Families for Addiction Recovery

Involuntary Treatment

Pathways to care for youth with concurrent mental health and substance use disorders by the Ontario Center of Excellence for Child and Youth Mental Health identifies that one of the major barriers to treatment for adolescents (those 12 – 24 years old) with concurrent mental health disorders is their inability to understand that their substance use is problematic. They won't consent to treatment because they don't see the need. This is a medical condition known as anosognosia, which means a person lacks insight that he/she has a disease. Anosognosia also occurs in persons with mental health disorders like schizophrenia and bipolar disorder.

In most States in the US this is not an issue in respect of minors because the age of medical consent is 18 years old. Parents can consent to treatment on behalf of their child until the child reaches 18 years of age. Further, there are a number of States in the US that allow parents to consent to treatment on behalf of an adult child struggling with addiction. This is not the case in Canada for adults and, depending on the province/territory, youth.

Health is a provincial matter in Canada so the laws in each province/territory differ. As a general rule, as long as someone has capacity, as defined in the provincial legislation, they must provide informed consent before they receive treatment. Ontario has no minimum medical age for consent. The attending physician must decide if the child has capacity and, if so, the child can refuse treatment. Some provinces do have a minimum age for medical consent of 14 or 16 years of age in which case a parent can consent to treatment on the child's behalf until the child reaches that age.

However, family members can intervene if their loved one has a mental disorder that will likely result in serious bodily harm (which has been interpreted to include psychological harm) to the person or another person or the physical impairment of the person. In this case there is an exception under the mental health laws in each jurisdiction. The exact test is different in each jurisdiction. If a person is found to be subject to such a mental health disorder, then there is an obligation on the part of the attending physician to hold the person until they are no longer at risk of harming themselves or others. This obligation to hold includes the right to treat in most jurisdictions except Ontario. In Ontario, if a person cannot be released because he at risk of harming himself or others, then he can still refuse treatment if he is found to have capacity. As a practical matter, at risk of serious bodily harm is interpreted as being at risk of killing oneself or someone else.

This situation was addressed by Dr. John Gray when he appeared as a witness in 2009 before The Select Committee On Mental Health and Addictions. The all-party Committee was established by the Ontario Government to listen to hundreds of experts, including professionals, patients and family members, to improve treatment for mental health and addiction.

Dr. Gray said:

> "The latest paper is called Treatment Delayed—Liberty Denied. The lead author is a law professor at UWO, Robert Solomon, and co-author, Dr. Richard O'Reilly. It's been recently published in the Canadian Bar Review.
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> As an aside, I might just mention that this latest study examined the plight of patients who because of Ontario law could not be treated. They could not, therefore, get well enough to be released. Examples in this paper are of people being detained without treatment for five, and two at 20 and one at 25—not months, but years; detained 25 years because they couldn't be treated. At $600 a day in hospital, or $219,000 a year of wasted money or $4.38 million for 20 years, that's a lot of taxpayers' money not to treat people and to deny them their liberty.
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> This paper that we wrote in Ontario could not have been written in British Columbia or most other provinces in this country or most other countries because they would treat people in these circumstances and they would be discharged."

The Final Report in 2010 of The Select Committee on Mental Health and Addictions contained 22 recommendations including these two:

> 21. The Ministry of Health and Long-Term Care should create a task force, incorporating adequate representation from, among others, mental health clients and their caregivers as well as mental health law experts, to investigate and propose changes to Ontario's mental health legislation and policy pertaining to involuntary admission and treatment. The changes should ensure that involuntary admission criteria include serious harms that are not merely physical, and that involuntary admission entails treatment. This task force should report back to the Ministry within one year of the adoption of this report by the Legislative Assembly. (pp. 14-16)
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> 22. The task force created to investigate and propose changes to Ontario's mental health legislation and policy should also investigate and propose changes to the Personal Health Information Protection Act, 2004. The changes should 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. (pp. 16-18)

In response to this report the Ontario Ministry of Health and Long Term Care in 2011 in Open Minds, Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy stated:

> "We will create a task force to examine current Ontario legislation related to involuntary treatment and sharing of health information (e.g., Mental Health Act, Child and Family Services Act, Personal Health Information Protection Act)." (p. 25).

Five years later, this has yet to be done. Implementing these changes would go a long way to helping families overcome barriers to treatment and keep family members out of jail. Ontario laws are the least protective in Canada with respect to these two issues. It should be noted that these proposed changes affect adults, not just youth.

