Involuntary treatment for substance use disorders in the provincial corrections system

Policy Brief

September 16, 2025

Overview

Involuntary treatment for substance use disorders in the corrections system has been presented as one option for addressing Ontario's drug toxicity crisis. In CAMH's expert opinion, this is not the answer. Our evidence-based voluntary substance use treatment system is inadequately accessible and under-resourced in both the community and the corrections system. We believe that building up this system is where government efforts are most needed. There are also evidential and ethical considerations that make involuntary treatment a challenging direction to support. In this policy brief, we provide a contextual overview of the substance use and substance use treatment landscape in Ontario and offer the government four recommendations for moving forward:

1. Build-up evidence-based voluntary substance use treatment and supportive housing
2. Support the effective and appropriate use of existing legal tools for involuntary hospitalization for people with severe and complex substance use disorders
3. Ensure that people in the corrections system have equitable access to evidence-based voluntary substance use treatment
4. Complete a thorough review of the evidence, ethics and system implications of involuntary substance use treatment and consult with experts

Background

On May 1st, 2025, the Ontario government announced plans to study the possibility of introducing involuntary treatment[i] for substance use disorders (SUDs) in the corrections system.[ii] This announcement came on the heels of other government policy aimed at people who use substances, including: limiting supervised consumption services, restricting public consumption of illegal substances, and enhancing penalties for trespassing on public property. It also follows on policy announcements from several jurisdictions across the country that are/are considering implementing involuntary treatment for people struggling with severe SUDs.

Calls to consider involuntary treatment for people with SUDs come amidst an ongoing drug toxicity crisis across the country and in Ontario. In 2024, 2231 Ontarians - or about 6 people a day - died due to opioid toxicity. While this mortality rate decreased by 26% when compared to 2021, it is still 34% higher than it was in 2019.[1] And these tragic deaths do not tell the whole story. In addition to

[i] Involuntary treatment typically refers to the practice of detaining someone in a hospital or hospital-like setting, and providing them treatment for their substance use disorder against their will. Other terms commonly used for this practice include involuntary care, forced treatment and coerced treatment.

[ii] For the purposes of this document, the corrections system refers to Ontario jails which house people on remand and those serving sentences of less than 2 years. In some cases – where indicated – it also includes those on probation and/or parole.

deaths due to opioid toxicity, there are increasing numbers of Ontarians requiring urgent and acute medical care due to opioid and other substance use:

- In 2023, there were 13,427 emergency department visits and 2,202 hospitalizations due to opioid poisoning.[2]
- Across the province, there has been a 15-fold increase in amphetamine-related emergency department visits over the last 20 years. [3]
- The number of people visiting CAMH's emergency department due to amphetamine use (mostly methamphetamine) increased by more than 700% between 2014 and 2021, and the number of people requiring inpatient admission due to amphetamine use increased by nearly 300% during that same time.[4]

This drug toxicity crisis is complicated by the concurrent housing and homelessness crisis.[5] Homelessness both contributes to and exacerbates problematic substance use and makes the drug toxicity crisis more visible in communities.

Given the impact of the drug toxicity crisis on people who use substances and the communities in which they live, policy efforts to address this issue are understandable. However, forcing people with SUDs into involuntary treatment once they are in the corrections system fails to reflect the needs of people who use substances, ignores the complexity of the substance use treatment landscape, and does not address the housing and homelessness crisis.

Currently, many people who are living in the community and who want to access evidence-based, voluntary substance use treatment are unable to do so. The system is at capacity and people are waiting weeks and months for care (including a range of supports and interventions such as medications, outpatient counseling, bed-based inpatient treatment, etc.). For those experiencing homelessness, their situation is exacerbated. Without access to safe and stable housing, it can be more difficult for people to engage in treatment and recovery. Further, there is existing provincial legislation which allows physicians to involuntarily hospitalize people with the most severe and complex substance use disorders under certain circumstances to offer them treatment, but these tools are underused in clinical practice.

