Families for
Addiction Recovery

Positions

Addressing the harms caused to individuals, families and society from the use of addictive substances requires a whole of society response.

Addiction

Addiction is not a choice. It is a chronic brain disease that requires treatment and management over time like other chronic illnesses. The National Institute on Drug Abuse (NIDA), a U.S. federal government drug use and addiction research institute, defines addiction as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.

Addiction is a **pediatric disease**. Ninety percent of the time it originates or is triggered by use before the age of 21. Addiction must be approached as a problem that affects our youth. Society has an obligation to protect youth from addiction (prevention) and protect youth with addiction (harm reduction and treatment).

People with addiction often have other mental health conditions. This complicates treatment and recovery.

Family Engagement

Addiction is a family disease. One family member may struggle with addiction, but the whole family suffers. Family involvement and support is important during active addiction, treatment and recovery. Outcomes are best when the people with addiction and their families learn coping skills and recover together.

People with addiction and their families should be involved in the development of drug policies and the development of best practices, standards of care and guidelines for harm reduction and treatment.

> **"Families of people with drug problems: implications for policy and practice**
>
> **Basics**
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> Adult family members of people who use drugs may experience a wide range of harms and need support services to help them address these. These include primary health care to address the anxiety and stress they experience, peer support, bereavement care and support for kin carers.
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> The needs and potential contribution of family members to the effectiveness of drug treatment should be recognised within drug policy and practice guidelines.
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> **Opportunities**
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> Involvement of adult family members of people with drug problems in policy and practice development as well as

> in the provision of peer support has the potential to improve provision of service generally, as well as specifically for family members.
>
> **Gaps**
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> Information on the extent and nature of provision of interventions for this group is currently limited, and research and monitoring in this area needs to be improved."
>
> – **From Health and Social Responses to Drug Problems, A European Guide, European Monitoring Centre for Drugs and Drug Addiction, 2017.**

Stigma

The following statement regarding the US health care system is equally true in Canada:

> "Stigma in the U.S. health care system contributes to disparities in funding for research and treatment of mental disorders in comparison with physical disorders and to the negative attitudes, beliefs, and behaviors of health care professionals toward people with mental and substance use disorders. Structural stigma is manifested in the health care system in the low quality of care for people with mental and substance use disorders and the limited access to behavioral health treatment and other services (Institute of Medicine, 2006; Schulze, 2007; Schulze and Angermeyer, 2003..."
>
> – **Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change (2016) (at p.45-46)**

Canada spends just over 7% of its public health budget on addiction and other mental health conditions but the burden of these diseases in Canada in 2013 was between 10% and 11% [1]. By comparison, countries like New Zealand and the UK spend 10% -11% of their public health budget on addiction and other mental health conditions. In 2012, the Mental Health Commission of Canada in *Changing Directions, Changing Lives, The Mental Health Strategy for Canada*, called for Canada to increase the amount it spends on addiction and other mental health conditions from 7% to 9% over 10 years. This recommendation pre-dates the federal government's commitment to legalize cannabis, which will generate income for the federal and provincial governments, and the current opioid overdose epidemic which is killing thousands of Canadians annually, many of them our youth and young adults with addiction and mental health conditions.

Stigma results in the chronic underfunding of treatment for addiction and other mental health conditions and a poor quality of care for those affected and their families. This stigma and discrimination must be acknowledged and redressed.

[1] **Institute for Health Metrics and Evaluation (2015). Global Burden of Diseases, Injuries, and Risk Factors Study, 2013. Data retrieved from http://www.healthdata.org/data-visualization/gbd-compare**

Reallocation of Resources

Addiction, like other chronic illnesses, requires a public health approach, not a criminal justice approach. This means shifting the focus of our limited resources from enforcement to education, prevention, harm reduction and treatment. Those involved in low level crimes to fund their addiction should not be criminalized but treated.

This is a fiscally responsible approach. The National Institute on Drug Abuse (NIDA) states that every dollar invested in addiction treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1. The **US Surgeon General's Report on Alcohol, Drugs, and Health in 2016** states that every dollar invested in treatment saves $4 in healthcare costs and lost productivity and $7 in criminal justice costs.

Education

To date, education campaigns have focused on the dangers of particular drugs which is not the core of the problem. We need to focus on education regarding addiction, drug policy, the stigmatization of those who use illegal drugs and the stigmatization of addiction.

