# Involuntary Treatment for Severe Substance Use Disorders[1]

## Key Points

- The debate on involuntary treatment (InvTx) for severe substance use disorders (SSUDs) in Canada involves considering evidence-based care, public safety and individual rights.
- InvTx is typically used when individuals are at risk of harming themselves or other people and lack capacity to make treatment decisions due to having an SSUD concurrent with a mental health disorder.
- SSUD often co-occurs with mental health disorders, highlighting the need for integrated care approaches.
- Voluntary treatment options for SSUD in Canada are limited, with barriers that hinder effective patient engagement and retention in care.
- International experiences with InvTx show ethical concerns, limited evidence of benefits and increased health harms, including higher mortality risk post discharge.
- Current evidence does not support that the benefits of InvTx outweigh its costs and harms. Further research is needed to guide its design and effectiveness.

## Overview

This brief explores InvTx for SSUDs by focusing on the evidence, legislation and diverse perspectives surrounding it. This brief provides a thorough overview of the issues InvTx poses for decision makers, health professionals, and policy and program developers. It does

[1] This document is part of a series of evidence briefs the Canadian Centre on Substance Use and Addiction has created to help people and communities understand and contextualize complex health solutions and the resources intended to address people's substance use health and wellness. Please also check out our briefs on opioid agonist therapy (Canadian Centre on Substance Use and Addiction, 2024a), drug checking (Canadian Centre on Substance Use and Addiction, 2024b) and supervised consumption sites (Canadian Centre on Substance Use and Addiction 2024c) The research findings in this document are primarily based on a review of academic and grey literature from 2016 to 2024. Earlier studies were included when more recent research was unavailable. The focus was on evidence review articles and related Canadian resources. International studies were included when Canadian literature was not available.

this by outlining the nuances of this complex topic, including how substance use health, treatment, human rights and public safety intersect.

This brief is intended to inform discussions on InvTx through evidence. The growing policy debate on InvTx for SSUDs in Canada stems from extensive harms, overdose deaths, a fragmented system of care and supports, and public safety concerns.

InvTx refers to instances where a person is temporarily held in a hospital or treatment facility without their consent when healthcare professionals or, more rarely, justices and first responders believe the person is at serious risk of harming themself or other people because of a mental health disorder and lack capacity to make treatment decisions due to having SSUD. The person can only leave once a physician deems the risk is reduced or managed.

InvTx already exists in Canada but is primarily applied to mental health disorders. For SSUDs, InvTx is typically only considered if there is a co-morbidity with a diagnosed mental health disorder, although this is not clearly stated in most legislation.

The rules around InvTx are not governed by the *Criminal Code of Canada* but by each provincial and territorial mental health act. These acts are each different and most define "disorder" without referencing the widely used *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (American Psychiatric Association, 2013), which has caused confusion as to the applicability of substance use disorders (SUDs).

There are also concerns about the effectiveness of InvTx for SUDs and SSUDs, as the evidence behind this approach is not strong. There are concerns of ethics, human rights and how they integrate into the broader social and health systems for SSUDs.

## What Is Involuntary Treatment?

This brief defines InvTx as a person's admission by a physician or judicial authority to a health facility for an SSUD without the person's consent after they are considered to be: 1. Lacking the capacity to make informed decisions and 2. at risk of harming themself or other people (Hall et al., 2014; O'Reilly & Gray, 2014).

InvTx typically involves hospitalization or psychiatric care for limited, but possibly repeated, periods of time. The treatment permitted at these facilities differs in each province and territory, as some are allowed to provide a person with medication and therapy, while others monitor a person to stabilize them and administer them treatment.

InvTx can also involve admitting a person who refuses life-saving medical care — such as treatment for a severe infection — to ensure they receive the urgent medical attention required to prevent serious harm or death to the person. This approach may be necessary when a person is unable to properly consent to emergency care due to impaired judgment or a lack of capacity to understand the risks.

From recent national discussion, there is confusion as to whether provincial and territorial mental health acts allow individuals to be placed in InvTx solely for SSUDs. InvTx is not new and already exists in varied scope and provisions under these acts. These acts apply to mental health diagnoses (Fischer et al., 2002; O'Reilly & Gray, 2014).

Coerced treatment is different from InvTx as it could be perceived as occurring when systems like criminal justice mechanisms influence an individual to enter treatment. In these cases, refusal to participate may lead to criminal penalties, such as incarceration (Berg & Burke, 2023).

In current public discourse, the goals of InvTx are often absent. Sometimes the goal is to protect someone from imminent harm and removing them from their environment can be effective in preventing death or harm during the period of admission.

If the elevated risk to the individual is driven by an infection related to injection of drugs for example, that risk can be mitigated during the admission. There is also the opportunity to engage the individual if they don't have intoxication symptoms. However, long-term success may require months of treatment and often ongoing prescribed medication use. The ability for involuntary treatment to have longer-term impacts or not is discussed below.

## What Is Severe Substance Use Disorder?

This brief frames discussions about SSUD within a substance use health (SUH) perspective. SUH views substance use along a spectrum of health, from no use to varying levels of risk (Community Addictions Peer Support Association, 2024). This framework emphasizes that everyone has a place on the spectrum, regardless of their relationship with substances, and that place may differ across time or drugs. An SUH approach promotes informed decision making while addressing stigma at every point along the spectrum.

