BENCHMARK

Invited Submission

A Look at Equality in Healthcare and Law Related to Substance Use Disorders

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Abstract

People with serious psychiatric illnesses, such as anorexia nervosa (AN), are often involuntarily hospitalized under mental health laws when they are deemed to be at risk of serious harm to themselves. Hospital admissions vary in length but often are long enough to provide treatment and stabilize symptoms. Severe substance use disorders (SSUDs) are also a serious psychiatric illness, yet lengthy involuntary hospitalization is not generally available to people with this diagnosis despite clear statistical evidence of the likelihood of harm and death. This paper discusses the disparities in how people with SSUDs are treated within mental health law and the healthcare system compared to people with other serious psychiatric illnesses, such as AN. To explore the topic, the author discusses historical aspects of addiction, related statistics, mental health law, case law, social policy, stigmatization, ethical considerations, and other international westernized practices. It is not suggested that SSUDs should explicitly be treated on an inpatient basis, but rather just like with other illnesses, it should be an option when someone is at serious risk of harm or death.

Key Words: substance use disorders; involuntary hospitalization; mental health law; anorexia nervosa; marginalization; stigmatization.

Introduction

Psychoactive substance use is well known to be a long-standing part of human history and has been recorded in earth's earliest records. Traditional uses were for medicinal, religious, and social purposes. Records of substance *misuse* also date back as early as the 17th century.[1] Many methods of treatment and prosecution have been used over time for people with substance use disorders (SUDs) with varying levels of success. Over time, society has wavered on whether substance use is "a sin or a disease".[2] It is possible that because of wavering perspectives, ongoing stigma, and deficits in funding, people with SUDs are treated differently in the health care system than people with other psychiatric illnesses.

People with serious psychiatric illnesses are often involuntarily hospitalized to treat and stabilize the symptoms of their illness before continuing ongoing treatment in the community, yet this does not seem to be the case with SUDs. This paper endeavours to discuss how people with severe substance use disorders (SSUDs) are treated within mental health law and the healthcare system compared to people with other serious psychiatric illnesses, such as anorexia nervosa (AN). It is not to suggest that SUDs should explicitly be treated on an inpatient basis, but rather just like other illnesses, there can come a time in disease progression that symptoms cannot be safely managed in the community.

To explore this question in depth, it is important to look at many factors, such as: statistics related to substance use and mental illness, legal frameworks, social policy, ethical considerations, and the current treatment practices in Canada and elsewhere in the world. There will be a focus on comparing patients with severe psychiatric illnesses, such as AN, with SUDs across Canada and specifically in British Columbia (BC) and Ontario.

As mentioned above, comparisons will be made between SSUDs and AN. The reason AN is focused on as a comparative, rather than another psychiatric illness, is because it has a number of similarities to SUDs. One commonality between AN and SUD is that the actions of the individuals often result in an outcome of self-harm which, in some cases, can lead to death. Other psychiatric illnesses may have more of a psychosis component, such as schizophrenia, and the symptoms and

[1] Marc-Antoine Crocq, "Historical and cultural aspects of man's relationship with addictive drugs" (2007) 9:4 Dialogues Clin Neurosci 355 [Historical Aspects].
[2] Ibid.

treatment of psychosis are less closely related to SUDs. AN and SUDs will be discussed further in the DSM-5 section of the paper.

Statistics Related to SUDs and other Psychiatric Illnesses

It is a well-known fact that mental illness and addiction in Canada are not uncommon. People suffering from severe psychiatric illnesses are often hospitalized to treat and stabilize the symptoms of the illness. At times, patients are involuntarily hospitalized and treated for the purpose of safety for themselves and others. Involuntary hospital admissions and the legal implications will be looked at more closely in the legal frameworks section of this paper. *Table 1*, below, outlines statistics regarding severe mental illnesses in comparison to SUDs.

Table 1: Statistics Related to Psychiatric Illness and Substance Use Disorders

	Other Psychiatric Illness	**Substance Use Disorders (SUDs)**
Prevalence	• 1 in 5 Canadians will experience mental illness in their life time.[3] • 3% of women and 0.3% of men will have an eating disorder.[4]	• 1 in 30 Canadians will meet the criteria for substance dependence.[5]
Rate of Hospitalization in Canada	• 33% of all hospitalizations are due to mental illness.[6] Of these hospitalizations: • Schizophrenia (& other psychotic disorders): 21%.[7] • Eating Disorders: 29%.[8]	• Only 8% of hospitalizations are directly attributable to substance abuse.[9]

[3] Mental Health Commission of Canada, *Quick Facts: Mental Illness and addiction in Canada*, 3rd ed. (Mood Disorders Society of Canada, 2009) at page 4 online: <mdsc.ca/documents>. [MHCC].
[4] Ibid at 5.
[5] Ibid at 6.
[6] Ibid at 28.
[7] Ibid.
[8] Ibid.
[9] Ibid at 31.

Average Length of Stay (LOS) in Hospital:	• Severe Mental Illness: 100.3 days (2005/06).[10] • Anorexia (BC): 3 weeks for symptom interruption admission. 12-15 weeks for recovery-focused admission. [11] • Anorexia (Ontario): Average 12 weeks.[12]	• Substance Related Disorders: 10 days.[13]
Rates of Relapse	• Anorexia: 9-52%.[14]	• 40-60%.[15]
Life Expectancy:	• Schizophrenia: 64.7 years (potential loss of 14.5 years of life). Global 2017 study.[16] • Anorexia: Likely to live 25 years less than the normal population.[17]	• Alcohol use disorders: potential loss of 24-28 years of life.[18] • Heroin users: 25-50 years of potential life lost compared to average life expectancy.[19]

[10] Ibid at 28.

[11] Ministry of Health, *Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services,* by Josie Geller et al (September 1, 2012) at page 89 online: <mh.providencehealthcare.org/sites/default/files/BC%20Eating%20Disorders%20Clinical%20Practice%20Guidelines.pdf>.

[12] Ottawa Hospital, *Guide: The Regional Centre for the Treatment of Eating Disorders (Adult Division),* (February 2009) at page 5 online: <www.ottawahospital.on.ca/en/documents/2017/01/eatdisbk-e.pdf/>.