Prevention

Prevention efforts occur at two levels; at the level of the individual and at the population level.

1. Level of the Individual

The major risk factors for addiction include a genetic predisposition, male gender, early initiation of use, other mental health conditions, certain personality traits, and environmental factors such as adverse childhood experiences (trauma), neglect or abuse.

Prevention efforts should include:

- screening, brief intervention and referral to treatment (**SBIRT**)
- addressing problematic personality traits (**Preventure**)
- protection from abuse or neglect
- education regarding drug policy, the stigmatization of those who use illegal drugs and the stigmatization of addiction.

2. Population Level

A public health approach to substance use means adopting regulatory measures that apply to everyone in order to reduce the overall harm of substance use across the population. These measures should include:

- a minimum age of purchase of 21
- a not for profit distribution model
- distribution by a government run monopoly which reports to the ministry of health (not the ministry of finance)
- no advertising or branding (which drive demand)
- minimum pricing adjusted annually to inflation
- increased taxes on increased concentrations of the substance.

There is a lot of evidence with respect to alcohol and tobacco that a minimum age of 21 minimizes harms and also evidence that it delays initiation in those 15-17 years of age. Early initiation is a major risk factor for addiction. This evidence is set out in our **Submission to the Task Force on the Legalization of Marijuana** (at pages 5-7) and **Ontario Cannabis Secretariat Discussion Notes.**

Harm Reduction

Harm reduction services save lives and do not enable addiction. Harm reduction services are a means to an end. The end is recovery.

Treatment

It has been estimated that 80-90% of people with addiction do not receive treatment. The greatest enabler of addiction is this lack of treatment. We must eliminate all barriers so that treatment is accessible, publicly-funded, timely, compassionate and evidence-based. Treatment meeting all these criteria is rarely available today. Those in detention or incarcerated who have addiction or other mental health conditions must receive the treatment they need and deserve.

1. Accessible

The Canadian Centre on Substance Use and Addiction (CCSA) conducted a survey of people in recovery in 2017 and the results were reported in **Life in Recovery from Addiction in Canada**.

Participants were asked to identify barriers to recovery. Of those surveyed, 35.8% identified not knowing where to go for help as a barrier to treatment. Persons with addiction often have other mental health conditions so their needs are complex. We need services across Canada that will help those struggling with addiction and their families navigate our system of care so that they receive the treatment that best fits their unique needs.

2. Publicly-funded and Timely

One quarter of the people in recovery who participated in the **Life in Recovery from Addiction in Canada** survey identified long delays for treatment as a barrier to treatment. Currently, a choice must be made between publicly-funded or timely treatment. Canada has a two-tiered system for treatment of those with addiction and/or other mental health conditions. Those whose families can afford to pay for treatment jump the wait list in Canada or go to the US for treatment while those who can't, wait.

The service gaps are greatest for youth, the vast majority of whom do not receive any treatment. The wait time at Ontario's Pine River Institute, the only long term residential treatment facility for youth in Ontario, was 14 months in 2012 and 16 months in 2017. There are currently over 200 youth on the wait list. Youth who are addicted often engage in criminal activity to fund their addiction. It is a result of their illness. It has been estimated that 70% of juvenile offenders have mental health conditions and/or addiction. Waiting for treatment detrimentally affects all family members and increases the risks to these youths.

> "The consequences of youth not receiving appropriate services are considerable. If left untreated, youth with concurrent disorders are at risk for a variety of unhealthy outcomes such as involvement with crime, homelessness, school dropout, risky sexual behaviour (Deas & Thomas, 2001) and suicide (Esposito-Smythers & Spirito, 2004). From a public health perspective, the costs associated with not treating a young person with a concurrent disorder are extensive. These youths often come into contact with multiple service systems throughout their lives including health care (e.g. emergency room, hospitalizations), justice, and social services (e.g. housing, financial assistance)."
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> – **Pathways to care for youth with concurrent mental health and substance use disorders, 2014, The Ontario Center of Excellence for Child and Youth Mental Health (p.8).**

Serious health problems including those arising from sexual abuse, physical abuse, HIV, Hepatitis C, substance use induced psychosis and overdose leading to permanent brain damage, heart attack or death should be added to this list of unhealthy outcomes. A wait list can be a death sentence.

We must reduce wait lists for treatment of addiction and other mental health conditions and protect those on the wait lists so they do not die or suffer harm while waiting for treatment.

