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Autonomy and (in)capacity to consent in adolescent substance use treatment and care: A commentary

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Introduction

British Columbia (BC), Canada, is an epicentre of North America's overdose crisis. This crisis is increasingly impacting adolescents (ages 10 to 19), prompting efforts to create a more comprehensive substance use treatment system for adolescents, including growing calls for involuntary approaches to substance use care [1, 2]. For example, a leading pediatric hospital in BC piloted a 'stabilization care' program whereby adolescents can be involuntarily held in hospital following an overdose. This approach could be expanded through initiatives such as recently proposed – and then withdrawn – amendments to BC's Mental Health Act, which would have allowed the involuntary hospitalization of adolescents who overdose to be rolled out in hospitals across the province [3]. The Mental Health Act already permits involuntary hospitalization of adolescents who are deemed a risk to themselves and others, including due to co-occurring substance use and mental health issues such as drug-induced psychosis. While involuntary hospitalization of adolescents who use drugs is sometimes warranted, the rapidly increasing rate at which it is occurring is deeply concerning. Indeed, annual involuntary hospital admissions in BC involving adolescents under 18 years of age climbed from 973 to 2454 between 2008/2009 to 2017/2018, representing a 162% increase. Many of these admissions involved adolescents experiencing concurrent mental health and substance use issues [4].

In our long-term research, clinical, and community work with adolescents who use drugs, we have indeed noted increasing numbers of young people being involuntarily hospitalized and deemed incapable of actively participating in their care. Parents, caregivers, guardians and clinicians feel tremendous responsibility to intervene and support adolescents who are using drugs intensively, but continue to have limited tools and resources with which to do so [5]. Taking full control of adolescents' care by involuntarily detaining them in hospital can often seem like the best or only option available. Moreover, it can seem clear to adults that these young people lack the capacity to make healthcare-related decisions.

Proponents of stabilization care, including involuntary admissions, argue that developmental concerns and the frequent presence of concurrent mental health issues – combined in some instances with the effects of drug intoxication and overdose – can impair adolescents' capacity to make sound, independent decisions regarding recommended treatment and care [6, 7]. They contend that it provides time for adolescents' mental status to improve, as well for providers to more robustly establish treatment needs and a safer discharge plan in collaboration with parents, caregivers, and guardians [7]. Families can be a critical resource in fostering young people's engagement in treatment and care, and yet often feel as though adolescents are discharged from hospitals too early and with insufficient consultation following an overdose [2, 7]. Our research, clinical, and community work strongly indicates that involving family members and other kinds of caregivers (e.g., Elders, teachers, friends, romantic partners) is oftentimes something that young people want and should be supported. However, we argue that this approach is undoubtedly more impactful in the context of *voluntary* adolescent substance use care.

The adolescents with whom we have worked over the past fifteen years often firmly believe that they are capable of making their own healthcare- and substance-use related decisions, even during periods of crisis and hospitalization. This dilemma drives the present commentary, wherein we examine interrelated issues of involuntary substance use care and adolescent autonomy and (in)capacity to consent. We argue that intensive substance use, concurrent disorders, and overdose events do not necessarily altogether erode adolescent capacity to consent. Clinicians and other stakeholders must take great care to recognize adolescent capacity, foster autonomy, and offer choice when working with youth who use drugs, even during moments when they may appear to lack the ability to participate in their own care. Our overarching aim with this commentary piece is to advance dialogue about how substance use care might be approached in ways that better foster adolescent self-determination and the kinds of trusting, supportive relationships with clinicians and caregivers that can be absolutely essential and lifesaving in the context of the toxic drug supply.

A brief primer on involuntary adolescent substance use care

Voluntary substance use treatment and care (e.g., residential programs, opioid agonist therapy) and harm reduction services can help adolescents to realize shorter-term healthcare goals and longer-term visions of recovery [1, 4]. Less clear are the merits and justifiability of involuntary care, despite ongoing debate [2, 5, 8, 9]. We have argued previously that involuntary approaches to substance use treatment and care – as thus far proposed and enacted – are not supported empirically or ethically [3]. Although involuntary care may indeed prove effective for some youth, perhaps in particular those with strong support networks, the (albeit limited) literature on involuntary care for adolescents suggests that this approach is more likely to fall

short on anticipated benefits, including with respect to addressing potentially harmful patterns of substance use and promoting engagement in care [1, 5, 10]. Extrapolating evidence from adult populations further suggests that, on the whole, involuntary substance use treatment and care does not improve outcomes and can cause harm [11, 12]. This is not to say that involuntary treatment and care should never be used with adolescents who use drugs; rather, it should be considered as one option – a last-resort option, in our view – in extremely complex and high-risk situations [2, 7]. Even so, it remains a contentious issue. This is evidenced by a recent, international consensus-establishing study on interventions for high-risk substance use and overdose among youth, in which consensus could not be reached on the appropriateness of involuntary admission due to its ethical implications and lack of supporting evidence [2].

In our own setting, hospital-based stabilization care initiatives have generated intense debate among drug user and family and caregiver activists on all sides of the issue. Many are alarmed by the steeply rising numbers of involuntary hospitalizations among adolescents, and argue that expanding involuntary approaches to care may ultimately do more harm than good [3, 5]. This is particularly the case for adolescents who use drugs to ameliorate pain, trauma (including intergenerational trauma and trauma rooted in experiences of family and caregiver violence), and forms of historical and structural oppression along axes of race, class, gender, sexuality, and ability. Crucially, none of these are meaningfully addressed by short-term hospitalizations, and experiences of trauma and oppression can actually be deepened by institutionalization [1, 13].