In the context of InvTx, SUH emphasizes the importance of addressing SUDs as an informed health and social matter rather than a criminal or moral judgment issue.

SSUD is a complex, health and social condition affecting a person's brain, behaviour, relationships, and overall well-being due to difficulties managing substance use. It is typically characterized by chronic substance use — such as alcohol and drug use — that causes significant health or social harm to the person or other people.

While the mental health acts in Canada do not refer to the DSM-5, it is the standard diagnostic assessment tool for SUD in the country. SUD is classified as mild, moderate or severe, based on 11 diagnostic criteria outlined in the DSM-5. An SSUD is defined by meeting six or more of these criteria.

This brief will distinguish between SUD and SSUD, as based on these definitions. Not all cases of SUD are "severe." This brief uses the medical terminology of the SUD diagnosis, as opposed to "addiction" (which is not a diagnosis and can be stigmatizing).

SSUD can arise from individual, social and structural factors like poverty, housing instability, systemic racism, and trauma (Smye et al., 2023; Whitesell et al., 2013). SSUD can cause strained relationships, job loss, housing instability, and experiences of discrimination or criminalization (Cohen et al., 2022; Lin et al., 2024).

Substance use may heighten risks of harm to oneself and other people, including health problems, violence, and trauma (Gratz & Tull, 2010). Stigma around substance use further isolates people who use substances and creates barriers to accessing and receiving care (Cernasev et al., 2021).

Half or more of people with an SUD experience co-occurring mental health conditions, such as anxiety or depression, which worsen and complicate efforts to address their SUH (Bahji, 2024; Lai et al., 2015; Sullivan et al., 2020). SUDs can result in behavioural impairments due to adverse changes in brain functioning and structure, or brain injuries. For example, oxygen deprivation due to opioid overdose can lead to brain injuries, while the use of stimulants like methamphetamines or cocaine may disrupt neural pathways, causing difficulties with cognition and behaviour (Lappin & Sara, 2019; Winstanley et al., 2021).

## Is Involuntary Treatment Effective and Evidence-Based?

There is limited evidence on the effectiveness of InvTx for SSUD (Bahji et al., 2023; Vélez et al., 2023; Werb et al., 2016). Studies come from diverse settings and often lack rigorous comparisons, making it difficult to draw firm conclusions of its benefits.

Research reviews have found that while some studies suggest InvTx can help people stay in treatment programs longer, most do not show significant improvements in reducing substance use or criminal reoffence (Bahji et al., 2023; Kisely et al., 2024). In some cases, InvTx has been linked to negative health outcomes, such as increased risk of overdose or death (Ledberg & Reitan, 2022; Scarpa et al., 2023; Rafful et al., 2018; Werb et al., 2016).

Overall, claims of InvTx benefits are largely anecdotal, and there is a significant lack of high-quality research to determine its effectiveness compared to voluntary treatment or no treatment at all (Pilarinos et al., 2020). This is especially true when looking at SSUD (Coleman et al., 2021; Hall et al., 2014).

InvTx programs are resource-intensive and costly (Bahji et al., 2023). With the general landscape of treatment and other supports for SUH gaps, increased focus on InvTx could potentially divert resources from more cost-effective, community-based treatment and prevention services that have stronger evidence backing and wider reach in reducing substance use harms.

Additionally, fears of being put into InvTx may discourage individuals in need from seeking voluntary care or cause them to leave treatment prematurely before reaching their goals of care.

## What Do Patients, Caregivers and Clinicians Say About Involuntary Treatment?

### Patients

While some patients report a sense of safety in InvTx for mental health, other patients report experiences of trauma and fear (Seed et al., 2016). Patients in InvTx settings report feeling unsafe due to violence, aggression and intimidation (Jenkin et al., 2022). Sometimes InvTx services are not provided through trauma-informed lenses, with care plans not considering past trauma (Health Justice, 2024), thus worsening patients' trauma. Many women in InvTx experienced privacy violations, unwanted proximity to men and re-traumatization (Hennesey et al., 2023). People with children in InvTx were often separated from them without support to maintain relationships with them (Tseris et al., 2022).

Positive outcomes of treatment are linked to person-centred care (perceived or real) and strong therapeutic bonds with clinicians, but these are not always found in InvTx (Seed et al., 2016). Readiness for change, client-led goals and outcomes of treatment have also been tied to positive outcomes of treatment for SUD, which are not always present in InvTx (Taha, 2018).

### Caregivers

A study on InvTx for SUD found that patients, caregivers (including parents) and families emphasized the need for significant improvements in voluntary treatment options rather than InvTx (Chau et al., 2021). Participants advocated for individual autonomy, peer advocacy and removing law enforcement from InvTx encounters. People who had a mental health visit with a family doctor or psychiatrist in the week before being admitted to the hospital were less likely to be admitted involuntarily (Lebenbaum et al., 2018). This suggests that involuntary hospitalization might be partly preventable if community-based care helps address psychiatric crises early.

