March 12, 2025

General guidance for physicians on the use of the *Mental Health Act* when treating adults with substance use disorders

FOREWORD

The *Mental Health Act* (the Act) allows for the establishment of mental health facilities, and the provision of services for the examination, diagnosis, and treatment of persons with a mental disorder. It also regulates the voluntary and involuntary admission of persons to a "designated facility", which is defined to include a Provincial mental health facility, psychiatric unit, or observation unit.

Dr. Daniel Vigo was appointed by Premier David Eby in June 2024 to serve as the Chief Scientific Advisor on Psychiatry, Toxic Drugs, and Concurrent Disorders. As Chief Advisor, Dr. Vigo was mandated to work across disciplines with the goal of improving care, including treatment for a growing population with overlapping mental health and substance use issues, frequently also affected by acquired brain injuries resulting from overdoses or trauma.

A key recommendation by Dr. Vigo was to provide clinicians with clarifications for how the Act may be used to better support the care and treatment of this complex population, including involuntary treatments of individuals that require it. This document provides clarification of the Act as it pertains to the involuntary treatment of adults in British Columbia with mental disorders, with a focus on those whose clinical picture includes substance use disorders.

It is important for practitioners and providers involved in the admission and treatment of patients under the MHA to be supported in making clinical decisions that are rooted in an understanding

of the full scope of existing treatment options as well as what is in the best interest of the patient. The clarifications provided by this memo are therefore intended to support both optimization of the application of the existing legislation when appropriate and the provision of rights-based, person-centered care.

INTRODUCTION

As further detailed in the *Guide to the Mental Health Act*, involuntary admission and treatment under sections 22 and 31 of the *Mental Health Act* (the "Act") can only be provided to a person who meets all of the following stringent criteria:

- the person is a person with a mental disorder which requires treatment;
- the disorder seriously impairs the person's ability to react appropriately to their environment or associate with others;
- 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 requires treatment in or through a designated facility; and
- the person cannot suitably be admitted as a voluntary patient.

For the purposes of this document, the criteria in the second and third bullets together will be referred to as "mental impairment".

No subtype of mental disorder is excluded from these provisions, and conversely, no specific subtype of disorder per se warrants treatment under these provisions.

For a person with a mental disorder to be involuntarily admitted and receive treatment under sections 22 and 31 of the Act, there needs to be a clear state of mental impairment.

Substance use disorders and the *Mental Health Act*

Involuntary admission and treatment under the Mental Health Act always engage concerns relating to the patient's liberty interest.

In the case of a person with substance use disorder, the powers of the Act must not be employed as a controlling intervention to curb risky decision-making or override the person's harmful or self-harmful behaviour if the decision-making or actions of the patient are unrelated to a state of mental impairment.

A person who continues to use a substance despite the direct negative consequences of such use (e.g., lung cancer, cirrhosis of the liver, overdoses, and death) should not be involuntarily admitted or treated under the *Mental Health Act* in the absence of a mental impairment, but should rather be offered voluntary treatment options.

There are three scenarios in which individuals with substance use disorders may be admitted under section 22 and receive treatment under section 31 of the Act:

1. **Concurrent mental and substance use disorders:**

   This is by far the most frequent situation, given that the comorbidity between severe mental disorders and substance use disorders is extremely high.

   In this case, the mental impairment most often results from psychosis, mania, or other

severe mental syndromes. The cause of admission under Section 22 must be clearly attributed to the syndrome producing the current impairment, and the mental disorder which is the cause of the syndrome.

Treatment under section 31 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. For example, in a patient with treatment resistant schizophrenia and substance use disorder, a combination of clozapine and long-acting buprenorphine may be required to decrease the behavioural and affective repercussions of the persistent psychosis. In such a patient, who based on experience would otherwise remain destabilized, deteriorate, and become a risk to self and others, buprenorphine would be used not to treat the patient's substance use disorder (which may persist unabated) but as an adjunct to antipsychotic treatment (i.e., seeking to decrease the psychotic syndrome).

2. Acute and severe psychiatric syndrome of unclear etiology:

A person with a known history of substance use disorder, or in a possible state of intoxication, presents with a syndrome that meets the criteria under section 22 of the Act, and is at that point impossible to attribute to a specific disorder subtype (e.g., mood disorder, psychotic disorder, or substance use disorder).

In that case the person could be admitted under section 22 and receive treatment under section 31 of the Act, and after psychiatric care has been provided, two scenarios are possible: the mental impairment may recede and not recur after the effects of any short-term medication wear off, in which case it could be concluded that it was the substance

that produced the mental impairment and the person can continue engaging with voluntary services as desired; or, after psychopharmacologic treatment under section 31 of the Act has stabilized the person (e.g., antipsychotic and/or mood stabilizing treatment), a significant state of mental impairment persists requiring ongoing medication and care, which leads to scenario 3, outlined below.

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

A person 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, or a neurocognitive disorder due to acquired brain injury. At this point, the patient becomes indistinguishable from the patients described in scenario 1, and may still be provided psychiatric care under section 31 of the Mental Health Act in order to treat the psychiatric syndrome causing the impairment.

Treatment of adults with substance use disorders under the Mental Health Act:

Frequently asked questions

1) Do these clarifications involve any changes to the *Mental Health Act* (the "Act")?

- No, the Act is not being changed at this time.

2) Can the Act be used to prevent risk-taking in a person without a state of mental impairment produced by a mental disorder?