[13] Canadian Centre on Substance Abuse, *The impact of substance use disorders on hospital use*, by M.M. Young & R,A. Jesseman (Ottawa: 2014) at page 11 online: <www.ccsa.ca>.

[14] Sahib S Khalsa et al. "What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa" (2017) 5:1 J Eating Disorders at page 1 [Systematic Review].

[15] A Thomas McLellan et al. "Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation" (2000) 284:13 JAMA 1689 at page 3.

[16] Carsten Hjorthøj et al. "Years of potential life lost and life expectancy in schizophrenia: a systematic review and meta-analysis" (2017) 4:4 Lancet Psychiatry at page 298.

[17] E J Harbottle, C L Birmingham & F Sayani. "Anorexia nervosa: a survival analysis" (2008) 13:2 Eat Weight Disord e32 at Results.

[18] J Westman et al. "Mortality and life expectancy of people with alcohol use disorder in Denmark, Finland and Sweden" (2015) 131:4 Acta Psychiatr Scand at page 297.

It is important to note that while people are not generally being admitted to hospitals for the treatment of SSUDs, they are being hospitalized at alarming rates for other conditions related to severe substance use. In 2017, the Canadian Institute for Health Information (CIHI) reported that approximately 77,000 hospitalizations are "due to conditions entirely caused by alcohol, compared with about 75,000 for heart attacks".[20] Examples were conditions such as alcohol poisoning, hepatitis, and liver failure. A highly publicized issue in the media currently is the epidemic global opioid crisis which will be discussed throughout this paper. The Canadian government reports that over 9000 people died in Canada between January 2016 and June 2018 related to opioids and the death toll increases annually.[21] The highest opioid death tolls are recorded in the provinces of BC and Ontario.[22]

Typically human life expectancy increases over time. In BC, the life expectancy increased by 3 years from 2001 to 2014, however, it decreased by 0.38 years from 2014 to 2016 and this was directly attributable to the opioid overdose crisis.[23]

In summary, the statistics show high rates of both mental illness and SUDs. Patients with other psychiatric illnesses are more likely to be hospitalized and will spend longer in hospitals compared to those with SUDs. People with SUDs are more likely to be hospitalized for comorbidities developed as a result of substance use than to be hospitalized for treatment of substance use. The research on life expectancy appears to show shorter life spans for those with SUDs compared to those with other psychiatric illnesses. The life expectancy in BC has decreased in recent years with

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[19] Shane Darke et al. "Years of potential life lost amongst heroin users in the Australian Treatment Outcome Study cohort, 2001–2015" (2016) 162 Drug & Alcohol Dependence at page 206.

[20] Canadian Institute for Health Information, *Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm*. (Ottawa: CIHI, 2017) at page 6 online: <www.cihi.ca/sites/default/files/document>.

[21] Ibid at Apparent opioid-related deaths.
[22] Ibid at Figure 1.

[23] Ye Xibiao et al. "Impact of drug overdose-related deaths on life expectancy at birth in British Columbia" (2018) 38: 6 Health Promotion & Chronic Disease Prevention in Canada at 250 online: <www.canada.ca/en/public-health/services/reports>.

a strong correlation to the opioid crisis in the province. Statistics for the national life expectancy are not yet available.[24]

Legal Frameworks in Canada

It is important to look at the laws affecting psychiatric hospital admissions and how they are interpreted to determine how and when patients can be admitted involuntarily. Each province in Canada has their own unique Mental Health Act (MHA). There are similarities amongst the different MHA's and also some notable differences. This section will compare relevant mental health legislation in BC and Ontario.

Mental Health Act

The MHA in Ontario is explained in part as the following: "The *MHA* sets out the criteria for voluntary, informal and involuntary admissions to specially designated psychiatric facilities…".[25] The MHA in BC is described as helping, "…provide people with mental disorders the treatment and care they need when they are not willing to accept it".[26]

When a physician conducts a medical exam on a patient that results in the belief that the patient requires involuntary admission to a hospital, the physician is required by law to fill out formal documentation for this purpose. In BC, this document is a called a Form 4[27] and in Ontario it is called a Form 1.[28] *Table 2* outlines some key similarities and differences between how a patient is involuntarily admitted, detained, and treated in BC and Ontario.

[24] Ibid.
[25] Ontario Hospital Association, *A Practical Guide to Mental Health and the Law in Ontario*, Revised Edition by Katharine Byrick & Barbara Walker-Renshaw (September 2016) at page 6 [Practical Guide].
[26] BC, Ministry of Health, "Guide to the Mental Health Act", 2005 Edition at page 1 [BC Guide].
[27] Ibid at 162.
[28] *Practical Guide*, supra note 25 at 19.

Table 2: Comparison of Involuntary Admission Process between Ontario and BC

Ontario[29]	BC[30]
Application by Physician for Psychiatric Assessment (FORM 1): The doctor assesses the patient and chooses Box A or Box B criteria. BOX A: *Serious Harm Test* • Physician deems that the patient is likely at risk of harm to self or others; or is unable to care for themselves; and the person appears to be suffering from a mental disorder likely to result in bodily harm or physical impairment to self or others. BOX B: *Patients who are Incapable of Consenting to Treatment* • Patient has an established mental disorder; has previously improved with treatment; without treatment poses a serious risk to themselves or others and is therefore rendered incapable of consenting to treatment.	**Medical Certificate (FORM 4):** • Physician exam determines that the patient has a mental disorder that requires treatment and seriously impairs the person's ability to react appropriately to his/her environment or to associate with others. And; • The doctor believes that the person requires treatment in a designated facility; and requires care, supervision and control in the facility to prevent deterioration and protect the person or others; and cannot be admitted voluntarily.
Process and Timeline Form 1: Filled out by a doctor who has examined the patient (within the last 7 days) in either the community or a hospital. • Patient must be brought to a designated facility within 7 days of the Form 1 being signed. • Allows the facility up to 72 hours to detain,	**Process and Timeline:** Form 4: Filled out by a doctor who has examined the patient (within the last 14 days) in either the community or a hospital. • Patient brought to designated facility within 14 days of the Form 4 being signed. • Allows the facility to detain, restrain, and *treat* the patient for up to 48 hours.

