Family members' perspectives of involuntary treatment for severe substance use disorder: A qualitative study

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INTRODUCTION

Involuntary treatment (IT) for severe substance use disorders (SSUD) has re-emerged as one of the most controversial issues in addiction policy and care, particularly amid escalating overdose deaths and harms associated with untreated addiction. (1,2)

Competing concerns have often produced a binary debate over whether IT should exist, rather than when intervention might be justified, how it should be delivered, and what safeguards would be required. (3,4)

Canadian mental health and consent legislation varies across provinces and territories but broadly attempts to balance individual autonomy with protection from serious harm. (5)

Evidence concerning the effectiveness and harms of IT remains limited and heterogeneous. A systematic review found insufficient high-quality evidence to support or refute IT for SUD, with the literature encompassing substantially different interventions ranging from punitive detention to therapeutic civil commitment incorporating evidence-based treatment. (6) Studies from Norway and Australia suggest that outcomes depend on clinical context and implementation and that people admitted involuntarily often have greater illness severity than those entering treatment voluntarily. (7,8,9) Norwegian research has also challenged assumptions that involuntarily admitted patients are uniformly unmotivated to change, suggesting that motivation may change during treatment. (9)

Nevertheless, available evidence does not establish IT as a broadly effective substitute for voluntary care, and concerns remain regarding coercion, autonomy, trauma, proportionality, human rights, ethics and unintended harms. (3,6,10) While debates surrounding IT often focus on these concerns, little research has examined the perspectives of family members who provide ongoing care while witnessing overdose, criminalization, deterioration, and profound social harms. (11-12)

This study examined family members' perspectives of IT for SSUD in Canada.

METHODS

This qualitative study was co-designed in collaboration with Families for Addiction Recovery (FAR) and was guided by the principles of Participatory Action Research. Between February and August 2024, the research team conducted 87 semi-structured, in-depth interviews with affected family members across Canada. Each interview lasted between one and two-and-a-half hours and was carried out virtually using Zoom. A purposive sampling strategy was employed to ensure diversity and relevance among participants.
Data were analyzed inductively using thematic qualitative analysis informed by Lofland et al.'s (2006) framework. (13)

RESULTS

Table 1. Relationship

Relationship with affected family member	n/%
Mother* (son)	54 (62%)
Mother (daughter)	17 (20%)
Father* (son)	4 (5%)
Father* (daughter)	2 (2%)
Sibling	3 (3%)
Other: Stepparent/son, spouse/partner, niece/aunt	7 (8%)

Table 2. Demographics

Characteristic	(%)
Gender	78 women (90%), 8 men (9%), 1 non-binary (1%)
Region	Ontario: 78%
Age group (most common)	60–69 years: 52%
Education	Higher education: 90%
Employment	Full-time: 49%
Co-residence with relative	Yes: 34%

Analysis identified five themes

1) Lack of capacity
2) Harms of not intervening
3) Nuanced perspectives of autonomy and rights
4) Futility of short-term holds
5) Ways to mitigating potential harms of IT

Across these themes, participants generally supported the need for IT in some circumstances involving SSUD, but their support was conditional on how, when, and for whom it would be used.

1. Lack of Capacity

Family members frequently discussed two related but legally distinct concerns: capacity to make treatment decisions and the ability to care for oneself safely. Concerns were pronounced for minors as family members questioned whether young people experiencing severe substance-related impairment could make informed decisions to refuse potentially life-saving treatment.

"I would say that involuntary treatment for minors… I would start with that. I understand it's not black-and-white, but the benefits outweigh the drawbacks. Because they're, I don't think capable of making truly informed consent as a child under the influence." (P31)

Additionally, family members of adults described situations in which they believed their relatives could not adequately appreciate treatment needs or care for themselves yet were repeatedly assessed as capable.

"I have tried to prove that she's incapable of taking care of herself. But every time I've had her in a psychiatric assessment, the psychiatrist says no, she can take care of herself… Like, you just don't get listened to." (P42)

Others questioned how capacity was assessed in acute-care settings and perceived the threshold for finding incapacity as excessively high.

"…they just wanted to get him out of the hospital; he was able to stand up." (P18) "If they can walk and talk, they're considered fit…" (P15)

A small number of participants also believed that pressures on hospital capacity or bed availability influenced decisions about admission or continued detention (P01, P63).

