POLICY Brief

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Saskatchewan's Involuntary Treatment Model for Severe Substance Use Disorder: An Analysis

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The toxic drug crisis continues to pressure governments to take action and deliver an effective response to an issue of growing public concern. In 2023, the Government of Saskatchewan committed to creating an additional 500 substance use treatment spaces. By February 2026, it reported that 312 treatment spaces of various types had been delivered.[1] Critics argue this expansion does not keep pace with the scale of the crisis[2] and that Saskatchewan currently has some of the longest wait times in the country for treatment, with individuals waiting up to six weeks or more for inpatient care.[3]

In May 2026, Saskatchewan passed the Compassionate Intervention Act[4] as part of the broader Recovery Oriented Systems of Care (ROSC) model,[5] constituting a new, involuntary, compulsory treatment model for severe, high-risk cases. The research evidence on involuntary treatment remains limited and demonstrates mixed results. Systematic reviews of involuntary treatment outcomes suggest that while such programs may increase treatment retention, most do not show any impact on substance use.[6,7,8] Moreover, findings suggest involuntary treatment is linked to an increased risk of overdose death following discharge.[9]

Involuntary treatment approaches frame the issue as an impairment in the individual's capacity and/or motivation to engage in treatment. However, motivation for change is complex and central to treatment engagement and positive recovery outcomes,[10] raising questions about the effectiveness of imposing treatment on individuals who may not be ready or motivated to participate. It is well established that individuals approach treatment and define recovery in different ways, meaning the pathways to recovery are more diverse and individualized than simply abstaining from use.[11] Involuntary approaches also do not account for health system barriers. Importantly, health system responsiveness – from addressing stigma to resource availability – is widely regarded as central to effectively responding to substance use issues.[12,13]

This Policy Brief provides an overview of Saskatchewan's *Compassionate Intervention Act* (the Act) and highlights specific considerations and potential impacts of the legislation. We rely on three primary sources: the Act, our consultation report[14] commissioned by MLA Nippi-Albright, and the Hansard from the Standing Committee on Human Services.[15] Regulations, policies, and procedures are forthcoming; therefore, recommendations are provided.

Overview of Saskatchewan's Compassionate Intervention Act[16]

The *Compassionate Intervention Act* establishes a new legal framework that grants the authority to apprehend, detain, assess, and mandate treatment for adults with a severe substance use disorder (SUD). The process may be initiated by peace officers (with or without a warrant), by referral from a medical professional, or, "any person" may apply to the provincial court for a warrant for the apprehension and assessment of an individual.

There are three criteria for apprehension and mandated treatment: (1) the person suffers from a severe SUD, (2) the person, on a balance of probabilities, is likely to cause harm to self or others, and (3) the person is deemed incapable of making their own treatment decisions. According to Minister of Mental Health and Addictions Lori Carr, "Compassionate intervention is for rare cases where a person's substance use puts their own life or the lives of others at serious risk."[17]

The Act establishes a Compassionate Intervention Board which must consist of at least three appointed members: one legal, one medical, and one other. At least one of these three members must be of "Indigenous ancestry". Three board members are then appointed to hearing panels where decisions are made by majority vote. They may issue up to six-week inpatient or up to six-month outpatient recovery orders. The Court of King's Bench, based on recommendations from a compassionate intervention centre's officer in charge, may mandate inpatient treatment orders for up to one year. Patients will have the right to legal counsel as well as the right to request one review per order.

All hearings and reviews will be closed to the public. The Act contains exemptions to the *Health Information Protection Act* (HIPA) alongside powers of public inquiry but promises confidentiality. Lastly, the Act grants broad immunity for the Board and all those carrying out the Act, so long as they act in good faith.

Potential Impacts

The *Compassionate Intervention Act*'s accompanying regulations, policies, and procedures have not yet been released. Accordingly, the concerns identified in this Brief are based on the legislative framework with recommendations intended to inform further development, implementation, and research. We focus on how risk, harm, SUD, and capacity are assessed and by whom, the Act's alignment with existing legislation, patient and Indigenous rights and representations, as well as accountability and oversight.