[29] Ibid at s3 (5-16)
[30] BC Guide, supra note 26 at 6-7

restrain, observe, and examine the patient (*note: does not include treatment) Form 3: Within 72 hours a different physician must fill out a Form 3 for involuntary admission. This is active for up to 2 weeks. Form 4: • 1st certificate of renewal active for 1 additional month. • 2nd certificate active for 2 additional months. • 3rd certificate active for 3 additional months. • After the 3rd certificate of renewal, if the patient still meets the criteria for involuntary admission, they would become subject to a certificate of continuation (Form 4A).	Form 4: Within 48 hours a different physician fills out a second Form for involuntary admission. Active up to 1 month. Form 6: Certificate renewal for 1 month. Can be renewed for another 3 months and an additional 6 months after that.

The MHAs in both BC and Ontario allow for the involuntary detention of patients in designated facilities as long as they meet the appropriate criteria outlined above in *Table 2*. Hospital certifications can be renewed for varying lengths of time as long as the patient still meets the criteria for involuntary admission. One major difference to note between the MHAs is that patients in Ontario cannot be involuntarily treated without consent from the patient or a substitute decision maker (SDM)[31], while in BC the patient can be involuntarily treated under the discretion of their physician once admitted to the hospital[32]. Ontario's laws may therefore make it more challenging to involuntarily treat someone with a SUD. As discussed later in the paper, the treatment component is important, particularly with opioid related disorders.

If the MHAs in both BC and Ontario were hypothetically applied to a patient suffering with severe AN, one can see how the legislation could allow for the involuntary admission of a patient with this illness. Patients with AN have high rates of relapse, mortality, and are often quite resistive to treatment.[33] By using either of the above MHA criteria, the admission would be based on (1) the

[31] *Ontario Mental Health Act*, RSO 1990, c M.7, s 15.
[32] *Mental Health Act*, RSBC 1996, c 288 at s 22 [BC MHA].

[33] Stephan Zipfel et al. "Anorexia nervosa: aetiology, assessment, & treatment" (2015) 2:12 Lancet Psychiatry at 1099.

person suffering from a mental illness; (2) the high likelihood that the patient will, or is, suffering severe physical impairment and; (3) their inability to care for themselves and/or voluntarily seek treatment. To keep a patient with severe AN admitted involuntarily for a prolonged period of time would mean that the patient has continued to meet the criteria for involuntary admission under the MHA. This may be evidenced by a combination of factors, such as the patient not gaining weight; obsessively exercising; inability to eat; and/or stating plans to continue to avoid eating once discharged.[34] If the above factors are likely to cause harm to the patient's health and well-being in a severely impairing way, then the patient will remain certified under the MHA until deemed healthy enough or capable to be discharged.

In comparison, a person with a SSUD is also suffering from a diagnosable mental illness, has a high likelihood of suffering severe physical impairment or death, is high risk to relapse, may lack the ability to care for themselves, and is unlikely to voluntarily seek assistance.[35] However, patients admitted to emergency departments with symptoms of a SSUD are often treated only for acute symptoms and then discharged without further treatment or referral for treatment for their SUD.[36] They are discharged from hospital despite health care providers knowing that the patient is likely to relapse and is at high risk for organ failure, overdose, and death.

It is arguable that the MHAs are being interpreted and applied differently for patients with AN versus patients with SSUDs. There appears to be a discrepancy in how the two disorders are treated despite both being formally recognized as mental disorders and meeting the legal criteria for involuntary admission.

DSM-5

This section will look at diagnostic criteria used by psychiatrists in diagnosing mental disorders. Physicians include diagnoses in legal documentation in patient medical files and the information may be used by courts and review boards. Therefore, it is important that diagnoses and diagnostic criteria are standardized within the medical field. "The Diagnostic and Statistical Manual

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[34] Jane Morris & Sara Twaddle. "Anorexia nervosa" (2007) 334:7599 Brit Med J at 895.

[35] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders DSM-5,* 5th ed, (Arlington, VA: American Psychiatric Publishing, 2013) at 483 [DSM].

[36] Gail D'Onofrio. "Treatment for alcohol and other drug problems: Closing the gap" (2003) 41:6 Annals Emergency Medicine at page 814.

of Mental Disorders (DSM) is regarded as the defining standard for mental health diagnoses (including substance use disorders in America and increasingly abroad)".[37] "The [diagnostic criteria sets]…are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder…".[38]

"Eating disorders…are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning".[39] AN's diagnostic criteria includes 3 main components: (a) restriction of food leading to significantly low body weight; (b) intense fear of weight gain or being fat, or persistent behavior interfering with weight gain despite low weight; (c) disturbance in the perception of one's own body weight or shape or lack of recognition of the seriousness of low body weight.[40]

For the purposes of this discussion, the writer is referring to patients with severe AN who, as a result of their illness, are experiencing major life concerns such as serious health complications with the potential for death and the inability to maintain education, employment, and healthy relationships.

The main feature of SUDs, as defined in the DSM-5, is "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems".[41] Eleven criteria (symptoms) are listed amongst "…groupings of *impaired control, social impairment, risky use, and pharmacological criteria*".[42] Examples of symptoms are: heavy and prolonged usage; multiple unsuccessful attempts to stop using; intense cravings; failure to fulfill work, school, or home obligations; continued use despite related physical and psychological problems; tolerance; and withdrawal.[43] SUDs have been recognized (albeit with changing definitions and criteria) since the DSM-1 was first created.[44]

A *severe* substance use disorder (SSUD) is characterized by an individual having 6 or more

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[37] Sean Robinson & Bryon Adinoff. "The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations" (2016) 6:3 Behavioral Sciences 18 at Intro [Classification].
[38] DSM, supra note 35 at 19.
[39] Ibid at 329.
[40] Ibid at 338-339.
[41] Ibid at 483.
[42] Ibid at 483-484.
[43] Ibid.
[44] Classification, supra note 37 at s 6.1.

of the eleven symptoms.[45] When referring to persons with SSUD throughout this discussion, this writer is referring to the population of people whose substance use has become so severe that it is negatively affecting all areas of their lives, causing issues such as poor health, imminent risk of death, loss of close relationships, safety concerns for themselves and others, lost income, homelessness, and decreased ability to perform activities of daily living such as maintaining personal hygiene.

