



November 29, 2025 (updated February 25, 2026)

**General guidance for physicians on treatment of children and youth
with substance use disorders under the *Mental Health Act***

INTRODUCTION

A document providing guidance for treatment of adults under the *Mental Health Act* (the “Act”) was distributed on March 12, 2025. This document builds on that guidance by providing additional details that pertain to children and youth who are minors under BC legislation (referred to in this document as “minors”), and are therefore also under the purview of the *Infants Act*.

Involuntary admission and treatment under sections 8, and 22 of the Act can only be provided to a person who meets all the following stringent criteria:

- the person has a mental disorder that seriously impairs their ability to react appropriately to their environment or associate with others, and requires treatment;
- the person requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration, or for the protection of the person or for the protection of others;
- the person cannot suitably be admitted as a voluntary patient.

For the purposes of this document, the criteria in the first and second bullets together will be referred to as “mental impairment”. No subtype of mental disorder is excluded from sections 8, 20, and 22 of the Act, and conversely, no specific subtype of disorder per se warrants admission or treatment under these provisions. In fact, whenever voluntary services are a feasible alternative to deliver evidence-based care, they should always be preferred, and admission against a person’s will should only constitute an option of last resort, when all alternatives have failed or would lead to serious risk to the life and health of the person or others. For a person with a mental disorder to be involuntarily admitted and receive treatment under sections 8, and 22 of the Act,



there needs to be a clear state of mental impairment. The vast majority of people diagnosed with any subtype of mental disorder, including substance use disorders, are unlikely to meet the criteria for involuntary admission and treatment under sections 8 and 22 of the Act. Indeed, presentations of most mental disorders such as, for example, substance use disorders, anxiety disorders, obsessive-compulsive disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom disorders, feeding and eating disorders, and personality disorders, will ordinarily not require involuntary admission and treatment except in extremely rare cases that meet the stringent criteria discussed in this document.

Further, the application of the Act to minors presents specific challenges. Of note, society does not usually allow minors to engage in activities that entail a high level of responsibility (such as voting) or a high risk to self and others without parental consent; and sometimes not at all, for example with respect to purchasing and/or consuming alcohol, or gambling. It is also recognized that due to their stage of neurodevelopment, children and adolescents lack sufficient cognitive development, most notably of functions requiring frontal lobe maturity such as impulse control or executive decision-making and planning capacity which adults presumably possess.

Thus, the responsibility for ensuring the wellbeing of minors and protecting their health generally lies with a responsible adult, usually parents or guardians until such functions are fully developed, which is conventionally set at a given age (deemed “adulthood”) despite wide interpersonal and developmental variation.¹

The *Infants Act* and Consent by a Minor

The *Infants Act* contains important provisions that must be considered when caring for minors. As indicated above, there are wide interpersonal variations in neurodevelopment. Therefore, though

¹ Though in this document we refer to “parent or guardian” for simplicity, in fact it is the legal guardian that can provide consent for a Minor (i.e., a parent who is not the legal guardian cannot provide consent for the Minor)



the default approach to decision-making should be that it is the parents or guardians' responsibility to accept or refuse care on behalf of a minor under their responsibility (as it is with any other decision that concerns the wellbeing of the minor), there are specific circumstances in which consent by a minor would be valid and sufficient. Section 17(3) of the *Infants Act* provides that consent to health care by a minor is only valid if two conditions are met: (1) the health care provider has explained the care to the person and is satisfied that the person understands the nature and consequences and reasonably foreseeable benefits and risks of that care; and (2) the health care provider has made reasonable efforts to determine and has concluded that the health care is in the person's best interests. If these conditions are met, the minor has the legal ability to consent to the health care, and the consent of the minor must be obtained before the care is provided. It follows that the minor's consent can only be taken as sufficient (as opposed to requiring parental consent) if both conditions are met: the provider is satisfied that the minor has a thorough grasp of the pros and cons of the intervention, **and** said intervention is in their best interest. Conversely, if the health care provider is not satisfied that the conditions under section 17(3)(a) and (b) of the *Infants Act* are met, then the health care provider could not deliver the intervention unless the parent or guardian provided their consent. Importantly, in such a situation the provider would be able to deliver the health care with parental consent, even if the minor does not agree.

How does this apply to providing care to Minors under the *Mental Health Act*?