### Clinicians

Clinicians reported some, or high, moral distress in using InvTx, particularly due to concerns about systemic failures (Walt et al., 2022). Clinicians also held concerns about the involvement of law enforcement and the criminal justice system in the legal commitment process. Most clinicians viewed InvTx as a last resort.

## Is Involuntary Treatment Used in Canada?

It is permitted to administer InvTx to people in Canada who have an SSUD with a concurrent mental health disorder.

Each province and territory has its own laws governing InvTx for mental health disorders. While these laws share common provisions, they differ slightly in their details.

To qualify for InvTx, a person must be diagnosed with a mental health disorder. However, provincial and territorial mental health acts generally do not specify whether an SUD is considered a mental health disorder, creating ambiguity about the inclusion of an SSUD. As a result, individuals with an SUD may only be subject to InvTx if they also have a diagnosed mental health disorder, based on current interpretations.

All provincial and territorial mental health laws require a person to be at risk of harming themself or other people to be considered for InvTx. This can include whether the person refuses a health treatment that could save their life and it is found to be in relation to their mental health or SUH.

The entire process includes checks and balances from healthcare professionals, especially during the renewal of InvTx. The process typically begins with a physician making an assessment that is confirmed by another physician. It can also sometimes begin due to court order. This results in a person being involuntarily kept for a short period of time, between 24–72 hours, depending on the province or territory. If the person is still found to be at risk of harming themself or other people or unable to knowingly consent, they may be involuntarily kept for a longer period (length is different for each province and territory) with possibility of renewal.

Many provinces and territories offer voluntary, community-based treatment after a person has been in InvTx to reduce repeat admissions; however, this is not always offered, even if available. Having previously been admitted into InvTx often means it is easier for a medical professional to involuntarily treat the patient again, as per the legislation.

## Is Involuntary Treatment Used Outside of Canada?

InvTx for substance use, including alcohol and drug use disorders, has been implemented in various countries.

In Sweden, the “LVM Act” (also described as a law that enables compulsory, closed care of adults with SUD) enacts InvTx if someone is at risk of serious harm due to substance use and refuses treatment (Ledberg & Reitan, 2022; Scarpa et al., 2023). However, only about 20 per cent of individuals under this system remains in care beyond two weeks.

Similarly, Switzerland introduced legislation in 2013 that permits InvTx for people with SSUD or mental health disorders, but its use is relatively rare and varies across regions (Habermeyer et al., 2018).

New South Wales, Australia's Involuntary Drug and Alcohol Treatment Program, established in 2012, detains individuals with SSUD for InvTx if they lack the capacity to make decisions (Kisely et al., 2024; Vuong et al., 2022).

In Massachusetts, U.S., the state can detain individuals in a psychiatric facility or treatment program for up to 90 days under Section 35, a Massachusetts law, if their substance use poses an immediate risk (Sinha et al., 2020). Sometimes, individuals are sent to correctional facilities due to lack of treatment care availability.

## What Are Canada's Current Gaps and Supports in Substance Use Health?

A review of Canada's SUH treatment landscape reveals key insights into the availability, accessibility, use and outcomes of current voluntary SUH treatments. It also shows gaps in current treatment options for SSUD.

There are various culture-based health models active across the country. At a high-level, there is the Western model, which sees health as the absence of disease, focusing on medication and behaviour treatment for SUH.

First Nations, Métis, and Inuit healing approaches view health and SUH as the connection of physical, emotional, mental, and spiritual well-being.

Other groups also hold distinct models, and the SUH systems are increasingly combining these perspectives (Sansone et al., 2022).

### Supports

For opioid use disorder (OUD), opioid agonist treatment (OAT), including methadone and buprenorphine or suboxone, is the gold standard treatment (Bruneau et al., 2018; Strang et al., 2020; Yakovenko et al., 2024). OAT is life saving, safe and effective medications that are well established as best practice treatment for OUD. It reduces the risk of overdose and death. It can stabilize and provide people living with OUD an opportunity to also engage more fully in counselling and other psycho-social support services to improve health and well-being (Canadian Centre on Substance Use and Addiction, 2024). However, OAT is not available to everyone seeking it, and there are many access barriers even when OAT is available (O'Connor et al., 2020; Pilarinos et al., 2023; Piske et al., 2020; Socias et al., 2022).

### Gaps

Canada's social and health landscape for SUH reveals significant gaps, particularly for individuals with SSUD. While SUD is usually a chronic condition requiring ongoing care, current, evidence-based options are limited and often inadequate for severe cases.

For stimulant use disorders, such as methamphetamine, the treatment availability and effectiveness gaps are even wider. There are no approved medication-supported treatments and, while there are psycho-social approaches that show some treatment benefits (i.e.,

contingency management), they are not routinely offered as part of care (Farrell et al., 2019; Hersi et al., 2024; Minozzi et al., 2024; Ronsley et al., 2020).

Despite efforts to expand SUH services, significant gaps remain, particularly in rural, remote and equity-deserving communities due to systemic barriers (Martin et al., 2018). Limited resources for SUD treatment — such as funding, trained professionals and infrastructure — lead to long wait times, inconsistent or inferior care, and barriers to support, especially for people with an SSUD (Health Canada, 2019).