Interestingly, the DSM-5 it-self draws a connection between eating disorders and substance use disorders:

> Some individuals…report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders.[46]

The above information draws similarities between eating disorders and substance use disorders, further solidifying the question as to why SUD patients are not provided with the same level of treatment in hospitals as eating disorder patients.

Consent and Capacity

Consent and capacity are important topics when talking about healthcare, law, hospitalization, and providing treatment to patients. Both BC and Ontario have legislation around consent and capacity, as well as substitute decision makers (SDM).

In BC, the consent legislation is called the *Health Care (Consent) and Care Facility (Admission) Act* (*Consent Act*). The *Consent Act* does not apply to patients once they are certified involuntarily under the *MHA*.[47] Under the MHA, patients can be involuntarily admitted and detained as well as receive treatment, such as medications, against their will.[48] For treatment to begin, except in emergency situations, the physician will sign a Form 5 to authorize treatment on the patient's

[45] DSM, supra note 35 at 484.
[46] Ibid at 329.
[47] *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 at s 2 [BC Consent Act].
[48] BC MHA, supra note 32 at s 22.

behalf if the patient does not consent to treatment.[49] The physician is responsible for deciding if the patient is capable to provide consent or not for psychiatric treatment.[50] In BC, incapability is determined by whether the patient demonstrates understanding (a) of the information they have been provided and (b) that the information applies to their situation.[51] An SDM would be contacted in accordance with the *Consent Act* if a patient deemed incapable required non-psychiatric treatment, such as antibiotics.[52]

In Ontario, the legislation regarding consent and capacity is called the *Health Care Consent Act (HCCA)*. Patients can be involuntarily admitted under the MHA and the *HCCA* does not negate the involuntary detention, however, the *HCCA* gives the patient the right to refuse treatment if they are deemed *capable*.[53] A person is deemed 'capable' regarding treatment decisions under the *HCCA* if they can (a) "understand the information that is relevant to making a decision about the treatment…" and (b) they can "appreciate the reasonably foreseeable consequences of a decision or lack of a decision".[54] If a person does not meet both parts of the capability test, then they will be deemed incapable and an appropriate SDM will be put in place under the *Substitute Decisions Act*.[55] One exception to the consent law is in emergency situations where treatment may be administered without the consent of a patient or SDM when the health care provider's opinion is that the person will experience severe suffering or is at risk of serious bodily harm.[56]

The main notable difference between Ontario and BC's consent laws is that in BC the physician can authorize treatment of an involuntary patient who is refusing treatment, whereas in Ontario, a SDM would have this role.

In looking at the application of the laws around consent and capacity, *The Practical Guide to Mental Health and the Law in Ontario* provides an example of incapacity under the second part of the test:

> A patient diagnosed with anorexia nervosa is able to understand and

[49] BC Guide, supra note 26 at 19.
[50] Ibid at 21.
[51] BC Consent Act, supra note 47 at s 7.
[52] BC Guide, supra note 26 at 22.
[53] *Ontario Health Care Consent Act*, S.O. 1996, c 2, Schedule A at s 10 [HCCA].
[54] Ibid at s 4(1).
[55] Practical Guide, supra note 25 at 2-8.
[56] HCCA, supra note 53 at s 25.

> intelligently discuss the nature and consequences of the illness and readily acknowledges that people have to eat or that they may die. In spite of this, the patient is not able to eat and maintains that he/she will be fine.[57]

The writer has applied the above statement to someone with a SSUD:

> *A patient is diagnosed with a SSUD and is able to understand and intelligently discuss the nature and consequences of the illness and readily acknowledges that people who use injectable opioids have a very high risk of organ failure, overdose, and death. In spite of this, the patient is not able to stop using opioids and maintains that he/she will be fine.*

It is challenging from both a legal and clinical perspective to differentiate the SSUD example from the AN example. One could draw the conclusion that, despite the similarities in the above situations, society has deemed that people with SSUDs have the choice to live at risk and are considered capable, but people with severe AN cannot live at risk and are deemed incapable. Again, it appears that the laws around consent and capacity are interpreted differently for patients with AN versus patients with SSUDs.

Case Law: Involuntary Hospitalization and Consent and Capacity

Numerous cases regarding consent and capacity have been heard by Consent and Capacity Boards (CCB), appellate courts, and the Supreme Court of Canada (SCC). The Ontario Court of Appeal held in the case of *Fleming v Reid (1991)* that the appellant's section 7 rights under the *Canadian Charter of Rights and Freedoms* had been violated by forcing medication onto patients who had previously expressed wishes not to receive neuroleptic medications.[58] Another well-known case is *Starson v. Swayze* in which the SCC held that the certified patient had the right to refuse

[57] Ibid at 2-6.

[58] *Fleming v Reid*, 1991 CanLII 2728 (ON CA) at Introductory Summary.

psychiatric treatment.[59] In this case, the SCC commented regarding Part B of the capability test and this quote has been cited in many following cases:

> While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition…As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms…Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.[60]

The *Starson* case is considered "the leading case on determining capacity" in Ontario[61]; however, interestingly, according to the BC Guide to the Mental Health Act, the finding does not apply in BC: "It was made under the Ontario mental health legislation which allows treatment refusal by involuntary patients who are found to be capable of making a treatment decision. In BC, the Act provides for compulsory treatment of all involuntary patients".[62]

This writer reviewed nine Ontario CCB cases from the timeframe of 2004 to 2018 on the topic of 'anorexia nervosa; consent to treatment; and involuntary hospital admission'.[63] The cases included both males and females, all diagnosed with AN, ranging in age from 12 to 31 years old. All of the cases involved the patient requesting a review of their involuntary status and/or the review of

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[59] *Starson v Swayze*, 2003 1 SCR 722, 2003 SCC 32 (CanLII) at Introductory Summary [Starson].
[60] Ibid at para 79.

[61] D'Arcy Hiltz & Anita Szigeti, *A Guide to Consent & Capacity Law in Ontario* (Toronto: LexisNexis Canada, 2018) at 169.
[62] BC Guide, supra note 26 at 22.

