

Rethinking involuntary admission for individuals presenting to Canadian emergency departments with life-threatening substance use disorders

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INTRODUCTION

Substance use disorders carry a substantial disease burden and premature mortality,¹ and have become a leading and growing cause for hospital service use across Canada.^{2,3}

People with severe substance use disorders experience high rates of serious comorbidities, and often use hospital emergency departments (ED) as the first and only point of medical care.³ With medical complexity compounded by stigma, and poorly resourced community care, this population is challenging to engage in treatment, and more likely than the general population to leave hospital against medical advice or without adequate intervention, facing a high risk of imminent and serious harm.⁴

Although increasingly involuntary detention of individuals with severe substance use disorders is being advocated for by families and community providers as a means of engaging this population in potentially life-saving treatment, scholars and practitioners have recently argued against the use of involuntary measures for this population, citing inconsistent evidence of effectiveness and better outcomes associated with voluntary treatment.^{5,6}

Given the unique role of emergency clinicians in hospital settings, and the opportunity to initiate evidence-based

treatments in hospital, this commentary explores the legal, ethical, and clinical grounds for and against involuntary admission and calls for further research, reflection, and dialogue on this important issue.

LEGAL BASIS IN CANADA

In Canada, involuntary admissions to hospitals are regulated provincially. Two involuntary admission criteria are consistent across all jurisdictions: (1) that an individual presents with a “mental disorder” and (2) that without involuntary admission, presentation of the “mental disorder” itself results in likely “harm.”

Most Canadian jurisdictions are aligned and endorse a definition of “mental disorder” derived from the Uniform Law Conference of Canada’s *Uniform Mental Health Act* (1987), which neither explicitly includes nor excludes substance use disorders. However, substance use disorders are designated as mental disorders in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.),⁷ and Canadian mental health tribunals have consistently determined substance use disorders to be mental disorders.⁸

Criteria for “harm” in provincial mental health legislations vary significantly across Canada and range from likely bodily harm to substantial mental or physical

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deterioration. Although available case law is scarce, provincial mental health tribunals have found that harms associated with substance use disorders can satisfy both the “serious physical impairment” and “serious bodily harm” criteria.^{9,10} Such precedent-setting decisions support the legal opinion that substance use disorders can satisfy both the “mental disorder” and “harm” criteria in all provinces and that involuntarily admissions for this population are possible under current provincial legislations.

Are legal provisions for involuntary admission then under-utilized in this population? Lack of awareness and publicly available legal precedents for the application of such legislation might contribute to possible under-utilization. Is the possible under-utilization of involuntary measures in people with severe substance use disorders, or the exclusion of people with substance use disorders from everyday interpretations of involuntary admission criteria, a manifestation of therapeutic nihilism, or worse, stigma, which further compounds this population’s marginalization? These questions merit further exploration and dialogue between service users, providers, families, and policy-makers.

As a caveat, we are *not* suggesting that involuntary admission should be considered as a general or appropriate way to initiate treatment for people with substance use disorder, but rather that people with severe substance use disorder should not be excluded on the basis of legal grounds from accessing the protections to health that might follow from involuntary admissions when their circumstances would otherwise mandate it.

ETHICAL BASIS

Under a bioethics lens, support for involuntary admission in mental health is clear under certain circumstances.⁸ From this perspective, involuntary admission can be ethically justified if the imperatives of medical care, beneficence, nonmaleficence, or justice, are significantly challenged by an individual’s presentation and risks.¹¹ Substance use disorders are characterized by compulsory use of substances and impaired capacity to reflect on and overcome cravings and urges, undermining affected individuals’ autonomy and placing them at risk of serious and imminent harm.⁵ In this sense, there is no cogent bioethical reason why the involuntary admission of people at imminent risk of harm for reasons related to substance use disorders ought to be considered categorically different to any other cause of involuntary

mental health admission, although the goals of treatment may vary.

