Brief on the Opioid Epidemic and Toxic Drug Crisis

Families for Addiction Recovery (FAR)

A Plea for Balance and Nuance

Families for Addiction Recovery (FAR) is a Canadian charity founded in 2016 by parents of teenagers who developed substance use disorder (SUD) in their teens. FAR was founded because the needs of our families are not being met. We provide free peer support services across Canada to family members of those struggling with SUD. FAR provides one-on-one and group support, as well as a live phone support line. All of our volunteers are trained in the Invitation to Change Approach, which is a combination of Community Reinforcement and Family Training (CRAFT), Acceptance and Commitment Therapy (ACT) and Motivational Interviewing (MI). It is a non-confrontational, compassionate and evidence-based approach.

We also educate about SUD and advocate for protective health laws and protective drug policies. FAR participated in the work of the Standards Council of Canada to develop the Mental Health and Substance Use Health Standardization Roadmap[1], as well as the work of Toronto Public Health to develop a decriminalization model for Toronto. As such, FAR may be uniquely positioned to make recommendations as we support decriminalization and modernizing our mental health acts, both of which are necessary if we are to treat substance use and SUD as a health issue and protect the safety of all.

This brief is being submitted in the hopes of providing balance and nuance to the issues. It has been concerning to see an increase in the polarization and politicization of these issues over time rather than unification through widespread common ground.

FAR endorses all of the recommendations submitted to HESA by the Canadian Society of Addiction Medicine (CSAM) and Children's Healthcare Canada. FAR supports decriminalization as well as involuntary treatment as part of a continuum of care and in certain circumstances. While it is recognized that involuntary treatment is within provincial/territorial jurisdiction, much has been said about it during the HESA Committee hearings to the detriment of families that have been advocating for long before the opioid epidemic and toxic drug crisis. FAR also has recommendations in addition to the CSAM and Children's Healthcare Canada recommendations.

1. **Treating all substance use as a health issue means the decriminalization of drugs for personal use**

Both the medical community and law enforcement support decriminalization of drugs for personal use. Much can be learned from the efforts at decriminalization in foreign jurisdictions and in BC. Aspects of any model may need to be altered to ensure public safety and continued societal support.

It is important to keep in mind that the main purpose of criminal law is to protect people from **other** people, not to protect them from themselves. It is our provincial and territorial mental health acts that are supposed to keep people safe from themselves. There is nothing inherently criminal in possessing or using substances. There is no harm to others in those activities alone although there could be harm to self. While substance use can result in harm to others, those harms (for example driving impaired, assault, theft, trafficking) are already illegal.

[1] https://scc-ccn.ca/resources/publications/mental-health-and-substance-use-health-standardization-roadmap

By way of analogy, prior to 1972 it was illegal in Canada to attempt suicide, the ultimate form of self-harm. We realized that self-harm is better dealt with through our mental health laws and we need to do the same now for SUD. Labelling everyone who possesses a drug for personal use as a criminal is harmful. Better strategies can be used to prevent/delay/deter the use of illegal substances that do not stigmatize and harm people.

FAR supports the CSAM recommendation on decriminalization.

2. Treating all substance use as a health issue means ensuring that the protections of the mental health acts and health care consent acts apply to those with SUD

Alcohol is the drug that has the greatest costs and harms in Canada, including costs to the criminal justice system. Alcohol is the only substance where harm to others exceeds harm to self. Yet because alcohol is legal, we are not having conversations about how to keep those with alcohol use disorder (AUD) or binge drinkers out of the criminal justice system.

The CCSA found:

> "The total cost of policing crimes resulting from substance use or substance-related legislation was **$5.3 billion** in 2020 (the latest year for which data are available). Alcohol accounted for $2.2 billion in policing costs for all offences, while all other substances accounted for $3.1 billion in 2020. Nearly half of the costs due to alcohol use ($977 million) were related to violent crimes, such as homicide and assault. In contrast, a larger proportion of policing costs attributable to other substances, including opioids, cocaine and other stimulants ($1.8 billion) were related to non-violent crimes, such as theft and arson." (CSUCH)[2].