[63] *CP* (Re), 2017 CanLII 58780 (ON CCB); *CS* (Re), 2017 CanLII 58796 (ON CCB); *DX* (Re), 2018 CanLII 57661 (ON CCB); *JC* (Re), 2015 CanLII 32547 (ON CCB); *JQ* (Re), 2011 CanLII 84618 (ON CCB); *L.G*. (Re), 2004 CanLII 44789 (ON CCB); *LA* (Re), 2015 CanLII 64011 (ON CCB); *SD* (Re), 2014 CanLII 81265 (ON CCB); *V.B.* (Re), 2005 CanLII 57729 (ON CCB).

their status of incapability to make decisions regarding treatment. In all of the cases, the CCB found that the patient met the criteria for involuntary hospital admission and/or incapability regarding treatment decisions. All but one of the cases made reference to the precedent set in the *Starson* case. The decisions were all based on the criteria of the *MHA* and the *HCCA*.

In an attempt to compare case law of AN and SUDs, the writer used the same search criteria for case law related specifically to 'SUD; consent to treatment; and involuntary hospital admission'. It was very challenging to locate case law related to patients with primary diagnoses of SUDs. As mentioned in other sections of this paper, the lack of case law is possibly reflective of the lack of involuntary admissions for patients with SUDs. After a review of approximately sixty cases, one case was located regarding a woman who was involuntarily admitted to hospital for a primary diagnosis of SUD (cocaine).[64] The CCB determined that she met the criteria for involuntary status and incapability related to treatment decisions. The finding was heavily based on the fact that the patient's SSUD caused her to leave the hospital against medical advice and therefore miss her life-preserving renal dialysis treatment which would cause her to likely die within 2-5 days.

Social Policy

The information in the above paragraphs appears to indicate some discrepancies around how AN and SUDs are treated in the hospital and law. The statistical evidence so far indicates that patients with AN have longer lengths of stay in hospital and are hospitalized with treatment more frequently than patients with SSUDs. A review of mental health law in the previous section indicates that the MHAs could, in theory, allow for the involuntary detention of patients with both diagnoses; however, the laws do not appear to be interpreted in the same way for both the illnesses.

The rates of relapse and high mortality are comparable between the two psychiatric conditions, yet the courses of treatment seem to indicate that AN is taken more seriously in terms of the attention it gets in hospitals. Many major city hospitals have inpatient psychiatric wards solely for patients with eating disorders with specialized psychiatrists, nurses, social workers, and psychologists. It is less common to find inpatient hospital wards deemed solely for SUDs, although some concurrent disorder units do exist for patients with psychiatric illness and SUDs. Despite BC

[64] *P* (Re), 2005 CanLII 57888 (ON CCB).

having the highest rate of opioid deaths in Canada, this writer's internet search was unsuccessful in finding any BC hospitals with specific SUD inpatient wards for patients with a primary diagnosis of SUDs.

There are a variety of reasons as to why SUDs are treated differently than other psychiatric conditions and numerous themes emerged in the writer's literature review. Some of the commonly noted themes in the literature included the history of substance use in society and its contribution to modern day stigma, the ongoing stigma around drug use and its effect on drug users and the health care system, and the financial impact of SUDs to society, healthcare, and the criminal justice system. Society and government prioritize funding and the allocation of resources to areas that are perceived to be important. There is a relatively small amount of current research available on the outcomes of involuntary hospitalization and SSUDs. This is briefly explored at the end of this section.

Brief History of Substance Use

As mentioned in the introduction of this paper, humans have used and misused substances for as long as records exist. Substances such as opioids, cannabis, cocaine, and alcohol have historical medicinal, religious, ritualistic, recreational, and cultural uses.[65] Initially, substance use was mostly considered acceptable and even encouraged amongst some cultures.[66] As time went on, the churches began to influence society's views, particularly on alcohol being a sin and morally wrong.[67] Industrialization and the resultant shift from farming to factory work also brought substance use to light.[68] It became increasingly inappropriate to consume substances as it conflicted with work ethic (such as punctuality and productivity) and users became socially isolated and referred to as "addicts".[69] Plantation owners provided cocaine to black slaves to increase productivity in the fields and, sadly, this later resulted in racial profiling with connections made between black people, drug use, and crime.[70] "Attitudes towards drug use and the increasing costs to a newly industrialized

[65] Historical Aspects, supra note 1 at Abstract.
[66] Classification, supra note 37 at s 2.4.
[67] Ibid at s 3.1.1.
[68] Ibid at s 3.1.3.
[69] Ibid.
[70] Ibid.

society resulted in the criminalization of substance use and the entrenched association of addiction with crime, an association which has persisted (even within the mental health field)".[71]

The Impact of Stigma on Substance Use

A literature review on stigma and substance use indicates that people with SUDs are still highly stigmatized within western society. "The studies reviewed predominantly indicated that the public holds very stigmatized views towards individuals with substance use disorders, and that the level of stigma was higher towards individuals with substance use disorders than towards those with other psychiatric disorders".[72] The same study identified that people with SUDs are perceived as dangerous, unpredictable, and immoral; are seen as lacking decision making skills; are blamed for their addiction; and are perceived that they should be able to "pull themselves together".[73] This type of stigma contributes to a lack of interest and empathy in substance users because there is a perception that the person is at fault and does not deserve help. Another important aspect is that many drugs associated with SUDs are illicit substances and, therefore, possession of the substance is punishable by law. The fact that many substances are illegal further reduces public empathy for people with SUDs as they are perceived to be criminals and not seen as suffering from an illness. A European study from 2014 found evidence that less money is spent on the treatment of disorders related to illegal drugs versus disorders related to legal substances such as alcohol.[74]

The literature also shows a multitude of harmful effects of stigma on people with SUDs, as well as to society as a whole. "Stigma can reduce willingness of policy-makers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address substance abuse problems, and may limit willingness of individuals with such problems to seek treatment".[75]

Healthcare Funding and Services

The government is influenced by voters to allocate funds to areas of public interest. Mental

[71] Ibid at s 4.
[72] Lawrence H Yang et al. "Stigma and substance use disorders: an international phenomenon" (2017) 30:5 Current Opinion in Psychiatry at Recent Findings [Stigma].
[73] Ibid at Discussion.

[74] Delfine Lievens, Freya Vander Laenen & Johan Christiaens. "Public spending for illegal drug and alcohol treatment in hospitals: an EU cross-country comparison" (2014) 9:1 Substance Abuse Treatment, Prevention, & Policy at page 11.
[75] Stigma, supra note 72 at Summary.

health and addictions receive less funding from the government than other areas such as cancer care and cardiology.[76] As a result, this contributes to less resources and advances in research.