From a broad human rights perspective, both the *Canadian Charter of Rights and Freedoms*¹² and the *United Nations Convention on the Rights of Persons with Disabilities*¹³ argue that every individual, regardless of mental disability, is to be considered equal before the law. Within this human rights context, ethical dilemmas arise when one is confronted with competing rights, such as autonomy, or the right for self-determination,^{5,6} v. the right to life and health.¹⁴

That said, autonomy need not be antithetical to the use of involuntary admission.¹¹ A pragmatic approach would view autonomy as a multidimensional construct in which clinicians aim to support individuals with substance use disorder in their first steps toward regaining autonomy, by engaging in life-saving treatment of their substance use disorder and related comorbidities.¹¹

CLINICAL CONSIDERATIONS

With both legal and ethical grounds allowing for the involuntary admission of people with severe substance use disorders at imminent risk of harm, what are key clinical considerations and barriers? First, although voluntary treatment, shown to be effective, may not be an option for some individuals with severe substance use disorders, research on the effectiveness of involuntary treatment of this population is scant and inconclusive.⁶ Is the immediate, short-term protection from harm enough to justify involuntary admission when the long-term outcomes are unclear? In some cases, it may be, if brief hospitalization allows for treatment of life-threatening comorbidities and engagement with community supports.

Second, with little guidance to clinically determine the risk threshold for involuntary admission for this population, it would be difficult to enact consistently in practice. Furthermore, the goals of concurrent medical, psychiatric stabilization and engagement in substance use disorder treatment require expertise and resources not readily available in either hospital or community settings in Canada, given the underfunding of such services and system fragmentation. Is there an opportunity for the development of practice guidelines and decision-making aids to support front line emergency clinicians, psychiatrists, and medical specialists in their work with this population?

Last, but not least, concerns have been raised that the possibility of involuntary admission might deter people with substance use disorders from appropriate help-seeking, further marginalizing this population.^{5,6} Consultation with people with severe substance use disorders in recovery, their families, and community organizations would be needed to further explore and mitigate against these concerns.

IMPLICATIONS

There is an urgent need to improve access to community based medical care, behavioral supports, voluntary residential treatment, and harm reduction services for people with substance use disorders across Canada. Among Canadian emergency physicians and their community counterparts, a variety of mechanisms would enable high-quality care for this population. These may include medical education, adequately resourced practice settings, research, and community advocacy. Such mechanisms necessitate a pressing call to action on numerous fronts.

First, knowledge and practice gaps in the care of people with substance use disorders will persist without adequate investments in research. Researchers should continue developing novel treatment approaches, as well as the evidence base on predicting risks of harm from substance use disorders, and the proximal and distal outcomes, including the potential benefits of involuntary admissions for the small group of individuals with severe, life-threatening substance use disorders.

On the clinical front, physicians can intervene to offer life-saving treatment without invoking mental health legislation, keeping in mind that premature discharge against medical advice may compromise outcomes and the ability to connect this population to much needed supports. Decisions about involuntary admission under provincial legislative provisions should never be taken lightly or applied liberally. Involuntary admission to the appropriate medical or psychiatric service may be considered, however, on a case by case basis, for select individuals whose escalating patterns of use, lack of or decreasing engagement with community supports, and complex comorbidities result in imminent and significant risk of harm. In the absence of clear guidelines or thresholds for admission, deciding on risks and potential benefits of an involuntary admission requires extensive collaboration with an individual's support network, and colleagues in Addictions and Psychiatry.

Advocacy and administrative action across hospital and community providers will be essential to secure adequately resourced practice settings, targeted education/capacity building, and permissive policies to support clinical care decisions about hospital admissions and practice-based research initiatives.

Finally, from a policy perspective, a clearer stance on the potential use of provincial legislative provisions in the context of substance use is required by relevant policy-makers, as is increased public reporting of adverse substance use outcomes to better inform research and practice.

Ultimately, the intent of such efforts is to improve care and outcomes for people with substance use disorders, and address knowledge, practice, and advocacy gaps for a highly marginalized population.

Box 1. Case example.

Consider this

Joseph drinks mouthwash and hard liquor daily and has a history of generalized anxiety disorder. He presents to the emergency department daily in relation to his harmful use of alcohol, including following severe intoxication, falls, and complex withdrawal. Despite intensive community supports, behaviors putting him at imminent risk of death continue to escalate, including falling asleep outside while intoxicated in sub-zero temperatures. He frequently leaves hospital against medical advice while medically unstable or in severe withdrawal. His community supports alert you to escalating high-risk behaviors, increasing isolation, poor physical health, and disconnection from services.

Is there a role for involuntary admission to stabilize medically, treat underlying anxiety, and re-engage with community supports?

Keywords: Bioethics, emergency medicine, involuntary admission, substance use disorder

Competing interests: None declared.

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