3. Compassionate and Evidence-Based

Given the historical chronic underfunding of treatment for addiction and other mental health conditions, Canada must build capacity to treat youth and adults with these conditions. Building capacity includes teaching and training medical students and doctors to inquire about, identify, intervene and treat addiction. Addiction medicine is not taught as a core course in any Canadian medical school. In addition, there is a significant shortage of addiction medicine specialists in Canada. (See **A Needs Assessment of the Number of Comprehensive Addiction Care Physicians Required in a Canadian Setting**).

Although it is recognized that addiction and other mental health conditions must be treated at the same time to be effective, this is still the exception to the rule.

The impact of these problems cannot be overstated. Persons with addiction and their families often lose hope when relapse occurs, believing the patient has failed when, in reality, often effective treatment was never received. Aside from these significant social costs, it is also a waste of resources to provide ineffective treatment.

In the words of two of Canada's most pre-eminent addiction medicine specialists:

> "The scandal is that there are evidence-based treatments for substance use disorder which are effective that are not being used."
>
> **– Dr. Meldon Kahan, Women's College Hospital, Toronto META:PHI presentation, May 24, 2017.**

> "Oftentimes, I hear people say that the addictions system is broken ... Actually, the system isn't broken, we need to build a functioning addictions system."
>
> **– Dr. Evan Wood, British Columbia Centre on Substance Use (BCCSU), CBC Interview, Sept. 16, 2016.**

A thorough discussion of what evidence-based treatment entails can be found in the **Requirements for Effective Treatment** section of this website.

4. Those not seeking treatment

The majority of people with addiction at any given time are not seeking treatment. The passive and harmful approach to date has been that:

- we must wait for them to hit bottom and
- they have to want help to be helped.

Those not seeking treatment incur the same harms of untreated addiction as those on a waitlist. Far too many people die before they hit bottom. We must be proactive and figure out why they are not seeking treatment. Any fears they may have about reaching out for help must be addressed, as must any other reasons they may not be seeking treatment.

(a) Stigma of criminalization and addiction

Just under 50% of participants in the **Life in Recovery from Addiction in Canada** survey said being worried about what people would think of them was a barrier to recovery. In other words, they feared being judged and stigmatized. When Portugal decriminalized the possession of all drugs for personal use and improved social determinants of health (housing, jobs) they saw a 60% increase in those seeking treatment.

Canada should follow suit, especially since we are in the midst of an opioid overdose epidemic. We must

do everything possible to encourage people to seek treatment. We also need an anti-stigma campaign to educate people, including physicians and mental health professionals, that addiction is a disease not a choice or moral failing, so people are not afraid to say if they have a problem or to seek treatment.

(b) Lack of insight

> "Of the 20 million people in the United States who suffer from a substance abuse disorder, 19 million of them – 95 percent – say they don't need help, according to the 2013 National Survey on Drug Use and Health. That is remarkably high regardless of symptoms or their severity. Even 90 percent of the over 8 million people who experience substance-related withdrawal symptoms – trembling hands, seizures, hallucinations – don't believe they need addiction care."
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> **– The End of Hitting Rock Bottom, Dec. 6, 2015, Boston Globe.**

Similarly, the major barrier to treatment identified by 55% of participants in the **Life in Recovery from Addiction in Canada** survey was not being ready, not believing you had a problem, or not believing the problem was serious enough.

Youth who are struggling with addiction often lack capacity to make decisions in their own best interests with respect to their alcohol or other drug use and refuse treatment. Our laws (either as drafted or as applied) in Ontario, and many other provinces, give priority to the right of the youth to refuse treatment which allows their disease to progress and puts them at great risk.

Not only is this bad public policy, it is in violation of the following articles of the UN Convention on the Rights of the Child:

- Article 3: Protection of the Best Interests of the Child
- Article 24: Right to Good Quality Health Care (their refusal of treatment acts as a complete barrier to treatment of their illness)
- Article 33: Right to be protected from the use of harmful drugs and from being used in the drug trade

Each province has different laws. We need to develop best practices across Canada in order to protect youth with addiction who are not seeking treatment. Where less intrusive measures including harm reduction have failed, we must consider compulsory bridges to care. See the **Involuntary Treatment** section of this website for further discussion on compulsory bridges to care.

We also need to develop best practices to protect adults with addiction who are not seeking treatment. (See Recommendation 21 in **The Final Report of The Select Committee on Mental Health and Addictions**, Ontario, 2010, and **Open Minds Healthy Minds**, 2011 (p.25).)