Failure to provide access to evidence-based voluntary substance use treatment in community settings means that some peoples' SUDs deteriorate to the point that they end up in the corrections system. Once involved in the corrections system, these individuals are at particularly high risk of overdose and death due to decreased drug tolerance and other factors.[6] Nonetheless, they continue to face barriers to receiving evidence-based voluntary substance use treatment and care in custody and when discharged.

Better access to voluntary substance use treatment is desperately needed in Ontario. Simply introducing involuntary substance use treatment into the corrections system will not get people with SUDs the care they need when they need it most.

Discussion and recommendations

Given the challenges that people with SUDs face in accessing evidence-based voluntary substance use treatment and care within community and correctional settings, efforts to implement involuntary treatment in the corrections system are misguided. Instead, CAMH recommends that the government focus on building more straightforward pathways to voluntary substance use treatment and related supports such as supportive housing. It is imperative that all people with SUDs can access evidence-based substance use treatment and care in the community voluntarily,

and on their own terms. For the small number of people with severe and complex SUDs who do not engage with these care and treatment options, CAMH recognizes the need to more effectively and appropriately use existing legal tools for involuntary hospitalization (and as way to introduce voluntary treatment options). These measures will help to ensure that people receive the substance use care they need before their SUD deteriorates to the point that police become involved and their lives are further upended by spending time in the corrections system.

We know, however, that we cannot prevent all people with SUDs from becoming involved in the corrections system. For those that do end up spending time in jails and/or on probation or parole, it is imperative that the government ensure that they also have access to evidence-based, voluntary substance use treatment and care both during and after discharge from custody, and more integrated and effective discharge planning from incarceration.

CAMH believes that building up the evidence-based voluntary substance use treatment system in the community and corrections system should be the priority. The suffering, encampments, deaths and increased crime rates we are seeing are a symptom of inadequate access to appropriate treatment, and the solution is to increase capacity in the voluntary system that people are desperately trying to access. If, in addition to this, the government still wishes to consider implementing involuntary substance use treatment in the corrections system, CAMH strongly recommends serious and thorough consideration of the evidence; legal, ethical and system implications; and consultation with experts in the field (including people with lived experience of substance use disorders and their families) before doing so.

Below, CAMH offers four detailed recommendations for how the Ontario government can begin to address the drug toxicity crisis and ensure people with SUDs get the care and treatment they need when they need it. While the key focus of this paper is on treatment, CAMH recognizes that this alone is not enough. To fully address the drug toxicity crisis and support people with SUDs we need a comprehensive and collective approach that includes health promotion, prevention and harm reduction, and that addresses mental health, poverty and homelessness.[7]

Recommendation 1: Build-up evidence-based voluntary substance use treatment and supportive housing

Treatment

The first and most crucial step in helping people with SUDs get the care they need and preventing their SUDs from deteriorating is to ensure that they have quick and easy access to evidence-based substance use care and treatment when and where they need it. Unfortunately, many substance use services are at capacity. Right now in Ontario people wait on average: 80 days for substance use case management; 253 days for substance use treatment; and 345 days for bed-based, residential substance use treatment.[8] Outpatient Assertive Community Treatment (ACT) teams, which provide care for people with the most complex co-occurring mental illness and SUDs are at 100% capacity province-wide.[9] There are also missed opportunities to connect people with substance use treatment when they are in acute health care settings. In 2020, only 1 in 18 patients discharged from Ontario hospitals after experiencing opioid toxicity were dispensed Opioid Agonist Therapy (OAT),[iii] despite this being the best time for treatment engagement and continuance.[10]

[iii] Opioid Agonist Therapy is an evidence-based treatment for addiction to opioid drugs (e.g. heroin, fentanyl) that involves taking the opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications prevent withdrawal and reduce cravings for opioid drugs. OAT helps people to stabilize their lives and to reduce the harms related to their drug use. (CAMH, 2016).

