Canadian Drug Policy Coalition
Coalition canadienne des politiques sur les drogues

Addition Treatment in Context: Principles for a System of Just, Accessible, and Voluntary Care

Position Statement

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Published December 30, 2025
Updated January 7, 2026

This statement outlines the Canadian Drug Policy Coalition's organizational perspective on addiction treatment: what it is, where it currently fails, and how it could meet the needs of people and communities. We affirm those who struggle with their relationship to substances. So too we affirm those who love and care for people who struggle. We believe that everyone should be able to access formal support if they desire to. Concurrently, we challenge the idea that addiction treatment *alone*—especially when it is inaccessible, of poor quality, culturally unresponsive, or coercive—can address either the social conditions that influence substance use, or the drug policies that drive substance-related harms.

Cultural attitudes exert considerable influence over public conversations about substance use. While there is growing recognition that substance use exists on a spectrum and is inseparable from social, economic and personal factors, "addiction" is still widely discussed as an individual phenomenon.[i] What is more, we observe with concern that our collective policy and attitudinal responses to deaths from the unregulated drug crisis increasingly focus narrowly on treatment—especially residential treatment—as the primary or only solution.

We can do better. More humane and effective responses are possible. Collectively, we can choose to shift our drug policies to focus on the best possible public health outcomes. Alongside this urgent and necessary upstream work, we can take immediate practical steps to improve substance use treatment and ensure all people can access high quality, responsive treatment services as part of universal healthcare.

This statement is intended to prompt decision-makers, advocates, and the public to critically reflect on Canada's addiction treatment system. We hope it will guide readers to consider how governmental approaches to addiction could centre well-being, dignity, choice, and equity.

This statement can be attributed to the Canadian Drug Policy Coalition as an organization and does not necessarily represent the many organizations and individuals with whom we collaborate.

Context: What we mean when we talk about addiction

Despite its prevalence in public conversation, addiction is a complicated phenomenon with no agreed-upon scientific definition.[ii] Popular understanding of it in Western thought has evolved over time.[iiiivv] For instance, 16th century Evangelicals discouraged addiction to sinful traits such as pride but praised those who were addicted to serving God.[vi] Later, after addiction became associated with substance use, British cultural commentators wrote of it as being a "private vice" for the

wealthy but an act of "political mischief" by the labouring poor.[vii] This "moral model" of addiction evolved in the mid-19th century when the American Psychiatric Association classified alcoholism and drug addiction under "sociopathic personality disturbance" in the first version of the Diagnostic and Statistical Manual of Mental Disorders. It was not until 1980, and the publication of the third version of the DSM, that the term "substance use disorder" (SUD) was introduced and called a mental disorder.[viii]

More recently, some have framed addiction as a chronic, relapsing brain disease. The "brain disease model" theorizes that addiction is primarily *caused* by biological processes that originate in the endocrine, neurotransmitter, and nervous systems and cause structural changes in the brain.[ixx] While there is evidence that substance use can *lead* to these outcomes, claims that addiction is primarily *caused* by biology are controversial among many researchers and clinicians.[xi]

We offer this abridged history to highlight that addiction is not like other illnesses. Most physical diseases have biological markers and can be detected by medical imaging or analyses of blood and urine. Conversely, addiction or "substance use disorder" diagnoses are based on self-reported behaviour and clinical interviews. These methods can be unreliable if they are influenced by the biases of a given assessor. Given the role of subjective observation in diagnosis, the ways that we define and discuss addiction therefore may reflect prevailing cultural attitudes as much as they do scientific advancements.[xiixiii] Socioeconomic factors, cultural context, and the legal status of a given substance exert significant influence over who gets diagnosed with a substance use disorder.

We acknowledge the many ways that drugs can impact the mind and body. Some people struggle enormously with their relationship to substances, and experience significant physical, psychological, and relational harm as a result. These lived realities emphasize the importance of ensuring evidence-based, high-quality support is accessible for those who seek it. However, it is important to remember that being diagnosed with a substance use disorder is not a neutral, objective process.