2. Harms of Not Intervening

Participants weighed the potential harms of IT against harms they attributed to untreated SSUD, including criminalization, exploitation, violence, overdose, loss of housing and relationships, and harms experienced by family members and others.

Criminalization

Many participants viewed criminal justice involvement as a consequence of an inability to intervene earlier. They described a system in which treatment could become more accessible only after behaviour associated with SSUD resulted in arrest or incarceration:

"But I think the system is broken when the only way you can get your child help is if they get caught by the law." (P73)

Another participant contrasted involuntary treatment with incarceration:

"For adults like, no, my son didn't want to go, but it's better than going to jail… to pretend that people have to want to get it is stupid, when your mind is so fried you don't know anything but that next drink." (P14)

Parents of minors also described concerns that substance use could expose young people to exploitation or illegal activity before treatment could be secured:

"So, we ended up taking him to the States against his will for treatment, because Canada wouldn't let us intervene. And as far as we were concerned, he's going to be arrested because he was selling cannabis, too… How was someone who's 14 years old maintaining their addiction when they had no money?" (P01)

Harms to People with SSUD, Families, and Others

Participants described profound deterioration in their relatives' lives, including loss of housing, relationships, custody of children, and personal safety:
"It's not my daughter anymore. It's the drug, and it's taken over her life. She lost her home. She's lost all their children; she has nothing. And yet nobody will help." (P23)
Some family members also described being exposed directly to violence or danger while attempting to protect their relatives. One parent recounted repeated unsuccessful attempts to obtain intervention for his daughter while she was being exploited:
"And during that period of time, I was almost killed two times by drug dealers. So, while trying to save my daughter, two times I was almost stabbed and killed." (P32)
For some participants, these experiences led them to conceptualize IT itself as a potential form of harm reduction—not because they viewed coercion as harmless, but because they weighed its risks against what they perceived as the immediate risks of non-intervention:
"Suppose it were my daughter prostituting herself or being pimped out, or my child committing crimes because they're trying to fuel a habit. I might arrange to get them involuntarily committed. Do I love that idea? No. But to me, it's a harm reduction option." (P66)
Participants also described substantial harms experienced by family members alongside those experienced by relatives with SSUD:
"She put her mouth over my nose, and I could feel her teeth… She has been assaulted and sexually assaulted multiple times now, and none of that has been enough." (P30)

3. Nuanced Perspectives on Autonomy and Rights

Participants frequently described tension between respect for autonomy and protection from serious harm. Rather than rejecting autonomy as an ethical principle, many questioned whether choices made during periods of severe substance-related impairment represented the kind of autonomous decision-making that treatment systems appeared to assume. These concerns were particularly prominent among parents of minors:
"Kids aged 13 are given autonomy. How the hell do you expect somebody with a brain disease, who, on top of that, is using mind-altering… [substances], to have autonomy and make good life and death decisions…?" (P22)
Some participants framed parental responsibility itself in terms of a duty to protect:
"Where's my right to protect my child and to do what I'm supposed to do? … I'm trying to protect my child now, and you're not even listening to me…" (P42)
Similar tensions were described by family members of adults. Participants questioned whether an emphasis on individual choice adequately accounted for the effects of SSUD on agency and decision-making:
"…the big thing is this sense of autonomy; it has to be their decision, and they have to be the ones seeking help, and they have to buy into it fully. And it's this agency that they no longer really even have." (P86)
Several participants also conceptualized rights more broadly than freedom from intervention, invoking rights to life, safety, and security for both the person with SSUD and others:
"It goes against the rights of that person to be safe, protected, and secure, as well as the rights of families. We were not safe with an adult in this house." (P09)