As a result, many people with SUDs go untreated, quickly disengage from care or rely on emergency services. This can also result in involuntary or coercive models becoming the first point of access to care (Berg & Burke, 2023). People may not even seek out treatment due to previous negative experiences within health and social services, such as racism, stigma or negative experiences in life, such as sexual assault (Livingston, 2020). They also may hold their own self-stigma and feel embarrassed or ashamed to seek treatment. These issues also make it difficult for individuals to remain engaged in care to have the outcomes they desire.

## How Does Involuntary Treatment Apply to Children under 18 Years Old?

InvTx for children under the age of 18 is usually governed under separate legislation due to distinct considerations. There is also no set age of consent in Canada, but rather the expectations of a person being able to understand what they are consenting to (Coughlin, 2018). So, children under 18 years old can consent to voluntary treatment.

InvTx for children under 18 exists under secure care legislation in seven provinces (Alberta, Ontario, Manitoba, New Brunswick, Nova Scotia, Quebec and Saskatchewan) (Hanon, 2016). This legislation allows for InvTx of children under 18 on initiative of their parents or caregivers in cases where the child is at risk of harming themself or other people due to mental health or substance use and can be court ordered. However, the impact of InvTx on children under 18 remains a complex and under-researched area.

Studies show that children's experiences of InvTx for psychiatric problems (not SSUD) can negatively affect trust in healthcare providers, leading to reluctance in disclosing suicidal feelings or seeking future help (Jones et al., 2021). While some children under 18 reported positive outcomes, such as increased family support and access to care, a majority described InvTx experiences as more punitive than therapeutic (Jones et al., 2021).

A study in Alberta found parents turned to InvTx measures for their children out of desperation to protect their child's safety when voluntary treatment was refused (O'Brien & Hudson-Breen, 2023). While some appreciated the temporary safety provided, many were disappointed by the limited impact on substance use and lack of follow-up support. Parents

also reported risks, including damaged trust, resentment from their child and exposure to negative peer influences.

The balance between the best interests of children as a vulnerable population and the need for intervention, particularly in cases of SUD, remains a challenging issue within Canadian health law and the broader framework of child protection.

## Are there Ethical Concerns for Involuntary Treatment?

InvTx raises ethical concerns, as it may violate individual rights by detaining and treating people without consent. Critics argue that non-emergency SUD treatment without explicit consent breaches standards of human rights and medical ethics, including those in the United Nations Convention on the Rights of Persons with Disabilities (Gerra & Clark, 2010; Kisely et al., 2024).

While related issues are complex in the specific contexts of SSUDs as described, there are concerns about infringements on peoples' autonomy and right to consent as well as privacy, beyond the limited evidence supporting its benefits for patients (Udwadia & Illes, 2020). The counter argument to this is that InvTx is a process in which autonomy is being returned to individuals through the provision of emergency care (Reid et al., 2020).

Studies of British Columbia's *Mental Health Act* show that while it aims to protect individuals, it often undermines their safety and rights, particularly for equity-deserving communities (Kolar, 2018). Canada's colonial history, including the displacement of First Nations, Inuit and Métis (FNIM) people, complicates InvTx, with some of these communities seeing it as another form of displacement (Sansone et al., 2022). The legacy of systemic racism and the residential school system contributes to mistrust in health care, with many FNIM, Black, and racialized peoples seeing InvTx as another form of oppression. This potentially puts InvTx practices at odds with Canada's commitments under the United Nations Declaration on the Rights of Indigenous Peoples and the Truth and Reconciliation Commission.

The evidence also showcases the importance of having community support after a person is released from InvTx, also due to the increased risk of overdose death and other health harms (Kisely et al., 2024). Failure to provide appropriate post-treatment support can be viewed as neglecting a duty of care and violating the respect for individuals' rights and dignity.

## How Does Involuntary Treatment Relate to Community and Public Safety?

There have been concerns about increasing burdens to communities and public safety from the current SUH crisis. The rise in drug overdoses and deaths over the past decade has put significant strain on emergency services and healthcare resources.

The estimated costs of lost productivity due to premature deaths and long- and short-term disability associated with substance use alone were $22.4 billion in 2020. (Canadian Substance Use Costs and Harms Scientific Working Group, 2023).

Communities are feeling the adverse impact, with apparent increased visible substance use raising safety concerns. For example, in Vancouver, violent attacks by strangers rose 35 per cent in 2021–2022 compared to pre-COVID pandemic levels, some involving individuals in acute substance use crises (Butler & LePard, 2022). Most suspects had been apprehended previously under the *Mental Health Act* and involved in prior violent crime incidents. But while the need to consider community and social interests in addressing these issues is clear, the appropriateness of InvTx-based responses requires careful assessment, particularly regarding the long-term impacts, patient interests, human rights, and the broader costs and benefits. This is especially true given very limited evidence for InvTx reducing criminal recidivism (Werb et al., 2016).

It is also important to consider whether there is capacity within the healthcare system to actualize substantively expanded InvTx responses without undermining other essential elements of SSUD care.

## Conclusions

The debate surrounding InvTx for SSUDs in Canada involves a complex effort of considering issues of evidence-based care, public safety concerns, and individual and patient rights.

