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National Guidance to Support Youth Substance Use Health in Canadian Pediatric Hospitals

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This guidance was developed in collaboration with the Canadian Advisory Group on Youth Substance Use. We thank the members of this group for their partnership, expertise, dedication and collaborative spirit:

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Conflict of Interest

The authors have no conflicts of interest to declare.

Background and Purpose

Pediatric hospitals serve as critical points of connection for youth presenting with a variety of health concerns.[1] Adolescence and emerging adulthood represent pivotal developmental periods when patterns of substance use often begin and early intervention can profoundly influence long-term health outcomes.[2,3] Every interaction with youth, regardless of the presenting condition or duration of the encounter, is an opportunity to provide compassionate, empathetic and nonjudgmental support.[4]

This guidance aims to support pediatric hospitals, service providers and systems in providing evidence-based supports for youth who use substances. It is intended for:

- **Service providers** to strengthen capacity to identify and respond to youth substance use health (SUH) needs and promote consistent, evidence-based practices;
- **Clinical leaders and administrators** to support organizational learning, resource allocation and hospital–community partnerships; and
- **Policy makers** influencing youth SUH services to inform policy development, support evidence-based practices and align resources across systems.

The overall goal is to enhance the quality, consistency and effectiveness of pediatric SUH care and ultimately improve outcomes for youth and their families across Canada.

Youth substance use is prevalent in Canada. In 2023–2024, 22 per cent of students in grades 7–12 reported alcohol use, 15 per cent reported vaping (with nicotine or other unknown content) and 12 per cent reported cannabis use in the past 30 days.[5] Substance use is associated with both acute and long-term harms. For example, from 2019 to 2023, unregulated drug toxicity was the leading cause of unnatural death among youth in British Columbia,[6] and cannabis-attributable hospitalizations for acute intoxication among children aged 0 to 14 nearly tripled between 2019 and 2020.[7] Harms related to substance use can also be chronic and wide-ranging, affecting multiple facets of life, including mental health impacts such as anxiety, depression, psychosis and impaired memory.[8,9,10,11] Because the brain continues developing into the mid-20s, sustained substance use can affect brain structure and function, as well as learning, attention, decision making and memory.[12,13] Together, these acute and chronic harms underscore the importance of timely early intervention.

Summary of Recommendations

Screening and Assessment

1. Youth aged 10 and over should be screened for SUH concerns[14] in all hospital settings, regardless of the primary reason for the visit.[15] All youth should be provided education on substance use starting as early as possible.[16] For youth who do not report substance use, anticipatory guidance should be provided to positively

reinforce healthy decisions and support open dialogue about substance use, including safer practices if use occurs.[17] See Appendix A for screening and assessment tools.

2. All youth who report substance use during screening should be offered education and opportunities to discuss their substance use health, regardless of whether they meet the diagnostic criteria for a substance use disorder.[18]
3. Responses to support youth SUH should be developed in partnership with youth and guided by their preferences, needs and level of risk identified through screening or assessment.[19,20] Families should be engaged as active partners in care,[21] with consideration to ethical and legal obligations balancing privacy and safety.[22]

Response Options

Brief Intervention

4. Motivational interviewing and psychoeducation should be used to provide brief interventions that support behavioural change related to substance use and offer practical strategies to reduce harms. Note: Brief intervention is not a replacement for treatment for youth living with a SUD.[23]

Withdrawal Management

5. Withdrawal can occur for almost all substances. Youth can benefit from medical care to support them during withdrawal. Withdrawal management should be offered regardless of engagement in additional treatment; however, it may not be sufficient on its own to reduce use and associated risks, such as return to use and risky loss of tolerance.[24]
6. The severity of withdrawal should be assessed, and medical support provided as necessary to stabilize youth health.[25] See the pharmacotherapy section below for common medications used for withdrawal management and treatment of SUDs that should be included on all hospital formularies.

Harm Reduction

7. Developmentally appropriate harm reduction approaches should be used for youth who engage in substance use, alongside education and discussion about frequency and risks.[26] Practical harm reduction strategies can be offered based on each young person's age, goals and circumstances.[27] Strategies may include providing naloxone kits, using drug testing services, providing education about the unpredictable drug supply and the harms of mixing certain substances, and encouraging youth not to use alone.[28]

Psychosocial Interventions

8. Evidence-based, developmentally appropriate psychosocial therapies should be offered as part of first-line treatment for youth with SUH concerns and their families,

either directly within the hospital or through referral to appropriate community services.[29] Refer to Appendix B for a list of evidence-informed psychosocial interventions.