The CEO of the Centre for Addiction and Mental Health (CAMH) in Ontario recently stated:

> Mental illness-including alcoholism and substance misuse affects 6.7 million Canadians – 20 per cent of our population, yet many Canadians do not have access to the treatment they need. Nearly four thousand Canadians die by suicide each year, and one thousand of them are our children. We must do more to address the health, economic and social justice issue of our time.[77]

The lack of appropriate funding for SUDs results in fewer hospital beds, less specialty staff training, fewer advances in research, and, therefore, a decreased ability to comprehensively treat these patients. A 2005 commentary on substance use discussed the double standard that officials and health professionals have about treating substance abuse. It said that while they embrace aggressive treatment for diseases that have poor prognoses (such as pancreatic cancer), they are skeptical about funding substance abuse treatment, in which rates of one-year remissions may be as high as 40-60 percent for alcoholism and drug abuse.[78] A plausible reason as to why physicians do not involuntarily admit people with SSUDs is due to the lack of available psychiatric hospital beds. Statistics show that Canada has the lowest number of mental health beds per capita in comparison to other westernized nations.[79] With the lack of resources and funding in mind, it becomes clearer as to why there are limited specialty inpatient programs for SUDs, overall less SUD hospitalizations, and shorter length of stays.

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[76] Canada, Office of Auditor General of BC, *Health Funding Explained 2*, (March 2017) online: <www.bcauditor.com/sites/default/files/publications/reports> at page 52.

[77] CAMH "According equitable funding for mental health care", *CAMH News & Stories* (10 March, 2017) online: <www.camh.ca>.

[78] Steven A Schroeder, "An Agenda to Combat Substance Abuse" (2005) 24:4 Health Affairs: Health Spending Worldwide, DOI: <10.1377/hlthaff.24.4.1005> at para Pessimism About Treatment Efficacy.

[79] Erin Ellis, "Mental-health gap in B.C.: Psych beds dwindle as community supports struggle to keep up", *Vancouver Sun* (23 December 2016) online: <vancouversun.com/news/local-news/mental-health-gap-in-b-c-psych-beds-dwindle-as-community-supports-struggle-to-keep-up>.

The epidemic opioid crisis over the last few years has brought SUDs to light for the general public through mainstream news and media. Shocking statistics on the death toll in Canada and knowledge of 'everyday Canadians' dying from unintentional overdoses is causing people to take a closer look at the issues. Mental health and addictions have become part of daily conversation for Canadians, and harm reduction practices, such as providing free clean needles to intravenous (IV) drug users, have become more acceptable to the public.

In response to the opioid crisis, many community SUDs services have been initiated such as opioid agonist treatment (OAT), injectable opioid agonist treatment (iOAT), opioid replacement therapy (ORT), Substance Use Treatment and Response Teams (START), Overdose Outreach Teams (OOT), and Overdose Prevention Sites (OPS or safe injection sites).[80] While these services exist in the community sector, many hospitals have unfortunately not yet initiated these practices. This could mean that if a person in the community who relies upon iOAT is hospitalized, they may not be able to continue to receive the equivalent treatment as an inpatient and are at higher risk for leaving the hospital against medical advice and relapsing.

> When injectable hydromorphone and diacetylmorphine are individually dosed and monitored, their opioid-related side effects, including potential fatal overdoses, are safely mitigated and treated by health care providers. In the midst of an opioid overdose epidemic, injectable options are timely to reach a very important minority of people who inject street opioids and are not attracted to other treatments.[81]

More and more research around the world, including in Switzerland, The Netherlands, Germany,

[80] Vancouver Coastal Health, "Substance Use Services" (2019) online: <www.vch.ca/your-care/mental-health-substance-use/substance-use-services>.

[81] Eugenia Oviedo-Joekes et al. "Safety profile of injectable hydromorphone and diacetylmorphine for long-term severe opioid use disorder" (2017) 176 Drug & Alcohol Dependence at 55.

Denmark, and Belgium, is showing the effectiveness of opioid therapies[82] and it is vital that these therapies become consistent in both hospital and community care.

SUDs Impact on Society

Everyone is affected by substance use in some way. It could be the loss of a friend or family member, being a victim of crime related to substance use, taxes increasing related to rising healthcare costs, or struggling with one's own substance misuse.

In 2017, there were 1265 opioid related deaths in Ontario and 1482 in BC, and of the opioid related deaths, 68% of people were between the ages of 20 and 49 years old.[83] Canadian hospital visits have increased by over 27% in the last five years and between 2016 and 2017 the rate of emergency department visits for opioid overdoses increased by 73% in Ontario.[84] A joint report by the Canadian Centre on Substance Use and Addiction (CCSA) and Canadian Institute for Substance Use Research (CISUR) says that in 2014 the cost related to substance use was $38.4 billion dollars (approximately $1100 per Canadian). $11.1 billion were healthcare related costs, $15.7 billion were costs associated with lost productivity, $9 billion were criminal justice costs, and the remaining $2.7 billion were other direct costs such as fire and motor vehicle damage.[85] These statistics are clearly showing a loss of many young members of society and a huge financial burden on healthcare, the criminal justice system, and economic productivity.

Ethical Considerations

Along with law and social policy, it is also important to look at the ethical considerations around forced substance use treatment. Much of the literature on ethical discussions centers on

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[82] Candice C Gartry et al. "NAOMI: The trials and tribulations of implementing a heroin assisted treatment study in North America" (2009) 6:1 Harm Reduction J 2 at page 3.

[83] Ottawa, Special Advisory Committee on the Epidemic of Opioid Overdoses, *National Report: Apparent Opioid-related Deaths in Canada* (Public Health Agency of Canada, 2018) online: <www.canada.ca/en/health-canada/services/substance-use/problematic> at Figure 1 & Table 1.

[84] Ibid.

