MANDATED CARE FOR YOUTH WITH DANGEROUS SUBSTANCE USE DISORDERS

One of the most challenging health issues facing pediatricians in British Columbia in their work with children and adolescents is substance misuse. Substance use disorders (SUDs) are a difficult health concern to deal with at any time. With the current fentanyl crisis we are experiencing an unprecedented need that is overwhelming our existing services. It has been a year since a public health crisis was declared in British Columbia, yet the morbidity and mortality rates continue to increase. The response to date has clearly not been able to deal with the crisis. Young people continue to die.

While we applaud British Columbia's much needed increase in the number of voluntary drug treatment programs, the response to the crisis does not address the evident gaps in our current system. An effective response to this public health emergency requires a coordinated system of services that can provide a full range of interventions geared to the on-the-ground needs of the young people and their families. This comprehensive "fabric of care" needs to be implemented as soon as possible. In the implementation of this system it must be kept in mind that one of the biggest gaps identified by parents and front line workers is the lack of mandated residential services, also known as secure care.

THE PROBLEM

There is ample evidence that dangerous drug use is a problem in BC. In 2016 there were 12 fatal overdoses in youth age 12-18 years and unknown number of non-fatal overdoses[i]. These young people come from all socio-economic groups and from all areas of the province. The numbers of young people dying or experiencing severe consequences appear to be on the increase in 2017. Some of these youth were engaged in drug treatment programs. Some were awaiting admission to treatment centers, care being delayed by inadequate resources. However from anecdotal evidence we know that a significant, but unquantified number, refused care. If we extrapolate data from other Canadian jurisdictions we can estimate that there may be more than 1000 youth per year in British Columbia engaging in severely dangerous behaviors yet refuse treatment. [ii]

SECURE CARE

The BC Pediatric Society Secure Care Working Group (SCWG) heard from a number of experts and advocates on issues related to mental health, substance misuse and secure care.

There are two general types of secure programs in Canada. The first tend to be of a shorter duration (< 10 days). The interventions focus on stabilization, assessment and, in the case of substance misuse, detoxification. This is an involuntary "time out" which allows time for crisis diffusion,

psychological and emotional regulation and the addressing of health and nutritional needs. It allows for a period of time within which the young person and the people trying to support them can recover from often overwhelming dynamics of the immediate crisis and are given the opportunity to reconnect with existing strengths and resources in a non-reactive manner. In the case of young people with substance misuse issues, it provides an opportunity for detox in a controlled and safe environment. The second phase is a longer mandated treatment phase which follows stabilization. While there is a variation in the legislation amongst the provinces all have legal provisions for the protection of the rights of young people placed in secure care.

The SCWG studied the efficacy of Secure Care in Alberta as that province has long standing secure care legislation, as well as a well-developed service network. We examined the network of secure programs offered through Hull Services in Calgary both because they offer a broad range of services and the organization has a reputation for offering leading edge and evidence based programs. In the fiscal year 2015/16 the agency provided secure services to 130 young people and another 180 were admitted to the PChAD program[iii]. The first priority of secure care at Hull Services is to rescue the youth from imminent risk of serious harm or death. Placing the youth in secure care achieves this goal. Moreover, secure care allows for the broader goals of assessing the overall needs of the youth; stabilization (drug detoxification, feed, clothe and provide safe and secure housing); developing a treatment plan and initiating it; reconnecting the youth with family and community resources; then discharging the youth in to a system of care. They are close 100% successful in these initial goals. This means that almost everyone entering the program is given a significant chance at beginning to address their presenting issues. This is significant given that these are young people who refuse to engage in voluntary services.

In terms of longer term outcomes, there is solid evidence that secure care is effective in achieving a sustained link between the admitted youth and services as over 60% of youth who enter into the Hull secure care program do not return and another 18% require no more than 2 cycles. This is a 78% success rate and provides concrete evidence that they continue to be linked up with services post discharge. The program consistently takes youth who are adrift without help and facilitates ongoing drug treatment.

The fact that secure care consistently links youth with substance use services is highly significant as it is widely accepted that youth who receive treatment for substance abuse do better than those who do not. In addition, Hull services reported that over 90% of youth who were involuntarily placed in the PChAD program feel that the program was of significant benefit to them and 77% would recommend it to their friends. This is a significant outcome given the involuntary nature of the intervention. It is clear through the ‘voice’ of the young people who have been in the program that they believe it has been beneficial to them.

Opposition to the province implementing secure care coalesced around three major concerns. Broadly speaking the first is that secure care would do more harm than good. The harms involve four areas. It should be noted that these are speculative concerns and there is no evidence from other jurisdictions that these are indeed issues.