Additionally, we emphasize that the legal status of a given substance shapes dominant narratives about it. Much of the confusion surrounding the nature of addiction stems from some substances being illegal. This can make it difficult to separate the effects of problematic drug use from the effects of problematic drug *policy.*[xiv] Drug prohibition and criminalization contribute to an atmosphere of pervasive distrust of people who use illegal drugs (PWUD) while promoting the inaccurate misconception that *all* illegal drug use is a symptom of and/or results in addiction.[xvxvixviixviii] We caution against this assumption: Research demonstrates that most PWUD do not meet the clinical criteria for a SUD.[xixxx] Of those who do, many develop a more moderate relationship with substances without ever engaging with addiction treatment services.[xxi] [xxii] Population-level public health data also suggest that rates of SUD diagnoses in Canada, though regionally disparate, have remained fairly stable over a decade.[xxiii] This contrasts with rates of fatal and non-fatal overdose over the same period, which increased significantly. There is broad consensus among experts that the key driver of overdose and overdose fatalities is the toxicity and unpredictability of the unregulated drug supply.[xxiv] [xxv]

Given these facts, we maintain that: a) we must understand patterns of substance use as well as definitions of addiction within the context of the legal, economic, social, and cultural factors that influence both; b) individuals must be empowered to decide if their relationship with substance use is a concern and what to do about it, and; c) discussion and debate about addiction must encapsulate contextual factors - foremost among them, drug-related laws and policies.

Substance use in context: Supporting people by addressing social inequalities

Almost everywhere, rates of SUD diagnoses are distributed unevenly across different populations.[xxvi] Some of the demographic characteristics associated with an increased likelihood of being diagnosed with a SUD include being poor or homeless, having Indigenous ancestry, belonging to a sexual or gender minority group, and having a disability.[xxvii] [xxviii] [xxix] [xxx] [xxxi] The reasons for this are complex: although it is not entirely clear that these populations always consume more substances than others, it is well documented that social inequalities contribute to living conditions that can make substance use functional or desirable.[xxxii] For example, some people experiencing homelessness report using stimulants to stay awake due to the fear of being assaulted and having their belongings stolen.[xxxiii] Stigmatization at the intersections of drug use and various forms of oppression, particularly ongoing colonial oppression and structural racism, also drives some drug use.[xxxiv] [xxxv] [xxxvi] We therefore recognize that for some people, persistent substance use can be a rational, protective strategy for surviving oppression.

Patterned disparities in SUD diagnoses also likely reveal the extent to which oppressed populations are subjected to intense scrutiny and surveillance from the police, government, medical system, social service industry, and general public.[xxxvii] [xxxviii] [xxxix] [xl] [xli] Their substance use may not be more frequent or intense than anyone else's, but it is certainly more surveilled and more visible.[xlii] This is evident in legislation and political rhetoric about outdoor substance use and public space. Unfortunately, rather than address the underlying societal causes of addiction and outdoor substance use, many elected officials blame individuals.[xliii] We have observed that addiction has become a convenient explanation from decision makers for the perception that outdoor drug use and social disorder are increasing.[xliv] [xlv] [xlvi] This is done without admitting that many people are experiencing material hardships, or that rates of poverty and homelessness have steadily risen across the country.[xlvii]

We are troubled by the fact that promises to open new residential addiction treatment facilities, and particularly involuntary treatment facilities, have usurped real commitments to solving the housing and affordability crises impacting almost every community across Canada.[xlviii] In touting additional treatment beds and coercive treatment as solutions to public substance use, leaders and policymakers have chosen to frame the issue as one rooted in individual behaviour, best solved through individual-level interventions.[xlix] This ignores the structural and systemic roots of these issues: the volatility and unpredictability of the unregulated drug supply alongside the housing and affordability crises. Through such framing and response, governments appear to absolve themselves of any meaningful action beyond announcing more treatment beds. While expanded access to treatment is a laudable goal, building more institutions is not a substitute for

investing in poverty reduction, affordable housing, low-barrier education, employment, and family reunification programs, or accessible, quality healthcare.

The addiction treatment system must work for people

Alongside the need to address the social, structural and policy drivers of harm, we urgently need significant improvements to the system of treatment services in Canada. For addiction treatment to be safe and effective, it should be accessible, high-quality, culturally responsive, upholding of human rights, and voluntary.[l] The current patchwork of systems that exists in Canada is not meeting these needs for far too many people who seek support.[li]

Under the Constitution Act, 1867, health care service design and delivery are provincial and territorial responsibilities. However, the federal government instrumentally shapes Canada's system of universal health care through national priority setting and resource allocation. Under the Canada Health Act, the federal government provides funding to provinces and territories through the Canada Health Transfer for hospital services and some extended health care. It does so on the condition that services meet criteria under the Health Act of being publicly administered, comprehensive, universal, portable and accessible. We affirm that addiction treatment must meet these criteria, and detail below principles that could support a safe and effective treatment system.