[85] Canadian Substance Use Costs & Harms Working Group, *Canadian Substance Use Costs and Harms,* by Canadian Institute for Substance Use Research (CISUR) & Canadian Centre on Substance Use and Addiction (CCSA) Ottawa: 2018 online: <www.ccdus.ca/Resource%20Library/CSUCH-Canadian-Substance-Use-Costs-Harms-Report-in-short-2018-en.pdf> at page 1.

whether it is ethical for people with SSUDs to have their individual liberties suspended by authorities who believe their SSUD requires detention and treatment.[86]

As noted throughout this paper, Canadian physicians are seemingly not involuntarily admitting patients with SSUDs into hospitals despite the argument that Canadian mental health laws could be interpreted for this use. Literature from the United States (US) indicates that many states have passed legislation, called Involuntary Civil Commitment (ICC) laws, specifically allowing for the involuntary admission and treatment of people with SUDs.[87]

In a US article published in 2017, two ethical arguments are discussed regarding ICC laws: (1) Substance use is a moral issue that does not impair autonomy enough to warrant ICC laws; versus (2) SUD is a disease meaning that the brain is compromised, such as with other psychiatric illnesses, and ICC laws may then be justifiable.[88]

Further discussion in the study goes on to say that those who believe that ICC laws are unethical argue that all pleasure seeking activities (such as engaging in high risk sports) could then be classified under ICC laws.[89] They believe that individuals are the best judge of themselves and should be left alone as long as they are not harming others. It is further argued in the same study that treatment for SUDs is not effective all the time for everyone and therefore should not be enforceable as it may not be 100% effective.

In the above study, people that believe ICC laws *are* ethical argue that it would in fact be unethical to do nothing while someone suffers or dies from a SSUD.[90] They question why society has deemed it okay for individual rights and freedoms to be revoked in other situations and why it would be any different for persons with SSUDs. In *Starson v. Swayze,* Justice Major wrote:

> The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness…unwarranted findings of incapacity severely infringe upon a person's right to self-determination.

[86] Matthew T Walton & Martin T Hall. "Involuntary Civil Commitment for Substance Use Disorder: Legal Precedents and Ethical Considerations for Social Workers" (2017) 32:6 Social Work in Public Health at 383 [Involuntary Commitment].
[87] Ibid.
[88] Involuntary Commitment, supra note 86 at 387.
[89] Ibid at 388-389.
[90] Ibid at 389.

> Nevertheless, in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention.[91]

Further scientific arguments in the same 2017 study point to neuroscience research that has established physiological reasons for SUDs explaining brain pathology. Lastly, it is mentioned that family members of people lost to SUDs have persuasively petitioned in favor of ICC laws to prevent further losses from society.

Recovery versus Ethics in Involuntary Hospitalizations

Anorexia

As previously noted, many large city hospitals have inpatient programs dedicated specifically to patients suffering with eating disorders such as AN. A literature review of research reveals that patients with AN who become involuntarily admitted may be treated by way of medication, activity restriction, bathroom access restrictions, and at times by force feeding via nasogastric tube.[92] Although often successful in weight gain, and recovery for some patients, these treatments inflict extreme restrictions on personal liberties. There is much ethical debate regarding forced treatment with AN. This paper is limited on the ability to expansively discuss all of the complex layers around forced treatment in AN. However, much of the literature on ethics and AN points to healthcare professionals needing to consider the patient's particular situation and review the principles of ethics.[93] It is noted in one study that, "Compulsory treatment may be an act of compassion: it shows that professionals recognize the severity of the illness…".[94] Compassionate efforts may be trumped by ethical dilemmas around quality of life when a patient is being restrained indefinitely in an effort to prolong their life by force feeding.[95] A further downside to involuntary hospitalization mentioned in a number of studies is the likelihood of damaging the therapeutic relationship between care provider

[91] Starson, supra note 59 at para 75.
[92] Gerald FM Russell. "Involuntary Treatment in Anorexia Nervosa" (2001) 24:2 Psychiatric Clinics North America at Abstract [Involuntary Treatment].

[93] P C Hébert & M A Weingarten. "The ethics of forced feeding in anorexia nervosa." (1991) 144:2 CMAJ 141 [Forced Feeding].
[94] Involuntary Treatment, supra note 92 at Abstract.
[95] Forced Feeding, supra note 93 at 142.

and the client.[96]

There is a lack of consensus in research on the definition of relapse, remission, and recovery in AN and, therefore, statistics on these topics are not considered reliable.[97] However, it is accepted that relapse in the first year following treatment is high.[98]

SSUDs

There is a relatively small body of Canadian research and literature available regarding outcomes of involuntary hospital admission for SSUD and this lack of information is possibly reflective of current practice to not admit patients with SSUDs to hospitals.

However, as previously mentioned, a number of the states in the US have ICC laws for substance use disorders and an accompanying body of research.[99] It is noted in some of the research that coercive treatment strategies are often negatively perceived despite the evidence of positive outcomes.[100] "Several studies have likewise demonstrated that civil commitment among substance abuse patients improves treatment outcomes".[101] An older study from 1989 did a comparative study between patients voluntarily admitted into treatment versus patients involuntarily admitted for methadone treatment. This study showed that both groups substantially improved in social functioning and in decreasing narcotic use and criminal activity even following treatment.[102]

There are substantial findings that socially sanctioned mechanisms of coercion are effective in initiating recovery and achieving positive clinical outcomes. Coercion involves an acceptance of the involuntary aspects of addiction as well as concern about the impact of addiction on society. Recommending and supporting appropriate venues of coercion may be seen as a paradigm shift in mental health treatment.[103]

A study conducted in Florida in 2013 aimed to answer the age-old question as to whether one

[96] Involuntary Treatment, supra note 92 at Abstract.
[97] Systematic Review, supra note 14 at 6.
[98] Ibid.

