Freedom of Information and Protection of Privacy (FOIP) Act

Division 2
Exceptions to Disclosure

Disclosure harmful to personal privacy

17(1) The head of a public body must refuse to disclose personal information to an applicant if the disclosure would be an unreasonable invasion of a third party's personal privacy.

(2) A disclosure of personal information is not an unreasonable invasion of a third party's personal privacy if

(a) the third party has, in the prescribed manner, consented to or requested the disclosure,

(b) there are compelling circumstances affecting anyone's health or safety and written notice of the disclosure is given to the third party,

(c) an Act of Alberta or Canada authorizes or requires the disclosure,

(d) repealed 2003 c21 s5,

(e) the information is about the third party's classification, salary range, discretionary benefits or employment responsibilities as an officer, employee or member of a public body or as a member of the staff of a member of the Executive Council,

(f) the disclosure reveals financial and other details of a contract to supply goods or services to a public body,

(g) the information is about a license, permit or other similar discretionary benefit relating to

(i) a commercial or professional activity, that has been granted to the third party by a public body, or

(ii) real property, including a development permit or building permit, that has been granted to the third party by a public body,

and the disclosure is limited to the name of the third party and the nature of the license, permit or other similar discretionary benefit,

(h) the disclosure reveals details of a discretionary benefit of a financial nature granted to the third party by a public body,

(i) the personal information is about an individual who has been dead for 25 years or more, or

(j) subject to subsection (3), the disclosure is not contrary to the public interest and reveals only the following personal information about a third party:

(i) enrolment in a school of an educational body or in a program offered by a post-secondary educational body,

(ii) repealed 2003 c21 s5,

(iii) attendance at or participation in a public event or activity related to a public body, including a graduation ceremony, sporting event, cultural program or club, or field trip, or

(iv) receipt of an honour or award granted by or through a public body.

(3) The disclosure of personal information under subsection (2)(j) is an unreasonable invasion of personal privacy if the third party whom the information is about has requested that the information not be disclosed.

(4) A disclosure of personal information is presumed to be an unreasonable invasion of a third party's personal privacy if

(a) the personal information relates to a medical, psychiatric or psychological history, diagnosis, condition, treatment or evaluation,

(b) the personal information is an identifiable part of a law enforcement record, except to the extent that the disclosure is necessary to dispose of the law enforcement matter or to continue an investigation,

(c) the personal information relates to eligibility for income assistance or social service benefits or to the determination of benefit levels,

(d) the personal information relates to employment or educational history,

(e) the personal information was collected on a tax return or gathered for the purpose of collecting a tax,

(e.1) the personal information consists of an individual's bank account information or credit card information,

(f) the personal information consists of personal recommendations or evaluations, character references or personnel evaluations,

(g) the personal information consists of the third party's name when

(i) it appears with other personal information about the third party, or

(ii) the disclosure of the name itself would reveal personal information about the third party, or

(h) the personal information indicates the third party's racial or ethnic origin or religious or political beliefs or associations.

(5) In determining under subsections (1) and (4) whether a disclosure of personal information constitutes an unreasonable invasion of a third party's personal privacy, the head of a public body must consider all the relevant circumstances, including whether

(a) the disclosure is desirable for the purpose of subjecting the activities of the Government of Alberta or a public body to public scrutiny,

(b) the disclosure is likely to promote public health and safety or the protection of the environment,

(c) the personal information is relevant to a fair determination of the applicant's rights,

(d) the disclosure will assist in researching or validating the claims, disputes or grievances of aboriginal people,

(e) the third party will be exposed unfairly to financial or other harm,

(f) the personal information has been supplied in confidence,

(g) the personal information is likely to be inaccurate or unreliable,

(h) the disclosure may unfairly damage the reputation of any person referred to in the record requested by the applicant, and

(i) the personal information was originally provided by the applicant.

RSA 2000 cF-25 s17;2003 c21 s5

Freedom of Information and Protection of Privacy **(FOIP)** *Act*

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Disclosure harmful to individual or public safety

18(1) The head of a public body may refuse to disclose to an applicant information, including personal information about the applicant, if the disclosure could reasonably be expected to

(a) threaten anyone else's safety or mental or physical health, or

(b) interfere with public safety.

(2) The head of a public body may refuse to disclose to an applicant personal information about the applicant if, in the opinion of a physician, a regulated member of the College of Alberta Psychologists or a psychiatrist or any other appropriate expert depending on the circumstances of the case, the disclosure could reasonably be expected to result in immediate and grave harm to the applicant's health or safety.

(3) The head of a public body may refuse to disclose to an applicant information in a record that reveals the identity of an individual who has provided information to the public body in confidence about a threat to an individual's safety or mental or physical health.

RSA 2000 cF-25 s18;2000 cH-7 s153

Freedom of Information and Protection of Privacy (FOIP) *Act*

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Cabinet and Treasury Board confidences

22(1) The head of a public body must refuse to disclose to an applicant information that would reveal the substance of deliberations of the Executive Council or any of its committees or of the Treasury Board or any of its committees, including any advice, recommendations, policy considerations or draft legislation or regulations submitted or prepared for submission to the Executive Council or any of its committees or to the Treasury Board or any of its committees.

(2) Subsection (1) does not apply to

(a) information in a record that has been in existence for 15 years or more,

(b) information in a record of a decision made by the Executive Council or any of its committees on an appeal under an Act, or

(c) information in a record the purpose of which is to present background facts to the Executive Council or any of its committees or to the Treasury Board or any of its committees for consideration in making a decision if

(i) the decision has been made public,

(ii) the decision has been implemented, or

(iii) 5 years or more have passed since the decision was made or considered.

1994 cF-18.5 s21

Freedom of Information and Protection of Privacy (FOIP) *Act*

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Advice from officials

24(1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to reveal

(a) advice, proposals, recommendations, analyses or policy options developed by or for a public body or a member of the Executive Council,

(b) consultations or deliberations involving

(i) officers or employees of a public body,

(ii) a member of the Executive Council, or

(iii) the staff of a member of the Executive Council,

(c) positions, plans, procedures, criteria or instructions developed for the purpose of contractual or other negotiations by or on behalf of the Government of Alberta or a public body, or considerations that relate to those negotiations,

(d) plans relating to the management of personnel or the administration of a public body that have not yet been implemented,

(e) the contents of draft legislation, regulations and orders of members of the Executive Council or the Lieutenant Governor in Council,

(f) the contents of agendas or minutes of meetings

(i) of the governing body of an agency, board, commission, corporation, office or other body that is designated as a public body in the regulations, or

(ii) of a committee of a governing body referred to in subclause (i),

(g) information, including the proposed plans, policies or projects of a public body, the disclosure of which could reasonably be expected to result in disclosure of a pending policy or budgetary decision, or

(h) the contents of a formal research or audit report that in the opinion of the head of the public body is incomplete unless no progress has been made on the report for at least 3 years.

(2) This section does not apply to information that

(a) has been in existence for 15 years or more,

(b) is a statement of the reasons for a decision that is made in the exercise of a discretionary power or an adjudicative function,

(c) is the result of product or environmental testing carried out by or for a public body, that is complete or on which no progress has been made for at least 3 years, unless the testing was done

(i) for a fee as a service to a person other than a public body, or

(ii) for the purpose of developing methods of testing or testing products for possible purchase,

(d) is a statistical survey,

(e) is the result of background research of a scientific or technical nature undertaken in connection with the formulation of a policy proposal, that is complete or on which no progress has been made for at least 3 years,

(f) is an instruction or guideline issued to the officers or employees of a public body, or

(g) is a substantive rule or statement of policy that has been adopted by a public body for the purpose of interpreting an Act or regulation or administering a program or activity of the public body.

(2.1) The head of a public body must refuse to disclose to an Applicant

(a) a record relating to an audit by the Chief Internal Auditor of Alberta that is created by or for the Chief Internal Auditor of Alberta, or

(b) information that would reveal information about an audit by the Chief Internal Auditor of Alberta.

(2.2) Subsection (2.1) does not apply to a record or information described in that subsection

(a) if 15 years or more has elapsed since the audit to which the record or information relates was completed, or

(b) if the audit to which the record or information relates was discontinued or if no progress has been made on the audit for 15 years or more.

(3) In this section, “audit” means a financial or other formal and systematic examination or review of a program, portion of a program or activity.

RSA 2000 cF-25 s24;2006 c17 s5

Freedom of Information and Protection of Privacy (FOIP) *Act*

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Disclosure harmful to economic and other interests of a public body

25(1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to harm the economic interest of a public body or the Government of Alberta or the ability of the Government to manage the economy, including the following information:

(a) trade secrets of a public body or the Government of Alberta;

(b) financial, commercial, scientific, technical or other information in which a public body or the Government of Alberta has a proprietary interest or a right of use and that has, or is reasonably likely to have, monetary value;

(c) information the disclosure of which could reasonably be expected to

(i) result in financial loss to,

(ii) prejudice the competitive position of, or

(iii) interfere with contractual or other negotiations of,

the Government of Alberta or a public body;

(d) information obtained through research by an employee of a public body, the disclosure of which could reasonably be expected to deprive the employee or the public body of priority of publication.

(2) The head of a public body must not refuse to disclose under subsection (1) the results of product or environmental testing carried out by or for a public body, unless the testing was done

(a) for a fee as a service to a person, other than the public body, or

(b) for the purpose of developing methods of testing or testing products for possible purchase.

1994 cF-18.5 s24;1999 c23 s15

Freedom of Information and Protection of Privacy (FOIP) Act

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Privileged information

27(1) The head of a public body may refuse to disclose to an applicant

(a) information that is subject to any type of legal privilege, including solicitor-client privilege or parliamentary privilege,

(b) information prepared by or for

(i) the Minister of Justice and Attorney General,

(ii) an agent or lawyer of the Minister of Justice and Attorney General, or

(iii) an agent or lawyer of a public body,

in relation to a matter involving the provision of legal services, or

(c) information in correspondence between

(i) the Minister of Justice and Attorney General,

(ii) an agent or lawyer of the Minister of Justice and Attorney General, or

(iii) an agent or lawyer of a public body,

and any other person in relation to a matter involving the provision of advice or other services by the Minister of Justice and Attorney General or by the agent or lawyer.

(2) The head of a public body must refuse to disclose information described in subsection (1)(a) that relates to a person other than a public body.

(3) Only the Speaker of the Legislative Assembly may determine whether information is subject to parliamentary privilege.

1994 cF-18.5 s26;1995 c17 s10;1999 c23 s17

Freedom of Information and Protection of Privacy (FOIP) Act

Part 1
Freedom of Information

Division 2
Exceptions to Disclosure

Information that is or will be available to the public

29(1) The head of a public body may refuse to disclose information

(a) that is readily available to the public,

(a.1) that is available for purchase by the public, or

(b) that is to be published or released to the public within 60 days after the applicant's request is received.

(2) The head of a public body must notify an applicant of the publication or release of information that the head has refused to disclose under subsection (1)(b).

(3) If the information is not published or released within 60 days after the applicant's request is received, the head of the public body must reconsider the request as if it were a new request received on the last day of that period, and access to the information requested must not be refused under subsection (1)(b).

RSA 2000 cF-25 s29;2003 c21 s6

FOIP Office
Alberta Health
10025 Jasper Avenue
19th Floor Telus Plaza North Tower
Edmonton, AB T5J 1S6

Report Date Time: 3/16/2023 10:22:03 AM

Summary
Disclosed in Part - 6 Pages
Released in Full - 258 Pages
Withheld - 182 Pages

Document Status Report

Folder Name :2022-G-0685
Disposition :N/A
Review Layer Name :Layer 1

Page #	Review Status	Redaction Codes
1	Disclosed in Part	18; N/R
2	Released in Full	-
3	Withheld	24(1)(a)
4	Withheld	24(1)(a)
5	Withheld	24(1)(a)
6	Withheld	24(1)(a)
7	Withheld	24(1)(a)
8	Withheld	24(1)(a)
9	Withheld	24(1)(a)
10	Withheld	24(1)(a)
11	Withheld	24(1)(a)
12	Withheld	24(1)(a)
13	Withheld	24(1)(a)
14	Withheld	24(1)(a)
15	Withheld	24(1)(a)
16	Withheld	24(1)(a)
17	Withheld	24(1)(a)
18	Withheld	24(1)(a)
19	Withheld	24(1)(a)
20	Withheld	24(1)(a)
21	Withheld	24(1)(a)
22	Withheld	24(1)(a)
23	Withheld	24(1)(a)
24	Withheld	24(1)(a)
25	Withheld	24(1)(a)
26	Withheld	24(1)(a)
27	Withheld	24(1)(a)
28	Withheld	24(1)(a)
29	Withheld	24(1)(a)
30	Withheld	24(1)(a)
31	Withheld	24(1)(a)
32	Withheld	24(1)(a)
33	Withheld	24(1)(a)

34	Withheld	24(1)(a)
35	Withheld	24(1)(a)
36	Withheld	24(1)(a)
37	Withheld	24(1)(a)
38	Withheld	24(1)(a)
39	Withheld	24(1)(a)
40	Withheld	24(1)(a)
41	Withheld	24(1)(a)
42	Withheld	24(1)(a)
43	Withheld	24(1)(a)
44	Withheld	24(1)(a)
45	Withheld	24(1)(a)
46	Withheld	24(1)(a)
47	Withheld	24(1)(a)
48	Withheld	24(1)(a)
49	Withheld	24(1)(a)
50	Withheld	24(1)(a)
51	Withheld	24(1)(a)
52	Withheld	24(1)(a)
53	Withheld	24(1)(a)
54	Withheld	24(1)(a)
55	Withheld	24(1)(a)
56	Withheld	24(1)(a)
57	Withheld	24(1)(a)
58	Withheld	24(1)(a)
59	Withheld	24(1)(a)
60	Withheld	24(1)(a)
61	Withheld	24(1)(a)
62	Withheld	24(1)(a)
63	Withheld	24(1)(a)
64	Withheld	24(1)(a)
65	Withheld	24(1)(a)
66	Withheld	24(1)(a)
67	Withheld	24(1)(a)
68	Withheld	24(1)(a)
69	Withheld	24(1)(a)
70	Withheld	24(1)(a)
71	Withheld	24(1)(a)
72	Withheld	24(1)(a)
73	Withheld	24(1)(a)
74	Withheld	24(1)(a)
75	Withheld	24(1)(a)
76	Withheld	24(1)(a)
77	Withheld	24(1)(a)
78	Withheld	24(1)(a)
79	Withheld	24(1)(a)
80	Withheld	24(1)(a)
81	Withheld	24(1)(a)
82	Withheld	24(1)(a)

83	Withheld	24(1)(a)
84	Withheld	24(1)(a)
85	Withheld	24(1)(a)
86	Withheld	29
87	Withheld	29
88	Withheld	29
89	Withheld	29
90	Withheld	29
91	Withheld	29
92	Withheld	29
93	Withheld	29
94	Withheld	29
95	Withheld	29
96	Withheld	29
97	Withheld	29
98	Withheld	29
99	Withheld	29
100	Withheld	29
101	Withheld	29
102	Withheld	29
103	Withheld	29
104	Withheld	29
105	Withheld	29
106	Withheld	29
107	Withheld	29
108	Withheld	29
109	Withheld	29
110	Withheld	29
111	Withheld	29
112	Withheld	29
113	Withheld	29
114	Withheld	29
115	Withheld	29
116	Withheld	29
117	Withheld	29
118	Withheld	29
119	Withheld	29
120	Withheld	29
121	Withheld	29
122	Withheld	29
123	Withheld	29
124	Withheld	29
125	Withheld	29
126	Released in Full	-
127	Released in Full	-
128	Released in Full	-
129	Released in Full	-
130	Released in Full	-
131	Released in Full	-

132	Released in Full	-
133	Released in Full	-
134	Released in Full	-
135	Released in Full	-
136	Released in Full	-
137	Released in Full	-
138	Released in Full	-
139	Released in Full	-
140	Released in Full	-
141	Released in Full	-
142	Released in Full	-
143	Released in Full	-
144	Released in Full	-
145	Released in Full	-
146	Released in Full	-
147	Released in Full	-
148	Released in Full	-
149	Released in Full	-
150	Released in Full	-
151	Released in Full	-
152	Released in Full	-
153	Released in Full	-
154	Released in Full	-
155	Released in Full	-
156	Released in Full	-
157	Released in Full	-
158	Released in Full	-
159	Released in Full	-
160	Released in Full	-
161	Released in Full	-
162	Released in Full	-
163	Released in Full	-
164	Released in Full	-
165	Released in Full	-
166	Released in Full	-
167	Released in Full	-
168	Released in Full	-
169	Released in Full	-
170	Released in Full	-
171	Released in Full	-
172	Released in Full	-
173	Released in Full	-
174	Released in Full	-
175	Released in Full	-
176	Released in Full	-
177	Released in Full	-
178	Released in Full	-
179	Released in Full	-
180	Released in Full	-

181	Released in Full	-
182	Released in Full	-
183	Released in Full	-
184	Released in Full	-
185	Released in Full	-
186	Released in Full	-
187	Released in Full	-
188	Released in Full	-
189	Released in Full	-
190	Released in Full	-
191	Released in Full	-
192	Released in Full	-
193	Released in Full	-
194	Released in Full	-
195	Released in Full	-
196	Released in Full	-
197	Released in Full	-
198	Released in Full	-
199	Released in Full	-
200	Released in Full	-
201	Released in Full	-
202	Released in Full	-
203	Released in Full	-
204	Released in Full	-
205	Released in Full	-
206	Released in Full	-
207	Released in Full	-
208	Released in Full	-
209	Released in Full	-
210	Released in Full	-
211	Released in Full	-
212	Released in Full	-
213	Released in Full	-
214	Released in Full	-
215	Released in Full	-
216	Released in Full	-
217	Released in Full	-
218	Released in Full	-
219	Released in Full	-
220	Released in Full	-
221	Released in Full	-
222	Released in Full	-
223	Released in Full	-
224	Released in Full	-
225	Released in Full	-
226	Released in Full	-
227	Released in Full	-
228	Released in Full	-
229	Released in Full	-

230	Released in Full	-
231	Released in Full	-
232	Released in Full	-
233	Released in Full	-
234	Released in Full	-
235	Released in Full	-
236	Released in Full	-
237	Released in Full	-
238	Released in Full	-
239	Released in Full	-
240	Released in Full	-
241	Released in Full	-
242	Released in Full	-
243	Released in Full	-
244	Released in Full	-
245	Released in Full	-
246	Released in Full	-
247	Released in Full	-
248	Released in Full	-
249	Released in Full	-
250	Released in Full	-
251	Released in Full	-
252	Released in Full	-
253	Released in Full	-
254	Released in Full	-
255	Released in Full	-
256	Released in Full	-
257	Released in Full	-
258	Released in Full	-
259	Released in Full	-
260	Released in Full	-
261	Released in Full	-
262	Released in Full	-
263	Withheld	24(1)(a)
264	Withheld	24(1)(a)
265	Withheld	24(1)(a)
266	Withheld	24(1)(a)
267	Withheld	24(1)(a)
268	Withheld	24(1)(a)
269	Disclosed in Part	17(1); 18; N/R
270	Released in Full	-
271	Withheld	24(1)(a)
272	Withheld	24(1)(a)
273	Withheld	24(1)(a)
274	Withheld	24(1)(a)
275	Withheld	24(1)(a)
276	Withheld	24(1)(a)
277	Withheld	24(1)(a)
278	Withheld	24(1)(a)

279	Withheld	24(1)(a)
280	Withheld	24(1)(a)
281	Withheld	24(1)(a)
282	Withheld	24(1)(a)
283	Withheld	24(1)(a)
284	Withheld	24(1)(a)
285	Withheld	24(1)(a)
286	Disclosed in Part	18; N/R
287	Disclosed in Part	18; 29
288	Withheld	27(1)(a)
289	Withheld	27(1)(a)
290	Withheld	22(1); 24(1)(a)
291	Withheld	22(1); 24(1)(a)
292	Disclosed in Part	18; 24(1)(a)
293	Withheld	24(1)(a)
294	Withheld	24(1)(a)
295	Withheld	24(1)(a)
296	Withheld	24(1)(a)
297	Withheld	24(1)(a)
298	Withheld	24(1)(a)
299	Released in Full	-
300	Released in Full	-
301	Released in Full	-
302	Released in Full	-
303	Released in Full	-
304	Released in Full	-
305	Released in Full	-
306	Released in Full	-
307	Released in Full	-
308	Released in Full	-
309	Released in Full	-
310	Released in Full	-
311	Released in Full	-
312	Withheld	24(1)(a)
313	Withheld	24(1)(a)
314	Withheld	24(1)(a)
315	Withheld	24(1)(a)
316	Withheld	24(1)(a)
317	Withheld	24(1)(a)
318	Withheld	24(1)(a)
319	Withheld	24(1)(a)
320	Released in Full	-
321	Released in Full	-
322	Released in Full	-
323	Released in Full	-
324	Released in Full	-
325	Released in Full	-
326	Released in Full	-
327	Released in Full	-

328	Released in Full	-
329	Released in Full	-
330	Released in Full	-
331	Released in Full	-
332	Released in Full	-
333	Released in Full	-
334	Released in Full	-
335	Released in Full	-
336	Released in Full	-
337	Released in Full	-
338	Released in Full	-
339	Released in Full	-
340	Released in Full	-
341	Released in Full	-
342	Released in Full	-
343	Released in Full	-
344	Released in Full	-
345	Released in Full	-
346	Released in Full	-
347	Released in Full	-
348	Released in Full	-
349	Released in Full	-
350	Released in Full	-
351	Released in Full	-
352	Released in Full	-
353	Released in Full	-
354	Released in Full	-
355	Released in Full	-
356	Released in Full	-
357	Released in Full	-
358	Released in Full	-
359	Released in Full	-
360	Released in Full	-
361	Released in Full	-
362	Released in Full	-
363	Released in Full	-
364	Released in Full	-
365	Released in Full	-
366	Released in Full	-
367	Released in Full	-
368	Released in Full	-
369	Released in Full	-
370	Released in Full	-
371	Released in Full	-
372	Released in Full	-
373	Released in Full	-
374	Released in Full	-
375	Released in Full	-
376	Released in Full	-

377	Released in Full	-
378	Released in Full	-
379	Released in Full	-
380	Released in Full	-
381	Released in Full	-
382	Released in Full	-
383	Released in Full	-
384	Released in Full	-
385	Released in Full	-
386	Released in Full	-
387	Released in Full	-
388	Released in Full	-
389	Released in Full	-
390	Released in Full	-
391	Released in Full	-
392	Released in Full	-
393	Released in Full	-
394	Released in Full	-
395	Released in Full	-
396	Released in Full	-
397	Released in Full	-
398	Released in Full	-
399	Released in Full	-
400	Released in Full	-
401	Released in Full	-
402	Released in Full	-
403	Released in Full	-
404	Released in Full	-
405	Released in Full	-
406	Released in Full	-
407	Released in Full	-
408	Released in Full	-
409	Released in Full	-
410	Released in Full	-
411	Released in Full	-
412	Released in Full	-
413	Released in Full	-
414	Released in Full	-
415	Released in Full	-
416	Released in Full	-
417	Released in Full	-
418	Released in Full	-
419	Released in Full	-
420	Released in Full	-
421	Released in Full	-
422	Released in Full	-
423	Withheld	24(1)(a)
424	Withheld	24(1)(a)
425	Withheld	24(1)(a)

426	Withheld	24(1)(a)
427	Withheld	24(1)(a)
428	Withheld	24(1)(a)
429	Released in Full	-
430	Released in Full	-
431	Released in Full	-
432	Withheld	24(1)(a)
433	Withheld	24(1)(a)
434	Withheld	24(1)(a)
435	Withheld	24(1)(a)
436	Withheld	24(1)(a)
437	Withheld	24(1)(a)
438	Withheld	24(1)(a)
439	Withheld	24(1)(a)
440	Withheld	24(1)(a)
441	Withheld	24(1)(a)
442	Withheld	24(1)(a)
443	Withheld	24(1)(a)
444	Withheld	24(1)(a)
445	Withheld	24(1)(a)
446	Disclosed in Part	18; 29

Shaire Ortillano

From: Robert Murdoch
Sent: October 20, 2022 1:02 PM
To: Erin L Jackson
Cc: Brian Lam
Subject: FW: PChAD Legislative Review docs
Attachments: 2020-09-30 FINAL PChAD Project - Deliverable 2.docx; 2020-06-30 FINAL PChAD Project - Deliverable 1.docx; 827C-PChAD_Eval_Rpt_F9NO_DIST.pdf; PChAD Evaluation Report_FINAL_V8 Jan13_2017.pdf

Hello Erin,

Are these these word documents what you are looking for? I also attached AHS' evaluations.

N/R

Is there anyway this got split?

Best,

Robert

Classification: Protected A

From: Erin L Jackson 18
Sent: April 21, 2022 12:22 PM
To: Robert Murdoch 18
Subject: FW: PChAD Legislative Review docs

Hi Robert,

These deliverables from the PChAD review Rebecca Devlin led might be helpful for the Boston model part of the j-scan you are putting together since New Zealand has "adult PChAD" and the grant recipient did a survey of similar legislation.

Erin

Classification: Protected A

From: Rebecca Devlin 18
Sent: November-24-21 10:07 AM
To: Erin L Jackson 18
Subject: PChAD Legislative Review docs

Hi Erin,

These are the two deliverables from the legislative review portion of the PChAD review.

Deliverable 1 is more of a general analysis/scan of legislation confining youth. Deliverable 2 provides analysis on specific questions we posed to the contractor (e.g., extending length of confinement, mandatory treatment).

Hope these are helpful and I'm happy to answer any questions.

Thanks
Rebecca

Classification: Protected A

Alberta Health Services

PROTECTION OF CHILDREN ABUSING DRUGS (PChAD)

FINAL EVALUATION REPORT

January 2017

Alberta Health Services
Provincial Addiction and Mental Health

Project Team

PROJECT SPONSORS

Ann Harding, Director, Provincial Addiction and Mental Health, Child, Youth and Family Initiatives

Steven Clelland, Director, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

LEADERSHIP

Kimberly Eggen-Armstrong, Manager, Provincial Addiction and Mental Health, Community and Specialized Initiatives, Child, Youth and Family Initiatives

Carla McLean – Manager, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

Anna Nadirova, Evaluation Lead, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

REPORT PREPARED BY

Anna Nadirova (Lead Author), Senior Research Officer, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

Yasemin Tulpar, Research Officer, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

Helaine Krystkowiak, Research Assistant, Provincial Addiction and Mental Health, Knowledge, Performance and Integrated Planning

Acknowledgments

This evaluation would have not been possible without the support of management and leadership within the Provincial PChAD Program and the members of the PChAD Steering Committee. Their leadership through this process was valued and appreciated.

We would particularly like to acknowledge and thank the staff from the PChAD protective safe houses in Calgary, Edmonton, Red Deer and Grande Prairie. Andrea Andrews, Tara Roth, Tara Schmidt, Christie Spronk, Shainon Swanston, Cory Waldrum and their colleagues provided invaluable support and input into the evaluation data collection. Their contribution was commendable, especially considering the need for continued operational responsibilities.

This report would not be possible without the contribution of survey respondents and focus group participants. We thank children, their parents or guardians, addiction counsellors, police officers, court clerks and judges for sharing their experiences and thoughts with us.

We highly appreciate the extensive contribution on the part of Doris Wylie from Community and Specialized Initiatives, Barbara Callaghan from Capacity and School Initiatives and Kathryn Krause from Knowledge, Performance and Integrated Planning on the data entry, evaluation logistics and other important tasks associated with this evaluation. We also would like to thank Zhijie (Sam) Shen and Sam Sugawara for their help with the provincial data analysis. The time commitment and expertise provided by these staff are invaluable for the successful completion of this report.

We hope that the evaluation findings will provide useful information on the successes and challenges of the PChAD program, experiences of diverse client and stakeholder groups and possible avenues for further improvement to meet emerging needs.

Copyright

This report has been prepared on behalf of Child, Youth and Family Initiatives – Provincial Addiction & Mental Health, Alberta Health Services for:

Alberta Health, Health Services
Provincial Addiction & Mental Health Branch

This report was prepared by:
Knowledge, Performance and Integrated Planning
Provincial Addiction & Mental Health
Alberta Health Services

Alberta Health Services

Table of Contents

List of Tables

List of Figures

Glossary of Terms

The Glossary of Terms defines terms used in the evaluation report.

AHS – Alberta Health Services

AHS Youth Addiction Services (YAS) - AHS Youth Services is dedicated to helping adolescents develop a lifestyle free from the abuse of alcohol, tobacco, other drugs and gambling. YAS works with youth, their families, professionals, and the community to address a full range of concerns related to adolescents and addictions. From education, information and prevention through to residential treatment and aftercare, YAS provides a broad continuum of services.

ASIST - Addiction System for Information and Service Tracking, which collects data for treatment, prevention and information services provided and entered by clinicians.

Parents/Guardians – parents or other legal guardians of a child admitted to the PChAD program

PChAD – Protection of Children Abusing Drugs program

PSH – Protective Safe House

Executive Summary

Evaluation Purpose

In August 2014 the Evaluation Areas of Inquiry document was developed by AHS staff in consultation with the PChAD Steering Committee. It outlined the evaluation questions to assess the impact of the 2012 PChAD Act amendments on PChAD clients, staff and stakeholders. The proposed evaluation also intended to gather information on what had been working well in the post-amendment PChAD program and what can be further improved.

PChAD Program

The Protection of Children Abusing Drugs Act (PChAD) was passed by Alberta Legislation on May 10, 2005 and implemented on July 1, 2006. The purpose of the PChAD program is to help children under 18 years of age whose substance abuse has caused or is likely to cause significant physical or psychological harm to themselves or others. The program provides an intervention for children who are refusing voluntary addiction treatment services and their families. Children in the PChAD program receive a detailed addiction assessment, social detoxification and stabilization.

The PChAD program is delivered in the four protective safe houses (PSH) in Edmonton, Calgary, Red Deer and Grande Prairie with the total of 25 beds available. The court-issued protection order covers both apprehension and confinement, allowing police to apprehend the children and transport them to the PSHs. Under the PChAD Act, children can be confined for 10 days, with a possibility of extension to 15 days. The confinement is intended to provide an opportunity for the initial detoxification, addiction assessment and the development of a discharge treatment plan for further treatments and supports using community-based services.

Amendments to the PChAD Act

The 2012 PChAD Act amendments cover the following areas (refer to the report for further details):

- consideration by the courts of specific types of information in determining whether the child is abusing drugs;
- extension of the PSH confinement from 5 to 10 days;
- authorizing police to apprehend and convey the child to a PSH or assist the parent/guardian in conveying the child;
- mandating attendance at the information (pre-application) session by parents/guardians as a prerequisite for a protection order application;
- outlining expiration provisions for a granted protection order;
- providing treatment in a facility other than a protective safe house;[1]

[1] This particular amendment was not examined in this evaluation due to lack of specific information on the exact numbers and whereabouts of the clients who received the off-site PChAD services.

- disclosure of information on the child's assessment to the parent/guardian;
- protection order review provisions for the parties other than the child who is subject to the protection order.

This evaluation aims to assess the implications of the PChAD Act amendments at various client and stakeholder levels. The current report identifies areas for improvement as the PChAD program continues to evolve and proposes recommendations for improvement.

The evaluation findings are delineated in this report according to the following eight major themes addressed by the evaluation:

1. Availability of Quality Information Regarding PChAD for the General Public and Potential Clients
2. Content of PChAD Pre-application Sessions and Its Effectiveness for Making the Decision to Use PChAD
3. Parents/Guardians' Readiness for the Protection Order Application and Court Hearing
4. Implications of the Specific Types of Information Considered by the Courts
5. Clients' Familiarity With the Protection Order Conditions and Utilization of the Right for a Protection Review
6. Appropriateness of the Transportation Arrangements: Client and Stakeholder Feedback
7. Client and PChAD Staff Feedback on the Stay at the Protective Safe Houses (PSHs)
8. Maintaining Treatment Momentum After Discharge from the Protective Safe Houses (PSHs)

Corresponding PChAD Act amendments (if applicable) are outlined in the beginning of each section along with the associated evaluation questions.

Evaluation Methodology

The evaluation used a mixed methods approach in data collection and analysis, involving both quantitative and qualitative methods. Quantitative data were collected via multiple surveys and analyzed using descriptive statistical techniques (frequency distributions and cross tabulations). Qualitative data originated from the extensive open-ended survey questions as well as from the client and stakeholder feedback obtained via focus groups (parents/guardians) and written feedback (i.e., feedback from the judges in response to the questions posed by the evaluation team). Inductive content analysis was applied to the qualitative data.

Surveys and Focus Groups

Comprehensive surveys were developed in alignment with the PChAD evaluation framework. Paper-and-pencil, online and telephone survey formats were used depending on the type of respondents, survey venues, and timing and purpose of the survey data collection. The survey data were collected from November 2015 through June 2016. The surveys included:

- Youth PSH Discharge Survey
- Parent/Guardian PSH Discharge Survey
- Parent/Guardian One Month Follow-up Survey (one month after discharge from the PSH)

- PChAD Staff Survey
- Court Clerk Survey
- Police Survey
- Addiction Counsellor Survey

Three parent/guardian focus groups were conducted in May-July 2016 in Grande Prairie, Edmonton and Calgary with the parents/guardians whose children were admitted to the PChAD program following the PChAD Act amendment year (2012).

Both the survey respondents and focus group participants were informed about the purpose of evaluation. They were also advised that their participation was voluntary and the answers would remain anonymous/confidential and would be reported aggregately with other respondents. Focus groups and follow-up telephone surveys were conducted by the AHS evaluation team members or staff none of whom were part of the PChAD program. The audio recording of the focus groups was done after obtaining consent from all participants before starting a focus group.

Feedback From the Court Judges

Feedback from the court judges was facilitated by the PChAD Steering committee members. Questions to the judges were developed and forwarded to judges for their written feedback. After written responses were collected, the feedback was rolled up according to the major themes by the Ministry of Justice staff and sent back to the AHS evaluation team.

PChAD Provincial Overview: Pre and Post PChAD Act Amendments

In order to provide a general background for interpretation of the specific evaluation findings based on the client and stakeholder feedback and to find out whether any dynamics in the program characteristics occurred following the PChAD amendments, province-wide overview of the general PChAD statistics was done using Alberta Health Addiction System for Information and Service Tracking (ASIST) data. The ASIST data included the PChAD Act amendment year (2012) as well as three pre-amendment years (2009-2011) and three post-amendment years (2013-2015)

A noteworthy trend in the ASIST data following the amendment year was a hike in the proportion of older adolescents admitted to the program. While up to 2012 about two-thirds (62-66 percent) of the admitted children were in a younger age group (12-15 years old) and about one-third (34-38 percent) encompassed older ages (16-17 years old), starting from 2013 these proportions split approximately half-by-half: 50-54 percent of 12-15 years old and 46-50 percent of 16-17 years old.

The total PChAD admission numbers grew gradually with some ups and downs - from 511 children in 2009 to 608 children in 2015. A large majority of all PChAD admissions over this seven year period were first time admissions or first time users of PChAD. The number of first time admissions showed a substantive increase in 2009-2011 (from 321 to 390 admissions or 18%), but after that plateaued and

hovered around 390-400. The total number of repeated admissions (2 times or 3 or more times) saw some increase from 2009 (105 admissions) up to 2011 (128) and then declined in the PChAD Act amendment year (104) and after (76-111 admissions in 2013-2015).

The number of application submissions for protection orders have not increased since 2012, but fluctuated up and down from year to year. On the other hand, the number of requests for order reviews grew steadily since 2009.

Evaluation Findings

1. Availability of Quality Information on PChAD to the General Public and Potential Clients

Although in theory it would be desirable to have a single, reliable source of public information on PChAD (i.e., AHS), in reality potential clients may tend to use multiple unauthorized resources. According to the parent/guardian survey, AHS related sources accounted only for half (53%) of the means used to first learn about the PChAD program. The remaining half included law enforcement, word of mouth (e.g., other parents, friends, relatives or co-workers), parent support groups, children and family support services, schools and various health or mental health support providers (e.g., a family doctor, psychiatrist, psychologist, etc.). There were different accounts of how easy it was to locate initial information about PChAD; some focus group participants noted that they had to go through multiple search steps before locating the needed information.

The feedback from parents/guardians suggests that more efforts to raise public awareness about PChAD are necessary to ensure those in need receive timely and accurate information. Relying on multiple information contacts will most likely continue (especially for the new potential clients). Thus it is important that accuracy and consistency of the PChAD related information is maintained across the information providers. AHS will continue to look for opportunities to share accurate and current information on the PChAD program with multiple stakeholders (including the community and the Government of Alberta), who potentially will be interfacing with families who are considering PChAD services.

2. Content of PChAD Pre-application Sessions and Its Effectiveness for Making the Decision to Use PChAD

After acquiring initial information available in the public domain on PChAD the next step in the process for parents/guardians is a pre-application information session with an addiction counsellor. According to the PChAD Act, attending a pre-application session is mandatory for a parent/guardian who would like to apply for a protection order to confine the child to a PSH.

Survey data indicate that pre-application sessions were available to most parents/guardians within one week or faster, which suggests good accessibility. Ninety two percent of the parents/guardians who were surveyed at their children's discharge from the PSHs, strongly agreed or agreed that the pre-

application sessions helped them make an informed decision whether they should apply for a protection order. Somewhat lower proportions (85-86 percent) strongly agreed/agreed that the pre-application sessions helped them learn about other programs that could benefit their child, understand the expectations for parent/guardian participation, and learn about supports for the families.

The addiction counsellor survey points to the comprehensive information delivered at the pre-application sessions. However there was a substantive variation in the reported duration of the sessions. As well, parent/guardian focus groups pointed out inconsistency in the quality of pre-application sessions and provided mixed feedback on the usefulness of the sessions in preparation for court appearances (the key information in the application process) – see the next section.

3. Parents/Guardians' Readiness for the Protection Order Application and Court Hearing

Both court judges and clerks considered a pre-application (information) session to be the appropriate preparation venue where parents/guardians should be given information on the reasons for seeking the protection order, how to appear in court, what to expect and how to give evidence.

The parent/guardian focus groups participants reported that they received mixed support in pre-application sessions, as some were told exactly the types of evidence to prepare for the court hearing, while others were not. Finding necessary information could be especially difficult for those who were not skilled at using computers or lived in rural areas, especially in remote areas where fewer supports or direct information sources are available and access could be difficult due to the greater distance to services.

Court clerks and judges feedback also point to possible gaps in the preparedness for the court appearance. For example, only 20% of the surveyed court clerks indicated that parents/guardians who come to file the court applications for the first time have a clear idea of the application procedure. As well, only 23% of the court clerks thought that the first-time applicants were well informed on what would happen during the protection order hearing. Congruently, the judges suggested that the applicants should be given information on the specifics of the court procedure, including providing the evidence in a written form (e.g., in an affidavit), which would help in presenting the evidence in a coherent, clear format.

These findings, as well as the addiction counsellors' feedback, imply that a consistent format of pre-application session delivery should be implemented across the province, including development of essential content as well as a carefully prepared, easy to use set of resources for addiction counsellors and parents/guardians.

4. Implications of Specific Types of Information Considered by the Courts

According to the amended PChAD Act, "In determining whether a child is abusing drugs, the Court must consider any evidence with respect to the following: (a) the age of the child; (b) the types of drugs being

used by the child; (c) the length of time that the child has been using the drugs; (d) the intensity, pattern and frequency of drug use by the child; (e) the impact of drug use on the child's life…" (Section 2.1[2])

When commenting on the implications of the specific types of information considered by the courts, the judges stressed the importance of the quality of the evidence provided by parents/guardians, who have to be well prepared for the court applications. For instance, the judges commented that the information received from parents/guardians on drug use does not always contain enough details, including outlining the evidence on each kind of "drug" used. The judges would hope that the educational information given to applicants before coming into court is helpful in informing them about the grounds for making an application. With respect to other information that is not currently included in section 2.1(2) of the Act, the judges responded that the evidence on previous PChAD stays (if applicable) and participating in and completing (voluntary) treatment program(s) would be helpful to the court.

From the parent/guardian perspective, 94% of the parents/guardians surveyed at discharge strongly agreed or agreed that the court gave their applications a fair consideration. The focus groups generated more detailed and critical feedback. The participants reported inconsistencies in the courtroom experiences, including the type and level of evidence required, the types of questions asked by the judge and grounds of granting the protection order. There was a concern that the evidence-gathering and pre-application processes are difficult and in some cases may impede access to the program. Lastly, parents/guardians felt that judges were disproportionately more demanding during review hearings, and felt this was not justified. Although nearly all focus group participants applied for extensions, only one received it.

The focus group participants suggested the following modifications to make court hearings more comfortable for children and their parents/guardians.

- The inclusion of drug testing results as evidence to inform the granting of a protection order would reduce the burden of verbal testimony on drug use.
- Children should not be exposed to parent/guardian's testimony, because it can be traumatic for the families, given that they already undergo stressful situations with a lot of negativity. Parents/guardians whose children were not present at the hearing reported that they thought that was a better way to conduct the process; an option to segregate the children during hearings should be considered.

5. Clients' Familiarity With the Protection Order Conditions and Utilization of the Right for a Protection Review

The amended PChAD Act contains provisions for the expiration of the protection order (50 days from the date of granting), as well as the rights of an extended spectrum of parties - the child, guardian(s), the Coordinator (AHS) or any other person, with the permission of the court, to apply for a review of a protection order. The evaluation examined the clients' awareness and utilization of these provisions.

According to the discharge parent/guardian survey, 81% of the respondents were informed about the protection order expiration clause. Three quarters of them received this information at the pre-application sessions and about half from the judge (some respondents indicated more than one information source).

The survey results attested to a high degree of awareness among the parents/guardians of their children's right to a protection order review (90%) and of their own right to a review (85%). Pre-application sessions and communication with the PSH staff were equally important sources for this information. However, much lower percentages knew that other parties (besides the child or the parent/guardian), can apply for a review - only 58, 57 and 37 percent respectively were aware of AHS' right for a review, another guardian's right for a review, or the right for a review by any other party.

Quite a high percent of the surveyed parents/guardians (40%) indicated that their children applied for a review to *end* the protection order. A comparable percent of children (39%) who were also surveyed at discharge reported applying for a review to end the order, and 16% of children reported other parties applying. As protection order review hearings (especially to end the order) may take place at the beginning of children's stay at the PSHs, the parent/guardian focus groups suggested that children should not be allowed to testify in the court while still detoxing and under the influence of drugs. Administering a drug test would determine whether the child is clean of drugs.

While the majority of the surveyed children felt that they had enough help during the review process, only slightly over half of the surveyed parents/guardians reported having necessary supports. According to them, "Support for the parents would be a large value when a review is conducted." The findings indicate that more supports should be provided for parents/guardians affected by the reviews, including better communication of information about what the review procedure entails and timely notification of the pending review to allow enough preparation time.

Based on the survey results, 14% of the parents/guardians applied for an *extension* of the protective orders, additional 4% reported other parents/guardian(s) applying, and 10% indicated that their children applied. Some parents/guardians mentioned that they "would have likely tried" to apply for an extension, but they did not know ("were never given the information") about this option.

6. Appropriateness of the Transportation Arrangements: Client and Stakeholder Feedback

According to the amended PChAD Act, "Subject to the regulations,… a police officer must exercise the authority" (Section 2.1[6]), i.e., apprehend and transport the child to the PSH.

Childrens' discharge surveys revealed mostly positive experiences with apprehension and transportation by police: 64% of the surveyed children reported feeling respected, 75% felt safe, 56% did not feel scared, 70% understood what was happening and 71% had an overall okay experience with police.

Positive experiences with police were also reported during the parent/guardian focus groups. Some were grateful to be able to request police apprehension as "it is the only resource available" when they did not know where their children were. Rural residents reported difficulties to get the police involved

as their detachments often only had a few officers on duty at any time. Parents/guardians also felt that 72 hours to find, apprehend, and transport a child was not a lot of time if any difficulties were encountered.

When asked in the survey about impacts of the PChAD Act amendment on police, 29% of police officers indicated that executing protective orders was a burden on police resources. Specific issues included bed availability, being short-staffed, planning time involved, delays in higher priority work, etc.). While apprehension and transportation by police is required under the PChAD Act, some adjustments may be suggested to ease pressures on the police resources, including continuing to use sheriffs as an alternative means of transporting children to the PSHs (after apprehension by police). As well, police feedback suggested that the coordination of apprehension and transportation should be enhanced, including securing bed availability for the child's arrival, providing officers with information on exact PSHs locations, and booking the beds as close to children's places of residence as possible to avoid unnecessary long-distance travel. The officers underscored the need for more active parent/guardian participation in coordination of apprehension and transportation, including inquiring about bed availability and making sure the protection orders are received by police in advance, to allow enough time for planning.

It followed from the police survey that PChAD-related training and resourcing of the police should be enhanced. Only 20% percent of the officers reported that they were provided either orientation or materials when they first became involved in PChAD, while 67% said they did not receive orientation or materials. Varied training opportunities and resources (including printing and distributing more information cards) could be provided by AHS and its staff. Also, an option of making PChAD part of the general police training and orientation was suggested, as well as allocating or hiring staff dedicated specifically to PChAD.

7. Client and PChAD Staff Feedback on the Stay at the Protective Safe House (PSH)

Overall, the majority of children surveyed at discharge expressed a positive stance towards various aspects of the PChAD program. They strongly agreed or agreed that staff were supportive (94%) and that they had enough opportunity to talk to the counsellor about their substance use (93%). At the same time, lower percentages thought that they gained more understanding about the effects of substance use on their health (82% strongly agreed/agreed and 10% disagreed), and that staying at the PSH was good for them (73% strongly agreed/agreed and 18% disagreed).

Ninety one percent of the parents/guardians surveyed at discharge strongly agreed or agreed that they were well informed on what will happen to their children at the PSH, and 81-85 percent strongly agreed/agreed that they were well informed on: the procedure for assessment and recommendations; information they would receive as a result; how they could be involved; and available supports for parents/guardians during and after PChAD.

However, half of the parents/guardians (based both on the discharge survey and one month follow-up survey) and over a quarter of the surveyed PChAD staff were of the opinion that the current length of stay in PChAD does not meet the needs of all children entering the program. The staff reported that not all children left the PSHs detoxed and far from all of them left stabilized. It was suggested that the decisions regarding the length of stay and/or extension of stay should be based on individual children's circumstances, needs and progress, and the staff and parent/guardians should be part of these decisions.

The surveyed children indicated that they liked socializing with their peers at the PSHs, and the staff confirmed negative networking among the children while in the PSHs. Negative networking can be counteracted by close consistent supervision, minimizing interpersonal engagement among children, maximizing their engagement with the staff and separating children who are more experienced in substance abuse from children with less experience. These strategies may require more staff and possibly other adjustments.

As far as family engagement is concerned, according to the child survey results, a majority of children (85%) talked to their family members during the PSH stay. The parent/guardian survey accounts of various types of engagement including telephone conversations (91% of parents/guardians), visits at the PSHs (69%), requesting information on the assessment and recommendations (66%), meeting with the family counsellor (54%) and counselling sessions jointly with the child (39%).

While the surveyed PChAD staff indicated that there was "always" or" most of the time" enough opportunity to involve the family in the child's assessment (58%) and discharge planning (64%), a quarter (26%) noted that the sufficient opportunity to involve the family in assessment occurred only "sometimes" or "rarely," and 20% mentioned the same with regard to the involvement in discharge planning. Child cooperation may be an important factor affecting family engagement, but the evaluation evidence also points to the possibility of the communication and availability of information to be a possible constraining factor.

Focus groups as well as one month follow-up parent/guardian survey, revealed that some parents/guardians felt excluded during their child's PSH stay and wanted to work more closely with the program and be able to "access information when they need it." Some were denied information on their child's progress and were told this information was confidential or were refused specific information, including which drugs their children admitted to using. In general, parents/guardians expressed a desire for better, consistent communication with the PSH and PChAD staff and for being part of the decisions.

The reasons for low attendance at education programs/sessions for parents during their children's stay at the PSHs (as evidenced by the parent/guardian survey at discharge), should be further investigated and the identified constraints addressed. Lack of time/scheduling conflicts, lack of information about these educational opportunities and living too far away were the major reported reasons for not attending.

8. Maintaining Treatment Momentum After Discharge From the Protective Safe Houses (PSHs)

PChAD is not a treatment program, but a mandated service that interrupts a child's substance use and provides detoxification, stabilization, assessment and recommendations for further voluntary treatment or support programs in the community. The evaluation used parent/guardian surveys at discharge from the PSH and one month after discharge, and also parent/guardian focus groups to assess the clients' experiences with planning for and utilization of the post-PChAD services.

According to the parents/guardians surveyed at discharge, the staff provided them with clear treatment recommendations for after the child's discharge (79% strongly agreed or agreed) and provided appropriate referrals for treatment and/or counselling after PChAD (80%). Eighty five percent of parents/guardians indicated that they were going to make use of the recommendations, and 77% of surveyed children were planning to follow the recommendations from their assessment. The staff survey suggested, however, that there could be instances when assessment and a discharge and treatment plan tailored for each child are not completed.

The one month follow-up survey captured positive feedback on PChAD. Parents/guardians commented that it "was a small time window but helpful," the program helped their child on the road for further treatment, and was exactly what the child needed at the time. They also mentioned having a good experience with the program staff and that the program was "well run."

However, according to the one month follow-up survey and focus groups, the connection between PChAD and follow-up treatments could be the weakest link in the desired continuum of services and supports, where a lot of positive momentum emanating from PChAD can be lost. The parents/guardians were frustrated by the long wait lists (lack of access), unavailability of the recommended services, and lack of information on services or supports (e.g., support groups). Rural residents felt disadvantaged in terms of the services available to them compared to their urban counterparts. The parents/guardians requested that, if possible, ongoing treatment recommendations and access to the relevant services are discussed with children and their parents/guardians while in PChAD, prior to discharge, as the required assessment (including mental health assessment if needed) is on the way. This would make it possible to make the follow-up appointments in advance.

Mental health issues co-occur with drug use and associated services and supports are very much in demand among the PChAD clients to ensure a comprehensive approach to their needs. The evaluation indicated that facilitation of an easier access to mental health services should be examined and the ties and referral pathways to available follow-up mental health services and programs strengthened. As well, services dedicated to beginning to address concurrent disorders like a standardized approach to mental health screening could be conducted while the children are in the PChAD program.

Because children present in various stages of change and readiness to decrease or abstain from substance use, parents/guardians suggested that mandatory (non-voluntary) treatments should be available for the children who will not consent to voluntary treatments or supports following PChAD.

Suggested Recommendations for improvement

The evaluation identified many positive aspects of the PChAD program and user experience. As well, the participants spoke to what they believed were the ways to improve the program. They identified systemic gaps, such as the disconnect between addiction and mental health services, facilitating more timely or immediate access to voluntary treatment following PChAD, and considering possibilities of additional mandated programs. Their comments were consistent with the topics of the Valuing Mental Health Report (Alberta Mental Health Review Committee, 2015), which outlines the key strategies to respond to the dynamic and complex issues associated with addiction and mental health care in Alberta. Thus, when planning changes and improvements to the PChAD program, it is imperative to consider the current Alberta addiction and mental health services integrated continuum of care.

It is also noteworthy that many of the recommendations were consistent with the 2014 findings of the PChAD Program Review and some of the work to address identified issues is underway.

Given that the stakeholder feedback is broader than the immediate operational PChAD mandate, the proposed recommendations encompass two major types based on their scope – those that are under direct PChAD operational jurisdiction ("PChAD") and those attributable to our cross-ministerial partners ("GOA stakeholders:" Human Services, Justice and Solicitor General, and Alberta Health).

Below only general recommendation statements are outlined. More details, including rationale, are available in the report. The following recommendations were suggested:

1. ***Improve access to reliable and consistent information regarding the PChAD program at all stakeholder levels including the general public.***
2. ***Pre-application information sessions consistently cover core program content and provide provincial PChAD developed resources and handouts.***
3. ***Provide sufficient orientation, resources and supports to ensure parents or guardians are well prepared for the court applications and hearings, including protection order and order reviews.***
4. ***In partnership with Justice and Solicitor General Stakeholders, explore recommendations for the courts to make court experiences more consistent, effective and less stressful for the families and children within PChAD programming.***
5. ***Work with the PChAD program, Ministry of Justice and Solicitor General to make the best use of the police resources to fulfill the PChAD Act's provision for children's apprehension and conveyance to the PSH by police.***
6. ***Examine the legal permissibility and practical applicability (including costs) of testing children for drugs.***
7. ***Develop consistent practices in engaging families and sharing information with parents and guardians.***

8. ***Explore the potential to increase staffing compliments in Protective Safe Houses to improve client supervision and enhance engagement between children and PChAD staff.***
9. ***Children in PChAD should have access to mental health services while confined in the PSH to fully integrate addiction and mental health services.***
10. ***Facilitate a seamless transition to post-PChAD treatment programs and services along the continuum of care.***
11. ***Examine options for enhancing immediate access to services for children leaving the PChAD program including review of service gaps and duplications in the Continuum of Care.***

Introduction

Background

PChAD Program

The Protection of Children Abusing Drugs Act (PChAD) was passed by Alberta Legislation on May 10, 2005 and implemented on July 1, 2006. The purpose of the PChAD program is to help children under 18 years of age whose substance abuse has caused or is likely to cause significant physical or psychological harm to themselves or others. The program provides an intervention to children who are refusing voluntary addiction treatment services and their families. Children in PChAD receive a detailed addiction assessment, social detoxification and stabilization.

Prior to PChAD there was no assessment, detoxification or treatment planning services for youth in Alberta who refused voluntary addiction services. The Act has provided parents or guardians the option to apply to courts for a protection order to apprehend a child who is using drugs and to have the child safely transported to a protective safe house where he/she is confined for 10 days and provided with assessment and detoxification services as well as with a post confinement treatment recommendations outlined in an assessment letter.

The PChAD program is delivered in the following four protective safe houses (PSH) throughout Alberta:

- Edmonton PSH – 9 beds
- Calgary PSH – 9 beds (as of April 2016)
- Red Deer PSH – 5 beds
- Grande Prairie PSH – 2 beds[2] (as of August 2014)

The protection order covers both apprehension and confinement, allowing police to apprehend the children and transport them to a PSH. Under the PChAD Act, children can be confined for 10 days, with a possibility of extension to 15 days. The confinement is intended to provide an opportunity for the initial detoxification, addiction assessment and the development of a discharge treatment plan for further treatments and supports using community-based services.

Once children arrive at the PSH, they are given the option to have their order reviewed by the Provincial Court within 24 hours. Should the children wish to challenge the court order, they are provided with appropriate legal representation. The Court may then revoke the order, in which case the child is discharged from the PSH.

Parents/guardians are required to be involved with the children during their stay at the PSH. However, the level of involvement depends on the child's cooperation. Children are discharged from the PSH with a detailed plan for further support or treatment based on their assessment. A child may choose to be

[2] Grande Prairie PSH combines two beds for PChAD and two beds for voluntary treatment.

involved in the development of their treatment plan, and parents/guardians are required to be involved with the discharge plan, since the child must be released into the custody of a responsible adult.

Amendments to the PChAD Act

Two phases of evaluation (in 2006/07 and 2007/08) were conducted to determine the implications of the PChAD program in terms of the services delivered and the impact of the services on youth and their families. Recommendations generated as a result of these evaluations informed some of the following 2012 PChAD Act amendments:[3]

- ***The court must consider specific types of information in determining whether the child is abusing drugs:***
  2.1(2) "In determining whether a child is abusing drugs, the Court must consider any evidence with respect to the following: (a) the age of the child; (b) the types of drugs being used by the child; (c) the length of time that the child has been using the drugs; (d) the intensity, pattern and frequency of drug use by the child; (e) the impact of drug use on the child's life…"

- ***Extension of the confinement at the protective safe house from 5 to 10 days:***
  2.1(3)(b) "A protection order may contain provisions authorizing… the director of a protective safe house to confine the child in accordance with the order for one period of not more than 10 days…"

- ***If ordered, a police officer must apprehend and convey the child to a protective safe house or assist the guardian to convey the child (if there are reasonable grounds to believe that the guardian cannot convey the child):***
  2.1(6) "Subject to the regulations, if a protection order contains provision referred to subsection (4), a police officer must exercise the authority."

- ***A guardian must attend an information session prior to applying for a protection order:***
  2(2) "A guardian may make an application… only if the guardian has, with regard to the application, attended an information session…"

- ***Expiry of a granted protection order within 50 days:***
  2.2 "If the child who is the subject of a protection order has not been confined in a protective safe house and the Co-ordinator has not taken any action under section 3(4) in respect of the child within 50 days from the date on which the protection order is granted, the order expires."

- ***Providing treatment in a facility other than a protective safe house:***
  3(4) "If the child is being treated in a health facility or is in a youth custody facility while the protection order is in effect, the Co-ordinator may assess the child, treat the child for the effects of detoxification and provide services to stabilize the child while the

[3] Province of Alberta (2012). *Protection of Children Abusing Drugs Act*. Edmonton, Alberta: Alberta Queen's Printer.

child is in that facility if the Co-ordinator is satisfied that the circumstances are appropriate for those purposes."[4]

- ***Disclosure of information to the guardian:***
  3(6) "If the Co-ordinator considers it to be in a child's best interests for a guardian of the child to have any information respecting the assessment of the child under subsection (3) or (4), the Co-ordinator may disclose the information to the guardian without the child's consent."

- ***Review of protection order, including parties other than the child who is subject to the protection order:***
  4.1(1) "An application to the Court for a review of a protection order may be made by (a) the child who is the subject of the order, (b) a guardian of the child, (c) the Co-ordinator, or (d) any other person, with the permission of the Court."

This evaluation aims at assessing the practical implications the abovementioned amendments, as well as how other important issues around PChAD have been addressed at various stakeholder levels. The current report identifies further areas for improvement as the PChAD program continues to evolve.

Evaluation Purpose

The PChAD evaluation is based on the Evaluation Areas of Inquiry document (August 6, 2014), which was developed in consultation with the PChAD Steering Committee. The evaluation was designed to assess the implications of the 2012 PChAD Act amendments for PChAD clients, staff and stakeholders by collecting feedback from the respective groups. The evaluation was also looking for information on what has been working well in the post-amendment PChAD program and what can be further improved.

The evaluation had the following general goals:

1. To document the experiences of PChAD clients (youth and their parents or guardians), PSH staff and varied stakeholders, including court judges, court clerks and police services, with the PChAD program and associated functions, including:
   (a) quality of information on PChAD available to the general public;
   (b) pre-application sessions quality and utility for parents/guardians;
   (c) impact of the specific evidence considered by courts on granting protection orders;
   (d) parents/guardians' experiences with the court hearing;
   (e) appropriateness and effectiveness of the youth transportation arrangements;
   (f) utilization of and experience with the extended options to access the review;
   (g) opportunities for parents/guardians to receive information on assessment and recommendations;
   (h) opportunities for parents/guardians' involvement in assessment and discharge planning.

[4] This particular amendment was not featured in this evaluation due to lack of specific information on the exact numbers and whereabouts of the clients who received the off-site PChAD services.

2. To assess the feedback from youth, parents/guardians, PSH staff and PChAD stakeholders on the increased (10-day) PSH stay.
3. To assess youth and parents/ guardians' experiences with the community services and supports following discharge from the PChAD program.
4. To collect suggestions from the PChAD clients, staff and stakeholders on how to improve the program including relevancy to the clients' needs.

Evaluation Methodology

The PChAD evaluation framework was developed by Performance Measurement and Knowledge Exchange and vetted with Child, Youth and Family Initiatives, Provincial Addiction and Mental Health, Alberta Health Services. The evaluation framework outlined the themes of interest and key questions to be addressed by the evaluation, as well as data sources. Evaluation progress updates were provided on a regular basis to the Provincial Addiction and Mental Health senior management, PChAD managers and the PChAD Steering Committee during its meetings.