9. Treatment planning for youth SUH should address biopsychosocial factors, social and structural determinants of health, psychiatric comorbidities and youth coping strategies to mitigate risk factors and strengthen protective factors.[30,31,32,33]

Pharmacotherapy

10. Evidence-informed off-label prescribing should be strongly considered. Although there is an evidence base supporting the use of medications to treat SUDs and manage withdrawal in adults, many pharmacological treatments are not formally approved for pediatric populations, which is common across youth health conditions. Clinical judgment, consultation and collaboration are essential.[34,35,36]
11. A number of medications used to treat SUDs and manage withdrawal symptoms may already be included on hospital formularies for other clinical purposes (e.g., benzodiazepines). Access to certain medications varies across the country. Based on expert consensus, the following is a minimal set of medications that should be included on all pediatric hospital formularies as standard of care to support youth SUH, including withdrawal management and ongoing treatment needs.[37]
    - Nicotine replacement therapy (patches, gum, lozenges, inhalers)
    - Opioid agonist treatment (buprenorphine/naloxone, buprenorphine extended-release injection, slow-release oral morphine, methadone)
    - Oral naltrexone and injectable naltrexone (not currently available in Canada)
    - Acamprosate
    - Take-home naloxone kits (intranasal and preloaded injectable)
    - Varenicline (starter package and prescription) and bupropion XL
    - N-acetylcysteine capsules
    - Topical capsaicin
    - Nabilone

There are no consistent standards for youth SUH pharmacotherapy; however, various guidelines exist.[38,39]

Ongoing and Community-Based Supports

12. Transitions between services should be supported through early planning, including the co-development of discharge or transition plans with youth and their families (where possible).[40,41,42] Direct connections to primary care and appropriate

community or inpatient services should be established,[43] and phased transitions coordinated with shared involvement and clear communication between hospital and community providers.[44]

13. Hospitals should have clear referral pathways to youth community-based supports and services, including peer support, integrated care, and culturally relevant care and resources where available and appropriate.[45,46]

Refer to the Care Pathway to Support Youth Substance Use Health in Pediatric Hospitals for practical guidance that supports the application of these recommendations.

Key Considerations to Ensure Quality Care

Youth-Specific Approaches

- Chronological age, developmental stage and cognitive milestones can help inform how care is tailored appropriately.[47,48]
- Routine dialogue about substance use, regardless of the reason for presentation to hospital, is key to early identification of health issues related to substance use and provides opportunities to engage youth in support and care.[49]
- While SUH care is every provider's responsibility, some aspects may require or benefit from collaboration across disciplines, including general pediatrics, adolescent medicine (where available), emergency medicine, psychiatry, psychology, addictions medicine, social work, acute pain services, pediatric nursing and psychiatric nursing. Best outcomes can be achieved when providers work in multidisciplinary teams to co-create solutions that meet the unique needs of youth. Pediatric units across disciplines should also have the capacity to manage non-medically acute withdrawal. Youth experiencing withdrawal should have access to integrated, developmentally appropriate care in any inpatient setting that meets their needs, without barriers across medical or psychiatric services.[50]
- A youth-centred, strengths-based and rights-based approach respects youth privacy, preferences and confidentiality (when possible), and tailors support to their identified goals while respecting autonomy in care decisions.[51] Youth and families should be engaged in the design and implementation of services and supports.[52] Dialogue at provincial and territorial levels continues to evolve about assessing decisional capacity for treatment of youth SUD, as well as how existing legislation may be used in situations where stabilization and assessment are needed to prevent acute harms related to substance use.[53]
- Youth moral and legal rights must be upheld, recognizing that decision-making capacity evolves over time and can be influenced by substance use, neurodiversity, chronological age, developmental age, and social and family contexts.[54,55.]

