THE COMPASSIONATE INTERVENTION ACT FOR SUBSTANCE USE DISORDER

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Jennifer Chouinard BA BSW MPP PhD Candidate
jennifer.chouinard@usask.ca

Maryellen Gibson BA MPH PhD Candidate
maryellen.gibson@usask.ca

This slide deck provides an overview of Saskatchewan's Compassionate Intervention Act. Any analysis of the legislation is that of the authors and does not represent the views of any affiliated institutions or organizations.

THE ACT'S OBJECTIVES

"1-2(1) The objective of this Act is to support the timely stabilization, assessment and treatment of persons who are suffering from **severe substance use disorders** and who, due to their disorder, are **likely to cause substantial harm to themselves or others**, in the immediate or imminent future.

(2) This Act is intended to provide the necessary, potentially life-saving, addiction treatment services to persons described in subsection (1) who, due to their severe substance use disorder, **are incapable of seeking out that treatment on their own**.

(3) The addiction treatment services provided pursuant to this Act are intended to provide effective treatment to the person in **the least restrictive and least intrusive manner**."

**emphasis added*

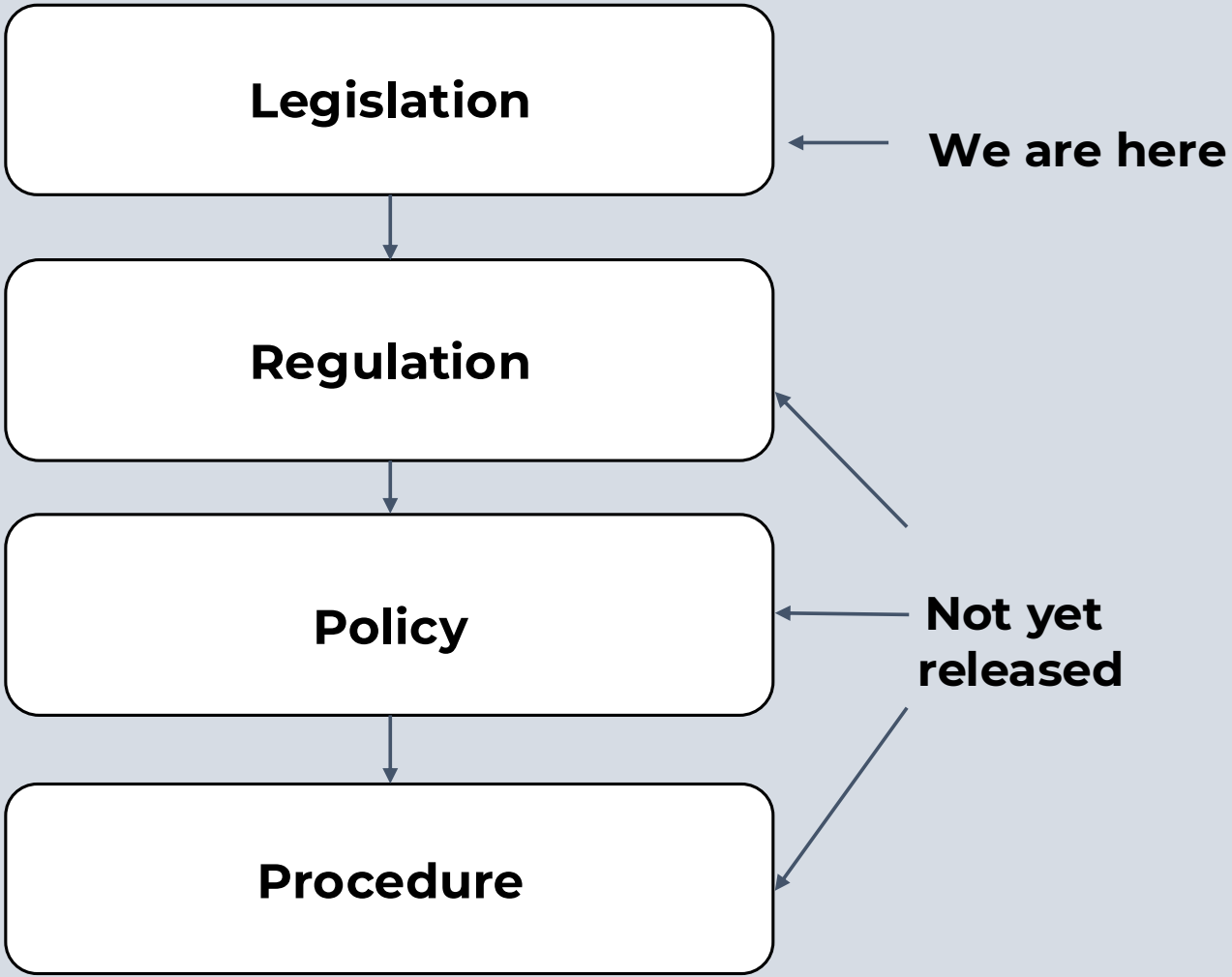
THRESHOLD FOR APPREHENSION & MANDATORY TREATMENT