[99] Alan A Cavaiola & David Dolan. "Considerations in civil commitment of individuals with substance use disorders" (2016) 37:1 Substance Abuse at 181 [Considerations].
[100] Edgar P Nace et al. "Socially Sanctioned Coercion Mechanisms for Addiction Treatment" (2007) 16:1 American J Addictions at page 16 [Socially Sanctioned].
[101] Ibid.
[102] M Douglas Anglin, Mary-Lynn Brecht & Ebrahim Maddahian. "Pretreatment Characteristics & Treatment Performance of Legally Coerced versus Voluntary Methadone Maintenance Admissions" (1989) 27:3 Criminology at page 553.
[103] Socially Sanctioned, supra note 100 at 21.

has to *want* to recover from their addiction to be successful in achieving recovery.[104] Patients were involuntarily admitted to an inpatient treatment centre under Florida's *Marchman Act*. This *Act* allows for involuntary admissions based on two criteria: (a) under good faith it is believed that a person is impaired by substance abuse; and (b) the impairment has caused the person to lose control of their substance use *and* is likely to (or has) caused harm to themselves or others *or* is so impaired in judgement that they cannot appreciate the need for treatment services.[105] The patients in the study were described as "some of the most resistant and, initially, disruptive patients".[106] Of the 100 participants in the study, 69 successfully completed treatment and the highest success rate was amongst the youngest patients. The conclusion of the study stated that the Act is "an incredibly effective intervention tool" and that it "…is likely the only means by which these patients could be compelled to enter treatment prior to the onset of much more destructive, life-harming consequences".[107] It further stated that "most of these combatant admissions come to terms with their circumstances and ultimately accept and thrive in treatment".[108] To provide a comparison, the study also mentions that in 2011 data was collected on voluntary patients at the same centre and the success rate in completing the program was 70%, versus the 69% of involuntary patients.[109]

A 2016 study regarding involuntary hospital admission for individuals with SUDs says that it "…may be viewed as a step towards motivating a person by providing a period of stabilization that allows the individual to make a more rational decision regarding ongoing treatment".[110] Further to this idea is that addiction itself is coercive and that "…autonomy also requires freedom from coercion".[111] The author states, "Once competency and coercion are distinguished, it is clear that both are requisite for autonomy. Mandatory treatment which relieves the coercive effects of addiction and permits the recreation or re-emergence of true autonomy in the patient can be the right thing to

[104] Timothy J Sweeney, Michael P Strolla & David P Myers. "Civil Commitment for Substance Use Disorder Patients Under the Florida Marchman Act: Demographics and Outcomes in the Private Clinical Setting" (2013) 32:1 J Addictive Diseases at page 108.
[105] Ibid at 109.
[106] Ibid at 112.
[107] Ibid.
[108] Ibid.
[109] Ibid.
[110] Considerations, supra note 99 at 185.

[111] Arthur Caplan, "Denying autonomy in order to create it: the paradox of forcing treatment upon addicts", Editorial, *Addiction* (December, 2008) 103:12 1919.

do".[112]

When deciding on whether involuntary admission and treatment of SSUDs is ethical, one must consider law, social policy, science, research, and human compassion.

Additional Thoughts and Implications

This paper has only touched on a few of the many complex layers associated with SUDs. Many factors contribute to how society is dealing with this multifaceted area of healthcare and further complicating it is the fact that every individual's situation is different and requires unique care. The next section highlights some topics that were not able to be discussed in detail within the boundaries of this paper but are important factors in the discussion.

Future Research and Literature

As previously noted, there is no current consensus on definitions in AN for relapse, remission, and recovery and the same is possibly true in the field of SUDs. The definition for recovery may not necessarily mean complete abstinence from a substance. Recovery will look differently for different people. For one, recovery may be complete abstinence but for another it may be reduction of substance use and the successful maintenance of housing and employment. This likely needs further exploration to establish some consensus for the sake of ongoing research.

Funding Needs

It appears from Canadian statistics that the areas of mental health and addictions continue to receive some of the lowest funding in comparison to other areas of healthcare. Without increased funding to hospitals and research efforts, data cannot be collected to determine if the creation of specialized SUD units would be successful for people with SSUDs. The Canadian government and health professionals should continue to watch research trends in other areas of the world to gauge the effectiveness of inpatient admissions. Funding for community programs seems to have increased in light of the opioid epidemic. Further funding in areas such as low income housing and long term treatment programs would likely be helpful for people with SUDs. Efforts to decrease the

[112] Ibid at 1920.

stigmatization of people with SUDs may improve society's support of providing more funding to SUDs.

International Approaches

In previous sections, some aspects of the American ICC laws were reviewed. Although Canadian MHAs do not exclude SUDs from the legislation, health practitioners may benefit from more specific criteria regarding SUDs to help guide clinical practice. Another interesting country to look at is Portugal as this country decriminalized personal possession and use of all drugs in 2001. Some of the main outcomes related to Portugal's decriminalization were: reduced illicit drug use among problematic drug users and adolescents; reduced burden of drug offenders on the criminal justice system; increased referrals and uptake of drug treatment; and a reduction in opiate-related deaths and infectious diseases.[113] The 2010 study concludes with:

> Decriminalization of illicit drug use and possession does not appear to lead automatically to an increase in drug-related harms. Nor does it eliminate all drug-related problems. But it may offer a model for other nations that wish to provide less punitive, more integrated and effective responses to drug use.[114]

The literature so far is not 100% definitive that all of the positive outcomes are attributable solely to the decriminalization of drugs, but it appears to have had an effect on the statistics.[115]

Final Thoughts

This writer does not think that involuntary hospital admission is required in all situations but believes that it is an important piece in the trajectory of treatment for people suffering with SSUDs who are at risk for imminent severe harm or death. Science has confirmed that SUDs are a disease of the brain and therefore are included in formal psychiatric diagnostic manuals. Canadian and

[113] C E Hughes & A Stevens. "What Can We Learn From the Portuguese Decriminalization of Illicit Drugs?" (2010) 50:6 Brit J Crim 1017.
[114] Ibid at 1018.
[115] Ibid.

international statistics confirm the lethalness of SUDs, as well as the burden on society. Canadian law allows for involuntary admission and treatment and international literature confirms successes in SUD recovery. Societal stigmas are reducing and moving in the right direction which will hopefully result in further empathy and resultant funding. Ethics will always need to be considered in extenuating cases; however, generally the involuntary admission of someone with a SSUD is no different than for someone with another serious psychiatric illness. Much information and momentum is still needed in the fields of mental health and addictions and although the current opioid overdose crisis is a terrible tragedy, it is bringing the issues and severity to light for the public and government and with that may come some change.

This paper has endeavoured to touch on each of these areas within the capacity and boundaries of this very complex topic. Based on the literature that has been reviewed, this writer is of the opinion that it is ethical to involuntary admit and treat people who are suffering with SSUDs. Although it may not be appropriate for everyone in every situation, it should be available as an option in extreme situations to be used as a life saving measure until the person can safely move on to less intensive outpatient support.

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Acknowledgements: none

Competing Interests: none

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Publication Date: February 1, 2020