Likelihood to Cause Harm

Risk assessments[18] for *harm to self* rely on broad criteria such as an individual's inability to meet basic daily needs, negative impacts on employment or relationships, or high-risk behaviours, history of overdoses and frequent interactions with emergency services, among other categories. The authority to apprehend individuals with or without a warrant, based on such expansive criteria, further increases discretionary power and raises concerns about overapplication. It is also worth noting that frequent interactions with emergency services could indicate that appropriate care pathways are not available and that including this in risk assessments could potentially increase fear-based aversion to accessing emergency care. Further qualifying and constraining these criteria through regulation and policy would ensure only the most severe cases are considered. At the same time, a history of impaired driving or intimate partner violence involving substance use are not included as relevant risk factors in the legislation, but likely should be, considering their high prevalence in Saskatchewan.[19 20]

The other risk assessment, likelihood to cause *harm to others*,[21] describes two specific types of harm: harm caused by caregivers and harm to community safety.[22 23] When read as a whole, the Act effectively frames unhoused individuals and vulnerable caregivers who use substances as primary targets for intervention, since many of the identified risk factors are closely associated with housing instability and other indicators of poverty. Special consideration is needed for these populations whose ongoing substance use is often attributed to the traumas associated with social and economic vulnerability. These concerns are further heightened by the Act's interaction with child protection legislation, which may broaden government authority over families in ways that many service providers and Indigenous individuals we consulted viewed as reminiscent of the historical practices associated with the Canadian residential school system.[24]

Substance Use Disorder

The Act provides its own definition and severity scale for SUD, diverging from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR).[25] The DSM-5 defines SUD using 11 specific criteria that must occur within a 12-month period, providing a structured and time-bound clinical diagnosis by a physician, psychologist, or psychiatrist. In contrast, Saskatchewan's compassionate intervention framework relies on broader, less clearly time-limited concepts like "severity" of SUD, risk of harm, and capacity. This shifts the focus from a defined diagnostic threshold to a more open-ended assessment of risk, which gives wider discretion for intervention and does not explicitly require diagnosis of a physician, psychologist, or psychiatrist in the law itself.

Professional Roles under the Act

"Prescribed addiction treatment professionals" and "assessment teams" are granted the power to determine patient capacity, with any specific qualifications deferred to regulations or the discretion of the health director.[26] In this way, significant authority is granted without naming "physicians" or defining minimum professional standards within the statute itself. As a result, the usual safeguards associated with regulated health professions—namely, licensing requirements, defined scopes of practice, and enforceable standards of ethical conduct and care—are not embedded in the legislation's text.

Minister Carr has confirmed that these roles will be occupied by "medical professional[s]" and further specified through regulations.[27] It will be of the utmost importance that the prescribed treatment providers be licensed addiction medicine physicians, since patient capacity determination and compulsory treatment decisions require advanced clinical training in risk assessment, differential diagnosis, and consent law. Even if addressed in regulations, questions will remain over why actual medical professionals were not named in the Act.

Patient Capacity

Patient capacity assessments also appear static in the Act as there are no defined reassessment timelines for clinical re-evaluation once a recovery order is issued. Without mandatory reassessment timelines, individuals may be subject to ongoing removal of civil liberties despite potential changes in clinical presentation upon withdrawal and stabilization, raising questions about proportionality and rights protections. This may be especially consequential for six-month orders or long-term orders up to a year. Regulations, policies and procedures that define re-evaluation periods for patient capacity would be in the best interest of patient rights.

Withdrawal and Discharge Planning

The Act does not specify how acute withdrawal will be managed at the point of apprehension or prior to admission. Nor does the Act clarify where a person will be detained during this time period. This phase of recovery is important as unmanaged withdrawal—especially from substances such as alcohol or benzodiazepines—can be medically dangerous and, in some cases, fatal.[28] [29] Elevated risk is not limited to acute withdrawal. As mentioned, periods of forced abstinence can elevate overdose risk upon discharge or return to use.[30] [31] The Act itself also does not address discharge planning. Comprehensive discharge planning will be imperative to support long term recovery and reduce harms associated with reintegration. Overall, clear evidence-based policies and procedures are needed for effective withdrawal management and discharge planning.

Comparison with Mental Health Legislation

Minister Carr and Minister McLeod have repeatedly suggested that *The Compassionate Intervention Act* is modelled after *The Mental Health Services Act*,[32] yet key protections offered in *The Mental Health Services Act* are missing from *The Compassionate Intervention Act*. For example, a clause establishing the supremacy of access to voluntary services,[33] mandatory physician-led medical evaluations,[34] and second medical opinions,[35] are all absent from the *Compassionate Intervention Act*.