In 2013 Ontario commissioned an exhaustive review of the mental health legislation in each province in Canada and in a select number of other countries. Some provinces have legislation that allows for the involuntary treatment (or secured care) of minors but these provisions are extremely restrictive both as to when they apply and what treatment facilities are available for this purpose.

For example, under the Ontario legislation there were only 3 institutions permitted to provide secured care and in 2011, when combined, these institutions had 38 beds.

Alberta, Saskatchewan and Manitoba, passed legislation in 2006 that allow parents to have a minor child apprehended, assessed and detoxed within 5 to 15 days. The minor is then presented with a treatment plan. It is up to the minor to decide if he/she will accept treatment. For those who do not choose to receive treatment and who are addicted to opiates, this could be dangerous after going through detox as their tolerance will be low and they will still have cravings, making overdose a real concern.

Families get a front row seat to the chaos and devastation that is active addiction. It is torturous for parents to watch their child harm themselves. Youth in active addiction are often involved in criminal activities to support their problematic substance use. It can get to a point where the family can't continue living with their child, often because their child has become verbally, emotionally or physically abusive. In these situations when faced with an ultimatum of treatment or homelessness, many children will choose treatment. What should happen to those who do not?

There are four possible alternatives:

- Homelessness
- Institutionalization:
  - Detention under the Youth Criminal Justice Act;
  - Children's Aid (where no treatment will be received); or
  - Health Care (Treatment)

In these circumstances the best outcomes are achieved if the adolescent enters treatment. Unfortunately this rarely happens. Realistically this alternative is only available if the child is threatening to cause or actually causing serious harm to himself or others .

There is no question that treatment is the most cost effective alternative. Research shows that every dollar spent on substance abuse treatment saves $4 in healthcare costs and $7 in law enforcement and other criminal justice costs.

Some studies have concluded that involuntary treatment does not work or that it is not as effective as voluntary treatment. There is no question that voluntary treatment is preferable to involuntary treatment and that involuntary treatment should only be used as a last resort. However, the conclusion in these studies that involuntary treatment isn't effective is problematic for six reasons:

1. It's the wrong question

The question is, do youth with addiction, and likely other mental health disorders, whose lives are in chaos, who are seriously self-harming and who do not see a need for treatment, have the capacity to make treatment decisions? Are they exercising free will, or are they a slave to their addiction? If they don't have capacity, do our laws need to be changed to provide greater protection, or is the problem not

in how our laws are drafted, but in how they are applied? If you look at the definition of addiction, it is a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. Many people want to stop, they can't and they die.

If a child does not have capacity, then in most provinces a substitute decision maker can make the decision. If the substitute decision maker is the parent, as is usually the case, then even if the chances of recovery are less than if the child were going to treatment voluntarily (which isn't an option), the parents are going to pick treatment because it is preferable to jail, homelessness, criminal activities and physical deterioration. If an operation on a cancerous tumour had only a 25% chance of success and the alternative was death, we would operate. It is unacceptable to parents with youth struggling with addiction that people use "it's not as effective as voluntary treatment" as an excuse not to treat.

2. The comparison should be involuntary treatment vs. no treatment

If voluntary treatment isn't an option, then the comparison that needs to be made is the comparison of involuntary treatment to untreated addiction and/or other mental health disorders. The outcomes of untreated addiction and other mental health disorders in youth include:

- chaotic living arrangements: homelessness, group homes (even where the child is from a functional home), psychiatric wards, juvenile detention and revolving door visits to hospital emergency departments;
- illegal activities: prostitution, drug dealing, and stealing to fund the addiction, and driving impaired;
- serious health problems: sexual abuse, physical abuse, HIV, Hepatitis C, substance use induced psychosis, suicide, overdose leading to permanent brain damage, heart attack or death; and
- dropping out of school.

All of these outcomes have great societal costs.

The majority of people with addiction do not want treatment. The percentage of youth with addiction who do not want treatment is even higher; estimates range between 70% to as high as 90%. We offer these youth and their families nothing until the youth hit "rock bottom". Some die and the survivors have experiences that make it harder for them to recover. No treatment is the worst outcome. This conclusion is consistent with the plethora of articles that speak to the importance of early intervention.

3. It's unlikely that effective treatment was provided

Did the involuntary patients in these studies receive effective, evidence-based treatment? Was there:

- integrated treatment (an assessment done for co-occurring disorders and concurrent treatment of any co-occurring disorders)?
- treatment of a sufficient duration (which NIDA would say is a minimum of 3 months)?