With respect to receiving involuntary care under sections 8 and 22, the Act does not differentiate between adults and minors, so there is no difference between them: the patient must meet the criteria specified in section 22, in which case section 8 of the Act authorizes the director to make treatment decisions and, if the person is incapable of appreciating the nature of treatment and their need for it, then treatment authorized by the director can be provided. It should be stressed that the correct, timely, and meaningful completion of the required forms under the Act including those that



authorize involuntary admission and treatment, notify a support person, and inform patients of their rights is of critical importance in safeguarding the rights of the patient. With respect to voluntary care, the Act differentiates between minors who are under 16 years of age and minors who are older, as it relates to the question of admission to hospital. Under section 20(1)(a)(ii) of the Act, a minor under 16 years of age may be admitted on the request of a parent or guardian if a physician or nurse practitioner examines the minor and concludes that they have a mental disorder for which inpatient treatment would be indicated, but a minor 16 years old and older cannot be admitted against their will at the request of a parent (of note, they can still be admitted involuntarily under Section 22 if they meet criteria).

Substance use disorders and the *Mental Health Act*

Admission and treatment against a person's will under the Act create concerns relating to the patient's liberty interest. In the case of minors, whether over or under the age of 16, these concerns should be carefully addressed with reference to the applicable provisions in the Act and the *Infants Act*. Just as with adults, inpatient care (voluntary or involuntary) must not be employed as a controlling intervention to curb risky decision-making or override the minor's harmful or self-harmful behaviour if the decision-making or actions of the patient are unrelated to a mental disorder. It is only if such behaviours can be ascribed by a physician or nurse practitioner to a mental disorder that treatment under the Act is appropriate, either voluntarily under section 20 or involuntarily under sections 8 and 22.

In summary, under section 20 of the Act, minors with substance use disorders (or any other subtype of mental disorders) can be admitted voluntarily as follows:

- if they are 16 years of age or older and request admission; or
- if they are under 16 years of age and a parent or guardian requests admission

provided that in both cases a physician or nurse practitioner is of the opinion that the minor has a



mental disorder that merits inpatient care. It is important to note that under our legislation, admission and treatment are two distinct steps, so after admission under section 20, a minor could receive safe and effective psychiatric treatment under one of the following two circumstances:

- with the consent of the minor, if the healthcare provider finds that the conditions set out in section 17(3)(a) and (b) of the *Infants Act* are met, or
- with the consent of a parent or guardian, if the healthcare provider finds that the conditions set out in section 17(3)(a) and (b) of the *Infants Act* are not met.²

Considerations about when to admit a Minor under section 20 vs. section 22 of the Act

In a situation where it is the clinical judgment of the provider that a minor under 16 years of age would benefit from a course of inpatient admission and treatment, but the minor rejects it, a key consideration is whether the likely benefit from admitting the minor against their will outweighs the potential negative experience of an admission and treatment the minor disagrees with. If the minor is suffering from a clear state of mental impairment and risk emerging from the mental disorder, then the issue is straightforward: the minor could be admitted under section 20 if a parent or guardian requests it (this would constitute a voluntary admission), or under section 22 which does not require a parent or guardian to request admission (this avenue becomes available if the minor meets all criteria for involuntary admission under section 22). If the existence of a mental disorder is ascertained and inpatient treatment is warranted, but the minor does not meet all criteria laid out in section 22 of the Act (with respect to risk to self and others and serious physical and mental deterioration) then admission under section 22 is not possible. In this case, admission under section 20 is available but has specific constraints that need to be considered: section 20 is subject to the provisions of section 21, which indicates that if the minor wants to leave the facility, they may request

² Of note, if the parent or guardian does not provide consent to an intervention deemed necessary to prevent serious injuries or preserve the life of the Minor by two physicians, section 29 of the Child, Family and Community Service Act allows for seeking a court order to provide the necessary healthcare.



a hearing by a review panel to review their admission, pursuant to section 25 of the Act, which would need to happen within 14 days of the request. The panel will review the decision to admit, and assess whether the minor meets the Act's definition of a person with a mental disorder, and if they disagree with the admitting physician, they will be discharged.³ Therefore, in order to proceed with the admission of an unwilling minor who meets criteria for section 20, the clinician may want to consider whether:

- the severity of the clinical picture and the risks associated with it clearly outweigh the potential negative effects of the unwilling nature of the admission (e.g., potential anger, trauma, loss of trust in parental figures and the system of care, avoidance of future therapeutic attempts, etc.)
- the severity of the clinical picture is such that a review panel can be expected to agree that the minor is a person with a mental disorder that seriously impairs their ability to react appropriately to their environment or to associate with others and requires treatment.
- the course of care is likely to produce a net clinical benefit (e.g., diagnostic clarification, stabilization and engagement with long-term therapeutic approach; initiation of pharmacological treatment, etc.) even if the patient is discharged within two weeks as a result of a decision by a review panel.