InvTx is typically applied in situations where a person is at risk of harming themself or other people and lacks autonomous capacity to make treatment decisions due to SSUD. Given that SSUD often co-occurs with mental health disorders, this overlap can complicate treatment efforts, underscoring the need for an integrated approach to care.

The existing voluntary treatment options for SSUD in Canada are limited. In addition, the current system presents significant barriers that make it challenging for individuals with SSUD to engage or maintain engagement effectively.

International experiences with InvTx have yielded ethical concerns, limited evidence for outcome benefits and findings of increased health harms among individuals who are involuntarily treated. These harms include increased mortality risk following discharge from InvTx.

The existing evidence does not convincingly suggest that the benefits of InvTx outweigh its costs and harms. A measured and evidence-informed approach to InvTx for SSUD would require further research to evaluate and guide its design, practices and effectiveness.

While improved treatment availability and outcomes for SSUD are universally desired, it is crucial to examine both the potential benefits and limitations of InvTx — for people living with SSUD — as a basis for informed policy development.

If InvTx is chosen, it should be viewed as a last resort, with the goals of InvTx clearly defined. It should include expanding access to evidence-based, community-centred care options that meet present needs and ensure that the perspectives of people affected by SSUD, along with healthcare professionals, are considered in policy making.

## References

American Psychiatric Association DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders, fifth edition: DSM-5™*. American Psychiatric Publishing, Inc.. https://doi.org/10.1176/appi.books.9780890425596

Bahji, A. (2024). Navigating the complex intersection of substance use and psychiatric disorders: A comprehensive review. *Journal of Clinical Medicine*, *13*(4). https://doi.org/10.3390/jcm13040999

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

Berg, D., & Burke, H. (2023). *Drug treatment courts: An evidence-based review with recommendations for improvement* [Policy brief]. Canadian Centre on Substance Use and Addiction. https://www.ccsa.ca/sites/default/files/2023-11/Drug%20Treatment-Courts-Review-and-Recommendations-en.pdf

Bruneau, J., Ahamad, K., Goyer, M.-È., Poulin, G., Selby, P., Fischer, B., Wild, T. C., & Wood, E. (2018). Management of opioid use disorders: A national clinical practice guideline. *Canadian Medical Association Journal*, *190*(9), E247–E257. https://doi.org/10.1503/cmaj.170958

Butler, A., & LePard, D. (2022). *A rapid investigation into repeat offending and random stranger violence in British Columbia*. https://news.gov.bc.ca/files/Prolific_Offender_Report_BCFNJC_submission.pdf

Canadian Substance Use Costs and Harms Scientific Working Group. (2023). *British Columbia profile: Canadian substance use costs and harms (2007-2020)*. Canadian Centre on Substance Use and Addiction. https://csuch.ca/documents/infographics/english/CSUCH-Canadian-Substance-Use-Costs-Harms-British-Columbia-Infographic-2023-en.pdf

Canadian Centre on Substance Use and Addiction. (2024a). *Opioid agonist therapy*. Ottawa, Ont.: Author. https://www.ccsa.ca/sites/default/files/2024-10/OAT-Evidence-Brief-en.pdf

Canadian Centre on Substance Use and Addiction. (2024b). *Drug checking*. Ottawa, Ont.: Author. https://www.ccsa.ca/sites/default/files/2024-10/Drug-Checking-Evidence-Brief-en.pdf

Canadian Centre on Substance Use and Addiction. (2024c). *Supervised consumption sites*. Ottawa, Ont.: Author. https://www.ccsa.ca/sites/default/files/2024-10/OAT-Evidence-Brief-en.pdf

Cernasev, A., Hohmeier, K. C., Frederick, K., Jasmin, H., & Gatwood, J. (2021). A systematic literature review of patient perspectives of barriers and facilitators to access, adherence, stigma, and persistence to treatment for substance use disorder. *Exploratory Research in Clinical and Social Pharmacy*, *2*, Article 100029. https://doi.org/10.1016/j.rcsop.2021.100029

Chau, L. W., Erickson, M., Vigo, D., Lou, H., Pakhomova, T., Winston, M. L., … Small, W. (2021). The perspectives of people who use drugs regarding short term involuntary substance use care for severe substance use disorders. *International Journal of Drug Policy*, *97*, Article 103208. https://doi.org/10.1016/j.drugpo.2021.103208

Cohen, A., Vakharia, S. P., Netherland, J., & Frederique, K. (2022). How the war on drugs impacts social determinants of health beyond the criminal legal system. *Annals of Medicine*, *54*(1), 2024–2038. https://doi.org/10.1080/07853890.2022.2100926

Coleman, M., Ridley, K., & Christmass, M. (2021). Mandatory treatment for methamphetamine use in Australia. *Substance Abuse Treatment, Prevention, and Policy*, *16*(1), 33. https://doi.org/10.1186/s13011-021-00370-1

Community Addictions Peer Support Association. (2024). *What do we mean by substance use health?* https://capsa.ca/substance-use-health/

Coughlin, K. W. (2018). Medical decision-making in paediatrics: Infancy to adolescence. *Paediatrics & Child Health*, *23*(2), 138–146. https://doi.org/10.1093/pch/pxx127