The evaluation used a mixed methods approach in data collection and analysis, involving both quantitative and qualitative methodology and data. Quantitative data were collected via multiple surveys and analyzed using basic statistical techniques (frequency distributions and crosstabulations). Qualitative data originated from extensive open-ended survey questions as well as from the client feedback obtained through focus groups. Inductive content analysis was applied to the qualitative data.

Data Collection

Surveys

Comprehensive surveys were developed in alignment with the PChAD evaluation framework. The surveys incorporated both closed-ended and open-ended questions. Open-ended questions were introduced to clarify close-ended responses and gain further insights into quantitative results. For example, the parents/guardians were asked to comment on how they first found out about the PChAD program. The parents/guardians were also asked to write what they liked the most or the least about PChAD as well as provide any other closing comments. Given that some children might come to the PSHs repeatedly, the child survey as well as parent/guardian survey asked the respondents about their *current* experience with PChAD, even if they were involved in the program more than once.

In addition to the paper-and-pencil surveys which were administered around the discharge time, parents/guardians were asked for their consent to be contacted to share their experiences one month following PChAD. The follow-up telephone survey was administered by the AHS staff who were unrelated to the PChAD program. The one month follow-up survey contained questions about access to and satisfaction with the post-PChAD services as well as the children's progress one month following PChAD. Three attempts were made to contact parents/guardians who signed the contact consent forms

when their children were discharged from PChAD. Each contacted parent/guardian was informed that their responses were voluntary, confidential and would be reported aggregately with other respondents.

In all, six individual surveys were created for each client and stakeholder group. The surveys were administered online, in a paper-and-pencil format or by telephone, depending on the survey data collection contexts (see Tab below). The PChAD Steering Committee members assisted with reaching the court clerks and members of the police service.

In addition to the surveys crafted specifically for the PChAD evaluation, the survey data from addiction counsellors that were collected for the 2015-2016 PChAD program review were used in this report (see Table1). The surveyed addiction counsellors were administering PChAD pre-application sessions, which upon 2012 amendments to the PChAD Act became mandatory for the parents/guardians who want access the PChAD program.

Table 1: PChAD Evaluation Surveys

Survey	Administration Method	Data Collection Period	Number of Respondents
Youth PSH Discharge Survey	Every youth discharging from a PSH was asked by the PSH staff to complete a paper-and-pencil survey on a voluntary basis	Nov 2015 - May 2016	173
Parent/Guardian PSH Discharge Survey	The parent/guardian of every discharging youth was asked by the PSH staff to complete a paper-and-pencil survey on a voluntary basis	Nov 2015 - May 2016	139
Parent/Guardian One Month Follow-up Survey	Parents/guardians of every discharging youth were asked by the PSH staff for their consent to be contacted by phone one month after discharge for their feedback on the follow-up services and their children's progress	February - June 2016	27
PChAD Staff Survey	All PSH staff were asked to answer an online survey	April – May 2016	50
Court Clerk Survey	An online survey was forwarded to Alberta court clerks	Sept – Oct 2015	24
Police Survey	An online survey was forwarded to Alberta RCMP officers	Sept – Oct 2015	142
Addiction Counsellor Survey	An online survey was forwarded during the PChAD program review to the addiction counsellors who delivered pre-application sessions to parents/guardians	July-Aug 2015	30

Parent/Guardian Focus Groups

Three focus groups were conducted in May-July 2016 in Grande Prairie, Edmonton and Calgary with the parents/guardians whose children were admitted to the PChAD program after 2012 (the year when the amendments were made to the PChAD Act). A moderator's guide was developed outlining the key focus group questions. The purpose of the focus groups was to obtain in-depth insights into the parents/guardians' experiences with the PChAD program, including how they found out and accessed PChAD, how it helped their children and what could be done better to meet their needs, what community-based services and supports were available to the youth and parents/guardians after discharge from the PChAD program and how useful these resources proved to be. In all, the focus groups intended to provide additional insights into the information obtained via the survey data. In total, nine parents/guardians participated in the focus groups, three male and six female, including two couples. Their experience with PChAD ranged from having a child admitted for the first or second time to a PSH to being guardians of children with multiple PSH stays.

Feedback From the Court Judges

Feedback from the court judges was facilitated by the PChAD Steering committee members. Questions to the judges were developed and forwarded to judges for their written feedback. After written responses were collected, the feedback was rolled up according to the major themes by the Ministry of Justice staff and sent back to the AHS evaluation team.

Evaluation Data Analysis

Majority of the collected survey data were quantitative in nature and were analyzed using SPSS statistical software. Descriptive statistical methods (frequency distributions and crosstabulations) were applied in combination with graphic formats to enhance visual component of the report for clarity and ease of results interpretation.

The qualitative data resulting from open-ended survey responses and comments as well as focus group responses were analyzed using inductive content analysis, coded, and reported based on prominent themes.

Consent

All paper, web-based and telephone surveys included an introduction providing information about the purpose of the evaluation, the anonymity/confidentiality of responses, and voluntary nature of participation. In all cases, participation only proceeded with consent of the respondent whose participation was requested.

Focus groups and follow-up telephone surveys were conducted by the AHS evaluation team members or staff none of whom were part of the PChAD program. PChAD staff were not present at the focus

groups. Focus groups participants were informed of the purpose of the focus groups and confidentiality of their responses. The audio recording of the groups was done after obtaining consent from all participants before starting a focus group.

Limitations

Possibility of Bias in the Data

Given the impracticality of applying randomized sampling to the populations surveyed for the PChAD evaluation, it is important to keep in mind that a bias could be introduced into the survey data. The survey data were collected from the voluntary participants and there is no way of knowing whether the individuals who volunteered to answer the survey were in any way systematically different from those who refused to participate. This could be especially true for the youth and guardian surveys, which were administered at the PSHs. This limitation should be kept in mind when the evaluation results are used for any generalizations or decision-making.

As well, some bias could be introduced in the information collected from the judges, because their written feedback was collected and summarized by Alberta Justice, which is their employing organization.

Survey Versus Focus Groups Data

Some sort of "disconnect" was observed between feedback from the parent/guardian surveys and focus groups, survey results being more "positive" compared to more "critical" focus group outcomes. This finding may be explained by the possibility that parents/guardians could generally like available information, services and other program outputs, but not every aspect of them. Focus groups provide an opportunity to deliberate in more detail on what works well or not so well. Additionally, the parents/guardians who volunteered to participate in the focus groups might be part of the group who experienced challenges either with their children's specific circumstances or PChAD's ability to meet the needs. Participating in a focus group provided the opportunity to have their voices heard. At the same time, survey participants might come from a more general population of guardians with a broader spectrum of PChAD-associated experiences ranging from very positive to very negative. Taken together, surveys and focus groups offer a variety of insights into a complex interplay of experiences, decisions, motivations and behaviors associated with PChAD.

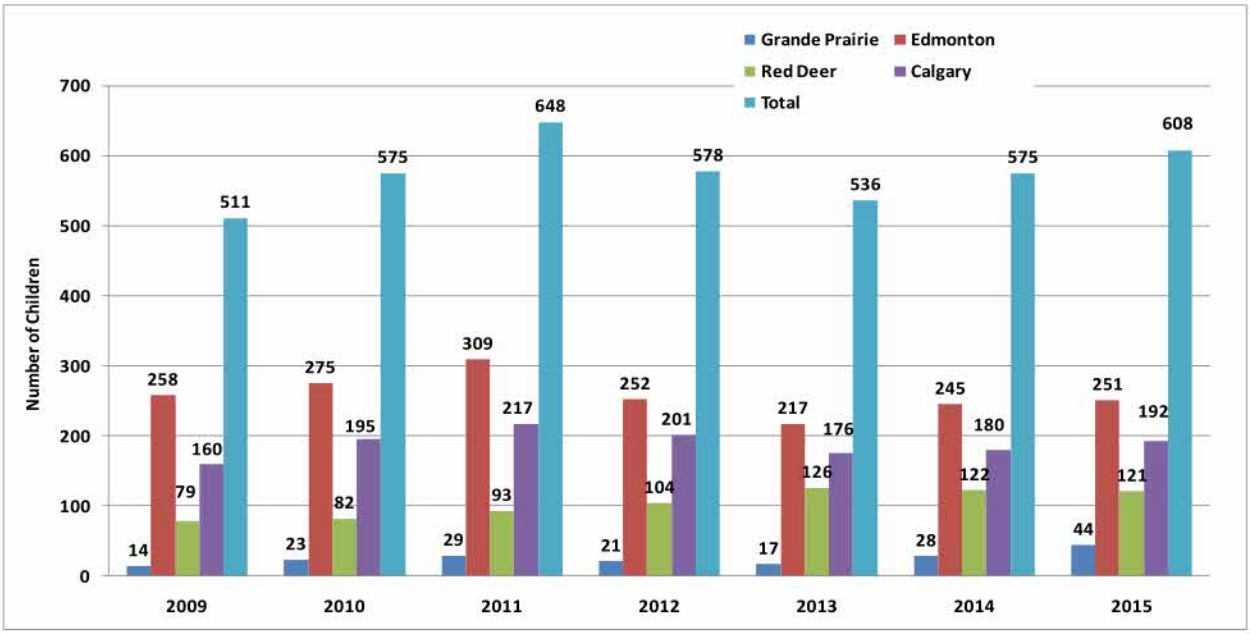
PChAD Provincial Overview: Pre and Post PChAD Act Amendment

This overview provides brief information on the scope the PChAD program province-wide as well as the pre- and post-2012 amendment dynamics. This general information, which is based on Alberta Health Addiction System for Information and Service Tracking (ASIST) data and data from the Solicitor General Office provides a useful background for understanding and interpretation of the specific evaluation findings described in the following sections of the report.

PChAD Admissions

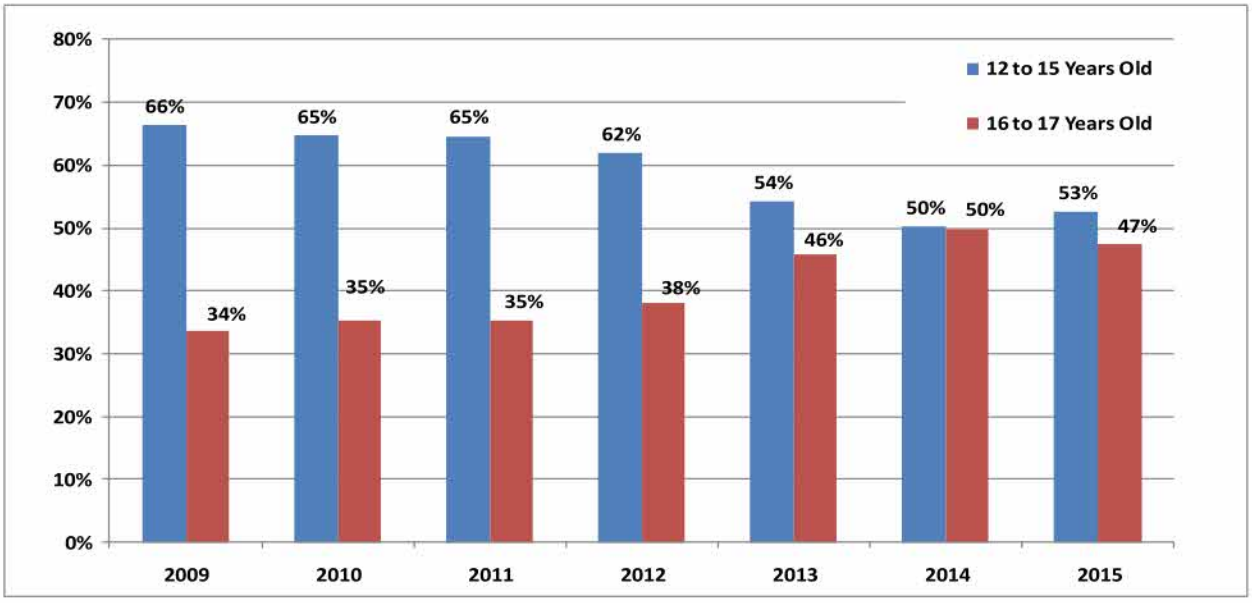
Figure 1 displays the data on PChAD admissions during the three years prior to the PChAD Act amendments (2009-2011), for the amendment year (2012) and for the three following years (2013-2015). Except for a surge in admissions in 2011 (both totally and locally), the total admission numbers grew gradually with some ups and downs: from 511 children in 2009 to 608 children in 2015. As to the individual PSHs, admissions in the Red Deer, Grande Prairie and Calgary PSHs have been slightly on the rise, whereas the Edmonton PSH did not show notable overall trends in the number of admissions.

Figure 1: PChAD Admissions (2009 - 2015)



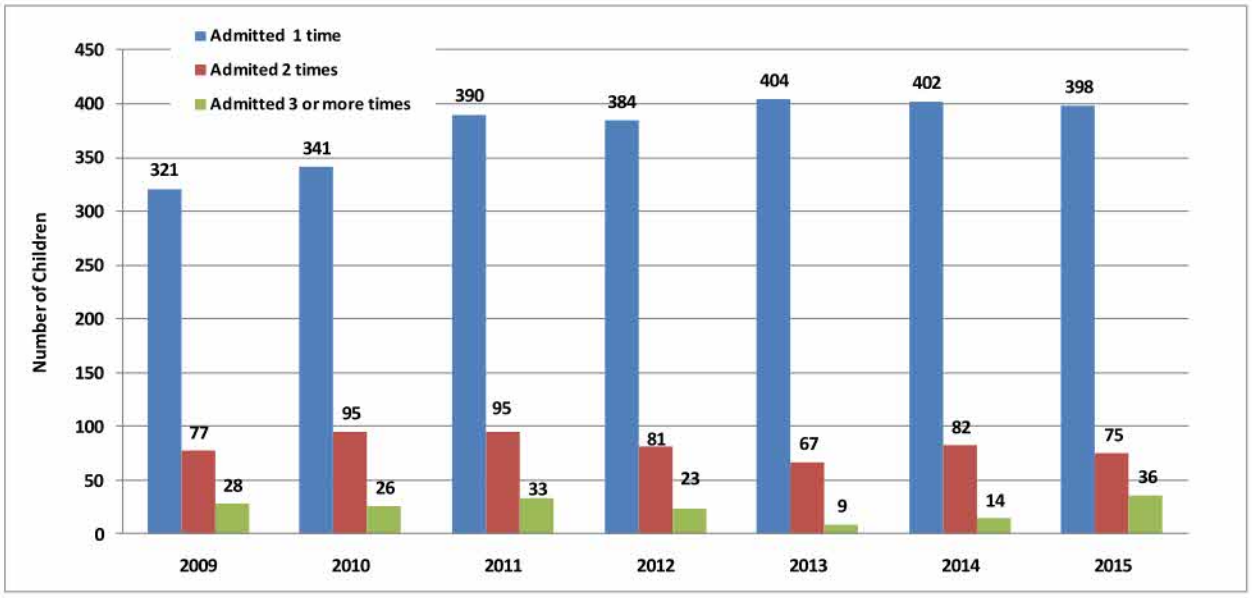
As shown in Figure 2 Figure 2, there have been substantive proportional changes in the age groups admitted to PChAD. The proportion of admission of children from older age groups grew steadily since 2009. A certain "surge" in this trend can be observed after 2012. While up to 2012 about two-thirds (62-66 percent) of the admitted children were in a younger age group (12-15 years old) and about one-third of admissions (34-38 percent) encompassed older ages (16-17 years old), starting with 2013 these proportions tended towards a half-by-half split: 50-54 percent of 12-15 years old and 46-50 percent of 16-17 years old.

Figure 2: PChAD Admissions by Age (2009 – 2015)



A large majority of PChAD admissions over the consider seven years were first admissions (see Figure 3). Their number showed a substantive increase in 2009-2011 (from 321 to 390 admissions or 18%), but after that plateaued and hovered around 390-400 mark. The total number of repeated admissions (2 times or 3 or more times) saw an increase up to 2011 and then experienced decline in the PChAD Act amendment year (2012) and after.

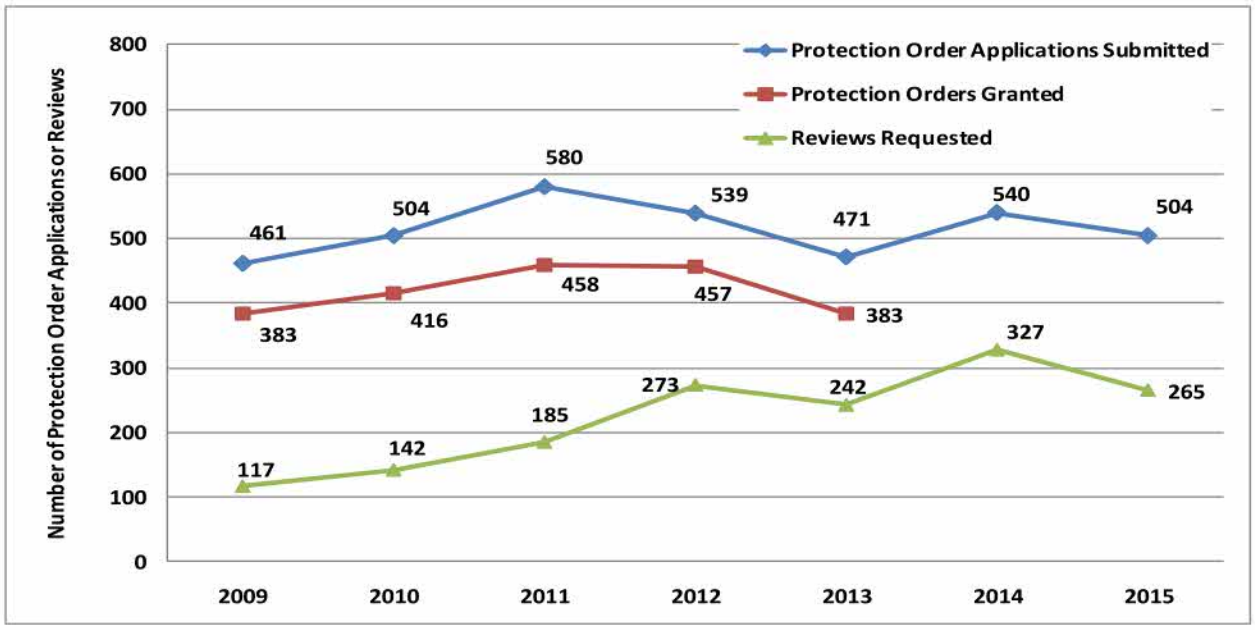
Figure 3: First and Recurring PChAD Admissions (2009 – 2015)



Protection Order Applications and Requests for Review

As illustrated in Figure 4 the number of application submissions for protection orders have not increased since 2012, but fluctuated up and down from year to year. On the other hand, the number of requests for order reviews grew steadily since 2009.

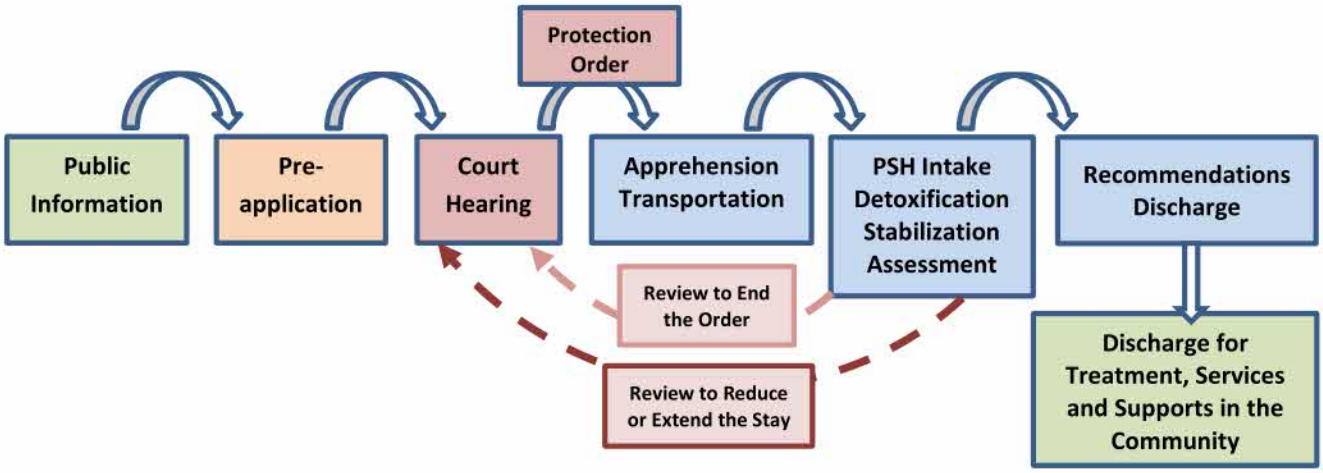
Figure 4: Court Applications for Protection Orders and Requests for Review (2009 – 2015)



Evaluation Findings

The evaluation findings shown in the following sections of the report were organized according to the major themes corresponding to the stages of the PChAD program (see Figure 5 below). Each section addresses a specific evaluation area, including objectives outlined in the evaluation framework, associated evaluation questions and results grounded in the collected data.

Figure 1: PChAD Program



1. Availability of Quality Information Regarding PChAD for the General Public and Potential Clients

Objective: Ensure that high quality information about the program is available to the public (including potential clients). The information should come from a single, consistent source - Alberta Health Services.

Evaluation Questions

1.1 How the PChAD clients (parents/guardians) first found out about the program?
1.2 Was available information (e.g., online or other) easy to find, understand and useful for making decisions?
1.3 Are there areas for improvement of PChAD-related information quality and availability?

Parent/Guardian Survey

In all, 139 parents/guardians responded to the survey at the time of their children discharge at the four protective safe houses (PSH) in Edmonton, Calgary, Red Deer and Grande Prairie.

Most survey respondents (41%) lived in Edmonton or Calgary, close to a third of them (30%) resided in other cities with population over 50,000 (e.g., St. Albert, Sherwood Park, Airdrie, Red Deer, Lethbridge, Medicine Hat, Grande Prairie or Fort McMurray), 9% lived in a city or town with population between 10,000 and 50,000 and 17% were from small communities with less than 10,000 residents (see Figure 6).

Figure 6: Parents/Guardians' Place of Residence (139 Respondents)

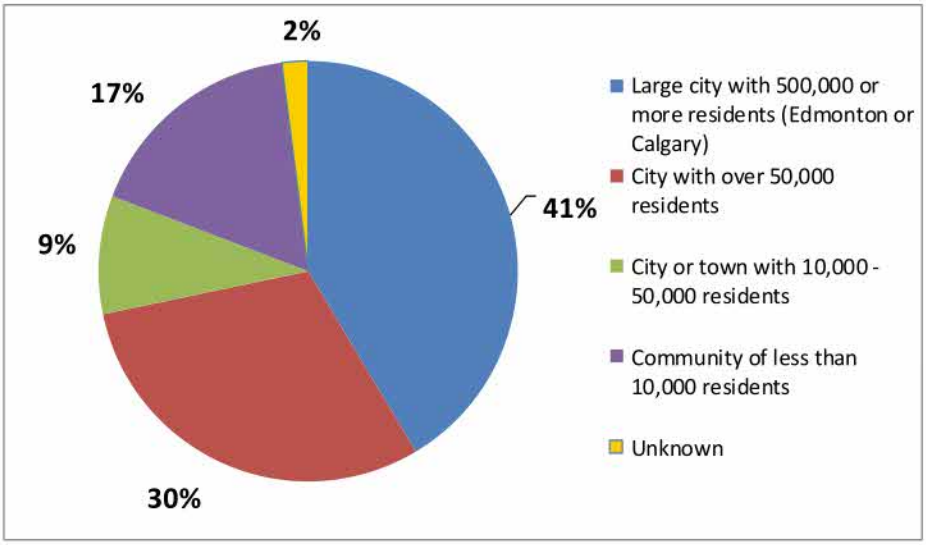
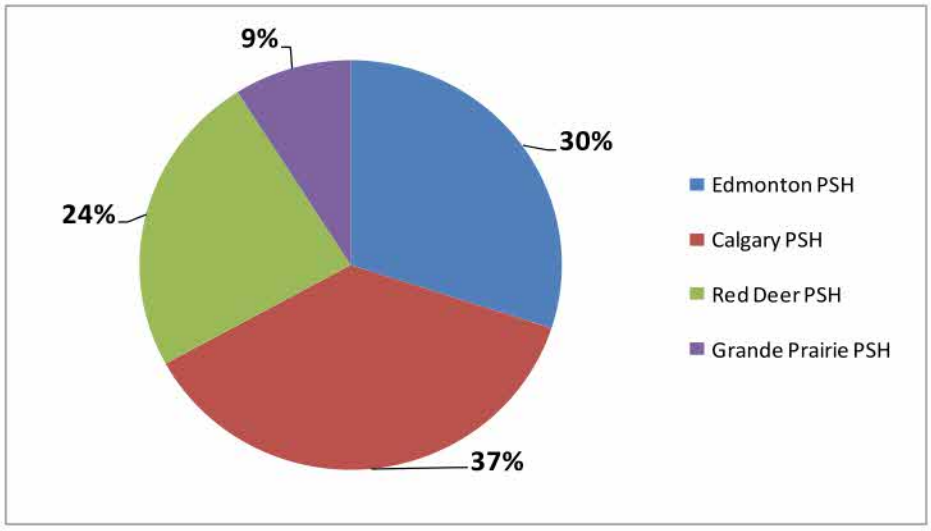


Figure 7 shows the survey respondent representation by individual PSHs.

Figure 7: Proportion of Surveyed Parents/Guardians by Protective Safe Houses (139 Respondents)



The parents/guardians were asked how they *first* found out about the PChAD program. Their responses are shown in Table 2.

Forty two percent of parents/guardians indicated that they first found about PChAD from AHS staff and/or addiction counsellor, 6% used Addiction & Mental Health 24 Hour Help Line and 4% used AHS website. Altogether, only slightly over half of the survey respondents (53%) used various designated AHS information sources. Nine percent of guardians learned about PChAD from various support groups, but half (50%) referred to "other sources." These diverse sources of information included RCMP/police and other law enforcement (e.g., a probation officer), word of mouth (including a variety of "non-official" sources such as other parents, friends, relatives or work), children and family support services, schools and various health/mental health providers (e.g., hospital or rehabilitation centre staff).

Eleven percent of guardians indicated using more than one initial source of information about PChAD – mostly two or three sources.

Table 2: How did you first find out about the PChAD program? (139 Parents/Guardians)*

Information Sources	Number of Guardians Used Information	% Guardians Used Information*	Details
AHS Related Sources - Total	76	53%	
AHS Staff/Addiction Counsellor	59	42%	--
Addiction & Mental Health 24 Hour Help Line	8	6%	--
Internet – AHS Website	5	4%	
Health Link	2	1%	--
Other Sources - Total	69	50%	
Internet – Website(s) Other than AHS	2	1%	--
Support Groups	12	9%	○ B.I.L.Y. (Because I Love You) ○ Parenting Class at AHS ○ PEP (Parents Empowering Parents) ○ PSECA (Protection of Sexually Exploited Children)
• RCMP/Police/ Law Enforcement	20	14%	--
• Word of Mouth	14	10%	Another parent, friend, relative, through work
• Children & Family Support Services	9	6%	○ CFS (Child & Family Services) ○ FCSS (Family & Community Support Services) ○ Social worker
• School staff	9	6%	School counsellor, teachers, principal
• Various Health or Mental Health Service Providers	9	6%	○ Rehabilitation centre ○ Youth shelter hospital ○ Family doctor ○ Psychiatrist ○ Hospital psychologist ○ Hospital social worker ○ CASA Child, Adolescent & Family Mental Health

* Note: Percentages may not add to 100%, because some guardians indicated using multiple sources of information.

Whatever the sources of initial information were, the majority of parents/guardians who responded to the survey found this information easy to locate and useful (see Table 3). Over a third of them strongly

agreed and about half of them agreed that the initial information about PChAD was easy to find, easy to understand and useful for making decisions. Some respondents did not express any opinion regarding the quality of initial information ("Neither Agree or Disagree" - 8 to 10 percent), while 8% disagreed that the information was easy to find and 5% disagreed that it was easy to understand.

Table 3: Utility of the Initial Information on PChAD (139 Parents/Guardians)

Initial information about PChAD was:	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree or Strongly Disagree N (%)	Did Not Respond N (%)	Total N (%)
Easy to find	53 (38%)	64 (46%)	11 (8%)	11 (8%)	0 (0%)	139 (100%)
Easy to understand	50 (36%)	69 (50%)	12 (9%)	7 (5%)	1 (1%)	100 (100%)
Useful for making decisions	49 (35%)	72 (52%)	14 (10%)	3 (2%)	1 (1%)	100 (100%)

Parent/Guardian Focus Groups

The three focus groups in Grande Prairie, Edmonton and Calgary intended to generate more comprehensive information about the parents/guardians' experiences than by just surveying them. In all, the focus groups confirmed the survey results suggesting multiple sources from which initial information on PChAD was obtained. Some focus group participants reported experiencing difficulties in locating initial information about PChAD as an option of helping their children. The focus group participants generated some ideas on how the information on PChAD, awareness about it and access to it can be improved.

PChAD Program Awareness Comes from Many Sources

Focus groups participants reported finding out about the PChAD program from a number of different sources, including AHS Addiction Services, Child and Family Services, community liaison police officers, and most commonly word of mouth from other parents/guardians either through existing community connections or parent support groups. Some parents/guardians had friends whose children were admitted to the PChAD program, or knew of friends of their own children who were admitted. One focus group participant reported specifically doing research online about the program after hearing about it from a friend before deciding that it was appropriate for her child. Others reported that their online research led them to AHS Addiction Services where they found out about the program. Some parents/guardians reported frustration trying to initiate court proceedings because the different steps of the process were not always clear, while others noted the great support and guidance provided by particular AHS Addiction Services counselors.

PChAD Program Should be Promoted

Several parents/guardians felt that more people should know about the PChAD program. One couple expressed a strong desire for better advertising and promotion because they had "floundered around with [their] son for 18 months" before finding out about the program, and wished they had known sooner. Prior to sending their son to PChAD, this couple felt they "could not intervene [in their child's behaviour] in any way, and were completely at a loss." When they finally learned of the program, they immediately used a PChAD apprehension order to learn the location of their son which was known to authorities, but legally unable to be disclosed to the guardians, as he was not deemed a missing person. Suggestions for program promotion included raising awareness with school administrators, advertising throughout the province, and creating an addictions hotline which could supply information to parents about PChAD and related programs on demand.

The feedback from the survey and focus groups suggests that multiple, not authorized by AHS, sources of information are often used by parents/guardians to first learn about PChAD. Although the majority of survey respondents agreed that it was easy for them to locate initial information about PChAD, some respondents disagreed, and some focus group participants also noted that the information was not easy to find and they had to go through multiple search steps before locating the needed information.

Implications for the Program Improvement:

- The feedback from parents/guardians suggests that more efforts to raise public awareness about PChAD are necessary to ensure those in need receive timely, relevant and accurate information. This could be accomplished by both continuous dissemination of information through various AHS-related sources and by reaching out to other potential information providers, which parents/guardians reported using (e.g., police, schools, children and family services, etc.) by delivering education and resources. The knowledge about PChAD can be disseminated via various means, including printed materials, presentations and webinars by AHS staff, mass media, social media, etc. It is important that accuracy and consistency of the PChAD related information is maintained across the information providers (see also Section 3 of this report). Broad outreach should result in building better awareness about and understanding of PChAD in various segments of the public and stakeholder groups.

2. Content of PChAD Pre-application Sessions and Its Effectiveness for Making the Decision to Use PChAD

PChAD Act Amendment: "A guardian may make an application… only if the guardian has, with regard to the application, attended an information session…" (PChAD Act, 2[2], p. 3).

Objective: Provide parents/guardians with a timely pre-application counselling and resources on the PChAD's purpose, practices, relevancy to their needs, and parents/guardians' responsibility to be involved.

Evaluation questions

2.1 How accessible are pre-application sessions? (Wait time).
2.2 What information is provided to parents/guardians?
2.3 How effective are pre-application sessions for a guardian to make an informed decision about placing his/her child in the PChAD program?

Addiction Counsellor Survey

The results from the addiction counsellor survey are discussed in this section of the report in conjunction with the parent/guardian survey and focus groups to better understand the role and effects of pre-application sessions in the information and support network surrounding the PChAD program. The 30 addiction counsellors who responded to the survey were representing all five AHS Zones. Fifteen counsellors (50%) worked in their current position for five or more years, nine (30%) – for one to four years and 6 counsellors (20%) were new to the position – worked for less than one year. Five counsellors (17%) reported providing PChAD pre-application sessions once a week or more frequently during the past 12 months, approximately half (14 counsellors or 47%) had pre-application sessions at least once a month or more often (two to three times a month), four counsellors (13%) delivered sessions approximately once in every two months and close to a quarter (7 counsellors or 23%) had infrequent sessions (once in three months or less frequently).

Pre-application Sessions Accessibility

Parent/Guardian and Addiction Counsellor Surveys

As stated in the PChAD Act amendment quoted above, a parent/guardian who would like to apply for a protection order to confine the child to a PSH first has to attend a pre-application information session with an addiction counsellor. Timing of the pre-application session is important given that children and families often need an urgent intervention. As shown in Table 4, a large proportion of parents/guardians who responded to the survey (42%) indicated that they did not wait at all to have a pre-application session with a counsellor and were admitted on the same day they requested the

session. Half of the guardians (53%) waited not more than one week, and only 6% waited more than one week.

Table 4: Parents/Guardians' and Addiction Counsellors' Accounts of Waiting Time for Pre-application Sessions (136 Parents/Guardians* and 30 Addiction Counsellors)

Survey Questions	On the same day N (%)	Within 1 week N (%)	Within 2 weeks N (%)	More than 2 weeks N (%)	Total N (%)
Parent/Guardian Survey: From the time you first requested a pre-application session, how soon did you see a counsellor?	57 (42%)	72 (53%)	5 (4%)	2 (2%)	136 (100%)
Addiction Counsellor Survey: From the time that parents/guardians first request a pre-application session, how long, in general, do they wait before seeing a counsellor?	18 (60%)	11 (37%)	1 (3%)	—	30 (100%)

*Note: The percentages are based on responses from 136 guardians; three guardians did not respond to the survey question.

The addiction counsellors' feedback on waiting time, which is also shown in **Error! Reference source not ound.**, is generally congruent with the parents/guardians' account. Similar to the guardians, over 90% of the counsellors contended that the waiting time would not exceed one week. However, a much higher percent of the counsellors (60%) believed that they would see clients on the same day a pre-application session is requested, compared to the parents/guardians (42%).

Pre-application Sessions' Duration and Content

Addiction Counsellor Survey

The addiction counsellor survey provides counsellors' account of the approximate duration of pre-application sessions and what specific information guardians receive (see Table 5 and Table 6).

Table 5 shows counsellors' responses to an open-ended survey question about average duration of a pre-application session. (Please note that the time categories overlap since the respondents were asked to put their own time frames). The durations of pre-application sessions reported by the addiction counsellors vary substantively. Close to half of the counsellors (43%) reported spending 60-90 minutes consulting parents/guardians, another 13% would spend 30-60 minutes. However, over a third of the counsellors (37%) reported spending 20-45 minutes. It would be challenging to pinpoint a "sufficient" session length, given that while a large portion of parents/guardians may be first time visitors, others whose children were confined to a PSH more than once, could attend pre-application sessions two or more times. Therefore a portion of guardians may be already familiar with the sessions' content and do not require detailed consultations.

Table 5: Duration of PChAD Pre-application Sessions (30 Addiction Counsellors)

Duration	Number of Counsellors	% of Counsellors
20 - 45 minutes	11	37
30 – 60 minutes	4	13
60 – 90 minutes	13	43
Did not respond to the question	2	7
Total	30	100

The addiction counsellors mentioned having the checklist to follow for pre-application sessions. Judging by the number of the reported topics (see Table 6), this checklist could be extensive and the parents/guardians who apply for the PChAD program for the first time may have questions and require a long session in order to be well informed of the appropriateness of PChAD for their needs and the next steps.

Table 6 contains addiction counsellors' responses to the open-ended survey questions regarding specific information and resources they provide to guardians. The listed themes may overlap (for example, the accounts of the programs or services alternative to PChAD), but the details are worth keeping for better understanding of the type of information provided.

Please note that the information featured in Table 6 should be viewed as examples provided by the addiction counsellors during the survey rather than a full account of what happens at pre-application sessions. Therefore not mentioning some aspects of information in the survey does not necessarily mean not providing them during the sessions.

As shown in Table 6, a large proportion of the counsellors (20 counsellors or 67%) mentioned providing an overview of the PChAD program, including its history and purpose, and what it offers or does not offer, to help parents/guardians decide whether it meets their needs and expectations. For example, one counsellor indicated that the most consistent message he/she shared with parents/guardians is that it is not a crisis program and another one tried to make sure guardians understand that PChAD is about detox and stabilization; treatment options will be provided for the child, but treatment is voluntary. As well, 20 counselors (67%) mentioned going through the PChAD Act. The most frequently referenced specific Act provision was the right to review a protection order (11 counsellors or 37%), other specific examples mentioned by one or two counsellors included length of stay in a PSH, the option to extend length of stay, notice of application requirement and expiration dates on protection orders.

Table 6: Information Provided to Parents/Guardians at Pre-application Sessions (30 Addiction Counsellors)

Type of Information	Number of Counsellors	%	Details
Overview of the PChAD program, explaining nature and aspects of the program	20	67%	○ The history of PChAD and its purpose ○ What the program offers and what it does not offer, e.g.: • It is not a crisis program and is based on a planned admission • PChAD provides detox and stabilization; treatment options will be given but treatment is voluntary ○ Alignment with the guardians' expectations
Overview of the PChAD Act provisions	20	67%	Mentioned generally or with specific details (see below)
Specifically:			
• **Notice of application requirement (2 days)**	2	7%	"PChAD Act, 5(1), p. 9
• **The review process and the right to review a court order**	11	37%	The surveyed addiction counsellors mostly referred to a child's rights to appeal
• **Expiration dates on protection orders**	1	3%	
• **Length of PSH stay**	2	7%	
• **Option of extending length of stay**	1	3%	
The PSH locations and differences	2	7%	
The daily program routine and expected child's experience	10	33%	"What occurs in the PChAD program"
Assessment and treatment planning process at the PSHs	9	30%	
Expectation/obligation for guardian/family involvement	12	40%	○ Including attending group and a family session ○ Expectation that family will be involved in the assessment process
Right to confidentiality and its limitations	15	50%	○ Child's right to confidentiality while at the PSH ○ Guardian confidentiality and the limits to said confidentially
Overview of the PChAD application process and associated logistics	19	63%	Including coordination between police, parent, PSHs and AHS regarding reserving a bed and transportation
Information about the court process	24	80%	Steps to obtain a protection order

(Table 6 Continued): Information Provided to Parents/Guardians at Pre-application Sessions (30 Addiction Counsellors)

Type of Information	Number of Counsellors	%	Details
Alternative youth addiction services and programs available in Alberta	9	30%	
Adult addiction services options, if applicable	1	3%	
Overview of possible services outside of Alberta	1	3%	
Reviewing continuum of AHS addiction services	13	43%	From less intrusive to most intrusive: Ranging from outpatient counselling to residential treatment
Voluntary treatment options/services by AHS or other providers (Note: some respondents mentioned providing "limited" information on non-AHS options but other reported providing information on "all of the voluntary services available")	27	90%	○ Individual addiction counselling ○ Outpatient counselling ○ Family counselling ○ Voluntary detox ○ Residential and (intensive) day treatment ○ Voluntary detoxification and stabilization ○ National Native Alcohol and Drug Abuse Program (NNADAP) ○ Employee Assistance Program (EAP) – Health Canada ○ InformAlberta.ca ○ Other community resources/ treatment options
Information on other counsellors and professionals, including independent/private	6	20%	○ Psychologists (Psychologist Association of Alberta: Psychologistsassociation.ab.ca) ○ Mental health workers or other addiction workers (other than AHS) ○ School counsellors
Available services, supports and resources after PChAD for clients and families	15	50%	○ Aftercare planning ○ Parenting workshops/ programming ○ Parent support groups
Information on mental health and/or mental health services	7	23%	

The counsellors' responses suggest that much attention is given to educating parents/guardians about various voluntary treatment options (mentioned by 27 or 90% of the counsellors,) to "encourage parents to think if their youth would access voluntary services." As well, the counsellors reported providing parents/guardians with a general overview of the continuum of AHS addiction services (13 counselors or 43%), as well as giving the information on counselling and professional services outside of AHS (6 counsellors or 20%). This diversified information intends to help in both the decision on the

appropriateness of PChAD for meeting specific client needs and deciding on the supports and treatments after PChAD.

Thirty to fifty percent of the addiction counsellors indicated informing parents/guardians on the following issues: "what occurs in the PChAD program," including the daily program routine and what a child is expected to experience in a PSH, assessment and treatment planning process at the PSHs, expectation/obligation for guardian/family involvement, and (child and parent/guardian) right to confidentiality and its limitations.

Providing information about mental health and/or associated services was specifically mentioned by 7 counsellors (23%). Further investigation is warranted into the provision and utility of mental health related information to parents/guardians and whether all of them have an opportunity to receive this information and guidance. Parent/guardian focus groups participants commented on an insufficient link between addiction and mental health services (see Section 8).

When answering a survey question about specific resources provided to parents/guardians for taking home after pre-application sessions, the addiction counsellors mentioned giving their clients the pamphlets that are provided through the provincial PChAD program outlining its history and what the program is about. As well, several counsellors referred to the "parent packages," which may contain the following AHS pamphlets:

- Voluntary Treatment Services for Youth
- Help Other Help Yourself: When Someone You Love is Addicted
- After Treatment: How to Support Someone in Recovery
- Addiction Services to Youth Handbook

Guardians also may receive other handouts some of which could be specific to individual PSHs, including:

- A flow chart created at the Youth Addiction Services (YAS) that details a guardian's journey through the entire process
- What happens while the child is in the PSH, details on programming provided there
- PChAD program expectations for parents
- Guide for seeking a protection order
- Information on particular drugs
- Styles of enabling
- Brochures on parenting/supporting a teen who is abusing substances
- Self-care, AHS pamphlets for bibliotherapy for parents and teens; sleep advice for parents and teens
- List of (local) resources available for families, including workshops for parents and support groups for parents, children and youth

- Links to online support
- Information on external supports, including counselling agencies (e.g., counselling resource sheet), Children's Services, Mental Health, etc.
- Addiction Helpline card

To sum-up, the addiction counsellors' accounts suggest that a broad range of resources may be available at pre-application sessions to parents/guardians on PChAD and associated/alternative services. As put by one of the counsellors: "We provide parents with a folder including literature about commonly used substances, all of the information we discussed in the session (PChAD Act, voluntary services, family services), parent support groups in the area, and various pamphlets for parents/guardians about substance use in teens."

Utility of Pre-application Sessions for Parents/Guardians' Decision to Use the PChAD Program

Parent/Guardian Survey

One of the key expected outcomes of pre-application sessions is helping parents/guardians assess their situations and decide whether the PChAD program is the best option for their children. When inquired about the effectiveness of pre-application sessions, 35 – 47 percent of parents/guardians strongly agreed that the sessions helped them make an informed decision on whether to apply for a protection order, learn about other programs that could be of help, learn what would happen to their children at a PSH, understand the expectations for parents/guardians' participation, and learn about the supports for themselves and their families (Table 7). Additional 44 – 50 percent agreed that they gained the above-mentioned benefits from the pre-application sessions (for the total of 85 – 92 percent of the respondents who strongly agreed or agreed).

However, while relatively high proportions of parents/guardians strongly agreed that pre-application sessions helped them make an informed decision regarding PChAD (47%) and learn what would happen to their children at PSHs (45%), somewhat lower percentages strongly agreed that they learned about other programs (39%) and about supports for themselves or their families (35%).

One to four percent of the respondents disagreed that they gained the above-mentioned benefits from the pre-application sessions and six to twelve percent did not express any opinion (i.e., neither agreed or disagreed) or did not respond to the question.

Table 7: Effectiveness of Pre-application Sessions as Reported by Parents/Guardians (139 Respondents)

The pre-application session was helpful in:	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree or Strongly Disagree N (%)	Did Not Respond N (%)	Total N (%)
Making an informed decision whether I should apply for a protection order	65 (47%)	63 (45%)	5 (4%)	3 (2%)	3 (2%)	139 (100%)
Learning about other programs that could be helpful for my child	54 (39%)	65 (47%)	11 (8%)	6 (4%)	3 (2%)	139 (100%)
Learning what would happen to my child during the stay at a PChAD Protective Safe House	63 (45%)	63 (45%)	8 (6%)	3 (2%)	2 (1%)	139 (100%)
Understanding the expectations for a parent or guardian participation while their child is at the Protective Safe House	59 (42%)	61 (44%)	14 (10%)	2 (1%)	3 (2%)	139 (100%)
Learning how a parent or guardian can be involved during their child's stay at the Protective Safe House	57 (41%)	61 (44%)	14 (10%)	4 (3%)	3 (2%)	139 (100%)
Learning about supports for myself or my family	49 (35%)	69 (50%)	11 (8%)	6 (4%)	4 (3%)	139 (100%)

3. Parents/Guardians' Readiness for the Protection Order Application and Court Hearing

Objective: Provide parents/guardians with appropriate information and resources on the requirements of the court hearing. Ensure that parents/guardians feel well prepared for and are as comfortable as possible with the court hearing.

Evaluation questions

3.1 How pre-application sessions prepare parents/guardians for the court hearing?
3.2 What other information sources parents/guardians may use?
3.3 Did parents/guardians have good understanding of how to apply for a protection order and the court hearing expectations?
3.4 Did parents/guardians feel they were well prepared for the court hearing?
3.5 Did the court personnel (court clerks and judges) believe the parents/guardians were well prepared for the court hearing?

Educating Parents/Guardians for the Protection Order Application and Court Hearing

The feedback from the parents/guardians and various stakeholders featured in this section suggest that preparing guardians for court hearings is an important function of pre-application sessions, including how to acquire and present the evidence to obtain a protection order.

Parent/Guardian Survey

In order to uncover all possible sources of information used by parents/guardians to learn how to apply for a protection order, the parent/guardian survey posed an open-ended question: "Where did you first learn how to apply for a protection order?" The resultant response categories are displayed in Table 8. Six percent of respondents mentioned directly pre-application sessions. Another 10% mentioned visits to an AHS counsellor or (youth) addiction counsellor, which may be a reference to pre-application sessions: "Youth addictions counsellor informed us & provided a step by step sheet." Twenty three percent generally mentioned AHS, Alberta Mental Health and Addiction Services. In all, various AHS-related information sources were mentioned by 39% of the surveyed parents/guardians. About a third of them (35%) reported using various "other" information sources to first learn how to apply for a protection order. These other sources of information included family or children services counsellor, social or support worker and various community organizations (mentioned by 14% of parents/guardians), as well as law enforcement (9%). Four percent of respondents claimed that they first learned how to apply for a protection order online ("I looked up PChAD online and found all the info I needed"), and one respondent indicated that he/she "…asked the [court] clerk for the application and she [clerk] gave it to me with literature."

Thirteen parents/guardians (9%) reported using more than one source of information, and 30 parents/guardians (22%) did not respond to the above-mentioned open-ended survey question.

Table 8: Where Did You First Learn How to Apply For a Protection Order? (139 Respondents)

Information Sources	Number of Guardians	% of Guardians
A Pre-application Session (Referred to directly by respondents)	9	6%
(Youth) Addiction Counselor; AHS Counsellor (May be a pre-application session)	14	10%
AHS; Alberta Mental Health; Addiction Services; Health Link (May be a pre-application session or other AHS-related sources)	32	23%
Child/Family Counsellors or Other Community Services or Supports: Family Counsellor; Children Services Counsellor; Social Worker; Support Worker; Aboriginal Support Worker; CASA[5]; Programs under PSECA[6]; Hull Services[7]; Wood's Homes[8]; Victim Services	19	14%
Law Enforcement (RCMP, Probation Office)	13	9%
Online	6	4%
Support Groups/Training Sessions	4	3%
School: School Counsellor, Teachers	3	2%
Through the Job/Friend	3	2%
Asked the court clerk directly for the application and associated information	1	1%
Did not respond to the question	30	22%

Given that, according to the parents/guardians' responses assembled in Table 8,they might obtain information on how to apply for a protection order from various sources other than pre-application

5 CASA Child, Adolescent & Family Mental Health

6 PSECA - Protection of Sexually Exploited Children Act

7 Hull Services "…is a registered charitable organization that provides an integrated continuum of services including specialized therapy, counselling and education. Hull helps children, youth and families who experience emotional and psychological disorders, behavioural problems, learning disabilities, mental illness, developmental delay, neglect, abuse and family breakdown" (quoted from: http://www.hullservices.ca/about-us)

8 Wood's Homes "…is a multi-service, non-profit children's mental health centre based in Calgary" (quoted from: http://www.woodshomes.ca)

sessions, it is difficult to directly attribute their accounts of success to these sessions. However, pre-application sessions may be instrumental in delivering important, "first-hand" information regarding the court application process, especially to the first time applicants, and therefore play a key role in building support systems around the PChAD program.

Addiction Counsellor Survey

As shown in Table 6 in the previous section, when asked about the information and/or resources provided to parents/guardians during pre-application sessions, 63% of addiction counsellors mentioned overviewing various aspects of the PChAD application process and 80% referred specifically to the court procedure for obtaining a protection order. This indicates that court related information should be available in some form at the majority of pre-application sessions or at all of them.

When asked in an open-ended survey question to describe the information provided to parents/guardians about the process of going to court and applying for a protection order, the addiction counsellors pointed to the availability of PChAD program handouts or guides (i.e., Guide for Applicants Seeking a Protection Order) outlining "the order of actions," including "steps at court." They also indicated that the step by step instructions can be printed off from the internet. Seven surveyed counsellors (23%) mentioned providing parents/guardians with written information associated with the court application, whereas another 11 counsellors (37%) described having working clients verbally through the process, including reviewing the "written literature" together and "trouble shoot any areas of concern."

Some counsellors provided examples of how the protection order application process is explained to parents/guardians, including the following account:

> "We verbally review the process of applying for an order and also provide a handout that is a guide for applicants seeking a protection order. We explain that once the pre-application session is complete they need to take the original confirmation of attendance checklist to the court house and give it to the court clerk who will provide them with an application. Once they receive the application they need to apply for both the protection order and if needed, an apprehension order where they would receive an order for the RCMP to pick up their child and transport them to the PSH. Once the application is complete they will be given a court data within 2 business days. They then need to contact the AHS 1-888 number provided on the application to inform them of their court date."

As well, the counsellors mentioned offering parents/guardians specific tips to assist with the court application and the steps following receiving a protection order, including:

- Direction on how to access court documents (so that they can be completed ahead of time)
- Insight about the potential wait times for a PChAD bed and encouragement to request sufficient time before the protection order expires

- Instruction on how to appear before the judge, present and speak in court." "…A lot of parents are nervous about how to address a judge…"
- Encourage parents/guardians to be prepared for the hearing, including summarizing their concerns for when they see the judge, bringing supporting documents to the court (e.g., the child's suspension[s] at school for being under the influence)
- Point out that "parents should be prepared to share (with the court) detailed reasons about why they feel a PChAD order is necessary"
- Information on local court days: "What day court is held in our city and other days court is held in nearby towns, what time court opens"
- Reminder to have a picture ID at court
- The process of scheduling a PChAD bed after the protection order is issued
- Explaining the option of the police picking the child up to escort him/her to the PSH once the protection order is granted
- Bringing the protection order to the RCMP detachment if requiring police transportation

Parent/Guardian Focus Groups

Inconsistent Quality of Pre-application Sessions: During the focus groups parents/guardians gave mixed feedback about the usefulness of pre-application sessions in preparation for attendance in court. Some found the whole process "very friendly and sympathetic to parents", adding that addiction counselors provided lots of useful information and coached parents through evidence gathering and other steps leading up to their appearance in court. Others, however, found the pre-application counseling session unhelpful with the counselor "just asking questions to fill out the forms."

It Is Difficult to Get Children into System: Parents/guardians reported that they generally found it difficult to get their children into the PChAD program, considering that the application takes some time, and guardians may receive mixed messages during the process. While some addiction counselors provided good advice, not all parents/guardians received the same support. This was demonstrated when some of them found out information about the process they had not known during the focus group discussions with other parents/guardians. The focus groups participants reported that they also received mixed support in pre-application sessions, as some were told exactly the types of evidence to prepare for the court hearing, while others were not. One parent/guardian felt "so frustrated" trying to dive into the system, and thought it would be especially difficult for those who lived in rural areas, or were not skilled at using computers.

Several parents/guardians mentioned the length of the process as particularly problematic: when their child is in a dangerous situation, it is frustrating to have to make an appointment to meet with a counselor, wait to receive a referral, submit the application, and then wait days for a hearing. This long process also requires parents/guardians take several days off work, which may not be possible for everyone.

Addiction Counsellors' Suggestions for Improvement (Open-ended Survey Data)

Overall, based on the survey data, addiction counselors appear to be well versed in the particulars of the court application process and subsequent steps to appropriately inform parents/guardians. However, the detailed information from parent/guardian focus groups suggests that the quality of pre-application sessions may vary and parents/guardians may be consulted not in a similar way across the sessions. Variation in average duration of pre-application sessions also indicates possible differences (refer to Table 5).

Ten addiction counsellors (33%) provided the following suggestions for improving the pre-application process:

- ***Optimize sessions' duration and/or content:*** "Parents are typically highly stressed, frustrated, and/or anxious when they come for a PChAD order. Providing so much information in one hour tends to be overwhelming. The process of applying for an order is very detailed and demands a lot from parents who may be in a state of crisis. Any way to reduce the feelings of being overwhelmed would be beneficial."
- ***Need a few straightforward information handouts:***
  - "Need simpler handouts for parents to guide them … through with steps - there are many (handouts) and they (parents) get confused."
  - "Having a flow chart that outlines the steps for applying for the order. Because at times I believe it is overwhelming for parents to receive so much information at once and there is a lot of steps to applying for an order."
- ***Need more involvement on the part of courts:*** "Alberta Court Services could have social workers trained to support guardians/families regarding family and youth court and guide them through process."
- ***Need more addiction counsellors' involvement in courts:***
  - "Counselors should be able to add recommendations to the court."
  - "More involvement with staff and parent during the court procedure. Having staff support the parent in person during the court process."

Parents/Guardians' Preparedness for the Protection Order Application and Court Hearing

Parent/Guardian Survey

Table 9 contains responses to the survey question asking whether and in what ways the initial information derived from various sources (refer to **Error! Reference source not found.** above) helped arents/guardians understand various aspects of the court procedure. Most parents/guardians (92%) indicated that it helped them understand how to apply for a protection order, 86% conveyed that it helped them understand what information the judge will need to make a decision, and 80% responded that the information helped them understand what questions the judge may ask them.

Table 9: Utility of the Initial Information on How to Apply for a Protection Order (139 Respondents)

This information helped me understand:	Yes N (%)	No N (%)	Did Not Respond N (%)	Total N (%)
How to apply for a protection order	128 (92%)	5 (4%)	6 (4%)	139 (100%)
What information the judge will need to make a decision	119 (86%)	13 (9%)	7 (5%)	139 (100%)
What questions the judge may ask me	111 (80%)	19 (14%)	9 (7%)	139 (100%)

Parent/guardians' accounts of their preparedness during the court hearing procedure are presented in Table 10. Slightly over a third of parents/guardians (37 – 38 percent) strongly agreed that they felt prepared for the court hearing and to speak to the judge. Additional 44 - 47 percent agreed that they felt prepared, 4 - 6 percent disagreed, and a small proportion (3 – 4 percent) did not respond to the above-mentioned survey items.

Table 10: Guardians' Accounts of Their Preparedness During the Court Hearing Procedure (139 Respondents)

	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree or Strongly Disagree N (%)	Did not Respond N (%)	Total N (%)
I felt prepared for the court hearing	53 (38%)	61 (44%)	13 (9%)	8 (6%)	4 (3%)	139 (100%)
I felt prepared to speak to the judge	52 (37%)	65 (47%)	12 (9%)	5 (4%)	5 (4%)	139 (100%)

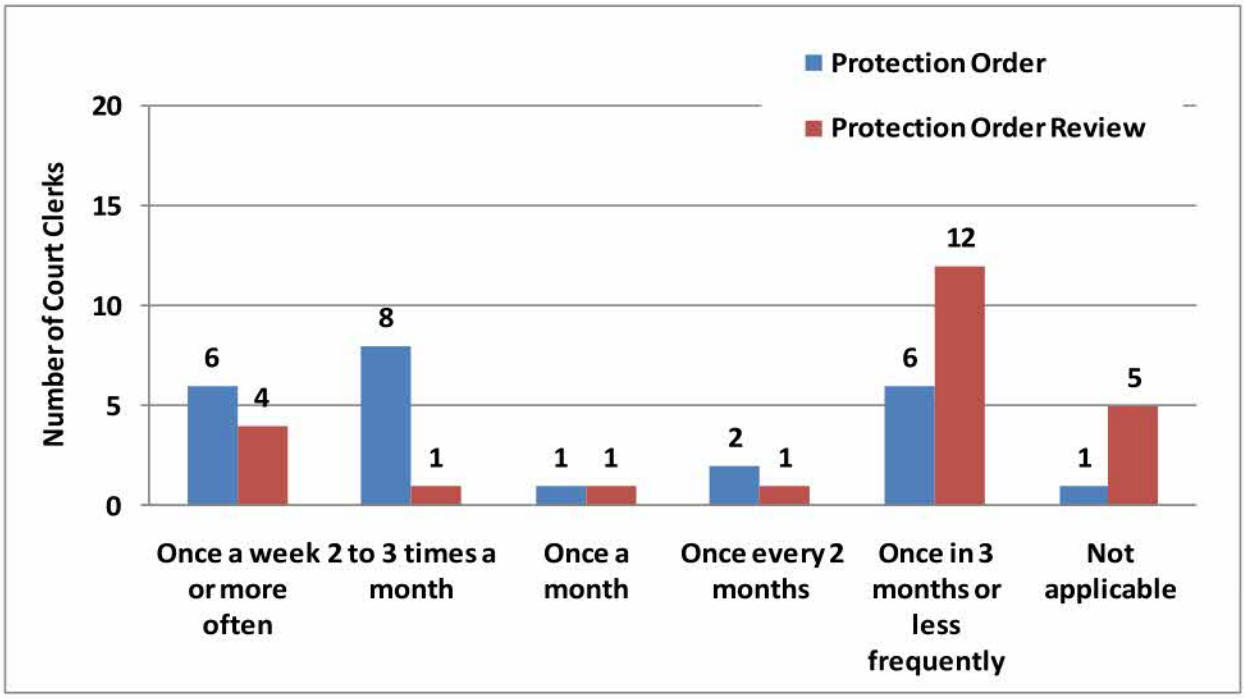
Court Clerk Survey

Communicating with court clerks would be the next major step for parents/guardians in their application for the PChAD program after completing a pre-application session. Court clerks could be an important source of information and assistance for parents/guardians with respect to the court process. The feedback from court clerks on the PChAD-related matters was collected through an online survey. The data from 24 clerks who indicated that they had association with PChAD were analyzed for this report.

The majority of the court clerks who responded to the survey (17 respondents or 71%) have been working with court applications under the PChAD Act for four years or longer and under one-third (7 court clerks or 29%) – for 1 to 3 years.

Figure 8 depicts frequency of receiving PChAD-related court applications in the past 12 months by the surveyed court clerks. The data demonstrate that the majority of surveyed clerks should have a substantive experience with applications for protection orders: a quarter of them (6 clerks or 25%) reported receiving protection order applications once a week or more often, and additional third (8 clerks or 33%) reported receiving applications at least 2-3 times a month.