Similarly, a recent study, Prevalence and correlates of alcohol and drug harms to others: Findings from the 2020 U.S. National Alcohol Survey[3] found that one-third of Americans (113 million) will suffer harms during their lifetime from another person's drinking versus 46 million from another person's drug use.

Yet, as pointed out in *Substance use as a public health issue: A critical review of the Canadian literature, 1896-2020*[4], drug policy in Canada is leaning towards more criminalization for illegal substances and more commercialization for legal substances, which is the opposite of a public health approach in each case.

Decriminalization is not enough

The current model for decriminalization in BC will not ensure those with SUD who are at risk of harming others stay out of the criminal justice system. Yet this is key to treating SUD as a health condition. Our current models for decriminalization are based on the false assumption that the main reason people are not seeking treatment is due to the stigma which decriminalization is intended to alleviate. However, a

[2] elink.clickdimensions.com
[3] https://www.phi.org/press/new-study-alcohol-and-drug-use-cause-significant-harms-that-go-beyond-the-individual/
[4] https://www.sciencedirect.com/science/article/pii/S0955395924003189?via%3Dihub

2017 survey of people in recovery[5] conducted by the CCSA found that the main barrier to treatment was that people were not ready, did not believe that they had a problem or that their problem was severe enough to warrant treatment. According to the BC Coroners Service Death Review Panel[6], 75% of those who died from drug toxicity were not seeking treatment (although not all those who died had an SUD).

To keep people out of the criminal justice system and ensure everyone's safety, we need treatment on demand and to ensure that the protections of the mental health acts and health care consent acts apply to those with SUD. This is the case regardless of whether the substances involved are legal or illegal.

Treatment on Demand

The State of Mental Health in Canada 2024[7] recently released by The Canadian Mental Health Association, states that "no province or territory is spending enough on mental health, in part because they're not obliged to." On average, they are spending 6.3% of their overall health budgets on mental health whereas they should be spending 12%. This must be urgently rectified. Bad things happen when people wait for treatment. They can change their mind about getting treatment, die by suicide, become incarcerated or homeless, or suffer serious harms from their substance use including death.

Applying health law protections to SUD is part of the solution

While health laws are a matter of provincial/territorial jurisdiction, they are relevant to the federal government. As explained in *The Mentally Ill: How They Became Enmeshed in the Criminal Justice System and How We Might Get Them Out*[8], commissioned by the Ministry of Justice Canada, if the provinces/territories do not catch people upstream in the mental health system, the federal government may well be catching them downstream in the criminal justice system:

> "It is recognized that health care is constitutionally a provincial/territorial domain but solutions, given that the problem of the over-representation of mentally ill individuals in the criminal justice system is largely one of "transinstitutionalization", must involve main stream civil mental health care."

Transinstitutionalization refers to the process by which the deinstitutionalization of those with mental health conditions in reality often results in them being admitted to another institution, such as prisons or long-term care homes.

The purpose of provincial/territorial mental health acts is to ensure the safety of all. While these laws vary from jurisdiction to jurisdiction, generally they provide an ability to detain people with a mental disorder who are at serious risk of harm to themselves or others and who are not seeking treatment. Further, our health laws regarding informed consent generally ensure that a substitute decision maker can make treatment decisions on behalf of someone who is incapable of making treatment decisions. These laws are intended to be protective in nature.

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[5] https://www.ccsa.ca/life-recovery-addiction-canada-technical-report
[6] https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/review_of_illicit_drug_toxicity_deaths_2022.pdf
[7] https://cmha.ca/what-we-do/policy-research/state-of-mental-health-in-canada/#documents
[8] https://www.justice.gc.ca/eng/rp-pr/jr/mental/mental.pdf

Remarkably, there is good evidence that these health laws are significantly underutilized when it comes to protecting those with SUD and those around them. The question isn't whether the protections of our mental health acts should apply to SUD, but rather why we have not historically extended these protections to those with SUD even where in many jurisdictions they clearly do apply. A Commentary[9] in the Canadian Journal of Emergency Medicine by physicians and lawyers questions whether this is due to "therapeutic nihilism, or worse, stigma".