Farrell, M., Martin, N. K., Stockings, E., Bórquez, A., Cepeda, J. A., Degenhardt, L., … McKetin, R. (2019). Responding to global stimulant use: Challenges and opportunities. *The Lancet*, *394*(10209), 1652–1667. https://doi.org/10.1016/S0140-6736(19)32230-5

Fischer, B., Roberts, J. V., & Kirst, M. (2002). Compulsory drug treatment in Canada: Historical origins and recent developments. *European Addiction Research*, *8*(2), 61–68. https://doi.org/10.1159/000052056

Gerra, G., & Clark, N. (2010). *From coercion to cohesion: Treating drug dependence through health care, not punishment*. United Nations Office on Drugs and Crime. https://www.unodc.org/docs/treatment/Coercion/From_coercion_to_cohesion.pdf

Giffen, P. J., Endicott, S. J., Boorman, S., & Canadian Centre on Substance Abuse. (1991). *Panic and indifference: The politics of Canada's drug laws: A study in the sociology of law*. Canadian Centre on Substance Abuse.

Gratz, K. L., & Tull, M. T. (2010). The relationship between emotion dysregulation and deliberate self-harm among inpatients with substance use disorders. *Cognitive Therapy and Research*, *34*(6), 544–553. https://doi.org/10.1007/s10608-009-9268-4

Habermeyer, B., Wyder, L., Roser, P., & Vogel, M. (2018). Coercion in substance use disorders: Clinical course of compulsory admissions in a Swiss psychiatric hospital. *Swiss Medical Weekly*, *148*(3536), w14644. https://doi.org/10.4414/smw.2018.14644

Hall, W., Farrell, M., & Carter, A. (2014). Compulsory treatment of addiction in the patient's best interests: More rigorous evaluations are essential. *Drug and Alcohol Review*, *33*(3), 268–271. https://doi.org/10.1111/dar.12122

Hanon, L. (2016). Youth secure care: The politics of forced treatment. *McGill Journal of Law and Health*. https://mjlh.mcgill.ca/2016/02/07/youth-secure-care-the-politics-of-forced-treatment/

Health Canada. (2019). *What we heard: Strengthening Canada's approach to substance use issues*. Author. https://publications.gc.ca/collections/collection_2019/sc-hc/H134-3-2019-eng.pdf

Health Justice. (2024). *Façade of safety: Gender-based violence in BC's involuntary mental health system*. Author. https://static1.squarespace.com/static/5e34ed207332cf46d561c2da/t/66eb2e463befa914a1d4f5b6/1726688853980/2024_SEP18_Final_FacadeOfSafety_Opt.pdf

Hennessy, B., Hunter, A., & Grealish, A. (2023). A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings. *Journal of Psychiatric and Mental Health Nursing*, *30*(3), 398–434. https://doi.org/10.1111/jpm.12889

Hersi, M., Corace, K., Hamel, C., Esmaeilisaraji, L., Rice, D., Dryburgh, N., … Hutton, B. (2023). Psychosocial and pharmacologic interventions for problematic methamphetamine use: Findings from a scoping review of the literature. *Plos One*, *18*(10), e0292745. https://doi.org/10.1371/journal.pone.0292745

Jenkin, G., Quigg, S., Paap, H., Cooney, E., Peterson, D., & Every-Palmer, S. (2022). Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives. *Plos One*, *17*(5), Article e0266935. https://doi.org/10.1371/journal.pone.0266935

Jones, N., Gius, B. K., Shields, M., Collings, S., Rosen, C., & Munson, M. (2021). Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social Psychiatry and Psychiatric Epidemiology*, *56*(11), 2017–2027. https://doi.org/10.1007/s00127-021-02048-2

Kisely, S., Bull, C., & Gill, N. (2024). Extending the reach of involuntary treatment to substance use disorders: Is it 'compassionate' or coercive care? *Australian & New Zealand Journal of Psychiatry*, *58*(12), 1017–1019. https://doi.org/10.1177/00048674241299215

Kolar, M. (2018). *Involuntary and coercive psychiatric treatment: A critical discourse analysis of British Columbia's Mental Health Act* [Master of Science in Nursing, University of British Columbia]. University of British Columbia. https://open.library.ubc.ca/collections/24/items/1.0375715

Lai, H. M. X., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, *154*, 1–13. https://doi.org/10.1016/j.drugalcdep.2015.05.031

Lappin, J. M., & Sara, G. E. (2019). Psychostimulant use and the brain. *Addiction*, *114*(11), 2065–2077. https://doi.org/10.1111/add.14708

Ledberg, A., & Reitan, T. (2022). Increased risk of death immediately after discharge from compulsory care for substance abuse. *Drug and Alcohol Dependence*, *236*, 109492. https://doi.org/10.1016/j.drugalcdep.2022.109492

Lebenbaum, M., Chiu, M., Vigod, S., & Kurdyak, P. (2018). Prevalence and predictors of involuntary psychiatric hospital admissions in Ontario, Canada: A population-based linked administrative database study. *BJPsych Open*, *4*(2), 31–38. https://doi.org/10.1192/bjo.2017.4

Lin, C., Cousins, S. J., Zhu, Y., Clingan, S. E., Mooney, L. J., Kan, E., … Hser, Y.-I. (2024). A scoping review of social determinants of health's impact on substance use disorders over the life course. *Journal of Substance Use and Addiction Treatment*, *166*, Article 209484. https://doi.org/10.1016/j.josat.2024.209484