(1) Severe substance use disorder

(2) Likely to cause harm to self or others

(3) Incapable of seeking treatment

ORDER OF AUTHORITY



GOVERNANCE STRUCTURE

LIEUTENANT GOVERNOR IN COUNCIL

- Appoints members to the Compassionate Intervention Board
- Makes regulations

COMPASSIONATE INTERVENTION BOARD

- At least three members: (1) legal, (2) medical, (3) other
- *1 member must be of Indigenous ancestry*

- Hearing and Review Panels (3 members: (1) legal, (2) medical, (3) other)
- *Member of Indigenous ancestry not required*

- Decision by **majority vote**. Hearings and review decisions are not made public.

REGISTRAR

- Compiles lists of eligible lawyers for patient counsel
- Appoints counsel if not privately retained
- Schedules hearing and review panels

OPERATIONAL STRUCTURE

MINISTER OF MENTAL HEALTH AND ADDICTIONS

- Appoints the Health Director and the Registrar
- Designates assessment & treatment centres

Ministry Appointed **HEALTH DIRECTOR**

- Designates Officer-in-Charge per centre
- Issues directives to assessment teams
- May inspect centres, order transfers between centres

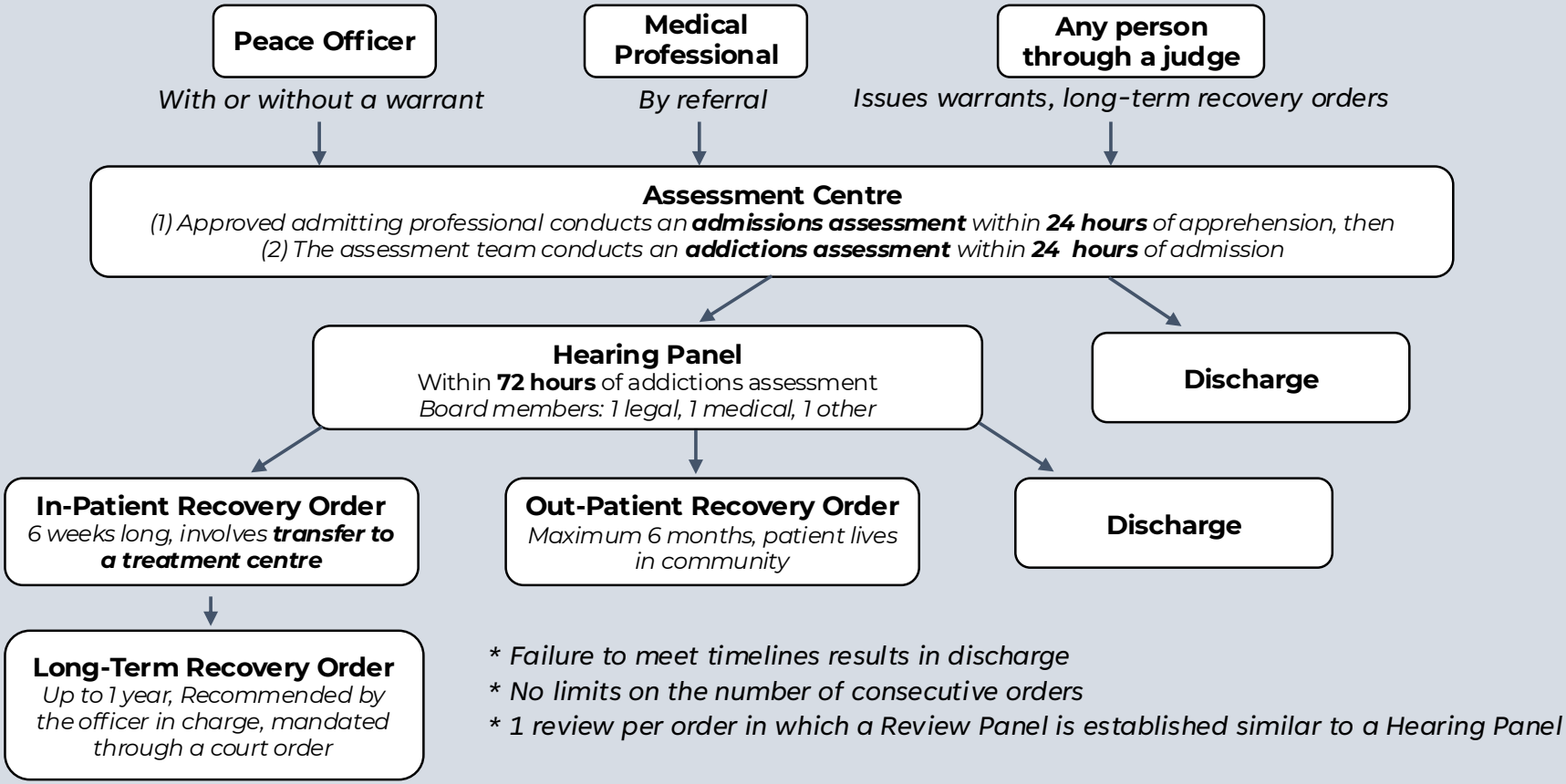
Health Director Appointed **OFFICER-IN-CHARGE (OIC)**