We have a two-tiered medical system. We have those families who have the know-how and financial means to get their loved ones who are refusing treatment to the United States (most States allow parents to consent to treatment on behalf of their minor and adult children with addiction) and the vast majority of families who do not.

5. Privacy Laws

Best practices must be developed across Canada with respect to privacy legislation as it applies to addiction and other mental health conditions to "ensure that family members and caregivers providing support to, and often living with, an individual with a mental illness or addiction have access to the personal health information necessary to provide that support, to prevent the further deterioration in the health of that individual, and to minimize the risk of serious psychological or physical harm". (See Recommendation 22 in **The Final Report of The Select Committee on Mental Health and Addictions**, Ontario, 2010, at p.21). See also **Open Minds Healthy Minds**, 2011 (p.25).

Recovery

Addiction is not an acute illness where you get treatment and you are cured. It is a chronic illness that must be managed over time like other chronic illnesses. This means that people in recovery need ongoing health care and community supports to help them remain in recovery. We must build these supports. These include recovery high schools, sober dorms, housing, employment and a continuum of care.

Recovery from addiction has several definitions. Although specific elements of these definitions differ, all would agree that recovery goes beyond the remission of symptoms to include a positive change in the whole person. There are many paths to recovery. There is no "one size fits all" solution. Abstinence is often, but not always, necessary. Abstinence by itself is not always sufficient to define recovery.

People who achieve recovery with medication assisted treatment (MAT) have sometimes been denounced by those who do not take medications, based on assumptions that using medication is inconsistent with recovery principles or a form of drug substitution or replacement. This must change. MAT is an evidence-based approach to recovery. Members of the National Alliance for Medication Assisted Recovery or Methadone Anonymous refer to themselves as practicing medication-assisted recovery.

Remission from addiction can take several years and multiple episodes of treatment and support. Even after a year or 2 of remission is achieved—through treatment or some other route—it can take 4 to 5 more years before the risk of relapse drops below 15 percent, the level of risk that people in the general population have of developing an addiction in their lifetime.

Just as the development of addiction involves profound changes in the brain, behavior, and social functioning, the process of recovery also involves changes in these and other areas. These changes are typically marked and promoted by acquiring healthy life resources—sometimes called "recovery capital." These recovery resources include housing, education, employment, and social resources, as well as better overall health and well-being.

Recovery support services (RSS) refer to the collection of community services that can provide emotional and practical support for continuing remission as well as daily structure and rewarding alternatives to substance use. RSS include mutual aid groups such as Alcoholics Anonymous, recovery coaching, recovery housing, recovery community centres, and recovery-based education.

Increasingly, RSS are being organized into a framework for infusing the entire health and social service system with recovery-related beliefs, values, and approaches known as a Recovery Oriented System of Care (ROSC). A ROSC uses long-term recovery management protocols, such as recovery management check-ups and telephone case management.

Drug Policy

1. Decriminalization

The possession and use of small amounts of drugs should be decriminalized.

(a) An Ethical Position

According to the **2016 Canadian Community Health Survey**, over 10% of Canadians aged 12 years or older reported using illegal substances in 2016. That's 3.2 million Canadians. Young adults aged 18-34 were most likely (21.5%) to report drug use in 2016. Prohibition is not preventing a lot of Canadians from using illegal drugs. It is maximizing the harm to both recreational users and those struggling with addiction.

The vast majority of people who use addictive substances (legal, illegal or prescribed) do not become addicted. They are not a danger to themselves or others. Giving them a criminal record is not justifiable. It has major lifelong consequences for employment and travel. Treating alcohol and tobacco differently than other drugs creates a double standard, is not evidence-based, and creates a false impression that alcohol and tobacco are safer than all currently illegal substances.

For those who have problematic substance use, it is harmful to criminalize them for having a mental health condition. Decriminalizing the possession of small amounts of drugs for personal use would go a long way to eliminating the stigma associated with addiction which prevents people from seeking treatment.

By analogy, prior to 1972 it was illegal in Canada to attempt to kill yourself. Today it is clear how irrational that law was. Criminal law is meant to punish people who harm other people, not to prevent people from harming themselves. It is time we realized the same for people struggling with addiction.