Considering the legal framework described above, there are four basic scenarios in which minors with substance use disorders may be admitted and treated even if they do not agree:

1. Concurrent mental and substance use disorders producing a state of mental impairment:

Comorbidity between severe mental disorders and substance use disorders is extremely

³ Per s. 1 of the MHA, a "person with a mental disorder" is defined as a "person who has a disorder of the mind that requires treatment and seriously impairs the person's ability to (a) react appropriately to the person's environment, or (b) to associate with others."



high, and most severe mental disorders have an onset during adolescence and youth. The mental impairment may result from psychosis, mania, or other severe mental syndromes. The specific disorder causing these syndromes of early onset may be difficult to ascertain unless close attention is paid to collateral information obtained from parents or providers of longitudinal care. In such cases, caution should be exercised to ensure that a minor is not prematurely discharged after an episode that required admission until sufficient collateral is obtained to allow for a diagnosis and a robust follow-up strategy.

If a physician or nurse practitioner determines that a minor under the age of 16 has a mental disorder that merits inpatient treatment, and a parent or guardian requests admission, the patient can be admitted under section 20, and if the minor does not understand the nature and consequences of treatment, then the parent or guardian needs to also consent to the subsequent psychiatric treatment.

Regardless of their age, minors can also be admitted under section 22 of the Act and treated under section 8 of the Act following the same procedure as for adults. Treatment under section 8 or with the consent of the parent or guardian needs to be holistic and include all psychopharmacologic and psychosocial interventions required to stabilize the patient, treat or mitigate the mental impairment, and decrease the risk posed to self and others.

2. Acute psychiatric syndrome of unclear etiology producing a state of mental impairment:

A minor with a known history of substance use disorder, in a state of intoxication, withdrawal, agitation, central nervous system depression, or post-overdose confusion, presents by themselves or is brought by their parents or police with a syndrome that meets the admission criteria under section 22 of the Act. At that point it may be impossible to



attribute the syndrome to a specific disorder subtype (e.g., mood disorder, psychotic disorder, or substance use disorder), but the existence of a mental disorder can be ascertained by the physician (importantly, the existence of a mental disorder, of which substance use disorders are a subtype, is a pre-requisite of any admission under the Act). Regardless of their age, minors can be admitted and treated under sections 8 and 22 of the Act. In addition, if the minor is under the age of 16, they can also be admitted under section 20 if requested by a parent or guardian. It is important to consider that in minors, substance use disorders are highly correlated with other concurrent mental disorders (which may include neurodevelopmental disorders, fetal alcohol spectrum disorder, etc.). There is also evidence that overdoses may be associated with suicidality and depression, a history that may not be revealed in acute settings. Therefore, minors who present with an overdose should be carefully assessed for associated mental disorders, which may require either close outpatient supervision or an inpatient setting, depending on the severity of the current presentation, the history, and the existing supports available to the patient. Minors who have just experienced an overdose can be in a heightened state of emotional dysregulation, demonstrate impaired impulse control, or be affected by post-overdose delirium, all of which affect insight, judgment, and decision-making. Such clinical presentations in and of themselves may generate a state of mental impairment sufficient to merit admission under section 22 or section 20 if a parent or guardian requests admission and a physician can ascertain that a mental disorder is causing it (scenario 4 below outlines the potential admission under section 20 of a minor who does not clearly meet criteria for admission under section 22).

After psychiatric care has been provided for the acute episode, two scenarios are possible:

- (a) The mental impairment may recede and not recur after the effects of any short-term



medication wear off. In some cases, even after careful assessment and access to collateral information from family, longitudinal caregivers, and others, no mental disorder can be ascertained after the acute episode has passed. In such cases, the health provider could conclude that it was the intoxication that produced the mental impairment and may decide to discharge the minor to continue engaging with voluntary outpatient services. The parents or guardians may be central for effective care planning and for ensuring continuity of care to detect a recurrence of the state of mental impairment or an undetected mental disorder.

- (b) After psychopharmacologic treatment (e.g., antipsychotic and/or mood stabilizing treatment) has stabilized the minor, a significant state of mental impairment may persist, requiring ongoing medication and care, which leads to scenario 3, outlined below.

3. After remission of the acute state, mental impairment persists:

A minor with a substance use disorder, who has not been previously diagnosed with another mental disorder, is found after stabilization to have a state of impairment that still meets the criteria under section 22 of the Act due to a previously undiagnosed mental disorder, which could be, for example, a psychotic disorder, a mood disorder, a neurocognitive disorder due to acquired brain injury, a neurodevelopmental disorder, or others. In this case, the minor's admission could continue under section 22, or under section 20 if the minor is less than 16 years of age and the parent or guardian requests it. Scenario 4 below outlines the potential admission under section 20 of a minor who does not clearly meet criteria for involuntary admission under section 22.