- One per centre, designated by the Health Director
- Oversees the administration of the Act within a designated centre
- Can recommend application to the Court for long-term order

Health Director Appointed **ASSESSMENT TEAM**

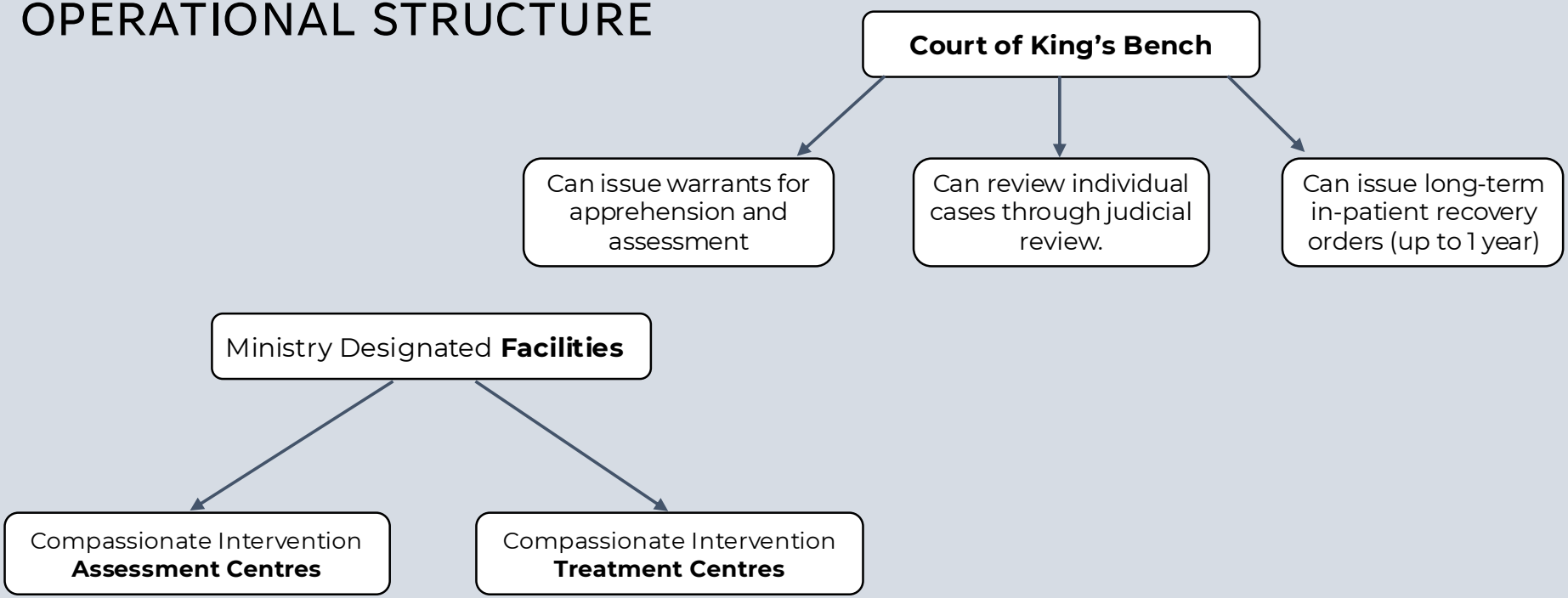
- The health director establishes policies and guidelines outlining the qualifications and requirements for individuals appointed to an assessment team.
- Each assessment team must comply with the health director's directives.
- Addiction treatment professionals assess patients and makes recommendations to the Compassionate Intervention Board