When people cannot access substance use treatment when they are ready, their substance use disorder is likely to get worse. They may also lose motivation to seek treatment again. That is why to improve access to evidence-based voluntary substance use treatment we encourage the government to prioritize implementation of the recommendations from Ontario's Chief Medical Officer of Health.[11] Specifically, we recommend that the government:

- Increase access to timely, low-barrier evidence-based substance use treatment in communities across the province, particularly Rapid Access to Addiction Medicine (RAAM) clinics for those with opioid use disorder. CAMH also recommends funding a pilot adaptation of the RAAM clinic model for those with methamphetamine use disorder.
- Increase access to voluntary, evidence-based residential substance use treatment, including higher acuity beds for those with severe SUDs and co-occurring mental illness and/or acquired brain injury, and ensure that psychiatric care is available in these settings. CAMH also recommends enhanced access to post-discharge supports and case management for this population.
- Increase the number of ACT teams across the province and ensure these teams are resourced to provide substance use care and treatment services to their patients.
- Enhance capacity of primary care settings, emergency departments and hospitals to provide substance use treatment. For example, the work of Ontario's Mental Health and Addictions Centre of Excellence (COE) to create integrated care pathways that connect people at high risk of alcohol and/or opioid related toxicity and death presenting at emergency departments with the substance use care and treatment that best meets their needs is a good first step at enhancing capacity within the system.
- Establish recommended minimum wait times for access to substance use treatment.

The Ontario government has already made steps to connect people to substance use treatment and related services in their communities through Homeless and Addiction Recovery Treatment (HART) Hubs. The challenge is that treatment and services available to patients differs from Hub to Hub. Therefore, CAMH recommends standardizing HART Hub services as well as supplementing the Hubs with a Centralized Addiction Psychiatry Network to provide equitable access to specialty addictions care (e.g. addictions psychiatry, medication consultations, virtual groups and programming) for patients and providers.

In addition to improving access to care, it is also imperative that people with SUDs get high quality, evidence-base care. Presently, not all substance use care and treatment programs are evidence-based. That is why CAMH supports the work of the COE in developing recommendations to standardize evidence-based residential substance use treatment,[12] and we recommend extending this work to all substance use treatment services and including oversight mechanisms for meeting these standards.

Housing

Timely access to voluntary evidence-based substance use treatment may not be sufficient on its own to support and sustain recovery for some people with SUDs, particularly those with more severe SUDs. For these individuals, affordable housing with wraparound supports is crucial for treatment engagement, recovery and relapse prevention. Unfortunately, in Ontario there is an

extreme lack of supportive housing. At least 36,378 people are currently on waiting lists for mental health and substance use supportive housing across the province, and the average wait time is about 4 years.[13] Not only is there an overall lack of mental health and substance use supportive housing, there is also a lack of *appropriate* supportive housing. Some people with severe SUDs need and prefer abstinence-based housing because they find it extremely challenging to commit to reduced substance use in an environment where substances are readily accessible and widely used. While this type of housing is not ideal for, or preferred by, everyone it should be readily available for those who have abstinence as part of their recovery goals. To best support recovery for people with severe SUDs who are homeless or under-housed, CAMH reiterates recommendations from Addictions and Mental Health Ontario to:

- Immediately invest $80 million to develop 1000 new units of mental health and substance use supportive housing in 2025/2026.[14]
- Invest $9 billion over the next ten years to build and operate at least 36,000 new supportive housing units across the province.[15]

A portion of these units should be abstinence-based (with the remaining units providing a range of options and supports for people with SUDs).

Recommendation 2: Support the effective and appropriate use of existing legal tools for involuntary hospitalization for people with severe and complex substance use disorders

The goal of building up the evidence-based voluntary treatment system and supportive housing infrastructure is to ensure that every Ontarian that wants to receive treatment for their SUD will have access to a range of services to support their recovery goals. Even with these choices available, however, there will be some individuals who do not engage with these treatment options. For those individuals who have a severe and complex SUD and are at risk of harm to themselves or others, it may be appropriate to use existing legal tools to detain them in hospital to offer them treatment.