4. Futility of Short-Term Holds

Participants commonly described existing short-term involuntary assessment mechanisms as difficult to access and insufficient to alter the trajectory of SSUD. Family members referred to these processes as "forming," generally describing brief psychiatric assessment and detention under provincial mental health legislation. Several participants reported repeated attempts to obtain involuntary assessment followed by rapid discharge:
"There's no way that a family member can keep someone longer than 72 hours. You can't do it." (P42)
Even when a hold was obtained, participants often perceived that it resulted in assessment or stabilization rather than treatment of the underlying SUD. This contributed to descriptions of a "revolving door" between crisis, emergency care, discharge, and recurrent harm.
One parent described repeatedly being unable to secure continued intervention despite legal advice that her daughter appeared to satisfy relevant criteria:
"…there's no point in my trying to form her again until there's something… that seems different than addiction because the way the hospitals treat it… I don't think my daughter is capable right now, even though they're saying she is. She is not calling the shots; fentanyl is calling the shots." (P30)
In contrast, one participant described an unusual instance in which a physician maintained a minor's hospitalization until residential treatment could be arranged. The parent subsequently reported that the young person viewed the intervention positively:
"…he was actually very grateful, and I'll say now that I think that it was for the best. As somebody with lived experience, he'll tell you right now that he does not think he should have been allowed to make those decisions on his own." (P31)

5. Ways to Mitigate Potential Harms of IT

Participants did not describe IT as acceptable under all circumstances. Many spontaneously identified conditions they believed were necessary to reduce the risk of coercive, ineffective, or punitive care.
First, participants emphasized the importance of timely voluntary treatment. They described brief periods in which relatives became willing to seek care and argued that failure to provide treatment during these periods could contribute to subsequent crises and potentially increase the perceived need for involuntary intervention.
Second, participants emphasized careful assessment of capacity and comprehensive evaluation of co-occurring psychiatric conditions. They wanted treatment systems to address SUD and concurrent disorders together.
Third, participants distinguished therapeutic involuntary care from punitive detention. They emphasized evidence-based addiction treatment and rejected models that they regarded as "incarceration by any other name":
"They don't belong in a psychiatric institution. They require evidence-based treatment, not necessarily a room with restraints and bare walls. But if that's what he needed for the first 10 days before it was arranged, while he was dealing with the acute effects of meth use, right?" (P31)
Participants also described ways to reduce coercion during apprehension itself, such as preferring mental health professionals rather than police where feasible, as law-enforcement involvement could be experienced as traumatic:
"About the police interaction, when we put my son in the hospital against his will, they handcuffed him… They put him in a padded cell, where he was still handcuffed. It was very traumatic, not what I expected, traumatic for him mostly." (P65)
Trauma-informed and culturally safe care were also identified as important safeguards, particularly given the potential for involuntary intervention itself to cause harm.
Finally, participants repeatedly emphasized duration and continuity of care. Brief stabilization without subsequent treatment, housing, aftercare, and social reintegration was viewed as unlikely to produce sustained benefit:
"I don't believe in forced treatment now, but I would believe in forced treatment if it actually was a year… If there were a place for people to go for detox, aftercare, and a treatment center… And then… after that, there's housing, there's a chance. There's something positive." (P25)

DISCUSSION & CONCLUSION

The principal contribution of this study is not simply that family members supported the availability of IT, but that their perspectives were grounded in longitudinal experiences from prolonged caregiving, recurrent crises, and repeated interactions with health and legal systems. These experiences shaped how they understood capacity, autonomy, harms, and the conditions under which involuntary intervention might be justified. Participants repeatedly distinguished therapeutic intervention from detention alone. Support for IT was conditional rather than categorical. They emphasized the importance of timely access to voluntary treatment, appropriate capacity assessment, evidence-based treatment of SUD and concurrent conditions, adequate treatment duration and aftercare, trauma-informed and culturally safe care, and safeguards protecting autonomy and other rights.
Participants concerns about capacity were consistent with research showing that people with SSUD are rarely found incapable with respect to treatment decisions related to substance use and with recent critiques of capacity assessments that rely heavily on a single point-in-time evaluation. (14,15). Participants' concerns about the harms of not intervening were also consistent with prior Canadian research suggesting limited use of existing mental health legislation in relation to SSUD.(5) Their accounts highlight the importance of considering both the potential harms of coercive intervention and the harms of non-intervention. Debates about IT may therefore be more productive when they move beyond the binary question of whether involuntary treatment should exist and instead examine the circumstances in which intervention might be justified, the thresholds and safeguards governing its use, and the quality and continuity of care provided.
Family members' longitudinal experiences represent one important source of knowledge and should be considered alongside the perspectives of people with SSUD and other affected stakeholders when developing clinical, ethical, and policy approaches to involuntary care.

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