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Involuntary Treatment Legislation in Ontario and Substance Use Disorders (SUDs); Fit for Purpose?

META:PHI Conference 2025, Session 2B

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Presenter Disclosure

Presenter: Angie Hamilton

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  - Executive Director and Board Member, Families for Addiction Recovery (FAR)
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Objectives

1. Understand the current involuntary treatment legislation in Ontario in the context of SUDs

2. Discuss shortcomings of the legislation, **as drafted or applied**, from the perspective of families/psychiatrists/physicians

3. Discuss recent approaches in other Canadian jurisdictions

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The Context

Final Report of the Select Committee (Ontario 2010)

The Select Committee believes, however, that the right to autonomy must be balanced with the right to be well. The Select Committee also believes that **our present laws tie the hands of health professionals and families and have contributed to the criminalization of mental illness, where individuals need to be arrested in order to receive care.**

While Ontario undoubtedly needs better access to community supports and hospital beds, some people will not avail themselves of such services because **it is the nature of their condition to deny that they are ill.** Furthermore, there are a number of psychiatric conditions for which a delay in treatment can result in an irreversible deterioration in health. Ontario's current legal framework is not adequately nuanced to address this predicament.

Angus Reid Poll, 2021

88% of Canadians are in favour of involuntary treatment for adults (not just minors) with opioid use disorder

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Ontario Association of Chiefs of Police

Resolution 2024-05

Calls on the ON Government to ensure that public hospitals/psychiatric facilities and other health facilities:

- be prohibited from refusing persons suffering from a mental health issue on the grounds that they are intoxicated
- establish policies and procedures that ensure persons in crisis who may be intoxicated receive the same consideration for examination, assessment and treatment by a physician
- provide these places necessary funding for adequate security and withdrawal management protocols to provide stabilization and appropriate treatment for persons in crisis that may have co-occurring SUD and/or are perceived to be intoxicated

Ontario Big City Mayors Resolution Oct. 18/24

We request the Province of Ontario to urgently review and consult on **updates to the Mental Health Act and Health Care Consent Act** to reflect current realities of this crisis, including through consultation with medical professionals, first responders and municipalities, to include a **determination of whether to expand the scope of and strengthen the existing system of mandatory, community-based residential mental health and addiction care treatment.**

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Health Laws Provide Solutions to Difficult Problems

What to do when:

- Someone is at serious risk of harm to self/others due to a “mental disorder” and isn’t seeking treatment (MHA)
- Someone lacks capacity to make treatment decisions (HCCA)

Purpose: Safety of the person and public

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Ontario Mental Health Act applies to SUD

- Criteria (1) mental disorder? Yes
  - Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Consent and Capacity Board
- Criteria(2) serious harm? Yes
  - Can be “serious bodily harm” or “serious physical impairment”
- “Precedent-setting decisions support the legal opinion that substance use disorders can satisfy both the “mental disorder” and “harm” criteria in all provinces and that involuntary admissions for this population are possible under current legislations.”
- Why underutilized? Speculated it is “**therapeutic nihilism, or worse, stigma**”.

- Reid N, Chartier LB, Orkin A, Klaiman M, Naidoo K, Stergiopoulos V. Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders. CJEM. 2020 Sep;22(5):629-632. doi: 10.1017/cem.2020.385. PMID: 32538339.

Capacity assessments for SUD?

CAMH Research Letter

Looked at the 10,463 reported reasons for decisions (RDs) of Ontario's Consent and Capacity Board over 21 years since reporting began in 2003:

- only 71 RDs contained substance use search terms (for OUD and AUD)
- only 6 RDs considered capacity to consent to SUD treatment
- only 1 CCB case upheld a finding of incapacity with respect to methadone treatment (didn't appreciate the purpose of methadone; didn't think he had an SUD)

"Individuals may be unable to consent to life-saving OAT and discontinuation of (or failure to start) OAT, particularly in a controlled hospital environment, may represent the greatest immediate threat to these patients' morbidity and mortality with an extremely toxic unregulated drug supply."

"...capacity to consent to or refuse SUD treatments should be considered part of psychiatric and medical care, particularly with methadone or buprenorphine."

Consent and Capacity Board Decisions

AM (Re), 2019 CanLII 46829 (ON CCB)

AJ (Re), 2021 CanLII 61415 (ON CCB)

43 year old mom of 2, PhD, lived with her family who initiated restraining order (facing homelessness). SUD, history of ODs resulting in near bathtub drowning, car accidents, hospitalizations. Consumed antifreeze. Found at risk of serious bodily harm from mental disorder (SUD) unless remained in hospital.

CC (Re), 2024 CanLII 53300 (ON CCB)

34 year old, schizophrenia, ABI, IV fentanyl use, hotel shelter. Assaulted mall security. Found incapable for anti-psychotic and Sublocade medications. CTO necessary to enforce compliance.

RL (Re), 2024 CanLII 22580 (ON CCB)

17 year old, stimulant/opioid use disorder, trauma, PTSD, attachment disorder, previous substance use psychosis, homeless, Form 2 by mother (fentanyl use), victim of 3 sexual and other assaults with substance use, risk of hypothermia, ODs. At risk of serious physical impairment from SUD unless detained in hospital.