Figure 8: Frequency of Receiving Applications from Parents/Guardians During the Past 12 Months for a Protection Order or for a Review of a Protection Order (24 Court Clerks)



The information displayed in Table 11 attests to a broad range of court clerks' responsibilities associated with PChAD protection order applications or order reviews and possible avenues of communicating to

parents/guardians the procedural information pertinent to the court. Court clerks also should have multiple instances to observe whether parents/guardians who apply for a protection order are well prepared to make this application and appear before the judge.

Table 11: Court Clerks Involvement With PChAD (24 Court Clerks)

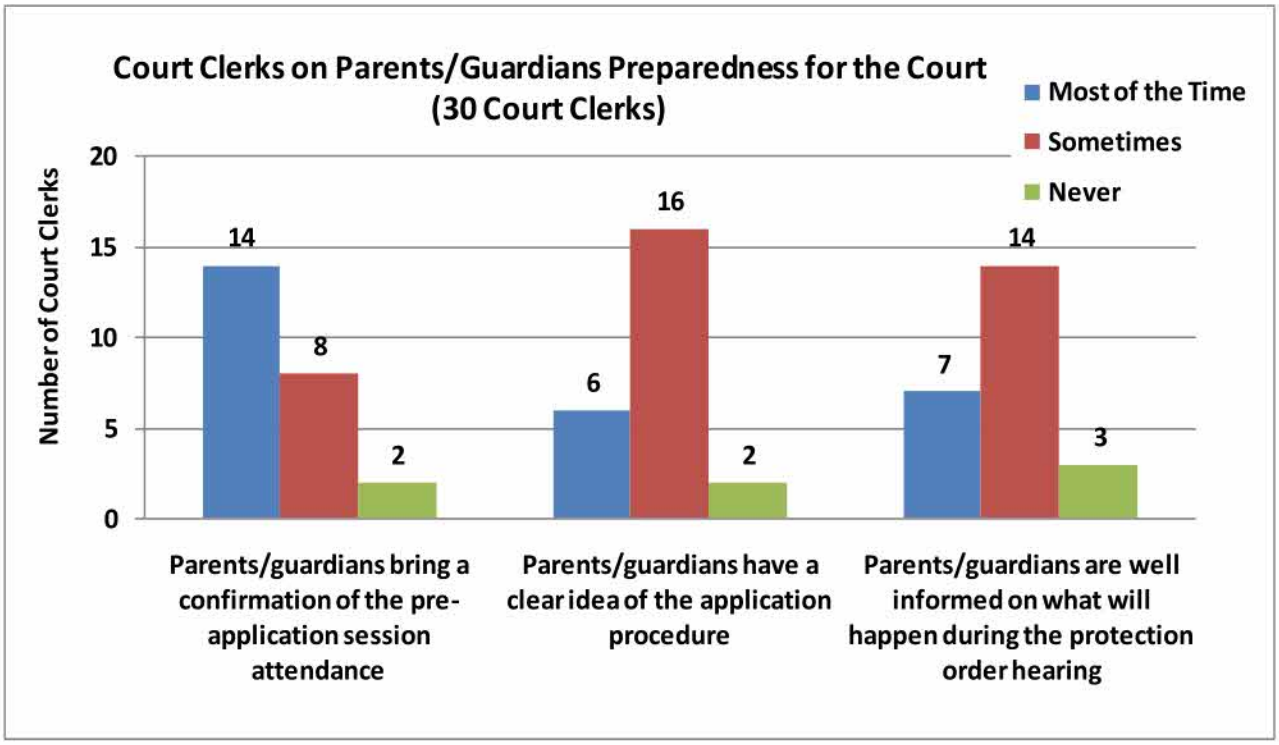
Responsibilities	Number of Clerks	%
Ensure a parent/guardian has a written confirmation of attendance of a pre-application information session	21	88%
Answer parents/guardians' questions	22	92%
Set up the hearing date	23	96%
Provide information on the hearing procedure	23	96%
Prepare court orders	19	79%
Remind parents/guardians to provide notice to the Co-ordinator through the PChAD 1-888 line	22	92%
Remind parents/guardians to provide notice to any other guardians	23	96%
Remind parents/guardians to provide notice to the child (when applying for a review of an order)	14	58%
Other responsibilities (specified by the respondents): • **Filing documents** • **Summarizing the court etiquette to applicants for PChAD** • **Preparing Affidavit of Service of PChAD application** • **Reviewing and signing orders** • **Explanation of the order and its terms (entry clause, 50 days of expiration, whom to provide copies of the order to if applicable, etc.)** • **Following up by faxing and providing orders to parties who require copies** • **Forwarding guardians to the nearest police agency (if necessary)**	5	21%

Figure 9 depicts court clerks' account on how well parents/guardians were prepared for the court when *first* applying for a protection order. In all, the court clerks believed that parents/guardians were rather "sometimes" prepared than prepared "most of the time." However, only a small number of clerks (2 or 3 of 24 survey respondents) maintained that parents/guardians were "never" prepared.

According to the clerks, parents/guardians demonstrated the highest level of awareness on the requirement to bring to the court a pre-application session attendance confirmation letter: 14 of 24 clerks or 58% reported that parents/guardians brought the required confirmation "most of the time."

At the same time, only six and seven clerks (25 and 29 percent respectively) thought that parent/guardians most of the time had a clear idea of the application procedure and were well informed on what will happen during the protection order hearing.

Figure 9: Court Clerks' Account of Parents/Guardians' Preparedness for a Protection Order Application When They Apply for the First Time (24 Court Clerks)



Guardian Focus Groups

Some parents/guardians complained that meetings with the court clerk were ineffective, and failed to provide them with basic information, such as a list of the types of evidence that would be required by the judge. The result of this was that some parents/guardians felt unprepared for court, and were unable to present the detailed logging of dates, times, and locations of events requested by the judge. In extreme cases, this resulted in a failure of the parent/guardian to obtain the PChAD protection order. This feedback underscores the importance of attaining a clear understanding among all parties involved of their respective roles in providing access to PChAD, including what type of information should be provided at a pre-application session with an addiction counsellor and what information and assistance pertinent to PChAD applications and reviews should be provided by a court clerk or other stakeholders.

Court Clerks' Feedback on What is Working Well With the Current Application Process and What Can Be Improved (Open-ended Survey Data)

Fourteen court clerks (58%) commented on what was working well with the current court application process and seven (29%) suggested various improvements. The clerks found it useful that parent/guardians see an addiction counsellor before scheduling a court appearance. As a result, "parents/guardians have a good idea as to what a PChAD order will entail by the time they attend the Courts for an application (loss of child's liberty, the purpose of the Order, etc.)." As well, the information parents/guardians receive is consistent with the information provided at the court. Court clerks stated that the application form is short and easy to complete and noted that the PChAD 1-888 number is very helpful for themselves and for parents/guardians.

When asked how the current application process could be improved, court clerks reported that there ought to be a better explanation of the court procedure. Parents/guardians may come in expecting to be granted a protection order immediately, because they don't know that there is a minimum of two days' notice before a hearing. This wait time may be even longer if a courthouse does not offer hearings daily. Court clerks suggested that AHS provides more information at the pre-application sessions about the two-day notice for a hearing day and possible wait times for beds.

Sometimes parents/guardians need more clarity on the purpose of a protection order, for example, that it is not a "parenting tool" (i.e., to discipline a youth) as well as on the required evidence: "Evidence of drugs must be presented in application." There were comments that parents/guardians seem to be "quite frustrated with the process," which may be intimidating for them. Thus, the question was posed about a possibility of a mental health professional, not a judge, making the decision in order to reduce stress in an "already very stressful situation." There was a suggestion to make the program information more publicly accessible, e.g., through social media, to increase awareness and understanding. Additionally, school administrators, trustees and police should be required to learn about the program so that they understand its benefits and limitations and are able to share that information with inquiring parents.

Court Judges' Feedback

When asked whether parents/guardians appear to be well prepared for court and if not, in what areas more preparation is needed, the court judges responded that in the information (pre-application) session, applicants should be given information about how to appear in court, what to expect and how to give evidence. Considering how emotional such applications are, some parents/guardians seem quite well prepared for court, but applicants (usually mom or dad) are often very upset about having to make such an application and so their thinking and presentation can be disjointed and hard to follow. It is also helpful if the affidavit is filled out fully and the parents/guardians have given sufficient reasons for seeking the order. That way a judge has much of the required evidence in the affidavit to review if parents/guardians become emotional or upset.

Implications for the Program Improvement:

- Survey data indicate that pre-application sessions were available to most parents/guardians within one week or faster, which suggests good accessibility. However, parent/guardian focus groups pointed out to the inconsistent quality of pre-application sessions and provided mixed feedback on the usefulness of pre-application sessions in preparation for attendance in court. Indeed, while the surveyed parents/guardians appeared to be quite assertive about the utility of the initial information (from the pre-application sessions or other) on how to apply for a protection order, feedback from the court clerks and judges implied possible gaps in their preparedness for the court.
- Specifically, the judges suggested that the applicants should be given information on how to appear in court, what expect and how to give evidence, including providing sufficient reasons for seeking the order. Giving the evidence in a written form (e.g., an affidavit) would help in presenting such evidence in a coherent, clear format.
- Based on these findings, it is suggested that a consistent format of pre-application sessions' delivery is implemented across the province, including essential content as well as carefully prepared, substantive but easy to use set of resources for addiction counselors and parents/guardians.
- Duration of pre-application sessions may vary for the first time and repeated applicants. As well, additional preparation sessions may be required to deliver high volumes of information more effectively (for example, if parents/guardians require extensive preparation for the court appearance).
- The evaluation uncovered multiple sources of information used by parents/guardians to become familiar with the particulars of applying for PChAD. Therefore AHS has to ensure consistency and accuracy of this information *across various sources*. This should include launching official social media sites, providing information and training to school administrators, police and other parties that may constitute potential sources of information which parents/guardians might use. The available evidence suggests that a single information source approach (exclusively through the AHS webpage or staff) might not work, because guardians tend to rely on varied resources. Therefore, a wide-ranging approach to dissemination of the reliable, consistent and practical information on PChAD may be essential for educating both the potential clients and the general public.
- As suggested by the surveyed addiction counsellors, more collaboration between the courts and addiction counsellors might be helpful in assisting parents/guardians with the court applications, including presenting required evidence and court testimony.

4. Implications of Specific Types of Information Considered by the Courts

PChAD Act Amendment: "In determining whether a child is abusing drugs, the Court must consider any evidence with respect to the following: (a) the age of the child; (b) the types of drugs being used by the child; (c) the length of time that the child has been using the drugs; (d) the intensity, pattern and frequency of drug use by the child; (e) the impact of drug use on the child's life…" (PChAD Act, 2.1[2], p. 4).

Evaluation Questions

4.1 What is the impact of considering evidence , including types of drugs used, length/intensity/pattern of drug use, impacts on the child's life, and previous addiction and treatment history on court's determination of:
- whether a child is abusing drugs,
- whether a protection order should be granted, and the length of the child's confinement?

4.2 Is there any other information (not included in section 2.1[2]) that would be helpful to the Curt in making decisions on:
- an application for a protection order, and
- a review of a protection order.

4.3 What was the parents/guardians' perception of the fairness of the court's procedure?

4.4 What is the impact of considered evidence on parents/guardians and youth?

4.5 What was easy or difficult in gathering and presenting to the court the evidence of substance abuse?

4.6 What was easy or difficult in making the case and obtaining a protection order or an extension of the child's stay at the PSH (following the court order review)?

The Court Perspective

Court Judges' Feedback

Regarding the impact of the amended section 2.1(2) in determining whether a child is abusing drugs, the judges commented that the information received from parents/guardians on drug use does not always contain enough details. In particular, the form filled out by the parent/guardian should specifically include the evidence on all the items listed in section 2.1(2). Using the exact wording would be preferred. Given that parents/guardians simply state drugs, alcohol and tobacco (but don't outline the evidence on each "drug") it would be helpful to have the evidence on each kind of "drug" delineated.

When inquired about the helpfulness of the evidence on specific areas included in section 2.1(2) (including types of drugs being used, length/intensity/pattern/frequency of usage, previous addiction, mental health, and treatment history and various impacts of drug use on the child's life), the judges noted that Family and Youth Court judges are fairly well-schooled in the nature of addictions and

adolescent challenges. As such, judges were of the view that the checklist of considerations in assessing indication of drug abuse is helpful but not critical.

In response to the question whether more information on drug use, such as impact of specific drugs on children and withdrawal symptoms would be beneficial to the Court, the judges stated that they were not sure how much more information on drug use would help them, given the constraints of the PChAD program. "We already know that most teens have not been using drugs for long enough to undergo withdrawal. The term of confinement is not long enough to really affect anything other than to give the teen and their family a bit of a reprieve and, hopefully, time to reflect on making smarter, safer choices *and/or agree to further treatment for addictions*. There is no treatment available within the program so we are not sure what more we need to know about the program itself or what can be accomplished outside of it."

As to whether the evidence has improved for considering an application for protection orders, a police apprehension or a protection order review, the judges were of the view that whether the amendments to section 2.1(2) have improved the quality of evidence before the court as such, applicants are often very upset and this can affect clarity of their presentation. The judges would hope that the educational information given to applicants before coming into court is helpful in informing them about the grounds for making an application; hopefully drawing a distinction between parent/teen conflict and drug or alcohol abuse by teens.

With respect to other information that is not currently included in section 2.1(2), but would be helpful to the Court in making decisions on an application for/review of a protection order or police apprehension, conveyance and/or assistance clause, the judges responded that:

- "The guardians should list the dates when the child has previously been on the PCHAD program, if any. Did the child previously agree to participate in a treatment program? What treatment program did the child attend and did the child complete the treatment program?"
- "In our experience, virtually all guardians want the police to apprehend, convey and assist. If the guardians could deal with the child on their own, they would not be coming to court to get a PChAD order. It is very rare for the parent to say that they will convey the child to the safe house. A better option is to have the automatic police involvement unless the guardian states otherwise."

The Parent/Guardian Perspective

Parent/Guardian Survey

Over half of the parents/guardians who responded to the survey (54%) strongly agreed that the court gave their applications a fair consideration, additional 40% agreed that the court was fair, and only one percent disagreed (see Table 12).

Table 12: Parents/Guardians' Accounts of the Fairness of Court Hearing Procedure (139 Respondents)

	Strongly Agree N (%)	Agree N (%)	Neither Agree or Disagree N (%)	Disagree or Strongly Disagree N (%)	Did not Respond N (%)	Total N (%)
I believe the court gave my application a fair consideration	75 (54%)	56 (40%)	4 (3%)	1 (1%)	3 (2%)	139 (100%)

More detailed, in-depth conversations during the parent/guardian focus groups provided a more critical perspective on the court hearing procedure (see below).

Parent/Guardian Focus Groups

Inconsistent Court Experiences: Parents/guardians reported inconsistencies in the courtroom experiences, including differences between types and amount of evidence required, and types of drug use that constitute a protection order. Parents/guardians reported varying experiences with the courts, both across multiple hearings with the same child, and between the focus group participants.

Some parents/guardians found judges granted protection orders rapidly, and asked for little or no evidence. Some of them had evidence prepared, but "the judge did not even let us finish, he granted [the order] immediately", even before they had a chance to present their evidence. In contrast, others found that judges demanded a high level of evidence, such as photographic proof of drugs and drug paraphernalia, medical test results showing drug use, previous contact with counselors and support agencies, psychiatric assessments, and documented dates, times, and locations of truancy and drug use events. In one case, parents/guardians were seeking a protection order for their child whose friend had died from drug use. They felt that this was clear evidence of risk of harm to the child, however the judge was unconvinced by this evidence, and declared "I am not hearing grounds for a PChAD [protection order] here." Parents/guardians used examples like these to illustrate how some judges have overly stringent requirements, and are reluctant to grant protection orders even when there appears to be reasonable grounds, while others do not require much evidence, basing their decision mainly on the parent/guardian's word. The focus group participants also reported that different judges asked completely different questions during the hearing. For example, some focused on specific drug use events, while others asked more about social circumstances, such as parenting and gang involvement.

One parent/guardian reported that their child was denied a protection order because he was "only using marijuana" and "this program is for kids using harder drugs". The parent/guardian felt that this was unfair because of the implicit requirement for a child's problems to worsen before intervention is possible.

Challenges in Obtaining Necessary Evidence and Information: Some parents/guardians expressed concern that the evidence-gathering and pre-application processes are overly difficult, especially for people who are not good with computers, or are living in rural areas. One parent/guardian speculated that "more parents would access the program if it was easier."

While some parents/guardians had to wait several days to receive a hearing, others were able to bypass some of the required steps by insisting the situation was an emergency to receive a hearing on the same day. In one case, parents/guardians were able to expedite a court hearing using their child's positive drug test from a doctor and physical drug paraphernalia. The expedited hearing waived the requirement for referral from AHS Addictions Services, and granted a protection order within two hours. Other parents/guardians expressed frustration at hearing this, as they had not known that any sort of expedited hearing was possible.

Challenges With Protection Order Reviews: Parents/guardians also reported differing experiences with protection order review hearings. In one case, a parent/guardian was denied an extension because the child's problem was "more mental [health]" and not directly addiction-related. Although nearly all focus group participants applied for extensions, only one received it. Parents/guardians felt that judges were disproportionately more demanding during review hearings, and felt this was not justified. One parent/guardian expressed great frustration that the large amount of evidence she had gathered for her child's hearing was "all for nothing" when her child was rapidly granted an appeal and allowed out of the PSH, but she could no longer use that evidence for a future PChAD application, and would have to gather new evidence instead.

Suggestions for the Future Court Hearings: The focus group participants put forward the following suggestions to make court hearings more comfortable for children and their parents/guardians:

- ***Inclusion of Drug Testing as Evidence:*** Parents/guardians expressed a desire for the results of drug testing to be included as evidence towards granting a protection order. They felt this would reduce the burden of verbal testimony, and prevent children from being able to lie to the court about their drug use. Some parents/guardians reported that judges seemed to side with children who claimed not to be using any drugs, which could have been avoided if the parents/guardians could have demonstrated their children's drug use through a positive drug test. The focus groups participants felt frustrated when judges did not grant a protection order because although they understood that judges were advocating for the child, it felt as though they were acting against the child's best interests when they opposed the parents/guardians who were trying to help the child.

- ***Children Should not be Exposed to Parent/Guardian's Testimony:*** Some guardians expressed a desire for their children to be sheltered from the parent/guardian testimony portion of the protection order hearing because it can be traumatic for the children to hear their parents/guardians listing all the ways they have been harmed by their children and how their children are harming themselves. One couple reported that their daughter specifically commented after leaving the PChAD program that it was extremely painful for her to sit in court and listen to her parents/guardians testify about her drug use and dangerous behaviour. Other parents/guardians themselves were uncomfortable having their children hear their testimony and requested there be an option to segregate their children during it. Parents/guardians whose children were not present at the hearing reported that they thought that was a better way to conduct the process, and sympathized with the discomfort felt by those who were forced to testify in front of their children.

Implications for the Program Improvement:

- Feedback from the court judges suggests that parents/guardians preparation for the court can be substantially improved to ease the process both for the applicants and the judges. This includes: parents/guardians having a clear idea to what particular situations the protection order applies (e.g., it should not be used to discipline the children) and what evidence they should prepare for the court (including carefully drafted written materials (e.g., providing detailed evidence on specific substance abuse in the forms).
- Parents/guardians should be prepared for the court at pre-application sessions. In this respect, special attention should be given to rural and remote areas to ensure all potential clients have equal access to the necessary information and resources.
- Parents/guardians' call for using a drug test as evidence makes sense because it would provide concrete proof of substance use, simplify the court hearing and increase its fairness.
- The suggestion for not exposing children to the parent/guardian testimony is also reasonable, given that the families already undergo stressful situations with a lot of negativity. At the same time, children hearing how their substance use has had a negative impact on their parents/guardians can be a meaningful and highly therapeutic intervention.
- It may be impossible to achieve full consistency across the courts in terms of examination of evidence and rulings due to the uniqueness of circumstances surrounding each protection order application. However, general consistency in the required evidence across the courts as well as in the criteria for granting a protection order would reduce perceived or actual "inconsistencies" in the clients' court experiences.
- Parents/guardians have to be fully and timely informed and aware of the complete spectrum of options to support their children, such as the possibility of expedited court hearings and order review options including application to extend the length of stay at the PSH (see also the following section).

5. Clients' Familiarity With the Protection Order Conditions and Utilization of the Right for a Protection Order Review

PChAD Act Amendment: "If the child who is the subject of a protection order has not been confined in a protective safe house and the Co-ordinator has not taken any action under section 3(4) in respect of the child within 50 days from the date on which the protection order is granted, the order expires" (PChAD Act, 2.2, p. 5).

PChAD Act Amendment: "An application to the Court for a review of a protection order may be made by (a) the child who is the subject of the order, (b) a guardian of the child, (c) the Co-ordinator,[9] or (d) any other person, with the permission of the Court" (PChAD Act, 4.1[1], p. 8).

Objective: Parents/guardians understand well the above-mentioned conditions associated with the protection order, including the terms of order expiration and the right to review.

Evaluation Questions

5.1 Were parents/guardians informed about the protection order expiration provision?
5.2 Were parents/guardians informed about the right to review a protection order?
5.3 How the right to review a protection order has been utilized by the PChAD clients and was necessary help available?

Awareness of the Protection Order Expiration

Parent/Guardian Survey

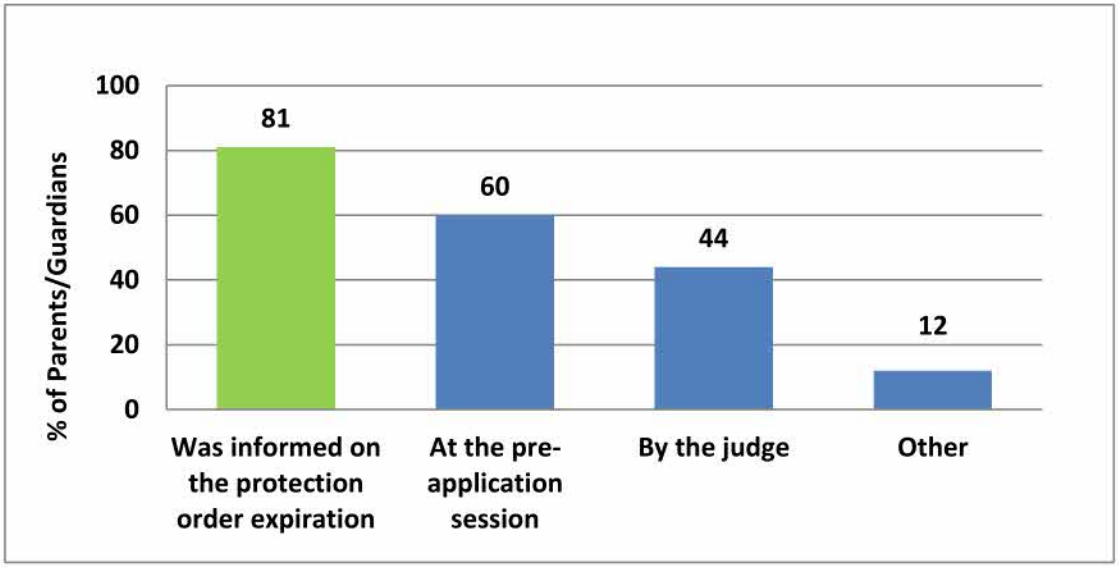
It is important that parents/guardians are aware that a protection order would expire if the action on confining a child to a PSH is not taken within the execution period granted by the judge. Among other factors, the awareness of the expiration date on the part of parents/guardians and PChAD staff is important for securing a PSH bed, since there could be a waiting period. Based on the open-ended comments from the surveyed parents/guardians, some judges could set the expiration date at 10 or 20 days - a much tighter period than the one specified in the PChAD Act.

As shown in Figure 10, 81% of the surveyed parents/guardians stated that they were informed about the protection order expiration clause. According to them, the major source of this information were pre-application sessions (60% of respondents specified this source), followed by the judge (44%). Twelve percent of the parents/guardians mentioned other information sources, including AHS 1-888 number, reading information on the protection order application or on the protection order, learning from previous PChAD applications, and also from RCMP, Child and Family Services, the child's caseworker, through a friend and through work. (Please keep in mind that the survey asked parents/guardians to

[9] The Co-ordinator represents Alberta Health Services (AHS).

check all information sources that may apply. This means that some of them might specify more than one source of information).

Figure 10: Parent/Guardian Awareness of the Protection Order Expiration Period (139 Respondents)



Awareness of the Right to Apply for a Review

Parent/Guardian Survey

The 2012 PChAD Act amendment broadened substantively the list of parties which can apply for a protection order review. The parents/guardians' feedback from past (pre-amendment) PChAD evaluations indicated the possibility of them not being informed about their children's right to a protection order review. Extending the spectrum of parties having the right to review as a result of the 2012 amendments to the Act reinforced the urgency of facilitating parents/guardian awareness and preparedness for potential requests for a review.

Figure 11Figure 11 through Figure 15 contain information on the surveyed parents/guardians' awareness about the various protection order review options. (Please keep in mind that the survey asked parents/guardians to check all information sources that may apply. This means that some guardians might specify more than one source of information).

Responses to the survey plotted in Figure 11 and Figure 12 attest to a high degree of awareness among the parents/guardians of their children's right to a protection order review (90% of respondents) and of their own (guardians') right to a review (85%). According to the parents/guardians, pre-application sessions and communication with the PSH staff were equally important for learning about a child's right to appeal (54 and 51 percent respectively) (see Figure 11). As far as their own right for a review is

concerned, the majority of parents/guardians learned about it from the pre-application sessions (two-thirds or 68%) and about one-third (32%) were informed by the PSH staff (see Figure 12 Figure 12).

Figure 11: Parents/Guardians' Awareness of Their Children's Right to a Protection Order Review (139 Respondents)

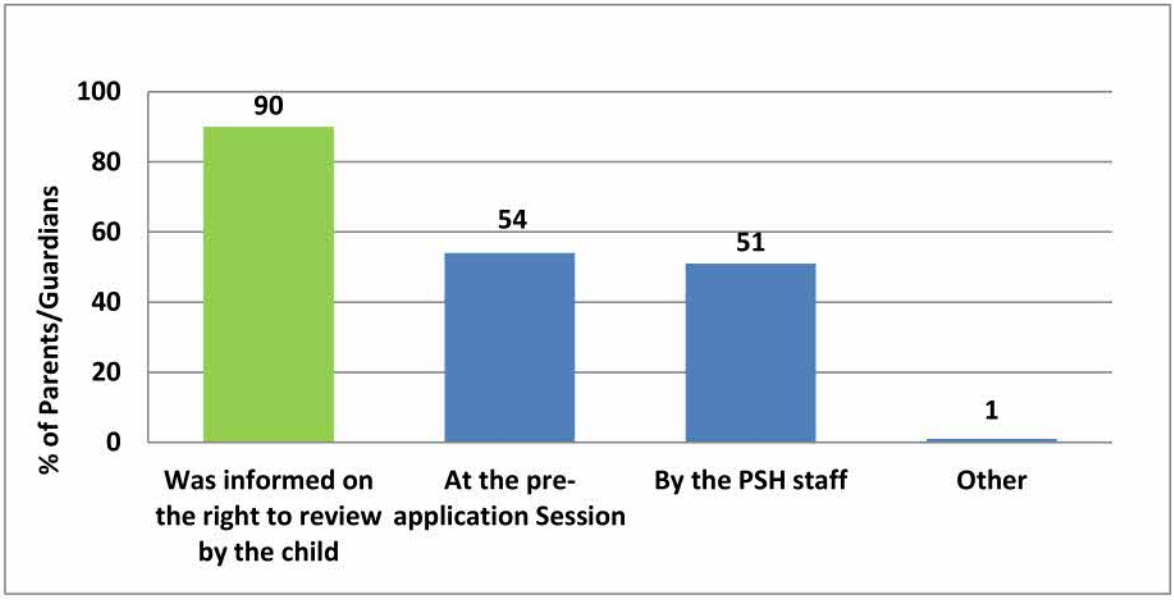
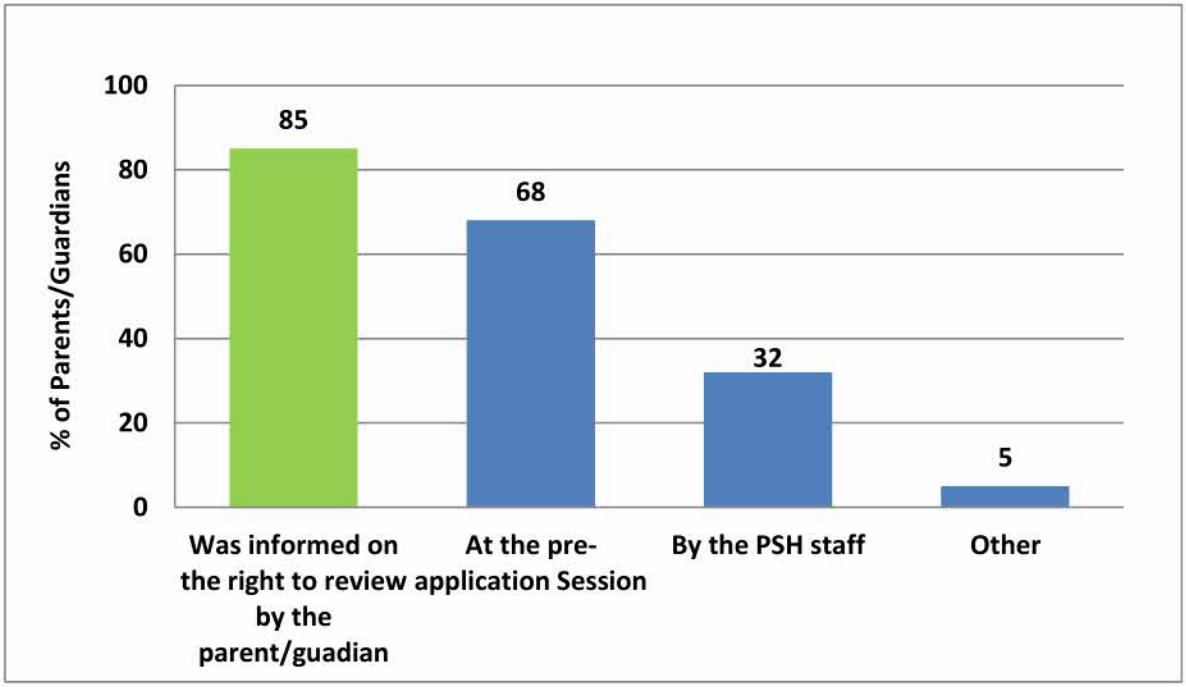


Figure 12: Parents/Guardians' Awareness of Their Own Right to a Protection Order Review (139 Respondents)



Survey results in Figure 13 and Figure 14 indicate that only slightly over half of the surveyed parents/guardians were informed of any other guardian's right for a protection order review (57%) or the right to review on the part of AHS (58%). This information was mostly obtained via pre-application sessions (around 40% of the parents/guardians) and to a lesser extent through the PSH staff (17-20 percent).

Figure 13: Parents/Guardians' Awareness of the Other Guardian's Right to a Protection Order Review (139 Respondents)

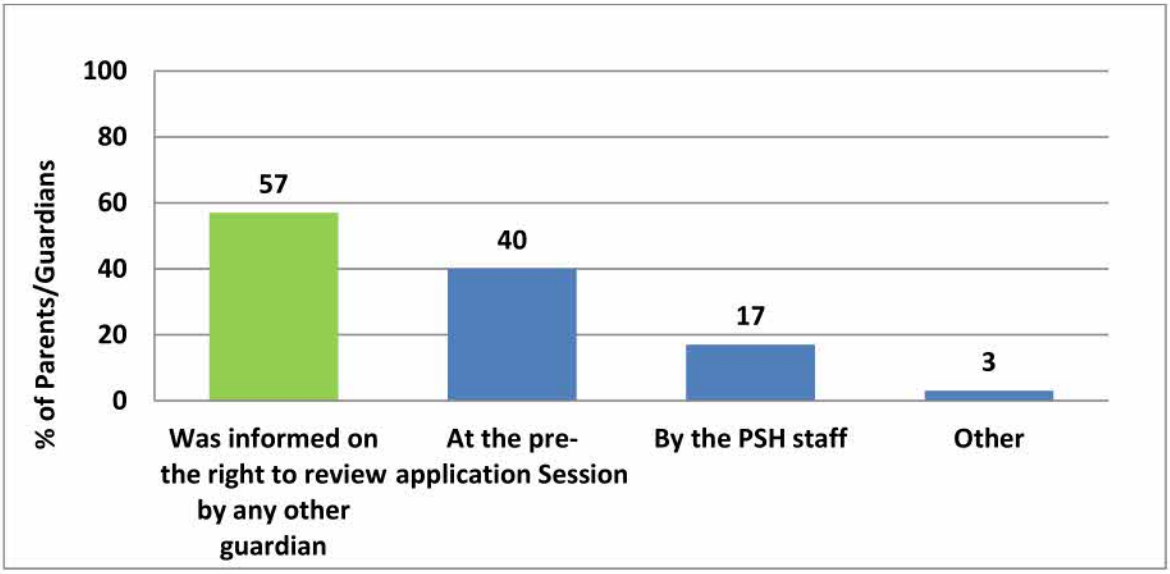
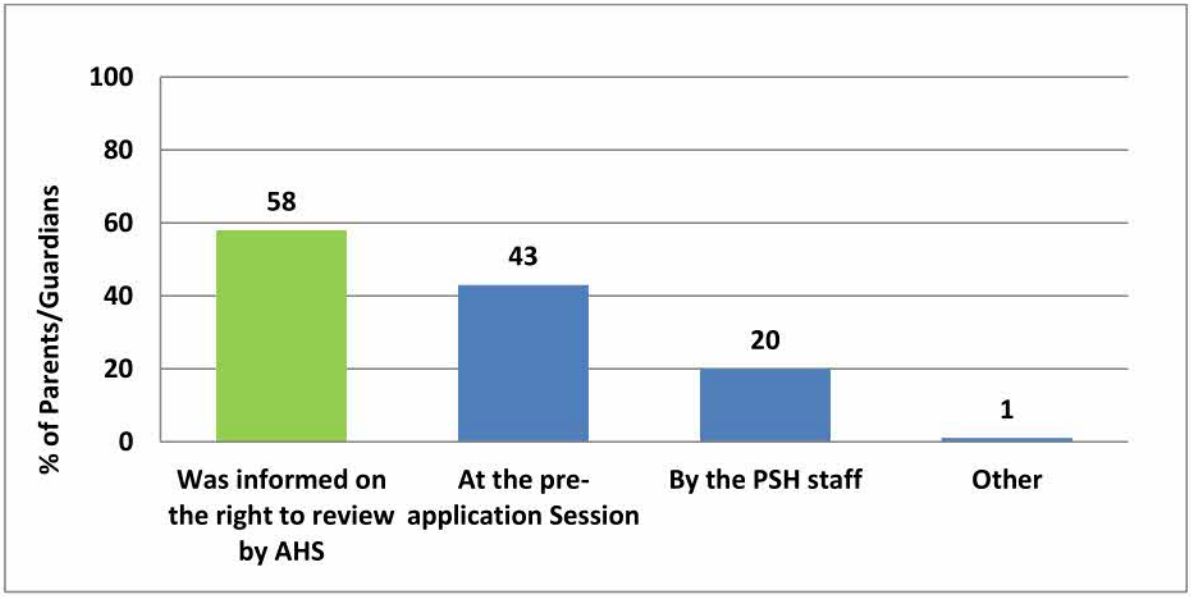
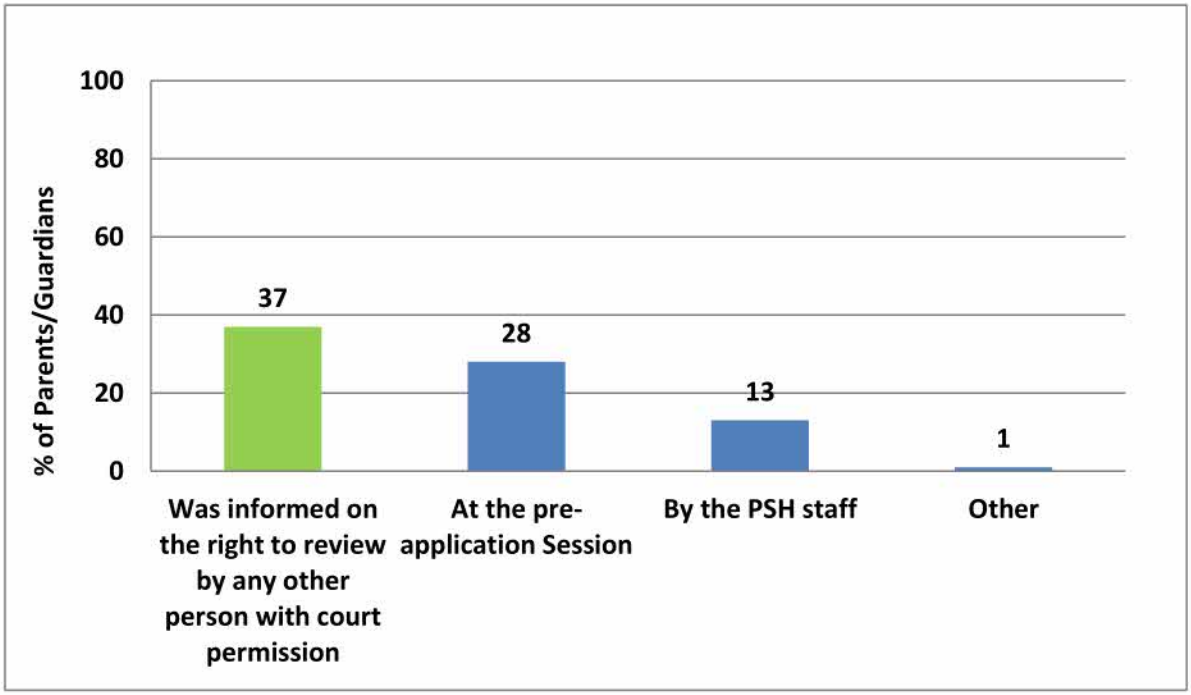


Figure 14: Parents/Guardians' Awareness of AHS Right to a Protection Order Review (139 Respondents)



Even a lower proportion of the surveyed parents/guardians (slightly over one-third or 37%) were aware that any other party may have the right to review the protection order with the court permission (see Figure 15). Those who were aware, learned about this condition during pre-application sessions (28%) and 13% were informed by the PSH staff.

Figure 15: Parents/Guardians' Awareness of the Any Other Party Right to a Protection Order Review (139 Respondents)



Utilizing the Right to Review a Protection Order

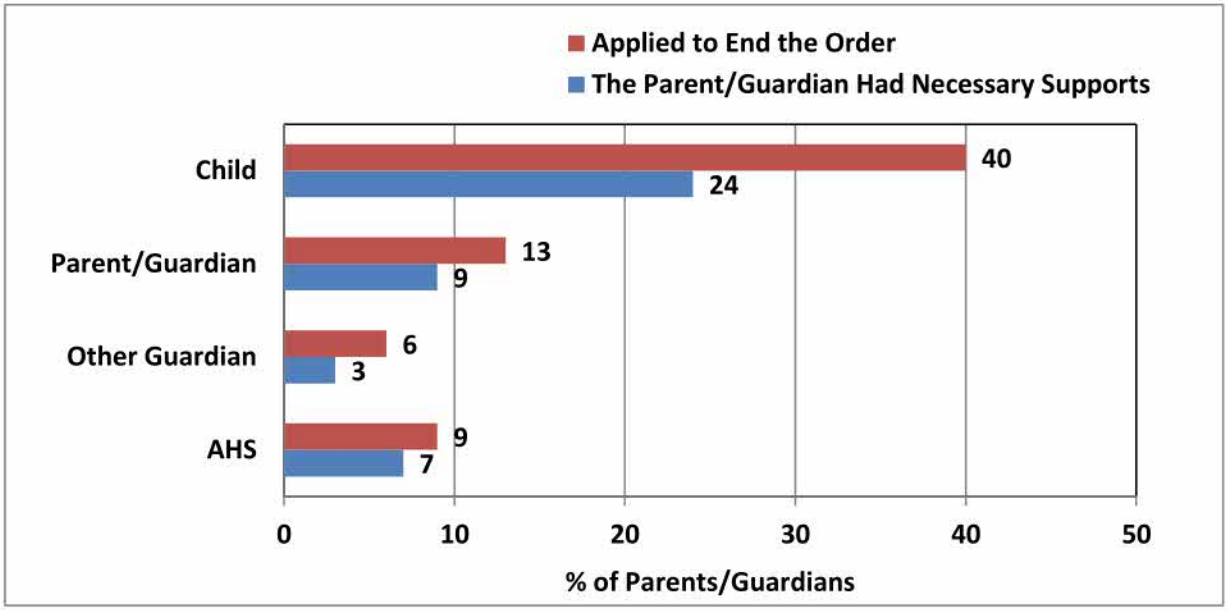
Parent/Guardian Survey

Figure 16 and Figure 17 illustrate the parents/guardians' accounts of their experiences with various types of protection order reviews. Please note that these survey results should be interpreted with caution, because not all parents/guardians would completely understand the order review process and available options.

Figure 16**Error! Reference source not found.** shows parents/guardians' experiences with the appeals to *nd* the protection order, including their perception of being supported during the order review process. As expected, quite high percent of the surveyed parents/guardians (40%) indicated that their children applied for a review to end the protection order. Slightly over half of these parents/guardians (24%) reported having necessary supports during the review process. Relatively low proportions of the parents/guardians filed their own applications to end the protection order (13%), as well as experienced

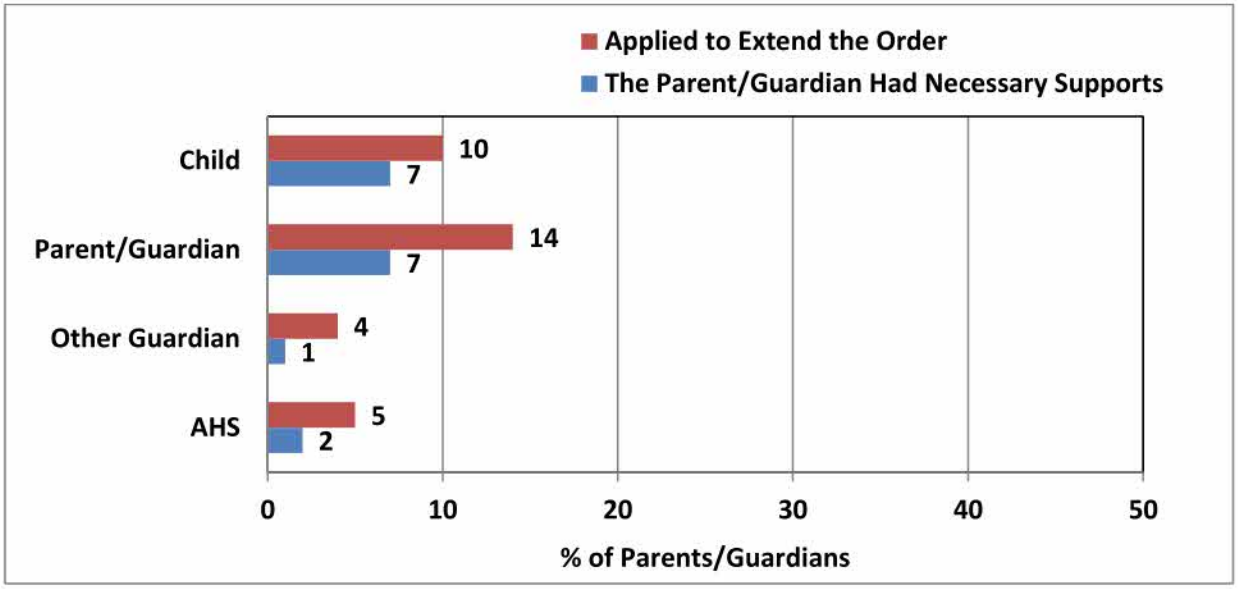
reviews on the part of other parents/guardians and/or AHS (six and nine percent respectively). Half or more of these parents/guardians confirmed having necessary supports throughout the review process.

Figure 16: Parents/Guardians' Experience With Applications to End the Protection Order (139 Respondents)



As demonstrated by Figure 17, based on the surveyed parents/guardians' experiences, the application rates for protection orders' *extensions* were quite low. Fourteen percent of the parents/guardians indicated that they applied for an extension themselves, additional 4% reported other parents/guardian(s) applying, and 10% indicated that their children applied.

Figure 17: Parents/Guardians' Experience With Applications to Extend the Protection Order (139 Respondents)



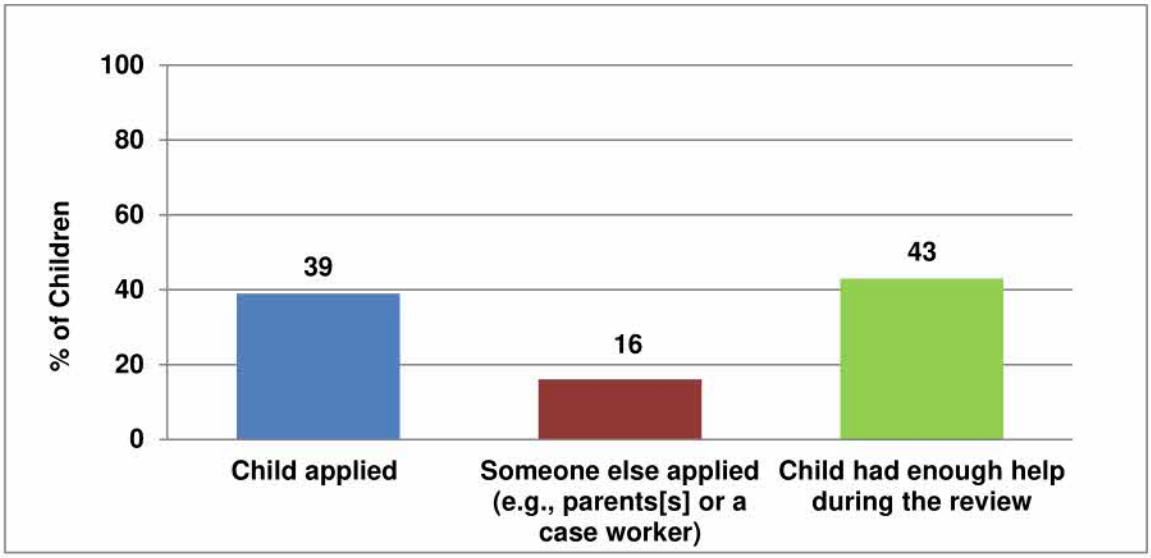
Parent/Guardian Focus Groups

***Children Should Not Be Permitted to Review While Detoxing**:* A large portion of protection order reviews (especially to end the order) takes place at the beginning of children's stay at PSHs. Some parents/guardians felt that their children should not be allowed to attend a protection order review hearing while they were still detoxing. This is because the children are not yet of a sound mind, and two parents/guardians reported their children felt traumatized after hearing their parents/guardians' testimonies against them. This experience was made worse by the fact that the children were still coming off drugs, and were not mentally prepared for the confrontation of the hearing. One parent/guardian suggested that children should have to demonstrate they are clean of drugs by performing a drug test before attending a hearing to show they are competent and capable of handling the event.

Child Survey

The survey of children at the time of their discharge from PChAD revealed that over a third of them (39%) applied for a protection order review and 16% reported someone else applying for a review of their protection order (including their parents/guardians, case worker, etc.) (Figure 18). The majority of these children (43%) felt that they had enough help during the review process.

Figure 18: Children's Application for the Protection Order Review (173 Children)



Availability of Supports for Protection Order Reviews

Parent/Guardian Survey

As described by the surveyed parents/guardians, "Support for the parents would be a large value when a review is conducted." However the survey results indicate that not all of the affected parents/guardians felt supported (see Figure 16 and Figure 17)) and part of them felt that "the process does not support families." When inquired in an open-ended question about what supports were lacking during the review, the overarching theme was lack of various aspects of key information and communication. For example, some parents/guardians reported that they did not "fully understand the process," including that a review was "a court case" and what was expected of them. They also commented on a "very short notice" for the review (e.g. on the same day or the day before the court). As a result they were not able to have their questions answered and get prepared for the review, including understanding what would happen during the court, who will be with the child there, etc.

Some parents/guardians also mentioned that they "would have likely tried" to apply for a protection order extension, for example, if a treatment plan for after PChAD was not finalized, but they did not know about the extension option ("were never given the information"). The parents/guardians believed that the information or supports should come from the "Safe House," "addiction worker in PChAD," and the court/court clerk.

Child Survey

A few (seven) children who provided specific comments on why they felt they were not supported during their protection order review believed their lawyers and the court judge were not helpful, felt

that them not having enough information resulted "in bad results in court," and also contended that their side of the story was not heard.

Implications for the Program Improvement:

- Given that the range of parties which can apply for a protection order review was substantively expanded as a result of 2012 amendments to the PChAD Act, more work should be done to inform parents/guardians of the possibilities and implications of such reviews. Based on the evaluation evidence, some parents/guardians were poorly informed even about most commonly occurring applications for a protection order review by the children and quite low percentages new that other parties (besides a child or a parent/guardian), can apply for a review.
- More supports should be provided for parent/guardian participation in the reviews. Unlike the surveyed children who applied for the review and felt that they had enough help during the review, about half of the surveyed parents/guardians who went through the reviews felt unsupported. Based on the parents/guardians' feedback, the supports should include better communication of information about what the review procedure entails and timely notification of the pending review to allow enough preparation time.
- As suggested by the parents/guardians, children should not be allowed to testify in the court at the review hearings while still under the influence of drugs.

6. Appropriateness of the Transportation Arrangements: Client and Stakeholder Feedback

PChAD Act Amendment: "Subject to the regulations, if a protection order contains provision referred to subsection (4), a police officer must exercise the authority." (PChAD Act 2.1[6])

Objective: Transport youth safely to the Protective Safe Houses (PSH) via appropriate means.

Evaluation Questions

6.1 What is the impact on the stakeholders of the PChAD amendment that if a protection order contains provision, a police officer must exercise the authority to apprehend and convey the child to the PSH?
- Is more scrutiny by courts required for ordered conveyance by police?

6.2 What are the police officers' experiences with the apprehension and conveyance of youth for the PChAD program?

6.3 Should alternative sources of transport to PSH be indicated?

6.4 What are the children's experiences with the apprehension and conveyance by police: What works and what can improve?

6.5 What are the parents/guardians' experiences with the apprehension and conveyance by police: What works and what can improve?

6.6 What are restraints and resource impacts to policing authorities?

Impact of Amendment on Provision Requiring Police Officer Apprehension and Conveyance

Court Judges' Feedback

Court judges indicated that the above-mentioned amendment has not resulted in a reduction (and possibly even an increase) in the number of applications from parents/guardians to apprehend their children by police. Also, the judges' feedback does not suggest increased court scrutiny with regard to conveyance and apprehension by police. Based on the judges' experience, most parents or guardians want police apprehension for their children, therefore the judges suggested applying the automatic police involvement with the possibility for parents/guardians to opt out. (See also Section 4: Implications of Specific Types of Information Considered by the Courts).

Police Survey

When asked their opinion of the 2012 amendment to the PChAD Act, 45% of police officers stated that they supported the act which is "clear on authority [and] responsibility of the officer." However, 13% of police officers argued that the amendment does not give enough detail, particularly as it does not specify the authority of using force (e.g., if children are violent), and what to do if no beds are available (e.g., permissibility of detaining child in police facilities). Some officers expressed concerns that

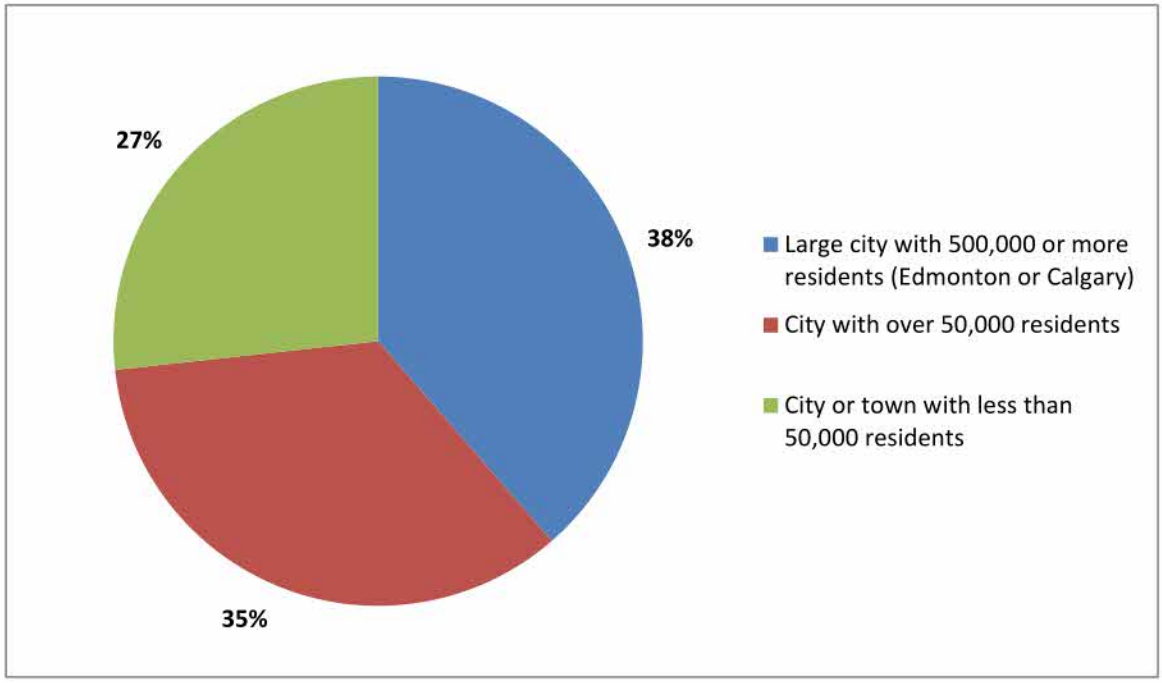
although the amendments are good in theory, executing orders can become "tremendously inconvenient" due to limited police resources. Nearly all officers reported some awareness of the amendments, but 27% stated that although there had been amendments, they did not notice any changes to their day to day activities.

Police Officers' Experiences with Apprehension and Transportation of Children

Police Survey

Out of 167 respondents, 142 police officers (85%) reported participating in either the apprehension or transportation of children under a PChAD protection order. Figure 19 shows where these police officers were located. Of the 142 officers involved with PChAD, 63% indicated that they also serve rural areas or reserves.

Figure 19: Police Officers' Location (142 Officers)



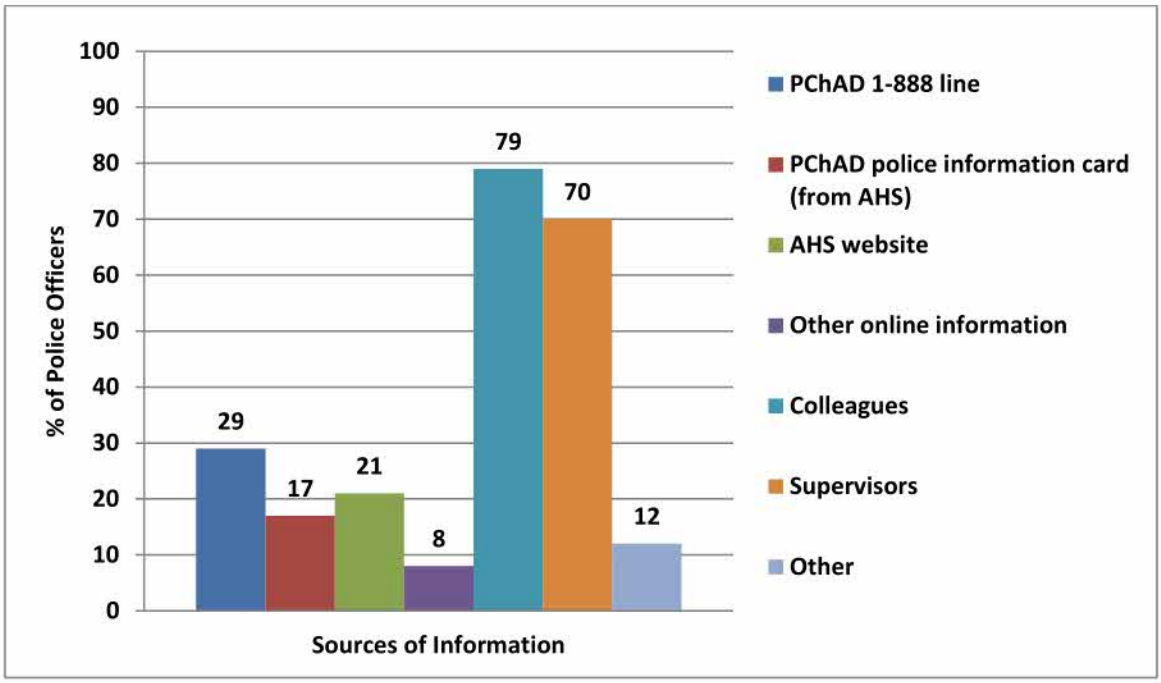
Aside from apprehension and transportation, 13% indicated other involvement in PChAD such as helping parents/guardians obtain protection orders, arranging transportation, and informing families and the public about the program. Table 13 shows how long police officers have been involved with PChAD, as well as frequency of involvement over the past year.

Table 13: Length and Frequency of PChAD Involvement (142 Police Officers)

	Number of Police Officers	%
Overall length of involvement with apprehension and/or transportation of children to PSHs		
1-6 months	5	4%
7-11 months	5	4%
1-3 years	27	19%
4-5 years	21	15%
More than 5 years	77	54%
No response	7	5%
Involvement in apprehension and/or transportation over the past 12 months		
Once a week or more	0	0%
2-3 times a month	5	4%
Once a month	8	6%
Once every 2 months	10	7%
Once every 3 months or less	112	79%
No response	7	5%

Figure 20shows the PChAD information sources police officers reported accessing most frequently. Other sources include consulting policy manuals, or contacting court clerks, Victim Services, Human Services, or PSHs themselves. Twenty-five percent of police officers reported wanting access to more information about PChAD, such as contact information of PSHs, updated policy documents, a guide for police, a guide for parents, and after hours support. Some police officers reported being unaware of resources such as the 1-888 line and police information card, and stated they would like access to them.

Figure 20: PChAD Information Sources Used by Police Officers (142 Respondents)



When asked whether apprehension, transportation, and intake into PSHs were well-coordinated between PChAD staff, police, and parents/guardians, 47% of police officers agreed while 35% disagreed. Those who disagreed felt that the coordination of the PChAD program was disorganized, mainly due to the fact that bed availability is not always clear, and sometimes police officers end up driving great distances to a PSH only to find that a reserved bed has been given away, or there was no space available to begin with. Officers argued that if the PChAD program was better coordinated between PChAD staff and parents/guardians, this would reduce the amount of time police spend on unnecessary driving and premature apprehensions. Police felt it would be beneficial for parents/guardians to take on more of the burden of coordinating their child's entry into a PSH, for example, checking bed availability. Furthermore, if it was easier to communicate with the PSHs directly, police felt this would reduce some of these challenges. Additionally, if PSHs were willing to hold beds for longer, it would be less of a struggle to apprehend and transport the children within the allotted time. Table 14 shows police officers' opinions about the involvement of police in apprehension and/or transportation of children to PSHs.

Table 14: Opinions of Police Involvement in Apprehension and/or Transportation (142 Police Officers)

	Number of Police Officers	%
Is the involvement of police in apprehension and/or transportation of children to PSHs:		
Appropriate?		
Yes	75	53%
No	40	28%
No response	27	19%
Well-resourced?		
Yes	39	28%
No	76	54%
No response	27	19%
Effective?		
Yes	79	56%
No	36	25%
No Response	27	19%
Efficient?		
Yes	48	34%
No	67	47%
No response	27	19%

Twenty eight percent of police officers felt that police involvement in apprehension is not appropriate. Some officers commented that police should be involved only in high risk cases. They also felt that police should not be required to transport children, because it as is a great burden on police resources (see the subsequent subsection: Constraints and Resource Impacts on Policing Authorities).