Establishing the supremacy of voluntary access to services requires those operating under *The Mental Health Services Act* to offer voluntary services first. Given that this protection is absent in *The Compassionate Intervention Act*, decision-makers and service providers should consider how to preserve and bolster voluntary pathways to care. We strongly recommend that policy and procedure ensure that voluntary access to treatment is offered and facilitated whenever possible prior to engaging in compassionate intervention. Such a process would support the Act's objective of using the least restrictive and least intrusive means.

Requiring initial medical assessment is also an important safeguard; it ensures that clinical presentations owing to non-psychiatric medical conditions are diagnosed and treated medically first. Relying on two physicians for assessment, diagnosis, and treatment recommendations ensures the proper standard of care is upheld. As such, regulations, policies or procedures requiring an initial medical evaluation as well as confirmation by a second physician ought to be strongly considered.

Legal Representation and Review

The Act promises legal representation for patients, through a roster of lawyers[36] but does not address the practical limitations of retaining lawyers for this type of work, nor the limitations on counsel representing clients deemed to lack capacity. As a result, the right to representation may face challenges. This is compounded by the Act's use of "may" (not "shall" or "must") for the registrar to replace counsel, meaning proceedings could potentially continue even after counsel withdraws without a guaranteed assignment of new counsel. When questioned on this word choice, Minister McLeod stated that legal representation is a patient's right throughout the process.[37] Policy and procedure then, must require the reappointment of legal counsel in such cases to ensure continuity of legal representation as a key procedural safeguard. Ongoing feedback from patients and lawyers will be important to effectively implementing patient representation. However, questions remain over whether one review per order is sufficient to satisfy procedural fairness in a dynamic clinical context.

Accountability and Oversight

According to Minister Carr the first compassionate intervention site has been assigned to the Saskatchewan Health Authority, at Saskatchewan Hospital in North Battleford and when fully implemented, assessment centres will be located throughout the province with Saskatchewan Hospital remaining the only treatment unit.[38] Though compassionate intervention facilities will be subject to inspection, there are no established timelines for inspection, and no treatment or facility standards are established in the Act. Facility oversight will fall under the authority of the Saskatchewan Health Authority[39] and the health director.[40]

The Act contains no requirements for public reporting or disclosure of aggregate, anonymized operational data. A commitment to public reporting would ensure the system is transparent to the people of Saskatchewan. Transparency through public reporting ensures the Act can be independently assessed for how it is applied in practice, whether it is achieving its stated objectives, or whether its impacts are proportionate and equitable over time. Given the research on involuntary SUD treatment is sparse, publicly available data would allow for further insight into the debate.

Indigenous Rights and Representation

Indigenous people are over-represented among those experiencing harms associated with substance use[41] despite use rates not necessarily being higher than the general population.[42] Notably, the Act's design suggests Indigenous representation may be limited in scope and influence. Although one board member must be of Indigenous ancestry, their appointment to panel decisions is not required and if it were, the majority vote would risk rendering their representation inconsequential.

Minister McLeod noted that the intent of the legislation is, in fact, to have one person of Indigenous ancestry on hearing panels for Indigenous patients but confirmed that this intent is not expressed in the legislation.[43] In response, an amendment was proposed to require reasonable efforts be made for Indigenous representation for Indigenous patients. Minister McLeod suggested this could be addressed in policy instead. This wasn't acceptable to MLA Meara Conway, who stated:

> Nearly a fifth of the population identifies as Indigenous in Saskatchewan. We know that these detention institutions today have a vast overrepresentation of Indigenous folks, and there are unique historical and ongoing reasons for that. The idea that we cannot get our act together to ensure that there is a mandatory makeup of at least one Indigenous individual on these panels, I just don't buy it... […] … given what is at stake here, the idea that we can't put the work in to ensure that one of those individuals is Indigenous, considering the makeup of this crisis today, is frankly… I'm asking you to do better…[44]

The Act also does not provide for cultural-based treatment for Indigenous patients and establishes no mechanisms for engaging or consulting with Indigenous leadership. In this way, the Act does not incorporate Indigenous decision-making, *Gladue* principles,[45] or Indigenous rights as required by Section 35 obligations under *The Constitution Act*, 1982. Minister McLeod, when pressed on the lack of consideration for Gladue principles specifically, reasoned that these principles only apply to punitive measures and that compassionate intervention is not punitive.[46] For MLA Betty Nippi-Albright, this was not acceptable:

> …no matter how it's spun, […] it's still going to impact the most traumatized people, and to not have that into consideration or not have that anywhere in here, it really speaks volumes to the Indigenous people that are already facing what they're facing today.[47]

Similarly, the First Nations Health Ombudsperson Dr. Diane Lafond took the position that: "[The Act] passed without independent review, ignored First Nations protocol processes and governance laws, and ignored every amendment that might have addressed serious concerns." The press release[48] continued:

> Free, Prior, and Informed Consent (FPIC), the United Nations Declaration on the Rights of Indigenous People (UNDRIP), and Duty to Consult have been violated. When the Canadian Government passed Bill C-15 in 2021, it didn't just apply to federal legislation; it committed all levels of Canadian government (federal, provincial, and territorial) to align their laws and policies UNDRIP principles. The Duty to Consult flows from Section 35 of the Constitution Act, 1982, which recognized and affirms existing First Nations Inherent Treaty rights. Saskatchewan cannot create legislation that materially harms First Nations peoples. Meaningful and documented consultation with the 74 First Nations of Saskatchewan must occur.

Considering the overrepresentation of Indigenous peoples in child welfare, [49] custody,[50] cases of missing persons,[51] and homelessness,[52] [53] our consultation report [54] concluded that the Act's design creates an increased and foreseeable risk of selective, racialized enforcement. Meaningful consultation with Indigenous people is therefore required to ensure regulations, policies, and procedures adequately address these concerns and that treatment is grounded in cultural humility and trauma- and violence-informed practices.

Final Remarks

The concerns raised in this Policy Brief suggest that Saskatchewan's Compassionate Intervention Act, as written, risks inconsistent application and disproportionate impacts on equity-deserving groups such as unhoused individuals, caregivers, and Indigenous People. Though these concerns may be addressed in regulation, policy, and procedure, implementation is likely to rely on a fair measure of trust in government and designated professionals. Minister McLeod expressed full confidence:

> …we have confidence in our peace officers that they will do the appropriate thing. We have confidence in our medical professionals, health professionals that will do the right thing. And we have confidence in our judiciary that they will do the right thing.[55]

MLA Conway did not agree:

> … if we're thinking that this isn't going to be weaponized or misused, we're kidding ourselves. I think there's a lot of concerns out there, and reasonably so…. there's going to be very few mechanisms in place to ensure that this system is not being misused.[56]

MLA Nippi-Albright, in her second reading response, called attention to trust as well, but from the perspective of service users:

> Trust is the foundation of effective care. When people fear that reaching out for help may result in detention, they stop reaching out. Services providers echoed this concern. They told us that if their work becomes associated with involuntary confinement, people will disengage…[57]

Similarly, several other representative organizations have released position statements calling for caution, restraint, and increased investment in voluntary services. They include the Saskatchewan Medical Association with the Saskatchewan College of Physicians and Surgeons,[58] the Canadian Society of Addiction Medicine,[58] John Howard Society of Saskatchewan,[60] and Moms Stop the Harm.[61]

Evaluating compassionate intervention is a priority issue for substance use researchers. Disproportionate impacts, particularly by racialization and gender, should remain a key focus. However, if there is no mechanism to access data for independent evaluation, researchers will have to establish alternative methods of data collection.

People who use substances, service providers, as well as advocates for civil liberties and health equity should be aware of the current contentions and potential implications and pay close attention to the Act's forthcoming regulations, policies, and procedures. Advocacy, particularly on civil liberties, Indigenous relations, equity, and transparency, may still influence the system's development.

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Jennifer Chouinard, BA BSW MPP, is a PhD candidate at the Johnson Shoyama Graduate School of Public Policy at the University of Regina and instructor in the School of Public Health at the University of Saskatchewan. Prior to her graduate studies, Jennifer was a registered social worker who practiced in the areas of crisis intervention, medical social work, and addictions counselling. Jennifer's current research interests include first responders' mental health, peer support, digital patient communities, and benzodiazepine regulation.

Dr. Maryellen Gibson

Dr. Maryellen Gibson (PhD) is a research associate in the School of Public Health at the University of Saskatchewan whose research focuses on substance use-related harms, harm reduction, and health inequities. Her work investigates the ways social systems and health policies influence the wellbeing of people who use drugs, highlighting the impacts of poverty, healthcare stigma, involuntary treatment, child and family services involvement, and housing insecurity.

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