Addiction creates changes in the brain that result in compulsive drug seeking in spite of adverse consequences. At its core, addiction is about self-harm. At the severe end, people struggling with addiction do not make decisions in their own best interest with respect to all aspects of their lives and they lose everything that matters to them – jobs, family and friends. They lose control over their lives which become chaotic. They consume substances that they know could kill them. It is a slow death (or quick in the case of overdose). It is irrational to believe that the threat of being incarcerated will deter their drug use.

(b) An Evidence-Based Position

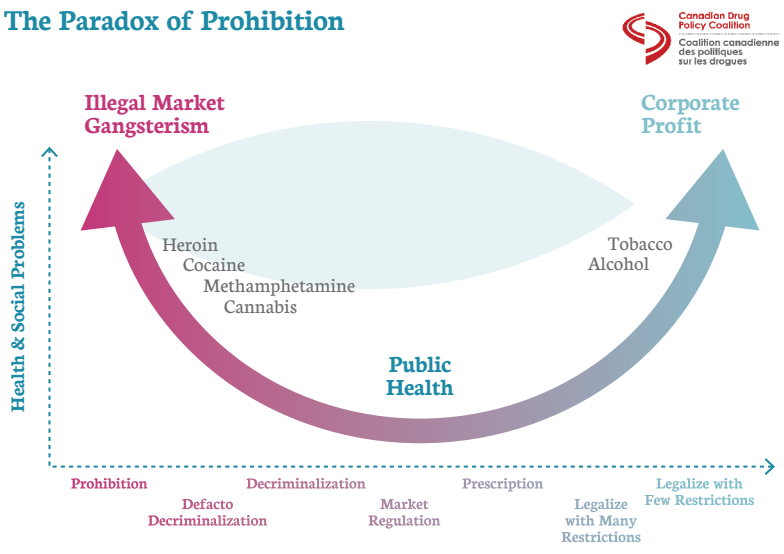
Portugal decriminalized the possession of all drugs for personal use in 2001 when 1% of its population was addicted to heroin. Portugal's experience of decriminalization, together with addressing social determinants of health (housing, jobs), resulted in an 80% decrease in overdose deaths and a 60% increase in those seeking treatment. Here are some of the other positive outcomes from Portugal as summarized by **Transform: Getting Drugs Under Control**:

- Levels of drug use are below the European average.
- Drug use has declined among those aged 15-24, the population most at risk of initiating drug use.
- Between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased.
- Rates of continuation of drug use (i.e. the proportion of the population that have ever used an illegal drug and continue to do so) have decreased.
- Newly diagnosed HIV cases for people who inject drugs fell from 1,016 to 56 between 2001 and 2012.
- New cases of AIDS for people who inject drugs decreased from 568 to 38 between 2001 and 2012.

> "The Global Commission on Drug Policy has consistently called for the decriminalization of personal use and possession, and for alternatives to punishment for non-violent, low-level actors in illicit drug markets. The criminalization of drug use and possession has little to no impact on the levels of drug use but instead encourages high-risk behaviors, such as unsafe injecting, and deters people in need of drug treatment from seeking it and from using other health services and harm reduction programs that would help them. The health, economic and social benefits of decriminalization have been shown in countries that took this step decades ago."
>
> **– Opioid Crisis Position Paper, 2017, The Global Commission on Drug Policy.**

2. Regulation and Control

As the diagram below illustrates, harms are minimized when a substance is strictly regulated. Harms are maximized when the market is illegal (unregulated) or commercialized (underregulated).



It is widely recognized that the war on drugs has been a costly failure. We regulate and control drugs not because they are safe. We do so because they are not safe, people use them anyway, and regulation is the best way to protect them (in the same way that we regulate alcohol, tobacco and prescription drugs). It also protects everyone from the harms of the black market including the enrichment of drug cartels. We must examine how to regulate the most commonly used illegal substances in order to minimize the harms of use.

> "The Global Commission on Drug Policy also calls for the elimination of illicit drug markets by carefully regulating different drugs according to their potential harms. The most effective way to reduce the extensive harms of the global drug prohibition regime and advance the goals of public health and safety is to get drugs under control through responsible legal regulation. Therefore, the commission adds two more far-reaching recommendations:
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> - End the criminalization and incarceration of people who use drugs nation-wide in Canada and the United States.
> - Allow and promote pilot projects for the responsible legal regulation of currently illegal drugs including opioids, to replace and bypass criminal organizations that drive and benefit from the current black market."
>
> **– Opioid Crisis Position Paper, 2017**