- Engaging caregivers, family and supportive adults as active partners in care can improve outcomes, engagement in services and treatment retention, and can reduce harm.[56,57] Taking a youth-centred approach and involving families can sometimes present challenges; providers should navigate these situations respectfully based on contextual factors and the acuity of the situation.[58]
- A youth-friendly environment uses stigma-free and youth-friendly language, offers quiet spaces and comforts such as warm lighting, privacy, snacks, blankets, phone chargers and Wi-Fi access, and creates a welcoming atmosphere that can improve engagement and outcomes.[59,60]

Meeting Youth Where They Are

- Youth may experience mental health, physical health and SUH concerns simultaneously. All should be addressed at the same time, and no one condition should be a barrier to addressing another, as care for one concern may positively affect others.[61]
- Concurrent disorders — SUD occurring alongside mental health disorders — are prevalent among youth[62,63] and should be treated together[64,65]
- Quality care requires ongoing monitoring of a youth's functioning and well-being, with care tailored over time to support them in achieving their desired outcomes.[66,67]

Foundational and Culturally Conscious Approaches to Care

- The negative impacts of substance use stigma[68] and the disproportionate SUH harms experienced by equity-deserving groups and First Nations, Métis and Inuit communities should be recognized.[69,70]
- Care should be trauma-informed and culturally safe. Providers can strengthen behavioural and cultural competency through training, self-reflection, humility and awareness of power dynamics that facilitate therapeutic connection and support anti-oppressive practice.[71,72]

"Honestly, if the doctor or the provider just has good energy or good vibes … you feel safe around them. That's what really would help. I think including [youth] in the decisions … [and] also taking into account their lifestyle and how prescriptions or medications would work … and listening to what youth have to say, and also just being genuine and being empathetic."

— Youth, Focus Group Discussion, July 2025

"I was feeling like I was being handed a lot of responsibility without sufficient support. The discharge plan didn't include clear followup instructions or connections to community services, so I had to do a lot of leg work myself to find resources."

— Caregiver, Focus Group Discussion, July 2025

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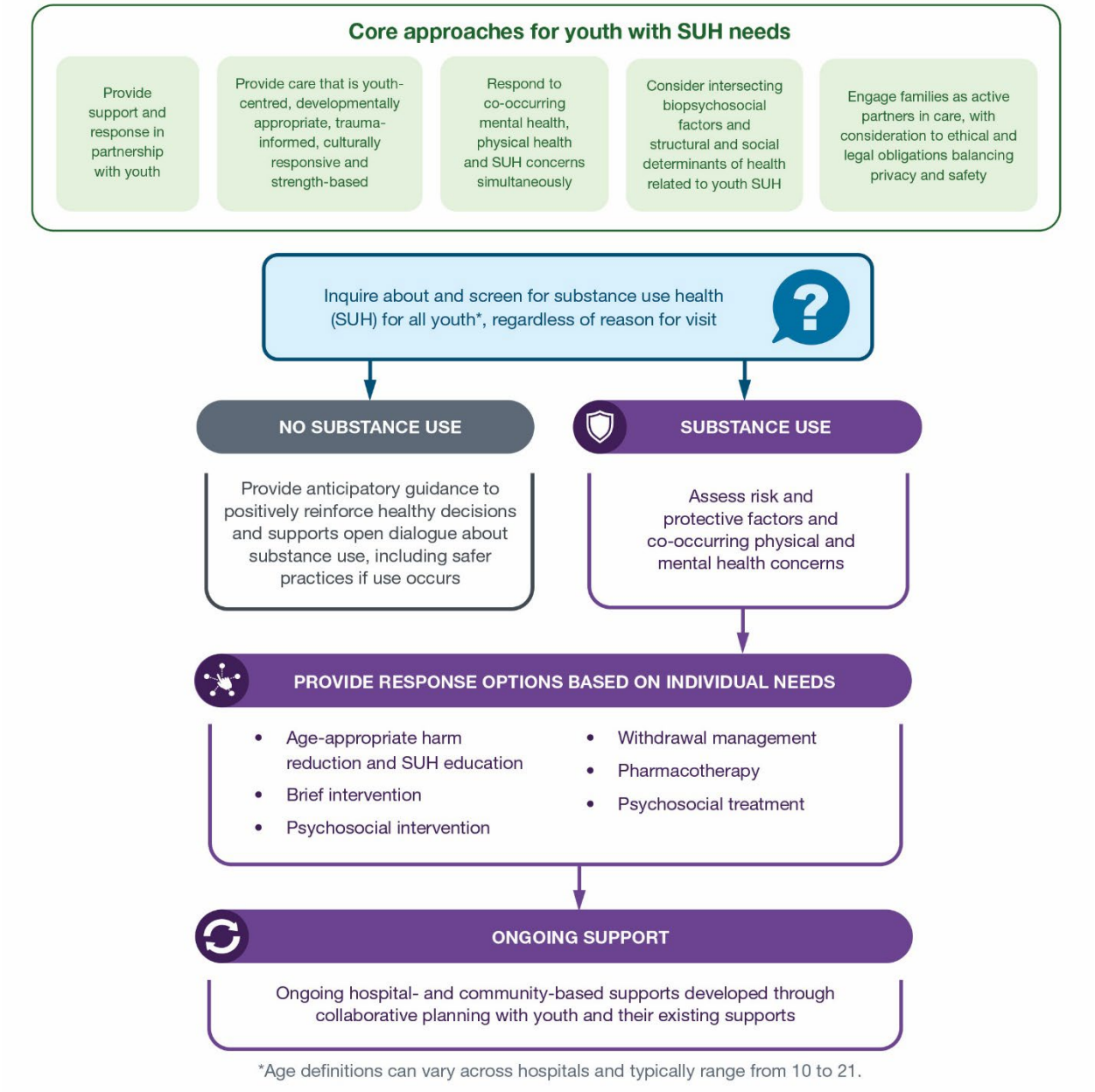
Care Pathway to Support Youth Substance Use Health in Pediatric Hospitals