4. A parent or guardian requests admission and treatment for a Minor with a mental disorder:

If the minor has a mental disorder, of which substance use disorders are a subtype, the



parent or guardian requests admission, and inpatient treatment is warranted at that time, several factors should be considered:

- If the minor is 16 or older, they cannot be admitted under section 20 against their will.
- If the minor is under 16 years of age, the health care provider needs to ascertain if the minor is able to provide valid consent to treatment. The test specified in Section 17 of the *Infants Act* requires two conditions be met: the provider needs to be satisfied that the minor understands the nature, consequences, as well as the reasonably foreseeable benefits and risks of the intervention; and the provider also needs to conclude, after reasonable efforts, that the intervention is in the best interests of the minor. Two scenarios may emerge in this context:
 - If the conditions for the minor to consent to treatment are met, the minor must consent to the treatment in order for it to be provided.
 - If the required conditions for the minor to consent to treatment are not met because the provider is not satisfied that the minor understands the nature, consequences, risks and benefits of the intervention which the provider has concluded is in their best interests, then the minor does not have the legal ability to consent. Consent for the intervention that is in the minor's best interest should be sought from the parents.

Considerations about First Nations, Metis, and Inuit children and youth

The adequate care of First Nations, Metis and Inuit children and youth is not possible without involving their families, communities, and Elders, or without a long-term treatment approach that includes land-based healing practices and reconnecting to



culture. These practices are insufficiently available throughout our system, which is a shortfall this document is unable to address. Further, emergency departments and designated facilities are western healthcare institutions, with long-standing systemic barriers for Indigenous peoples, and the mental healthcare system should prioritize reducing stigma, avoiding traumatizing practices, and providing culturally safe care. With respect to the provision of care under the Act to Indigenous children and youth, providers need to ensure that services meet the British Columbia Cultural Safety and Humility Standard, and if unsure about how to achieve this, they should consult in advance with the Indigenous Health area of their Health Authority. Of note, ensuring that all voluntary options have been tried and/or are unsuitable for the urgency of the situation becomes of singular importance for Indigenous communities in light of the history of unwarranted detention in health and educational settings, and the resulting, persisting trauma. This guidance document is wholly insufficient to address the specific needs of Indigenous peoples, but it is important to highlight that, in accordance with the Declaration on the Rights of Indigenous Peoples Act, Indigenous peoples have the right to their traditional medicines and to maintain their health practices, and have an equal right to the enjoyment of the highest attainable standard of physical and mental health. In terms of this document, providers need to deliver services in a way that avoids stigma or re-traumatization, that minimizes disruption of the child and youth's connection with their families and communities, ensuring that the urgent and life-saving interventions are provided with the goal of facilitating access to follow-up services that contemplate access to culturally safe practices.

Final considerations about the criteria specified in section 17 of the *Infants Act*



as they may apply to a Minor being assessed for admission for psychiatric treatment at the request of a parent or guardian

As described previously, if a minor is being assessed for admission at the request of their parent or guardian, the health care provider needs to ascertain if the minor's consent to treatment would be valid, as described above. Of note, the test that needs to be applied under the *Infants Act* is situation-specific, i.e., it applies to the validity of the consent at a given time for a given intervention, as opposed to being a blanket determination of the minor's ability or inability to consent in general. In practical terms, it requires the provider's continuous assessment of two related aspects of the situation: the patient's ability at that point in time to clearly understand the risks and benefits of a specific intervention; and, whether the specific intervention being considered is in the best interest of the minor.

It follows that in order to apply this test, the provider needs to (a) have clarity about which intervention is in the best interest of the minor and the nature, consequences, risks and benefits of the intervention, (b) be able to explain this to the minor; and (c) have clarity about whether the minor has received the provider's explanation about the intervention, including its nature, consequences, risks and benefits, and understands them to the provider's satisfaction.

Three different clinical situations need to be considered at this point:

(1) A situation in which, from a medical standpoint, psychiatric treatment is an option, but other options can also be explored without unduly compromising the minor's life and health. This would be the case, for example, of minors with mental disorders on the milder end of the spectrum, expressing a preference for counselling, peer-based supports, or self-management. In such a case, if the provider is satisfied that the



intervention is in the minor's best interest, and that they have understood the explanation about its risks and benefits, then both conditions in section 17(3)(a) and (b) of the *Infants Act* are met, and the minor's consent to the treatment would be valid. With the minor's consent, the provider could explain the rationale to the parents as to why their request for admission cannot be fulfilled, as well as provide guidance as to how to monitor their child's wellbeing and detect potential increases in severity that would merit reassessment.