Some police officers reported process failures such as being required to transport a child great distances to a PSH only to find the designated bed had been given to another child. Another officer reported that he was instructed to drive a child to a more distant PSH, even though there was a bed available much closer. Close to a third of police officers feel "there needs to be better communication [...] on how to determine bed availability". These inefficiencies are frustrating to police officers, who attribute them largely to insufficient coordination and communication from program staff.

To combat these issues, some suggested that police officers should only become involved after parents/guardians have demonstrated that they are unable to apprehend and transport a child themselves. Alternately, detachments should hire dedicated PChAD officers, so "as not to take away core policing resources".

A few officers felt that transportation by police keeps children safe, and police are often in a better position to apprehend children than parents/guardians are because they know where children hang out. Two officers commented that having sufficient training improves the apprehension and conveyance of

children, and it is best when children are unaware of the pending apprehension. Some officers felt that involving police is beneficial because it gives children the opportunity to talk to someone other than their parents/guardians. The following are the most common police officer suggestions to improve apprehension and transportation procedures:

- Encourage more parent/guardian involvement
- Improve coordination and communication between stakeholders (AHS, PSH, parents/guardians, police)
- Pre-arrange PSH bed availability prior to apprehension
- Add more PSH beds
- Only involve police in high risk cases
- Add more PSH locations
- Make PSH beds available in child's home community
- Allow parents/guardians to request police presence at apprehension for support
- Pre-arrange transportation before apprehension
- Hire officers dedicated to executing orders
- Reduce requirement of police to transport children over long distances

Staff Survey

When asked about communication between staff and police services about children's apprehension and transportation, 64% of staff felt that communication was efficient either always or most of the time. In addition, 68% of staff felt that communication with AHS Provincial Coordinators about children's placement in PSHs was efficient either always or most of the time. Approximately one third of staff felt that communication was sometimes inefficient, were unsure about communication efficiency, or did not respond. A few staff noted that evening and weekend communication with AHS needs to be improved in particular.

Alternative Sources of Transportation to PSHs

Police Survey

In open-ended survey comments, 23% of police officers stated that transportation should not be done by police, citing reasons such as undue burden on police resources, and driving distances that are too far. Police officers recounted short-notice transports that were over five hours in one direction and left their communities and detachments short-staffed, in addition to requiring transporting officers be paid overtime. This great strain on police resources is even worse in rural detachments which may only have one or two officers on duty at any time. Twenty-three percent of police officers noted that children are generally cooperative during apprehension and transportation, and some argued that police officers should not be required to transport in cases where children are willing to go. Fifteen percent of police officers argued that police should only be involved in high risk cases, for example when the child has

been violent in the past or is likely to flee. One officer felt that police should not be involved as it reduces children's trust in police, and makes the experience more traumatic than necessary. Police officers suggested that standard transportation should be taken over by other agencies such as Alberta Sheriffs (9%), AHS (7%), or CFSA (2%), or by parents/guardians themselves (5%).

If it is not possible to reduce police involvement in transportation, officers made some suggestions to reduce the burden of this task. Increasing the number of PSHs and beds across the province would reduce transportation distances. This would also address the difficult position police officers are in when all PSH beds are occupied and officers must either wait to apprehend the child, or detain the child in police custody while waiting for a bed to become available. Two officers suggested creating a dedicated holding space for children who are waiting for a PSH bed to become available. This would reduce the timing difficulties associated with apprehension, particularly in the scenario where officers must delay apprehension until a bed becomes available which can be difficult due to time restrictions on the protection order.

Children's Experiences with Apprehension and Transportation by Police

Child Survey

Of the children who responded to the survey, 82% reported living in a city, 18% in a town, village, or farm, and 1% did not respond Figure 21 shows each surveyed child's place of residence relative to their safe house: the graph shows that Calgary PSH accepted the most children from other cities, while Red Deer PSH accepted the most children from towns, villages, and farms.

Figure 21: Children's Place of Residence by PSH (173 Children)

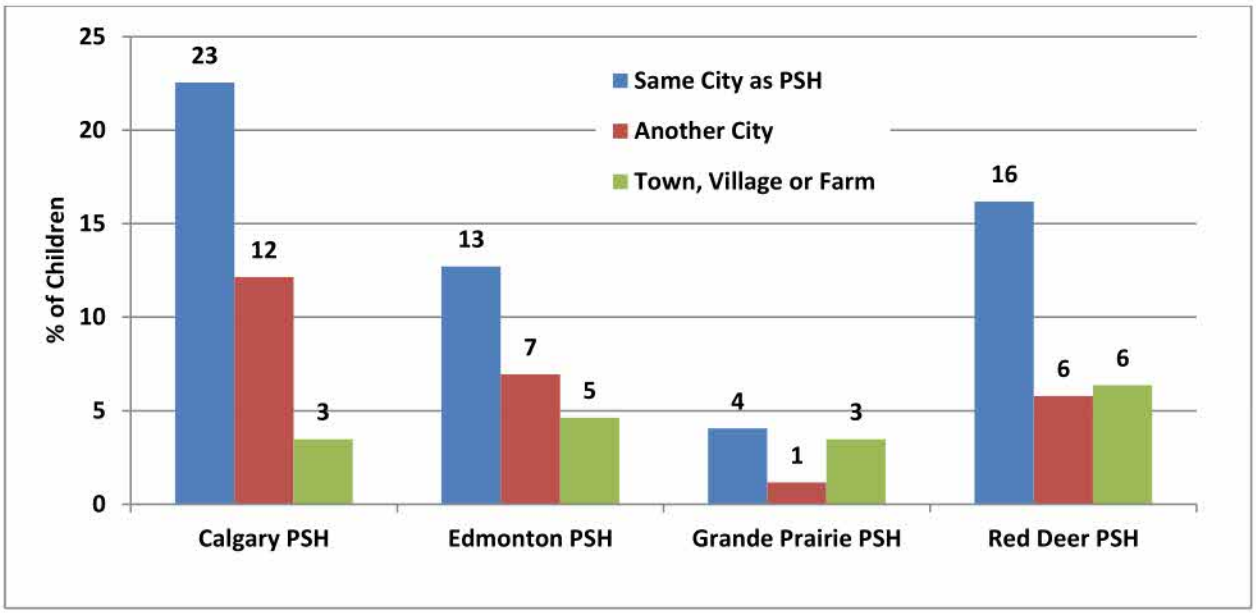


Figure 22 shows how many times each child had been in a PSH: for the majority (58%), this was their first time in a PSH.

Figure 22: Number of Times Each Child Has Been in PSH (173 Children)

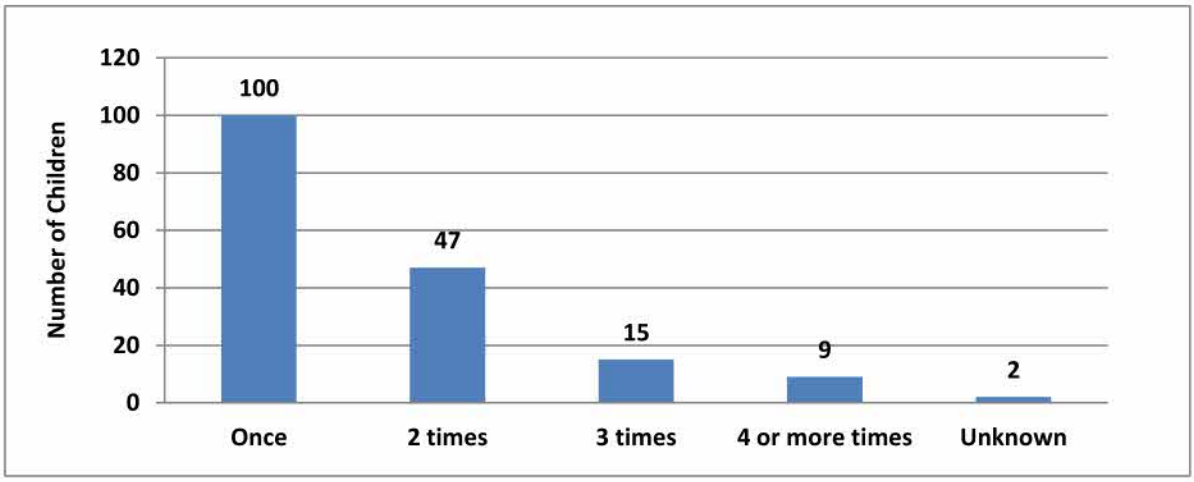


Table 15 shows who the surveyed children reported brought them to the PSH for their current stay. The majority (68%) were brought by police, while the next most common was for children to be brought by parents/guardians, caseworkers, or social workers (21%).

Table 15: People Who Brought Children to PSH (173 Children)

	Number of Children	%
Who brought you to the PSH?		
Police	117	68%
Parent/guardian, caseworker or social worker	37	21%
Other family member	3	2%
Someone else	2	1%
No response	14	8%

Children who had been transported to a PSH by police were asked how they felt about the experience. Table 16 shows that 64% of children reported feeling respected, 75% felt safe, 56% did not feel scared, 70% understood what was happening and 71% had an overall okay experience with police. Cross-tabular analysis revealed that children were less likely to feel scared when being transported by police the more times they had been in a PSH. There was also a trend towards the use of police transportation for

children living in towns, villages, and farms, while children living in cities were less likely to have been brought by police transport.

Table 16: Children's Experiences With Police Transportation to PSH (117 Children)*

	Number of Children	%
I felt respected		
Yes	75	64%
No	31	26%
No response	11	9%
I felt safe		
Yes	88	75%
No	17	15%
No response	12	10%
I felt scared		
Yes	40	34%
No	66	56%
No response	11	9%
I understood why the police brought me here		
Yes	82	70%
No	25	21%
No response	10	9%
Overall, my experience with police was okay		
Yes	83	71%
No	20	17%
No response	14	12%

*Only includes children who responded yes to being transported to the PSH by police.

Children who reported that their experience with police was not okay most commonly gave the following reasons:

- Police were rude
- Police were physically rough
- Transportation was uncomfortable (e.g., sitting in a police car while restrained)
- Did not like being restrained
- Police did not explain what was happening
- Held for a long time

Other responses mentioned specific concerns about apprehension, including the fact that apprehension was frightening, and that children did not like being confined or restrained. Some children complained

about being held for too long, thought the holding cells were uncomfortable, or did not like being left alone in a holding cell. Two children objected to police involvement because they felt they did not belong in PChAD, and one reported generally mistrusting the police.

Police Survey

Twenty-nine percent of police officers commented that children react negatively to apprehension and transportation, especially if they are intoxicated or high. One of them stated that nine times out of 10, the child is "very angry and uncooperative upon initial contact," while another reported that children often react poorly to police because "they think they are going to jail." Twenty percent of police officers reported that children are generally cooperative, though a few may be confused. Although children don't like it, having "patience and the right attitude" helps police explain what is happening and gain the child's cooperation. A few officers reported that for many children, this may be their first encounter with police, which "can't leave a positive feeling with them." Eight percent of police officers felt that clear communication with the child is important to the successful apprehension and transport of children to PSHs.

When police officers were asked whether they had ever restrained a child while carrying out a protection order, 6% said always, 36% said sometimes, 37% said never, and 21% did not respond. Table 17shows the methods of restraint police officers reported using.

Table 17: Methods of Restraint Used by Police Officers (59 Police Officers)*

	Number of Police Officers	%
Handcuffs	52	88%
Soft control	6	10%
Physical force	6	10%
Leg restraints	4	6%
Vehicle restraint	4	6%
Spit mask	1	2%

*Only includes police officers who responded that they sometimes or always used restraints. Percentages may not add to 100%, because some police officers indicated using multiple types of restraints.

When police officers were asked what criteria they use to judge whether or not to use a restraint, 37% said they would use restraint if the child seemed likely to be violent, and 16% would use restraint if the child seemed likely to flee. The following are other common reasons given by police officers to use restraints while transporting a child to a PSH:

- Restraint used if child resisting apprehension
- Restraint required for police transport

- Restraint use judged by child's past behaviour
- Restraint use judged by criminal code or apprehension policy
- Restraint used if child intoxicated or high

When asked whether they had ever held children in custody prior to transport to a PSH, 4% of police officers said always, 32% said sometimes, 43% said never, and 21% did not respond. Table 18 shows the average length of time police officers reported having held children in custody. The most common reasons given for holding children in custody were waiting for other officers to arrive to transport children to a PSH (18%), and waiting for a bed to become available at a PSH (12%). A few officers reported apprehending children before beds become available due to concerns that the child would run away if there was any delay. Others were concerned that children might harm themselves if not apprehended immediately, or had to wait to find out which PSH the child was being sent to.

Table 18: Average Length of Time Child Held in Custody (48 Police Officers)

	Number of Police Officers	%
1-3 hours	20	42%
4-6 hours	10	21%
7-10 hours	2	4%
> 10 hours	3	6%
Other	8	17%
No response	5	10%

Parent/Guardian Focus Groups

Two parents/guardians discussed their children's experiences with police apprehension and conveyance. One child found the experience scary and traumatic: he was sitting outside getting high when four officers came and took him to the PSH. He told his mom that if she was going to send him to PChAD again, he would go voluntarily because he did not want to be apprehended by the police again. Another child called her parents/guardians and asked them to get her into PChAD because she was not being allowed to leave the people she was with. Her parents/guardians called several police stations before finding officers who were willing to go pick her up immediately, and she was very grateful.

Parents/Guardians' Experiences with Apprehension and Transportation by Police

Parent/Guardian Survey

The majority of parents/guardians (61%), indicated during the evaluation survey at the PSH that their child was admitted to the PChAD program for the first time. Table 19 shows the number of times parents/guardians reported their children had been admitted to a PSH including the current stay.

Table 19: Number of Times Child Admitted to PSH Including Current Stay (139 Parents/Guardians)

	Number of Parents/Guardians	%
Once	85	61%
2 times	31	22%
3 times	7	5%
4 or more times	9	7%
No response	7	5%

Seventy-six percent of parents/guardians reported that police transported their children to the PSH, while 15% did not use police transport and 9% did not respond. This is in alignment with the 68% of children who reported they had been transported by police. The following are the most common reasons parents/guardians gave for requesting police assistance with transportation:

- Child unwilling to go voluntarily
- Child likely to run away
- Parents/guardians unable to locate child
- Child had been aggressive
- Police can ensure safe arrival
- Wasn't sure if child would go voluntarily

A few parents/guardians reported that they were either unable to transport the child themselves (don't have a car, can't take time off work), or they needed the police to apprehend the child from an unsafe location which the parents/guardians could not access. In two cases, the judge mandated police transport, and in one case the parents/guardians did not know there was an option to transport the child themselves.

Of the twenty-two parents/guardians who responded that the police did not transport their child to the PSH, twenty-one reported they were the ones who transported their children, while one child transported himself.

When asked why they had decided to place their child in the PChAD program, parents/guardians gave many reasons, the most common of which are shown in Table 20.

Table 20: Reasons for Placing Child in PChAD Program (139 Parents/Guardians)*

	Number of Parents/Guardians	%
Excessive drug use	62	45%
Excessive drug and alcohol use	23	17%
Child putting self in dangerous situations	20	14%
Wanted child to receive treatment	15	11%
Child running away	15	11%
Wanted child to come off drugs	14	10%
Mental health concerns	8	6%
Wanted to protect child	8	6%
Child aggressive	7	5%
Child skipping school	7	5%
Child a danger to themselves	6	4%
Child out of control	6	4%
Out of options	6	4%
Child breaking the law	5	4%
Child unable to control own substance use	5	4%
Child unwilling to attend voluntary treatment	5	4%
Family negatively affected	5	4%
Wanted child to receive education about substance use	5	4%
Concerned about child's health	4	3%
Heard positive things about the PChAD program	4	3%
Excessive alcohol use	3	2%
Other/no response	11	8%

*Percentages may not add to 100%, because some parents/guardians indicated multiple reasons.

Other responses included wanting to remove a child from a dangerous situation, wanting to scare a child, or the child requesting help with their own substance abuse.

Parent/Guardian Focus Groups

Most parents/guardians reported positive experiences with police. Some parents/guardians were grateful to be able to request police apprehension as "it is the only resource available" when parents/guardians do not know where their children are. Parents/guardians living in rural areas reported that it was difficult to get the police involved as their detachments often only had a few officers on duty at any time. Parents/guardians also felt that 72 hours to find, apprehend, and transport a child was not a lot of time if any difficulties were encountered. Some parents/guardians felt that RCMP officers were more sympathetic toward parents/guardians than city police who "did not have the resources" to find a child, and were only willing to go apprehend if the parents/guardians did the legwork to determine the child's location.

Constraints and Resource Impacts on Policing Authorities

Police Survey

Twenty-three percent of police officers commented on their level of satisfaction with the training or orientation they received. Of these, 72% reported that current training or orientation was inadequate, citing several reasons, including out of date training materials and a lack of PChAD orientation during general police training. Many reported that the only training they received was word of mouth from colleagues and supervisors when a PChAD order was first received. Respondents felt that new officers would need guidance, and suggested including a field training component about PChAD because it's difficult to learn about the program on paper, and "easier to understand when you are in the field." Table 21 describes whether police officers perceived new officers would know how to proceed when presented with a protection order for the first time.

Table 21: Police Perceptions of Clarity of Protection Order Instructions (142 Police Officers)

	Number of Police Officers	%
Yes, someone seeing a protection order for the first time would understand what to do	71	40%
Why?	• Order contains directions • Policy contains process • Supervisors explain what to do	
No, someone seeing a protection order for the first time would not understand what to do	57	50%
Why not?	• Directions on order are unclear • Directions on order may be missing • Research into process is required • Procedures change • Policy difficult to locate	
No response	14	10%

Only 20% percent of police officers reported that they were provided either orientation or materials about PChAD when they first became involved in apprehension and/or transportation, while 67% said they received nothing, and 13% did not respond. The police officers who responded yes reported receiving the following types of orientation or training materials:

- The purpose of the PChAD program
- Details of the PChAD Act, including the role of police
- Procedures to follow when presented with a protection order requiring police apprehension and/or transportation

Of the police officers who received orientation, 66% found it helpful, while of those who only received PChAD materials, 45% found them helpful to understanding PChAD and the role of police.

Table 22 summarizes how easily available police officers perceive various information sources about PChAD to be.

Table 22: Ease of Availability of PChAD Information (142 Police Officers)

	Number of Police Officers	%
Information is easily available about the PChAD Act		
Agree or strongly agree	80	56%
Neither agree nor disagree	23	16%
Disagree or strongly disagree	27	19%
No response	12	9%
Information is easily available about the role of police in PChAD		
Agree or strongly agree	73	51%
Neither agree nor disagree	19	13%
Disagree or strongly disagree	38	27%
No response	12	9%
Information is easily available about procedures for a police officer to follow		
Agree or strongly agree	71	50%
Neither agree nor disagree	22	16%
Disagree or strongly disagree	37	26%
No response	12	9%

A few officers reported that the program information they have access to is insufficient and needs to be improved. For example, two officers reported that the PSH locations were unclear, and one reported that his detachment did not have contact information for the PSHs.

Thirteen percent of respondents commented that they have access to helpful PChAD resources, such as information sheets with directions and the PChAD hotline which is available during business hours. However, some respondents reported consistent issues accessing certain information, such as PSH locations. Of those who commented specifically on program knowledge, 29% reported that PSH locations were unclear. For this reason, respondents suggested that the PSH locations should be listed on the orders, and requested better access to police instruction cards, which some officers did not know about. Furthermore, several police officers requested access to a 24 hour hotline which could provide information about orders after hours.

When asked about impacts of the amendment on police work, 29% of police officers said that executing orders is a burden on police resources mainly because police officers have to spend lots of time coordinating bed availability, as well as researching the process if they are unfamiliar with it. Many police officers reported that it takes too much effort to confirm bed availability, and suggested that parents be responsible for this task instead. Additionally, police officers often receive orders from parents on short notice, so they are unable to plan pre-scheduling additional staff to conduct child

apprehension and transportation. Table 23 shows police officer concerns about resourcing impacts of the PChAD amendment.

Table 23: Police Concerns About Resource Impacts of Executing Apprehension and Conveyance Orders (142 Police Officers)*

	Number of Police Officers	%
Executing orders is a burden on police resources	41	29%
Bed availability should be confirmed prior to court granting order	26	18%
Executing orders leaves detachments short-staffed	20	14%
Planning time would reduce burden on police	14	10%
Executing orders delays higher priority work	10	7%
Police should not have to determine bed availability	6	4%
Hire officers dedicated to executing orders	5	4%

*Percentages may not add to 100%, because some police officers indicated multiple concerns.

Officers reported feeling frustrated at the lack of available bed space, often having to delay apprehension until a bed can be found. Some officers also felt that their involvement was an unnecessary use of resources because the PChAD program is ineffective as the kids think "it's a joke," and it's "completely useless as there is no support or counselling" within the program. Officers felt that many children simply return to their previous lifestyles and behaviours immediately after leaving the PChAD program.

Fifteen percent of police officers commented that police should not be involved in apprehension, except in high risk cases. They also felt that police should not be required to transport children, as it is a great burden on detachments to have two officers away for an entire day or more because they are driving children five or six hours to a PSH. Additionally, apprehension and transportation is especially difficult for small detachments that only have one or two officers on staff at any given time. Officers suggested that AHS or Alberta Sheriffs could conduct transportation after parents/guardians have demonstrated that they themselves are unable. Some officers felt that police involvement is actually detrimental because it reduces the child's trust in police authorities.

Implications for the Program Improvement:

- The police survey suggests that apprehension and transportation by police can be a substantive strain on the police resources. While apprehension and transportation by police is required under the PChAD Act, some adjustments may be suggested to ease pressures on the police resources, including continuing to use sheriffs as an alternative means of transporting children to the PSHs (after apprehension by police) as well as other areas for improvement (see below).
- The surveyed police officers were of the opinion that the coordination of apprehension and transportation should be enhanced, including securing bed availability for the child's arrival, providing officers with information on exact PSHs locations (e.g., make the locations listed on protection orders), and booking the beds as close to children's places of residence as possible to avoid unnecessary long-distance travel). The officers underscored the need for more active parent/guardian participation in coordination of apprehension and transportation, including inquiring about bed availability and making sure the protection orders are received by police in advance, to allow for planning for apprehension and transportation.
- According to the police survey, PChAD-related training to and resourcing of the police should be enhanced. Varied training opportunities and resources (including printing and distributing more information cards) could be provided by AHS and its staff. As well, a recommendation could be made to the Ministry of Justice and Solicitor General to make PChAD part of the general police training and orientation, including field training. As well, staff dedicated specifically to PChAD could be allocated or hired.

7. Client and PChAD Staff Feedback on the Stay at the Protective Safe Houses (PSHs)

PChAD Act Amendment: "A protection order may contain provisions authorizing... the director of a protective safe house to confine the child in accordance with the order for one period of not more than 10 days..." (PChAD Act, 2.1[3][b], p. 4)

PChAD Act Amendment: "If the Co-ordinator considers it to be in a child's best interests for a guardian of the child to have any information respecting the assessment of the child under subsection (3) or (4), the Co-ordinator may disclose the information to the guardian without the child's consent" (PChAD Act, 3[6], p. 6)

Objective: There are adequate opportunities for effective youth assessment, stabilization and planning for future treatment and supports as well as for parents/guardians' involvement along the way.

Evaluation Questions

7.1 Did parents/guardians find the (increased) stay in the PSHs (10 days with possibility of 5-day extension) sufficient for meeting their children's needs, or did they prefer other options?
7.2 Did children find the length of stay in the PSHs (10 days with possibility of 5-day extension) just right, or did they prefer other options?
7.3 Did program staff think that the current length of stay in the PSHs (10 days with possibility of 5-day extension) sufficient, or did they prefer other options?
7.4 Are the PChAD staff aware and alert of the possibility and consequences of negative networking among the children?
7.5 Did children believe they received sufficient/adequate counselling during their stay at PChAD?
7.6 Did children have their family involved?
7.7 Did parents/guardians have opportunities to be actively involved during their children's stay with PChAD (e.g., in assessment and/or planning for treatments and supports after PChAD?
7.8 Did parents/guardians have the opportunity to access their child's assessment information?
7.9 Where educational opportunities available to guardians during their children's stay with PChAD?
- Did the guardians find the supports and education adequate and useful?
- What were the reasons for non-participation?

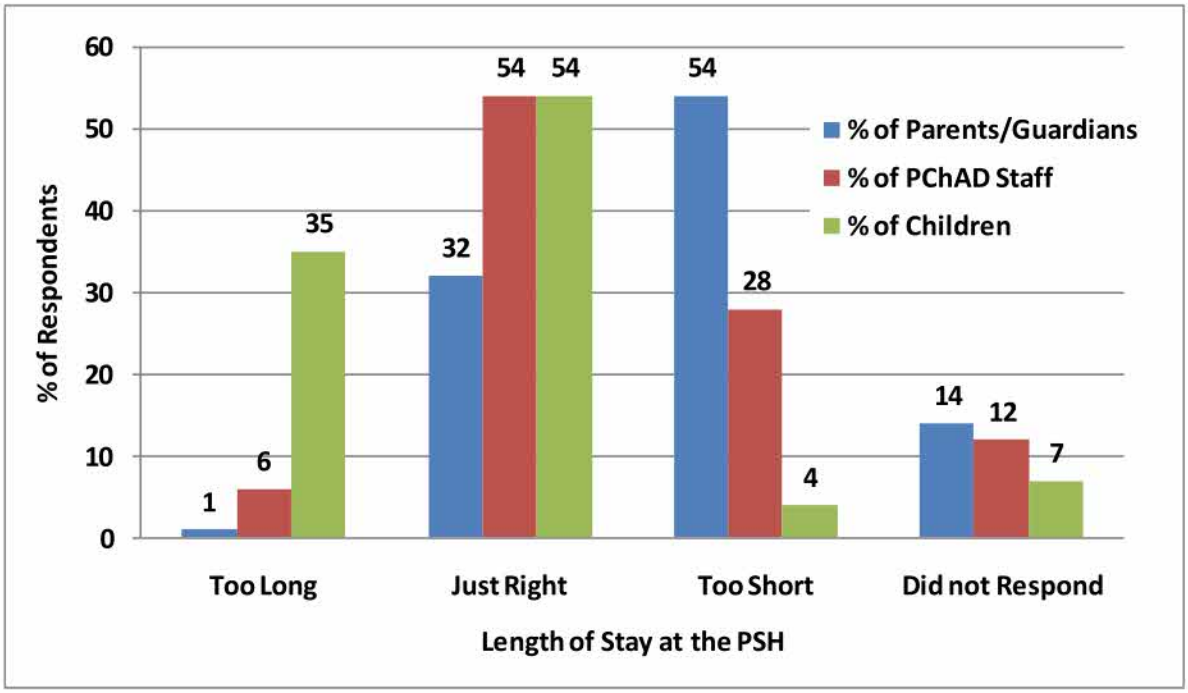
Optimal Length of Stay at a PSH as Perceived by Parents/Guardians, PChAD Staff and Youth

Parent/Guardian, PChAD Staff and Child Surveys

There were similar questions asked across parent/guardian, PChAD staff and client (children) surveys about the preferred (optimal) length of stay as perceived by the respondents. Figure 23 illustrates notable variations among the above-mentioned groups in their accounts of what the most appropriate

length of stay should be. While low percentages of the surveyed parents/guardians and staff thought that the length was too long (one and six percent respectively), over a third of the child respondents (35%) considered it to be too long. Over half (54%) of both the staff and children were in agreement that the stay was "just right," whereas only 32% of the parents/guardians thought this way. Instead over half of the parents/guardians (54%) believed that the stay was too short, compared to slightly over a quarter of the PChAD staff members (28%) and only 4% of children.

Figure 23: Preferred (Optimal) Length of Stay at the PSHs (139 Guardians, 50 PChAD Staff and 173 Children)



All surveyed groups were asked about their suggestions with regard to the most optimal lengths of stay. Amongst 55 parents/guardians who commented (39% of the total number of the parent/guardian respondents), the overwhelming majority thought that the length of stay should be extended to:

- one month or longer (up to two months) – 17% of the total number of surveyed parents/guardians
- 3-4 weeks – 11%
- 2-3 weeks – 8%

The surveyed PChAD staff who considered the stay to be too long suggested options in the range of 5-7 days or 7-10 days, and those who thought that the length of stay was too short suggested longer periods of stay ranging from 2-3 weeks to 3-4 weeks.

Among the 61 children who thought that the length of stay was too long, over half (33 children) proposed a 5-day stay or shorter and another 28 indicated 5-10 days as a desired length of stay. Only 9 children (5% of the total number of survey respondents) suggested longer periods of stay ranging from 12-15 days to 15-20 days.

Parent/Guardian Focus Groups

***Length of Stay Too Short**:* Focus group feedback for the parents/guardians resonates with the above-discussed parent/guardian survey results. Focus group participants indicated that the current length of stay is too short, with nearly all suggesting that the PChAD program should be a minimum of 30 days. The following reasons for suggesting 30 days were given:

- Some secure treatment programs start at 30 days.
- Some treatment programs say that children only really begin detoxing after 10 days, and that anything less than a 30 day program is "not worth it."
- Evidence suggests that detox from certain drugs is not complete after 10 days, and the length of stay should be based on evidence.
- The cost of paid services is often prohibitive, so if lengthening the PChAD program makes it more effective this would reduce the financial burden on families.
- One child reported only beginning to think about making changes in his life at the end of a 15 day stay (including extension).
- One child who completed PChAD told her guardians that she felt 10 days was not long enough; she wanted 21 days or even longer because she felt safe and secure at the PSH.
- One parent/guardian reported that it took her child 30 days until she began to stop blaming her mother and started feeling sorry about her drug use.

Parents/guardians suggested that the length of stay could be tailored to individual children with counselors assessing their progress every 7 days to determine whether they need to stay another week. This way, children would not be released from the PChAD program before they start showing improvement. They also noted that the PChAD program may be less effective if the staff are poorly trained. They argued that a shorter stay with staff who are better educated and trained may lead to better outcomes than a longer stay with staff who are not adept at handling addiction and mental health issues.

PChAD Staff Survey

Open-ended Comments: Congruently with the parent/guardian focus groups participants, some PChAD staff, when commenting in the survey on the length of PChAD stay, noted that it should depend on the specific circumstances and needs of an individual child, based on level of engagement and detox: "Some need more time while others could leave the program earlier." Unlike the parents or guardians, the PChAD staff were not advocating for a very prolonged stay. However, the staff acknowledged that

sometimes "the youth need more time to acquire more support" and extend beyond the initially granted 10 days. Specifically:

- It takes some time for a child (up to 5 days) to come to terms with the situation and get started with the program.
- Sometimes valuable assessment time is lost due to weekends, holidays or elopements.
- It may be not enough time for stabilization or detoxification. According to the staff, you "start to see changes around day 7/8" and while 10 days is sufficient to detox, there could be not enough time for stabilization or working with families in the assessment process, developing a transition plan and connecting children to the supports they need.

As commented by one staff, "We see a difference in the youth who stay for 15 as opposed to 10 [days] and it allows for more family work to be done." As well, recognizing that "it takes 21-28 days to break a habit," the staff suggested that "there should be an alternative program that is longer for those who are in need."

Results of the staff survey data analysis assembled in Table 24 support the above staff's comments. In total, relatively small percent of staff (12 and 20 percent) contended that there is *always* enough time for the children's assessment and discharge planning. Additional 46-48 percent indicated that the available assessment/planning time is sufficient "most of the time." (For a feedback on the opportunity for family involvement see the sub-section "Parent/Guardian Engagement").

Table 24: PChAD Staff Accounts of the Opportunities to Complete Youth Assessment, Discharge Treatment Plans and Involve Families During the PSH Stay (50 Staff)

	Always	Most of the Time	Sometimes	Rarely	Uncertain	Did not Respond	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
There is enough time to:							
Conduct thorough assessment of a youth during the PSH stay	6 (12%)	24 (48%)	8 (16%)	4 (8%)	8 (8%)	4 (8%)	50 (100%)
Develop a discharge plan for a youth during the PSH stay	10 (20%)	23 (46%)	7 (14%)	2 (4%)	4 (8%)	4 (8%)	50 (100%)

The Possibility and Consequences of Negative Networking Among Children While in PChAD

Child Survey

As demonstrated in Table 25, a sizeable proportion of the surveyed children who went through the PChAD program (134 children or 78%) indicated that they liked to socialize (talk) to their peers at the PSHs. This finding raises a question about the possibility of negative networking among children while staying at the PSHs. Such networking may intensify with the length of PSH stay and can potentially exacerbate the issues that these children are already facing.

Table 25: Children's Accounts of Social Encounters While in PChAD (173 Children)

Activities at the PHS:	Liked It N (%)	Neither Liked or Disliked N (%)	Did Not Like It N (%)	Does Not Apply to Me N (%)	Did not Respond N (%)	Total N (%)
Talking to other youth staying here	134 (78%)	19 (11%)	5 (3%)	5 (3%)	10 (6%)	173 (100%)
Staff-led groups with other youth staying here	113 (65%)	40 (23%)	9 (5%)	2 (1%)	(5%)	173 (100%)
Talking to the PSH Staff	139 (80%)	18 (10%)	5 (3%)	2 (1%)	9 (5%)	173 (100%)
One-on-one talk(s) with the counsellor	113 (65%)	39 (23%)	8 (5%)	4 (2%)	9 (5%)	173 (100%)

While enjoying talking to the PHS staff as much as talking to their peers, the children were far less enthusiastic about participating in the staff-led groups with other youth as well as one-on-one conversations with the counsellor.

PChAD Staff Survey

Table 26 details the PChAD staff responses to the survey question regarding the effects of the connections children are making at the PSH. Only a small percent of staff (4%) considered the networking among the children to be entirely positive and a higher percent (16%) indicated that the connections among the children would produce mostly negative effects. The majority (62%) maintained that the effects tend to be mixed – both positive and negative.

Table 26: PChAD Staff Feedback on the Networking Among Children While in PChAD (50 Staff)

In your opinion, are the effects of connections youth are making at the PSH with other youth…	Positive N (%)	Both Positive and Negative N (%)	Negative N (%)	Neither Positive or Negative N (%)	Did not Respond N (%)	Total N (%)
	4 (8%)	31 (62%)	8 (16%)	1 (2%)	6 (12%)	50 (100%)

Based to the staff's open-ended survey comments, the potential direction of the relationships among children in PChAD depends both on their internal state of mind and stage of change (i.e., whether they want and ready to facilitate positive changes in their own lives) as well as varied interpersonal dynamics. On a positive note, some may take their PSH stay as a learning opportunity, support each other and make positive connections with the staff and counsellors. It also may depend on "… who establishes themselves as the leader in the house. If it's an individual who is looking to make a positive change then that can transfer to the other youth who feel they need to do so as well. Otherwise the opposite can happen." As well, in a combined voluntary/PChAD setting voluntary clients sometimes may have a positive influence on PChAD clients.

On the other hand, "youth are most influenced by their peers and so putting them in a program where they are not willing to recognize their drug problem makes them vulnerable to other youth who are more experienced in the drug… culture." Clients may glorify their drug use to each other, feed off each other and not focus on recovery. "More street entrenched youth can influence others to join them." Sometimes children with violent backgrounds can instigate fear in others or they will try to influence others with their experience. There have been times when youth from rival gangs or old gangs have been together, which would not contribute to the positive environment.

According to the staff, "teens have the ability to find each other following their stay" and "generally these relationships are not focused around positive activities." Ten staff (20%) mentioned specifically the possibility of clients reconnecting once they are discharged from the program to start using drugs together. "Sometimes they network with peers who use worse drugs than they do and then began hanging out with them following discharge." "Some kids come in here knowing very little about drugs but leave knowing a lot more…"

What Can Be Done to Minimize Negative Networking

PChAD Staff Survey

The various ways to reduce negative networking in PChAD, as suggested by the PChAD staff in open-ended survey comments, are outlined in Table 27.

Table 27: Minimizing Negative Networking Among PChAD Clients (50 PChAD Staff)*

What, in your opinion, can be done to minimize negative networking among the youths?	Number of Staff	%
Continuous close monitoring/supervision	13	26%
Make sure children are engaged more with the staff, not their peers	8	16%
Separating children who are at risk of negative networking	7	14%
Increased staffing and training	5	10%
Change the PChAD name to "inpatient services" to avoid labelling/stigma outside of the program	1	2%
It is a difficult task to reinforce/Not sure	7	14%
Did not comment	11	22%

*Percentages may not add to 100%, because some staff members had more than one suggestion.

Consistent Supervision: Although acknowledging that it is difficult to monitor children 24/7, a quarter of the surveyed staff underscored the importance of adequate supervision, monitoring children's interactions and redirecting them from negative topics: "Have two staff minimum on the floor in each room with youth engaging in activities and conversations."

Engage children more with the staff: The staff suggested to "minimize the down time in the program by having a more relevant and engaging schedule." This should involve "less time in groups" (including group counselling), more direct one-on-one counselling with the staff in a private setting, which allows a child "to be open and honest without retribution or the other peers overhearing." Given that only 65% of surveyed PChAD child clients "liked" the one-on-one talks with the counsellor (see Table 25), the additional ways to make one-on-one counselling sessions more engaging and meaningful to children may have to be explored.

As well, there was a suggestion for "more staff engagement during activities such as board games, card games or anything recreational so it's not just the youth who are together playing a game."

Separating Children Who Are at Risk of Negative Networking: Negative interactions can be prevented by separating children who know each other, separating children during group times and meal times, mixing children from different cities ("not all local kids"), transferring (in extreme cases) a client to

another PSH, and keep "minimal" drug users from the heavier users, in which case "you would literally need a separate program to do so effectively." A better building/facility would also support appropriate supervision and separation.

Increased Staffing and Training: One-on-one time between clients and staff and adequate supervision would require more staffing and possibly more training (e.g., to supervise and engage children). In addition, it would help to "have some staff from the corrections field/protection services onsite full time" (for the larger PSHs).

Supports and Benefits Acquired by Children During the PChAD Program

Child Survey

Table 28 shows children's recollections of their PChAD intake experiences. Please note that the survey was conducted at around discharge time and the children's recollection of the intake might change after going through the program. In all, the accounts of the intake were predominantly positive. Most surveyed children acknowledged that they received a clear explanation during the intake of what PChAD program and protection order were and what were their legal rights. Those who did not think that the intake went well, sited mostly emotional reasons, including not understanding what was going on and becoming very upset, frustrated and "stubborn."

Table 28: Children's Accounts of the PChAD Intake (173 Children)

PSH Intake Experiences:	Yes	No	Did not Respond	Total
	N (%)	N (%)	N (%)	N (%)
In all, the intake here went well.	156 (90%)	12 (7%)	5 (3%)	173 (100%)
I was told why I was here.	153 (88%)	10 (6%)	10 (6%)	173 (100%)
The PChAD program was clearly explained to me.	157 (91%)	7 (4%)	9 (5%)	173 (100%)
My legal rights were clearly explained to me.	153 (88%)	9 (5%)	11 (6%)	173 (100%)
I was told what a PChAD protection order is.	155 (90%)	7 (4%)	11 (6%)	173 (100%)

Table 29 details children's accounts of their experiences while in the PSHs as well as the perceived resultant benefits. Overall, the overwhelming majority of surveyed children expressed a positive stance towards various aspects of the PChAD program. They especially agreed with the notion that the PChAD

staff were supportive (62% strongly agreed and another 32% agreed) and that they had enough opportunity to talk to the counsellor about their substance use (61 and 32 percent respectively). At the same time, lower percentages confirmed that they gained more understanding about the effects of substance use on their health (42% strongly agreed, 40% agreed and 10% disagreed). As well, relatively low percent believed that in all, staying at the PSH was good for them (45% strongly agreed, 28% agreed and 18% disagreed).

Table 29: Children's Accounts of the PChAD Related Supports and Benefits (173 Children)

	Strongly Agree	Agree	Disagree/ Strongly Disagree	Does Not Apply to Me	Did Not Respond	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
The staff explained what to expect during my stay.	77 (45%)	83 (48%)	4 (2%)	5 (3%)	4 (2%)	173 (100%)
In all, PChAD staff were supportive.	107 (62%)	55 (32%)	5 (3%)	2 (1%)	4 (2%)	173 (100%)
After staying here I understand more about the effects of substance use on my health	72 (42%)	69 (40%)	17 (10%)	8 (5%)	7 (4%)	173 (100%)
I had enough opportunity to talk to the counsellor about:						
My substance use	105 (61%)	56 (32%)	4 (2%)	5 (3%)	3 (2%)	173 (100%)
How to make my life better	101 (58%)	54 (31%)	9 (5.2%)	4 (2.3%)	5 (3%)	173 (100%)
How to make my relationships with other people better	91 (53%)	64 (37%)	9 (5.2%)	4 (2.3%)	5 (3%)	173 (100%)
In all, I believe staying here was good for me.	78 (45%)	48 (28%)	31 (18%)	6 (4%)	10 (6%)	173 (100%)

Supports Acquired by Parents/Guardians During the PChAD Program

Parent/Guardian Survey

Table 30 shows the parent/guardian survey feedback on the information received during the children's stay at the PSHs. Ninety one percent strongly agreed or agreed that they were well informed on what will happen to their children at the PSH, and between 81 and 85 percent strongly agreed/agreed that they were well informed about the procedure for assessment and recommendations, information they

would receive as a result, how they could be involved while the child is at the PSH, and available supports for parents/guardians during and after PChAD.

Table 30: Parents/Guardians' Feedback on the Information They Received During Their Children's Stay at the PSH (139 Respondents)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree/ Strongly Disagree	Did Not Respond	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
During my child's current stay at the PSH, I was well informed about:						
What will happen to my child at the PSH.	72 (52%)	54 (39%)	6 (4%)	3 (2%)	4 (3%)	139 (100%)
The procedure for assessment and developing recommendations.	61 (44%)	55 (40%)	12 (9%)	7 (5%)	4 (3%)	139 (100%)
The information I will receive on assessment and recommendations.	60 (43%)	53 (38%)	17 (12%)	5 (4%)	4 (3%)	139 (100%)
How I could be involved during my child's stay.	57 (41%)	58 (42%)	15 (11%)	5 (4%)	4 (3%)	173 (100%)
Available supports for parents or guardians (e.g., counselling and education) during the child's stay at the PSH.	59 (42%)	55 (40%)	12 (9%)	9 (7%)	4 (3%)	139 (100%)
Available supports for parents or guardians (e.g., counselling and education) after the child's discharge from the PSH.	62 (45%)	55 (40%)	10 (7.2%)	8 (6%)	4 (3%)	139 (100%)

Parents/Guardians' Access to Their Children's Assessment Information

Parent/Guardian Survey

Parent/guardian survey yielded mixed feedback regarding the opportunity to access the assessment information. While 81 % of the surveyed parents/guardians strongly agreed or agreed that they were notified during their children's stay at the PSHs about what information on assessment and recommendations will be available to them (see Table 30), only 66% of them indicated that they requested this information from the staff (see Table 34 in the following sub-section on the

parent/guardian engagement). More detailed focus group information casts additional light on this issue and calls for better communication and access to information (see below).

Parent/Guardian Focus Groups

Improve Communication and Access to Information: Several parents/guardians reported feeling excluded during their child's PSH stay. When they called to ask about their child's progress in the PChAD program, they were told this information was confidential. Some parents/guardians were frustrated when they were repeatedly told "your child is working the program", when they actually wanted specific information about their behaviour and treatment. Parents/guardians wanted to know about the levels within the PChAD program and how they could help their children achieve them, but were told they were only able to get this information from the children themselves. One focus group participant felt disappointed when filling out a post-PChAD survey because several questions asked about specific therapies and techniques used by their children while in PChAD, and she was only able to respond "I don't know" as this information was never shared with her.

Some parents/guardians expressed a strong desire to know which drugs their children admitted to using to help them understand the seriousness of their situations and were very discouraged when PChAD staff refused to share this information. Parents/guardians felt entitled to this information as their children were still minors and knowing what drugs their children were using could help determine what kind of treatment they needed. In general, almost all parents/guardians expressed a desire for better communication with the PSH and PChAD staff. Additionally, they were disappointed to hear that information sharing with parents/guardians was inconsistent: one parent/guardian received daily phone call updates from the child's counsellor, while another (whose child was in the same PSH at the same time) did not receive any updates, even when she called in herself.

Utilizing Education Opportunities for Parents/Guardians

Parent/Guardian Survey

Table 31 depicts parent/guardian feedback on attending education sessions for parents during their children's stay at the PSHs. Only about a third of the respondents (30%) indicated that they attended the sessions and of those who attended approximately 80% believed that the choice of programs was adequate and they were able to find a program(s) or session(s) that would meet their needs.

Table 31: Parent/Guardian Participation in the Educational Activities (139 Respondents)

	Yes N (%)	No N (%)	Did Not Respond N (%)	Total N (%)
Did you attend any programs or education sessions for parents, guardians or families while your child was at the PSH?	**42 (30%)**	83 (60%)	14 (10%)	139 (100%)

Those Who Attended (42 Respondents):	Yes N (%)	No N (%)	Did Not Respond N (%)
Was the choice of programs or education sessions adequate?	**33 (79%)**	**3 (7%)**	**6 (14%)**
Did you find a program(s) or session(s) that meet your needs?	**34 (81%)**	**2 (5%)**	**6 (14%)**

Among 70 parents/guardians who provided the reasons for not attending the education sessions or programs, the major reason was having no time, being busy at work or at home (e.g., no child care) or sessions' schedule being in conflict with the work schedule (see Table 32). A third (34%) of the parents/guardians of the 70 parents/guardians who commented on the reasons for non-attending reported one of the above-mentioned reasons. A substantial proportion (20%) indicated that they did not know about the available opportunities. Ten percent lived too far, 16% were utilizing or planning to utilize alternative options (e.g., seeing a family therapist, being involved in a parent support group, etc.) and additional 4% had already attended or finished counselling or training.

Table 32: Reasons for Not Attending Education Sessions or Programs (70 Parents/Guardians)

Please tell us the reason why you did not attend:	Number of Parents/Guardians	%
Have no time/Busy at work or at home/Scheduling issues	24	34%
Did not know/Was not informed about the sessions	15	21%
Utilized or plan to utilize alternative opportunities	11	16%
Live too far ("live out of town")	7	10%
Had already participated in similar activities	4	6%
Health issues	3	4%
The length of the child's stay at the PSH was very short	2	3%
Other comments	4	6%
Total Number of parents/guardians who commented	70	100%

In summary, based on the parent/guardian survey feedback, the majority of people who attended the education sessions or programs conveyed that their needs were met. However, the reported attendance was quite low (30%). Being busy, scheduling issues, lack of awareness as well and the distance were the major reasons for not attending,

Parent/Guardian Engagement

Child Survey

According to the child survey results assembled in Table 33, a large majority of children (85% in total) communicated (talked) to their family members during their stay in the PSH. As far as family meetings with the counsellor were concerned, less than half (48%) of children indicated that they "liked it." Additional 24% indicated that they "neither liked nor disliked" this type of communication, and 11% responded that they did not like it.

Table 33: Children's Accounts on the Family Involvement During the PSH Stay (173 Respondents)

	Strongly Agree N (%)	Agree N (%)	Disagree/ StronglyDisagree N (%)	Does Not Apply to Me N (%)	Did Not Respond N (%)	Total N (%)
I talked to my family during my stay	76 (44%)	70 (41%)	16 (9%)	7 (4%)	4 (2%)	173 (100%)
Please tell us what you think about activities at the PSH:	**Liked It** N (%)	**Neither Liked or Disliked** N (%)	**Did Not Like It** N (%)	**Does Not Apply to Me** N (%)	**Did not Respond** N (%)	**Total** N (%)
Meeting(s) with the counsellor and my family	83 (48%)	42 (24%)	19 (11%)	19 (11%)	10 (6%)	173 (100%)

Parent/Guardian Survey

Table 34 shows the parent/guardian accounts of various types of engagement with their children during the PChAD program. Based on the survey results, the most common form of involvement that almost all respondents utilized were telephone conversations with their children (91%). Far lower percentages of the parents/guardians (69 and 66 percent) visited their children at the PSHs and requested information on the assessment and recommendations. Just slightly over half of the respondents (54%) reported meeting with the family counsellor and even lower percent had counselling sessions jointly with the child (39%). Many parents/guardians indicated more than a single type of engagement and only 10 of them (7%) reported not being engaged in any of these activities.

Table 34: Parents/Guardians' Engagement During Their Children's PSH Stay (139 Respondents)

Types of Engagement	Number of Parents/Guardians	%
Talk to the child on the phone during his/her current stay at the PSH	127	91%
Visit the child during his/her current stay at the PSH	96	69%
Request information on the child assessment and recommendations from the staff	92	66%
Meet with the Family Counsellor	75	54%
Have counselling sessions at the PSH jointly with the child	54	39%
Other participation	10	7%
I was not involved in any of these activities	10	7%

When asked in an open-ended survey question to about the reasons for non-involvement, the parents/guardians put forward the following reasons:

- Living too far from the PSH (living out of town, long hours to travel, cannot afford gas, etc.)
- Child refusing contact
- Work commitments
- The child's length of stay was short (e.g., 5 days)/Child was released early

Some parents/guardians mentioned maintaining telephone communication with the counsellor or the PSH staff to get updates as an alternative way to be engaged.

Parent/Guardian Focus Groups

Children Should be Required to be Actively Engaged: Nearly all parents/guardians felt that their children should be required to participate in programs during their PChAD stay, including family activities. Parents/guardians reported being told that the family component of PChAD is only carried out "if it's the kid's idea", so some children either refused to participate at all or only participated to a limited degree. Parents/guardians agreed that the children should not be in control of this because they are required to take the child home at the end of the stay and everything possible should be done to ease that transition.

One parent/guardian reported that her child agreed to participate in a family session once and everyone got something out of it: she found out about her child's triggers and risk factors, while the child found out things he hadn't known as well. The parent/guardian was especially disappointed when her child refused to participate again because she felt it had been such a beneficial experience. Another focus group participant suggested that judges should hold children back in the PChAD program until they

agree to participate in assessments and activities. Parents/guardians were frustrated that judges allowed their children to leave even if they had not completed a single activity during their stay.

It seems inconsistent that parents/guardians are required to attend parent programs, while the children are not required to attend their own programs. One parent/guardian pointed out that the messaging children receive is contradictory: they are told "your sobriety is your choice", while they are forced to be in PChAD. However, since the children are forced to be at the PSH, they should be forced to participate in the activities as well.

Staff Survey

The results of the staff survey complement the parent/guardian feedback and corroborate the notion that parent/guardian engagement (which is required in the program) may be occasionally difficult to accomplish due to a limited time of a PSH confinement or lack of cooperation on the part of some children (see Table 35 and Table 36).

Table 35: PChAD Staff Accounts of the Opportunity to Involve Families During the PSH Stay (50 Staff)

	Always	Most of the Time	Sometimes	Rarely	Uncertain	Did not Respond	Total
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
There is enough opportunity during a youth's confinement to:							
Involve the family in the assessment	8 (16%)	21 (42%)	9 (18%)	4 (8%)	4 (8%)	4 (8%)	50 (100%)
Involve the family in the discharge planning	8 (16%)	24 (48%)	6 (12%)	4 (8%)	4 (8%)	4 (8%)	50 (100%)

As shown in Table 35, only eight PChAD staff, or 16% of 50 respondents confirmed that there was "always" enough opportunity to involve the family in the child's assessment and discharge planning, and additional 42 and 48 percent indicated that there was enough opportunity "most of the time." A quarter (26%) noted that the sufficient opportunity to involve the family in assessment occurred only "sometimes" or "rarely," and 20% mentioned the same with regard to the family involvement in discharge planning.

Information in Table 36 illustrates that cooperation on the part of the children may be an important factor that can affect (positively or negatively) family engagement and other key PChAD practices and outcomes. A third of the staff (32-36 percent) maintained that the children rarely or never refused to participate in assessment or discharge planning, whereas 48 and 40 percent respectively contended that "sometimes" children refused participation in these key activities.

Table 36: Children's Cooperation at the PSHs (50 Staff)

	Most of the Time N (%)	Sometimes N (%)	Rarely/ Never N (%)	Uncertain N (%)	Did not Respond N (%)	Total N (%)
Youths refuse to participate in assessment	1 (2%)	24 (48%)	16 (32%)	3 (6%)	6 (12%)	50 (100%)
Youths refuse to participate in discharge planning	2 (4%)	20 (40%)	18 (36%)	4 (8%)	6 (12%)	50 (100%)

Discharging from the PSH

The PChAD staff and children surveys contain questions aimed at assessing the children's progress (detoxification and stabilization) and state of mind at the time of discharge from the PSHs.

Staff Survey

As illustrated in Table 37, a large majority of the surveyed PChAD staff (80% in total) confirmed that each child was detoxed by the time of living the PSH either always (30%) or most of the time (50%). As far as stabilization is concerned, only half of the staff (52%) thought that each child was stabilized at discharge either always (10%) or most of the time (42%).

Table 37: PChAD Staff Accounts of Children's Outcomes at the Discharge (50 Staff)

	Always N (%)	Most of the Time N (%)	Sometimes N (%)	Uncertain N (%)	Did not Respond N (%)	Total N (%)
Each youth is detoxed by the time he/she leaves the PSH	15 (30%)	25 (50%)	3 (6%)	1 (2%)	6 (12%)	50 (100%)
Each youth is stabilized by the time he/she leaves the PSH	5 (10%)	21 (42%)	17 (34%)	1 (2%)	6 (12%)	50 (100%)

Child Survey

While 82% of the surveyed children planned to reduce their substance use after leaving the PChAD program (agreed and strongly agreed that they were planning to reduce the use), only 49% intended stopping using altogether and 41% disagreed with the notion of completely stopping substance use (see Table 38).

Table 38: Children's Plans Regarding Future Substance Use (173 Children)

	Strongly Agree N (%)	Agree N (%)	Disagree/ Strongly Disagree N (%)	Does Not Apply to Me N (%)	Did Not Respond N (%)	Total N (%)
I plan to reduce my substance use	71 (41%)	71 (41%)	13 (8%)	11 (6%)	7 (4%)	173 (100%)
I plan to stop substance use altogether	47 (27%)	38 (22%)	71 (41%)	11 (6%)	6 (4%)	173 (100%)

These findings are consistent with the feedback from the PChAD staff discussed in the previous part of this section referring to various stages in the children's readiness to take advantage of the program and work towards a positive change (see the preceding sub-section: What Can Be Done to Minimize Negative Networking). As well, the findings confirm the notion that the PChAD program is the first steering step in a child's journey to the full recovery, and underscore the need for continuous follow-up treatment and supports for children and families after leaving PChAD (see the next section).

Implications for the Program Improvement:

- A quarter of surveyed PChAD staff and over half of parents/guardians were of the opinion that the current length of stay and extension of stay in the PChAD program (10 days stay with 5 days extension) do not meet the needs of all children entering the program. For example, PChAD staff suggested that not all children left the PSHs detoxed and far from all of them left stabilized. The decisions regarding the length of children's stay and/or extension of stay at the PSHs should be based on individual children's circumstances, needs and progress, which should be regularly assessed by the PChAD staff. Staff and parent/guardian voices should be part of these decisions.
- The feedback from the children suggests that they liked socializing with their peers at the PSHs, and the PChAD staff confirmed the existence of negative networking among the children while in the PSHs. Negative networking can be counteracted by close consistent supervision, minimising interpersonal engagement among children, maximizing their engagement with the staff and separating children who are more experienced in substance abuse from children with less experience. These types of changes may require more staff (including more highly trained staff), facility modification and possibly developing different strands of PChAD programs targeting different clientele (e.g., heavy, long-term drug users and children who were not heavily involved in substance abuse).
- The evaluation evidence suggests that parent/guardian engagement during their children's confinement at the PSHs may be enhanced by extended stays of children at the PSHs, facilitating parents/guardians' access to the information on their children's assessment and recommendations, making family sessions (a counsellor, parents/guardians and a child) more appealing to the children, and putting more responsibility for the family engagement on the children (e.g., condition length of stay at the PSH on their willingness to cooperate and engage).
- The reasons for low parent/guardian attendance at education programs or sessions for parents during their children's stay at the PSHs (as evidenced by the parent/guardian survey at discharge), should be further investigated and the identified constraints addressed. Lack of time/scheduling conflicts, lack of information about these educational opportunities and living too far were the major reasons for nonattendance identified by this evaluation. However many other constraining factors may interfere, including poor variety or choice of the sessions, not enough sessions, as well as sessions not meeting the participants' needs.

8. Maintaining Treatment Momentum After Discharge from the Protective Safe Houses (PSHs)

Objective: Relevant information, treatment planning and referrals are provided to children and parents/guardians for appropriate aftercare following discharge from the PChAD program.

Evaluation Questions

8.1 Did families (children and parents/guardians) receive appropriate assessments and plans/recommendations/referrals for the follow-up counselling, treatment and/or other supports after discharge from the PSH?
8.2 Did children and parents/guardians intend to continue with the recommended supports after PChAD?
8.3 What were the experiences in accessing and using aftercare resources following discharge from PChAD?

Children's and Parents/Guardians' Experiences With the PChAD Discharge Recommendations

PChAD Staff Survey

During their stay at a PSH, it is intended that all children receive a substance use assessment and treatment recommendations for after their discharge from the PChAD program. Table 39 shows how often staff report that children receive assessments, discharge plans, and treatment plans while in the PChAD program. The majority of staff report that children regularly receive all of these services, with treatment planning being the least certain as 16% of staff reported that children only receive tailored treatment planning "sometimes."

Table 39: Assessment, Discharge Planning, and Treatment Planning for Each Child (50 Staff)

	Number of Staff	%
Assessment is completed for each child.		
Always or most of the time	41	82%
Sometimes	1	2%
Rarely or never	0	0%
Uncertain	2	4%
No response	6	12%
A discharge plan is developed for each child.		
Always or most of the time	39	78%
Sometimes	2	4%
Rarely or never	1	2%
Uncertain	2	4%
No response	6	12%
Counsellors create a treatment plan to meet each child's needs.		
Always or most of the time	34	68%
Sometimes	8	16%
Rarely or never	0	0%
Uncertain	2	4%
No response	6	12%

When asked how they would improve the PChAD program, one staff member suggested that compliance with treatment recommendations should be considered as part of repeat PChAD applications. That is, counsellors providing letters of support for PChAD applications should review whether previous discharge recommendations were carried out with parents; if recommendations were not carried out, parents should be required to provide rationale for this. This could help to cut down on repeat PChAD applications, especially those that occur more than once within a short span of time.

Staff members also echoed a desire for more mental health support following PChAD, including possible direct entry into residential treatment programs, or psychiatric services. Staff wished that "more could be provided to parents," such as long term treatment options, or family support workers to follow-up and help implement treatment recommendations.

Child Survey

When asked whether their assessments and recommendations were well explained, 91% of children agreed or strongly agreed, while only 3% disagreed or strongly disagreed, 2% reported that this did not apply to them, and 4% did not respond. Table 40 shows children's intentions to pursue treatment and

follow staff-suggested recommendations following their discharge from the PChAD program. Over three quarters of children indicated intentions to follow their assessment recommendations after discharge, while only half reported planning to attend another treatment or counselling program following PChAD.

Table 40: Children's Intention to Seek Treatment Following PChAD (173 Children)

	Number of Children	%
I plan to follow the recommendations from my assessment		
Strongly agree	71	41%
Agree	63	36%
Disagree or strongly disagree	23	13%
Not applicable	9	5%
No response	7	4%
I plan to go to another treatment or counselling program		
Strongly agree	38	22%
Agree	50	29%
Disagree or strongly disagree	60	35%
Not applicable	19	11%
No response	64	4%

Parent/Guardian Survey

The majority (80%) of surveyed parents/guardians indicated that during or prior to their child's discharge from PChAD, they received clear treatment recommendations and appropriate service referrals. Additionally, the majority of parents/guardians reported that they actively participated in their child's discharge planning, and intended to follow the treatment recommendations suggested by the PChAD counsellor. Table 41 shows how satisfied parents/guardians were with different aspects of the treatment recommendations, including their involvement in planning them.