Ontario's *Mental Health Act (MHA)* gives physicians the authority to involuntarily detain individuals with a 'mental disorder' in a psychiatric hospital if they also meet other requisite legal criteria in the *MHA*. While 'mental disorder' is not defined in the *MHA,* it is accepted both clinically and legally that SUDs are 'mental disorders'. Therefore, so long as a person has a SUD and meets the other criteria in the *MHA,* they can be involuntarily detained in hospital under certain circumstances. Involuntary detention begins with the issuing of an Application for Psychiatric Assessment (Form 1) which allows an individual to be detained in a psychiatric facility for up to 72 hours for an assessment. If further detention is necessary, a Certificate of Involuntary Admission (Form 3) can be issued which permits hospitalization for up to two weeks, so long as criteria continue to be met. If a person no longer meets the *MHA* criteria, however, they must be discharged unless they agree to remain in hospital voluntarily.

While a person can be legally detained under the *MHA,* the authority to provide them with treatment is a separate consideration under the *Health Care Consent Act (HCCA)*. Being involuntarily detained in Ontario does not automatically authorize health care providers to give treatment against a person's wishes. Instead, if the person is capable of making treatment decisions, their acceptance or refusal of treatment must be legally respected. If the person is not capable of making treatment decisions, the health care provider still may not force treatment, but must turn instead to a substitute decision-maker for a decision to accept or decline treatment on the person's behalf. This can lead to situations where a person may meet the criteria for involuntary hospitalization, but not receive treatment while in hospital. The main goal of involuntary

hospitalization for those with severe and complex SUDs however, is to support withdrawal and give the patient time to meaningfully contemplate engagement in voluntary substance use treatment.

Despite the existence of Form 1 and Form 3 as legal tools to involuntarily hospitalize people with severe and complex SUDs who meet the required criteria, it appears that they are underused in clinical practice for this population. One of the reasons that these tools may be under-used is lack of awareness by physicians that they can use a Form 1 and Form 3 for people with SUD – that under the *MHA*, a 'mental health disorder' can include a SUD.[16] There is also concern among some physicians that, due the non-linear nature of recovery, they may need to invoke a Form 1 and/or a Form 3 on repeated occasions. This can lead to understandable hesitation about using such heavy-handed tools to override patient autonomy. Another pressing concern is the lack of hospital capacity, particularly if a Form 3 is used to detain a person beyond 72 hours. Hallway healthcare remains a reality across the province, and the psychiatric bed space needed to detain someone with a SUD may not be readily available. Further, physicians may be concerned about the lack of substance use treatment options available in the community to support the individual post-discharge.[17] People who have experienced involuntary hospitalization because of their severe and complex SUD will likely need intensive treatment options, such as ACT teams and/or residential bed-based treatment, once they leave an acute hospital setting. As noted in the previous section, these programs are at capacity/have long wait times.

Ideally, the need to involuntarily detain someone in hospital to engage them in treatment would not be necessary. However, even with a range of evidence-based voluntary treatment options in the community there will be a small number of people with severe and complex SUDs who may need this level of intervention. To best support the effective and appropriate use of existing legal tools for involuntary hospitalization for people with severe and complex SUDs, CAMH recommends that that the government provide resources for experts to:

- Provide education and support to physicians, especially Emergency Department physicians, on the opportunities for use of Form 1 and Form 3 for people with SUDs.
- Study the demand for and effectiveness of using Form 3s for people with severe and complex SUDs who meet the appropriate *MHA* criteria. Because the use of Form 3s for people with SUDs is minimal there is need to gather evidence on the effectiveness and feasibility of this approach.

It is important to note, however, that any decision to support the effective and appropriate use of Form 1 and Form 3 for people with SUDs will be limited by current psychiatric bed capacity.