(2) Alternatively, a situation could emerge in which, from the point of view of the treating physician, psychiatric care is, with clarity and no credible alternative, in the best interest of the minor, but outpatient treatment would be preferable; or, a situation in which both inpatient treatment and outpatient treatment could be effective. The latter is frequently the case in patients with moderate to severe disorders for which the effective interventions are intensive and multimodal, often encompassing psychopharmacotherapy plus highly structured psychosocial interventions that require either outpatient treatment by interdisciplinary teams, or the highly structured milieu of inpatient settings. Examples of these would be severe borderline personality disorder, eating disorders, and substance use disorders. Which one (inpatient or outpatient) is in the best interest of the minor will depend on various circumstances such as the quality of the available options, the family environment, the impact of the minor's willingness on the expected effectiveness of the intervention, and the severity of potential foreseeable harms or risks associated with each option. In this situation, for the consent to be valid, the healthcare provider needs to be satisfied that after reasonable efforts (which include investigating aspects related to the disorder, the body of evidence for effectiveness, as well as the actual treatment options available to the specific minor in



question) the option that is in the best interest of the minor has been identified; and, that the minor has understood the explanation provided about the risks and benefits of the intervention. If at this point the minor consents, they receive the treatment. If they do not consent, they do not receive the treatment.

An additional caveat should be considered at this point: if the disorder in question is so severe that without psychiatric care it could predictably result in severe harms, including disability or death, then the physician, applying their independent clinical judgment, may not be satisfied that the minor has understood the explanations provided, may consider that the minor does not understand the risks and benefits, and may therefore determine that the minor does not meet the conditions set out in section 17(3)(a) and (b) of the *Infants Act*. In this context, and given that the provider finds that the care is medically required and consent needs to be obtained (because the minor does not meet criteria for Section 22 of the Act, which would warrant involuntary care), the provider should seek it from a parent or guardian before providing the health care.

(3) Finally, a scenario may occur in which from the point of view of the treating physician admission for inpatient psychiatric treatment is, with clarity and no credible alternative, in the best interest of the minor. This is frequently the case for severe disorders in an acute phase (e.g., a depressive episode with active suicidality, a psychotic episode with severe behavioural disorganization, psychomotor agitation or depression with or without a pre-existing diagnosis), or in a subacute but worsening state for which effective outpatient options have been tried and failed. In these cases, the provider would explain to the minor the consequences, risks and benefits of the required inpatient treatment, as well as the absence of outpatient alternatives. If the provider is



not satisfied that the minor has understood the explanation and the risks and benefits of the treatment, then the provider may determine that the minor does not meet the conditions set out in section 17(3)(a) and (b) of the *Infants Act*. Given that inpatient treatment is medically required, at this point the provider should seek consent from a parent or guardian before providing the health care (unless the minor meets criteria for section 22, in which case involuntary admission is warranted).



Treatment of Children and Youth with Substance Use Disorders
Under the Mental Health Act: Frequently Asked Questions

- 1) Does the guidance set out in this document involve any changes to the Act?
 - No, the Act is not being changed in relation to this document.

- 2) Is having a substance use disorder sufficient cause to warrant involuntary admission under section 22 of the Act?
 - No, the Act includes stringent requirements related to mental impairment, risk to self or others, and serious mental or physical deterioration for involuntary admission and treatment under sections 8 and 22 of the Act, and it is important to emphasize that the vast majority of people diagnosed with any subtype of mental disorder, including substance use disorders, are unlikely to meet the criteria. More importantly, as above, notwithstanding that substance use disorders are defined as mental disorders in standard psychiatric and medical nosology, section 22 of the Act should not be invoked for the purpose of treating the substance use disorder or addiction in and of itself. All admissions and treatment under sections 8, and 22 should be applied only where the stringent criteria required by the Act are met.

- 3) How does admission and treatment work under section 20 of the *Mental Health Act*? Can minors be admitted against their will at the request of the parents just for a substance use disorder?

In principle, a minor with any health condition that from a medical standpoint would merit inpatient treatment could be admitted and provided with medical care, even without the minor



agreeing to it, if (a) a parent or guardian requests it and (b) the minor is incapable of understanding the nature and consequences of consenting or refusing to consent to the proposed treatment and is therefore incapable of making an informed decision about it. In the context of mental disorders, admission procedures are regulated by the *Mental Health Act*. Specifically, for minors under the age of 16 with a substance use disorder (or any other mental disorder) that is severe enough to warrant voluntary inpatient care from a medical standpoint, even in the absence of a state of mental impairment and risk as described in section 22, admission to a mental health facility could occur if a parent or guardian requests it under section 20. Before treatment could be provided, the health care provider would also need to obtain consent (from the minor, if the requirements of section 17(3)(a) and (b) of the *Infants Act* are met, or from a parent or guardian if they are not).

As highlighted above, it is important to note two caveats to the application of section 20 where the parent or guardian is consenting to treatment of the minor in the case of substance use disorders that do not fall within the general parameters of the first three of the four scenarios outlined above (i.e. do not include a state of mental impairment and risk that clearly meets criteria for admission under section 22).