Accessible

Though formal data is lacking, anecdotal evidence suggests that a significant portion of addiction treatment occurs outside of hospital and outside the care of physicians, through privately-operated service providers.[lii] Such services are currently excluded from the guarantees of the Canada Health Act and thus fall far short of the Act's criteria. Consequently, both the federal and provincial/territorial levels of government have deferred their jurisdiction to create a robust addiction treatment system while permitting many of the services that do exist to be owned and operated for profit by the private sector. We are alarmed by the fact that addiction treatment services, often sought by people and families in times of significant distress and vulnerability, can be delivered by for-profit businesses. While some people find support through the current system, we maintain that addiction treatment services ought not be delivered in a private for-profit setting. Because governments do not consistently track or publish this information, it is unclear nationwide how many residential addiction treatment facilities are publicly funded, how many are privately run for-profit, and how many receive a combination of private and public funding.

The main consequence of privatizing addiction treatment is that it is not readily accessible to most people. Navigating the fragmented treatment landscape is arduous, with wait lists for publicly funded withdrawal management services, outpatient services, and residential facilities often being several months long.[liii] [liv] [lv] This is particularly true for those living in remote and rural communities, including on First Nations, for whom accessing primary and tertiary medical care may require extensive travel.[lvi] [lvii] People who urgently need addiction related services therefore have the options of either paying for it themselves, the costs of which are prohibitive for many, or waiting

until a publicly funded spot becomes available.[lviii] Some die of unregulated drug toxicity before this happens.[lix]

Enhancing the capacity of the public treatment system to meet demand should be an immediate priority for elected officials. All people should have access to regulated, high quality, evidence based voluntary addiction treatment as part of universal health care in Canada. We advocate for a decisive shift away from reliance on privately owned and operated services. Treatment must instead be aligned with the foundational principles of universal healthcare under the Canada Health Act. This will entail collaboration between all levels of government, health professionals, and professional regulatory bodies to accelerate intake and service delivery while reducing disparities between urban and rural regions. Services must also be integrated into the broader healthcare system and be available for as long as they are needed, not on a time limited or temporary basis.

High-Quality

Presently, the largely unregulated addiction treatment industry parallels the unregulated drug market and its attendant harms. Canada does not have national standards for addiction treatment. With the exception of Québec, provincial accreditation systems for residential facilities, where they exist at all, do not meaningfully enforce expected standards of care.[lx] [lxi] Most jurisdictions have no training or certification requirements for those providing care through private addiction treatment programs.[lxii] It is therefore unsurprising that a recent jurisdictional scan concluded that residential treatment facilities are largely permitted to operate without real quality control or government oversight.[lxiii]

Accountability mechanisms for treatment providers are limited in part because government representatives are not appointed to intervene when services employ poor clinical practices. Residential facilities are also not required to track service user outcomes or publicly share reports of abuse or deaths, meaning those who seek support lack reliable means by which to assess the track record and quality of the services being offered. This predominant context of low-to-no oversight and low-to-no regulatory accountability creates alarming opportunity for the abuse of people who are seeking support.[lxiv] Reports of abuse and harm in addictions treatment centres are widespread and damning, often reported only after former or current service users contact the media.[lxv] This would be considered unacceptable in other sectors and areas of the health care system.