PROCESS & PROCEDURE



* *Failure to meet timelines results in discharge*
* *No limits on the number of consecutive orders*
* *1 review per order in which a Review Panel is established similar to a Hearing Panel*

OPERATIONAL STRUCTURE



** There are no qualifying criteria for facilities stated in the Act.*

** Designated facilities are subject to inspection, however there is no required timeline and **no public reporting** requirement*

SEVERE SUBSTANCE USE DISORDER

Subjects under the Act are referred to as **“patients.”**

“Substance use disorder” is **not defined according to the Diagnostic and Statistical Manual** (DSM–IV-TR) and there is **no reference to formal diagnosis** by a physician, psychiatrist, or psychologist. In fact, the terms “physician”, “psychiatrist” and “psychologist” never appear within the Act.

The Act addresses the **severity of substance use disorder** as follows:

“1-5 For the purposes of this Act, the severity of a person’s substance use disorder must be assessed by considering the extent to which the following factors apply to the person:

(a) the person demonstrates **a pattern of severe intoxication or severe impairment** due to substance use;

(b) the person demonstrates **a poorly controlled or unstable medical condition** caused by, exacerbated by or otherwise related to the person’s substance use;

(c) the person demonstrates **an inability to meet the person’s basic needs of daily living**;

(d) **any other prescribed factor**.” **emphasis added*

LIKELIHOOD TO CAUSE HARM

“Likelihood to cause harm” is evaluated on **a balance of probabilities** (more likely than not) using broad criteria, such as:

- History of overdoses
- Frequent service interactions
- Previous compassionate intervention
- Negative impacts on health, employment, or relationships
- Impact on medical conditions
- Inability to meet daily needs
- Substantial mental or physical deterioration
- High-risk behaviours

“Likelihood to cause harm to others” is assessed according to:

- Unable to care for another person in the person’s care
- Harmful behaviour towards another person in the person’s care
- Negatively impacting community safety

Both include:

- **Any other prescribed factor**

CONSENT & CAPACITY

Capacity assessments **do not explicitly require a second opinion.**

Capacity appears to be assessed by a **prescribed "addiction treatment professional."** The Board then considers that assessment when deliberating on issuing a recovery order. This exact assessment timeline is not clear within the Act.

If a patient is deemed to lack capacity and is issued a recovery order, a **proxy** or **personal decision-maker** may be appointed to make treatment decisions.

Patients who retain their capacity will have the **right to refuse treatment;** however, they **will not be able to refuse observation, monitoring, assessment, or clinical advice.**

PRIVACY & INQUIRY

The Act grants the Compassionate Intervention Board **powers of public inquiry.** Meaning, they will have the authority to compel personal information and records. This power is similar to that of the courts.