First, evidence for mandated treatment of addiction in and of itself is mixed, so the severity of the case (the risk of death, disability, or harm to others, for example) should be such that the expected benefits of treatment clearly outweigh the potential negative effects of admitting and treating a minor against their will. Second, sections 21 and 25 of the Act provide that a minor admitted under section 20 would be entitled to request a hearing before the Mental Health Review Board, the panel may review the physician's decision and, if it disagrees that the minor has a mental disorder that seriously impairs their ability to interact with others and the environment, it may order the discharge of the patient. In this instance, given that such



discharge can take place as early as within two weeks of admission, long term therapeutic effects may not have had time to occur, leaving the minor with a sense of distrust in the parent or guardian and system of care, and in the parents and caregivers a sense of futility and helplessness. All of which can potentially make future treatment more difficult and worsen long term outcomes. So the decision to admit and treat a child or adolescent against their will rests largely on whether the risk of death or disability that would be averted by admission under section 20 justifies the potential short- and long-term iatrogenic effects of admission and treatment in these particular circumstances.

- 4) Are any subtypes of mental disorders excluded from admission under sections 20 or 22 or treatment under section 8 of the Act? And do any subtypes require such admission or treatment under the Act?

No, as indicated above, the Act does not exclude any specific subtype of mental disorder provided that all criteria for admission (voluntary or involuntary) are met. Similarly, no disorder requires treatment under these sections of the Act *per se*.

- 5) Can I use opioid agonists or antagonists to involuntarily treat a patient with a substance use disorder in the absence of a state of mental impairment under section 8 of the Act?

No. Any involuntary treatment under the Act requires admission due to a state of mental impairment meeting stringent criteria (or demonstrable clinical certainty of recurrence of such a state in the patient with a mental disorder). The substance use disorder itself cannot be treated on an involuntary basis under section 8 of the Act if a state of mental impairment and resulting risk is absent.

- 6) If a patient meets criteria for involuntary admission under section 22, can I use opioid agonists or antagonists under section 8 of the Act?

The Act does not preclude the use of any specific psychopharmacotherapy that can be



legitimately considered psychiatric treatment. Some studies in adults have found positive effects of opioid agonists and antagonists on psychotic symptoms, potential neurobiological mechanisms have been proposed in the literature, and their ability to prevent serious mental and physical deterioration are well-established, especially in the case of buprenorphine (i.e., by reducing the risk of full agonist opioid toxicity). A systematic review concluded that “it is not only the anti-craving action of opiate agonism, but also its effectiveness on the psychopathological level that qualifies it as to be viewed as a powerful tool in treating mental illness”.⁴ Studies found that antipsychotics and opioids interfere with dopaminergic transmission through the same neuronal targets, and that buprenorphine specifically proved effective against hallucinations and delusions.⁵ With respect to opioid antagonists, results are mixed, with naloxone administration improving psychotic symptoms in some patients but not others.⁶ Of note, these studies highlighting potential off-label benefits of opioid agonists and antagonists, refer to their effectiveness in adult patients with psychosis.

Hence, on a case-by-case basis and when in the physician’s judgment there is an adequate psychiatric rationale and the potential benefit of using these drugs in a minor outweighs the risks, these drugs can be included as part of psychiatric treatment to treat the mental disorder that justified the admission under section 22 of the Act, and with the goal of preventing serious mental and physical deterioration. In other words, where, in the judgement of the treating physician, buprenorphine, for example, is appropriate and clinically indicated for patients whose mental impairment and resulting behavioural syndrome do not resolve with first-line medication

⁴ Maremmani AG, Rovai L, Rugani F, Bacciardi S, Dell’Osso L, Maremmani I. Substance abuse and psychosis. The strange case of opioids. *Eur Rev Med Pharmacol Sci.* 2014;18(3):287-302.

⁵ Clouet DH. A biochemical and neurophysiological comparison of opioids and antipsychotics. *Ann N Y Acad Sci.* 1982;398:130-9.; Schmauss C, Yassouridis A, Emrich HM. Antipsychotic effect of buprenorphine in schizophrenia. *Am J Psychiatry.* 1987 Oct;144(10):1340-2.

⁶ Heikkilä L, Rimón R, Terenius L. Dynorphin A and substance P in the cerebrospinal fluid of schizophrenic patients. *Psychiatry Res.* 1990 Dec;34(3):229-36.; Volavka J, Anderson B, Koz G. Naloxone and naltrexone in mental illness and tardive dyskinesia. *Ann N Y Acad Sci.* 1982;398:97-102.



alone, long-acting buprenorphine may be used as an adjunct to, for example, an antipsychotic in a patient with schizophrenia and opioid or polysubstance substance use disorder (i.e. when the patient is already suffering the risks and harms of opioid dependence and overdose).