Appendix A: Screening and Assessment Tools

The tools below are the most commonly used tools for youth SUH in Canadian pediatric hospitals:

Tool	Scope	Description	Administration Time	Language
Car, Relax, Alone, Forget, Friends, Trouble 2.1 (CRAFFT)[1] CRAFFT 2.1 + Nicotine (CRAFFT 2.1 +N)	Substance use	A validated two-part behavioural health screening tool that can be self-administered or clinician-administered. It includes four questions about substance use in the past year and six questions related to risk behaviours. The +N version includes 10 additional questions related to nicotine use (vaping and tobacco products).	Five–10 minutes[2]	English, French Available in more than 35 languages
Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence (HEEADDSSS)[3]	Psychosocial screening (includes substance use as a domain)	A conversational screening tool used to build trust and rapport and identify hidden or emerging risks, including substance use, to inform care planning.	Flexible	English
Home, Education/Employment, Activities & Peers, Drugs & Alcohol, Suicidality, Emotions, Discharge resources (HEADS-ED)[4]	Psychosocial screening (includes substance use as a domain)	A triage and screening interview tool designed to help clinicians obtain a history, identify mental health and SUH concerns, and guide referral decisions. It includes a three-point scale for each section, ranging from “no action needed” to “needs immediate action/severe functional impairment.” Note: HEAADDSSS is a general screening tool, whereas HEADDS-ED is more commonly used in emergency and acute care settings as a rapid triage tool.	Five minutes	English, French

Tool	Scope	Description	Administration Time	Language
Strengths, School, Home, Activities, Drugs, Emotions, Sexuality, Safety (SSHADESS)[5]	Psychosocial screening (includes substance use as a domain)	A modified HEADSS screening tool that uses a strengths-based approach. It is an interview framework that provides a structured approach to adolescent psychosocial interviews while exploring emotional well-being and adolescent risk behaviours (e.g., substance use, protecting oneself during intercourse).	Flexible	English
Screening to Brief Intervention (S2BI)[6]	Tobacco (nicotine), alcohol and cannabis, followed by other substances	A validated rapid screening tool that asks three questions about the frequency of tobacco (nicotine), alcohol and cannabis use in the past year. An affirmative response prompts additional questions about substance use. Responses for each substance can be categorized by level of risk for meeting the diagnostic criteria for a substance use disorder. Frequency-of-use categories are paired with actionable next steps for healthcare providers. The tool can be self-administered or clinician-administered.	Under two minutes	Not reported SBIRT program (includes S2BI) materials available in multiple languages

The following additional tools are used less often but may be appropriate depending on the setting and identified needs:

Tool	Scope	Description	Administration Time	Language
Detection of alcohol and drug Problems in Adolescents (DEP-ADO)[7]	Substance use	A 27-item screening and assessment tool that evaluates alcohol and substance use. It assesses use of different substances (e.g., alcohol, cannabis) over the past year, instances of alcohol use during single occasions, and harms associated with alcohol or other drug use. A culturally adapted and validated version for First Nations in Quebec is available.	15 minutes, plus two minutes for scoring	English, French