- medication assisted treatment (MAT) where appropriate (particularly for opioid use disorder and alcohol use disorder) with a sufficiently long taper?
- individual and/or group therapy?
- family therapy or reunification?
- a continuum of care, from detox, residential, intensive outpatient, outpatient and ultimately routine follow-up by the appropriate service providers (psychiatrist, family physician, therapist)?

Most patients, whether voluntary or involuntary, do not get all of this, relapse occurs, gains are lost and the patient is blamed and the conclusion reached that "treatment didn't work" when the truth is effective treatment was never received.

4. Relapse does not mean treatment failed

Relapses are common even where treatment is voluntary and should not be the only determinant of whether treatment has been successful. Recovery is a learning process. It takes time and often it takes relapses to learn. Addiction is a chronic illness that must be managed over time like diabetes or hypertension.

5. The evidence is that it works as well as voluntary treatment

Decades ago the Stages of Change Model was developed by researchers of alcoholism to help professionals understand their patients struggling with addiction and help motivate them to change. The stages are:

- precontemplation
- contemplation
- determination
- action
- maintenance

Clearly if someone is motivated to change their problematic substance use, then treatment will be more efficient because the first two stages of change have are already been completed. That does not mean that treatment will be less effective if someone enters treatment at the precontemplation stage.

The National Institute on Drug Abuse (NIDA) and others have taken the position that involuntary treatment works.

Brad Reedy, Cofounder and Clinical Director of Evoke Therapy Programs, a program that specializes in wilderness therapy treatment, states:

> **Don't they have to want to change?**
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> Ultimately yes, people have to want to change in order to change. But part of our job as parent is creating motivation for that change – offering the child a proverbial carrot so that they might work toward a healthy goal is a primary parental responsibility.
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> A colleague of mine worked in a parent-coaching program. In this program, which usually follows some form of residential treatment for the child, the parent is assigned a coach and the child is assigned a mentor. After running this program for years, my colleague observed the following phenomenon. There are basically three classes of families he sees. First, both the child and parents are motivated. Those tend to be successful. Second, neither the child nor the parent is motivated. They have very little success avoiding problems and relapses with these families But the third class, which he referred to as "chasers," describes parents who are motivated and a child who is not – at least not intrinsically. Incredibly, they have the same success rate with the chasers as they do in the cases where both the child and the parents are motivated. This observation is very similar to the one I have concluded in my career, which is supported in the literature of Joanna Bettmann, a researcher in the field of wilderness therapy. She reported that a client's desire or readiness for change was not related to significant therapeutic improvement.
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> **– From The Journey of the Heroic Parent by Brad Reedy, PhD**

Ambivalence to change is common in people struggling with addiction. There is a whole field of therapy called motivational interviewing which has been developed specifically to help therapists motivate their clients to change.

6. Youth have not been studied

Most research regarding the effectiveness of involuntary treatment has been carried out on adults, not youth. It remains an open question as to whether the research regarding adults would apply to youth. Our criminal laws, as well as many other laws, are more protective of youth because their brains are still developing and have not matured. It stands to reason that our involuntary treatment laws should be more protective for youth for the same reasons. The evidence is that addiction impedes the maturation of the adolescent brain.

7. Conclusion

> "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

To put matters in perspective, Canada has a multitude of laws restricting the rights of adolescents even though most adolescents do not have brain disorders. Adolescents are not given the right to enter into binding contracts, vote, drive a car, purchase alcohol or cigarettes, use a tanning salon or give a valid consent to sex with an adult. However, youth who are struggling with a chronic relapsing brain disorder that affects their capacity to understand that they need treatment are being given the right to make life or death decisions regarding treatment. This is hypocritical.

One thing is certain – the status quo is unacceptable. 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.

Finally, sometimes an assumption is made that involuntary treatment means abstinence-based treatment. This does not have to be the case. Sometimes intervention is necessary to stabilize so harm reduction is possible. Involuntary treatment should include medication assisted treatment, where appropriate.

FAR's position is that best practices need to be established regarding the support and protection of youth with addiction and/or other mental health disorders who are not seeking treatment. Currently the laws in each province/territory are different. Youth who are struggling with addiction and other mental health conditions who are not seeking treatment are at risk of "dying in the alley with their rights intact" as some psychiatrists have phrased it. Canada is long overdue for a national discussion on how to best support and protect these youth.

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).)