Livingston, J. D. (2020). Structural stigma in health-care contexts for people with mental health and substance use issues: A literature review. Ottawa, Ont.: Mental Health Commission of Canada. https://www.researchgate.net/profile/James-Livingston/publication/341945036_Structural_Stigma_in_Health-Care_Contexts_for_People_with_Mental_Health_and_Substance_Use_Issues_A_Literature_Review/links/5eda7dcc299bf1c67d42177e/Structural-Stigma-in-Health-Care-Contexts-for-People-with-Mental-Health-and-Substance-Use-Issues-A-Literature-Review.pdf

Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: Achieving its potential. *The Lancet*, *391*(10131), 1718–1735. https://doi.org/10.1016/S0140-6736(18)30181-8

Minozzi, S., Saulle, R., Amato, L., Traccis, F., & Agabio, R. (2024). Psychosocial interventions for stimulant use disorder. *Cochrane Database of Systematic Reviews*, (2). https://doi.org/10.1002/14651858.CD011866.pub3

O'Brien, D., & Hudson-Breen, R. (2023). "Grasping at straws," experiences of Canadian parents using involuntary stabilization for a youth's substance use. *International Journal of Drug Policy*, *117*, Article 104055. https://doi.org/10.1016/j.drugpo.2023.104055

O'Reilly, R. L., & Gray, J. E. (2014). Canada's mental health legislation. *International psychiatry : bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, *11*(3), 65–67. https://www.ncbi.nlm.nih.gov/pubmed/31507766

O'Connor, A. M., Cousins, G., Durand, L., Barry, J., & Boland, F. (2020). Retention of patients in opioid substitution treatment: A systematic review. *Plos One*, *15*(5), Article e0232086. https://doi.org/10.1371/journal.pone.0232086

Pilarinos, A., Barker, B., Nosova, E., Milloy, M.-J., Hayashi, K., Wood, E. ... DeBeck, K. (2020). Coercion into addiction treatment and subsequent substance use patterns among people who use illicit drugs in Vancouver, Canada. *Addiction*, *115*(1), 97–106. https://doi.org/10.1111/add.14769

Pilarinos, A., Kwa, Y., Joe, R., Dong, H., Grant, C., Fast, D. ... DeBeck, K. (2023). Methadone maintenance treatment discontinuation among young people who use opioids in Vancouver, Canada. *The Canadian Journal of Psychiatry*, *68*(2), 89–100. https://doi.org/10.1177/07067437221136468

Piske, M., Zhou, H., Min, J. E., Hongdilokkul, N., Pearce, L. A., Homayra, F. ... Nosyk, B. (2020). The cascade of care for opioid use disorder: A retrospective study in British Columbia, Canada. *Addiction*, *115*(8), 1482–1493. https://doi.org/10.1111/add.14947

Rafful, C., Orozco, R., Rangel, G., Davidson, P., Werb, D., Beletsky, L., & Strathdee, S. A. (2018). Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs. *Addiction*, *113*(6), 1056–1063. https://doi.org/10.1111/add.14159

Reid, N., Chartier, L. B., Orkin, A., Klaiman, M., Naidoo, K., & Stergiopoulos, V. (2020). Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders. *Canadian Journal of Emergency Medicine*, *22*(5), 629–632. https://doi.org/10.1017/cem.2020.385

Ronsley, C., Nolan, S., Knight, R., Hayashi, K., Klimas, J., Walley, A., Wood, E., & Fairbairn, N. (2020). Treatment of stimulant use disorder: A systematic review of reviews. *Plos One*, *15*(6), Article e0234809. https://doi.org/10.1371/journal.pone.0234809

Sansone, G., Fallon, B., Vandermorris, A., Swardh, K., & Blackstock, C. (2022). *Effectiveness of interventions for the prevention and treatment of substance use disorders among First Nations, Métis and Inuit populations*. Toronto, Ont.: Policy Bench, Fraser Mustard Institute of Human Development, University of Toronto. https://socialwork.utoronto.ca/wp-content/uploads/2022/06/Policy-Brief-Substance-Use-Interventions-for-FNMI-Populations-Final-Web.pdf

Scarpa, S., Grahn, R., & Lundgren, L. M. (2023). Compulsory care of individuals with severe substance use disorders and alcohol- and drug-related mortality: A Swedish registry study [Original Research]. *Frontiers in Psychiatry*, *14*, Article 1106509. https://doi.org/10.3389/fpsyt.2023.1106509

Seed, T., Fox, J. R. E., & Berry, K. (2016). The experience of involuntary detention in acute psychiatric care. A review and synthesis of qualitative studies. *International Journal of Nursing Studies*, *61*, 82–94. https://doi.org/10.1016/j.ijnurstu.2016.05.014

Sinha, M. S., Messinger, J. C., & Beletsky, L. (2020). Neither ethical nor effective: The false promise of involuntary commitment to address the overdose crisis. *Journal of Law, Medicine & Ethics*, *48*(4), 741–743. https://doi.org/10.1177/1073110520979384