Autonomy and (in)capacity to consent

A common thread across critical analyses of involuntary care is that such approaches under-consider the historical, socio-political and institutional dynamics influencing adolescent substance use and patterns of engagement and disengagement with care [3, 5, 13]. We argue that these dynamics can also be neglected in assessments of adolescent autonomy and capacity to consent. For example, in our experience, the possibly erratic or ‘shut down’ modes of communication that are sometimes seen among adolescents in hospital can reflect moments of refusal and self-protection in the context of ongoing, harmful experiences of racism and other forms of structural oppression and institutionalization [1, 14, 15]. In these kinds of encounters, there is a need for clinicians to focus on engendering a sense of connection and safety before/while making assessments of capacity, such as by allowing trusted family members, caregivers, or other support persons to be present and using age-appropriate and trauma-informed approaches (e.g., anticipating histories of institutional trauma, providing real and meaningful care choices). When gauging an adolescent’s capacity, clinicians may solicit independent input from family members, caregivers, and other support persons, but it is crucial that young people’s safety, confidentiality, and trust are prioritized [2, 7, 13]. We have observed time and time again that when safety, confidentiality, and relationship- and trust-building are not prioritized, the result can be disengagement from care (and not just hospital-based care) among young people who are often in desperate need of support.

We worry that assessments of autonomy and capacity to consent in involuntary care encounters can too often proceed from the assumption that these adolescents are mentally compromised as a result of drug intoxication and overdose or are "mentally ill" and therefore

unable to actively participate in decisions about their care. Although substance use and mental illness can certainly co-occur in complex ways [4], we are concerned about the conflation of mental illness and substance use that we increasingly see underpinning involuntary care practices and policies. This conflation appears to be part of an impetus towards inappropriately ‘disordering’ adolescents who use drugs within and beyond hospital settings. Viewing intensive substance use as a mental illness is often borne out of a desire to de-stigmatize adolescent substance use; yet, it can inadvertently eclipse efforts to understand what drugs are doing for young people in the context of overlapping oppressions, as well as how entrenched experiences of oppression shape modes of communication and refusal in institutional contexts [1, 14]. When clinician assessments of decision-making and consent capacity rely too heavily on assumptions about adolescents’ clinical presentation and histories, key contextual dynamics may go un(der)acknowledged and un(der)addressed [1]. At minimum, this can result in adolescents feeling like they are not being listened to or understood, in some cases reinforcing for them the appropriateness of erratic or shut down modes of communication. We again underscore the need for clinicians to take time to carefully assess the historical, social, and structural domains shaping adolescents’ substance use and broader life and family circumstances when they present to hospital, even in contexts of high-stress and (relatively) time-limited healthcare encounters, such as post-overdose care.

We recognize that debate will continue surrounding adolescents’ autonomy and capacity to consent in the context of severe substance use and mental health issues alongside distinct family, caregiver, and developmental considerations. However, we encourage those working in this sphere to critically reflect upon conceivably hidden drivers of (mis)conclusions about adolescent capacity, such as the perspective that substance use disorders are in and of themselves

incapacitating mental illnesses. It is imperative that assessments of capacity and autonomy include careful consideration of the broader historical, institutional, family, and social contexts of adolescents' lives. Too often, individual-level problematizations and care responses (usually coming from well-meaning clinicians with limited resources and tools who are trying very hard to save lives and prevent harm) obscure these contexts and how they shape substance use, what we commonly gloss as 'mental health,' and engagement and disengagement with care.

Conclusion

Clinicians working with adolescents who use drugs, including those who have overdosed, can have a tremendous impact on their care and treatment trajectories. Encounters and relationships between adolescents and clinicians can foster greater engagement with care over time, which can be lifesaving in the context of the current overdose crisis. Yet, our long-term research has demonstrated that many adolescents in our setting feel ambivalent about engaging with treatment and care, and in particular highly medicalized and institutionalized hospital-based care [1, 13]. This is especially so when engagement with treatment and care has the potential to echo and deepen the harms that adolescents have previously experienced across services and systems that include the child welfare and criminal justice systems [1]. When engaging with these adolescents, clinicians should endeavour to watch and listen closely and uplift – rather than undermine – their capacities for making decisions about their own lives and care. The focus should first and foremost be on relationship- and trust-building and modelling care that is voluntary, collaborative, and reflective of adolescents' priorities and needs, while also responsive to family and caregiver dynamics, resources, and needs [13]. For some adolescents, this will involve making connections to harm reduction programming and/or substance use treatment; for

others, the focus may be on sexual health, mental health, pain management, family therapy, or housing and income supports. Still others will present as adamantly disengaged from hospital-based care (and implicated clinicians). This suggests opportunities to liaise with those supports with whom adolescents have established rapport, such as trusted family members and caregivers, peers with lived and living experience, Elders, and outreach and primary care teams, who can act as interlocutors and advocates between hospitals and community, and who are well positioned to build meaningful and lasting relationships with adolescents. No matter the clinical context, we see it as essential to make every effort possible to promote adolescents' self-determination and continued engagement with care on terms that work for them. This support must be offered on a voluntary basis if we are to optimize trust, relationship-building, and engagement with lifesaving care over the longer-term.

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Contributions

All authors contributed to the conception of this work, drafted the manuscript and/or revised it critically for important intellectual content, gave final approval of the version to be published, and agreed to be accountable for all aspects of the work.

Conflict of Interest

The authors declare that there is no conflict of interest. The views expressed in this commentary are solely our own and do not necessarily reflect the views of our affiliated organizations.

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