Moreover, in a political context where treatment has become the de facto “solution” to the unregulated drug crisis, the addiction treatment industry wields enormous political power and influence. Alongside cultural framing of addiction treatment as morally unimpeachable, this political power has led to an environment wherein it is taboo to critique or question how treatment services are delivered, even in cases of demonstrable failures and scant evidentiary support. Specifically, residential addiction treatment facilities still overwhelmingly mandate abstinence.[lxvi] [lxvii] This approach puts service users at a greatly elevated risk of overdose if they return to the unpredictable, unregulated drug market with a reduced drug tolerance.[lxviii] Relatedly, a substantial portion of addiction treatment is ideologically rooted in the twelve steps and traditions of Alcoholics Anonymous (AA).[lxix] We affirm that some people benefit from the twelve steps, and

recognize their positive impacts and personal significance for those people. However, scientific evaluations of the efficacy of twelve-step programs are plagued by methodological difficulties and inconclusive for people who use criminalized substances.[lxx lxxi lxxii] Many report feeling constrained by their rigidity, dogmatism, and implicit or explicit religiosity, as well as how narrowly they define "success" when abstinence is compulsory.[lxxiii lxxiv lxxv] It is thus highly concerning that the twelve steps remains the default addiction treatment modality. Yet these legitimate critiques are dismissed in ways that are difficult to imagine in other health care or service delivery settings.

Thus, expanded access to addiction treatment must be met with equally seismic improvements in treatment quality. Addiction treatment service delivery must adhere to the norms and best practices established through rigorous empirical evaluation. The modalities available to people should be grounded in contemporary evidence demonstrating that treatment is most helpful when it is flexible, guided by the individual ("patient centered"), and accompanied by primary care access and material supports such as stable housing.[lxxvi lxxviilxxviii] In this context, twelve step programming could be offered as one optional component of a holistic and evidence-based treatment regime. We also recommend public funding for treatment being contingent upon regular demonstration through independent assessment that regulations, standards of care, and patients' rights are being upheld. Finally, we recommend the creation of centralized provincial databases of all treatment services and the introduction of standardized and transparent mechanisms to track service user outcomes.[lxxix]

Culturally responsive

Despite our calls for evidence-based addiction treatment, we are careful to not be deterministic about what constitutes "evidence." Too often, scientific and medical experts overprescribe solutions to addiction that do not account for the unique features of diverse communities and individual needs. For instance, we take seriously the claims of Indigenous peoples that mainstream approaches to treatment can reproduce patterns of colonial violence by imposing western norms and values onto them.[lxxx] We also acknowledge that mainstream approaches may not resonate with immigrant, refugee, and diaspora communities who arrive in Canada with culturally specific beliefs.[lxxxilxxxii] In addition to drug-related stigma and discrimination, PWUD from these groups must contend with systematic dispossession, displacement, and social dislocation that erect profound barriers to achieving social and economic health.[lxxxiii lxxxiv lxxxv] To be effective, addiction treatment options must be responsive to the cultural context, realities and needs of a greater diversity of people who use drugs, including Indigenous peoples, people from varied cultural, ethnic and geographic backgrounds, and sexual and gender minorities.[lxxxvi]

In the context of addiction treatment, cultural responsiveness implies supporting community-led responses and incorporating relevant cultural factors, cultural humility and safety into the planning, implementation, and evaluation of services more broadly.[lxxxvii] It means moving away from individualistic western models that primarily frame health as the absence of disease.[lxxxviii] In their place, it may place emphasis on the wisdom and worldviews traditionally found in a particular community. For example, many Indigenous communities tend to adopt a more expansive definition of health than is found within the mainstream treatment system, including focus on relationality and the interconnectedness of individuals, families, other kinship structures, and the natural

world.[lxxxix] [xc] Increasingly, elements of western and traditional treatment are also being viewed as complementary.[xci] [xcii] While it is not our place to describe in detail what culturally responsive services should include, as this will vary greatly, we endorse diverse communities being equipped and resourced to lead all stages of service delivery. They are best placed to know what works for them. Further, and relatedly, culturally responsive treatment should address structural risk factors such as poverty, housing deprivation, and inequitable access to services, as well as historic and current experiences of racial and ethnic trauma that negatively impact health outcomes.[xciii]

Voluntary

The topic of involuntary treatment for addiction is a growing policy debate, and politicians increasingly tout its expansion as a solution to various social challenges. Involuntary treatment, or forced abstinence, can refer to instances of a person being held without their consent in a secure facility. They are sometimes apprehended by law enforcement before a medical professional, justice, or other decision-maker decides that they pose a risk of harm to themselves or others. They are released from custody only after they are deemed to no longer be a risk. This form of involuntary treatment can thus be relatively brief (e.g., overnight or 72 hours) or last for months, depending on an individual's circumstances and the capacity of the healthcare system. More broadly, involuntary treatment may also refer to restrictions or demands being placed on behaviours while living in community, such as requirements to consume certain medications. Involuntary treatment is already in effect in every provincial jurisdiction for people who have been diagnosed with mental illnesses.[xciv] [xcv] Much of the growing policy debate surrounds the push to expand the use of involuntary treatment to include those whose only diagnosis is a substance use disorder.[xcvi] [xcvii] Often, though, PWUD are already captured under provincial Mental Health Acts because the Acts do not include clear conceptual or behavioural distinctions between mental illness and substance use.