Further, recent research[10] conducted by the Centre for Addiction and Mental Health (CAMH) is evidence that those with severe addiction are not being assessed to determine if they have capacity to make treatment decisions with respect to their SUD. It states, **"Individuals may be unable to consent to life-saving OAT [Opioid Agonist Therapy for Opioid Addiction], and discontinuation of (or failure to start) OAT, particularly in a controlled hospital environment, may represent the greatest immediate threat to these patients' morbidity and mortality with an extremely toxic unregulated drug supply."**

Many of the common concerns regarding involuntary treatment for SUD are addressed in *Involuntary treatment for severe addiction is better than doing nothing*[11].

It is often argued that involuntary treatment is a violation of rights. However, a person's rights can conflict. This is explained in The Final Report of the Select Committee on Mental Health and Addictions (Ontario, 2010)[12]:

> "The Select Committee believes, however, that the right to autonomy must be balanced with the right to be well. The Select Committee also believes that our present laws tie the hands of health professionals and families and have contributed to the criminalization of mental illness, where individuals need to be arrested in order to receive care. While Ontario undoubtedly needs better access to community supports and hospital beds, some people will not avail themselves of such services because it is the nature of their condition to deny that they are ill."

Finally, it is also often argued that those seeking treatment voluntarily cannot access it and therefore involuntary treatment should only be provided once there is treatment on demand. This is mental health triage. It is the same thing as saying we will not apply the protections of our mental health acts to SUD even though they apply, and we will not allow substitute decision makers to choose treatment for their incapable loved ones. While many question the legality and ethics of intervening, the legality and ethics of **not** intervening in these circumstances are of greater concern.

A common scenario for family caregivers

We have permission to share the following case of one of the mothers receiving support through FAR's programs. Her son has bipolar disorder and is addicted to methamphetamine. He was recently released from jail to homelessness in a manic state with no medication or prescriptions. He cannot reside with her

[9] https://pubmed.ncbi.nlm.nih.gov/32538339/
[10] https://journals.sagepub.com/doi/10.1177/07067437241261488
[11] https://globe2go.pressreader.com/article/281754159831210
[12] https://mdsc.ca/documents/Publications/Final%20Report_Select%20Report%20on%20Mental%20Health%20and%20Addict%20ENG%20Aug2010.pdf

as he has previously destroyed her property and has physically assaulted her and another family member. The following statements were made while she was crying and gasping for breath:

> "Why can't I get him help? It's ridiculous. **We look after our animals better.** Physicians aren't helpful. They are the ones who should get it. They say they can't force meds. But we should be able to if they are a harm to themselves or others to keep everyone safe. Once he is on his meds he is a normal person in society and can function. If not, he can't function. He is, like, possessed…"

Though she fears for his safety and those around him, she doesn't call the police. Based on previous experience, the police will take him to the hospital for an assessment, but he will be released. He will know she spoke with the police and she fears for her own safety.

To summarize, involuntary treatment, done right, is not about prohibition or punishment. It is about protecting those who cannot protect themselves due to untreated SUD and other mental health conditions. It is also less expensive than the common alternatives, being revolving door incarcerations, hospital visits and homelessness.

3. Update prescribed alternatives programs

There are valid concerns regarding current safer supply programs, including the risk of diversion. Most concerns can be mitigated by ensuring prescribed alternatives are necessary for stabilization purposes, are part of a treatment plan, and that precautions are taken to avoid and monitor diversion, including more options for alternatives that better match tolerance levels.

4. Compliance with the United Nations Convention on the Rights of the Child (UNCRC)

Drug toxicity is the leading or one of the leading causes of death of youth in Canada. Research by ODPRN[13] shows that while opioid related toxicities significantly increased for adolescents (15-17) and young adults (18-24) in Ontario during the pandemic, treatment with OAT significantly decreased for young adults and remained low and stable for adolescents. There was a fourfold decrease in residential treatment.

The word “neglect” has been used to describe the state of care in Canada for those with mental health conditions including SUD.[14][15] This is particularly true for youth who often face longer waitlists for treatment.