The first is that opiate using youth are at risk of overdose post discharge due to loss of drug tolerance. This is a valid concern but has been successfully addressed in other jurisdictions through the creation and implementation of strict discharge guidelines including the use of suboxone when indicated. The second major harm, especially for street entrenched youth, is that youth discharged from secure care may have no place to live having lost their precarious housing while in care. This possibility should once again be mitigated through effective discharge planning. A third major harm is that youth forced in to care, and youth who qualify for mandated care, may avoid service institutions as a result of their experience or fear of being placed in care. We found no evidence that this is occurring in Alberta. The last, and most pervasive, potential harm is that if the province invests in secure care it would mean diverting much needed dollars from other aspects of the SUD prevention and treatment continuum. We see this as a false dichotomy as the province must do both.

The second major concern is that secure care is ineffective. We could find no evidence to support this assertion. Mandated care is accepted practice worldwide and across Canada. The Hull Services secure program in Calgary has shown that secure care can be effective in linking youth up with treatment services in a sustained fashion. Here in BC, youth who have been subjected to mandated care through the youth justice system can attest that even within the current suboptimal system of care in BC, mandated care can be of tremendous benefit.

The third major concern was that secure care would be invoked when other less intrusive measures have not been tried. This speculative concern does not seem to be supported by the evidence. It is broadly accepted that best practices involves the use of the right intensity of intervention at the correct time rather than run through a gamut of ineffective, less intrusive interventions before finally choosing an effective one. In addition, optimal secure care regulations would entail independent oversight and the right for youth to appeal.

SUMMARY

The secure care working group was in complete unanimity in concluding that the province of British Columbia urgently needs to improve all aspects of care provided to youth with SUD. B.C. must create a comprehensive system of substance use services that consistently meet the needs of youth and their families in communities across the province. This system must include residential and community-based youth substance use services, harm reduction service and supports for families or caregivers as well as prevention and early intervention supports. Most SCWG participants felt that secure care must be part of the services offered to youth and that the implementation of secure care should not wait until all improvements are complete, as many youth may die, or suffer irreparable harm in the meantime. **It is quite clear however that the creation of Secure Care provisions in B.C. is not a panacea and will be of limited help for our youth if effective steps to create a "fabric of care" are not implemented.**

There is a small, but significant number of youth in BC with serious SUD and who refuse treatment and as a result face imminent risk of serious harm or death. Most provinces in Canada recognize that secure care for these youth is one vital aspect of the continuum of care for SUD. In fact,

mandated care is now part of the standard of care for youth with SUD across most of Canada. The onus is therefore on B.C. to provide justification for the absence of secure care provisions in our province. **We feel that there is no evidence that secure care "doesn't work" and despite the absence of high quality studies in the literature, there is a great deal of 'real world" evidence that secure care can be extremely beneficial.**

British Columbia has been debating implementing secure care at least since the 1990s. The lack of action has been a source of frustration for all stakeholders but in particular for parents who find themselves helpless in their struggle to help their children and for service providers who have run out of tools to address the crisis. Secure care is a less stigmatizing and more cost effective intervention than the current ad hoc criminal justice approach.

The details of secure care legislation and regulations will take time to craft. Major issues need to be addressed, such as defining the role of the MCFD and the MOH in secure care. Successfully tackling these issues will take many months. In the meantime, some youth may die as a result of inaction. An interim solution is already being used in B.C. as the MHA is currently being used to mandate admission to hospital because of serious SUD. Currently the MHA is being used in an inconsistent fashion however it can be a valuable tool if appropriate clinical guidelines and safeguards are developed.

RECOMMENDATIONS

These following recommendations were accepted by the BCPS Board:

1) The BC Pediatric Society recommends that B.C. creates a comprehensive system of substance use services that consistently meet the needs of youth and their families in communities across the province. This system must include residential and community-based youth substance use services, harm reduction service and supports for families or caregivers as well as prevention and early intervention supports.

2) The BC Pediatric Society recommends that the province of BC take immediate steps to implement secure care for youth in BC with serious SUD

3) The BC Pediatric Society recommends that the province create Clinical Practice Guidelines to enable the use of the MHA to ensure the safety of youth with serious SUD, facilitate stabilization and allow for treatment initiation.

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[i] BC Coroners report

[ii] Hull Services report to the SCWG, March 30, 2017, rate of secure care in Calgary is 225/1,000,000 persons X 4.6 million British Columbians = 1035

[iii] Personal communication Hull Services, April 2017