Recommendation 3: Ensure that people in the corrections system have equitable access to evidence-based voluntary substance use treatment

While preventing people with SUDs from entering the corrections system should be the priority, we know that even with measures in place to support access to evidence-based voluntary substance use treatment in the community there will be people with SUDs in provincial custody. And as of right now, there are significant number of people with SUDs entering the corrections system - many of whom are also experiencing mental illness and homelessness. [18]

People in the corrections system have the right to receive health care and the Ontario government provides a list of the full range of health care services, including substance use care and treatment that are available to those in custody.[19] The government also has a specific policy in place to provide OAT to those with opioid used disorder who are in custody. Despite these commitments, concerns have been raised over the years about limited access to evidence-based treatment for

SUDs in the corrections system.[20] Inconsistent access to treatment and care has been attributed to staff shortages and frequent lockdowns,[21] while delivery of OAT can be complicated by limited physician knowledge and reluctance to prescribe.[22] Physicians have expressed hesitancy to prescribe OAT to people in short-term provincial custody (i.e. those on remand) because of well-recognized difficulties in making links to community-based OAT providers and other substance use treatments and supports upon discharge.[23] Problems with continuity of care into the community are particularly concerning as there are significantly higher rates of drug overdoses and drug toxicity deaths in the post-discharge period.[24]

Because people with SUDs in the corrections system are particularly vulnerable to overdose and death (as well as number of additional social and economic disruptions as a result of incarceration), it is imperative that they are able to voluntarily access the same evidence-based substance use treatment and care that is available in community settings. Therefore, CAMH recommends implementing recommendations from Ontario's Chief Medical Officer of Health[25] and Ontario's Chief Coroner[26], and specifically:

- Remove barriers, and ensure timely and safe access to evidence-based medical care and treatment for all people with SUDs in the corrections system. This includes withdrawal management support and access to OAT.
- Enhance access to additional voluntary, evidence-based substance use treatment and care for people with SUD who are in custody for longer periods of time (e.g. 30+ days).
- Improve continuity of OAT and connections to other substance use treatment and care post-discharge by establishing partnerships between correctional facilities and evidence-based voluntary substance use treatment and related supports in the community.

To further enhance continuity of care and support to individuals with SUDs in the immediate post discharge period, the government should also consider offering a 'bridging' program that directly connects people in the correctional system to community-based substance use care and treatment service providers before discharge.

Recommendation 4: Complete a thorough review of the evidence, ethics, and system implications of involuntary substance use treatment and consult with experts

The first three recommendations in this document and their focus on building up the evidence-based voluntary substance use treatment system in the community and corrections system are the ones we recommend that the government prioritize as part of its efforts to address the drug toxicity crisis in the province. If the government still wishes to explore implementing involuntary treatment for SUDs in the corrections system, then CAMH recommends that they consider the following:

- ***What does the research evidence say?*** While research evidence should not be the only consideration on whether to implement involuntary substance use treatment in the corrections system, there should be compelling evidence to support the decision. A recent, comprehensive review of involuntary treatment for SUDs found that there is a lack of high-quality evidence to support or refute its effectiveness.[27] ` Effectiveness' in these studies was typically determined based on objective outcome measures of changes in substance use, treatment retention and/or criminal recidivism, with limited if any focus on alternative/additional measures such as patient, family and healthcare provider perspectives. Further, effectiveness of involuntary treatment was compared to voluntary treatment, but there is little to no evidence about the efficacy of involuntary treatment

when compared to no treatment at all. Therefore, the government will need to determine if they are comfortable implementing an unproven program, especially one that has inherent risks (see more below).

- ***How will patient rights be protected?*** Patient rights, such as autonomy, are foundational to Canada's health care system and independent, informed decision-making is prioritized and protected under Ontario's *HCCA*, and upheld by the Supreme Court of Canada. (These rights also apply to those in the corrections system). Introducing involuntary treatment for SUDs within the corrections system could be seen to infringe on patient rights and would require significant changes to the *HCCA* (or would require the *HCCA* to be overridden by public safety legislation), and be subject to legal challenges. On the other hand, SUDs can themselves be seen to impact autonomy and decision-making.[28] The government will need to make a balanced determination – is the need for involuntary substance use treatment in the corrections system so great that it takes precedence over patient rights?