Canada is a signatory to the United Nations Convention on the Rights of the Child (UNCRC). Canada could be considered to be in breach of three provisions of the UNCRC:

- Article 3 which provides that all of our laws must be drafted in accordance with the best interests of the child.
- Article 12 that provides that children have a right to healthcare.

[13] https://odprn.ca/wp-content/uploads/2023/06/Opioids-among-Adolescents-and-Young-Adults-Infographic.pdf
[14] https://www.theglobeandmail.com/opinion/article-a-crisis-of-neglect-how-society-can-help-those-with-mental-illness/
[15] https://cmha.ca/what-we-do/policy-research/state-of-mental-health-in-canada/#documents

- Article 33 which provides that children have a right to be protected from illegal drugs and the illegal drug trade.

Aside from the fact youth are, at times, waiting more than a year for treatment for mental health conditions including residential treatment for SUD, if they are not seeking treatment our laws, as drafted and/or applied, usually prevent parents in Canada from intervening where their child is refusing treatment for SUD. A Commentary[16] in the CMAJ discussed the protection of minors under the UNCRC:

> "Read as a whole, the sensible interpretation of the UNCRC is that addicted minors, in their best interests, should receive treatment, regardless of their refusal, so they can recover, instead of being harmed by criminalization or untreated and progressive addiction. This conclusion is supported in a 2009 report[10] from a conference held at the University of Toronto, which concluded the following:
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> - putting the best interest of the child first would require substantial changes in current models of formal health care;
> - strategies are required to keep young people out of the criminal justice system;
> - codes of conduct by the colleges of health professionals on the best interests of the child are required."

5. Support family caregivers

The toxic drug supply and SUDs are destroying families. Canada is facing an unprecedented shortage of healthcare providers, especially in the area of mental health and substance use health. Family caregivers often act as first responders, default case managers and provide the bulk of support to their loved ones with little support from service providers. They are the most motivated and least expensive form of care and support. They need education, resources and support in their own right. Some will become caregivers to their child for life. The oldest caregivers supported by FAR were in their late 80's and early 90's.

Sometimes single elderly parents, usually mothers, are living with their child who has SUD and/or other mental health conditions in unsafe environments. They will not evict their child and are willing to suffer mental, financial and sometimes physical abuse to avoid their child becoming homeless. This is described as a public health crisis in the U.S. by Judith Smith in her book, *Difficult: Mothering Challenging Adult Children Through Conflict and Change*. These caregivers should not have to choose between their own safety and that of their child.

Summary of Recommendations

FAR endorses all recommendations of CSAM and Children's Healthcare Canada and, in addition, recommends:

1. The federal government dedicate a minimum of 12% of the overall health care budget for mental health and substance use health care and take all steps necessary to ensure that each province/territory does the same.

[16] https://www.cmaj.ca/content/192/5/E121#:~:text=Letters-,Secure%20care%3A%20a%20question%20of%20capacity%2C%20autonomy%20and%20the,best%20interests%20of%20the%20child

2. The federal government update prescribed alternatives programs to ensure that prescribed alternatives are necessary for stabilization purposes, are part of a treatment plan, and that precautions are taken to avoid and monitor diversion, including more options for alternatives to better match tolerance levels.

3. The federal government ensure that all levels of government comply with the UNCRC with respect to adequate funding for mental health and substance use health for children and youth, and ensure that all health laws and policies are drafted and implemented in the best interest of the child.

4. The HESA Committee accept the offer of Children's Healthcare Canada to convene leading child experts to testify and provide further insights on the pressing needs of children and youth in the context of the crisis if the Committee has not already done so. Ideally, this would include their views on decriminalization as well as harm reduction, safer supply and involuntary treatment for children and youth.

5. The federal and provincial/territorial governments collaborate to provide the resources and policies necessary to incorporate family caregivers into the healthcare system as partners in care and provide education, counselling, training and peer support to them in order to maximize the quality and quantity of support they can provide to their loved ones with SUD and other mental health conditions and reduce the possibility of homelessness.