: 1 877 304-2676
Fax: (250) 304-2678
Website: www.freedomquestyouthservices.ca

Elizabeth Fry Society
827 Seymour Street,
Kamloops, BC V2C 2H6
Tel: (250) 374-2119
Fax: (250) 374-5768
Website: www.efrysoc.com

Family Resource Centre
Society for the North Okanagan
Suite #201 – 3402 – 27th Avenue,
Vernon, BC V1T 1S1
Tel: (250) 545-3390
Email: info@vernonfrc.ca
Webmail: www.vernonfrc.ca

The Bridge Youth & Family Services Society - Kelowna
1829 Chandler Street,
Kelowna, BC V1Y 3Z2
Tel: (250) 763-0456
Email: info@thebridgeservices.ca
Website: www.thebridgeservices.ca

Special thanks to the following organizations, whose generous support allows this manual to be made available free of charge

Bridge Electric Corp.
11091 Hammersmith Gate
Richmond, BC V7A 5E6
Tel: 604-273-2744
Fax: 604-273-4814

Brookswood Veterinary Hospital
4059 – 200th Street
Langley, BC V6A 1K8
Tel: 604-534-4174

Country Quest Farms
2999 West 53rd Avenue
Vancouver, BC V6N 3W2
Tel: 604-224-2689

Dogwood Building Maintenance
415 Monteray Avenue
North Vancouver, BC V7N 3A9
Tel: 604-988-9877
Fax: 604-988-8402

Eagle Underwriting
Pacific Inc.
600 – 409 Granville Street
Vancouver, BC V6C 1T2
Tel: 604-683-0506
Fax: 604-683-0588

Feature Millwork Inc.
Suite #301 – 204 Cayer Street
Coquitlam, BC V3K 5B1
Tel: 604-522-7951
Fax: 604-526-9750

Robert Fenton Law Corp.
Suite #303 – 1080 Howe Street
Vancouver, BC V6B 1R8
Tel: 604-688-6733
Fax: 604-408-4771

Fine Arts Dental Laboratories Ltd.
1375 Boundary Road
Vancouver, BC V5K 4T9
Tel: 604-298-4232
Fax: 604-298-3133

Hesdon Holstiens
4484 – 112th Street
Delta, BC V4R 3N3
Tel: 604-590-2434

International Enexco Ltd.
2080 – 777 Hornby Street
Vancouver, BC V6Z 1S4
Tel: 604-683-7361
Fax: 604-662-3231

Jones & Co. Interior Design
11023 Lyon Road
Delta, BC V4E 1J4
Tel: 604-543-8411
Fax: 604-543-8416

Kroll's Surrey Pharmacy
9656 King George Hwy.
Surrey, BC V3T 2V5
Tel: 604-581-3636
Fax: 604-581-3637

Multimetro Real Estate Group
5th Floor – 666 Burrard Street
Vancouver, BC V6C 3J8
Tel: 604-683-1444

Rainbow Food & Gas
42220 Yarrow Central Road
Chilliwack, BC V2R 5E4
Tel: 604-823-4646
Fax: 604-823-9646

M.A. Stewart & Sons Ltd.
12900 - 87th Avenue
Surrey, BC V3T 4W8
Tel: 604-594-8431
Fax: 604-594-8455

Spartano Realty Corp. Ltd.
#201 – 1448 Commercial Drive
Vancouver, BC V5L 3X9
Tel: 604-253-2631
Fax: 604-253-2632

Summit Customs Brokers
#2060 – 5200 Miller Road
Richmond, BC V7B 1L1
Tel: 604-278-3551
Fax: 604-278-3529

Sutton Westcoast Realty
#300 – 1508 West Broadway
Richmond, BC V6J 1W8
Tel: 604-714-1700
Fax: 604-733-7188

Dr. Tin Y. Tang
103 – 2620 Commercial Drive
Vancouver, BC V5N 4C4
Tel: 604-872-2565

Tri-City Finishing
363 David Street
Victoria, BC V8T 5C1
Tel: 250-381-1989
Fax: 250-381-5086

Unlimited Accounting Services
Suite #206 – 6411 Buswell Street
Richmond, BC V6Y 2G5
Tel: 604-273-3006
Fax: 604-273-3706

Waggot's Seafoods Ltd.
M – 07 – Park Royal South
West Vancouver, BC V7T 1A1
Tel: 604-925-4140

Wallenius Wilhelmsen
820 Dock Road
Delta, BC V3M 6A3
Tel: 604-521-6681

Need Help?

Speak with someone about a situation, obtain information about drugs, or find out about counselling, support groups and treatment centres in your area. Call:

ALBERTA:	**1-866-332-2322**
BRITISH COLUMBIA:	**(604) 660-9382 or 1-800-663-1441**
CRYSTAL METH ANONYMOUS:	**(604) 633-4242 (Vancouver)**
MANITOBA:	**(204) 944-6200**
NEW BRUNSWICK:	**(506) 452-5558 or in Moncton (506) 856-2333**
NEWFOUNDLAND:	**(709) 752-4919**
NOVA SCOTIA:	**(902) 424 5920**
NORTHWEST TERRITORIES:	**(867) 873-7049**
NUNAVUT:	**Baffin Region (867) 473-2659** **Kitikmeot Region (867) 983-4075** **Kivaliiq Region (867) 645 2171**
ONTARIO:	**1-800-565-8603**
PRINCE EDWARD ISLAND:	**Charlottetown — (902) 368-4120**
	Souris — (902) 687-7111 **Montaque — (902) 838-0959** **Summerside — (902) 888-8380**
QUEBEC:	**(514) 527-2626 or 1-800-265-2626**
SASKATCHEWAN:	**(306) 787-5826**
YUKON:	**(867) 667-5777**

NEED SUPPORT NAVIGATING THE MENTAL HEALTH SYSTEM?

CONNECT WITH MNBC'S REGIONAL MENTAL HEALTH NAVIGATORS!

Expanded mental health team

MNBC'S Ministry of Mental Health and Harm Reduction is excited to share that our team has expanded to include four Regional Mental Health Navigators!

What support is available?

The Regional Mental Health Navigators will be working to support Métis individuals and communities to navigate mental health and substance use resources.

Connect with a Navigator in your area!

Vancouver Island:
Kelsey Todd (ktodd@mnbc.ca)

Thompson/Okanagan/Kootenays:
Michelle Padley (mpadley@mnbc.ca)

Lower Mainland/Fraser Valley:
Selena Jensen (sjensen@mnbc.ca)

Northern:
Sheri Gee (sgee@mnbc.ca)

QUESTIONS?
MENTALHEALTH@MNBC.CA

MÉTIS NATION BRITISH COLUMBIA