Table 41: Satisfaction With Discharge Recommendations and Planning, and Intention to Utilize Recommendations (139 Parents/Guardians)

During or prior to my child's discharge from the PSH:	Number of Parents/Guardians	%
The staff provided me with clear treatment recommendations for after my child's discharge		
Strongly agree	49	35%
Agree	61	44%
Neither agree nor disagree	10	7%
Disagree or strongly disagree	10	7%
Not applicable	3	2%
No response	6	4%
The staff provided me appropriate referrals for treatment and/or counselling after PChAD		
Strongly agree	53	38%
Agree	58	42%
Neither agree nor disagree	9	7%
Disagree or strongly disagree	9	7%
Not applicable	4	3%
No response	6	4%
I was an active participant in the discharge conversation about the next steps following PChAD		
Strongly agree	59	42%
Agree	55	40%
Neither agree nor disagree	8	6%
Disagree or strongly disagree	8	6%
Not applicable	3	2%
No response	6	4%
I am going to make use of the recommendations provided by the counsellor		
Strongly agree	66	48%
Agree	51	37%
Neither agree nor disagree	11	8%
Disagree or strongly disagree	0	0%
Not applicable	4	3%
No response	7	5%

When asked about types of programs or treatment services they intended to use, the majority of the parents/guardians (81%) reported that they planned to use AHS services, while 33% planned to use non-AHS services, and 12% reported they did not know yet (see Table 42).

Table 42: Types of Treatment Services Parents/Guardians Intended to Use (139 Parents/Guardians)*

	Number of Parents/Guardians	%
Programs/treatment options within AHS	113	81%
Programs/treatment options outside of AHS	46	33%
Don't know	16	12%

*Percentages may not add to 100%, because some parents indicated more than one type of programs.

In the open-ended comments, some parents/guardians reported that their children were discharged without a plan in place because the child was released early following a review hearing. One parent/guardian expressed frustration that her son completed his stay with "no good plan" for when he was discharged at the end of his stay. Another respondent felt that her child's assessments and recommendations were based too much on the child's input, and did not consider the parent/guardian's input enough, even though parents/guardians know their child's history and behaviour well.

Parents/guardians also expressed concerns about lack of adequate mental health supports following discharge from PChAD. One parent/guardian felt that his child's addiction problems were driven by mental health issues, but there were no AHS pediatric mental health services available in rural Central Alberta. Another parent/guardian argued that mental health assessment during PChAD should not be voluntary because of its close links to addiction issues. She felt that her child could have received recommendations for mental health supports following discharge if he had chosen to complete a mental health assessment while he was at the PSH. "Mental health is a huge component to why children are falling into addictions and without help in that regard they are going to have a much more difficult time following through with after treatment care from leaving PChAD."

Finally parents/guardians expressed concern that their children will not comply with discharge recommendations because they "do not want help upon release," and are in PChAD to begin with because they refuse to go into voluntary treatment."

Parent/Guardian Focus Groups

Recommended Treatment Programs Full: Parents/guardians reported that access to recommended treatment programs post PChAD was one of the biggest barriers to attending services, noting that many treatment programs are full with long waitlists. For example, the ACTION Youth Intensive Day Treatment Program was recommended to a child, and although she was interested in attending, her parent/guardian found out that there was a two month wait list. By the time the child received a spot in the program, she was no longer interested in attending. Another parent/guardian placed her child on the waitlist for Child, Adolescent and Family Mental Health (CASA) residential services, as suggested in

her child's Assessment letter, only to find that the expected wait time was nine to twelve months. Her child was unable to wait this long, became discouraged, and returned to drug use after several months.

Some parents/guardians felt that discharge recommendations should not include programs with long waitlists, as the chances of successfully enrolling their children after many months are small. Parents/guardians felt treatment options suggested in the Assessment letter should be readily available to their children "before the window of opportunity is gone." Alternately, a holding facility should be provided where children can wait to be admitted to treatment programs in a low pressure, drug free environment. A few parents/guardians felt that treatment programs should not be able to turn children away because the need for services is so great. Both parents/guardians and children were frustrated at their inability to immediately attend voluntary treatment following PChAD, especially when both PChAD and voluntary services were located in the same facility, and moving from one service to other was just a matter of "walking across the hall".

Parents/Guardians Want Time to Plan for Discharge: As many of the recommended treatment programs have waitlists, parents/guardians expressed a desire to receive discharge recommendations prior to their child's departure from PChAD so they could begin applications as soon as possible. One guardian wanted her son to see a psychiatrist immediately after PChAD while he was still sober, as was recommended, but because the wait time was several days, the child had started using again by the time he received an appointment. Parents/guardians felt it would be feasible to share recommended follow-up programs with parents/guardians early on, as most children are recommended to attend the same major programs.

Children Refuse to Attend Voluntary Services: Parents/guardians expressed frustration that many of the discharge recommendations suggest that their children attend voluntary treatment services, when the fact that they had a PChAD protection order indicates that they may be unwilling to attend voluntary treatment. One child asked to be placed in PChAD again following her discharge because she knew "she wasn't strong enough for voluntary." Other children were recommended to the ENVIROS[10] program, but refused to attend voluntarily, even though the program has extremely positive reviews. Parents/guardians wished for mandatory treatment programs following PChAD for the children who were unwilling to attend voluntary treatment.

Parents/Guardians Want Seamless Transition to Treatment Services: Parents/guardians wished that children who completed PChAD could be transferred directly to treatment services without being sent home first. Streamlining the transition between PChAD and follow up programs would capture treatment momentum generated during PChAD, and would prevent children from being able to use drugs between discharge from PChAD and admission to another program. Although some counselors do begin referrals for follow-up services for children while they are still in the PChAD program, this is not consistent or efficient. One parent/guardian was told that the counselor would submit her child's

[10] ENVIROS is for non-profit social service agency that creates individualized learning experiences in safe environments.

application to the Foothills Adolescent Centre, but found out only shortly before her son's release that the counselor had not begun the paperwork. The parent/guardian was disappointed as her son was willing to transfer to Foothills from PChAD, and she was concerned that he would change his mind when he was discharged and sent home. Parents/guardians felt that PChAD staff could use their expertise to strengthen children's treatment applications and liaise directly with treatment staff to persuade admission for high risk children. One parent/guardian suggested that having an outsider, such as a PChAD staff member, encourage the child to attend treatment could be more effective than having a parent/guardian suggest it. Transitioning children directly to follow up services would also reduce the burden on parents/guardians who feel they have few or no supports to cope following their child's discharge.

Rural Residents Disadvantaged: Parents/guardians living in rural areas argued that they were disadvantaged as fewer community support services are available compared to cities. Parents/guardians reported feeling envious of all of the "wonderful places" for children struggling with addiction in cities. One parent/guardian was told that since there are no community services available near her home, "you are what we have to offer the child". This made her feel incredible pressure to maintain her child's sobriety without any help.

Unlike the cities, many rural areas do not have drop in services for children who are urgently struggling with a desire to use drugs. In some communities, there is only one addiction counsellor who works one day a week, so their wait list is long, and accessing their services is inconvenient. Some communities also do not have Narcotics Anonymous meetings: one parent/guardian reported that the closest meeting to her is house is two hours away. These large distances to services can be problematic for children who are on probation and have curfews. It is difficult to have a child home before their curfew if they have to drive hours away for evening services, since they cannot miss school. Rural parents/guardians felt frustrated by these practical inequalities that urban parents/guardians did not experience.

Parent/Guardian Feedback on Their Experiences One Month Following PChAD

Parent/Guardian Follow-up Survey One Month After Discharge From PChAD

The first month following discharge from the PChAD program may be a critical period for ensuring children's sustained success on the road to recovery, including maintaining and reinforcing their desire and will to continue with the recommended voluntary treatments. At discharge from the PSHs parents/guardians were asked for their consent to be contacted one month after their children leaved the program to share experiences with the follow-up services and their children's progress. In all, 27 parents/guardians answered a telephone survey one month after discharge. Their feedback is discussed below.

Of the 27 surveyed parents/guardians, 19 respondents (70%) said that their children were admitted to the PSH for the first time, while 8 respondents (30%) indicated that their children were confined more than once. Over half of the surveyed parents or guardians (16 respondents or 59%) said that their children were living at home after PChAD, while others referred to other living arrangements, including children staying with friends. Two parents/guardians (7%) were not sure where their children were living one month after discharge from PChAD.

Following Through With Post-PChAD Supports: Services for Children

One month after PChAD the majority of the surveyed parents/guardians (19 respondents or 70%) were either very satisfied or somewhat satisfied with the assessment and recommendations received at the end of their children's stay at the PHS, while a quarter (7 respondents or 26%) were very dissatisfied or somewhat dissatisfied (see Table 43).

Table 43: Satisfaction With the Assessment and Recommendations (27 Parents/Guardians)

How satisfied were you with the assessment and recommendations for further treatment received at the end of your child's stay at the PSH?	Number of Parents/Guardians	%
Very Satisfied	9	33%
Somewhat Satisfied	10	37%
Somewhat Dissatisfied	5	19%
Very Dissatisfied	2	7%
Not Applicable	1	4%

Specific dissatisfactions were not as much regarding the quality of assessments and recommendations but more so around the associated communication issues, as well as difficulties with implementing the recommendations after release from PChAD. Consistent with other parent/guardian feedback discussed

in previous parts of this report, some parents/guardians said that they never received information on assessment and recommendations or received insufficient information. For example, one parent complained: "I never received the assessment, it was only provided to the youth. This is an extreme measure. As a parent who has just gone through an emotional roller coaster with everything involved, it would be helpful to have a look at the assessment." Other parents/guardians mentioned that the family was not given information regarding family counselling even after asking for it and also more communication and contact (with PChAD staff) would be appreciated "prior to hearing recommendations presented at discharge." It also followed from the open-ended survey comments that parents/guardians themselves could be a source of miscommunication: "Other parent was involved in this process and had not shared this information, [I am] not aware of follow-up recommendations."

Over a quarter of the surveyed parents/guardians (7 respondents) were disappointed with the unwillingness on the part of their children to follow through with the recommendations, even though, according to some parents/guardians, these recommendations were "good" or "great." Consequently, and congruent with other feedback discussed in the previous segments of the report (e.g., from parent/guardian focus groups), some parents/guardians voiced the need for more "mandatory options" lack of which limits the efforts to "mobilize more supports." As well, there were suggestions to make the PChAD program longer than 10-15 days in order for it to be more impactful.

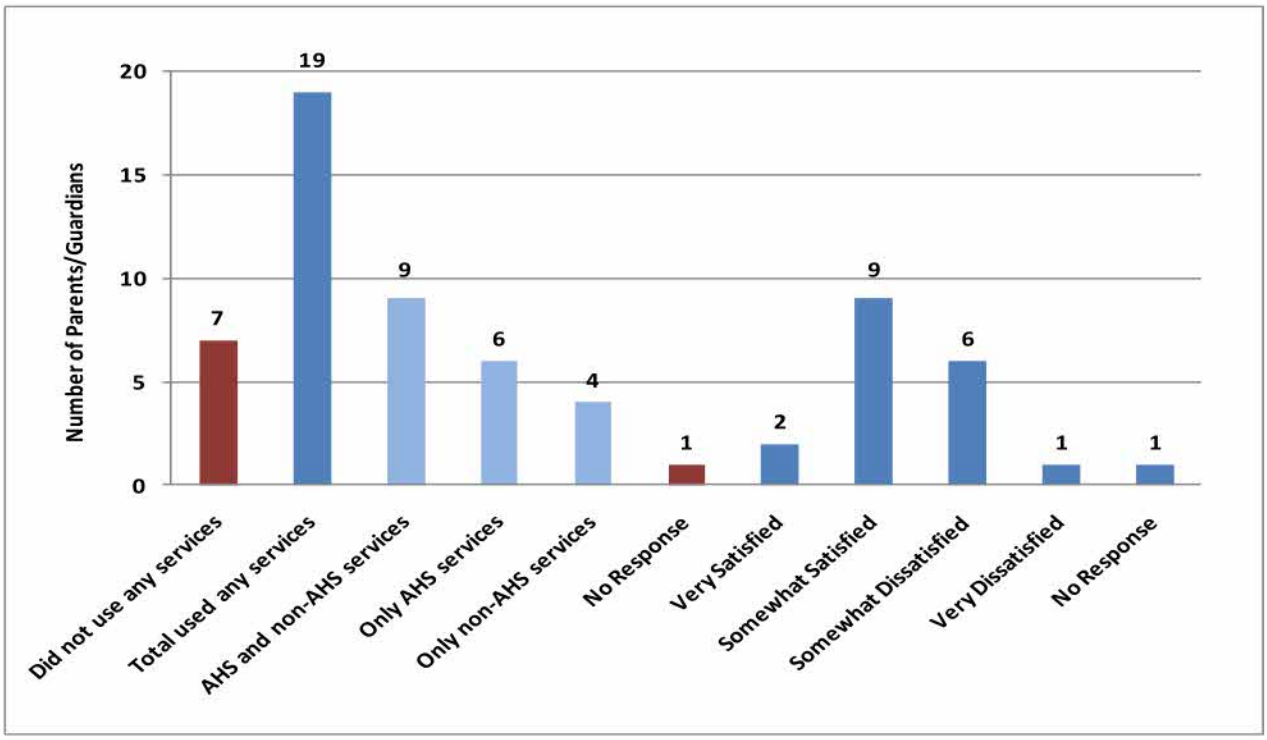
Finally there were comments about the accessibility of the recommended programs and availability of supports:

- "[The child] has had some difficulty getting into the program that was suggested in the recommendations."
- "[It] would be good to have more involvement with caseworker as part of planning for this [follow-up options]."

Figure 24 combines responses to the questions about the types of help and supports received by children after discharge from the PSHs and the degree of parent/guardian satisfaction with the availability of support and treatment resources in their communities after discharge.

As shown in Figure 24, over two-thirds of the parents/guardians who responded to the follow-up survey (19 respondents or 70%) indicated that their children had been receiving some type of help or support after discharge from the PSHs. About half of these respondents said that they used both AHS and non-AHS services; the remaining respondents mentioned resorting either to services provided by AHS only or only to non-AHS services.

Figure 24: Using Help and Support Services for Children After Discharge from the PSHs and Satisfaction With the Availability of Support or Treatment Services in the Community (27 Parents/Guardians)



The examples of AHS services that were used alone or in combinations with other AHS or non-AHS services included:

- completing a 15-day voluntary residential detox program
- getting inpatient mental health support/treatment with other follow-up supports
- receiving (weakly) addiction/mental health counselling
- receiving family counselling
- getting outpatient/day treatment (e.g., the ACTION program, Youth Addiction Services, etc.)

The following non-AHS services were mentioned:

- receiving various types of personal/family counselling, including using Aboriginal family enhancement services, Vantage Community Services[11], etc.
- getting support from the school system (e.g., school-based therapy/psychology, including working with a school psychologist, school counsellor, family liaison worker, etc.)

[11] "Based in central Alberta, Vantage Community Services helps youth, adults, and families by providing counselling, transitional housing for youth, life skills training, and in-house treatment for mental illness" (quoted in: http://www.vantagecommunityservices.ca)

- staying in a group home
- joining various residential programs, such as AARC (Alberta Adolescent Recovery Centre)[12] Grimmon House,[13] Youth Assessment Centre[14], etc.
- getting depression treatment from a family doctor.

As demonstrated in Figure 24, over half of the 19 parents/guardians whose children received help or support after PChAD were somewhat satisfied or very satisfied with the availability of support and treatment resources in their communities (11 respondents), while over a third (7 respondents) were somewhat dissatisfied or very dissatisfied. The parents/guardians provided the following explanations for their dissatisfaction:

- One of the major reasons for dissatisfaction (expressed by 7 respondents) was the impossibility of accessing services due to the inability to get the children to follow through the recommendations and lack of involuntary treatment options, including services for older teens.
- Availability and accessibility of the services was another major area of concern. According to the respondents, it takes a long time to tap into the community resources, such as residential programs, and wait lists for many programs are of several months.
- Some parents/guardians mentioned lack of information and coordination, including difficulties/struggles with finding out about services and resources (at least initially) pre- and post-PChAD, as well as lack of coordination and difficulties of navigating among the services. This includes "inconsistency with [different] practitioners knowing different information about treatment options," and the need for services "to work more in conjunction with each other, providers need to know about other services."

These various areas of concern culminate into the general notion that there is not enough services and supports available for some family situations and needs.

[12] "AARC [Alberta Adolescent Recovery Centre] provides long-term, cost-effective, family-centric, full-time addiction treatment, designed for the exceptional needs of adolescents. Clients stay in recovery homes with host families. Treatment is based on a unique 12 step (AA) model that promotes peer counselling and lifelong abstinence, accepting that addiction is a chronic disease" (quoted from: http://aarc.ab.ca/)

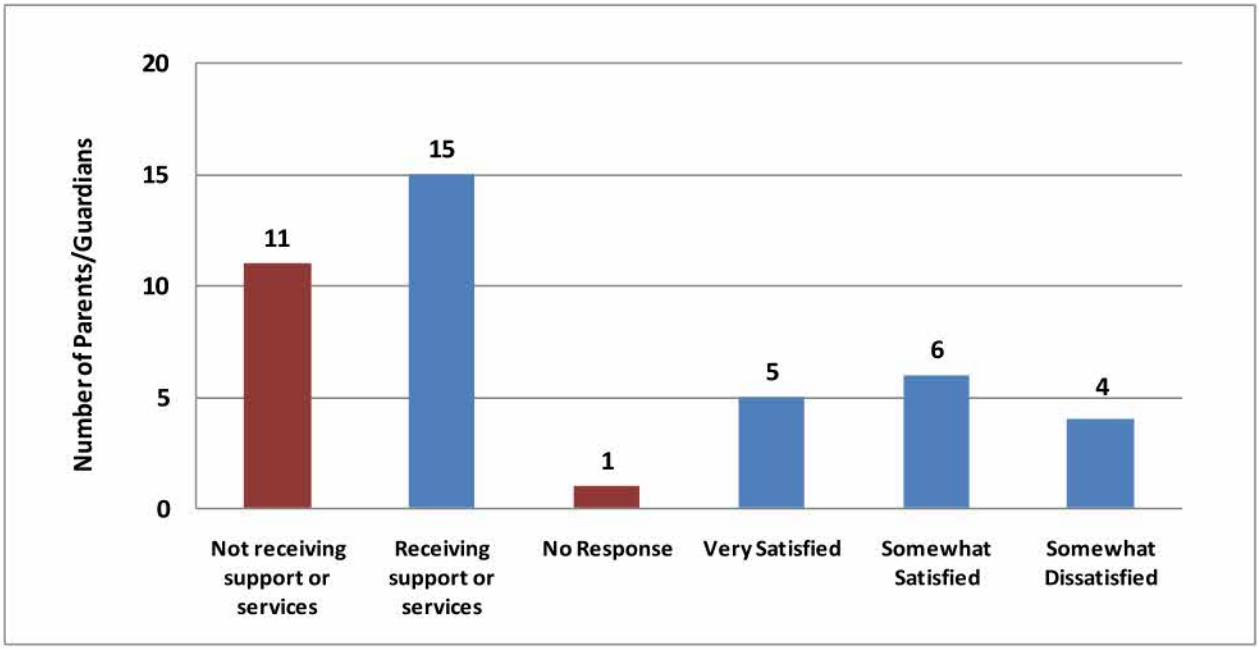
[13] "Grimmon House is a six bed residential treatment program for female youth who are at-risk or involved in sexual exploitation. Grimmon House is a voluntary program available to both Children's Services and the Community. As Grimmon House is a provincially funded program, youth throughout Alberta have access to this holistic and therapeutic program without cost" (quoted from: http://www.boysandgirlsclubsofcalgary.ca/programs/community-based-care-supports/grimmon-house)

[14] Youth Assessment Centre provides a residential program for youth who require stabilization and assessment. Also provides assessments for proper placements to other programs.

Using Services for Parents/Guardians

Figure 25 outlines the supports or services for parents, guardians or families that were accessed by the follow-up survey respondents. Over half of the surveyed parents/guardians (15 or 56%) received some support or services from various (AHS and/or non-AHS) sources, but a substantive portion (11 respondents or 41%) were not receiving any services or supports. Among the 15 parents/guardians who accessed the services, close numbers (four to six) were either very satisfied, somewhat satisfied or somewhat dissatisfied.

Figure 25: Receiving Any Supports or Services for Parents, Guardians or Families from AHS or Other Sources (27 Parents/Guardians)



Getting personal and family counselling and attending parent support groups were the major types of supports or services utilized by the surveyed parents or guardians. Private family therapy/counselling, getting supports through school and youth corrections were also mentioned. Specifically mentioned services included:

- AARC family counselling and support
- Key Connections Consulting[15]
- Wood's Homes[16]

[15] Key Connections Consulting Inc. is a multidisciplinary team of professionals who work collaboratively to provide a customized and comprehensive approach that ensures individuals are provided with a coordinated service that fits their unique needs. Assessment and Treatment approaches are tailored to each individual to support successful outcomes. The services offered include: Behaviour Consultation, Counselling and Play Therapy (see: http://www.keyconnectionsconsulting.com/services).

- Vantage Community Services
- PChAD parent sessions (while the child was in the PChAD program and after discharge)
- Parent support groups, including EPIC parent group (AHS Youth Addiction Services).

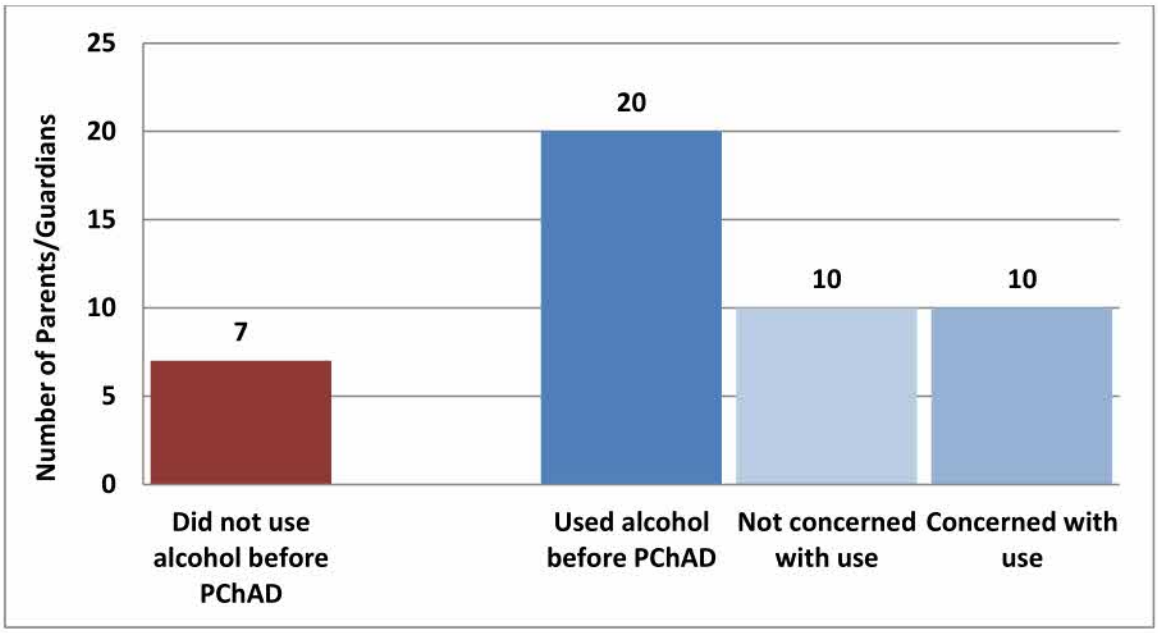
Four parents/guardians who were "somewhat dissatisfied" with the services wished for more availability and accessibility in terms of the assortment of services, times and locations, reduced wait times and ease of locating information about the services. "[It] would be nice to have groups offered on other days, e.g., Saturdays. Also [I] found information difficult to access – [it] would be good if a parent could Google Calgary parent support groups and find options."

Parents/Guardians Accounts of Their Children's Progress One Month Following PChAD

Use of Alcohol

Figure 26 shows the surveyed parents/guardians' accounts of their children's use of alcohol before admission to PChAD. Three quarters (20 respondents or 74%) indicated that their children used alcohol, but only half of these respondents expressed concern about alcohol use (10 parents/guardians). Some parents/guardians mentioned in the associated open-ended comments that "alcohol use was not of a concern" and there was a "greater concern with other drugs" and "other behaviours." One parent noted that he/she "did not find out [the] daughter was using alcohol until she was in PChAD."

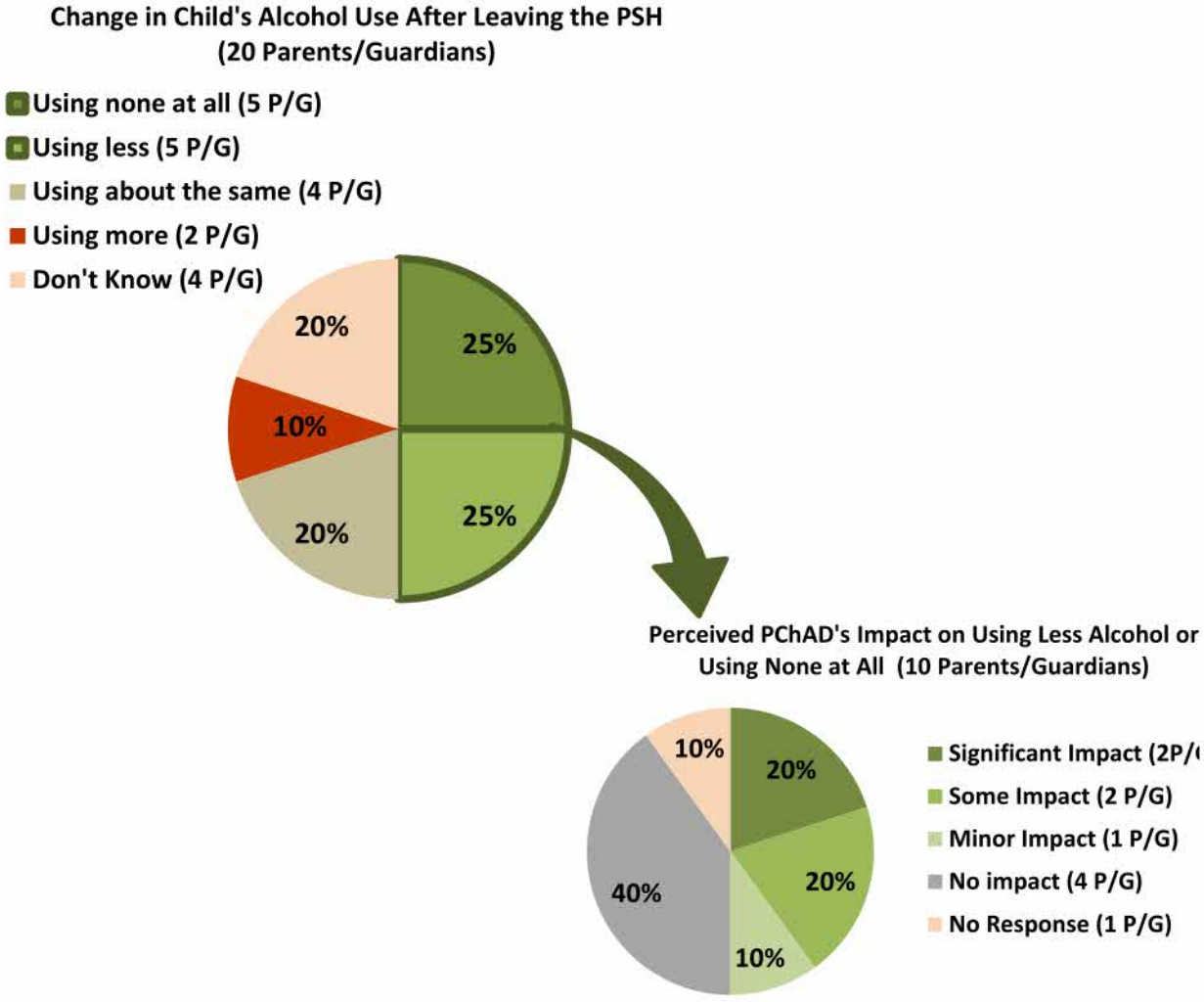
Figure 26: Child's Use of Alcohol Before PChAD (27 Parents/Guardians)



[16] Wood's Homes "...is a multi-service, non-profit children's mental health centre based in Calgary" (quoted from: http://www.woodshomes.ca)

When inquired whether there was any change in their children's use of alcohol after leaving the PSH, half of 20 parents/guardians who reported pre-PChAD use of alcohol said their children were "using less" alcohol after leaving PChAD or using "none at all" (10 respondents altogether or 50%) (see Figure 27). Only two (10%) said their children were "using more," four (20%) stated that the use was "about the same" and another four did not know. Of the 10 parents/guardians who reported that their children either reduced or ceased using alcohol after staying at the PSH, four (40%) attributed this positive change to the PChAD impact ("significant impact" or "some impact"), another 4 respondents (40%) perceived no PChAD impact, one (10%) perceived a "minor impact," and one parent/guardian did not respond to the question (Figure 27). (Please note that the percentages reported in Figure 27 are based on very small numbers of respondents).

Figure 27: Changes in Use of Alcohol After PChAD and Perceived PChAD Impacts (20 Respondents Who Said Their Children Used Alcohol)

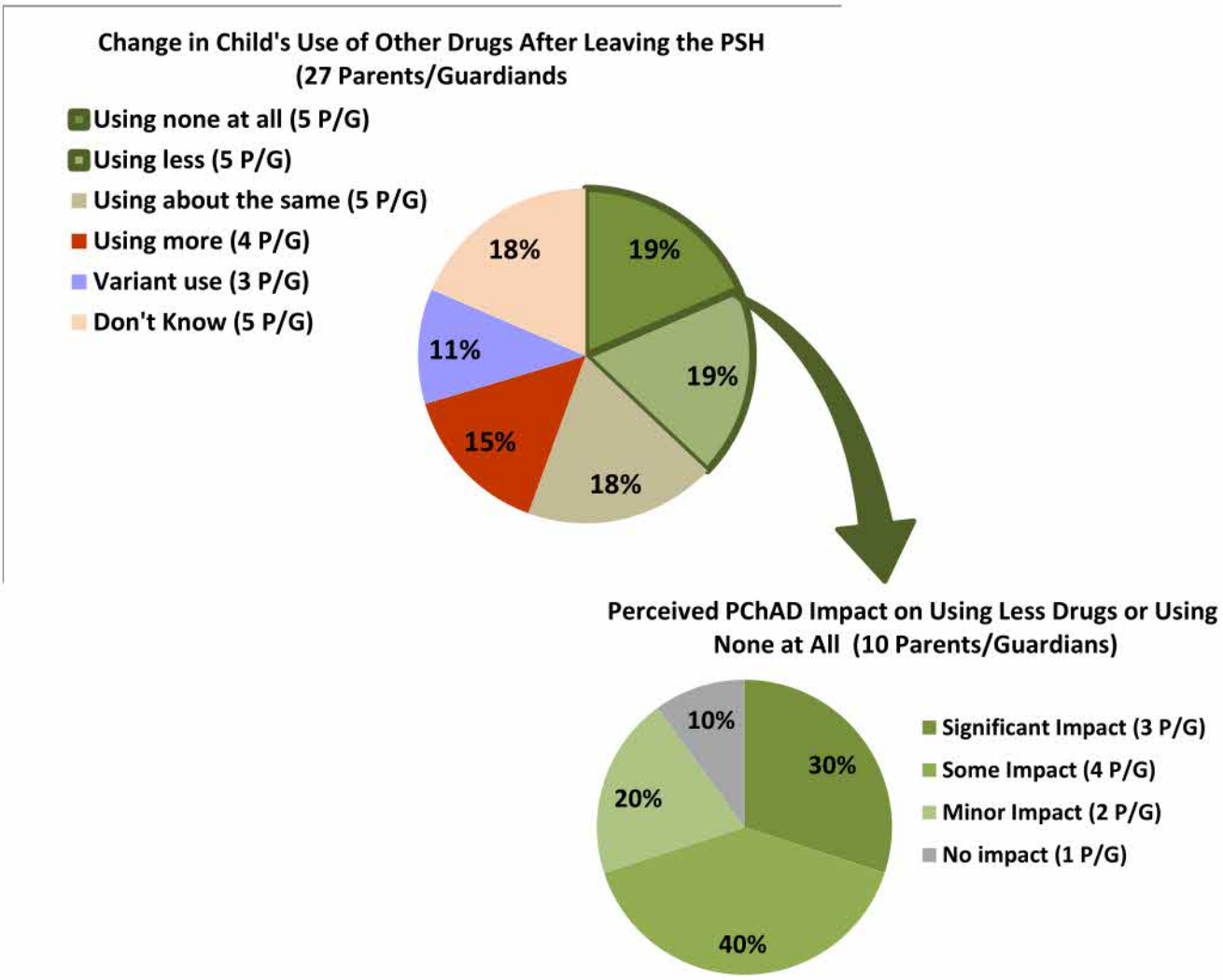


Use of Other Drugs

While not all parents/guardians who reported their children using alcohol were concerned about alcohol use, *all* 27 follow-up survey respondents indicated that their children used "other drugs" prior to PChAD and expressed concern about it. The specific examples of drugs used included marijuana (cannabis), methamphetamine/crystal meth and psilocybin.

As shown in Figure 28, overall 10 respondents (38%) reported their children either using less drugs or not using at all following PChAD. Five (18%) observed the same extent of usage, four (15%) reported increased use and three (11%) noted variant use (e.g., initial decrease with increase after, or fluctuations in use over time).

Figure 28: Changes in Use of Other Drugs After PChAD and Perceived PChAD Impacts (27 Respondents)



As illustrated in Figure 28, a majority of the 10 parents/guardians who indicated that their children were using less drugs after leaving PChAD or not using at all, credited PChAD for this: seven respondents or 70% said that the program had a "significant impact" or "some impact." Two parents/guardians (20%) noticed a minor impact and one perceived no impact. (Please note that the percentages reported in Figure 28 are based on very small numbers of respondents).

Parents/guardians provided extensive open-ended comments on the pre- and post-PChAD dynamics of the drug use and attitudinal changes in their children.

It was clear from the open-ended responses that family dynamics might have substantive influence on a child's progress following discharge from PChAD. Some children run away from home or were not leaving at home, and their parents/guardians were not sure about the intensity of drug use after PChAD. A the same time there were positive accounts that some children were not using or using less one month after discharge from the PSH. Close supervision at home or through follow-up programming was mentioned as an important practice of maintaining positive momentum after PChAD. According to one parent, "…daughter had not had opportunity to use as she has been supervised or in programming ever since completing [PChAD]." Another parent commented that, "…youth is using less drugs because she has been home a lot more than in the past prior to the PChAD program."

Five parents/guardians (19%) reported relapses: "At first, it was less. Then later, she relapsed and was using more." "Change was most evident after first couple of weeks but then program's impact faded..." Some children had also diversified the range of used substances. As well, there were accounts of variant intensity of drug use over time: "…Her use was up and down." "[It is] variant – immediately after, [it] was less. Then [the child] was using cannabis more than previous. Now down to less again."

Table 44 captures examples of the parents/guardians' reflections on the various effects of PChAD on their children, including changing attitudes and the way of thinking after education, counselling and experiences in the PSHs. This parent/guardian feedback also supports the conclusions made in previous portions of this report that children's motivation and readiness for making positive changes may vary. This underscores the necessity of customized follow-up supports and treatments to maintain and reinforce positive PChAD effects.

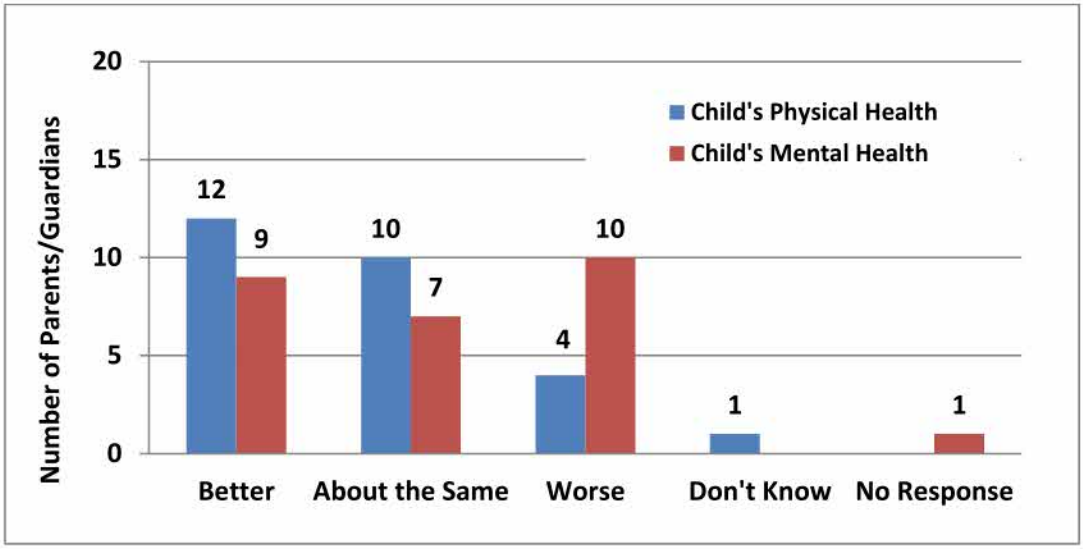
Table 44: Parent/Guardian Comments on Their Children's Progress Following PChAD

Change in Drug Use One Month After PChAD	Parent/Guardian Comments
Using Less or Not Using	• [PChAD] gave son a break from his habits. • PChAD has given the youth a lot more time to reflect, which was absent in the past. Father believes that this has reduced her utilization of drugs. • PChAD has had a positive effect because it allowed youth the time to do much needed reflecting. • Daughter told…that she learned some things about drug effects/consequences, but said she would keep using regardless. • He [child] did not like it there [PSH] and asked how he could avoid coming back again; feedback he got was stop using and get help. • Mother believes that counselling at the PSH helped in reducing [the] child's use of drugs.
No Change in Use	• Initially [the] child did not seem to change much but over time mom has noticed that son is thinking about things in a different way.
More or Variant Use	• [PChAD] has affected his [child's] behaviour in general, he is more aware of potential consequences. • Impacted in a negative way initially as the daughter was very angry about being put in the [PChAD] program and then ran away and binge-used.
Don't Know	• Peer experiences affected him [the child] – seeing others going through withdrawal (e.g., heroin). • Lots of education – was very positive, helped her [the child] see consequences. Also exposure to peers – [she] saw negative effects of other youths' experience of using.

Perceived Health and Behavioural Changes in Children One Month After PChAD

The one month follow-up survey asked parents/guardians to assess their children's physical and mental health condition in comparison to the situation prior to their admission to PChAD (see Figure 29). The highest proportion of the survey respondents (12 or 44%) perceived improvement in their children's physical health post-PChAD and relatively few (4 respondents or 15%) reported worsening of physical health. A very different pattern emerged for the perceived situation with mental health, with much more respondents indicating worsening in their children's mental health one month post-PChAD. Specifically, over a third of the parents/guardians (10 respondents or 37%) maintained that their children's mental health became worse, another third (9 respondents or 33%) reported it becoming better and a quarter (7 respondents or 26%) perceived their children's mental health condition to be "about the same."

Figure 29: Parents/Guardians' Reflections on their Children's Physical and Mental Health One Month After PChAD (27 Respondents)



The responses to the questions about post-PChAD family relationships (with the parent/guardian or other family members) are plotted in Figure 30. One-third of the parents/guardians (9 respondents or 33%) indicated improvement in the relationships with their children and the same proportion reported better relationships between the children and other family members. Relatively high proportions reported these relationships staying the same (10 and 12 respondents or 37 and 44 percent respectively). A quarter or less reported worsening of the relationships (7 and 5 respondents or 26 and 20 percent).

Figure 30: Perceived State of Family Relationships One Month After PChAD (27 Respondents)

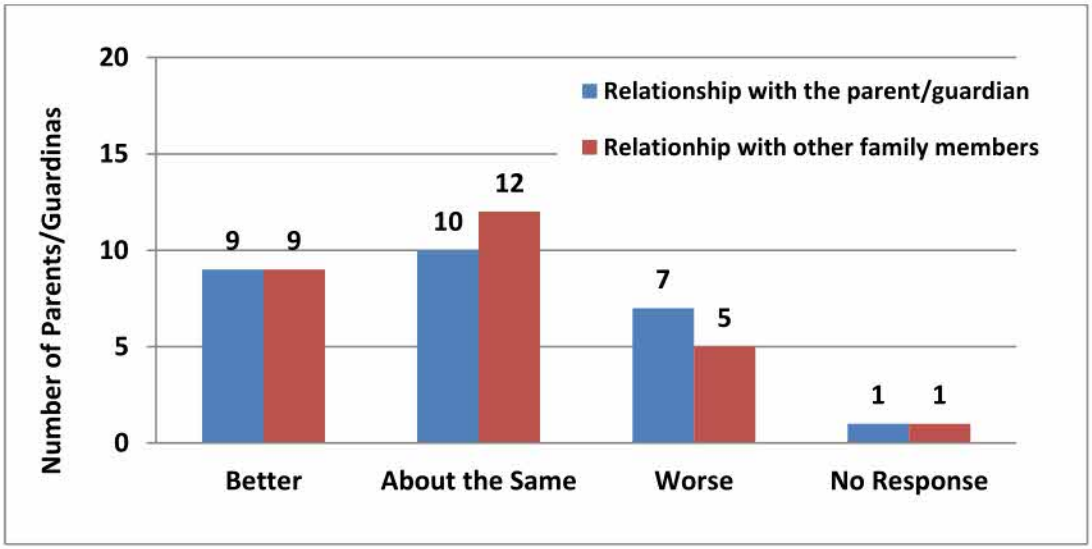
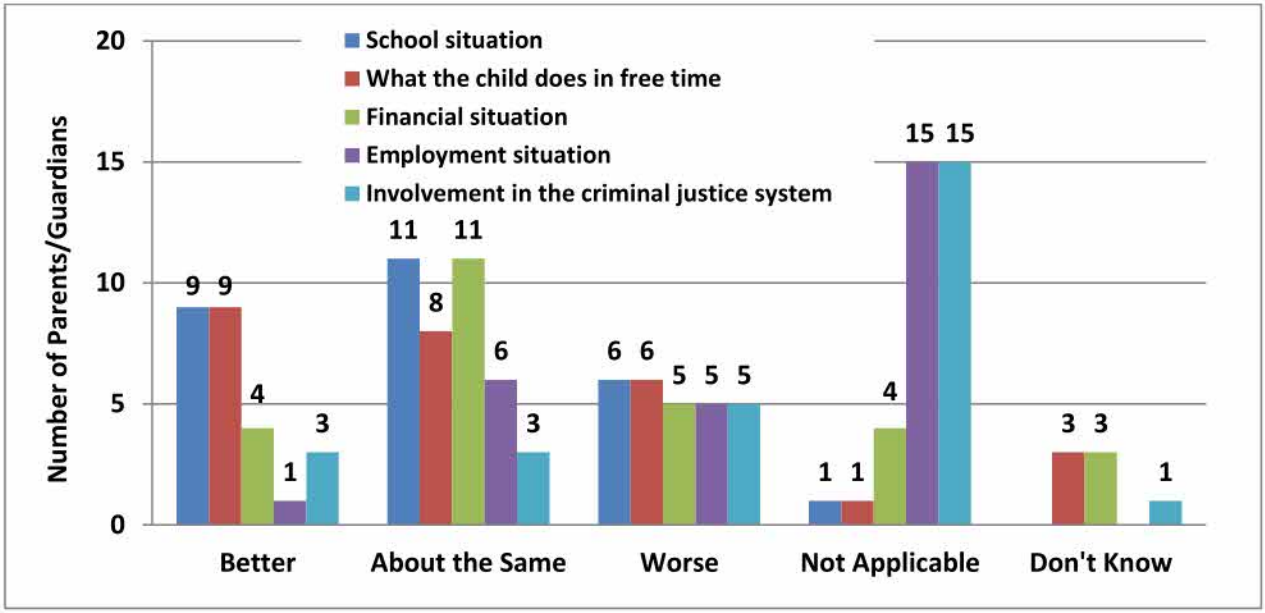


Figure 31 outlines parents/guardians' responses to the questions concerning the post-PChAD dynamics in various aspects of children's life and behavior associated with school, leisure pastime, financial and employment situation and involvement in the criminal justice system.

Figure 31: Perceived Changes in Children's Lives One Month After PChAD (27 Parents/Guardians)



While similar numbers of parents/guardians (five or six of them or roughly 20%) noted a worsened situation across all listed aspects of children's life and behavior, other responses varied depending on a specific life/behavioral aspect. For example, equal, relatively high numbers of parents/guardians (nine respondents or 33%) mentioned improvements in their children's school situation and of what their children do in their free time. Open-ended comments elaborated on the specific circumstances associated with the school aspect. One parent/guardian, for instance, mentioned improvements in her child's mental health due to learning coping strategies at the PSH and "increased adherence to medications that manage [the] child's mental health." This might be conducive to the child "trying harder to attend school and not miss classes" and also to improvement in her part-time employment situation. Another parent mentioned that the daughter is "now attending school" because she does not want to go back to the inpatient treatment, and the third parent commented that, the son "is attending [school] more… but has problems with authority figures there." Additional 11 parents/guardians (41%) said that the school situation did not change (is "about the same") and 8 respondents (30%) did not notice changes in their children's leisure pastime.

With regard to their children's financial situation the largest group of the respondents (11 or 41%) indicated no change ("about the same), while relatively small and close proportions reported it becoming better (four respondents or 15%), worse (five respondents or 19%) or that it was not

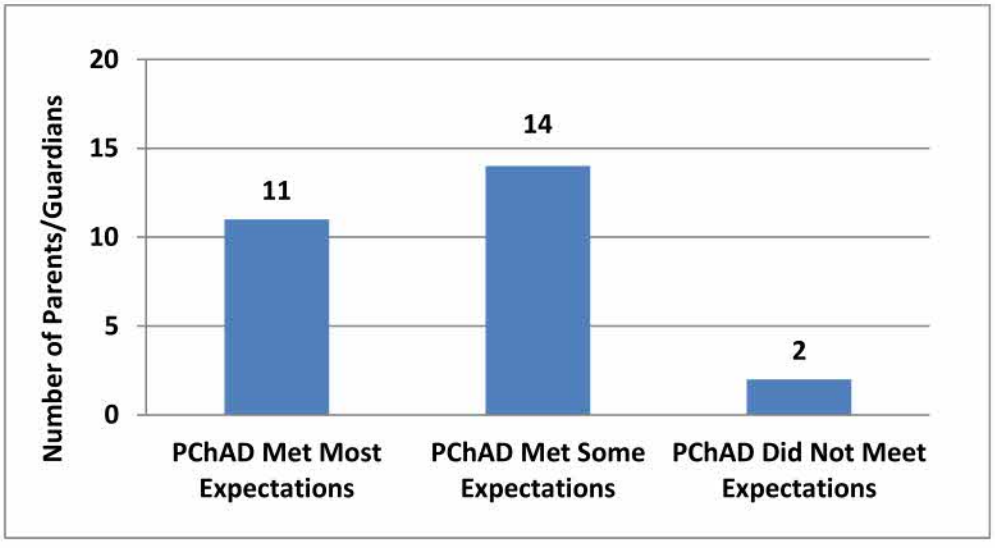
applicable to their children (four respondents or 15%). It is interesting that, according to the parents/guardians, having no money may indicate improvement, since a child has no means to purchase drugs.

As far as the data on situations with children's employment and involvement in the criminal justice system are concerned, a caution should be exercised when interpreting associated results, because over half of the surveyed parents/guardians indicated that these situations were "not applicable" to their children (15 respondents or 56%). Keeping this in mind, we can conclude that the employment situation for the post-PChAD children either stayed the same or worsened one month after discharge (of the 12 respondents for whose children the employment related question was applicable, six said the employment situation was the same, five said it worsened and only one parent/guardian indicated that it became better). As to the children's involvement in the criminal justice system, a substantive part of the 12 respondents for whose children this situation applied, suggested that this situation worsened (five respondents), and the remaining responses split equally between the situation becoming better or staying the same (three respondents each) and not knowing the answer (one respondent).

One Month Retrospect: Overall, Did the PChAD Program Meet Parents/Guardians' Expectations?

As demonstrated in Figure 32, over half of the 27 parents/guardians who responded to the one month follow-up survey confirmed that PChAD met some of their expectations (14 respondents or 52%). Eleven respondents (41%) believed that most of their expectations were met and only two (7%) parents/guardians indicated that PChAD did not meet their expectations.

Figure 32: Parent/Guardian One Month Follow-up Feedback on PChAD Meeting Their Expectations (27 Respondents)



The comments from the parents/guardians who said the program met most their expectations or some expectations reflected general understanding that the program could be "a temporary solution to a big problem." Still, parents/guardians commented that:

- "[This] was a small time window but helpful."
- "Program helped [the] daughter on [the] road to further treatment."
- "Overall [the parent is] happy with [the] program, family was kept informed of process, [the] daughter has responded well since discharge."
- PChAD was exactly what was needed for her [the daughter] at the time…"
- "…It was a pretty decent program that gave her [the daughter] quite a bit of help."

Six of 27 parents/guardians (22%) specifically mentioned having "a good experience with program staff." "…Staff were great, really impressed with them." "…Program staff were fantastic, supportive." Another three respondents (11%) commented that the program was "well run."

However, a large proportion of the follow-up survey respondents also voiced their expectations and suggestions of what could be done to make the program more responsive to the clients' needs (see the next sub-section).

One Month Retrospect: What Changes Parents/Guardians Would Like to See in PChAD?

The parents/guardians who responded that PChAD program met only some of their expectations or did not meet expectations (59% of respondents altogether) were asked to comment on the reasons for not to be (fully) satisfied with the program. In addition, the concluding open-ended question asked: If you were able to change the PChAD program, what changes would you suggest? Responses to these two questions are summarized below.

- ***Would like the program to be longer (13 respondents or 48%):*** Close to half of parents or guardians who responded to the one month follow-up survey wanted to "see the program to be longer." According to them 10 days or 10-15 days in the PSHs is insufficient and (minimum) 30 days "would be the best." The various justifications for a longer stay included ensuring complete detoxification of children who "are probably just starting to get clear of substances" in 10 days, as well as increasing stabilization, addressing mental health issues and adding more services/programming - "more components of therapy work." The parents/guardians wanted flexibility in the decisions on the length of stay depending on the "individual youth situations," for example, basing length of stay on individual assessment results or compensating for holiday time and staff unavailability to provide assessment. As well, more "calm-down" time may be needed for some children who are very angry with their parents/guardians for putting them in the program in order to prevent post-PChAD issues, such as running away from home and relapses in drug use.
- ***Would like the program to "go beyond detox" and services diversified (11 respondents or 41%):*** The parents/guardians articulated the need for more "multidisciplinary team approach"

in PChAD, namely "to have more programming beyond detox." Specific suggestions included providing social skills development and ongoing treatment, customizing/tailoring programming more for individual situations depending on the type and intensity of children's needs (e.g., past trauma, mental health concerns, etc.), as well as directing assessment and treatment at looking "at the underlying issues," including "causes of [drug] using" and "reasons behind self-medication." Reinforcing "mental health component," including (mandatory) mental health assessment, related programming and referrals was a common thread in the parent/guardian feedback. The diversification may also include adding more male staff to PChAD "to connect with male youth."

- ***Would like to have a more "family-centered model" (9 respondents or 33%):*** A number of parents/guardians were concerned about experiencing "not too much family involvement," reported that "family did not feel heard" and wished for a "more family-centered model:" "More family involvement and contact should happen as part of the process." In particular, parents/guardians wanted to be able to "work closer with the program" and "have more of a role in communication [and] ability to help with decisions," including being able to "access information when they need it." These types of concerns may also be relevant to other parties who are involved in supporting the child. "[A] caseworker would have appreciated some sort of itinerary about what was happening with the youth while in program. Would also like to see programming after detox…"

  The surveyed parents/guardians also wanted more of family supports, such as counselling and mediation, help with finding information about resources/options for after PChAD, connecting the children to the resources in the community, and connecting with other parents who are dealing with similar issues, including having more parent support meetings.

- ***Would like enhanced coordination and access to follow-up services (8 respondents or 30%):*** Parents/guardians' wish for more extensive parental/family involvement in PChAD included being able to work together with the PChAD staff on the follow-up treatment planning. At the same time, the parents/guardians did not want to be left on their own in decision-making regarding the follow-up treatments: "…If a young person requires further treatment, this decision should be able to be made by program staff, not just be left up to parent/family." The parents/guardians wanted staff to play a more active role in connecting children with additional mental health and other programs, services and facilities in the community prior to discharge. As well, the respondents called for more collaboration between services:
  - "…The system should work together for treatment planning…"
  - "[The] program seems to be a silo. [It] should be coordinated with other services…" (This should include the links to mental health programs).

- ***Difficulties with access to PChAD and issues with the order review process (5 respondents or 19%):*** According to some parents/guardians, PChAD is an "amazing program but hard for

families to access." This includes the time and effort involved and supports for legal procedures. "Dealing with legal aspects/requirements to spend many hours at court was very stressful, had to take many days off work." "Court hearings, overall process could be made easier for families." With regard to the order review process, one parent believed that the successful appeal by his daughter resulted in her early discharge which did not benefit the child. Another respondent "had issue with [the] fact that youth are able to have a lawyer but supporters cannot," as well as with unavailability of the "main keyworker" who knows the child to answer questions in the court. Finally, there was a call for the PChAD program to be "promoted more to families who may benefit from it," suggesting that lack of information can in some cases thwart access.

- **Would like to have involuntary/mandatory treatment options available (3 respondents or 11%):** Some of the parents/guardians believed that involuntary treatment options are have to be offered for specific situations: "[PChAD] program is helpful for short-term impact in order to detox and get the youth off the street. Some kids need more intensive/ongoing/longer-term programming and therapy. [It] would be helpful to have more involuntary services."

Implications for the Program Improvement:

- Based on the evaluation results, the connection between the PChAD program and follow-up treatments could be the weakest link in the desired continuum of services and supports, where a lot of positive momentum emanating from PChAD can be lost. While the PChAD staff wanted parents/guardians to explain why the recommended voluntary options had not been utilized when repeat applications for PChAD were made, the latter were frustrated by the long wait lists for or unavailability of the recommended services. Access and long wait issues are indicative of the current general problems across addiction and mental health services in the province and are expected to improve as the whole system progresses. In the meanwhile, the PChAD staff are to continue to make direct referrals to other programs and ensure parents understand how to navigate the Alberta Mental Health system and how to access services post PChAD.
- Throughout the surveys and focus groups parents/guardians suggested that mandatory (non-voluntary) treatments have to be available for some children who would not consent to voluntary supports and treatments.
- If possible, ongoing treatment recommendations and access to the relevant services should be discussed with children and their parents/guardians while in PChAD, prior to discharge. This would make it possible to make the follow-up appointments in advance.
- Based on the evaluation participants' feedback, mental health issues co-occur with drug use and associated services and supports are very much in demand among the PChAD clients to ensure a comprehensive approach to their needs. Thus, easier access to mental health services should be facilitated by strengthening the ties and referrals to the available mental health services and programs. As well, concurrent services while the children are in PChAD could include providing mental health screening.
- There was consistent feedback from the parents/guardians (across the surveys and focus groups) for lengthening children's stay at the PSH or adopting a flexible approach to the length of stay depending on the specific circumstances and assessment results. The associated suggestions included diversification of the programs and treatment options available "beyond detox."

Suggested Recommendations for Improvement

The evaluation results demonstrated that the PChAD program makes a positive difference in children's and families' lives and provides an important intervention in their recovery journey. PChAD is often a last resort in the addiction and mental health continuum of care and is effective in interrupting a child's substance use, creating the opportunity for a detoxification, stabilization, detailed addiction assessment and treatment planning.

While this evaluation identified many positive aspects of the program and user experience, participants spoke to what they believed were the avenues for improving the PChAD program and the child and family experience in both accessing and participating in PChAD services. Participants identified systemic gaps, such as the disconnect between addiction and mental health services, facilitating more timely or immediate access to voluntary treatment following PChAD, and considering possibilities of additional mandated programs. The stakeholders' comments were consistent with the topics featured in the Valuing Mental Health Report (see the References), which outlines the key strategies to respond to the dynamic and complex issues associated with addiction and mental health care in Alberta. Thus, when planning changes and improvements to the PChAD program, it is imperative to consider the current Alberta addiction and mental health services integrated continuum of care.

It is also noteworthy that many of these recommendations were consistent with the 2014 findings of the PChAD Program Review and that some of the work to address issues raised in the recommendations has already begun.

Given that the varied stakeholder feedback captured in this evaluation is in many respects broader than the immediate operational PChAD mandate, the proposed recommendations were split in two major types based on their scope – those that are under direct PChAD operational jurisdiction ("PChAD") and those attributable to our cross-ministerial partners ("GOA stakeholders:" Human Services, Justice and Solicitor General, and Alberta Health).

Recommendations
1. Improve access to reliable and consistent information regarding the PChAD program at all stakeholder levels including the general public. The evaluation findings show that potential PChAD clients tend to obtain information from a broad variety of parties (e.g., police, justice, schools, child and family services, counsellors, health care facilities, parent support groups etc.). This evidence suggests that it would be impossible to "contain" PChAD-related information to the "official" (AHS only) sources and broader dissemination of information is necessary. ***a. PChAD systematically disseminate accurate and up to date information among the stakeholders that may play a part in sharing information on PChAD with parents or guardians.*** Use varied media, including printed materials (e.g., brochures, pamphlets and manuals), presentations, training sessions, online courses and webinars delivered by AHS or PSH staff, etc. ***b. Collaborate with all GOA Stakeholders and other community partners to refer potential clients to the "original" AHS information – AHS website and staff, to increase consistency in information dissemination.*** ***c. PChAD to ensure ongoing improvement of the practical value and availability of the PChAD-related information for the general public via the AHS website and publications, mass media and social media.***
2. Pre-application information sessions consistently cover core program content and provide provincial PChAD developed resources and handouts. The feedback from parents/guardians revealed that information given at the required pre-application information sessions may lack consistency. ***a. PChAD pre-application sessions provide core content across the province. A consistent set of handouts and resources be developed by Provincial PChAD and made available at all pre-application sessions.*** ***b. PChAD to ensure that AHS counsellors who provide pre-application information sessions are authorized and are required to take standardized training to ensure consistency in delivering accurate content.***
3. Provide sufficient orientation, resources and supports to ensure parents or guardians are well prepared for the court applications and hearings, including protection order and order reviews. It was indicated within the evaluation findings that there was no clear understanding among the parents/guardians of who specifically was responsible for providing them with the essential information on the specifics of the court application for a protection order. Based on the information collected during the evaluation, pre-application sessions appear to be de facto deliverers of such information. This is consistent with the judges' opinion that preparation for the court should happen at these information sessions.