- 7) Can I use opioid agonists or antagonists to treat a patient under 16 years old with a substance use disorder who meets admission criteria under section 20 of the Act (i.e. admitted at the request of the parent or guardian)?

In this case, if the treating physician determines that the minor is not able to provide valid consent, any safe and effective treatment could be provided with the consent of the parent or guardian. Of note, if a medication is being used off-label (which is very frequent for children and youth because of the lack of high-quality evidence for this age-group), then this should be explicitly discussed, including the potential harms or lack of effectiveness involved in such therapeutic attempts.

- 8) Which opioid agonist or antagonist should be used when providing treatment under the Act?

This document does not seek to prescribe specific clinical interventions or replace clinical judgment in any particular case. The appropriate interpretation of the existing evidence tailored to the specific circumstances of a patient is always up to the best judgement (and under the responsibility) of the treating physician and healthcare team. Any psychopharmacological approach for these highly complex patients, especially minors, should carefully consider both the intended effects as well as the potential unintended ones (side effects, worsening clinical picture, loss of trust in care, etc.). This document does not seek to recommend any specific approach, nor to provide an exhaustive list of what pharmacological approaches should be considered. Rather, this document clarifies that no specific psychopharmacological intervention is a priori excluded if it is assessed by the treating psychiatrist as capable of mitigating the state of mental impairment and risk produced by the mental disorder.

- 9) Can a minor admitted under section 20 still apply for a review panel? How about a second opinion?

They have the same right to a review panel as other patients admitted under the Act, but they do not have the right to a second opinion.

- 10) Can a minor access an independent rights advisor?

A minor admitted under section 22 should be provided access to an independent rights advisor.



11) The following clinical vignettes illustrate appropriate applications of voluntary or involuntary admission under sections 20 or 22 respectively, and involuntary treatment under section 8 of the Act for patients in scenarios such as those described in the first part of this document. It should be stressed that these vignettes are provided for illustrative purposes only and do not constitute a clinical guideline nor are they intended to replace individual clinical judgment. Each clinical situation is different, and each patient requires careful consideration by the treating physician, who is ultimately responsible for applying their best judgment, clinical acumen, and understanding of the legal framework:

- An 18-year-old patient with severe concurrent disorders is involuntarily admitted under section 22 and treated under section 8 of the Act in an inpatient unit due to persisting mental impairment resulting from refractory psychosis. Despite partial stability, and based on previous history, the treating clinician determines that the patient may be at risk of death due to increased behavioural disorganization (e.g., dangerous actions undertaken due to command hallucinations, such as running into traffic, attacking random strangers, or using fentanyl to silence auditory hallucinations) while on leave or upon discharge. In this case, and given the failure of first line treatments, the clinician decides to treat the minor with a combination of depot antipsychotic and depot buprenorphine under section 8, making sure to provide a clear psychiatric rationale (i.e., the primary goal of the pharmacotherapy is to improve treatment-resistant psychotic symptoms and their cognitive or behavioural repercussions, as well as to prevent serious mental and physical deterioration; the goal would not be to treat the addiction itself, which may persist).
- A 17-year-old patient suffers repeated crystal meth induced psychotic episodes so severe that they result in harms to self and/or others, including overdoses due to contamination with opioids and random attacks on strangers. These episodes resolve and do not recur



with antipsychotics: even when crystal meth is used, psychosis and resulting behavioural disorganization are much less severe, significantly reducing risk to self and others, as well as mental and physical deterioration. However, the patient systematically discontinues antipsychotics against medical advice when unsupervised, and severe episodes recur in the context of crystal meth use, again resulting in harm to self or others. The responsible physician decides that involuntary admission under section 22 of the Act is warranted for this severe recurrent psychosis. Treatment under section 8 consists of depot antipsychotics, which the responsible physician has determined are indicated to treat any form of recurrent psychosis, especially if adherence is inconsistent putting the patient and others at risk. In this case, the physician is treating the recurrent psychosis and its behavioural repercussions, and not the substance use disorder, which may persist.

- A 16-year-old youth presents with a presumptive opioid overdose after being found unresponsive; vital signs are recovered with a dose of naloxone. He has a black eye and an old suppurative wound in his knee, through which the patella is visible. The youth is brought to the emergency department and is confused, combative, refuses medical care, indicates that nothing is wrong with him, that his knee is healing, and demands to be discharged. The youth denies requests by staff to contact parents or other caregivers, and indicates that he needs to leave because he is in danger of abduction, refusing to provide additional details. Given the behavioural syndrome, compatible with post overdose delirium and an underlying mental disorder, as well as the risk of substantial mental and physical deterioration should overdose reoccur or behavioural disorganization persist, the responsible physician decides that involuntary admission and treatment under sections 8, and 22 of the Act are warranted, until thorough assessment is completed by obtaining collateral information from parents or guardians, providers of longitudinal care, or others.



