CSAM Canadian Society of Addiction Medicine

SMCA La société médicale canadienne sur l'addiction

Position Statement on *Involuntary Treatment*

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The Canadian Society of Addiction Medicine (CSAM-SMCA) is a national society of regulated health professionals and scientists committed to helping Canadians understand substance-related and behavioural addiction, and recover with dignity. Addiction, including substance use disorders, are complex chronic health conditions that require long-term treatment approaches, often along a spectrum of care. We support evidence-based practice in all four pillars of addiction care including prevention, harm reduction, treatment, and enforcement.

CSAM-SMCA encourages an evidence-informed approach to all policy and program development decisions impacting people with substance use disorders and addiction. This includes the consideration or enactment of involuntary addiction treatment.

Existing and proposed involuntary treatment legislation and programs differ significantly across the country, including with regard to the legislative framework (e.g. use of the mental health act vs. alternative legislation), duration of involuntary treatment, target population (e.g. substance use disorder alone vs. concurrent mental health diagnosis; incarcerated people), scope, and consideration for decision-making capacity and appeal. It is important to note that involuntary treatment exists on a spectrum, including interventions such as intensive case management and community treatment orders. This statement is focused predominantly on inpatient involuntary addiction treatment for adults, as the most restrictive form of involuntary care.

A large meta-analysis developed by the CSAM-SMCA Policy Committee and published in the Canadian Journal of Addiction in 2023 concluded that "there is a lack of high-quality evidence to support or refute involuntary treatment for persons with [substance use disorders]" (Bhaji et al., 2023). The literature to date is generally of low quality, where treatments are poorly described (including whether or not evidence-based treatment like opioid agonist treatment was offered), follow-up is shorter-term, and focuses largely on alcohol and cannabis, with little to no data reported on fentanyl and methamphetamine. Additionally, it is drawn from diverse international settings, with no available Canadian data. As such, there is limited guidance from the literature to help inform good policy.

While many jurisdictions are exploring inpatient involuntary addiction treatment, there is a lack of high-quality evidence to either support or refute this approach to care. Based on the limited evidence available, CSAM-SMCA recommends against large-scale rollout of involuntary inpatient treatment for severe substance use disorder or addiction.

References

Bahji, A., Leger, P., Nidumolu, A., Watts, B., Dama, S., Hamilton, A., & Tanguay, R. (2023). Effectiveness of involuntary treatment for individuals with substance use disorders: A systematic review. Canadian Journal of Addiction, 14(4), 6–18. https://doi.org/10.1097/cxa.0000000000000188

Truth and Reconciliation Commission of Canada. (2015). Truth and reconciliation commission of Canada: Calls to Action. IR4-8-2015-eng.pdf

If involuntary treatment is to be pursued, we recommend the following considerations:

1. Involuntary treatment should be used only for people with severe substance use disorder who are declining voluntary treatment, are experiencing considerable harm from their substance use, and where the harms of not intervening are likely to exceed the harms of involuntary treatment.
2. Involuntary treatment should be as brief as possible, and provided in the least restrictive treatment setting.
    a. If voluntary treatment is an option, it should be used instead.
        i. If voluntary treatment is not accessible, development of evidence-based and accessible voluntary treatment services should be prioritized urgently by governments and funding agencies.
3. Implementation of involuntary treatment must recognize the risk of perpetuating racism in healthcare and repeating generational harms, in direct violation of the TRC Healthcare Call to Action #18.
    a. Any involuntary treatment needs to be culturally competent, and have in place safeguards against inadvertently over-identifying and harming those who are Indigenous, minorities and/or marginalized.
    b. Services and evaluation frameworks should be co-designed with Indigenous and lived/living experience representation to minimize risks.
4. Involuntary treatment should be managed medically by expert care providers, providing ongoing assessments and evidence-based treatment of intoxication, withdrawal, and associated medical and/or psychiatric comorbidity.
    a. Assessment and treatment must be comprehensive, addressing bio-psycho-socio-spiritual needs of individuals, including extensive aftercare planning to maintain engagement and prevent overdose upon transition to voluntary services.
5. Capacity for making treatment decisions related to substance use disorder or addiction should be evaluated on an ongoing basis.
    a. Having addiction alone is not grounds for deeming a person as lacking this capacity.
    b. Pharmacotherapy should not be imposed on people who retain capacity to make treatment decisions related to addiction. Appropriate pharmacotherapy should be offered with informed consent.
6. A person being held involuntarily must have reasonable access to an appeal process that involves an objective third party.
    a. Individuals should be made aware of their right to appeal upon being detained and at regular intervals thereafter.
7. Outcomes (both short and long-term) of involuntary treatment policies and programs must be subject to rigorous evaluation by an objective third party and made publicly available in a de-identified form.
    a. Initial programs must aim to identify patient characteristics that predict both positive and negative outcomes, to guide targeted application of involuntary treatment in situations where benefits outweigh harms.
    b. Legislation governing involuntary treatment should be reviewed and adjusted based on objective findings at regular intervals, and at any point that substantial concern for harm is identified by the evaluators.
8. Funding, development and operation of involuntary treatment programs should not come at the expense of enhancing resources for voluntary evidence-based interventions along the entire spectrum of care, including prevention, harm reduction, enforcement and recovery-based options.
    a. Evidence-based treatment on demand should be available to all Canadians seeking addiction care.
    b. Investments in improving the social determinants of health, such as housing and income, are critical to long-term success of both voluntary and involuntary addiction treatment efforts.

CSAM-SMCA calls on all leaders and jurisdictions to continue to fund and support expansion of evidence-based interventions across the four pillars of addiction care: prevention, treatment, harm reduction, and enforcement.