- No. Preventing poor decision-making in an unimpaired adult, or controlling a person's choices, however risky, cannot form the basis for involuntary admission or involuntary treatment under the Act. In the absence of a current mental impairment (or certainty based on history that treatment non-compliance by patient will lead to recurrence of mental impairment) treatment options must be voluntary.

3) Are substance use disorders considered mental disorders?

- From a medical and clinical perspective, the answer is yes: all standard psychiatric and medical nosologies, including the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association) and the International Classification of Disease (World Health Organization) include substance use disorders as one of the major subtypes of mental disorders.

  However, while the Act does not expressly prescribe nor exclude any particular subtype of mental disorders from its ambit, it is important to emphasize that the vast majority of people diagnosed with any subtype of mental disorder are unlikely to meet the criteria for

involuntary admission and treatment under sections 22 and 31 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 elsewhere in this document.

- More importantly, as above, notwithstanding that substance abuse disorders are defined as mental disorders in standard psychiatric and medical nosologies, the Act should not be invoked or relied upon for the purpose of treating substance abuse or addiction in and of itself. All admissions and treatment under sections 22 and 31 should be applied only where the stringent criteria required by the Act are met, as discussed elsewhere in this document. Finally, the prescribed forms for admission and treatment under the Act must be completed and require the physician (or nurse practitioner, where applicable) to clearly explain how and why a patient meets the involuntary admission criteria, and to provide clear descriptions of the treatment plans.

4) Are any subtypes of mental disorders excluded from admission or treatment under sections 22 and 31 of the Act? And do any subtypes require involuntary 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 involuntary admission and treatment are met, and that the mental syndrome producing the impairment is adequately described and clearly attributed

to a mental disorder. Similarly, no disorder per se requires involuntary treatment under the Act.

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

- No. Any involuntary treatment under the Act requires a state of mental impairment meeting stringent criteria (or demonstrable clinical certainty of recurrence of such a state). The involuntary treatment must be directed at the mitigation of the mental impairment. The substance use disorder itself should not be treated on an involuntary basis under the Act.

6) Can I use opioid agonists or antagonists under section 31 of the Act?

- The Act does not preclude the use of any specific psychopharmacotherapy that can be legitimately considered psychiatric treatment. Some studies have found positive effects of opioid agonists and antagonists on psychotic symptoms, and potential neurobiological mechanisms have been proposed in the literature. Indeed, 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".[1] Studies found that typical antipsychotics and opioids interfere with dopaminergic transmission through the same neuronal targets, and that buprenorphine specifically proved effective against hallucinations and delusions.[2] With respect to opioid antagonists, results are mixed, with naloxone administration improving psychotic symptoms in some patients but not others.[3] Of note, these studies highlighting potential off-

[1] 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.
[2] 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.
[3] 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,

label benefits of opioid agonists and antagonists refer to their effectiveness in patients with psychosis. Hence, on a case by-case basis and when in the physician's judgment there is an adequate psychiatric rationale, these drugs can be included as part of psychiatric treatment under section 31 of the Act to treat the mental disorder that justified the involuntary admission under section 22 of the Act (e.g., where appropriate and clinically indicated in the judgement of the treating physician for patients whose mental impairment does not resolve with antipsychotic medication alone, buprenorphine may be used as an adjunct to an antipsychotic in a patient with schizophrenia and substance use disorder).

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

- This document does not seek to provide guidelines for clinical care or replace clinical judgment in any particular case. The appropriate interpretation of the existing evidence tailored to the benefit of a specific patient is always up to the best judgement of the treating physician and team. Any psychopharmacological approach for these highly complex patients should carefully consider both the intended effects (e.g., buprenorphine as an adjunct to antipsychotics to improve psychosis and its behavioural repercussions) 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

Anderson B, Koz G. Naloxone and naltrexone in mental illness and tardive dyskinesia. Ann N Y Acad Sci. 1982;398:97-102.

priori excluded if it is assessed by the treating psychiatrist as capable of mitigating the state of mental impairment produced by the mental disorder.

8) **The following clinical vignettes illustrate appropriate applications of involuntary admission under section 22 and involuntary treatment under section 31 of the Act for patients in scenarios such as those described in the first part of this document:**

- A patient with severe concurrent disorders is involuntarily admitted under section 22 and treated under section 31 of the Mental Health Act in an inpatient unit due to persisting mental impairment resulting from refractory psychosis. Despite partial stability, and based on previous history, 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 the auditory hallucinations) while on leave or upon discharge. In this case, a combination of depot antipsychotic and depot buprenorphine may be indicated under section 31, as long as the treating clinician provides a clear psychiatric rationale (i.e., the pharmacotherapy is not intended to treat the substance use disorder, which may persist, but to improve psychotic symptoms and their cognitive or behavioural repercussions).

- A patient suffers repeated crystal meth induced psychotic episodes so severe that they result in harms to self and/or others. These episodes resolve and do not recur with antipsychotics, but the patient systematically discontinues antipsychotics against medical advice when unsupervised, and psychotic episodes recur in the context of crystal meth use, again resulting in harms to self or others. The responsible physician can decide that involuntary admission and treatment under the Act is warranted for this severe recurrent

psychosis. Treatment under section 31 could consist of depot antipsychotics, which 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.

NOTE: This document pertains to the treatment of adults. A similar document focusing on admission and treatment of children and youth under the *Mental Health Act* will follow.