Tool	Scope	Description	Administration Time	Language
Brief Screener for Tobacco, Alcohol, and Other Drugs (BSTAD)[9]	Tobacco, alcohol and cannabis, followed by other substances	A self-reported screening tool that asks about frequency of substance use to identify the level of risk for meeting the diagnostic criteria for a substance use disorder in adolescents. It begins with three questions about use of tobacco, alcohol and cannabis in the past year. If any of these substances is reported, follow-up questions about additional substances are asked.	Five minutes	English
National Institute on Alcoholism and Alcohol Abuse (NIAA) youth screening tool[10]	Alcohol	A two-question screening tool used to identify alcohol use among youth in the past year and assess risk of alcohol-related problems. One question asks about personal alcohol use and one asks about friends' alcohol use.	Two minutes	English
Alcohol Use Disorders Identification Test (AUDIT/AUDIT-C)[11,12]	Alcohol	A 10-question screening tool to evaluate alcohol use, drinking patterns and related concerns (e.g., not being able to stop drinking once started). A reference chart showing the approximate number of standard drinks in various alcoholic beverages is provided. AUDIT-C is a shorter version with three questions focused on alcohol consumption.	Two minutes for administration and three minutes for scoring	English, French Available in about 40 languages
Cannabis Abuse Screening Test (CAST)[13]	Cannabis	A six-item questionnaire that asks about cannabis use in the past year. Items are rated on a five-point scale from never to very often, with total scores ranging from 0 to 24.	Two–three minutes	English, French and other languages
Cannabis Use Disorder Identification Test — Revised (CUDIT-R)[14]	Cannabis	An eight-item questionnaire that screens for cannabis use in the past six months, including domains related to consumption, cannabis-related concerns, dependence and psychological features.	Two–four minutes	English, French and other languages
Global Appraisal of Individual Needs – Short Screener (GAIN-SS)[15]	Concurrent disorders (mental health and substance use health)	A structured self-reported tool with 20 questions that screens for the frequency of symptoms and behaviours in the past year related to internalizing psychiatric disorders (e.g., depression), externalizing psychiatric disorders (e.g., ADHD), substance use disorders, and crime or violence-	Five–10 minutes	English, French and other languages

Tool	Scope	Description	Administration Time	Language
		related concerns (e.g., being in a fight, carrying a weapon).		

Appendix B: Psychosocial Interventions

The following tables include a variety of evidence-based therapeutic approaches that have demonstrated effectiveness in improving outcomes related to youth SUH needs (not limited to SUDs). Interventions should be chosen in collaboration with youth and with consideration of youth psychosocial context. Interventions should also be delivered using a compassionate, culturally responsive and nonjudgmental approach. Parent and family involvement should be incorporated where appropriate, and referrals to community-based or longer-term services can occur at any point.

Brief and Single-Session Interventions

Brief interventions can be delivered in a limited amount of time (typically one to five sessions lasting about five to 30 minutes) and can have a high impact. These interventions are the responsibility of every provider who interacts with youth and do not require specialist training. They are particularly relevant in settings such as emergency departments, outpatient and acute care, but can be used in any clinical setting.

Brief interventions focus on actions that can be taken immediately, regardless of whether a young person identifies their substance use as a concern or is interested in formal treatment. Even when an adolescent is not ready to engage in treatment or pursue referrals, meaningful clinical actions can still be taken in the moment, such as providing education on substance use, harm reduction information and supplies, and motivational interviewing.

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
Motivational interviewing (MI)	13–24 years	• Should be used with adolescents and young adults who use substances.[16,17] • Foundational approach for engaging youth in care, building trust and exploring ambivalence about change.	• Provides training and resources to support provider confidence and competence in having age- and developmentally appropriate conversations about substance use with youth and families. • Supports consistent and early touchpoints by embedding SUH into

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
			routine care, regardless of provider or setting. • Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches.
Motivational enhancement therapy (MET)	10–24 years	• Uses the principles of motivational interviewing but is delivered in a more structured format. It may be used for substance use and may have greater efficacy when combined with other psychosocial interventions.[20]	• Provides training and resources to support provider confidence and competence in having age- and developmentally appropriate conversations about substance use with youth and families. • Supports consistent and early touchpoints by embedding SUH into routine care, regardless of provider or setting. • Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches.
Psychoeducation	10–24 years	• Provides insight and education about substance use, its effects and associated risks.[21, 22] • Includes substance use education for parents and families.[21]	• Provides training and resources to support provider confidence and competence in having age- and developmentally appropriate conversations about substance use with youth and families. • Supports consistent and early touchpoints by embedding SUH into routine care, regardless of provider or setting. • Enables integrated supports by establishing policies and providing

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
			resources to incorporate evidence-informed approaches.
Harm reduction	10–24 years	• Provides developmentally and age-appropriate harm reduction education and equipment for youth, parents and families. [16, 23]	• Provides training and resources to support provider confidence and competence in having age- and developmentally appropriate conversations about substance use with youth and families. • Supports consistent and early touchpoints by embedding SUH into routine care, regardless of provider or setting. • Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches.