We join a growing chorus of voices expressing serious concern about involuntary treatment for addiction and justifications to expand it.[xcviii] We do not take lightly that some people report having benefited from involuntary treatment. We further acknowledge the many individuals, families and communities who fear for their loved ones' safety and are desperate for solutions as they navigate the inadequate options currently available to them. However, we reject the claim that widespread use of forced treatment is an appropriate response to the realities before us.

The narrow circumstances in which limited involuntary treatment may be appropriate do not justify its widespread use. There is limited evidence to suggest that involuntary substance use treatment is safe or effective.[xcix] [c] Some studies demonstrate that coercion may contribute to people staying in treatment longer, but evidence has failed to demonstrate that they will exit treatment healthier, happier, more stable, or with reduced substance use.[ci] [cii] [ciii] Conversely, data link involuntary treatment to risk of non-fatal and fatal overdose after being discharged.[civ] [cv] Many people who have been treated involuntarily also associate it with persistent trauma and severe violations of their health and safety, largely because there are even fewer safeguards in place to prevent abuse for involuntary patients than there are for voluntary patients.[cvi] [cvii] Research indicates that people who have been subjected to involuntary treatment may be less willing to engage with voluntary health services in the future, thereby worsening their health and social outcomes, as well as the health and social outcomes of communities overall.[cviii]

Policymakers have failed to invest in voluntary, evidence-based, regulated treatment, while concurrently neglecting their obligations to address structural determinants of health, such as housing and poverty. In the context resulting from these policy choices, governments have granted themselves the latitude to frame involuntary treatment as the only viable solution for anyone who struggles with their relationship to substances, and particularly anyone who does so while experiencing visible poverty. Those in power have situated structural issues as individual problems

and are deploying forced treatment to clear homeless encampments and displace people deprived of housing out of public view.[cix] Given the dearth of options available for those seeking help, it is unsurprising that many people now see the expansion of forced treatment as necessary or positive despite a lack of evidence to support such programs. We again affirm those who seek support for themselves or their loved ones and emphasize the responsibility of governments to ensure such support is available. However, absent meaningful, significant public investment in both voluntary, regulated, evidence-based treatment as well as the means to improve structural and material determinants of health, it is deeply unjust to advocate the broad expansion of involuntary treatment.

Conclusion

High quality, voluntary addiction treatment has an important role to play in supporting people who struggle with their relationship to substances. However, it cannot and should not be the primary policy response to social problems created by poverty, housing insecurity, criminalization, and systemic discrimination or to deaths from the unregulated drug crisis. A treatment system that is inaccessible, of poor quality, culturally unresponsive, and coercive fails to meet the needs of the people it is meant to serve.

We call on all levels of government to reimagine addiction treatment as one component of a broader, integrated approach to health and social equity. Whereas the current system asks individuals to change without changing the conditions around them, a better path forward means accurately identifying the roots of societal challenges, and broadening focus from individual blame to collective responsibility. This includes expanding access to accessible, high-quality, culturally responsive, and voluntary services that are aligned with the principles of universal healthcare. It also requires transforming the policies and laws that drive many substance-related harms. Only then can we imagine responses to addiction that are compassionate, just, and truly effective.

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[i] "Framework for a Public Health Approach to Substance Use" Canadian Public Health Association, 2024 https://www.cpha.ca/framework-public-health-approach-substance-use#:~:text=Substance%20use%20can%20be%20viewed,'drugs'%20are%20used%20synonymously

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[v] Across cultures and geographies, there is a diversity of thought on concepts of addiction and substance use. For an example that looks beyond popular Western concepts, explore Thunderbird Partnerships Foundation resources on Indigenous concepts of wellness: https://thunderbirdpf.org/?resources=indigenous-wellness-framework-reference-guide

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