Smye, V., Browne, A. J., Josewski, V., Keith, B., & Mussell, W. (2023). Social suffering: Indigenous peoples' experiences of accessing mental health and substance use services. *International Journal of Environmental Research and Public Health*, *20*(4), Article 3288. https://doi.org/10.3390/ijerph20043288

Socias, M. E., Wood, E., Le Foll, B., Lim, R., Choi, J. C., Mok, W. Y., … OPTIMA Research Group within the Canadian Research Initiative in Substance Misuse. (2022). Impact of fentanyl use on initiation and discontinuation of methadone and buprenorphine/naloxone among people with prescription-type opioid use disorder: Secondary analysis of a Canadian treatment trial. *Addiction*, *117*(10), 2662–2672. https://doi.org/10.1111/add.15954

Strang, J., Volkow, N. D., Degenhardt, L., Hickman, M., Johnson, K., Koob, G. F., … Walsh, S. L. (2020). Opioid use disorder. *Nature Reviews Disease Primers*, *6*(1), Article 3. https://doi.org/10.1038/s41572-019-0137-5

Substance Abuse Mental Health Services Administration. (2016). *Impact of the DSM-IV to DSM-5 changes on the National Survey on Drug Use and Health*. Substance Abuse and Mental Health Services Administration (US). https://www.ncbi.nlm.nih.gov/pubmed/30199183

Sullivan, M. C., Strainge, L., Blackmon, J. E., Cruess, S. E., Wheeler, D., & Cruess, D. G. (2020). Assessing an epidemic: Utility of the diagnostic and statistical manual of mental disorders, fifth edition level 2 substance use screener in adult psychiatric inpatients. *Journal of Addictions Nursing*, *31*(1), 9–16. https://doi.org/10.1097/jan.0000000000000318

Taha, S. (2018). *Best practices across the continuum of care for treatment of opioid use disorder*. Ottawa, Ont.: Canadian Centre on Substance Use and Addiction. https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Best-Practices-Treatment-Opioid-Use-Disorder-2018-en.pdf

Tseris, E. J., Hart, E.B., & Franks, S. (2022). "My voice was discounted the whole way through": A gendered analysis of women's experiences of involuntary mental health treatment. *Affilia*, 37(4), 645–663. https://doi.org/10.1177/08861099221108714

Udwadia, F. R., & Illes, J. (2020). An ethicolegal analysis of involuntary treatment for opioid use disorders. *The Journal of Law, Medicine & Ethics*, *48*(4), 735–740. https://doi.org/10.1177/1073110520979383

Vélez, M., Waddell, K., DeMaio, P., Bain, T., Ali, A., Bhuiya, A., … Wilson, M. (2023). *Rapid synthesis: Use and regulation of involuntary substance-use treatment for adults* Hamilton, Ont.: McMaster University Health Forum [MHF product code: RS 108]. https://www.mcmasterforum.org/about-us/products/project/use-and-regulation-of-involuntary-substance-use-treatment-for-adults

Vuong, T., Gillies, M., Larney, S., Montebello, M., & Ritter, A. (2022). The association between involuntary alcohol treatment and subsequent emergency department visits and hospitalizations: A Bayesian analysis of treated patients and matched controls. *Addiction*, *117*(6), 1589–1597. https://doi.org/10.1111/add.15755

Walt, G., Porteny, T., McGregor, A. J., & Ladin, K. (2022). Clinician's experiences with involuntary commitment for substance use disorder: A qualitative study of moral distress. *International Journal of Drug Policy*, *99*, Article 103465. https://doi.org/10.1016/j.drugpo.2021.103465

Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fischer, B., Strathdee, S. A., & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*, *28*, 1–9. https://doi.org/10.1016/j.drugpo.2015.12.005

Whitesell, M., Bachand, A., Peel, J., & Brown, M. (2013). Familial, social, and individual factors contributing to risk for adolescent substance use. *Journal of Addiction*, *2013*(1), Article 579310. https://doi.org/10.1155/2013/579310

Wild, T. C., Roberts, A. B., & Cooper, E. L. (2002). Compulsory substance abuse treatment: An overview of recent findings and issues. *European Addiction Research*, *8*(2), 84–93. https://doi.org/10.1159/000052059

Winstanley, E. L., Mahoney III, J. J., Castillo, F., & Comer, S. D. (2021). Neurocognitive impairments and brain abnormalities resulting from opioid-related overdoses: A systematic review. *Drug and Alcohol Dependence*, *226*, Article 108838. https://doi.org/10.1016/j.drugalcdep.2021.108838

Yakovenko, I., Mukaneza, Y., Germé, K., Belliveau, J., Fraleigh, R., Bach, P., … & Bruneau, J. (2024). Management of opioid use disorder: 2024 update to the national clinical practice guideline. *Canadian Medical Association Journal*, 196(38), E1280–E1290. https://doi.org/10.1503/cmaj.241173

**About CCSA**

CCSA was created by Parliament to provide national leadership to address substance use in Canada. A trusted counsel, we provide national guidance to decision makers by harnessing the power of research, curating knowledge and bringing together diverse perspectives.

CCSA activities and products are made possible through a financial contribution from Health Canada. The views of CCSA do not necessarily represent the views of Health Canada.

ISBN 978-1-77871-210-4