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
Peer-support models	10–24 years	• Connect youth with substance use disorders to peer-support groups and other recovery-oriented services in the community.[16] • Build hope, reduce stigma and promote engagement, and are recommended as an adjunct to clinical care.[16, 24]	• Provide training and resources to support provider confidence and competence in having age- and developmentally appropriate conversations about substance use with youth and families. • Support consistent and early touchpoints by embedding SUH into routine care, regardless of provider or setting. • Enable integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches.

Higher-Intensity Therapeutic Interventions

Medium- and longer-term interventions involve ongoing work with the young person over time and typically include repeated sessions. These interventions may be offered through inpatient and outpatient programs, as well as community-based services.

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
Contingency management	10+ years	• Can be used for SUDs,[25] including stimulant use,[16, 18] cannabis use[19] and benzodiazepine dependence.[16] • Considered a mainstay of stimulant use treatment.[19] • Little research among youth with OUD.[26]	▪ Supports clear pathways, connections, referrals and followup to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
			resources to incorporate evidence-informed approaches.
Peer-support models	10+ years	• Connect youth with substance use disorders to peer-support groups and other recovery-oriented services in the community.[16] • Build hope, reduce stigma and promote engagement, and are recommended as an adjunct to clinical care.[16]	▪ Support clear pathways, connections, referrals and followup to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enable integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as contingency management into hospital care.
Family therapies	10+ years	• Can be instrumental in achieving successful outcomes for youth with substance use disorders[26] and an important component of child and youth concurrent disorders support.[27] • Include multidimensional family therapy, brief strategic family therapy, family behaviour therapy, functional family therapy and multisystemic therapy.[20, 24, 25] • Provide emotional support, help monitor between followup appointments and support medication adherence.[20, 26] • May be counterproductive in certain situations. Youth should guide who is involved in their treatment.[16]	▪ Support clear pathways, connections, referrals and followup to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enable integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as contingency management into hospital care.
Adolescent community reinforcement approach (A-CRA)	10+ years	• Clinician-delivered tailored interventions that help adolescents develop rewarding lifestyles that do not centre on substance use.[20]	▪ Supports clear pathways, connections, referrals and followup to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing resources to incorporate evidence-

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
			▪ informed approaches such as contingency management into hospital care.
Cognitive behavioural therapy (CBT)	13+ years	• Helps youth develop coping strategies, recognize cognitive distortions and prevent recurrence. Also effective for youth with co-occurring conditions like depression or anxiety. • Considered a mainstay of alcohol and stimulant use treatment (alongside contingency management).[18] • Shown to reduce self-reported opioid use in adults.[28]	▪ Supports clear pathways, connections, referrals and follow-up to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as contingency management into hospital care.
Acceptance and commitment therapy (ACT)	10+ years	• Emphasizes acceptance techniques (e.g., accepting rather than avoiding or denying feelings).[20]	▪ Supports clear pathways, connections, referrals and follow-up to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as contingency management into hospital care.
Mindfulness-based cognitive therapy (MBCT)	10+ years	▪ Emphasizes mindfulness techniques (e.g., meditation) and can be used for SUDs.[20]	▪ Supports clear pathways, connections, referrals and follow-up to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as

Intervention	Age Range Studied	Key Points	Hospital and System-Level Considerations
			contingency management into hospital care.
Mindfulness-based substance abuse treatment for adolescents (MBSAT)	12+ years	▪ Group-based program that incorporates mindfulness, self-awareness and substance use treatment strategies for youth.[29]	▪ Supports clear pathways, connections, referrals and follow-up to connect youth from hospital care to longer-term psychosocial and community-based supports. ▪ Enables integrated supports by establishing policies and providing resources to incorporate evidence-informed approaches such as contingency management into hospital care.

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