Recommendations
a. ***PChAD to collaborate with Justice and Solicitor General Stakeholders to clarify the roles and responsibilities among the stakeholders for preparing guardians for the protection order applications, preparing evidence and review hearings.***   b. ***PChAD to collaborate with Justice and Solicitor General Stakeholders and develop handouts on: a) step-by-step process to prepare and apply for a protection order; b) particulars of order reviews; and c) option to apply for extension.***   c. ***PChAD to develop provincial guidelines to ensure that all parents/guardians receive timely notification when their child applies for a review hearing.***
4. In partnership with Justice and Solicitor General Stakeholders, explore recommendations for the courts to make court experiences more consistent, effective and less stressful for the families and children within PChAD programming.   The evaluation found that parents/guardians noted inconsistencies in the court process, including evidence required for granting a protection order. They also felt uneasy about testifying in courts in front of their children and would prefer that the hearings are organized in a way that prevents additional negative encounters and stress on families. This suggestion is worth considering, given that parents/guardians are expected to be engaged and communicate with their children during the PSH confinement.   a. ***PChAD to collaborate with Justice and Solicitor General Stakeholders to establish requirements for the presented evidence as consistent as possible across the courts. This would also apply to the criteria on which a judge would grant or deny a protection order.***   b. ***PChAD to collaborate with Justice and Solicitor General Stakeholders to explore options to avoid parent/guardian court testimonials in front of the children to decrease added stress on families.***   c. ***PChAD to conduct an environmental scan/literature review to determine best practices on the impact of children learning how their substance use has had a negative impact on their guardian and family.***   d. ***PChAD to ensure that counselling is available to children and/or families to support the sharing of evidence during the Review Process.***

Recommendations
5. Work with the PChAD program, Ministry of Justice and Solicitor General to make the best use of the police resources to fulfill the PChAD Act's provision for children's apprehension and conveyance to the PSH by police. The surveyed police officers indicated that children's apprehension and conveyance, including the requirement for long distance transportation had resulted in a substantive strain on the police resources, especially in small detachments. The officers also pointed to the lack of information and education about PChAD. ***a. GOA Stakeholders consider the use of Alberta Sheriffs as an alternative way of transporting children to the PSHs. Justice and Solicitor General Stakeholders to assess the current strains on the police resources and possibilities of addressing them by dedicating special staff to PChAD, and hiring additional staff.*** **b. PChAD to collaborate with Justice and Solicitor General Stakeholders to enhance information and training provided to the police to ease the pressures associated with executing a protection order.** ***c. PChAD to ensure that 'Police PChAD Information Cards' are printed and disseminated to police detachments throughout the province.*** ***d. PChAD to collaborate with Justice and Solicitor General Stakeholders to explore if information on the specific PSHs locations can be included on the protection orders.*** ***e. PChAD to work with Justice and Solicitor General Stakeholders to explore additional avenues to enhance the placement coordination, including increasing parents/guardians' involvement in and responsibility for confirming a bed availability prior to children's apprehension, as well as communicating with police in advance to allow enough time for planning.***
6. Examine the legal permissibility and practical applicability (including costs) of testing children for drugs. Evaluation findings suggested that testing children for drugs would add clarity to the evidence presented at courts (e.g., attain the needed balance between self-reported and "hard" evidence) as well as to the information used to develop PChAD assessments and recommendations. ***a. PChAD to explore with Alberta Health, Human Services Stakeholders and AHS lawyers the legal permissibility of drug testing in PSH in order for the courts to determine: a) if the drugs are used; b) what types of drugs are used; and c) avoid children's testimonials during protection order reviews while still under the influence of drugs, and include this information as part of the assessment and treatment planning processes.*** ***b. PChAD to conduct a Literature Review of implications of mandatory drug testing youth.***

Recommendations
7. Develop consistent practices in engaging families and sharing information with parents and guardians. Evaluation results indicated that parents or guardians should be more actively/directly engaged with PChAD. Enhanced access to information on assessment and treatment recommendations is key for parent/guardian engagement. ***a. PChAD to consult with parents/guardians and Human Services Stakeholders to develop and implement a consistent practice across all PSHs to engage families and share assessment and treatment recommendation information in alignment with the principles of Family Centered Care and in accordance with the Mature Minor Policy and Procedures.***
8. Explore the potential to increase staffing compliments in Protective Safe Houses to improve client supervision and enhance engagement between children and PChAD staff. Continuous monitoring and supervision was most frequently mentioned by the surveyed PChAD staff as a means to minimize negative networking among youth while at the PSHs. Maximum interaction with the staff was also mentioned as a way to counteract negative peer networking and strengthen positive effects of the program. ***a. PChAD to share this feedback with AHS Zone Managers and explore realistic options for staffing enhancements.***
9. Children in PChAD should have access to mental health services while confined in the PSH to fully integrate addiction and mental health services. Concerns about access to concurrent mental health services were expressed by parents/guardians in this evaluation, with emphasis on a very strong need for youth to receive a mental health screening and how to integrate mental health and/or psychiatry services in PChAD. ***a. PChAD to discuss staffing and training options with AHS Zone Managers to provide Mental Health Screening to all youth in PChAD to explore opportunities with Alberta Health Stakeholders for funding to hire trained mental health staff in each zone.*** ***b. PChAD to collaborate with Zone Managers to enhance concurrent capability of PChAD.***
10. Facilitate a seamless transition to post-PChAD treatment programs and services along the continuum of care. The evaluation findings point to the difficulties in accessing various treatment opportunities following children's discharge from PChAD due to long wait lists or unavailability of the required services in some locations. ***a. When possible, PChAD will make post discharge referrals before children are discharged from the PSHs and work to facilitate successful transitions and access to other programs and services.*** ***b. When possible, PChAD to ensure that parents/guardians are provided with the list(s) of***

Recommendations
available treatment options/recommendations prior to their children's discharge from the PSHs, to facilitate timely transitions for follow-up care. ***c. Where possible, prior to discharge from the PSH, a discharge meeting is conducted with the children and parents/guardians with focus on ensuring a shared understanding of the assessment and subsequent treatment recommendations and referrals.***
11. Examine options for enhancing immediate access to services for children leaving the PChAD program including review of service gaps and duplications in the Continuum of Care. The majority of parents or guardians who participated in the evaluation suggested that the PChAD program was too short and that there are no mandated follow-up treatment programs. Furthermore, dependent on a child's readiness for change, children are often not willing to participate in voluntary treatment or the waiting time for programs was too long. ***a. Provincial Addiction and Mental Health to examine, with GOA stakeholders and Zone operational partners, gaps in addiction and mental health services for children and youth and options for addressing these gaps.*** ***b. PChAD to explore with Zone operational partners and contracted addiction service providers the feasibility of prioritizing access to services for children leaving PChAD.*** ***c. PChAD to explore with GOA stakeholders and Zone operational partners the legal and fiscal feasibility for new mandatory addiction and mental health treatment program(s).***

References

Alberta Mental Health Review Committee (2015). *Valuing Mental Health*. Alberta Health Services. Retrieved from: http://www.health.alberta.ca/documents/Alberta-Mental-Health-Review-2015.pdf

Province of Alberta (2012). *Protection of Children Abusing Drugs Act*. Edmonton, Alberta: Alberta Queen's Printer.

Shaire Ortillano

From: Brian Lam
Sent: November 15, 2022 9:57 AM
To: Erin L Jackson
Subject: Revised Safe Sobering BN
Attachments: Draft BN for Decision re Safe Sobering - Nov 15 2022.doc

Hi Erin,

For your review.

Thanks,
Brian Lam, MPA, MA
Senior Policy Analyst, Legislation and Policy Unit
Ministry of Mental Health and Addiction

Classification: Protected A

Attachment is the same BN in the previous pages, no disclose

From: Brian Lam
To: Erin L Jackson
Subject: RE: Safe sobering BN
Date: November 15, 2022 3:50:00 PM
Attachments: Draft BN for Decision re Safe Sobering - Nov 15 2022.doc

---

Here you go.

N/R

Thanks

Brian Lam, MPA, MA
Senior Policy Analyst, Legislation and Policy Unit
Ministry of Mental Health and Addiction

Classification: Protected A

From: Erin L Jackson 18
Sent: Tuesday, November 15, 2022 3:46 PM
To: Brian Lam 18
Subject: Safe sobering BN

Hi Brian,

Will you be able to send over the revised safe sobering BN at some point tomorrow morning? I'd like to review before noon, if possible.

Erin Jackson, LL.B
Manager, Legislation and Policy Unit
Addiction & Mental Health Division, Alberta Health

Office: (780) 422-1344
Cell: 17(1)

Classification: Protected A

Shaire Ortillano

From: Erin L Jackson
Sent: November 21, 2022 3:35 PM
To: Brian Lam
Subject: SAD Referral Pathways - Strategic Engagement Plan - Nov 2022
Attachments: SAD Referral Pathways - Strategic Engagement Plan - Nov 2022.docx

Importance: High

Classification: Protected A

Shaire Ortillano

From: Brian Lam
Sent: November 21, 2022 3:46 PM
To: Robert Murdoch
Subject: FW: SAD Referral Pathways - Strategic Engagement Plan - Nov 2022
Attachments: SAD Referral Pathways - Strategic Engagement Plan - Nov 2022.docx

Same attachments as the previous ones

Importance: High

Please put on sharepoint and share. N/R

Thanks,
Brian Lam, MPA, MA
Senior Policy Analyst, Legislation and Policy Unit
Ministry of Mental Health and Addiction

Classification: Protected A

From: Erin L Jackson 18
Sent: Monday, November 21, 2022 3:35 PM
To: Brian Lam 18
Subject: SAD Referral Pathways - Strategic Engagement Plan - Nov 2022
Importance: High

Classification: Protected A

From: Tara White
To: Coreen Everington; Kenton Puttick; Jennifer Poirier; Carolyn Gregson; Evan Romanow; Kevin Wipf
Subject: Article re Involuntary Treatment
Date: November 25, 2022 8:24:55 AM

FYI - [redacted]

Tara White, MPA, MSW
(She/Her)
Director
Policy Implementation Unit
System Enhancement and Legislation Branch
Ministry of Mental Health and Addiction
Ph: 780-422-2700
Email: [redacted]

Classification: Protected A

From: Erin L Jackson
To: Jurgita Kornijenko; Brian Lam; Robert Murdoch
Subject: FW: Briefing packages
Date: December 9, 2022 1:07:16 PM
Attachments: 4 BN Administrative Panel (clean).doc
4.1 Attach1 Drug Treatment Courts.docx
4.2 Attach2 Jurisdictional Scan.docx
3 BN Mandated Treatment (clean).doc
3.1 Attach1 PChAD Review Final Report, 2020.pdf
3.2 Attach2 PChAD Program Review Report, 2020.pdf
3.3 Attach4 PChAD Jurisdictional Comparison.docx
3.5 Attach5 PChAD Review Recommendations.docx
2 BN Safe Sobering.doc
2.1 Attach1 Jurisdictional Comparison.docx
1 BN Advice to Deputy Minister - Administrative Ticketing (Dec 9.22) 1130.docx

---

Final versions of what was sent for your records/version control. Note – I'm guessing we'll get feedback after the weekend (maybe from Coreen/Bryce or even Evan or Kevin), which I will of course pass along, but just want to make sure you can see what went up.

Erin

Classification: Protected A

From: Coreen Everington [redacted]18
Sent: December-09-22 12:43 PM
To: Bryce Stewart [redacted]18
Cc: Lindsey Graham [redacted]18 Evan Romanow [redacted]18
Kevin Wipf [redacted]18 Kenton Puttick [redacted]18 Erin L Jackson
[redacted]18
Subject: Briefing packages

Good afternoon Bryce,

The team has pulled together four sets of briefings for you to support deepening your understanding of the new legislation we're contemplating. Please note we are in various stages of our thinking – some more refined and crisp than others.

[redacted]24(1)(a)

We look forward to your further thoughts, questions and advice.

Coreen

Drug Treatment Court Funding Program

Summary document

PURPOSE

To provide a summary of the Drug Treatment Court Funding Program (DTCFP) evaluation report (2021), recidivism study (2021), and a report from Calgary's drug treatment court (DTC) (2020).

BACKGROUND

Drug Treatment Court Funding Program

- In Canada, the DTCs were introduced as pilot demonstration projects in Toronto in 1998 and in Vancouver in 2001, using funding from the Crime Prevention Investment Fund of the National Crime Prevention Strategy. After Canada's Drug Strategy was renewed in 2003, the DTCFP was established in 2004. The DTCFP is now a component of Canada's Drugs and Substances Strategy (CDSS) (formerly the National Anti-Drug Strategy).
  - The Drug Treatment Court Funding Program provides contribution funding to the provinces and territories for the development, delivery and evaluation of the DTCs in Canada.
  - This approach recognizes the complex social, economic, cultural, and health factors that contribute to problematic substance use and seeks to prevent re-offending in more comprehensive ways.
- To date, the DTCFP has established funding agreements with 8 provinces and two territories (PTs) to fund 13 DTCs.
  - The total transfer payment budget for the DTCFP was $18.7M for the fiscal years 2016-17 to 2020-21.
  - The total combined operations and maintenance (O&M) and salary budget from 2016-17 to 2020-21 was $2.8M.
- The DTCFP aims to reduce crime committed as a result of a substance use disorder/drug dependency through court-monitored treatment and community service support for non-violent offenders with drug addictions.
  - DTCs are provincial and territorial courts that target adult, non-violent offenders who have been charged under the *Controlled Drugs and Substances Act* (CDSA) or the Criminal Code of Canada, in cases where their substance use disorder was a factor in the offence.
  - DTCs provide an alternative to incarceration by offering the offender an opportunity to participate in a court-monitored, community-based drug treatment process.
  - DTCs typically prioritize applicants who are difficult-to-serve offenders with serious drug addictions that can threaten community safety, raise public fear of crime and disorder, and place considerable demand on both the criminal justice and health care systems.

Objectives of the DTFCP	Key elements of the DTCs	DTC process	DTC eligibility criteria
- To promote and strengthen the use of alternatives to incarceration with a particular	- A dedicated court that monitors the DTC participant's compliance and	- Application Process: The offender submits a formal application to the DTC soon	- Adult individuals;

focus on vulnerable populations; - To support offenders in addressing their cycle of addiction and criminal behaviour as a means of reducing criminal recidivism; and - Collect information and data on the effectiveness of the DTCs in order to promote best practices and the continuing refinement of approaches.	progress, and can either impose sanctions or provide rewards; - The provision of appropriate drug treatment plan with a strong case management component developed for each participant to assist them in overcoming substance use disorder; - Community supports, through referrals to social services (such as safe housing, stable employment and/or education) that can help stabilize and support the offender in making treatment progress and in complying with the conditions of the DTC.	after an arrest. Any person charged with an offence is encouraged to apply for a DTC program in circumstances where a substance use disorder has contributed to the offence being committed. - Crown Screening: The Crown attorney reviews applications and assesses them against specified eligibility criteria depending on the specific DTC site (e.g., non-violent offenders and criminal behaviour that is a result of a substance use disorder, guilty plea to criminal charges). - Admission Process: Eligible applicants are interviewed by treatment personnel to determine their needs. The case is then presented to the DTC judge. If rejected, the offender will be returned to the regular court process. - DTC Program Participation: Prior to program commencement, the participant must plead guilty to the charges laid before them. Once	- Individuals addicted to a controlled substance in Schedule I of the CDSA; - charged with a CDSA or Criminal Code offence within territorial jurisdiction of the DTC in question or with provincial Crown consent (in more remote areas, participation is not limited to offences committed in the city where the DTC is located but participants are required to live in the city where the DTC is located for the duration of their program); - crime was committed to support the offender's addiction; - applies voluntarily to the program; - must not pose a risk to public safety; - required to submit an application form; - must acknowledge responsibility for the act or omission that forms the basis of their offence; - agrees to abide to specific bail conditions;

		admitted to the program, participants make regular court appearances, submit to random and frequent drug testing, and attend scheduled treatment sessions. - Program Completion: A participant is generally required to stay in the DTC program for 12 to 18 months. To successfully complete the program, participants must meet several criteria established by the DTC, which typically refer to compliance with program conditions, no further criminal convictions, indicators of social stability, and a period of abstinence from substance use. Participants who successfully complete the DTC program may receive a non-custodial sentence.	- accepts to undergo random drug screening throughout their time in the program and comply with other program rules; - undergoes Crown eligibility review; and, - undergoes treatment eligibility review (where applicant is either deemed appropriate for treatment or not as assessed by DTC and/or service providers).

Evaluation of the Drug Treatment Court Funding Program – Final Report (2021)

- In December 2021, the Department of Justice Evaluation Branch conducted an evaluation of the DTCFP with the results released in the Final Report "Evaluation of the Drug Treatment Court Funding Program" (as per the Justice 2020-21 Internal Audit and Evaluation Plan).
  - The evaluation covered the fiscal years 2016-17 to 2020-21, and assessed activities undertaken by the Justice Programs Branch to support the implementation and management of the DTCFP, and the effectiveness and efficiency of the Program.

Positives of the DFCP	Shortcomings of the DFCP
• DTCs provide a sentencing alternative in the criminal justice system, participants receive a lesser non-custodial sentence upon successful completion of the program. • DTCs incorporate accepted best practices, such as health-based approaches, clear and predictable rewards and sanctions, and the treatment of co-occurring disorders. • DTCs utilize individualized treatment plans and participant-centred services that are generally accepted as being responsive to the needs and identity factors of participants. • Almost all jurisdictions are exploring DTC expansion, including establishing additional centres or increasing capacity to meet demand. Some have expressed an interest to add new streams of participants for DTCs such as an early intervention DTC (diversion prior to guilty plea), DTCs for lower risk participants or those with less serious offences, an Indigenous focused DTC, and a harm-reduction focused DTC (e.g., different success criteria, different graduation criteria). - At some sites, some flexibility is already being incorporated into the eligibility criteria. For example, at the Edmonton DTC, there is case-by-case consideration of charges involving violence. • Literature suggests that DTCs are a cost-effective alternative to the traditional criminal justice response. This is achieved through addressing underlying addiction and criminogenic factors which, in turn, reduces the revolving door of contacts with the criminal justice system because they minimize the costs of the court (e.g., judge, lawyers, police, legal aid, probation, etc.) and avoid the cost of incarceration in a correctional facility. - An evaluation of the Winnipeg DTC in 2015 found that: Drug courts return an average of $2.21 to the justice	• DTCs serve a small sector of the population, with an average of 21 participants per site in 2016 increasing to an average of 23 participants per site in 2019. • DTC participants are mainly men (74 per cent) with the average age being 31 to 39 years of age. - 55 per cent of the DTC participants were Caucasian men, 27 percent were Indigenous, 3 per cent Black, and 15 per cent of participants were classified as other. • DTC eligibility criteria or potential barriers may unintentionally impact access to DTCs or exclude some groups more than others. For example, Indigenous and racialized individuals, as well as women, are under-represented among DTC participants. Some of the reasons could include: - For women this could be due in part as a result of the types of charges women offenders may have when they become involved in the criminal justice system (e.g., assault), which could disqualify them. Further, suitability assessments could also sometimes put women candidates at a disadvantage if there is a lack of a particular service available at the local level for women (i.e., a DTC will not admit a candidate for which services needed are not available). Also, there are more housing and withdrawal management options and services for men than there are for women. - Individuals from under-represented groups may be unwilling to participate due to distrust of the justice system. Indigenous participants in particular may not at all agree that the justice system works for them or has an interest in their well being. - As those with violent charges are often ineligible, Caucasian participants may be over represented in DTC programs relative to the criminal justice system as a

system for every one-dollar invested and up to $12 in community impacts for every dollar invested.
  - Calgary's 2019 evaluation reported that their DTC led to avoidance of $7.4 million in the cost of incarceration for the average one year in custody graduates did not serve.
- There is evidence that DTCs reduce substance use during the program, as well as provide other positive outcomes (social, employment) for participants.
- The DTCs are believed to be effective in reducing recidivism (See recidivism study findings below).
- As an unintended outcome, the DTCs were seen to positively contribute to advancing the use of collaborative sentencing alternatives in the criminal justice system. For participants, a potential negative outcome of participation in the DTC is accumulating additional charges during the program.

result of perceived bias in the justice system. Racialized groups may have historically been targeted more by police and may be more likely to be seen as connected with a 'gang' and/or be charged with committing a 'violent' offence (e.g., resisting arrest) than members of other groups.
  - The DTC's 'history of violence' exclusion criteria is likely to be disproportionately screening out some racialized groups more than others. Some stakeholders noted that it could be worth considering having different DTC criteria for Indigenous applicants who may, for example, have been convicted for issues pertaining to family violence.
- Other barriers to access:
  - Lack of broad-based awareness of the program on the part of defence counsel.
  - Location of the courts - all DTCs are currently located in urban centres (downtown locations), which are more likely to have greater availability of the community-based resources (housing, addictions treatment, social services) that are integral features of the DTC model. Those living outside of the downtown core, smaller centres and rural areas, and possibly First Nations communities that lack these resources are underserved by DTCs.
  - Depending on their charge, potential participants could opt for a shorter custodial sentence rather than the lengthy and involved prospect of participating in a DTC.
  - Requirement for a guilty plea to their charge as part of the sentencing process may create a disincentive to participation.
  - Practical barriers to participation such as transportation, work and/or child care to comply with court and treatment requirements.
  - Variable approaches of the Crown to assessing eligibility (from conservative to more flexible interpretations that

	consider contextual factors with input from the DTC team). • Demand for the DTCs may exceed supply/capacity in some locations. A few DTCs reported having a waitlist and some DTCs expressed they could serve more participants if they had more resources to do so (including more staff). • Gaps in services were observed for some DTCs, particularly in the areas of housing, mental health services, and aftercare. For example, in some jurisdictions where there are insufficient transitional housing options available for women, a woman requesting admittance to the DTC but requiring transitional housing may be declined due to the limitations of their local service provision context. • The Drug Treatment Court Information System (DTCIS) is the primary vehicle for DTCFP-funded DTCs to report on their activities and outcomes on a national/federal basis; however, there are numerous data limitations. • Program Retention: Among those who started the program during the period under study, about one-third of participants completed the program. - Overall, 29% of participants completed the program during the study period and the average duration of the program was 15 months. • While most jurisdiction are in support of DTC expansion, common challenges include insufficient funding, insufficient necessary supports in the community, and a need for more awareness and support from stakeholders that can impact DTC efforts.

<u>Drug Treatment Court Funding Program – Recidivism Study (2021)</u>

- As part of the 2021 Evaluation of the DTCFP, the Evaluation Branch contracted Statistics Canada to conduct a statistical analysis of DTCs' impact on recidivism.

- The study was designed to determine if participation in DTCs reduces the likelihood of recidivism, relative to a comparison group of justice-involved non-participants.
    - Participation in DTCs was seen to reduce the likelihood of recidivism. During the first 60-365 days of follow up, DTC participants were significantly more likely (108 per cent more likely) to be charged than the non-participants; often for administration of justice offences. However, within the first year (64 per cent more likely), and up to three years at risk, DTC participants were significantly less likely to receive any new charges (36 per cent less likely at any point after 365 days).

<u>DTCs Alberta context - background</u>

- When DTCs began in Canada as part of the Treatment Action Plan of the National Anti-Drug Strategy, a federal government pilot project, funding was provided to six sites through the Federal Drug Treatment Court Funding Program.
    - In 2005, Edmonton DTC responded to a call for proposals and commenced operations as one of the six sites that received funding.
    - In 2007, Calgary DTC commenced operations providing the only community alternative to incarceration for non-violent drug-addicted offenders whose crimes are driven by addiction.
- Before the DTC expansion and funding commitment announced in 2019, the Calgary and Edmonton DTCs were funded in the 500,000 from the federal government, and the remaining $213,000 was provided by the province.
    - Until 2021 and new federal funding was provided, the federal government funded 16% of the total costs for Alberta's DTCs.
    - In 2021, Alberta successfully applied for an increase in the federal funding for the province's DTC and now receives about 40% of the total costs for the DTCs:
- Since the commencement of their operations, the DTCs in Alberta (Calgary and Edmonton) have developed as separate entities, and prior to new governmental funding agreements in 2020 the DTCs were only available to a very select few participants (30-45 provincially per year) and only in two geographical locations in the province.
- In 2019, the Alberta provincial government committed 20 million dollars to support the increase of access to DTCs for drug-addicted offenders in Alberta. This commitment included:
    - Capacity expansion to the existing DTCs in Edmonton and Calgary (from approximately 40 participants to 80 participants annually);
    - Expansion of DTCs in medium sized communities in Alberta (for example, Red Deer, Medicine Hat, Lethbridge, Grande Prairie and Fort McMurray); and
    - Creating customized services to give smaller rural communities access to DTC programming.

<u>Calgary Drug Treatment Court (CDTC) Report Findings (2020)</u>

- In July 2020, the CDTC Society released a Report "Real Help for Addicted Offenders: Further Evidence from the Calgary Drug Treatment Court" (Report) to provide evidence based data.
    - The study included 87 participants who graduated from the CDTC program during the 9 plus year period between April 1, 2010 and June 30, 2019.
    - The analysis included post-program convictions during an average period of 3.84 years (the time frame ranged from 3 months to 9 years for some participants taking into consideration the time between graduation and study end date (June 30, 2019)).

- According to the Report, data on criminal convictions and contact with Calgary Police for these graduates showed:
  - 66.7% had no convictions for any new offences since graduation.
  - Graduates had a total of 2,803 convictions prior to program admission and 279 convictions following graduation.
  - These graduates had a total of 1163 pre-program convictions compared to 279 post-program convictions. This equivalent pre/post comparison shows a decrease of 76.1% in convictions at an average 3.84 years post-graduation.
  - Nearly 70% who graduated between 3 and 4 years before the study end date had no new convictions.
  - Police had 67.3 per cent fewer contacts with graduates after graduation.
  - 70.1 per cent were free from substantive criminal convictions and charges after graduation.
  - The program's graduation rate is 51.6% (2016-2019).
- CDTC target population are those who are at high risk to re-offend and have high needs. Prior to program admission:
  - 42 per cent were living in a homeless shelter or on the street; 35 per cent were temporarily housed with friends or family or in transitional housing.
  - 82 per cent were unemployed.
  - 89 per cent were earning less than $15,000 per year.
  - 100 per cent were committing crime to obtain money for drugs (primarily theft (62 per cent) and drug-trafficking (54 per cent).
  - 72 per cent were exposed to one or more types of childhood abuse/trauma.
  - 89 per cent were assessed at high risk to re-offend and 73 per cent were assessed as having high needs (i.e., homelessness, unemployment, and lack of pro-social supports).
  - Graduates were age 14 on average at the onset of drug use.
  - 71 per cent were youth (age 13-24) at the time of their first conviction.
  - 84 per cent identified a physical health issue.
  - 73 per cent reported having an existing mental health issue/diagnosis.
- The annual cost to serve a participant in the CDTC program is $27,000/year. Analysis of the cost avoidance and savings related to recidivism for graduates of the CDTC shows:
  - CDTC saves society $15 - $20 million per year in the cost of stolen goods alone;
  - Avoidance of $7.4 million in the cost of incarceration for the average 1 year in custody graduates did not serve as a result of successfully completing the program;
  - Avoidance of over $300,000 in police response costs for 45 program graduates, at an average 2.3 years following graduation;
  - Avoidance of over $300,000 in the cost of services involved in delivering the warrant/incarceration cycle (for 45 graduates at an average 2.3 years following graduation).
- Completion status by drug(s) of addiction at the CDTC (for participants who entered the program since its inception in 2007):
  - Those addicted to cocaine were most likely to graduate (51.8%).

- There is a similar rate of successful completion/graduation for those with an addiction to methamphetamines (47.3%) and those with an addiction to opioids (47.1%). If the completion rate for those with a heroin addiction is combined with the other opioids/opiates, the rate of success for this group is slightly lower (45.6%)
- Those addicted to heroin, were most likely to have an unplanned discharge (55.9%), followed by those with an addiction to alcohol (54.5%).
- The completion rate was relatively consistent across groups of participants experiencing addiction to a single drug and those with poly-drug addiction.

	Alberta Potential *Compassionate Intervention Act* **(anticipated to be introduced in 2023)**	**Massachusetts** *Massachusetts General Law Chapter 123, Section 35*	**Washington** *Involuntary Treatment Act RCW 71.05.585*	**Australia** *Police Powers and Responsibilities Act 2000, s. 379*	**Portugal** *Law n.º 30/2000, of 29 November Law-Decree n.º 130-A/2001 of January 23*
Age of the individual (or adult/youth)	Both	It appears to be both since applications can be made to juvenile court.	Both, 13 years and older	Both	Does apply to minors, at least to youth under the age of 16.
Circumstances for the application (e.g., substance use disorder/harm to themselves or others, drug possession, etc.)	By referral by police to the administrative panel due to a non-violent criminal/statutory offence (when an offence is committed primarily as a result of a substance use disorder) or by request from law enforcement, family members, legal guardians when an adult or youth is at risk of serious harm to themselves or others as a result of	After testimony and argument, the judge decides if there is clear and convincing evidence that: The person has an alcohol or substance use disorder; and there is a likelihood of serious harm to self or others as a result of their substance use disorder.	Determine if symptoms of the individual's mental disorder or substance use disorder places the individual at risk due to the **likelihood of serious harm**[i], and/or **grave disability**[ii].	Minor drug offences[1]	No application, offender is referred to the commission after being found in possession of substances under a criminalized limit.

[1] Minor drug offences are the possession of 50g or less of cannabis; or possession of a thing that is used, or has been used for smoking cannabis. They do not include offences involving the production, supply or trafficking of cannabis.

	substance use disorder.				
Who can make an application	Law enforcement, family members, legal guardians, etc.	Police officer Physician Spouse Blood relative Guardian Court official	Anyone within the state of Washington. Is typically referred by: family members, first responders, care givers, medical providers, and care providers	No panel. The police investigate the offence, question the individual and make a decision whether the offender is eligible for drug diversion. If eligible, the offender is offered an opportunity to participate in and complete a drug diversion assessment program. The police then make an appointment with the closest available provider (only in Queensland).	Police issues an administrative penalty
Who receives/hears an application	An administrative panel and potentially a separate Indigenous administrative panel to serve Indigenous populations.	Petitions may be filed at any District or Juvenile Court	Courts	N/A	Administrative Panel

The individual is assessed[2] before order issued		Yes. At the court hearing, the court shall order an examination by a qualified physician, psychologist, or social worker.	Yes, at Secure Withdrawal Management and Stabilization facility (SWMS) for up to 120 hours. The individual must be released after the initial 120 hours, unless the treatment team determines that the individual is still at risk and petitions the court. The	Yes, a qualified Queensland Health program provider conducts a combined assessment, education and counselling session (two-hour session). The individual then works with the program to develop a personal plan to stop using illicit drugs	
Initial length of confinement	TBD	Any time under 90-days	14-day	Personalized treatment plan. If a person completes a drug diversion assessment program they: - Will not be charged with a criminal offence for the minor drugs offence; - Will not have to attend court for the minor drugs offence; or - Will not have a criminal record for the minor drugs offence; - They will also learn about the consequences of illicit drug use and get access to information	See below.

[2] Assessed or examined by health care practitioner (e.g., physician, addiction specialist, nurse)

				and support to stop their drug use.	
Length of extended confinement	TBD	The statute states the commitment may be up to, but not exceed 90 days.	If the individual does not stabilize within the 14 day commitment, the facility may petition the court, who may order a 90 day commitment, and the individual will be transitioned to a long-term community bed or a state hospital bed.	N/A	There appears to be time limit on treatment. Instead Portuguese law allows for the penalties for possession to be suspended if offender cooperates with a treatment plan or other conditions. The maximum a penalty can be suspended is 3 years. The penalty is either applied in the case of non-compliance or the treatment plan or conditions is completed and proceedings are filed.

[i] **Likelihood of serious harm** means a substantial risk that physical harm will be self-inflicted, inflicted upon another, or inflicted upon the property of others. This includes threats or attempts to commit suicide or harm oneself, or behavior that causes harm or places another person of reasonable fear that they will be harmed, or behavior that caused substantial loss or damage to the property of others.

[ii] **Grave disability** means that that due to the individual's mental disorder or substance use disorder, the individual is in danger of serious harm resulting from a failure to provide for their essential needs of health and safety; or demonstrates a severe deterioration in routine functioning evidenced by increasing loss of volitional control over their actions and is not currently receiving care that is essential for the individual's health and safety.

Final Report:

Protection of Children Abusing Drugs Act Review

Alberta

Table of Contents

Executive Summary

The *Protection of Children Abusing Drugs Act* (PChAD) and program provides a court-mandated 10-day confinement for detoxification, assessment and stabilization of young people under 18 years of age using drugs. In response to a recommendation in the Alberta Child and Youth Advocate's 2018 *Into Focus: Calling Attention to Youth Opioid Use* report, Alberta Health undertook a review of the PChAD Act and program. This report summarizes the findings of that review and resulting actions for change approved by the Minister of Health and Associate Minister of Mental Health and Addictions.

The review consisted of a program review, legislative review, and external stakeholder engagement. As part of engagement, Alberta Health heard from young people, their families, Indigenous communities, service providers, and community organizations.

The review found that most stakeholders reported that the PChAD program provides a safe, secure place for youth to detox. Other strengths of the current program include good coordination between the PChAD program and treatment services at some sites (Edmonton) and in providing an option for guardians who have often exhausted all other avenues of help for their child. Through detox, the PChAD program connects these young people to supports and services they can access to begin building their recovery capital.

Despite these strengths, there are issues in program design and operation that can be grouped into three categories: accessing the PChAD program, PChAD program operations (i.e. at the protective safe house), and post-PChAD discharge.

With respect to accessing the PChAD program, guardians report the application process can be challenging and the court process traumatizing, with those living in rural, remote and reserve/settlement communities experiencing added difficulties of travel times to access the PChAD program. Access to the PChAD program by Indigenous Albertans is further hampered by low community awareness.

In terms of PChAD program operations, the picture is complex. Although protective safe house services fulfill the mandate of the Act in providing detoxification, ongoing operational variation between protective safe houses and coordination with other service providers results in different supports and services available to these complex youth depending on the safe house to which they are admitted.

The desire to increase the length of the PChAD program and the absence of addiction treatment were strong themes throughout the review. The PChAD program provides enough time to detox from most substances, but many youth are not ready or lack the necessary support to take the

next step in the recovery journey. As a result, some return to using substances and sometimes to further PChAD protective safe house admissions. Young people and families also report difficulties accessing addiction treatment after leaving the PChAD program. For those that do seek treatment, Alberta Health heard clearly that youth and families require additional support to ensure they can access the services they need.

In 2020 the Government of Alberta completed a multi-sector review in response to a serious assault of a member of the public by a youth in 2018. *Multi-Sector Review: Youth Assault of a Member of the Public* recommended that "the Government of Alberta review secure settings to determine if they are meeting the needs of youth with complex service needs" to ensure that children and youth have secure and safe settings to maximize the potential for recovery. Secure services, including the PChAD program, share similar difficulties in coordinating services, sharing necessary information, and meeting the complex needs of admitted youth. Additionally, the same youth are often admitted to multiple secure service programs, including those under the *Protection of Sexually Exploited Children Act* and the *Child, Youth and Family Enhancement Act.* Generally, and most recently during engagements for the PChAD review, stakeholders also expressed desire for system-level improvement in secure services, including better coordination, more tailored services, and fewer transitions.

Some of the findings of this review, such as feedback on regarding the length of time at the protective safe house, inclusion of addiction treatment, and other feedback that would require amendment of the PChAD legislation to change, could be considered and possibly addressed via a review of secure settings. Alberta Health will also continue to work with partners, including Children's Services, to ensure that the findings of this review are incorporated into any work to respond to the recommendations of the Multi-Sector Review.

Minister-approved Actions

Program Change Actions

Work to implement these program changes will be initiated in collaboration with AHS and cross-ministry partners.

Accessing the PChAD program
1. *AHS* to develop consistent materials and venues for community engagement to increase the awareness and understanding of the PChAD program among youth-serving organizations and institutions (e.g., not-for-profits and school boards), First Nations, Métis

communities and organizations, Indigenous-serving organizations, and parent-supporting organizations.

2. *Alberta Health* to work with Justice and Solicitor General to develop policy to enable ongoing access to teleconferencing for rural and remote families to use when applying for or reviewing a PChAD protection order with the Provincial Court, where infrastructure and funding opportunities are available.

PChAD program operations

3. *AHS Provincial Addiction and Mental Health* to develop consistent standards and reporting across all protective safe house sites, and look to find efficiencies in program delivery.

4. *AHS* to increase information sharing with parents/guardians on the progress of their child through the program, and increase information sharing and coordination with community addiction treatment providers, mental health providers, and peer supports to create pathways for youth post-discharge.

5. *AHS* to improve community connections for Indigenous youth accessing the PChAD program by working with the AHS Indigenous Health Hub, and First Nations and Métis communities and organizations, and review PChAD program policies to identify and remove any barriers to supporting Indigenous cultural and healing practices.

Post-PChAD discharge

6. *AHS* to facilitate smooth transition to post-PChAD program services, including where possible facilitating direct connection or referral to recovery-oriented services prior to discharge from the protective safe house.

7. *Alberta Health to work with AHS* to build stronger relationships between the PChAD program and the wider addiction treatment ecosystem to create clearer pathways for youth to access recovery-oriented services and supports post-discharge.

8. *AHS* to develop and implement outcome measurement tools to better understand the short and mid-term outcomes for youth leaving the PChAD program, and use these data for continuous, evidence-based improvement.

Review Purpose

In 2018 the Alberta Child and Youth Advocate (Advocate) released a report *Into Focus: Calling Attention to Youth Opioid Use* (*Into Focus*), that detailed the narratives of twelve young people who died by opioid poisoning.

Six of these young people had been subject to a PChAD protection order and confined at a protective safe house in the course of their struggle with addiction. As a result, one of the five recommendations of the *Into Focus* report was that "Alberta Health undertake a review of the Protection of Children Abusing Drugs Act and its policies, so the related services better meet the needs of young people and their families."

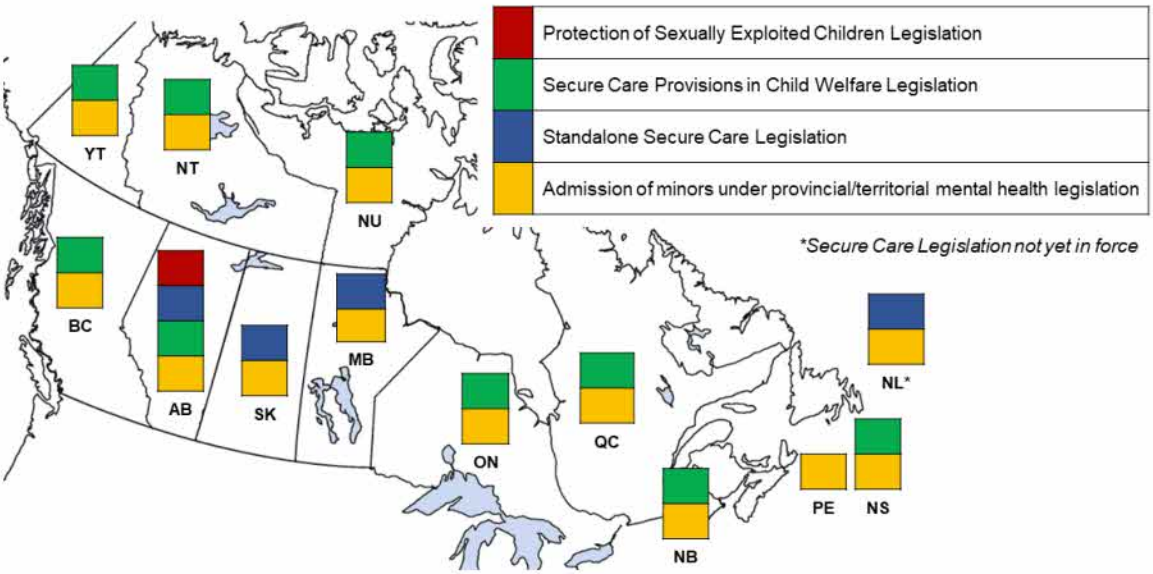
Government accepted this recommendation and undertook a review of the PChAD Act and program, which concluded in October 2020. This report summarizes the findings of the review and lays out actions for change, approved by the Minister of Health and Associate Minister of Mental Health and Addictions, to enhance the PChAD services young people receive.

Background

Secure services

Overview

Secure services for youth are those provided to care for and support a young person in a secure residential setting (i.e., the young person cannot leave voluntarily). They are typically used only when other services are insufficient to ensure the safety of the young person.



Most Canadian provinces and various international jurisdictions have some form of secure youth services legislation, but there is variation on how it is conceived and applied.

Considerations for secure services

The *Canadian Charter of Rights and Freedoms* (the *Charter*) guarantees several rights that are potentially at odds with the notion of secure services, and have affected the development of secure treatment legislation in Canada. These include:

- Right to life, liberty and security
- To not be arbitrarily detained
- If detained, the right to be informed of the reason and to access a lawyer

- Any limit on a *Charter* right must be reasonable and demonstrably justified

As a result, secure care legislation in Canada has safeguards to protect implicated *Charter* rights (e.g., children are informed of why they are in secure care), and only limits a child's rights under the *Charter* to the extent needed to protect the child from harm.

Secure care legislation in Alberta

In Alberta, for example four different statutes provide for non-criminal secure care of young people.

Act	Description
Mental Health Act	*Purpose:* The main piece of legislation in Alberta dealing with the assessment, detention and treatment of people with serious mental illness. Applicable both to adults and youth. *Confinement period:* Initially 30 days, with the possibility of renewal.
Child, Youth, and Family Enhancement Act (CYFEA)	*Purpose*: A secure services certificate or order can be issued if a child is determined to present harm to themselves or others or to stabilize and assess the child, and less intrusive measures are not adequate to sufficiently reduce the danger. *Confinement period:* Maximum of 30 days
Protection of Sexually Exploited Children Act (PSECA)	*Purpose:* Offers protection to young people under the age of 18 who are at risk of sexual exploitation through their involvement or risk of involvement in prostitution, through a court-mandated program. *Confinement period:* Maximum of 47 days (5 day initial confinement, with the possibility of up to two 21 day extensions)
Protection of Children Abusing Drugs Act (PChAD)	*Purpose:* Authorizes a young person under the age of 18 to be apprehended, conveyed and confined to a protective safe house for assessment, detoxification, and stabilization. *Confinement period:* up to 10 days, with the possibility of an extension to 15 days.

Secure care for substance use

Alberta, Saskatchewan and Manitoba all have legislation in force providing specifically for secure settings for young people using substances. Newfoundland has legislation that was passed in 2016 but is not in force.

The PChAD Act is comparable to other similar legislation across Canada. However, Alberta has a comparably lesser focus on the rights of the young person subject to the order. For example, the PChAD Act does not require assessment of youth by a health care professional and comparably fewer safeguards to ensure a young person is informed of the right to legal counsel and provided an opportunity to exercise that right.

A summary of some key features of these acts is shown below. See Appendix 1 for a detailed cross-jurisdictional comparison.

	Maximum confinement*	Includes treatment?
British Columbia Bill 22: Mental Health Act Amendment Act (not passed)	9 days	No
Alberta *Protection of Children Abusing Drugs Act*	15 days	No
Saskatchewan *The Youth Detoxification and Stabilization Act*	15 days	No
Manitoba *Youth Drug Stabilization (Support for Parents) Act*	7 days	No
Newfoundland *Secure Withdrawal Management Act* (not in force)	20 days	No

* Maximum confinement = Initial confinement + extension (where existing)

Of note, Saskatchewan's *Youth Detoxification and Stabilization Act* also provides for 30-day community orders, allowing the young person to receive detoxification, assessment and stabilization services in the community.

Internationally, New Zealand enacted the *Substance Addiction Compulsory Assessment and Treatment Act* in 2017. The Act authorizes a compulsory treatment order for a person (adult or child) with a severe addiction with impaired capacity to make treatment decisions. Certificates are valid for a maximum of 56 days or until a person no longer meets the criteria under the Act (whichever is earlier).

PChAD Program

The Protection of *Children Abusing Drugs Act* (PChAD) was passed in 2005 and implemented in 2006. Amendments to the Act were made in 2012 and AHS conducted an evaluation of the PChAD program in 2017. PChAD protective safe houses are licensed as residential addiction treatment service providers under the *Mental Health Services Protection Act*.

The guardians of young people who are misusing drugs and unwilling to attend voluntary addiction treatment services may apply for a PChAD order. Guardians apply to the Provincial Court of Alberta for PChAD protection orders.

Criteria include that the young person is using drugs to the extent that "the use caused or is likely to cause significant psychological or social harm to the child, or physical harm to the child or others". For example, a young person using opioid drugs is at risk of opioid poisoning, or a young person's use of methamphetamine may have caused them to engage in violent behaviour towards themselves or others.

A protection order allows the young person to be apprehended, conveyed and confined to a Protective Safe House for up to 10 days for detoxification, stabilization an assessment. After a protection order is granted, a guardian must call AHS to reserve a PChAD program bed at a protective safe house before their child can be admitted. A judge may extend the order for an additional 5 days on application.

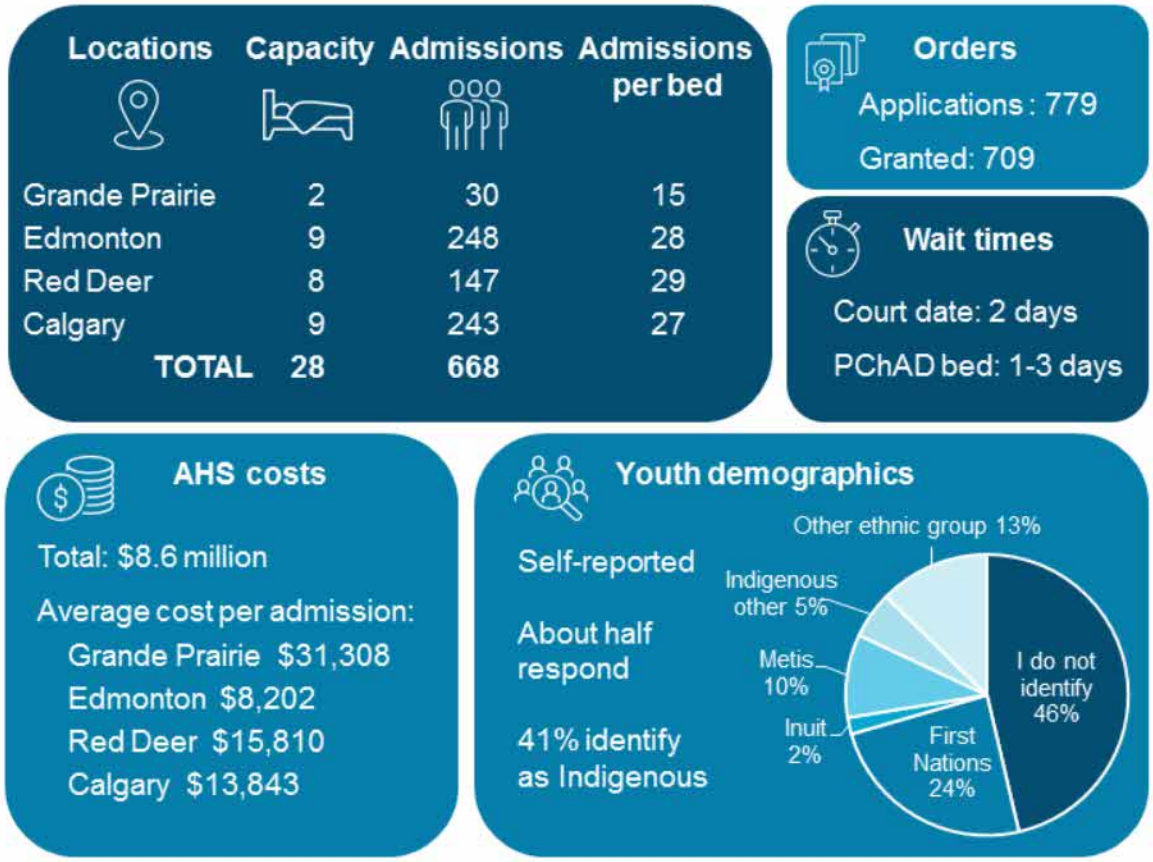
At the end of the confinement period, the young person is discharged into their guardian's care. Information on recommended further services and

how to access them are provided in the young person's treatment plan (e.g., telephone number, location, hours of operation). Referrals to some services, particularly those within AHS, may also be made by protective safe house staff for the young person. However, all services are voluntary; there are no involuntary addiction treatment services in Alberta. It is also the responsibility of the young person and their guardian to follow up on the recommendations in the treatment plan (e.g., contact the service provider, secure transport there).

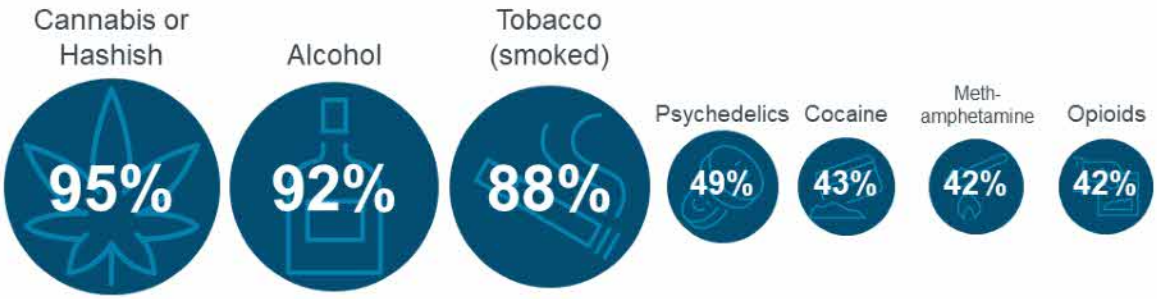
AHS is the coordinator of the PChAD program and is responsible for the delivery of all services at protective safe houses. Court processes are the responsibility of the courts and apprehension and conveyance of youth is the responsibility of peace officers.

Current State

Some key information on the PChAD program for the 2018/2019 fiscal year is illustrated below. Data are the best available but in some cases data are incomplete and/or self-reported.



Substances used



Notes: Youth self-report substances used; most report using multiple substances, which may account for the prevalence of cannabis, alcohol, and tobacco use. Wait times shown are typical wait times. Costs related to police and court processes are unavailable. Data shown are for the 2018/2019 year.

Review Results

Alberta Health's review process included a program and legislative review, along with intensive stakeholder engagement. This allowed a fulsome review of all aspects of PChAD: the legislation itself, how it is currently working operationally, and feedback from PChAD program users, service providers and other interested groups. Alberta Health also sought cross-ministry input where relevant.

Program review

Alberta Health contracted with ThreeHive Consulting (ThreeHive) to conduct a review of the PChAD program and policies. This review included a literature review, interviews with PChAD program stakeholders (Children's Services staff, AHS staff, Police Services staff, guardians and a youth), written comments from judges and clerks, and observations from tours of three PChAD protective safe houses (Red Deer, Calgary, and Edmonton). Inclusion of youth and guardian perspectives in the program review were limited; only two guardians and one youth were interviewed.

Program Review Findings

ThreeHive delivered a final report to Alberta Health in March 2020, providing results, analysis and recommendations emerging from the findings.

This work indicated that all stakeholder groups engaged view the PChAD program as being beneficial to youth experiencing addiction and drug use. Protective safe houses are meeting the mandate of the act and supporting children as they detox and stabilize, though the current length is not enough for some youth.

Key findings of the evaluation included:

- General
    - Information on other programs similar to the PChAD program is limited (e.g., involuntary detox programs in other jurisdictions)
- Accessing the PChAD program:
    - Program awareness and information has improved but still has room for improvement, along with consistency of that information across different sources (e.g., different AHS programs or staff).

- PChAD program operations:
    - Family involvement in treatment is vital. Previous work, including AHS' 2017 evaluation of the PChAD program spoke to the benefits of family engagement; this is echoed as a key values and tenets of recovery-oriented systems of care. The PChAD program offers family counselling during a young person's stay at the protective safe house and guardian engagement via regular phone calls or visits with their child is encouraged.
    - Cross-sector coordination remains challenging (e.g., between AHS and Children's Services, police)
    - Confinement length is inadequate for some youth (e.g., due to longer detox time)
    - Detox is important, and so is treatment, which is not currently part of the PChAD program
- Post-PChAD discharge
    - Outcomes for young people after they have left the PChAD program are currently unknown (e.g., at discharge, at 6 months)
    - Access to recommended post-discharge services is limited. Guardians report that services are sometimes not available in their community or there is a long wait list.

Low participation of youth/parents is a key weakness of the ThreeHive program review, with only two guardians and one young person interviewed. In particular, the program review did not seek or receive input from Indigenous stakeholders, so findings and recommendations do not reflect Indigenous perspectives or experiences.

Stakeholder engagement conducted by the AHS Design Lab (discussed below) sought to ensure Indigenous perspectives were included in the PChAD review by seeking detailed, qualitative input from youth and families, and offering grants to Indigenous organizations to conduct community-led engagement.

Stakeholder Engagements

Additional stakeholder engagement was required to remedy the engagement deficiencies in the ThreeHive review, and vet input gathered during that process.

Alberta Health planned and conducted stakeholder engagement between July and September 2020, targeting:

- Young people experiencing/who have experienced addiction, and their families
- Indigenous communities
- Community stakeholders

Engagement at a glance

Alberta Health heard from:

- 12 young people and 12 guardians, via detailed interviews
- 35 individuals representing 22 community organizations, including youth addiction service providers
- 2 Indigenous communities

See Appendix 2 for a list of participants.

Youth and families

The AHS Design Lab (Design Lab) was engaged to design and conduct in-depth, qualitative user interviews with young people who experience addiction, and their families (guardians). Interviews of youth were conducted by other young people, in a peer-led process.

The Design Lab interviewed 12 young people and 12 guardians. Interviewees were drawn from across Alberta[1], with varying degrees of experience with PChAD (i.e., no admissions, one admission, multiple admissions), and included Indigenous and black participants. To supplement this input Alberta Health reviewed correspondence from Albertans regarding the PChAD program.

Key input received included:

- Accessing the PChAD program

Vignette: Brodie's story

Appendix 4 highlights the PChAD experience of Brodie, one of the youth who shared their story in an interview.

[1] Calgary, Edmonton, Red Deer, Grande Prairie, and Cardston.

- Processes (e.g., pre-application, court) can be difficult to navigate, intimidating, burdensome and traumatizing for families.

- PChAD program operations
  - Youth and families valued that the PChAD program provided a safe, secure place for young people to detox.
  - The length of confinement is not long enough to provide an opportunity for lasting change. Upon leaving the PChAD program, youth may have physically detoxed from substances, but are not yet mentally ready and willing to continue their recovery journey and accept voluntary treatment services. Many youth decline further supports when they leave the protective safe house.
- Post-PChAD discharge
  - The PChAD program did not meet the expectations of many parents, who felt it "did not work" for their child.

  Community resources, including addiction treatment and other supports for youth experiencing addiction are not adequate; resources may be unavailable or have long wait times.

Journey map

Input from youth and families was used to construct a journey map (Appendix 3) that illustrates the actions and emotions youth and families experience during PChAD, and the opportunities they identified for improvements.

Trauma of court

One parent described the shock and distress seeing their child's name on the electronic display outside of the courtroom.

Indigenous communities

Alberta Health used a community-led engagement approach, offering small grants to six regional Indigenous organizations to support them to design and conduct engagement with their communities.

Two organizations, the Metis Settlements General Council and Stoney Nakoda Tsuut'ina Tribal Council applied for and received engagement grants. Engagement grants asked the organizations to report on specific key topics as requested by Alberta Health.

Both organizations conducted a meeting with their health directors for their engagement.

Key input received included:

- Accessing the PChAD program
  - Awareness and understanding of the PChAD program in communities is poor.
  - The PChAD process is burdensome and unrealistic for First Nations and Métis people to access and takes too long for a young person and family in crisis to access services they need (e.g., system navigation, transportation to court and to the safe house).
  - The court process is harmful and stigmatizing for families.
  - The current Act does not allow for non-guardians to apply for protection orders for youth, presenting an issue in cases where non-guardians (i.e. other family members) may be more actively involved in the care of a child.
- PChAD program operations
  - Both communities had limited awareness and understanding of PChAD, but emphasized the importance of ensuring PChAD provides culturally appropriate services that reflect the needs of First Nations and Metis communities.
  - Youth require treatment and ongoing support beyond the 10-15 day detox time the PChAD program offers (e.g., addiction, mental health, family and social services support).
- Post-PChAD discharge
  - Youth and families living in Metis settlements do not have access to the addiction and mental health resources they need outside of the PChAD program. Services are often not available in or near to the community and those that are have long wait times.
  - There appears to be poor understanding of the outcomes for young people after they leave the PChAD program (e.g., Do they enter treatment? Do they continue using substances?).

Community stakeholders

To seek feedback from other stakeholders the Design Lab held two online community workshops. Participants included PChAD program and other addiction service providers, AHS, community, professional and school organizations, interest groups, and Indigenous organizations.

Workshops sought input from stakeholders on the current and potential future state of the PChAD program. Stakeholders also had the opportunity to provide feedback on what was heard from youth and family interviews.

Key input received included:

Stakeholders in the provider ecosystem indicated they appreciated the opportunity to come together and discuss shared concerns.

- Overall
  - Input received from youth and families (described above) is generally reflective of the experience of workshop participants.
- It is important that appropriate services are available to support youth at all stages of their addiction and recovery journey.
- Accessing the PChAD program
  - Some community organizations (e.g. school boards) lack awareness and understanding of the PChAD program.
- PChAD program operations
  - Some youth would benefit from services not currently available (or widely available) at protective safe houses, such as medically supported detox and mental health supports. Though many youth admitted to the PChAD program have diagnosed or probable concurrent disorders, supports to appropriately care for such youth are currently limited.
  - Diverse feedback in support of and against increasing the length of confinement and mandatory treatment.
    - Those supporting these ideas typically referred to a desire to keep youth safe and to provide youth with more time in PChAD to decide to pursue treatment. These stakeholders felt that mandatory treatment although not ideal, is better than no treatment.

        - Stakeholders who disagreed with these ideas often referred to the destabilizing effect secure care can have on youth (e.g., impact on family relationships), and felt the possible benefits of mandatory treatment do not outweigh the potential harms.
    - It is important that PChAD program services are based on evidence and best practice.
    - There is a lack of communication and integration of services (e.g., AHS, justice, community).
- Post-PChAD discharge
    - At discharge, many youth are not psychologically ready for treatment and require more time to be ready for change.

Legislative Review

As the PChAD Act implicates a range of complex legal issues related to the *Canadian Charter of Rights and Freedoms* (*Charter*) privacy and other rights of the young person subject to a PChAD protection order, Meadows Law was contracted to conduct a legislative review.

The legislative review involved a jurisdictional scan of secure care legislation in Canada and internationally, identification and analysis of legal issues relevant to the PChAD Act, and providing recommendations respecting those issues.

Charter

The PChAD Act implicates a number of *Charter* rights, including:

- The right to liberty, under section 7 of the *Charter* (the youth does not have a choice about being detained)
- The right to security of the person, under section 7 of the *Charter* (the state is interfering with the personal autonomy of the youth)
- The right not to be arbitrarily detained or imprisoned, under section 9 of the *Charter*
- It also has the potential to engage section 12 of the *Charter*, which deals with the right not to be subjected to any cruel and unusual treatment or punishment.
    - Detention for non-punitive reasons has been considered a treatment and will be determined to be 'cruel' and 'unusual' if the law is grossly disproportionate to the objective of the law.

When developing legislation, governments must seek to protect *Charter* rights as much as practicable. Where legislation may negatively impact *Charter* rights, that impact must be reasonable, demonstrably justified and most provide proper procedural protections (e.g., in secure services, the right to seek a review of the protection order). In other words, the PChAD Act must achieve its legislative and policy objectives while recognizing and respecting youth's *Charter* rights.

Parental and young person's rights

With respect to parental rights, parents are generally presumed to act in their child's best interest. The PChAD Act and program involves parents, and assists them to act in their child's best interests and is not a situation where the state is interfering with the parent-child relationship.

Some secure care legislation defines how a person is required to consider the best interests of the youth, though the PChAD Act does not currently contain such a definition.