- Parents of a 15-year-old girl bring her to hospital and request she be admitted because of a pattern of dangerous drug use. Upon interrogation the parents indicate that, aside from the use of multiple drugs (they have found various bags with powder of different colours in her room, as well as cannabis) and a deterioration of her grades and performance at school, her mood has not changed. They are unaware of any serious harmful or traumatic situation having occurred to their child, and have no knowledge of an overdose. They describe a pattern of dangerous behaviour starting around puberty, including polysubstance use and sexual activity they find objectionable. The youth, assessed separately, confirms the parents' overall description and adds that her parents have overly rigid expectations, do not take her needs into account, and try to prohibit her being alone with potential sexual partners until she is an adult. She acknowledges occasional opioid, stimulant, and cannabis use, but indicates that she and her friends always use testing strips in order to avoid fentanyl. She acknowledges inconsistent use of condoms or birth control mechanisms. The youth indicates she is aware of the risk she is taking, and agrees to outpatient care but does not in any way accept the need for admission, which she indicates would lead to a rupture in her relationship with the parents. After careful consideration, applying the test of section 17(3)(a) and (b) of the *Infants Act*, the treating physician finds that this youth could provide valid consent. Furthermore, her behavioural syndrome, however risky, does not seem to the treating physician to be necessarily caused by a state of mental impairment or by a mental disorder (which may be present, but may not be causally linked to the behaviours in question). The complex clinical picture appears compatible with the challenges of adolescence heightened by various personality traits and interpersonal dynamics, and the treating physician decides to attempt outpatient management rather than admission against the youth's will. With the minor's consent, the physician explains



the rationale to the child's parents, and recommends the parents consider consulting a family therapist to improve the family dynamic. They all agree to implement a structured outpatient treatment plan and closely monitor the minor for signs of mental impairment, risk of serious mental or physical deterioration, or harm to self or others, so that they can reassess the need for inpatient care if necessary. In summary, the treating physician does not think this youth should be admitted under section 20 or 22 of the Act at this point as she does not meet the criteria under either section.

- A 14-year-old youth is brought by his parents with a presumptive opioid overdose after being found unresponsive and only recovers his vital signs after multiple doses of naloxone. Initially he is confused and scared, with poor recollection of events. He gradually becomes aggressive, indicates that nothing is wrong with him, demands to be let go, refuses any interrogation, and forbids the doctor from talking to his parents, without providing a rationale for it. In light of the severity of the clinical picture (the minor would have died had he not received multiple doses of naloxone and may have suffered brain injury due to the period spent in respiratory arrest) the treating physician concludes that thorough assessment and treatment is required: on the one hand, the lack of insight about the severity of the clinical picture coupled with the aggressive refusal to engage with the treatment team are evidence of a current state of impairment that may result from post overdose confusion or a yet undiagnosed mental disorder, including a neurocognitive disorder due to acquired brain injury or a pre-existing neurodevelopmental or psychotic disorder. In light of the current syndrome, which makes it impossible for the provider to explain the nature, consequences, risks and benefits of the health care and be satisfied of the minor's understanding, the physician makes a determination that the conditions set out in section 17(3)(a) and (b) of the *Infants Act* are not met. Given that health care intervention is medically required, the



physician seeks collateral information and consent to treatment from the parents. The parents provide the following background: the child had a sudden change of personality, mood, and behaviour after an episode of aggression a year ago, in which he was beat up by a group of boys for unclear reasons. Initially he couldn't sleep due to nightmares, then he turned inwards and ceased communicating with the parents. He started using multiple drugs and had suffered at this point three overdoses, each time more difficult to revert. The patient had always refused treatment and during the previous two emergency department admissions he had been discharged once the post overdose delirium had cleared despite their protests. The parents suspect there were other episodes but they do not have direct or specific information regarding said episodes.

After repeated failed attempts to get the child's perspective on his history and current status, to establish a therapeutic rapport, and to explain the consequences, risks and benefits of the intervention, the physician admits the child as a "voluntary" patient under section 20 of the Act at the request of the parents, due to the state of mental impairment resulting from the post overdose delirium, in the context of a substance use disorder and the high likelihood of a concurrent mental disorder, the need to prevent substantial mental and physical deterioration, and the need to protect the child. The physician is of the opinion that the cause of this syndrome is the polysubstance use disorder and a concurrent mental disorder to be further assessed, diagnosed, and treated during the inpatient course of psychiatric care, for which the parents provide consent. With consent of the parents, buprenorphine is initiated, in addition to other psychiatric medication that the child refers had worked in the past to reduce anxiety and difficulty sleeping.