

## **“SECURE CARE”: MORE HARM THAN GOOD**

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Key points:

- In response to the ongoing overdose crisis and its impact on young people, the province of British Columbia has been considering following other jurisdictions' lead and implementing Secure Care legislation, which would permit the apprehension, detention, and forced treatment of youth who are engaged in high-risk substance use.
- Existing evidence suggests that mandatory addiction treatment does not lead to significant improvements in substance use outcomes and can be destabilizing, increasing the risk of subsequent overdose
- Coercive approaches to substance use risks undermining trust and our ability to connect youth who live with intergenerational, childhood, or institutional trauma with the health and social services they need most
- Investing in accessible, evidence-driven interventions and building meaningful connections with youth will serve to better protect their health and safety than will the belief that legislation can be used to "fix" them.

Many who overdose on drugs in British Columbia (BC) are youth under the age of 19 (1) and calls for 'Secure Care' legislation have intensified. Secure Care legislation would legitimize the detention and forced care of youth who are deemed to be at immediate risk of serious physical or psychological harm and is intended as a last resort mechanism to protect youth who are engaged in high-risk substance use. In Canada, Secure Care legislation has been enacted in Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Nova Scotia (2). However, restricting the liberties of youth in an attempt to protect them from overdose and other drug-associated harms is a flawed approach, and may have unintended consequences.

Secure Care models vary by province. In some jurisdictions, parents and guardians are permitted to request court-mandated treatment for the youth under their care, while other jurisdictions restrict mandatory treatment to youth in the criminal justice system. Treatment type and duration also vary by province, but stabilization and "detoxification" are the primary goals of all Secure Care programs in Canada. In BC, "Bill M 202: Safe Care Act", dictates the process by which youth are apprehended, detained, and discharged from Safe Care facilities, but offers no details on the types of treatment to be provided.

To advocates of Secure Care, the proposed legislation is viewed as a tool to help youth in crisis who are resisting engagement with health and social services. Youth who are addicted to drugs are believed to lack control over their actions, and parents and guardians often feel responsible to intervene but often don't have the tools to do this. The difficulties of navigating a largely non-existent system of addiction care for youth mean that parents and caregivers are often unable to connect youth with evidence-based treatments (3). Therefore, it is understandable that many families and caregivers are demanding additional tools to intervene and protect youth from potentially deadly high-risk substance use.

While Secure Care may prove effective for select youth with strong supports, the evidence for mandatory treatment is weak. In a meta-analysis of research on juvenile drug courts in North America, research suggests that youth mandated into treatment demonstrated no statistically significant improvements in substance use during or following treatment (4). Evidence from adult populations provides further grounds to oppose Secure Care. In a systematic review of studies on court-mandated treatment, authors found that forced treatment did not improve substance use outcomes. Rather, findings indicated higher levels of mental duress, homelessness, relapse, and overdose following discharge from mandated treatment among adults (5).

It is important to recognize that while addiction treatment programs are effective for some, they can also be destabilizing and cause harm. For example, it is well documented that rapid withdrawal and abstinence-oriented treatments lower opioid tolerance and, given the high likelihood of post-treatment relapse, increase the risk of fatal overdose after treatment (6). While extrapolating research from adult to youth populations must be done with caution, these findings suggest that forcing youth into abstinence-oriented treatments through Secure Care can be expected to have unintended, even deadly, consequences.

Another concern with Secure Care is that it fails to acknowledge that the youth who use drugs may live with intergenerational, childhood, or institutional trauma. In a Vancouver cohort of street-involved youth who use drugs, nearly 50% had encountered the child welfare system and over 35% had involvement with the criminal justice system (7, 8). For these youth, trust in health and social services has often been severely compromised and coercive approaches risk further undermining our ability to connect youth to the services they need most. This hampers efforts to promote health-seeking behaviours and prevent drug related harms including fatal overdoses. Given the historical and ongoing effects of colonization, the use of a Secure Care approach with Indigenous youth raises further concern. The legacy of colonization has resulted in an over-representation of Indigenous youth within the child welfare and criminal justice systems (9) suggesting that Indigenous youth may be particularly vulnerable to Secure Care measures. The forced care of young Indigenous people who engage in substance use may represent a continuation of colonial policies and state repression of Indigenous peoples.

Instead of resorting to coercive measures, providing coordinated addiction treatment services across a continuum of care will better serve to combat the current overdose crisis and drug related harms. Other necessary measures include ensuring access to evidence-based interventions that address early determinants of health and span from prevention and education to harm reduction services, and from substitution treatment to residential programs. Furthermore, despite success among adults, there is often hesitation to offer certain harm reduction and addiction treatment modalities to youth. For example, substitution treatments, such as Methadone and Suboxone, have been shown to reduce the consumption of street-sourced opioids, improve uptake of other treatment interventions, and reduce rates of overdose among youth, but are often withheld from youth for fear that they encourage substance use and dependence (6, 10). Needle exchange and supervised drug consumption programs are other evidence-based interventions that are less-frequently offered to youth despite demonstrated benefits in reducing serious drug related harms (10). Measures to improve utilization of these

types of evidence-based interventions by youth will provide more opportunities to protect the health and well-being of youth who use drugs.

While the allure of Secure Care is understandable, we must acknowledge the gaps within the existing youth addiction care system and the potential for severe unintended consequences that may result from coercing youth into addiction treatment and care. Until we restructure our institutions and make the necessary investments in early interventions so that all families and youth have the emotional, social, and material supports needed to flourish, Secure Care should not proceed. In the short term, investing in accessible, evidence-driven interventions and building meaningful connections with youth will serve to better protect their health and safety than will the belief that legislated coercion can be used to “fix” them.

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