From the perspective of the rights of the young person, the question is whether the PChAD Act achieves the objectives of the legislation while recognizing and respecting the rights of the youth as a person under the *Charter*. To achieve this, secure care legislation has key provisions for ensuring that the young person's rights are protected and that the focus remains in the best interests of the young person. Provisions vary by statute but may include:

- The young person may apply for review of confinement
  - Under the PChAD Act the young person may request the order be reviewed by a judge.
- Access to a lawyer
  - Young people confined under the PChAD Act are informed that they have the right to a lawyer and are provided with the telephone number of the Legal Aid Society of Alberta.
- Provision of information to the young person about their rights
  - On admission to a protective safe house, youth are informed about their rights (e.g., to a lawyer, to request a review of the order).
- Assessments of the young person at specified times
  - While confined at a protective safe house, the youth must be assessed. However, the PChAD Act does not require assessment of a youth prior to a protection order being granted; the decision whether to confine a youth is made by a judge on the basis of evidence presented to them by the youth's guardian.
  - PChAD-like legislation in Saskatchewan[2] and Manitoba[3] require that a specialist (e.g., physician, addictions counsellor) assess the young person on arrival at the detoxification facility. If the specialist finds that the young person does not meet the criteria for confinement, the young person is released. The assessment and agreement of a second specialist is also needed to continue to confine the young person for the duration of the order.

[2] *The Youth Drug Detoxification and Stabilization Act*
[3] *The Youth Drug Stabilization (Support for Parents) Act*

- Assessments in order to initiate and continue secure care are a key factor in the protection of a minor's rights under the *Charter*, and provide a safeguard for ensuring that detention is in the best interests of the minor.

Length of time for confinement

Some stakeholders would like the length of confinement under the PChAD Act to be increased from the current 15-day maximum to at least 30 days. Stakeholders differ in the reason they want the confinement length increased. Reasons heard as part of this review include to provide additional time to detox from substances, to provide additional time for psychological stabilization (and so hopefully make a decision to pursue treatment), or to ensure a young person remains in a safe location.

The length of confinement under the PChAD Act is currently comparable with other provinces with similar legislation (i.e., PChAD-like statues), where the maximum confinement is between 7 and 20 days.[4] Increasing the length of confinement would require an amendment to the PChAD Act, and would need to be supported by evidence showing that the increased confinement length is proportional to Act's objectives, and includes procedural protections for the youth.

Inclusion of treatment

In other Canadian jurisdictions with secure care legislation specifically for substance use (i.e., PChAD-like statues), their mandate is similar to that of the PChAD Act: detoxification, assessment, and stabilization. Though treatment plans are typically developed, treatment is not mandatory.

There is precedent in Alberta for involuntary treatment, particularly of minors, under the *Mental Health Act*. Under that Act, nearest relatives can make treatment decisions for an individual if they are a minor or a qualified health professional deems them mentally unfit to make decisions themselves.

If treatment were to be part of the PChAD program, certainty regarding consent to treatment would be important (i.e., be certain who can and cannot consent to treatment of the young person while confined under the Act). As the PChAD Act does not contain such provisions and Alberta does not have omnibus consent and capacity legislation, it would be necessary to include consent to treatment provisions in the PChAD Act.

---

[4] The *Secure Withdrawal Management Act* (Newfoundland) provides for a maximum confinement of 20 days, but is not in force. With respect to legislation in force, the longest maximum confinement length is 15 days (Alberta's PChAD Act and Saskatchewan's *Youth Detoxification and Stabilization Act*)

Analysis

Throughout this review, a common theme was that the PChAD program is valued as a safe place for youth to detox; a place where they are not at risk of the many different harms they usually encounter. This was heard from guardians, community organizations and even youth.

Many of the young people admitted to the PChAD program have refused voluntary supports, or if they were to seek them, would have difficulty accessing other services due to admission restrictions (e.g., past behaviour, criminal involvement). Guardians have often exhausted all other options before turning to the PChAD program. In addition to safe detox, the PChAD program tries to connect youth to supports and services they can use to build their recovery capital.

Following the 2017 AHS evaluation of the PChAD program, AHS has successfully implemented improvements in a number of areas, including PChAD program information availability and consistency, information sharing with guardians, and staff training.

Despite these strengths, there are r issues in program design and operation. Specific program changes, outlined below, would enable PChAD to better support youth through detox, take the next steps on their recovery journey, and improve outcomes for young people and their families. Implementing these changes would also more firmly root PChAD within a recovery-oriented continuum of care for youth who experience addiction.

These issues can be grouped into three categories: accessing the PChAD program, PChAD program operations (i.e. at the protective safe house), and post-PChAD.

Accessing the PChAD program

Since the 2017 AHS PChAD program evaluation, AHS has made improvements in the accessibility of the PChAD program, with better availability and consistency of information.

However, accessing the PChAD program continues to pose difficulties for guardians. This includes lack of awareness, difficulty navigating the process or barriers posed by systems not designed for families in crisis. Indigenous engagement identified potential issues where a youth's parent or guardian may not be well positioned to determine if a protection order is needed, as other family members may be more involved in day-to-day care. Should changes to the PChAD Act be contemplated in the future, consideration should be given to extending criteria to allow other individuals involved in a youth's life to apply for a protection order.

Improvements to information availability and awareness among community organizations and Indigenous communities are required. Many community organizations lack familiarity with the PChAD program and awareness in Indigenous communities is also low, as evidenced by

feedback received in stakeholder engagements. Once families have started the application process, the system is complex and burdensome for families to understand and navigate, especially for Indigenous people. Processes can be traumatic, stigmatizing and create barriers.

People in remote and rural communities face greater difficulties accessing the PChAD program. Lack of transportation options in these communities and long travel times make it challenging for parents/guardians to access court services to secure a PChAD protection order, and youth are taken far away from their communities and support structures to access the protective safe houses. Lack of trained police in rural and remote communities, compounded with the time required to transport youth across large distances (especially in northern Alberta), make transportation to the protective safe house difficult. Future consideration could be given to improving transportation options or adding safe house locations, which would require additional engagement with stakeholders and partners.

PChAD program operations

Services at PChAD protective safe houses are targeted to meet the mandate of the legislation: detox, stabilization and assessment. However, operational variation between the four protective safe houses and coordination with other service providers is an ongoing issue, leading to different supports available to youth depending on the safe house to which they are admitted. Greater provincial oversight of policies, processes and procedures would help align the four protective safe houses and improve coordination.

Indigenous young people have access to Elders while at the protective safe house, however there are opportunities to improve. Indigenous stakeholders emphasized that to meet the needs of Indigenous youth and continue to provide culturally safe services, the PChAD program should support wise practices rooted in Indigenous knowledge, making space for these teachings and practices in protective safe houses.

Stakeholders also noted that youth admitted to PChAD are also sometimes admitted to other secure settings, where there are similar and overlapping issues to those discussed in this review. Though information sharing with families (e.g., treatment plans) and coordination with other services has improved in recent years, it still requires improvement. This would help better coordinate a youth's care when they leave the PChAD program. Many youth interviewed would also like to see peer support offered during and after their stay at a PChAD protective safe house. Better connection to community services and peer supports helps toward the youth's long-term journey to recovery.

Into Focus reported that some youth spend a lot of their time physically withdrawing, with little time to engage in services. Though the current confinement length under the PChAD Act is in line

with similar legislation of other jurisdictions, many stakeholders and the ThreeHive program review also called for a longer period of confinement at the protective safe house to increase the likelihood youth are able to make a decision to continue their recovery journey. Other Alberta legislation providing for secure care of minors has longer potential confinement periods (e.g., the *Child, Youth and Family Enhancement Act* allows for up to 30 days confinement under a secure services certificate).

Throughout the review, all stakeholders agreed that treatment is important for youth experiencing substance use. A significant proportion of youth decline voluntary treatment after discharge from the PChAD protective safe house; data from AHS indicate that roughly 45% of youth who accessed the PChAD program in 2019 accessed AHS addiction and mental health services within 30 days of discharge.[5] Uptake of voluntary treatment options may be hindered by a youth's neurological development; the brain's frontal lobe undergoes substantial changes during the teenage years, which can produce motivational and judgement challenges even for youth who do not experience addiction. Stakeholders shared diverse perspectives on how best to increase the number of youth receiving treatment. Mandatory treatment would ensure youth receive treatment, though evidence on the potential harms and benefits of involuntary treatment is complex and at present unclear. Additional work is required to gain a better understanding. Future consideration may be given to mandatory treatment for some youth, guided by an assessment of the best interests of the young person. For example, it is possible that provisions for treatment decisions on behalf of a patient included in Alberta's *Mental Health Act*, Part 3, sections 26-28, could serve as a foundation upon which to build similar considerations in the PChAD Act. Section 28(4) of the *Mental Health Act* also specifies considerations for determining the best interest of the patient, which could be adapted into the PChAD Act. Treatment could also be made more accessible by improving access to voluntary recovery-oriented services after their PChAD protective safe house admission (discussed below).

Mandatory treatment and a longer detention length would both require amending the PChAD Act and implicates complex legal issues (e.g., *Charter* rights) which would require substantial additional analysis and development. Should amendments to the PChAD Act be contemplated in the future, consideration could be given to exploring these elements.

[5] This number does not include youth accessing non-AHS services in communities, which is not captured in AHS data. The actual number may be higher.

Post-PChAD discharge

Parents and most youth find the time at the PChAD protective safe house valuable, but struggle to build on any momentum generated to take further steps on their recovery journey. Though youth leave with a treatment plan, it is often up to the family to take the next steps towards engaging services; the PChAD program ends at discharge. Young people and families report feeling on their own and asking "so what now?" Treatment options can be limited and navigating the system alone after discharge from the protective safe house is daunting.

Families and youth require more support to access health, social and peer support services after discharge from the protective safe house, and a smoother transition from the safe house into these services. Many youth accessing the PChAD program build strong, trusting relationships with protective safe house staff, and continuing contact with staff could address this transition and navigation issue. Active case management by protective safe house staff both during and after the youth's stay could help maintain these relationships, provide the youth with added motivation to follow through on the treatment plan, and provide extra information and support to families. This approach would also support obtaining better data on outcomes for young people post-PChAD. By making it easier for youth and families to follow treatment plans, more youth can be engaged in treatment and recovery.

Existing initiatives can also be leveraged to support increased access to youth addiction treatment. The Government of Alberta is on track to exceed its original goal of adding 4,000 publicly funded treatment spaces to support Albertans dealing with addiction and mental health issues. It is anticipated that this initiative will increase the number of youth treatment spaces, supporting youth and their families across Alberta to more easily access addiction and mental health supports.

Not enough is known about the outcomes for youth discharged from the PChAD protective safe house as AHS does not conduct post-discharge follow-up. In order to know if the PChAD program, and potential changes to the PChAD Act, are helping youth, government needs to understand youth outcomes better (e.g., via exit and follow-up surveys).

Youth admitted to PChAD are also sometimes admitted to one more or other secure care programs. However, many of the issues with the PChAD program are shared by other secure services in Alberta, for example coordinating different services for youth and sharing information between providers. All programs also find meeting the needs of the complex youth admitted (e.g., mental health, addiction, trauma, homelessness) during confinement, planning for post-discharge supports, and transition to adult services challenging. Multiple external reviews have recommended a joint review of all secure care legislation in Alberta. Most recently, the 2020 Multi-Sector Review recommended the Government of Alberta review secure settings to

determine if they are meeting the needs of youth with complex service needs. Some of the other findings of this review, such as the difficulty families report in navigating the PChAD process, especially when in crisis, and the feedback from Indigenous communities regarding the important role non-legal guardians may play in a young person's life, could be considered and possibly addressed via a review of secure settings.

Alberta Health will continue to work with partners, including Children's Services, to ensure that the findings of this review are incorporated into any work to respond to the recommendations of the Multi-Sector Review.

Minister-Approved Actions and Next Steps

Based on the key themes that emerged and analysis of these themes, the following actions for changes to the PChAD program are outlined.

Actions were developed with a mind to ensuring PChAD program services are evidence-based and carefully designed so that they meet the needs of young people and their families, which was a key recommendation from the review.

Actions were developed in consideration of findings from the program review, legislative review and stakeholder engagement.

The actions below will involve additional development with stakeholders, including AHS, other Government of Alberta ministries, and community stakeholders. Additional work will also identify what additional funding may be required. Work to implement these actions will begin in 2021.

Actions for Program Change

Accessing the PChAD program

1. *AHS* to develop consistent materials and venues for community engagement to increase the awareness and understanding of the PChAD program among youth-serving organizations and institutions (e.g., not-for-profits and school boards), First Nations, Métis communities and organizations, Indigenous-serving organizations, and parent-supporting organizations.

2. *Alberta Health* to work with Justice and Solicitor General to develop policy to enable ongoing access to teleconferencing for rural and remote families to use when applying for or reviewing a PChAD protection order with the Provincial Court, where infrastructure and funding opportunities are available.

PChAD program operations

3. *AHS Provincial Addiction and Mental Health* to develop consistent standards and reporting across all protective safe house sites, and look to find efficiencies in program delivery.

4. *AHS* to increase information sharing with parents/guardians on the progress of their child through the program, and increase information sharing and coordination with community addiction treatment providers, mental health providers, and peer supports to create pathways for youth post-discharge.

5. *AHS* to improve community connections for Indigenous youth accessing the PChAD program by working with the AHS Indigenous Health Hub, and First Nations and Métis communities and organizations, and review PChAD program policies to identify and remove any barriers to supporting Indigenous cultural and healing practices.

Post-PChAD discharge

6. *AHS* to facilitate smooth transition to post-PChAD program services, including where possible facilitating direct connection or referral to recovery-oriented services prior to discharge from the protective safe house.

7. *Alberta Health to work with AHS* to build stronger relationships between the PChAD program and the wider addiction treatment ecosystem to create clearer pathways for youth to access recovery-oriented services and supports post-discharge.

8. *AHS* to develop and implement outcome measurement tools to better understand the short and mid-term outcomes for youth leaving the PChAD program, and use these data for continuous, evidence-based improvement.

.

Appendices

Appendix 1 - Cross Jurisdictional Comparison

	British Columbia *Bill 22: Mental Health Act Amendment Act* **(not passed)**	**Alberta** *Protection of Children Abusing Drugs Act*	**Saskatchewan** *The Youth Detoxification and Stabilization Act*	**Manitoba** *Youth Drug Stabilization (Support for Parents) Act*	**Newfoundland** *Secure Withdrawal Management Act* **(not in force)**
Age of the young person	Under 19 years	Under 18 years	12-17 years	Under 18 years	12-17 years
Who can make an application	Physician	Guardian	Guardian, person with a close personal relationship, or youth worker	Guardian	Facility manager, with guardian's consent
Who receives an application	Stabilization facility	Court	Court	Court	Court
Child is assessed[6] before order issued	Yes	No	Yes	Yes	At the discretion of the judge
Initial length of confinement	2 days	10 days	5 days OR 30 day community treatment order	7 days	10 days
Length of extended confinement	7 days	5 days	15 days	None	10 days
Right of young	Yes, to the facility	Yes, to the court	Yes, to a review panel	Yes, to a review panel	Yes, to be re-assessed, or to the court

[6] Assessed or examined by health care practitioner (e.g., physician, addiction specialist, nurse)

	British Columbia *Bill 22: Mental Health Act Amendment Act* **(not passed)**	**Alberta** *Protection of Children Abusing Drugs Act*	**Saskatchewan** *The Youth Detoxification and Stabilization Act*	**Manitoba** *Youth Drug Stabilization (Support for Parents) Act*	**Newfoundland** *Secure Withdrawal Management Act* **(not in force)**
person to review					
Right of young person to legal counsel	Must be informed or right to a lawyer at admission	Must be informed or right to a lawyer at admission	Right to a lawyer during a review	Must be informed of right to a lawyer at apprehension and admission	Must be informed of right to a lawyer upon apprehension, and after admission

Appendix 2 - Stakeholder Listing

Workshop participants

Name	Organization, role
Joel Mader	Alberta Adolescent Recovery Center (AARC)
Donny Serink	Alberta Adolescent Recovery Center (AARC)
Kenton Puttick	Alberta Health
Kim Eggen-Armstrong	Alberta Health Services
Ann Harding	Alberta Health Services
Jan Olson	Alberta School Board Association
Alessandra Venturo	Boys and Girls Club Calgary
Craig Barabash	Calgary United Way
Denise Milne	CASA services
Troy Janzen	College of Alberta Psychologists
Christina Riehl	College of License Practical Nurses of Alberta
Chris Sullivan	Enviros Wilderness School Association
Pam Long Time Squirrel	Kainai Children Services
Carolyn Wells	Kainai Children Services
Julie Walker	Métis Child and Family Services
Whitney Issik	MLA, Calgary-Glenmore
Angela Welz	Moms Stop the Harm
Laura Hynes	Nightwind Treatment Centre
Carol Moores	Nightwind Treatment Centre
Larissa Toutant	Nightwind Treatment Centre

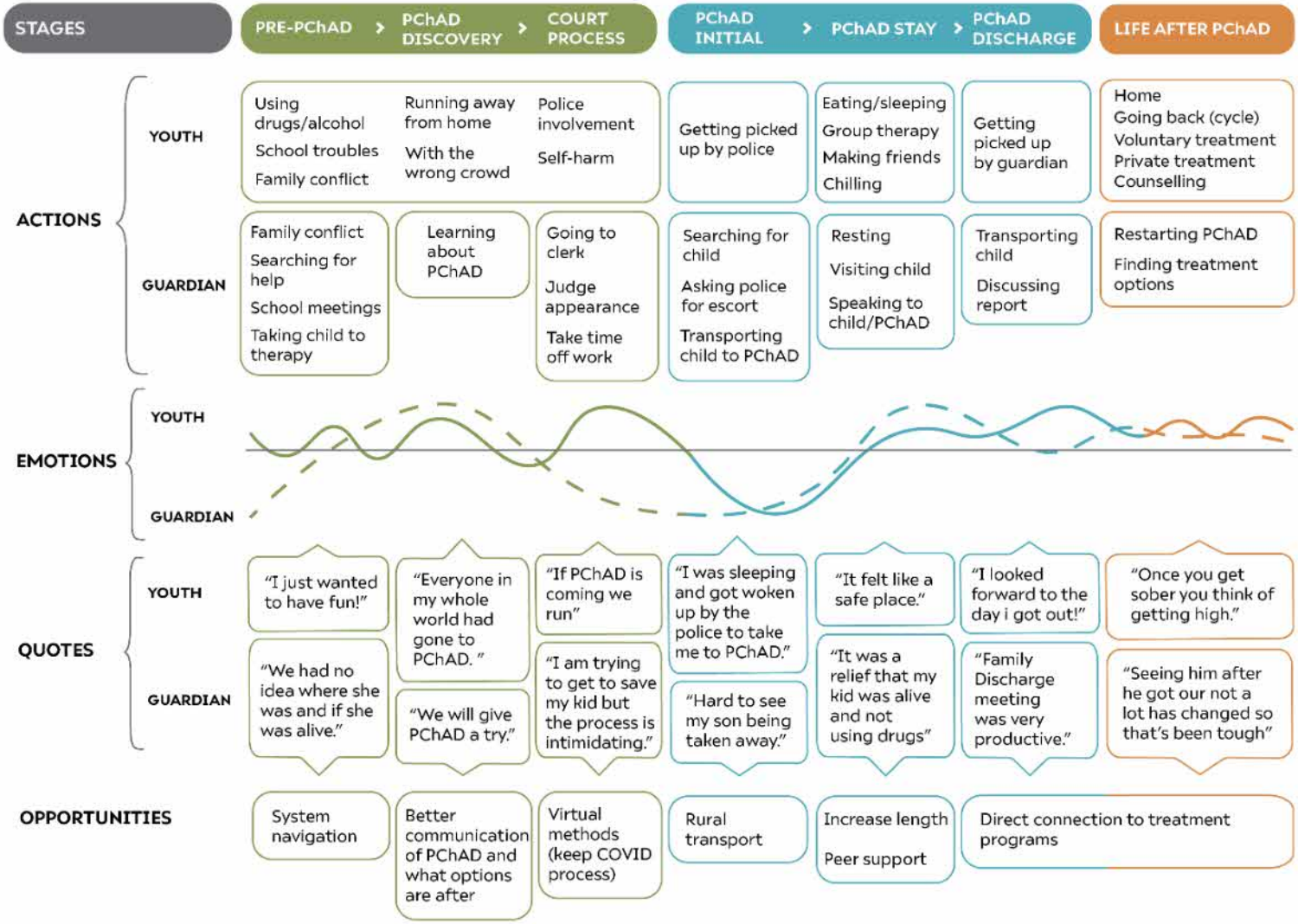
Lerena Greig	Parents Empowering Parents Society
Tracy Palmquist	PChAD Protective Safe House Manager
Valerie Daoust	PChAD Protective Safe House Manager
Amy Cote	PChAD Protective Safe House Manager
Rick Oliver	PChAD Protective Safe House Manager
T Malcolm Campbell	Physician
Kim Stone	RCMP
Samantha Lowe	The Mustard Seed Society
Nancy Dyer	Venture Academy
Teresa Hay	Venture Academy
Chelsea Mulvale	We Matter Campaign
Frances Moore	We Matter Campaign
Brian Ross	Wood Buffalo Wellness Society
Jo-Anne Packham	Wood Buffalo Wellness Society
Angela Ross	Wood Buffalo Wellness Society
Jessica Day	Youth Empowerment and Support Services (YESS)
Carol Moores	Youth Success

Appendix 3 - Journey Map

Thematic analysis was conducted of all the interviews to identify emotions, quotes, and opportunities for both families and youth. These were mapped onto a journey map (see following page).

A journey map is a visual representation to describe step by step how a service-user interacts with a service or a system.

PChAD Journey Map



Appendix 4 - Vignette: Brodie's Story

Although every young person has their own story and experience, Brodie's story is emblematic of the strengths of PChAD and how complex it can be to help youth recover from addiction.

Brodie, adopted as a child, was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Fetal Alcohol Spectrum Disorder (FASD). He used to do well in school but started doing weed (cannabis) and got into the wrong crowd. At the age of 13, he got kicked out of his home and started staying at the shelter. He eventually got introduced to meth (methamphetamine) and molly (ecstasy) and started getting in trouble with the police. According to Brodie, he initially started doing the 'heavier' drugs for fun and finally started using them to deal with his difficult life situation.

"People do drugs to numb the pain or survive…. When you get dumped by your whole family and get on the street it f**** with your brain." Brodie also mentioned that he was also selling drugs so that he could make enough money to eat and survive. His mother still had guardianship over him; she felt worried about his safety, so she asked the social worker for help and the social worker told her about PChAD. For Brodie, getting woken up one day by the police to get escorted to PChAD was a very unpleasant experience.

"I was really angry and hated my mom!" "The first two times I was there was because I was doing meth. The other times I was there just because I was doing weed." Brodie didn't like being involuntarily confined for ten days at PChAD, but soon he started to like it there.

"At PChAD, you have to follow the rules. There is a routine you have to follow, and the discipline helps. You get to do exercise, go outside. Every single day you have two classes as a group and to work on yourself. I was a shelter kid, so I never ate enough food. In PChAD, you got five meals a day. It's like a group home… it's kinda nice!"

Brodie found PChAD helpful; he mentioned, "I wouldn't have stopped if it wasn't for the staff who cared about me." However, Brodie went to PChAD five times and what made him change was that "the detox helps you enough to clear your mind to start thinking of what are you going to do with your life." Brodie believed it came down to his will power to break the cycle. However, he felt many kids at PChAD are in difficult situations and without support it can be difficult to break the cycle.

"Lots of kids at PChAD are from rough backgrounds and have nothing to live for….kids are doing drugs because of their mental illness, and they don't have the right supports to help them."

Brodie is now 19. He receives Assured Income for Severely Handicapped (AISH) and has started going to adult school. "I now have enough money to cover my basic necessities. I don't have to sell or do drugs to survive. I can start focusing on other things." He plans to go to college and learn a trade skill to become self-employed.

	British Columbia *Bill 22: Mental Health Act Amendment Act* **(not passed)**	**Alberta** *Protection of Children Abusing Drugs Act*	**Saskatchewan** *The Youth Detoxification and Stabilization Act*	**Manitoba** *Youth Drug Stabilization (Support for Parents) Act*	**Newfoundland** *Secure Withdrawal Management Act* **(not in force)**
Age of the young person	Under 19 years	Under 18 years	12-17 years	Under 18 years	12-17 years
Who can make an application	Physician	Guardian	Guardian, person with a close personal relationship, or youth worker	Guardian	Facility manager, with guardian's consent
Who receives an application	Stabilization facility	Court	Court	Court	Court
Child is assessed[1] before order issued	Yes	No	Yes	Yes	At the discretion of the judge
Initial length of confinement	2 days	10 days	5 days OR 30 day community treatment order	7 days	10 days
Length of extended confinement	7 days	5 days	15 days	None	10 days
Right of young person to review	Yes, to the facility	Yes, to the court	Yes, to a review panel	Yes, to a review panel	Yes, to be re-assessed, or to the court

[1] Assessed or examined by health care practitioner (e.g., physician, addiction specialist, nurse)

Right of young person to legal counsel	Must be informed or right to a lawyer at admission	Must be informed or right to a lawyer at admission	Right to a lawyer during a review	Must be informed of right to a lawyer at apprehension and admission	Must be informed of right to a lawyer upon apprehension, and after admission

Of note, Saskatchewan's *Youth Detoxification and Stabilization Act* also provides for 30-day community orders, allowing the young person to receive detoxification, assessment and stabilization services in the community.

Internationally, New Zealand enacted the *Substance Addiction Compulsory Assessment and Treatment Act* in 2017. The Act authorizes a compulsory treatment order for a person (adult or child) with a severe addiction with impaired capacity to make treatment decisions. Certificates are valid for a maximum of 56 days or until a person no longer meets the criteria under the Act (whichever is earlier).

Protection of Children Abusing Drugs

Program Review

Prepared for Alberta Health by

ThreeHive CONSULTING

Acknowledgements

Three Hive Consulting would like to acknowledge the important contributions of staff at Alberta Health, Alberta Health Services and the PChAD Protective Safe Houses, as well as the youth and guardians who participated in interviews.

Authors

Shelby Corley, MA CE

Samantha Larose, MSc CE

ThreeHive CONSULTING

March 2020

Table of Contents

Executive Summary

Alberta's *Protection of Children Abusing Drugs* (PChAD) *Act* intends to help children and youth under the age of 18 whose use of drugs (including alcohol) presents a danger to themselves or others. The PChAD Program is funded by Alberta Health and operated by Alberta Health Services. Legal guardians of children and youth under the age of 18 may apply for a protection order if their child's drug use is causing significant psychological or social harm to the child, or physical harm to the child or others. The child may be confined in a Protective Safe House (PSH) for up to ten days, where they are assessed, treated for detoxification and provided with services to stabilize.

In 2018, the Office of the Child and Youth Advocate released its investigative review "Into Focus: Calling Attention to Youth Opioid Use in Alberta," which included a recommendation to review the PChAD Act and its policies to support improvement of services for children, youth and their families. This evaluation is a response to that 2018 investigative review.

This evaluation poses questions about the acceptability, accessibility, appropriateness, effectiveness, efficiency and safety of the PChAD Program. Sources of data include:

- Literature review of best practices and other programs related to involuntary confinement of youth
- Interviews with seven Children's Services staff, 20 Alberta Health Services staff and four Police Services staff
- Written comments from two judges and 20 clerks
- Interviews with two parents/guardians of PChAD participants
- One PChAD participant
- Observation of three Protective Safe Houses
- Alberta Health Services' 2017 evaluation of the PChAD Program

Key findings and recommendations

Information about PChAD has improved, but should be more consistent

Recommendations: Identify ways to enhance program awareness, and ensure consistency of information across AHS sites, programs and staff.

Youth outcomes are unknown

Recommendations: Develop and implement a system for continuous monitoring of program performance, including standardized outcome assessments and post-discharge surveys of guardian and youth experiences.

Cross-sector coordination remains challenging

Recommendations: Explore solutions to allow staff within and outside of AHS to view real-time bed availability at PSH sites. Establish information sharing agreements across PChAD/AHS and Children's Services to reduce wait times for client information.

Confinement length is inadequate for some youth

Recommendation: Explore options for length of confinement. Consider a minimum length of 15 days, with the option for the initial court order to be up to 30 days if recommended through an AHS assessment.

PChAD is important, and so is treatment

Recommendation: Consider extending the mandate beyond detox to include the possibility of treatment.

Access to recommended post-discharge services is limited

Recommendations: Ensure all staff understand the availability of post-treatment options – what services are available, where are they located, and when they may be needed by PChAD youth. Explore IT solutions that can help with the coordination of treatment planning at discharge.

Family involvement in treatment is vital

Recommendation: Explore ways to better integrate families into PChAD and treatment planning to better support youth in implementing change post-program.

Information on similar programs is limited

Recommendations: Continue to monitor the literature for new information on best practices for involuntary detox and stabilization services for youth. Share learnings from PChAD at conferences and journals to encourage communities of practice and knowledge sharing.

Introduction

Alberta's *Protection of Children Abusing Drugs* (PChAD) *Act* intends to help children and youth under the age of 18 whose use of drugs (including alcohol) presents a danger to themselves or others. Legal guardians of children and youth under the age of 18 may apply for a protection order if their child's drug use is causing significant psychological or social harm to the child, or physical harm to the child or others. Before applying for a protection order, guardians must attend a PChAD Pre-Application Information Session with an AHS addiction counsellor.

The Provincial Court of Alberta then issues a protection order authorizing a police officer to apprehend and convey the child to a protective safe house (PSH) or assist the guardian in conveying the child to a protective safe house. The period of confinement in the protective safe house may be no more than ten days. There may be a delay in acting upon the protective order while awaiting availability of a bed in an Alberta Health Services facility, which are located in Calgary, Red Deer, Edmonton and Grande Prairie.

While in the safe house, the child is assessed, treated for detoxification and provided with services to stabilize. The child may be discharged earlier than ten days if such discharge is deemed appropriate. Recommendations for ongoing treatment may be made. Guardians are responsible for picking up their child at the end of the period of confinement.

Alberta's PChAD Act came into effect in 2005. In 2018, the Office of the Child and Youth Advocate released its investigative review "Into Focus: Calling Attention to Youth Opioid Use in Alberta," which included a recommendation to review the PChAD Act and its policies to support improvement of services for children, youth and their families.

This evaluation is a response to the 2018 investigative review and acts as an external follow-up to the internal PChAD evaluation conducted by Alberta Health Services in January 2017[1]. This report is referenced several times in this evaluation report.

---

[1] *Alberta Health Services (2017), Protection of Children Abusing Drugs (PChAD): Final Evaluation Report 2017*

Evaluation Overview

In February and March 2019, Three Hive Consulting worked with Alberta Health to develop a plan to guide the evaluation of the PChAD program. The following six dimensions were used to guide the primary evaluation questions as well as the relevant sub-questions. The themes and questions are presented in the figure below followed by an overview of methods.

Themes & Questions

Acceptability	To what extent is the PChAD Program administered in a way that is respectful and responsive to user needs, preferences and expectations? expectations?
Accessibility	To what extent is the PChAD Program accessible to those who need it?
Appropriateness	To what extent is the PChAD Program aligned with accepted or evidence-based practice?
Effectiveness	To what extent is the PChAD Program achieving its intended outcomes?
Efficiency	To what extent are resources required for the PChAD Program used optimally?
Safety	To what extent are mechanisms in place to minimize opportunities for children to be harmed as a result of their involuntary detention?

Data Sources

The following data sources were used to answer the evaluation questions. Prior to undertaking any data collection, an ethical review of the project was completed using a screening tool developed by A Project Ethics Community Consensus Initiative (ARECCI) as part of Alberta Innovates[2]. In addition to the screening tool, a Second Opinion Review was completed to ensure data collection methods and tools were ethical and all potential risks were identified. Data collection tools can be found in Appendix B.

Literature Review

In February and March of 2019, a literature search was conducted to obtain information about best practices and other programs related to involuntary confinement of youth. The literature search started with a key terms search in peer-reviewed journals and was followed by a review of reference lists from all found articles. Additional information about the literature search methodology is presented below.

- Databases included: Academic Search Complete, PubMed, EBSCO, Google Scholar (to identify any journals missed by the first three databases).
- Search terms included, but were not limited to:
    - youth; adolescents; young people; teen*; child*
    - involuntary treatment/detention/confinement; mandated/coerced care; detox*; addiction; substance/drug abuse; drugs; protective safe house; detox facilities
- Other search criteria: English language and one of the 34 OECD nations.

Initially only peer-review sources were included. Due to the lack of relevant articles, grey literature (e.g. letters to journals, commentary, brochures) was included. A list of sources used for this work can be found in Appendix A.

Interviews

Interviews were planned for several stakeholder groups: Alberta Health Services (AHS) staff, Children's Services staff, Police Services, judges, parents/guardians and children. Only two interviews were conducted with a parent or guardian, one interview was completed with

[2] https://albertainnovates.ca/programs/arecci/

a child and no interviews were conducted with judges. There was a lack of willingness to participate and limited capacity for PChAD staff to recruit more participants from these stakeholder groups.

Contact information was provided for 31 AHS staff, eight Children's Services staff, and four police services staff. Interview participants represented multiple zones and PChAD PSH sites (Calgary, Edmonton, Grande Prairie, and Red Deer). The selected staff represented various roles including leadership, counsellors, care assistants, case workers, sergeants, and other allied health professionals. Invitations to participate were sent by email directly by Three Hive Consulting or through a PChAD site manager. Participants were contacted for participation up to three times.

- 20 AHS staff interviews were completed from March through May 2019
- Seven interviews were completed with Children's Services staff in August and September 2019.
- Four interviews were conducted with Police Services staff in September 2019
- Two parent interviews were conducted in October 2019
- One interview with the former PChAD youth was completed in November 2019
- Two judges and nine clerks provided written comments on interview questions in November and December 2019

Interviews were all conducted over the phone and recorded. Audio recordings were then transcribed prior to be analyzed for key themes.

Site Visits

The Project Lead and Research Consultant from Three Hive Consulting were invited to tour the PSH sites to obtain a better understanding of the program and apply findings to this evaluation. In March 2019 tours were scheduled and completed at three of the four PSH sites.

Results

Results are presented for each of the six main themes: acceptability, accessibility, appropriateness, effectiveness, efficiency, and safety. For each theme, the primary associated question is highlighted followed by results for each of the accompanying sub-questions. Findings are also organized by the source of data. Where relevant, findings from the 2017 PChAD evaluation conducted by Alberta Health Services is also presented.

1. Acceptability

To what extent is the PChAD Program administered in a way that is respectful and responsive to user needs, preferences and expectations?

1.1 To what extent are guardians satisfied with their experience?

Parent Interviews

Both parents interviewed for this evaluation were satisfied with the program and felt that it was a good experience for them and their child.

> *"...it went perfectly fine, it was excellent. The only thing I didn't like about it was waiting in court at the hearing, that's the only thing I didn't like. Other than that, it went good."*

One parent felt that the program is 'pretty realistic' and gave their child what they needed in the moment. However, this parent felt that their child could have had more mental health assessments.

> *"Overall, I think it served its purpose and gave him some time to get clarity."*

January 2017 Evaluation Findings

In 2016 AHS conducted three focus groups with parents and/or guardians in Calgary, Edmonton and Grande Prairie as well as discharge (n=139) and follow-up (n=27) surveys following involvement with the PChAD program. A major theme across these sources of data included information availability and a lack of consistency in information.

With regard to their experiences accessing the PChAD program, some of the main themes from the focus group included inconsistent information and challenges associated with the complexity of accessing the program. The participants also expressed frustration during the initial phases of obtaining the court order. When asked about overall satisfaction, focus groups participants felt that the program should be a minimum of 30 days with the ability to tailor length of stay to individual children needs.

The parent/guardian survey found that the majority of parents were happy with the feedback and communication while their child was at the PSH. However, a couple of parents in the focus group expressed feeling excluded during their child's PChAD involvement. In the follow-up survey, 70% of parents were "very satisfied" or "somewhat satisfied" with the assessments and recommendations their child received while at the PSH.

Staff Interviews

Interviews with AHS staff working in the PChAD protective safe houses and Children's Services staff included questions about the perceptions of the parent or guardian experience. More specifically, questions focused on feedback received from parents and the extent to which improvements were made to improve guardians' experiences.

Around half of staff reported that guardians felt overwhelmed by the process of obtaining the court order and gaining access to PChAD for their youth. Several staff explained that the process is felt to be complicated for families. Moreover, a few staff felt that the strain was more around navigation of the system, rather than a lack of information.

Staff were not explicitly asked about parent or guardian satisfaction with the program although a few felt that parents seemed relieved when their youth was in PChAD. A couple of staff reported that some parents expressed a desire for the period of time to be extended past the existing five-day extension.

> *"But this is only a 10-day program, so we can identify the issues, but we cannot solve the issues, that is a challenge between the parents and the program sometimes."*

Judges' and Clerks' Comments

While judges and clerks could not comment on the outcomes of PChAD for parents and guardians, they did note that many parents are frustrated and nervous by the time they reach court.

1.2 To what extent are children satisfied with their experience?

Interviews with children who recently participated in PChAD were intended to be a source of information for this evaluation. For this evaluation only one interview with a child was completed. To ensure the evaluation includes some additional findings from children, findings from the Youth PSH Discharge survey (as discussed in the January 2017 AHS evaluation) are included.

Youth Interview

The one interview was with a former PChAD participant who had attended the program a few times. This child felt that the program was helpful as it "kept me sober and clean, keeping me in a safe place." The one area identified as being not satisfactory was the amount of time youth are allowed outside. The interviewee explained that the amount of "outside time" has been shortened recently to ten minutes. This made them feel "cooped up inside, stuck inside there." The youth felt that the amount of time in the program was appropriate and also felt that they had a good relationship with program staff. They did, however, feel that the staff at PChAD didn't spend enough time explaining the treatment plan.

January 2017 Evaluation Findings

The Youth PSH Discharge survey (2015-16) found that over half of children felt the length of their stay was "just right," while 35% felt it was too long. This is in contrast to the majority of parents/guardians reporting that the program was felt to be too short. Around 90% of children felt that their intake went well, that the PChAD program and protection order was explained to them and that they understood their rights.

Overall, when asked if they believed their stay at a PChAD PSH was good for them 45% "strongly agreed," 28% "agreed," and 18% "disagreed" or "strong disagreed."

2. Accessibility

To what extent is the PChAD Program accessible to those who need it?

2.1 How do guardians find out about the program?

Parent Interview

One of the two parents interviewed found out about PChAD from a private mental health practitioner. They felt that they had everything they needed to navigate the process, from the court date to the discharge of their child.

> *"...nothing was confusing about it, it was straightforward..."*

The other parent, however, was given different information about accessing PChAD at two different times from different AHS sites. This parent indicated that they had a high degree of health system literacy and were able to navigate on their own, but that their pre-existing knowledge of PChAD through employment was important in being able to navigate.

Staff Interviews

Interviewed Children's Services and AHS staff identified several main sources from which parents or guardians first heard about PChAD. Many of the following were identified by staff across the different PSH sites: word of mouth, school (school counsellors), Children's Services, Probation Officers, Police/RCMP, Emergency Departments, youth shelters, mental health practitioners, Child & Family Services, Foothills Addiction Centre (for Calgary clients), Social Workers, AHS. Many staff identified AHS and the AHS website as a primary source of information; however, many staff also felt the website was limited and should include more information. A couple staff felt that the program should be advertised more or promoted more through the AHS website.

When asked about the sufficiency of information to navigate the process, almost all staff reported that parents or guardians are overwhelmed or stressed at the start at the PChAD process. A couple staff felt that the volume of information provided at the start of the process can be challenging to navigate. Several staff mentioned the online limitations associated with obtaining PChAD specific information. The majority of staff did feel that the pre-application sessions provided by the program are very valuable to parents and guardians.

> *"I think we definitely do our best to convey the information to them, but I also am mindful that most parents that come to our doors are in their own crisis, so I think sometimes it's hard for them to retain all the information."*

With regards to gaps in the available information, the majority of AHS staff commented on the complexity of the information rather than the existence of information gaps. A couple Children's Services staff felt that some information gaps existed. On the other hand, a common theme across all staff was the lack of awareness of the existence of PChAD for parents or guardians searching for help in a time of crisis. A couple staff specifically mentioned the lack of awareness for youth located outside of Edmonton and Calgary.

> *"If you're in Edmonton or you're in Calgary you are probably okay. But if you're in like a smaller town or community there's a lot of gaps in terms of information and in terms of understanding like the process and unfortunately because it goes through the courts it is very complicated."*

When prompted for what specific areas of information are lacking, the majority of staff felt that it was around the court process. This appeared to be the most complex aspect of the program and as a result is viewed as needing improvement. As discussed, staff often referred to the pre-application sessions as a great step in supporting parents and guardians in starting the PChAD process.

Online Resources

To understand the availability of online resources specific to PChAD from an external perspective, such as a parent or guardian, a simple search engine search was conducted. Specifically using the search terms "PChAD" or "Protection of Children Abusing Drugs" in Google resulted in websites for AHS, the Government of Alberta, and the Parents Empowering Parents (PEP) Society. These three were the main search results that were province wide.

January 2017 Evaluation Findings

The AHS evaluation included several questions about the information needs of parents/guardians. Focus groups and surveys also found information to be an emerging theme. Some of the recommendations given in response to these themes included:

- Improve access to reliable and consistent information regarding the PChAD program at all stakeholder levels including the general public.
- Pre-application information sessions consistently cover core program content and provide provincial PChAD developed resources and handouts.
- Provide sufficient orientation, resources and supports to ensure parents or guardians are well prepared for the court applications and hearings, including protection order and order reviews.

- Develop consistent practices in engaging families and sharing information with parents and guardians.

2.2 Are there barriers to access?

January 2017 Evaluation Findings

Akin to findings presented for the information needs of parents/guardians, barriers to access were often attributed to the inconsistency and complexity of information. The recommendations generated by AHS in their report with respect to enhancing information and understanding corresponds with removing barriers to access.

Focus groups conducted for the AHS evaluation of PChAD did find that barriers to access were more frequently mentioned when discussing program utilization post-discharge from PChAD. Moreover, wait times were viewed as a main barrier to accessing follow-up services.

Parent Interviews

One parent did not identify any barriers to accessing the program but did mention the high level of fear they felt on the court date and how that was a stressful part of gaining access to PChAD for their child.

The other parent mentioned the inconsistency of information as being a barrier to accessing the program. This same parent also explained that their child was offered a bed in another city due to limited local availability. Although this gave their child access, the distance from their home was not ideal.

Staff Interviews

Staff interviews included questions on the perceived barriers to access for parents or guardians. There were a few themes that emerged across all sites and staff roles. The first was a fear that the court order would damage the parent or guardian's relationship with their child or dependent. Several staff explained that there is a lot of fear not only with the potential impact on the family relationship but also with the process in general.

> *"I do believe that there is the fear of actually taking that step, because it does require them to actually put their kid in a secure facility and they may not want to ruin the relationship that they have."*

Another commonly mentioned theme attributed to be a main barrier to access was the overall lack of awareness. This theme was expressed by almost all staff across questions related to information and access.

"...especially from the smaller communities, there may be a lack of knowledge for the parents that there is a program like this..."

A couple other themes that emerged as barriers to access included the overall amount of time and energy required to access the program (i.e. going to court), the parent or guardian having their own mental health or addiction struggles, and the concern that program may be more extensive than their child requires (i.e. their youth uses marijuana which may be less problematic than other drugs).

"...some parents that can be pretty terrifying to go to court and to get up in front of the court room and speak of the challenges and struggles that you're having with your child."

Judges' and Clerks' Comments

One judge noted that having to appear in court can be a barrier for families who struggle to find or afford childcare for other minors in their households. A clerk suggested that there are likely families who are unaware of PChAD, and that lack of awareness presents a barrier. Another clerk suggested that the complicated AHS intake process is a barrier for some.

"I believe the AHS intake process is what holds them back. It takes a lot of time and complicates the process for guardians who are already very stressed and distraught."

2.3 How consistently are admission criteria applied?

January 2017 Evaluation Findings

One additional recommendation from 2017's evaluation report that came as a result of key themes from surveys and focus groups was directly related to admission criteria.

- In partnership with Justice and Solicitor General Stakeholders, explore recommendations for the courts to make court experiences more consistent, effective and less stressful for the families and children within PChAD programming.

Staff Interviews

All staff felt that the majority of children granted court orders were appropriate for the program. A few staff did explain that the acuity of the children accessing PChAD has increased which was attributed to the growing use of opioids and behavioural issues. A couple staff explained that although the right children were accessing the program, sometimes parents and guardians did not clearly understand that the purpose of the program is solely for detox, stabilization and assessment.

"I definitely think the kids that we do get definitely need to be in the program."

When asked whether or not they felt the admission criteria was being applied consistently, almost all felt that it was. Only one staff member felt that the judges were not always consistent.

There was some commentary from Children's Services staff that it was more difficult for them to get access to PChAD for the children they work with than for parents and guardians. With greater behavioural challenges and longer histories of contact with intervention and judicial systems, some Children's Services staff felt that AHS was less willing to accept the children they work with because of the intensity of behavioural management required.

2.4 Are there children who should be accessing the program but are not?

Staff Interviews

All staff felt that there are likely children who would benefit from PChAD that are not accessing it. This is mostly attributed to lack of awareness of the program by the parents or guardians as well as barriers identified for question 2.2.

2.5 To what extent are PSH beds available when an order has been granted?

Staff Interviews

The availability of beds varied across the different sites. Staff reported that beds were often busier in Calgary and Edmonton and sometimes youth have to wait a couple of days. Red Deer and Grande Prairie staff felt that there was often not a long wait, if any, for youth accessing the PChAD PSH. All sites discussed the "ebb and flow" nature of the bed demand but all reported that often a bed is ready within 24 hours. A couple of staff elaborated on the option for parents or caregivers to send their child to another site if Calgary or Edmonton is full. However, they said that this option is not often used. A couple Calgary staff discussed their increase from six to nine beds in 2015 and how helpful it was for improving access.

Police Interviews

Some police felt that the number of beds and locations isn't sufficient, while others reported minimal wait times. Perception of bed availability varied by location. They felt that this impacts the amount of transfer requests and distances travelled. For example, a couple officers felt that their staff have had to travel long distances to get youth to available beds. Other police officer spoke about the complexities of asking for transport from a small RCMP unit that may only have a couple staff on at one time. Likewise, sometimes they reported

challenges with findings staff to locate the child and transport them to the PSH. They felt that this takes their staff away from other responsibilities. One interview with a police officer from a major urban centre felt that better communication is needed between police and staff (PChAD and Children's Services).

Parent Interviews

One parent explained the process of calling first to ensure a bed was available. This individual felt the timeframe in which their child was given access to a bed was acceptable. The other parent explained that the bed available for their child was located in a different city, which they were not anticipating.

Judges' and Clerks' Comments

One judge noted that it would be helpful for them to be able to access bed availability information. A clerk also wrote that bed availability "always seems to be an issue," that parents are often not aware that they may have to wait for a bed to become available and that orders sometimes expire while waiting for a bed.

2.6 Are there demographic trends in those using the program?

Current AHS program data was not available for this evaluation.

2.7 To what extent are the recommended post-program services available in a timely fashion?

Staff Interviews

> *"A lot of services that we're referring to clients aren't able to get in to right away, so I think that's definitely a barrier to them being successful in their plans."*

A number of questions asked in the staff interviews centred around the accessibility of programs and services following discharge from the PChAD program. The majority of staff across all sites identified the struggle with wait times for other services. For example, many staff discussed the long wait for accessing mental health services or treatment centres and the impact this has on transitions of care. Staff in Calgary and Edmonton acknowledged that the main cities have access to more programs and services, although wait times are still a barrier to access.

> *"There's not enough treatment centres then there's no treatment centre for concurrent disorders. Yeah, there's definitely a gap in the system there."*

When asked whether or not parents or guardians have the necessary support to navigate the care path for their children, answers were mixed from staff. Many staff felt that parents are provided with all necessary supports to navigate the system for their child, but whether or not they do is up to the youth and their family. Likewise, a couple of staff explained the tailored approach to discharge planning and how they do their best to ensure next steps are clear and recommendations are appropriate to the child.

> *"I think parents do the best they can with what they have, some parents are on it...you give them a recommendation [and] it's like it was done yesterday... And there are parents who are so entrenched in their own stuff and struggling that that's not happening."*

Staff also reported the efforts in connecting parents to other community services or pathways to care but are cognisant that too many suggestions may not be helpful. A few staff mentioned that rural clients are often at a disadvantage as in some areas "things are a lot more spread out." A couple of staff felt that the capacity for parents to navigate the system could be enhanced if Children's Services could offer more support at discharge.

Parent Interviews

One parent felt that PChAD gave a lot of helpful suggestions, such as keeping their child busy (e.g. drawing or colouring) and arranged for follow-up appointments with a psychologist. At the time of the interview the parent was waiting for space at a treatment centre for their child.

The other parent felt that the PChAD staff were unable to recommend specific services because their child lives in a different city than the PSH site they attended. The parent was aware of some mental health services in their home city but expressed concern with the amount of time their child would have to wait to access local programs.

2.8 How well integrated is the PChAD program with relevant programs?

Staff Interviews

A couple of staff mentioned integration or collaboration with voluntary detox or rehabilitation programs. They explained that this gives youth the option to switch to voluntary AHS detox or treatment services when a bed is available. This integration of services is only available for one PSH site due to sharing a facility with voluntary youth detox supports, but is viewed as a beneficial resource to youth if they choose to move to voluntary treatment. Aside from this co-location, no other examples of integration were shared.

3. Appropriateness

To what extent is the PChAD Program aligned with accepted or evidence-based practice?

3.1 How appropriate are PSH facilities for delivering the PChAD Program?

Literature Review

Availability of literature on the appropriateness of protective safe house facilities (PSH) facilities was minimal. The National Institute of Health (NIH) in the United States developed a guide for detoxification and substance abuse treatment for adolescents (2006). The guide provides an overview of what is needed in terms of facilities and treatment. It is recommended that patients are provided with a 'secure, clean environment with observation and supportive care' when going through detoxification (2006). The guide also outlines the importance of adolescents being separated from adults during treatment and that all patients need to be screened for other psychiatric conditions (2006). No literature was found on guidelines for PSH facilities or involuntary treatment settings in general for Canadian youth programs.

Site Visits

In March 2019, site visits were completed by Three Hive Consulting. Physical facilities vary, although all provide clean, secure accommodations.

The Calgary PSH was secure and clear processes were in place for accessing the building. Once inside, youth had several areas to spend their time – including a gym, games room, and multiple living rooms. The hallways containing the nine bedrooms were also perceived to be very secure and in close proximity to the main staff room. With regards to safety, cameras were visible in all areas, bedrooms were free of all potential hazards and a safe room was available for youth requiring segregation. Although the PSH is oriented and furnished according to program mandate needs, the overall impression was a safe, comforting space.

The Grande Prairie PSH was a renovated home in a residential area. Modifications had been made for security, and video cameras installed. Youth had bedrooms with comfortable furnishings, and there were common rooms for games and television, quiet spaces for reflection and consultations. There was art on the walls and supplies for crafts and activities to keep children engaged. The backyard was fully fenced and locked. Overall, this PSH felt very "homey."

In contrast, the Edmonton PSH felt much more "institutional." Due to its co-location with another AHS facility, the site was busier and had more security protocols. Common areas had comfortable furnishings, each child had their own bedroom and there was a secure room for any required segregation.

3.2 What does research suggest regarding best practice for involuntary detention for addictions programs?

Literature Review

Involuntary youth confinement for detoxification programs and policies vary across Canadian provinces and on an international level. An extensive literature search was conducted in March and April 2019 and found that there was a lack of studies that specifically focused on involuntary drug abuse treatment programs for youth. Moreover, the following summary includes articles that are related to the PChAD program, but may differ with respect to the target population, location of program (e.g. acute care versus residential), and the political context in which the programs were developed.

Involuntary Detention for Addictions Programming

In 2010 a comparison of policies and/or legislation was conducted using World Health Organization studies from 90 countries (Israelson & Gerdner, 2010). They found that 80% of these countries had laws related to compulsory or involuntary treatment for substance abuse, but the focus was almost always on adult substance abuse (2010). They did acknowledge that a few countries had laws that focused on compulsory commitment to care (CCC) for both adults and children (2010).

Looking at the United States, policies on involuntarily treatment of youth for drug abuse varied from state to state, but all allowed for parents or caregivers to make care decisions until the age of 18. For example, drug abuse treatment or detoxification can be obtained for a child under the age of 18 without a court order (Hazelden Betty Ford Foundation, 2017). In 2014, 44% of youth admitted to substance abuse services were court ordered to receive treatment (SAMHSA, 2014).

In the Canadian context the most similar legislation and accompanying programs to Alberta's PChAD program were found in Saskatchewan as the *Youth Drug Detoxification and Stabilization Act* (Read, 2017) and in Manitoba through the *Youth Drug Stabilization (Support for Parents)* Act (McKay-Panos, 2009). In 2006 Alberta, Saskatchewan and Manitoba all passed legislation allowing parents or caregivers to involuntarily detain a child for 5 to 15 days for drug abuse treatment (Families for Addiction Recovery, 2018). Other provinces had less defined legislation around involuntary treatment for youth abusing drugs. A report from the Families of Addiction Recovery described the current lack of clarity

with involuntary treatment laws (2018). This group, like many other studies worldwide, discussed the lack of research on involuntary treatment for youth and how it is unclear whether findings for studies of adults can be appropriately applied to treatment for children (2018).

Although Saskatchewan has a similar process and programming to PChAD with a maximum stay of 15 days, their legislation includes a requirement to see a physician for assessment first and for extensions past the initial five days (Government of Saskatchewan, 2015).

Other articles have been published with a focus on policy review in British Columbia and Ontario. In 2009 the Legislative Assembly of Ontario passed a motion for a committee to develop a comprehensive care plan for addictions and mental health for children and young adults (2009). In 2011 the Ontario Ministry of Health and Long-Term Care published a strategy plan that included the development of a task force to specifically evaluate legislation around involuntary treatment (Ontario Ministry of Health and Long-Term Care, 2011). A couple of B.C. based studies concluded that more integration of services and better transitions in care are needed for youth accessing substance abuse programs (Cox et al., 2013; Turpel-Lafond 2016). The study by Cox and others surveyed youth that had utilized substance abuse services and one main improvement suggested was to ensure they are supported as they transition to other services as well as when they transition into adulthood (2013). Also in B.C., a group of physicians provided commentary on the potential risks related to trust of adults, higher risk of overdose due to lowered tolerance after the confinement period, and the need for discussion of these risks before changing legislation (Pilarinos et al., 2018).

3.3 To what extent is the PChAD program delivered in alignment with best practice?

Literature Review

Best Practice for Involuntary Detention for Addictions Programs

A 2014 study by Hall et al. focused primarily on an adult population but concluded that more rigorous evaluation and research is required to understand efficacy (Hall et al., 2014). This is in line with the youth-focused literature, which also called for an expansion to the existing body of knowledge surrounding compulsory treatment.

An Australian study by Klag and others (2005) conducted a critical analysis of 30 years of coerced substance abuse treatment. They found that the body of literature was inconclusive and recommended that more research on the efficacy of coerced drug abuse research is needed, particularly for adolescents (2005). Further, they discussed how the majority of literature is from the United States from a justice system perspective and that minimal

replication of these studies has been done elsewhere or for youth (2005). Likewise, an Australian review of efficacy literature concluded that peer-reviewed literature on coerced care is limited for both the adult and youth populations (Bright & Martire, 2013).

There was more literature available on involuntary inpatient care related to psychiatric treatment. Many of these studies were conducted by Nordic countries. Kaltiala-Heino published two studies in Finland on the involuntarily referral of minors to psychiatric treatment (2004, 2010). The 2004 study found that approximately half of patients involuntarily referred for psychiatric care were also abusing drugs and/or alcohol. This study pointed out the complexity of addictions and comorbidities associated with mental health and addictions in general (2004). The 2010 study compared diagnoses for both voluntary and involuntarily treated patients; analyses found that substance use disorders were common with involuntarily treated youth. The authors argued that more guidance is needed for clinicians on the requirements for compulsory care, but that it may be appropriate when a patient is clearly unable to make competent decisions for oneself (2010). There were two limitations to these studies with respect to the purpose of this literature review – the involuntary care referrals were given by health professionals and the patients were detained in an acute care setting with a psychiatric focus. The complexity of involuntarily treated children and youth was also discussed in a Norwegian study that compared voluntary and involuntary treatment (Opsal et al., 2013).

A Swedish analysis of medical documentation focused on justification for involuntary psychiatric care for youth (Pelto-Piri et al. 2016). Although this study once again focused on health professional referrals to inpatient psychiatric are, some of the findings were relevant to involuntary youth care in general. Moreover, this study concluded that there were two main arguments used by the referring health professional: protecting the patients from themselves and necessity of treatment (2016). The authors of this article felt that more research was needed pertaining to children and adolescents (2016). Also in Sweden, an epidemiological study of multiple clinics data reported an increase in involuntary treatment with drug abuse being one of the most frequent diagnoses (Engstrom, 2007).

An American study looked at whether motivation type, internal or external, impacts treatment (Battjes et al., 2003). The authors concluded that in some cases external pressure is needed to get youth the treatment they need, but they also recognize the challenges with motivating youth in general (2003). Another similar study looked at the treatment response comparing court mandated to self-motivated drug abuse treatment in youth (Yeterian et al., 2013). This prospective study found that mandated or involuntary treatment often resulted in an initial strong response to treatment, which diminished over time (2013). In conclusion, this study argued that in cases where the child is mandated to obtain treatment, this method may be more effective for them compared to voluntary treatment (2013). The study did not comment on how the nature of services contributes to these outcomes.

One Canadian article presented an ethical approach to youth requiring secure care for substance abuse (Clark et al., 2018). They argued that involuntary secure care needs to meet the following criteria: 1. beneficence (effectiveness), 2. autonomy (least intrusive), 3. non-maleficence (does not cause more harm than it helps prevent), and 4. justice (free from discrimination and fair) (Clark et al., 2018).

Another Canadian study used qualitative data to understand therapeutic engagement for children obtaining mandated services (Ungar & Ikeda, 2017). They found that youth preferred "informal supporters" that are more laid-back, but the data suggested that youth also responded well to "administrators" or staff who enforced the rules, which authors argue suggests a need for a mix of therapeutic approaches by staff (2017).

Minimal literature was found with regards to the support of the families and caregivers of children detained for treatment. One study did look at the effectiveness of treatment with respect to parent involvement and argued that parent engagement in mandated treatment is likely to result in better clinic outcomes, although did not provide detail on the nature of that parental engagement (Mauro et al., 2017).

Staff Interviews

All staff felt that youth in the PChAD program are offered an appropriate level of services at the PSHs based on the mandate of the program. The majority of staff made comments about how the supports offered by the PSH sites are meeting the needs of youth with respect to the detox and stabilization. Staff felt that the facilities are needed and beneficial to the youth admitted to the PSH.

> *"I think we are delivering like the maximum that we can provide to the kids, like the purpose of PChAD is stabilisation, detoxification and the assessment and connecting them to the services after PChAD."*

When asked about gaps, almost all staff shared the same response. They felt that the biggest gap in PChAD services is around mental health. More specifically, they feel like youth would benefit from psychiatry while at the PSH. In general, the majority of staff mentioned mental health as a main area requiring more supports.

> *"...there's gaps, definitely in terms of like the mental health. I think we need to have a psychiatrist attached to our program and that's something I know we've been trying to get for a year or so."*

Another gap in service mentioned by several staff was centred around on-site medical services. A few staff explained the complexities associated with opioid detox and how medical expertise would be valuable to the program.

"And we are seeing a huge opioid crisis right now. So kids are coming in and they're expected to engage in a therapeutic process when it takes five to six days for them to feel even good you know, if they've been using opioids."

"We're needing to move towards more of a medical model versus a social model because of the drugs we're seeing."

When asked about services being aligned with best practice or being evidence-based, staff agreed that the PChAD program is aligned with best practices and is evidence-based. More specifically, staff discussed their use of trauma-informed care, harm reduction strategies and a culture of aligning with new evidence.

"We do have a lot of training on trauma-informed care and how to work with trauma. So I think we're definitely aligned there with best practice. We have the flexibility to use a lot of clinical judgment, which is really nice."