- ***How will substance use stigma and health equity be addressed?*** The stigma around substance use and towards people with SUDs is pervasive in our society, including beliefs that SUDs are a choice and people who use substances are dangerous. Introducing involuntary substance use treatment within the corrections system could reinforce these negative perceptions by conflating substance use and substance use treatment with punishment (instead of sending the correct message that treatment is healthcare). Involuntary treatment for SUDs in the corrections system could also be used inequitably and target certain groups of people, especially those that are marginalized, homeless, Indigenous and/or racialized - groups that are already over-represented in the corrections system. For Indigenous and racialized people, involuntary treatment could be experienced as another form of oppression stemming from historical and ongoing colonialism and systemic racism in Canada.[29] These stigma and health equity concerns must be considered in any discussions about introducing involuntary treatment for SUDs in the corrections system with explicit plans on how they will be addressed.

- ***What are the system and resource priorities for the province?*** Implementing involuntary treatment for SUDs within the corrections system would be expensive. Extensive funding would be required to develop secure treatment facilities and build staffing capacity. Therefore, the government will need to determine if investing in an unproven treatment program for a small number of individuals is a fair distribution of scarce public funds when evidence-based voluntary substance use treatment and related services – which maximize health benefits for more people and are potentially more cost effective - remain under-resourced and unable to meet the demand.[30]

- ***How will patient and staff safety be protected?*** Implementing involuntary substance use treatment within the corrections system could have both patient and staff safety concerns. Patients could experience risks from forced withdrawal, as well as possible choking hazards from involuntary medication administration. Also, depending on medication

administration protocols, patients could be subject to restraint use and its inherent harms if medication is forced. Similarly, patients could be subjected to various forms of punishment (e.g. segregation) for failure to participate in treatment regimens. Forcing patients to take medication or participate in other substance use treatment could then result in responsive aggression and violence, putting staff at risk. If involuntary substance use treatment is implemented in corrections settings, the government must ensure that safe withdrawal management and other patient and staff safety protocols are in place. Further, given the increased risk of overdose and death upon discharge from the corrections system, follow-up supports must be provided to any individual who has received involuntary substance use treatment while in custody.

- ***What are patient and family perspectives?*** The government should consult with a range of experts in the field before making any decisions to provide involuntary substance use treatment in the corrections system. The perspectives of those who will be impacted the most – patients and families – are of crucial importance. Patients and families hold diverse views on the use of involuntary treatment for substance use disorders. Some patients who have received involuntary treatment for mental illness have reported a sense of safety, while others have experienced fear and trauma.[31] Reported experiences from family are much more limited.[32] From our experiences at CAMH, patients and families just want help when and where they need it most – preferably, voluntarily and in their own community.

Summary and next steps

It is CAMH's expert opinion – based on current system needs, ethical considerations and lack of compelling research – that involuntary substance use treatment in the corrections system is not the answer to Ontario's drug toxicity crisis. We recommend instead that the government focus on building up the voluntary substance use treatment system in the community and within the corrections system as part of their efforts to meet the needs of people with SUDs and the communities in which they live. If the government still wishes to study implementing involuntary substance use treatment in the corrections system, then we strongly recommend that they complete a thorough review of the evidence, ethics and system implications, and consult with experts, including patients and families. If a decision is made to move ahead with implementing involuntary substance use treatment in the corrections system, then it should be introduced as a pilot program where outcomes and effectiveness (including patient and family perspectives) are studied and publicly disclosed. The program should be introduced carefully, given the risks involved, and include clear policies and protocols. The decision-making process should be transparent and justifiable to all stakeholders, particularly those who will be most affected by the decision. The program should only be made available to the small set of people with serious and complex SUDs who have not engaged with voluntary options.

As the government moves forward on their plans to address the province's drug toxicity crisis, CAMH offers our experience and expertise to help develop a substance use treatment system that meets the needs of all Ontarians.

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