Concerns/Barriers

- Ineffective/traumatic
- Violates ethics
- Violates rights
- Violates autonomy/informed consent
- Prioritize voluntary treatment
- Deters people from seeking voluntary services
- Destroys family relationships
- Disproportionately affects Indigenous population

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Ineffective/Traumatic?

Bahji, 2023 (CSAM Systematic Review)

- lack of high-quality evidence to support **or refute** IT for addiction in comparison to voluntary treatment

Ineffective compared to what? The alternative is untreated addiction:

- human trafficking, sexual exploitation, incarceration, being homeless, suicide, and serious health issues including brain injuries and death
- that's traumatic

We can build a system where any harms/trauma of involuntary care are less than the harms/trauma of untreated addiction

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Bahji, 2023

5 of the 10 negative studies (50%) did not involve evidence-based treatment for involuntary patients; 3 of 10 only involved voluntary patients. Only two studies, both Norwegian, compared voluntary to involuntary patients where both received evidence-based treatment.

Pasareanu, 2016

- 6 month follow-up: **significant reduction in drug use in both groups** for preferred substance (61% VA vs. 37% IA); Amphetamines (75% vs. 53%); Cannabis (61% vs. 62%); abstinence (50% vs. 24%) **but much higher ODs for IA (22% IA vs. 1%VA)**

Opsal, 2019

- Majority of IA at highest stage of readiness to seek help at admission and neared VA at discharge. **Only predictor of drug use at follow up was severity of SUD at admission; readiness to change was not a factor.**

Is there a better alternative to involuntary treatment?

Consumption and Treatment Services (CTS) and harm reduction can save those who use these services. However:

- What percentage of people with severe addiction use these services?
- Some people who are unwilling/incapable of accessing treatment are also unwilling/incapable of practicing harm reduction.

What then?

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Ethics

- We only seem to be questioning the ethics of intervening
- Let's question the ethics of not intervening in circumstances where the mental health acts apply, especially for minors
- Does the status quo for minors amount to neglect by the health care system? Neglect, for minors, is a form of child abuse.

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BC Mental Health Act (MHA)

MHA criteria for involuntary admission

1. the person is a person with a **mental disorder** which requires treatment;
2. **the disorder seriously impairs the person's ability to react appropriately to their environment or associate with others;**
3. **the person requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration, or for the protection of the person or for the protection of others;**
4. the person requires treatment in or through a designated facility; and
5. the person cannot suitably be admitted as a voluntary patient.

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New BC Guidance March, 2025

Does not amend the MHA. Clarifies that no subtype of mental disorder is excluded (ie. SUD).

For the purposes of this guidance document, the criteria in the second and third bullet (previous slide) together will be referred to as “mental impairment”. There must also be mental impairment.

Three scenarios where MHA may apply to SUD:

1. Concurrent disorders;
2. Known SUD or intoxicated, and an acute and severe psychiatric syndrome of unknown etiology; or
3. After remission of acute state, mental impairment persists.

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Alberta

Compassionate Intervention Act to be introduced in the spring or fall.

Two facilities of up to 150 residents being built.

Insights from White Paper (March 25/25)

- framed as a healthcare intervention: procedural fairness, person-centred, longer bed-based treatment, long-acting medications, social reintegration, mutual support interventions, transition and aftercare

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Insights from the literature

– minimize law enforcement involvement for transport
– procedural fairness and involvement in the process
– integrate voluntary and involuntary populations
– evidence-based, person-centred treatment
– integrate treatment for concurrent disorders
– longer term
– transition/aftercare/social reintegration
– provide overdose prevention and harm reduction education

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Thank You

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What is a Rights Based Approach for minors?

The UN Convention on the Rights of the Child

- Article 3: Best Interests of the Child
- Article 24: Access to Health Care Facilities and Services
- Article 33: Right to be protected from the use of illegal drugs and from being used in the drug trade

Secure care: a question of capacity, autonomy and the best interests of the child Angie L. Hamilton, Daphne G. Jarvis, Barbara E.L. Watts, CMAJ Feb 2020, 192 (5) E121-E122; DOI: 10.1503/cmaj.73252

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Duty to Protect Minor After Overdose

"It is inappropriate to expect a youth who has just received naloxone for a drug overdose to be capable of informed consent with regards to the notification of their legal guardian in order to gather vital information and to ensure a safety plan post discharge. It is equally inappropriate to expect the youth to be fully competent to consent to, or refuse, treatment options."

"Many physicians are guided by the concept that adolescents are fully competent to make medical decisions and if they choose to continue on a path of life-threatening drug use it is within their rights to do so. This approach is inconsistent with our current understanding of adolescent neurodevelopment and existing laws to protect teens."

Warshawski T, Warf C. It is time for an ethical, evidence-based approach to youth presenting to the ED with an opioid overdose. Paediatr Child Health. 2019 Sep;24(6):374-376. doi: 10.1093/pch/pxz011. Epub 2019 Feb 19. PMID: 31528108; PMCID: PMC6735634.

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A Duty to Protect

"It is time to recognize that confinement for the purposes of merely "stabilizing" the child … is insufficient. Confinement must also serve the legitimate purpose of treatment. This will allow the system to better serve the long-term health of the child…"

- Source: Public Fatality Inquiry Report to the Minister of Justice and Solicitor General, The Honourable Judge Lloyd W Robertson into the death of MHC, 17 of Calgary, Alberta (2017)

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Brianna MacDonald (13)

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