4. Effectiveness

To what extent is the PChAD Program achieving its intended outcomes?

4.1 To what extent are staff consistently trained?

Staff Interviews

Staff reported a variety of training opportunities and practices for their roles at PChAD. Some of the training resources include job shadowing at PChAD, internal AHS training, online coursework (through AHS), trauma-informed courses, models for assessment tools, legislation training, legislation amendment training (2011), education for pre-application session facilitation, non-violent crisis intervention (NVCI), CPR and suicide prevention. Staff also mentioned the relevance of their previous schooling or professional experience. Many staff felt that a lot of learning for new staff comes from existing PChAD or Children's Services staff and a strong team dynamic was reported by all sites.

"I guess my PCHD specific training would be most of it is informal training through like peer supervision or supervisor supervision."

All staff felt that they had all the information they require to work within or with the PChAD program. Moreover, a few mentioned the continuous mentorship within their team and having a supervisor as a resource for additional information.

"...one of the things I enjoy most about PChAD is the amount of resources and supports that are available."

A few staff felt that with the increase in acuity and complexity of mental health concerns and concurrent disorders, more training could help support clients. These same staff did express that the current level of resources and team support is effective for staff to do their job.

"...also training around concurrent disorders, so how both mental health and substance use affect each other and kind of the circular pattern of that."

Police Services

Most police services interviewees reported that they received very little PChAD training and sometimes none at all. One interview officer reported that the main source of PChAD specific training they received was online. Another participant did not identify any PChAD specific training but felt that some of their prisoner transport training applied. Police agreed that the transport requirements do not require too much additional training, but gaps exist with respect to information and communication about program processes and access.

Judges' and Clerks' Comments

Judges and clerks varied in their opinions of whether they had appropriate training. While an Edmonton judge commented that they had a PChAD representative come speak with them, a clerk in another location reported having no training at all.

"I have no idea if I have all the information because I have had no training on the process. I have had to learn as I go and stumble my way through."

4.2 To what extent are the appropriate assessments conducted during treatment?

Staff Interviews

Staff felt that although youth are getting the right assessments there is room for more psychiatric or medical assessments during their time at the PSH. In general, staff felt that they do their best to meet youth where they are at and get relevant assessments done.

"I think if we had a psychiatrist within our program that we would be able to do more work in terms of the mental health piece."

Document Review

PChAD assessment forms and letters were shared for each PSH site. Although many of the same topics are included in these documents (e.g. reason for PChAD assessment, history of

alcohol and other drug use, and behavioural observations) the structure of these forms varied across the four zones. The inconsistency was acknowledged by staff and an Assessment Working Group with membership from all zones developed a cohesive PChAD assessment form that is to be implemented at all sites moving forward.

4.3 What proportion of children leave with treatment plans that can be immediately implemented?

Staff Interviews

> *"...like we are providing the support that is accurate for the kids, but willingness to access these supports can be challenging."*

During the staff interviews, a set of questions prompted discussion around how well staff feel youth are able to act on their treatment plan and if they leave with a treatment plan that can realistically be implemented. The resounding theme across all staff was the variability across youth. Moreover, success after the program is very client dependent and influenced by their specific needs. In some cases, staff reported that a child may not be ready to change and therefore the plan may not be executed. Many staff also discussed the influence of families' willingness or ability to change their parenting practices or their own drug consumption, and how a family in crisis may not be willing or able to act on the given recommendations.

> *"I mean due to the nature of our service as being like court mandated, I think a lot of our clients are not necessarily in a place where they're ready to make changes."*

> *"I'd say maybe two out of ten kids follow-up with recommendations."*

Parent Interviews

Both parents interviewed noted challenges in implementing treatment plans. While they both agreed that the recommendations made in those plans were helpful, finding information, getting to locations and waiting for available spaces presented challenges to timely implementation of the plans. One parent noted that they were provided with a phone number for the adult mental health team, who would not see their child, rather than the youth mental health team.

> *"...we only have three child psychologists, two of which are winding down their practices to retire. So now, [child's name]'s going to have 25 days clean, this would be the optimal time to do [their] mental health assessment. But now [they're] going to be returning home, likely returning to using, and a psychiatrist appointment is going to be months in the making."*

4.4 How effective is the PChAD program in ensuring children are stabilized?

Staff Interviews

Almost all staff recognized that some children are not ready to be discharged at the end of their court-ordered time. Staff felt that in many cases the detox and stabilization process, as mandated, is complete for the youth but they may not be ready to make further changes. In other cases, such as youth with opioid additions, detox may take longer and therefore they are unable to participate in therapeutic group sessions until the latter half of their stay.

> *"Ten days is a very short time and we're here to connect them with resources as best as we can. We see a lot that are not ready, they're in the kind of pre-contemplative stage where they feel they don't have any sorts of issues around with substances or anything like that. And then we have kids that are absolutely ready to make that connection."*
>
> *"Ten days has never been long enough."*
>
> *"If the legislation is changing, I would say to allow for longer periods."*

For a few staff, this discussion led to feedback around extending the length of stay or encouraging extensions for those that need one, if a thorough assessment has been undertaken. A couple of staff noted that some youth return to the program regularly for additional detox and stabilization support. A couple sites mentioned their relationships with voluntary programs and their ability to recommend these options to youth if a bed is available and they are willing to engage in voluntary support.

4.5 To what extent does the PChAD program engage in regular evaluation of the quality of its services?

AHS conducted the first evaluation of PChAD over 2015 and 2016, with results reported in January 2017. No other comprehensive evaluation of PChAD was undertaken.

Staff Interviews

The majority of interviewed staff across various sites and roles felt that the PChAD program engages in continuous quality improvement.

> *"I think we're always assessing what's working and what's not, what could be tweaked a little bit, what could we add, what is now obsolete, because we're getting a different clientele."*

No formal ongoing monitoring processes were reported.

5. Efficiency

To what extent are resources required for the PChAD Program used optimally?

5.1 To what extent are available resources aligned with demand for services?

Staff Interviews

According to staff, youth are often able to get a bed within a couple of days. Likewise, staff across all sites feel that the resources and subsequent services are meeting the needs of clients. Several staff identified some resources that would better equip the PSHs – mental health supports (e.g. psychiatry) and medical support to help with the complexities associated with opioid detox and stabilization. A few staff felt that the length of time at the PSH could be longer, but the actual supports in place are ample.

> *"I think the programming is sufficient, and I also think the length of time - of course I would like to feel that I support the parents, I would like to see it a little bit longer so that we can provide a little bit more support in helping them transition from one service to another."*

Judges' and Clerks' Comments

One clerk wrote that bed availability "always seems to be an issue," although this concern was not mentioned by other clerks or judges.

5.2 How effective is the coordination of police transports with bed availability?

Staff Interviews

AHS staff were asked about their perception of the coordination of police transports. Several of them were unable to comment as they were not involved with admitting youth. Staff that had previous experience with receiving youth from police felt that the transportation support provided appeared to be working and has improved over time. A couple mentioned that they had not received any feedback from youth on their experience, which they deemed to be a good sign.

"I think police officers are more familiar with the PChAD program and these types of services, whereas before when I initially started, I think there was a lot of pushback from police to help support our program."

Several staff identified areas for improvement with respect to police transport. In many cases they felt that police were unaware of the required processes such as calling in advance to ensure bed availability as well as the paperwork required upon drop off of the child. Moreover, a couple of staff felt that some of the disconnects were associated with out-of-town transfers to the PSH. In these cases, it was felt that the police or RCMP officers were not as familiar with the program. In general, police transport for youth already in the same vicinity of the PSH appeared to be more coordinated.

"Then we also have some police who don't follow the steps they need to around calling the main 1-888 number to make sure that the bed is ready..."

Police Interviews

Interviews with police services staff found that improvements are needed in the coordination of transport. More specifically, police officers felt that communication between stakeholders could be better as well as the environment youth are transported in. For example, one officer felt it would be more comfortable if youth were not transported in a police vehicle. An officer reported that work is being done to improve the way they transport children and to understand expectations. A couple police interviews suggested that the current expectations are "unrealistic." Interviewees did not, however, have suggestions for alternative ways of ensuring safe transport of unwilling youth.

"We want to do it and provide that service but we're looking to do it in perhaps a little bit more in an efficient manner."

6. Safety

To what extent are mechanisms in place to minimize opportunities for children to be harmed as a result of their involuntary detention?

6.1 What policies are in place to support the physical safety of children and staff in PSHs?

Staff Interviews

All AHS staff across the four sites identified policies for the physical safety of youth while staying at a PSH. The majority of staff talked about the continuous monitoring of youth both in-person and through the camera system as well as being 'pre-emptive' with any potential concerns. Likewise, a few staff felt that having reports from staff on the previous shift helped them better prepare for any potential safety concerns.

> *"...at the beginning of every shift, we try to see where the problem lies, how we can work with the youth and everybody brings their skillset to the program and we just try to do the best that we do."*

Several staff discussed the knowledge of how to use restraints as well as the availability of the safe or quiet rooms for segregation. They felt that although these resources are not used frequently, they are a good solution when physical safety is of concern.

> *"...everybody's trained in crisis intervention and how to manage that kind of stuff. So I feel like they are safe, as safe as we can keep them, and the staff do a very good job of maintaining that with what resources we have."*

A couple of staff suggested areas or policies that could be improved with respect to physical safety. The first is a better understanding of the mental health piece, with the understanding that emotions trigger potential unsafe behaviours. A couple staff felt that the physical searches conducted upon arrival at the PSH could be enhanced as sometimes substances are brought in.

> *"I don't think that they always do a thorough enough search... we have had youth bring substances into the house and then they've shared them with the other youth, so that puts the other youth at risk of their safety."*

6.2 How do PSHs prevent negative group talk?

Staff Interviews

When staff were asked about relationship between youth while in the PSH they reported that relationships and dynamics varied. In some cases, youth knew each other from before PChAD which staff felt could be negative or positive depending on the previous relationship. Staff felt that it was important to monitor the interactions and/or keep the youth away from one another. The majority of staff emphasized the constant monitoring and supervision of youth and their relationships with other youth.

> *"I've seen it vary quite a bit in terms of their relationship, sometimes it's really positive, because the youth can encourage each other. But on the flipside, sometimes they can be like a negative influence on each other too, making more negative connections in the community."*

Many staff also discussed the emphasis on encouraging positive or healthy conversations. One site is located in the same vicinity as a voluntary program and staff reported that the youth who voluntarily admitted themselves seemed to have a positive influence on the PChAD youth.

6.3 How are children's relationships with guardians supported?

Staff Interviews

All sites and staff emphasized the importance of supporting relationships with parents, guardians and families. Youth are encouraged to have visits as well as phone call with their parents/guardians. With the exception of the first 48 hours, youth are allowed to make calls to their family and participate in supervised visits. Parents are encouraged to call every day, even if their child will not take their calls.

> *"...they have access to their kids, they can phone them, kids can phone their parents, you know, you have some parents who are way more invested in others, or way more capable to be invested than others."*

Staff at the PSHs report making phone calls to update the parent/guardian every day or every second day. Several staff mentioned having the support of a family counsellor to help support the relationship between youth and their parent/guardian.

> *"The piece here is that a lot of times it's not just the youth who is pre-contemplative for a crisis, the parent is as well, right, with their own set of stuff, so we kind of try to meet them where they're at as well."*

Along with the regular updates, a few staff felt that they often had to remind parents of the purpose of the program (i.e. to detox, stabilise and assess) and what to expect post-program).

Parent Interviews

One parent felt that PChAD helped the relationship they have with their child, particularly with communication and knowing how to better support their child.

> *"...we're all a family now, the biggest impact is that we all communicate as a family now, whereas before we sort of kept our emotions in, our feelings in, now it seems like it's more open now, like if you're feeling bad or feeling good, we sort of show that feeling of how we're feeling, so then we can respond as a family on how to advise that person on how to be feeling. If they're feeling good, we support them, if they're feeling bad, we support them and tell them what to do, try not to think about it too much. Now it's as a family, intact."*

The other parent explained that they had a strained relationship with their child and as a result communication was challenging. This parent reported that only one phone call occurred, and the family meeting was the day before their child was discharged. It was felt that more facilitation of communication would have been helpful. This parent also recognized that the distance from their home to the PSH was a barrier in having more than one in-person visit.

Youth Interview

The child that was interviewed did not go into detail about the relationship with their family. However, the child felt that PChAD was supportive of making phone calls and gave prompts or advice during family conversations.

6.4 How safe are children and staff during transport?

Staff Interviews

All staff felt that children are safe during transport with police or RCMP. However, a couple of staff did express concerns for safety when transporting children to court. This sentiment appeared to be from one site that had different processes for youth and their court reviews. The suggestion from these staff was to allow video conferencing for court reviews. They feel this would save on travel time, not take staff away from the PSH, and reduce safety concerns.

"I also feel there are safety concerns with staff transporting youth to court for their reviews, whereas all the other sites have CCTV on site - so all the reviews can happen without taking the youth off-site."

Police Interviews

Police felt that youth are safe while in transit. One officer mentioned that two officers are required for transport which is to not only ensure the safety of the youth, but also of the officers. Moreover, some of the transports take several hours resulting in a long day which can potentially impact safety. Likewise, another officer felt that having two officers and/or an officer the same sex as the youth is important in case any allegations are made following transport.

"...we always ensure they're transported with two officers. We don't have an option at the moment, so we transport in a police vehicle so in terms of safety, it's a safe environment. ... I don't necessarily think it's the best environment for them."

Youth Interview

The interviewed child reported that they did not receive transport from police during their last PChAD order and was instead transported to the PSH by their parents.

Discussion & Recommendations

The discussion is organized by each of the six themes and the accompanying questions. In addition to answering the evaluation questions, recommendations are presented at the end of each section.

1. Acceptability

To what extent is the PChAD Program administered in a way that is respectful and responsive to user needs, preferences and expectations?

1.1 To what extent are guardians satisfied with their experience?

Parents appeared to be satisfied with their experience, with the exception of the complex navigation preceding their child entering PChAD and the system navigation required after discharge. Interviews with the two parents that were available for the evaluation suggest that the PChAD program was what they expected and that it did help their child. They were less satisfied with the complexities of the court order, availability of a local bed, and access to post-program services in a timely manner. The difficulties associated with obtaining information on PChAD and navigating the court order process were also highlighted in the January 2017 AHS report and mentioned by several staff in the 2019 staff interviews.

Parents from the 2017 report felt that the program could be longer in duration (e.g. 30 days) and staff in 2019 also reported hearing this from parents.

1.2 To what extent are children satisfied with their experience?

Only one child that had previously entered the PChAD program was available to be interviewed. This youth reported that the program helped them to be "sober and clean" and felt that the PSH was a safe place. In general, this youth was satisfied with PChAD but felt that their experience could have been better had they been allowed outside more and if more time was spent discussing their treatment plan. To further answer this question, data from the 2015-16 Youth PSH Discharge survey were included in this evaluation. This survey

found that 73% of PChAD participants "strongly agreed" or "agreed" that their stay at a PSH was good for them. The survey also found that the majority of children felt the length of the program was good and that the intake process was informative.

More recent information from PChAD participants is required to better understand the extent of their program satisfaction.

Recommendation 1: Implement a parent and youth survey to understand their experience and outcomes after participation in the PChAD program, both upon discharge and again at three to six months following discharge.

2. Accessibility

To what extent is the PChAD Program accessible to those who need it?

2.1 How do guardians find out about the program?

Multiple sources were employed to understand how guardians find out about PChAD. The parent interviews highlighted two sources: a mental health practitioner and AHS. The parent that heard about the program through AHS found that the information was inconsistent between sources. Staff identified many sources that introduce the program to parents. Some of the most mentioned sources included: word of mouth, schools, Children's Services, AHS and police services.

An online search was conducted to identify the primary online sources. The most frequent websites were for AHS, the Government of Alberta and the Parents Empowering Parents (PEP) Society.

Once aware of the program, all stakeholders mentioned the importance of the pre-application session for understanding processes. Staff interviews as well as findings from the 2017 AHS evaluation highlighted the amount of information and potential for parents to be overwhelmed.

2.2 Are there barriers to access?

Parents felt that barriers to access included inconsistent information, fear, and the stress associated with the court order process. Staff expanded on these barriers by including fear of damaging family relationships as well as the energy required to obtain access to the program for their child. Staff also discussed the struggles parents or guardians may be having with their own addictions or mental health issues and how this is often a barrier to access for their child.

2.3 How consistently are admission criteria applied?

In 2017 one of the recommendations was to enhance consistency in the court process. However, staff interviews in 2019 found that almost all staff felt that admissions criteria are applied consistently.

2.4 Are there children who should be accessing the program but are not?

Staff across all zones felt that there are likely many children who would benefit from PChAD but are not accessing the program. This is mainly attribute to a lack of program awareness with parents.

2.5 To what extent are PSH beds available when an order has been granted?

Staff and parents generally felt that PSH beds were available in a reasonable amount of time following a granted court order. Some staff mentioned a slight delay and one parent explained that their child had to go to another city to access the PChAD program. Police services, on the other hand, felt that PChAD could use more PSH sites and beds. They often mentioned that for some youth beds were only available in other cities or zones. A judge suggested that knowledge of real-time bed availability would be helpful to their work.

2.6 Are there demographic trends in those using the program?

Data was not available for trend analysis for this evaluation. Future evaluation work would benefit from a thorough analysis of demographic trends.

2.7 To what extent are the recommended post-program services available in a timely fashion?

All interviewed staff and parents felt that recommended post-program services were susceptible to long wait times. Both stakeholder groups felt that the recommendations to programs and services were appropriate, but the issues with timely access were viewed as an obstacle to continued navigation of the system.

2.8 How well integrated is the PChAD program with relevant programs?

With the exception of co-location with voluntary detox and rehabilitation for the Edmonton PSH site, program integration was not mentioned by staff. There appears to be no logical next step for youth following PChAD discharge, but rather a disconnected system of system of services that is challenging to navigate.

Recommendation 2: Identify ways to enhance program awareness (e.g. brochures for schools or community programs, more information on the AHS website, etc.). Continue to offer pre-application information sessions and encourage participation across all parents or guardians considering PChAD.

Recommendation 3: Ensure consistency of information across AHS sites, programs and staff. Identify and share a location (e.g. AHS Insite) to house up-to-date PChAD information that AHS staff can easily access when needed. Determine which roles require understanding of PChAD and implement mandatory training on the program through the AHS e-learning platform.

Recommendation 4: Explore solutions to allow staff within and outside of AHS to view real-time bed availability at PSH sites.

Recommendation 5: Coordinate better with other services (e.g. voluntary treatment facilities) to improve timely access to recommended services.

Recommendation 6: Ensure all staff understand the availability of post-treatment options – what services are available, where are they located, and when they may be needed by PChAD youth.

Recommendation 7: Explore IT solutions that can help with the coordination of treatment planning at discharge. Establish information sharing agreements across PChAD/AHS and Children's Services to reduce wait times for client information.

3. Appropriateness

To what extent is the PChAD Program aligned with accepted or evidence-based practice?

3.1 How appropriate are PSH facilities for delivering the PChAD Program?

The PChAD program and PSH facilities are unique and as a result similar programs are not available in the literature. Very little information is available pertaining to involuntary detox and treatment facilities for youth. The United States' National Institute of Health's guide for detoxification and substance abuse treatment for adolescents providing a "secure, clean

environment with observation and supportive care to youth" (NIH, 2006). Evaluators visited PSH sites in 2019 and they assessed them to be secure and clean while offering constant observation and support to the youth. Based on these guidelines the PSH facilities used for the PChAD program are judged to be appropriate for their mandate.

3.2 What does research suggest regarding best practice for involuntary detention for addictions programs?

As mentioned above, there is a deficit of literature specifically related to involuntary detention for youth addictions. The most relevant information is available through the two other Canadian youth detox programs in Saskatchewan and Manitoba. Although the mandate is similar across the three provincial programs, the processes and lengths of confinement differ. In the United States, court order procedures and requirements for youth varied significantly from Alberta's legislation and in turn is not easily compared due to PChAD's context. Some grey literature (e.g. Families for Addiction Recovery, 2018) highlights the need to have clearer guidelines on best practice for involuntary detention.

3.3 To what extent is the PChAD program delivered in alignment with best practice?

The literature review utilized articles on involuntary addictions and detox care to understand alignment with best practice. It is important to note that much of the literature represents programs that are considered "in-patient" and housed in acute care and the majority of literature accessed represents adult populations. There is little consistency in best practice for youth and many epidemiological as well as policy studies recommended further research into best practice for children and youth.

There were some common themes across staff interviews and some of the literature with regarding to best practice. This included the involvement of family in the process, the use of psychiatric assessments and the involvement of medical staff to better support the complexities associated with opioid detoxing.

Recommendation 8: Continue to monitor the literature for new information on best practices for involuntary detox and stabilization services for youth. Share learnings from PChAD at conferences and journals to encourage communities of practice and knowledge sharing.

4. Effectiveness

To what extent is the PChAD Program achieving its intended outcomes?

4.1 To what extent are staff consistently trained?

Training resources varied across sites and roles. Some of the consistent training resources that were mentioned included the online PChAD legislation training, pre-application session training, and online AHS materials. All health zones mentioned the use of job shadowing for new staff. Many AHS staff felt that much of their previous education and experience was relevant and used in their position at the within or working with PChAD.

Although training outside the legislation and pre-application sessions may differ, all staff felt like they had all the information they need to do their job. Staff also mentioned the support and training they received from their team within the PSH. Staff feel that they receive adequate training but could use more resources for supporting mental health needs and concurrent disorders.

When police services staff, judges and clerks were asked about their PChAD training, there was less consistency in their answers. Some mentioned that they had no PChAD training, a couple mentioned the online overview and others felt that they only required training in transport safety, which they had already acquired.

4.2 To what extent are the appropriate assessments conducted during treatment?

Staff felt that youth are getting appropriate assessments whenever possible and relevant. However, they did feel that more psychiatric and medical assessments would benefit youth.

A document review found variation across the sites and zones with respect to assessment forms. In July of 2019 an Assessment Working Group created a unified form that will now be used for assessments across all PSH sites.

4.3 What proportion of children leave with treatment plans that can be immediately implemented?

Immediate implementation of treatment plans varies greatly across youth, according to PChAD and Children's Services staff. Staff feel it is dependent on the child's willingness to change. One PSH staff member felt that "two out of ten kids" follow through on their

treatment recommendations from the PChAD program. For parents, challenges in implementing treatment plans are related to system navigation and service availability.

4.4 How effective is the PChAD program in ensuring children are stabilized?

Staff generally felt that the PChAD program if effective in the mandate to detox and stabilize. Most staff felt that many children are not ready to leave the program at the end of ten days. Some staff discussed the complexities from opioids and how a longer detox and stabilization period would be better. Most staff felt that extensions are important for many children in the program.

4.5 To what extent does the PChAD program engage in regular evaluation of the quality of its services?

Interviewed staff felt that the PChAD program has a culture of wanting to improve and evaluate service quality. Staff feel there is continuous effort to engage in quality improvement and assessing "what's working and what's not," however no regular monitoring of performance was reported.

Recommendation 9: Explore options for length of confinement. Consider a minimum length of 15 days, with the option for the initial court order to be up to 30 days if recommended through an AHS assessment.

Recommendation 10: Consider extending the mandate beyond detox to include the possibility of treatment. Establish criteria to determine whether youth should receive treatment while at PChAD.

Recommendation 11: Explore ways to better integrate families into PChAD and treatment planning to better support youth in implementing change post-program. For example, family treatment or continued support after discharge.

Recommendation 12: Develop and implement a system for continuous monitoring of program performance, including standardized outcome assessments and the post-discharge surveys of guardians' and youth experiences suggested in Recommendation 1.

5. Efficiency

To what extent are resources required for the PChAD Program used optimally?

5.1 To what extent are available resources aligned with demand for services?

The majority of PChAD and Children's Services staff felt that the number of beds is aligned with current demand, although knowledge of bed availability is lacking outside of AHS. Several staff felt there could be more resources related to mental health supports (e.g. psychiatry) and medical support (e.g. opioid detox).

5.2 How effective is the coordination of police transports with bed availability?

The coordination of police transports was viewed as an area for improvement by some PChAD staff and all police services staff. More clarity is needed in processes and required documentation. One example from program staff was to make sure police are calling the PSH's to confirm availability of a bed prior to transporting the youth. Police felt that communication could be enhanced with the PSHs and expectations of police transports should be better defined. A couple police officers suggested that they could be more efficient but recognized the challenges with the staffing required for transporting youth.

Recommendation 13: Seek to better understand the use and optimization of available PSH beds to identify opportunities for enhanced efficiency as well as access, and consider developing a system for real-time access to bed availability information.

Recommendation 14: Explore the feasibility of integration or co-location with other services or programs with an emphasis on mental health supports (e.g. psychiatry or family counseling) and medical staff (e.g. on-site nurses).

Recommendation 15: Establish a working group with police services (RCMP and municipal police forces) to establish clear processes, enhance communication and identify areas to make the transport process more efficient (e.g. shared transport between different municipalities to reduce long travel days).

6. Safety

To what extent are mechanisms in place to minimize opportunities for children to be harmed as a result of their involuntary detention?

6.1 What policies are in place to support the physical safety of children and staff in PSHs?

All staff highlighted the continuous monitoring of youth during their stay at a PSH. More specifically, staff mentioned the camera systems and communication between staff at shift change to identify potential problems. Some staff mentioned the availability of safe rooms for segregation and restraints if a situation requires their use. A couple staff felt physical searches could be better to ensure drugs do not enter the PSH.

6.2 How do PSHs prevent negative group talk?

Staff discussed the continued emphasis on having healthy and positive conversations. They also mentioned the monitoring of relationships between youth at the safe house to ensure negative group talk doesn't occur. When necessary, staff separate youth who may have known each other in the past and have a pre-existing negative relationship.

6.3 How are children's relationships with guardians supported?

The PChAD program appears to support relationships between youth and their parent or guardians. Moreover, staff at the PSH discussed both allowing and encouraging communication between youth and their parent or guardian. Many staff discussed providing updates to parents and facilitating monitored phone calls or in-person meetings. One parent felt that PChAD helped to improve their relationship with their child while the other parent felt more communication may have been helpful. The interviewed child felt supported by staff to have conversations with their family.

6.4 How safe are children and staff during transport?

Staff from PChAD and police services all felt that transport to the PSH was safe for youth. The only concern regarding safety was with respect to the long travel days for police offers transporting youth to an available bed far from their current residence.

Recommendation 16: Offer additional training opportunities to staff for managing and accommodating youth behavioural changes.

Conclusion

All stakeholder groups view the PChAD program as being beneficial to children struggling with addictions and drug use. The PSHs are meeting the requirements of the mandate and supporting children as they detox and stabilize. Variability in how PChAD is implemented across the province continues to exist, although efforts have been made to increase consistency. Continuation of this program with a possible longer length of confinement, and with improvements to post-discharge treatment coordination, is viewed as vital to the population being served. Further, continued monitoring and evaluation of this program, including the voice of youth and their families, is important for understanding the program's value.

Appendices

Appendix A: References

Battjes, R. J., Gordon, M. S., O'Grady, K. E., Kinlock, T. W., & Carswell, M. A. (2003). Factors that predict adolescent motivation for substance abuse treatment. *Journal of substance abuse treatment*, *24*(3), 221-232.

Bright, D. A., & Martire, K. A. (2013). Does coerced treatment of substance-using offenders lead to improvements in substance use and recidivism? A review of the treatment efficacy literature. Australian Psychologist, 48(1), 69-81.

Center for Substance Abuse Treatment. (2006). Detoxification and substance abuse treatment. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64110/.

Clark, B. A., Preto, N., Everett, B., Young, J. M., & Virani, A. (2018). An ethical perspective on the use of secure care for youth with severe substance use.

Cox, K., Smith, A., Peled, M., & McCreary Centre Society. (2013). Becoming whole: Youth voices informing substance use system planning. Vancouver, B.C.: McCreary Centre Society.

Engström, I. (2007). The" Forced to help" study: study design, methods and epidemiological data. BMC psychiatry, 7(S1), S104.

Families for Addiction Recovery. (2018). Involuntary Treatment. Retrieved from: https://www.farcanada.org/app/uploads/2018/08/FAR-Involuntary-Treatment-03.pdf

Government of Saskatchewan (2015). Information for Parents: Youth Drug Detoxification and Stabilization Act. Retrieved from: http://publications.gov.sk.ca/documents/13/99233-youth-drug-parent-brochure.pdf.

Hall, W., Farrell, M., & Carter, A. (2014). Compulsory treatment of addiction in the patient's best interests: More rigorous evaluations are essential. Drug and Alcohol Review, 33(3), 268-271.

Hazelden Betty Ford Foundation (2017). Involuntary Commitment for Substance Use Disorders. Retrieved from: https://www.hazeldenbettyford.org/education/bcr/addiction-research/involuntary-commitment-edt-717.

Israelsson, M., & Gerdner, A. (2010). Compulsory commitment to care of substance misusers–a worldwide comparative analysis of the legislation. The Open Addiction Journal, 3(1).

Kaltiala-Heino, R. (2004). Increase in involuntary psychiatric admissions of minors. Social psychiatry and psychiatric epidemiology, 39(1), 53-59.

Kaltiala-Heino, R. (2010). Involuntary commitment and detainment in adolescent psychiatric inpatient care. Social psychiatry and psychiatric epidemiology, 45(8), 785-793.

Klag, S., O'Callaghan, F., & Creed, P. (2005). The use of legal coercion in the treatment of substance abusers: An overview and critical analysis of thirty years of research. Substance use & misuse, 40(12), 1777-1795.

Mauro, P. M., McCart, M. R., Sheidow, A. J., Naeger, S. E., & Letourneau, E. J. (2017). Parent and Youth Engagement in Court-Mandated Substance Use Disorder Treatment. Journal of child & adolescent substance abuse, 26(4), 324-331.

McKay-Panos, L.(2009). Using the Coercive Power of the State to Deal with Child Prostitution and Drug Abuse. Law Now (33), 3, 1-5.

Mental Health Services Administration (SAMHSA). (2016). Treatment Episode Data Set (TEDS): 2004–2014. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-84, HHS Publication No.(SMA) 16–4986. Rockville: Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality.

Ontario Legislative Assembly (2009). Select Committee on Mental Health and Addictions Final report, Navigating the journey to wellness: the comprehensive mental health and addictions action plan for Ontarians. Retrieved from: http://www.ontla.on.ca/committee-proceedings/committee-reports/ files_pdf/Select%20Report%20ENG.pdf

Ontario Ministry of Health and Long-Term Care. (2011). Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy. Queen's Printer for Ontario.

Opsal, A., Kristensen, Ø., Larsen, T. K., Syversen, G., Rudshaug, B. E. A., Gerdner, A., & Clausen, T. (2013). Factors associated with involuntary admissions among patients with substance use disorders and comorbidity: a cross-sectional study. BMC health services research, 13(1), 57.

Pelto-Piri, V., Kjellin, L., Lindvall, C., & Engström, I. (2016). Justifications for coercive care in child and adolescent psychiatry, a content analysis of medical documentation in Sweden. BMC health services research, 16(1), 66.

Pilarinos, A., Kendall, P., Fast, D., & DeBeck, K. (2018). " Secure Care": More Harm Than Good. [Commentary]

Read, K. L. (2007). A Legislative Commentary: The Youth Drug Detoxification and Stabilization Act. Sask. L. Rev., 70, 199.

Turpel-Lafond, M. (2016). A review of youth substance use services in BC Victoria. BC: BC Representative for Children and Youth.

Ungar, M., & Ikeda, J. (2017). Rules or no rules? Three strategies for engagement with young people in mandated services. Child and Adolescent Social Work Journal, 34(3), 259-267.

Yeterian, J. D., Greene, M. C., Bergman, B. G., & Kelly, J. F. (2013). Does mandated treatment benefit youth? A prospective investigation of adolescent justice system involvement, treatment motivation, and substance use outcomes. Alcoholism treatment quarterly, 31(4), 431-449.

Appendix B: Interview Guides

AHS Staff Interview Guide (updated March 27, 2019)

First, thank you for agreeing to participate today. My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting. Alberta Health has hired Three Hive Consulting to conduct an evaluation of the PChAD program. As part of that evaluation, we'd like to gather perspectives from AHS employees who work with the PChAD program.

The interview should take about 30 minutes to complete. It may take more or less time, depending on how much you are able to share. You can refuse to answer any questions or withdraw at any time without fear of retribution. Do you consent to do this interview?

Do you consent to our audio-recording the interview to ensure the data collection is complete? The tape file will be used to transcribe the interview. The transcription will be anonymous and the audio-recording will be erased after the evaluation is completed. Data will be analyzed and reported with other health care provider data.

Finally, do you have any questions before we start the interview?

Icebreaker
Our questions will ask about various topics including staff training, information available, and delivery and coordination of services.

I'd like to start by asking you about your job, and how it's connected to the PChAD program.

- Job title, zone, nature of work
-

Training and information
Can you tell me a bit about any PChAD-specific training you've been involved in?

- Do you have all the information you need about PChAD?
- Do you feel like the people you work with have all the right information?

How do parents or guardians find out about PChAD?

If you work with parents or guardians, do you feel that they get all the information they need to navigate the entire process?

- Are there information gaps? For example, do they know what kind of evidence they need to bring to court?
- Do parents ever complain to you about a lack of information, or about complicated or inconsistent information?

In your time working with PChAD, have you seen any improvements made to staff training? Any improvements to communication and the information that is made available to parents?

Admitting youth
In your perspective, are the right children being granted court orders?

In your perspective, are admission criteria applied consistently?

Are there children you think should be in PChAD, but their guardians aren't accessing it?

- Can you tell us about what might be preventing those guardians from accessing court orders? <probe for capacity to navigate system, understanding of program, fear of damaging relationships, etc.>

Once orders are granted, how often is a bed immediately available? Can you tell me anything about bed availability or capacity?

Can you comment on the coordination with police transporting youth?
- What works well?
- Have you seen improvements in coordination?
- What challenges continue to exist?
- How safe are children during transport?

<u>During program</u>
While children are admitted to the protective safe house, what is your perspective on the services that are delivered?
- Are children getting the right services? Too much, too little?
- Are there gaps in needed services during the program?
- In your view, are those services in line with what you know of best practice, or evidence? Are there services that don't align with best practices?

Can you provide any comments on the nature of relationships between youth who are in the protective safe house?
- Are relationships positive or negative?
- What is done to mitigate the risk of negative relationships/negative group talk? How are positive relationships nurtured?

Can you talk about how the physical safety of children is protected in the protective safe house?
- Are there risks to safety that continue to exist?

Can you tell me a bit about how relationships with parents/guardians are supported while children are in the protective safe house?
- Are there enough opportunities for calls or visits?
- What is done to ensure calls or visits are safe and supportive of the child's best interests?

In your view, are the right assessments done for every child?

During your time working with PChAD, have you seen any improvements made to service delivery while children are in the protective safe house?

<u>Discharge</u>
When the child's court-ordered time in the protective safe house is done, how well prepared do you feel they are to act on their treatment plans?
- Do all children leave with a treatment plan that can realistically be carried out?
- Are recommended services available immediately?
- Do you encounter children who you think are still not prepared for discharge at the end of their court-ordered time?
- In your view, are children ready and willing to change?

Do you feel that children and guardians have the capacity to navigate recommended services?
- Do they have access to the right supports to navigate?

- What gaps exist?
- What have you seen that demonstrates successful outcomes?

Conclusion

If you could change one thing about the PChAD program, what would it be?

Overall, how do you feel about your experience with the PChAD program?

Do you have any thoughts or suggestions that we haven't covered already?

Follow up

Thank you so much for sharing your perspectives today. We greatly appreciate you taking time from your busy day.

Police Services Interview Guide

First, thank you for agreeing to participate today. My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting. Alberta Health has hired Three Hive Consulting to conduct an evaluation of the PChAD program. As part of that evaluation, we'd like to gather perspectives from police services employees who work with the PChAD program.

The interview should take about 15 minutes to complete. It may take more or less time, depending on how much you are able to share. You can refuse to answer any questions or withdraw at any time without fear of retribution. Do you consent to do this interview?

Do you consent to our audio-recording the interview to ensure the data collection is complete? The tape file will be used to transcribe the interview. The transcription will be anonymous and the audio-recording will be erased after the evaluation is completed. Data will be analyzed and reported with other health care provider data.

Finally, do you have any questions before we start the interview?

Icebreaker
Our questions will ask about various topics including staff training, information available, and delivery and coordination of services.
I'd like to start by asking you about your job, and how it's connected to the PChAD program.

- Job title, nature of work
- Region of work

Training and information
Can you tell me a bit about any PChAD-specific training you've been involved in?

- Do you have all the information you need about PChAD?
- Do you feel like your colleagues have all the right information?
- Are there gaps in training, or in the quality or availability of relevant information?
-

In your time working with PChAD, have you seen any improvements made to staff training?

If you work with parents or guardians, do you feel that they have all the information they need to navigate the entire process?

- Do they have realistic expectations of support available from police?

Transporting youth
Can you comment on the coordination of police transports with AHS and bed availability?

- From what you see, how often are beds available when a court order is granted?
- What works well in coordinating with families and AHS?
- Have you seen improvements in coordination?
- What challenges continue to exist?
-

In your view, how safe are youth during transport?

- Can you comment on how safe youth feel during the transport process?

Can you suggest any improvements to make the police transport process better?

Conclusion
Do you have any recommendations for changes to the PChAD program?

Overall, how do you feel about your experience with the PChAD program?

Do you have any thoughts or suggestions that we haven't covered already?

Follow up
Thank you so much for sharing your perspectives today. We greatly appreciate you taking time from your busy day.

PChAD Youth Interview Guide

TELEPHONE SCRIPT	
May I please speak to **<youth name>**?	
Possible respondent responses	Suggested interviewer response
"They are not here/available"	Is there another time I could reach **<him/her>?** **<If yes, record date and time to call back>** Ok, I'll call back later. Thank you for your time. **<Terminate call>**
"They are too unwell to speak"	Sorry to hear that. I was going to invite **<him/her>** to take part in an interview. I am sorry to have disturbed you. **<Terminate call>**
"Who's asking?"	My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting. We are speaking with people who have been involved with an AHS program and would like to ask **<youth name>** if s/he would like to participate.
"How did you get my name/number?"	Your phone number was obtained from Alberta Health Services, who told us that they would be interested in doing an interview.
"Yes, this is s/he speaking"	My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting who Alberta Health has hired to complete an evaluation of the PChAD program. We are asking to talk youth who have been involved with the PChAD program to get their feedback. Do you have about 30 minutes to talk with me? **<If 'no'>** Is there a better time to call? <If 'no'> That is okay. Thank you for your time. **<Terminate call>** **<If 'yes', continue to Consent>**

Consent

Great. I will give a little bit of background information before we continue. Your participation is voluntary, and your answers will be confidential. As I mentioned, we are interested in your experience with the PChAD Program and would like feedback to inform its evaluation.

There may be questions that are difficult to talk about, so you can skip any questions you do not feel comfortable answering or even stop and withdraw at any time. There are no right or wrong answers – honest answers are the most helpful.

Do you consent to our audio-recording the interview to ensure we capture the conversation accurately? The audio file will be used to transcribe the interview. The transcription will be anonymous and the audio-recording will be erased after the evaluation is completed. Data will be analyzed and reported with other data from youth.

Do you have any questions before we start?
<If 'yes', answer questions>

Is it okay to proceed? **<If 'no,' ask for a better time. If 'yes,' proceed.>**

Okay, I'll turn on my recorder now.

Icebreaker
Our questions will follow the order of first finding out about the court order, then about your time in the protective safe house, and what happened after.

My first question is about how you would like me to refer to your parent or guardian while we're speaking. Should I say "your guardian" or "your aunt/your dad/your mom/your grandparent?" **<refer to the guardian by the youth's preferred terminology throughout the rest of the interview>**

Learning about court order and transport
How did you first find out about the court order placing you in the PChAD program?

- Did your parents/guardians tell you they were trying to get a court order?

How were you brought to the protective safe house?

- By parents/guardians or by police?
- How did you feel on your way there?
- Did you feel safe? What helped to you to feel safe/led to you feeling unsafe?

Did you understand what was happening?

- Where you were going?
- Why you were going there?
- How long you would stay there?
- What else to expect?

When you had questions, were they answered in a way that satisfied you?

Is there anything else you'd like us to know about your experience getting to the protective safe house?

At the PSH
Next I'll ask you about your time staying at the protective safe house.

Can you tell me a bit about your experience staying there?

Were there activities that you enjoyed? Activities that you didn't like?

Did you feel safe?

What were your relationships with staff like?

- Were you comfortable asking questions?

Did you spend much time talking with other youth?

- Do you feel like the other youth were positive or negative influences? In what way?

Were you able to speak with your parents/guardians?

- How did the staff help to ensure those visits/calls went well?
- Were there things that did not go well? Could staff have done anything differently to make those visits/calls better?

How do you feel about the number of days you spent there—was it too short? Too long?

Court

Did you go to court at all during your time at the protective safe house?
<if 'yes,' ask questions below>

Did you know what would happen at court?

Did you feel prepared for your court appearance?

Did you feel like you had enough support to go to court?

- What would have helped you? What was really helpful?

After discharge

How did you feel about the treatment plan that was created for you?

- Did you feel like you would be able to do the things in that plan?

Can you tell me about your experience trying to follow through with that plan?

- Were services available when you needed them?

Conclusion

Overall, how do you feel about your experience with the PChAD program?

- Satisfied?

What was most helpful?

If you could change one thing, what would it be?

Do you have any thoughts or suggestions that we haven't covered already?

Follow up

Thank you so much for sharing your perspectives today. Alberta Health and Alberta Health Services are committed to making improvements to the PChAD program.

Can you provide your mailing address for us to send you the $20 gift card as a token of appreciation for your time? **<turn off recorder and write down address>**

SUPPORT SERVICES

Health Link: 811 (available 24/7)
Addiction helpline: 1-866-332-2322 (available 24/7)
Mental health helpline: 1-877-303-2642 (available 24/7)

PChAD Guardian Interview Guide

TELEPHONE SCRIPT	
May I please speak to **<guardian's name>**?	
Possible respondent responses	Suggested interviewer response
"They are not here/available"	Is there another time I could reach **<him/her>?** <If yes, record date and time to call back> Ok, I'll call back later. Thank-you for your time. **<Terminate call>**
"They are too unwell to speak" (physically unwell)	Sorry to hear that. I was going to invite **<him/her>** to take part in an interview. I am sorry to have disturbed you. **<Terminate call>**
"Who's asking?"	My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting. We are speaking with people who have been involved with an AHS program and would like to ask **<guardian name>** if s/he would like to participate.
"How did you get my name/number?"	Your phone number was obtained from Alberta Health Services, who told us that they would be interested in doing an interview.
"Yes, this is s/he speaking"	My name is **<interviewer name>** and I am an evaluator with Three Hive Consulting who Alberta Health has hired to complete an evaluation of the PChAD program. We are asking to talk with parents or guardians who have used the PChAD program to get their feedback. Do you have about 30 minutes to talk with me? **<If 'no'>** Is there a better time to call? <If 'no'> That is okay. Thank you for your time. **<Terminate call>** <If 'yes', continue to Consent>

Consent

Great. I will give a little bit of background information before we continue. Your participation is voluntary, and your answers will be confidential. As I mentioned, we are interested in your experience with the PChAD Program and would like feedback to inform its evaluation.

There may be questions that are difficult to talk about, so you can skip any questions you do not feel comfortable answering or even stop and withdraw at any time. There are no right or wrong answers – honest answers are the most helpful.

Do you consent to our audio-recording the interview to ensure we capture the conversation accurately? The audio file will be used to transcribe the interview. The transcription will be anonymous and the audio-recording will be erased after the evaluation is completed. Data will be analyzed and reported with other family data.

Do you have any questions before we start? **<If 'yes', answer questions>**

Is it okay to proceed? **<If 'no,' ask for a better time. If 'yes,' proceed.>**

Okay, I'll turn on my recorder now.

Icebreaker
Our questions will follow the order of first learning about and accessing PChAD, then getting your court order, your child's time in the protective safe house, and what happened after.

How did you first get learn about the PChAD program?
- Prompts: from online searches, word of mouth, from AHS staff?
- Did you consult any other information sources?

Accessing PChAD
Can you tell me a bit about your experience with AHS prior to getting your court order?

I have some questions specifically about the information you received about PChAD.
- Did you get enough information about PChAD?
- Was the information given to you in a way that was easy to understand?
- Was program eligibility clear?
- Were there things you should have been told, but weren't?
- Did you have the right information at the right time?

When you had questions, were they answered in a way that satisfied you?

Court
Next I'll ask you about getting your court order.

Did you know what kind of evidence you would need to bring to court?

Did you feel prepared for your court appearance?

Did you feel like you had enough support to navigate this process?
- What would have helped you? What was really helpful?

If you went back to court to ask for an extension of the order, can you tell me a bit about that experience?

After order
When your order was granted, was a bed available for your child?

Can you tell me a bit about your experience having your child transported to the protective safe house?
- Did you feel your child would be safe?
- Did you have enough/timely communication from police and Alberta Health Services?
- Were there parts of that process that weren't clear to you? Parts that were challenging?
- What went well?
- What didn't go well?

During order
Were you kept informed about how your child was doing while they were at the protective safe house?

Were you able to visit or speak with your child if you wanted to?

- How did the staff help to ensure those visits/calls went well?
- Were there things that did not go well? Could staff have done anything differently to make those visits/calls better?

After discharge
How did you feel about the treatment plan that was created for your child?

Can you tell me about your experience trying to follow through with that plan?

- Were recommended services available when you needed them?

Conclusion
Overall, how do you feel about your experience with the PChAD program?

- Did it make a difference for the child? Did you notice a change in the child?
- What was the biggest impact?

Do you have any thoughts or suggestions that we haven't covered already?

Follow up
Thank you so much for sharing your perspectives today. Alberta Health and Alberta Health Services are committed to making improvements for guardians and children.

Can you provide your mailing address for us to send you the $20 gift card as a token of appreciation for your time? **<turn off recorder and write down address>**

SUPPORT SERVICES
Health Link: 811 (available 24/7)
Addiction helpline: 1-866-332-2322 (available 24/7)
Mental health helpline: 1-877-303-2642 (available 24/7)

Recommendations Tearaway

Recommendation 1: Implement a parent and youth survey to understand their experience and outcomes after participation in the PChAD program, both upon discharge and again at three to six months following discharge.

Recommendation 2: Identify ways to enhance program awareness (e.g. brochures for schools or community programs, more information on the AHS website, etc.). Continue to offer pre-application information sessions and encourage participation across all parents or guardians considering PChAD.

Recommendation 3: Ensure consistency of information across AHS sites, programs and staff. Identify and share a location (e.g. AHS Insite) to house up-to-date PChAD information that AHS staff can easily access when needed. Determine which roles require understanding of PChAD and implement mandatory training on the program through the AHS e-learning platform.

Recommendation 4: Explore solutions to allow staff within and outside of AHS to view real-time bed availability at PSH sites.

Recommendation 5: Coordinate better with other services (e.g. voluntary treatment facilities) to improve timely access to recommended services.

Recommendation 6: Ensure all staff understand the availability of post-treatment options – what services are available, where are they located, and when they may be needed by PChAD youth.

Recommendation 7: Explore IT solutions that can help with the coordination of treatment planning at discharge. Establish information sharing agreements across PChAD/AHS and Children's Services to reduce wait times for client information.

Recommendation 8: Continue to monitor the literature for new information on best practices for involuntary detox and stabilization services for youth. Share learnings from PChAD at conferences and journals to encourage communities of practice and knowledge sharing.

Recommendation 9: Explore options for length of confinement. Consider a minimum length of 15 days, with the option for the initial court order to be up to 30 days if recommended through an AHS assessment.

Recommendation 10: Consider extending the mandate beyond detox to include the possibility of treatment. Establish criteria to determine whether youth should receive treatment while at PChAD.

Recommendation 11: Explore ways to better integrate families into PChAD and treatment planning to better support youth in implementing change post-program. For example, family treatment or continued support after discharge.

Recommendation 12: Develop and implement a system for continuous monitoring of program performance, including standardized outcome assessments and the post-discharge surveys of guardians' and youth experiences suggested in Recommendation 1.

Recommendation 13: Seek to better understand the use and optimization of available PSH beds to identify opportunities for enhanced efficiency as well as access, and consider developing a system for real-time access to bed availability information.

Recommendation 14: Explore the feasibility of integration or co-location with other services or programs with an emphasis on mental health supports (e.g. psychiatry or family counseling) and medical staff (e.g. on-site nurses).

Recommendation 15: Establish a working group with police services (RCMP and municipal police forces) to establish clear processes, enhance communication and identify areas to make the transport process more efficient (e.g. shared transport between different municipalities to reduce long travel days).

Recommendation 16: Offer additional training opportunities to staff for managing and accommodating youth behavioural changes.

PChAD Review Recommended Actions

Note: Actions in **bold black font** are being implemented by Alberta Health Services (AHS).

Actions highlighted in red are the recommendations that were not sent to AHS. These recommendations could not be immediately implemented within existing budgets or legislative frameworks.

Program Change Actions

Accessing the PChAD program
1. ***AHS*** **to develop consistent materials and venues for community engagement to increase the awareness and understanding of the PChAD program among youth-serving organizations and institutions (e.g., not-for-profits and school boards), First Nations, Métis communities and organizations, Indigenous-serving organizations, and parent-supporting organizations.**
2. *AHS* to conduct a needs assessment to identify if and where new PChAD program beds or protective safe houses are needed to improve access to the program, with a focus on underserved areas of Alberta (e.g., First Nations communities, Metis settlements, and areas of high demand).
3. ***Alberta Health*** **to work with Justice and Solicitor General to develop policy to enable ongoing access to teleconferencing for rural and remote families to use when applying for or reviewing a PChAD protection order with the Provincial Court, where infrastructure and funding opportunities are available.**
4. *Alberta Health to work with Justice and Solicitor General* to develop options to improve access to peace officers for apprehension and transportation of youth living in rural and remote areas to protective safe houses. This could include exploring use of AHS-provided transport, training for peace officers regarding cultural safety and competency, and apprehension in a non-criminal context.
PChAD program operations
5. ***AHS Provincial Addiction and Mental Health*** **to develop consistent standards and reporting across all protective safe house sites, and look to find efficiencies in program delivery.**
6. *AHS* to develop policies and procedures to ensure appropriate and consistent services at all protective safe houses, including medically assisted detox and enhanced mental health support, as required.
7. ***AHS*** **to increase information sharing with parents/guardians on the progress of their child through the program, and increase information sharing and coordination with community**

	addiction treatment providers, mental health providers, and peer supports to create pathways for youth post-discharge.
8.	***AHS* to improve community connections for Indigenous youth accessing the PChAD program by working with the AHS Indigenous Health Hub, and First Nations and Métis communities and organizations, and review PChAD program policies to identify and remove any barriers to supporting Indigenous cultural and healing practices.**
Post-PChAD discharge	
9.	***AHS* to facilitate smooth transition to post-PChAD program services, including where possible facilitating direct connection or referral to recovery-oriented services prior to discharge from the protective safe house.**
10.	***Alberta Health to work with AHS* to build stronger relationships between the PChAD program and the wider addiction treatment ecosystem to create clearer pathways for youth to access recovery-oriented services and supports post-discharge.**
11.	*AHS* to include transitional and post-discharge support for all youth admitted to the PChAD program and their families. This includes that a case manager at the protective safe house staff works with youth before discharge to build a relationship, maintains contact with the youth and their family after discharge and provides support to help the youth access treatment, and other supports after discharge from the PChAD program.
12.	***AHS* to develop and implement outcome measurement tools to better understand the short and mid-term outcomes for youth leaving the PChAD program, and use these data for continuous, evidence-based improvement.**

Potential Legislative Change Actions

Legislation consolidation

13. *In collaboration with Children's Services, Alberta Health* explore the possibility of consolidating or aligning Alberta's non-criminal secure care legislation.

    - The 2020 Government of Alberta Multi-Sector Review: Youth Assault of a Member of the Public recommended that "the Government of Alberta review secure settings to determine if they are meeting the needs of youth with complex service needs."

Applying for a protection order

14. *Alberta Health* to explore the possibility of amending the PChAD Act to also allow people with whom a young person has a close personal relationship and youth workers to apply for a PChAD protection order.

Assessment of youth

15. *Alberta Health* to explore the possibility of amending the PChAD Act to include a provision requiring assessment of the youth on arrival at the protective safe house in order to determine if the young person should be confined.
    - Such a provision would require that two different qualified health professionals assess the young person after their arrival at the protective safe house to determine whether they meet the criteria for confinement under the Act.
    - Should a young person not meet confinement criteria, they would be discharged into the care of their parent/guardian and connected with appropriate community services.

Confinement Length

16. *Alberta Health* to explore the possibility of amending the PChAD Act to provide for a longer confinement length, to a maximum of 90 days, with a stage-gated process of assessments to determine the appropriateness of confinement at various points in their recovery journey at the protective safe house.

Community detox and addiction treatment

17. *Alberta Health* to explore the possibility of amending the PChAD Act to provide for:
    a. Issuing a community order for youth to receive detox, assessment and stabilization services in a community setting (i.e., not at a PChAD program protective safe house).
    b. Mandatory treatment while at the protective safe house.

Attachment 1: Jurisdictional Scan - Safe Sobering Legislation and Policies – December 2022

Issue:	AB	MB	NB	NFL	NS
Safe Sobering Legislation	Gaming, Liquor and Cannabis Act	Intoxicated Persons Detention Act	Intoxicated Persons Detention Act	Detention of Intoxicated Persons Act	Liquor Control Act
Summary	A **peace officer** who finds a person **publically** intoxicated can hold the person in custody for up to **24 hours** in a **police cell** until recovery or an application is made for their release.	A **peace officer** who finds a person **publically** intoxicated can hold the person in custody for up to **24 hours** in a (designated) **detoxication**[1] **centre** or **police cell** until recovery or an application is made for their release.	A **peace officer** who finds a person **publically** intoxicated can hold the person in custody in a **police cell** until recovery or an application is made for their release. (i.e. **no time limit for detainment**).	A **peace officer** who finds a person **publically** intoxicated **and a danger to themselves, others or causing a nuisance** can hold the person in custody for up to **48 hours** in a (designated) **detoxification centre** or **police cell** until recovery or an application is made for their release.	A **peace officer** who finds a person **publically** intoxicated can hold the person in custody for up to **24 hours** in a **police cell, any available treatment service, hostel or facility for care** until recovery or an application is made for their release.
Remaining after 24 Hours[2]	Not permitted.	Only if the person consents and is in a detoxication centre.	No time limit for detainment.	A person can remain past the **48 hour limit** if **2 qualified medical practitioners** sign a written certificate indicating a lack of recovery.	Only if the person consents.
Separate Detox Centre for Safe Sobering	N/A.	Detoxication centres designated **by the Minister**	N/A.	Detoxification centre must be a **hospital** designated **by Lieutenant-Governor in Council** upon advice of the Minister of Health and Justice.	N/A. However, detainment could occur in an existing treatment service location, hostel or facility of care.
Defining Recovery	Recovery means the person is no longer a danger to themselves/others or causing a nuisance.	Recovery means the person is no longer a danger to themselves/others or causing a nuisance.	Recovery means the person is no longer a danger to themselves/others or causing a nuisance.	Recovery means the person is no longer a danger to themselves/others or causing a nuisance.	Recovery means the person is no longer a danger to themselves/others or causing a nuisance.
Application for Release	A person capable of taking care of the person taken into custody undertakes to take care of that person.	Can be made by a family member or "person who **appears to be suitable** and capable of taking charge of the person, into the charge of the applicant"	Can be made by a family member "**or by an adult** who **appears to be suitable** and capable of taking charge of the person, into the charge of the applicant"	Can be made by a family member "**or by a person of the age of majority** who **appears to be suitable** and capable of taking charge of the person, into the charge of the applicant"	A person capable of doing so undertakes to take care of the person in custody upon their release.

[1] Confirming that "Detoxication" is indeed how it is spelled in the legislation.

[2] A separate facility for detainment allows for options to provide transitionary and voluntary detoxification service after an individual has sobered up especially if those services are offered onsite and/or if the arrangements can be made on the site.

Child Custody	No special provision.	No special provision.	Officer in charge of custody will provide oral or written notice to parent stating place and reason for detention. (makes applicable references to the Provincial Offenses Procedure for Young Persons Act)	No special provision.	No special provision.
Exemption from Liability	Applies if officer or other person performing duties with respect to the custody does so **in good faith**.	Applies if officer, **person employed in a detoxication centre or other person** performing duties with respect to the custody does so **in good faith**.	Applies if officer has **reasonable grounds** for belief and **does not use any more force than is necessary**.	Applies if officer or other person performing duties with respect to the custody does so **in good faith**. This includes if an officer had **reasonable grounds** for belief and neither the officer or other person **use more force than is necessary**. Furthermore, all persons are exempt from issues stemming from examining or treating a person against their will if brought into the detoxification centre.	Does not appear to have this provision.
Amendments	N/A	Bill 229 amends the Act to clarify that the Act applies to a person under the **influence of drugs** as well as alcohol.	N/A	**S2.1**, added 2004 cL-3.1 s24 indicating that the *Labrador Inuit Land Claims Agreement Act* takes precedence over any inconsistencies or conflicts.	Not entirely clear.
Challenges to Legislation	N/A	R. v. Alexson, 2015 MBCA 5 Court of Appeal ruled that the Act was intra vires and that confinement does not necessarily take the legislation into the realm of criminal law. The justification of confinement to prevent the person from being a danger to themselves or others is sound and different from criminal confinement due to the individual posing a threat to society.	N/A	N/A	Not entirely clear.

Outstanding Concerns	Likely similar to those presented in R v Alexson.	There are concerns that the police may use the Act to detain a person ostensibly for their "protection" if no criminal grounds are found. The most controversial part of R v Alexson was that the Court was fine with the Act being applied in a private residence based on police having a common law duty to prevent crime and protect property and life regardless of whether it is in public or in private.	Likely similar to those presented in R v Alexson.	Likely similar to those presented in R v Alexson.	It is unclear how a peace officer is able to detain an individual in a facility that is not designated (purpose built) or in a police cell. The Act does not appear to provide a liability exemption provision for officers exercising their ability to apprehend and detain an intoxicated person.
Deaths in Custody	Unknown at this time. JSG report in 2015 suggest there were a few deaths in the span of a few years.	Joe John Tssessaze, 47 – died while detained under the Act. There have also been sporadic reports of deaths for criminal detainments for intoxication.	Insufficient data.	Insufficient data.	Insufficient data.

Jurisdictions that do not appear to have safe sobering legislation

Issue:	**BC**	**ON**	**SK**
Relevant Legislation	Liquor Control and Licensing Act	Liquor License and Control Act	Alcohol and Gaming Regulation Act
Summary	A **peace officer** may arrest an individual without warrant on reasonable grounds that the individual is intoxicated in a public place.	A **police officer** or **conservation officer** may arrest an individual without a warrant if the officer is of the opinion that the individual is intoxicated in a place where the general public is invited or permitted access to or any part of a residence that is used in common by persons occupying more than one dwelling in the residence **AND** if it is necessary to do so for the safety of any person.	An officer under the Act may arrest without warrant an individual that is intoxicated in a public place or on any permitted premises.

From: Jurgita Kornijenko
To: Kenton Puttick; Erin L Jackson; Brian Lam; Robert Murdoch
Subject: Edmonton journal article - involuntary treatment
Date: December 14, 2022 11:46:30 AM
Attachments: image001.png

Hi everyone,

Just sharing for information if you haven't seen this article yet:

David Staples: Alberta UCP follows lead of B.C. NDP on involuntary drug treatment

[redacted] 29

Jurgita Kornijenko
Senior Policy Analyst
Legislation and Policy Unit
Ministry of Mental Health and Addiction | Government of Alberta
Office: (780) 643-1349 | Email: [redacted] 18

Classification: Protected A