The personal health information that is collected, **may be shared for the purposes of the Act**, even where it would otherwise be protected under the *Health Information Protection Act (*HIPA).

In response, the Act promises **confidentiality**, requiring that **only reasonably necessary personal information be shared** for the purposes of the Act.

PROCEDURAL SAFEGUARDS & LEGAL REPRESENTATION

Patients have the right to:

- Be advised of the **reasons for their detention.**
- Participate in Compassionate Intervention **hearings.**
- Request **1 review per recover order to be reviewed** by the Compassionate Intervention Board.
    - Patient relocations cannot be reviewed or appealed.
- Apply to the **Court of King's Bench for judicial review.**
- Access **legal counsel at no cost.**
    - Timelines for lawyer–client contact are not defined.
    - Reappointing legal counsel appears discretionary if a patient's lawyer withdraws or is otherwise unable to represent the patient.

IMMUNITY

Individuals exercising powers or performing duties under the Act are **protected from personal liability** so long as they act in good faith.

Board members and those working for **the Board cannot be compelled to testify** or provide records in court about information they obtained in the course of their work.

OUR PROPOSED AMENDMENTS

1. Require physicians as the health providers and decision-makers in legislation.
2. Establish a voluntary request for services clause, similar to section 17 of *The Mental Health Services Act*.
3. Require full medical evaluation prior to addiction assessment.
4. Require unanimous board and panel decisions rather than majority (s.3-2(4), s.3-3(6)).
5. Change the burden of proof from a balance of probabilities to beyond a reasonable doubt (s.6-1(1), s.6-8(1), s.7-5 (2)(3)).
6. Require the registrar appoint new legal counsel should patient counsel withdraw or be otherwise unable to represent the patient (s.8-6).
7. Establish a mechanism for public reporting.
8. Establish a timeline for facility inspections (s.8-8).
9. Establish a timeline for re-evaluation of decision-making capacity.
10. Acknowledge substance use disorder as a DSM diagnosis (s.1-3, s.1-5).
11. Include impaired driving and domestic violence, and/or history thereof, in risk assessments of likelihood to cause harm to others (s.1-6(2)).
12. Offer cultural programming at Indigenous' leaders' discretion.
13. Require a person of Indigenous ancestry on hearing and review panel decisions where the patient is of Indigenous ancestry (s.3-2(2), s.3-3(2)).
14. Increase the limit of one review per order (s.7-1(2)).
15. Establish legislated diversion pathways:
    a) From *The Criminal Code of Canada* to *The Compassionate Intervention Act*
    b) From *The Compassionate Intervention Act* to *The Mental Health Services Act*.
16. Remove the transfer of apprehension powers to any person (s. 6-2).

See Chouinard, J. & Gibson, M. (March 14, 2025). "Bill 48: The Compassionate Intervention Act Consultation Report" available at surgesk.ca

THE MENTAL HEALTH ACT V. COMPASSIONATE INTERVENTION

	Mental Health Services Act	Compassionate Intervention Act
Voluntary Treatment Access	Protected	Not protected
Service Delivery	Public	Public, not prohibited from private sector expansion
Initial Medical Evaluation	Required	Basic medical care will be provided
Capacity Assessments & Treatment Providers	Physicians, Psychiatrists	“Addiction treatment professionals” “Assessment teams”
Second Medical Opinion	Yes	No
Substitute Decision-Maker (SDM)	Physician with duty to consult	SDM can be appointed
Privacy of Health Information	HIPA protected, narrow exceptions	HIPA applies but broad exemptions exist. Confidentiality clause in lieu.

DEFINING CLINICAL ROLES

Decision-making roles are identified: **“admitting professional,” “addiction treatment professional”** and **“assessment teams.”**

The Act itself does not require or name any registered professions, deferring instead to the health director or regulations.

Structuring care through regulated professions is an important safeguard for patients since regulated professionals are accountable to a standard of care and a code of ethics.

In The Standing Committee on Human Services (May 4, 2026), the Official Opposition introduced amendments to include:

- *protections for voluntary service access*
- *full medical evaluations for patients prior to mandated treatment*
- *“physicians” as the primary decision-makers and service providers*

All three amendments were defeated.

CONSENT & CAPACITY

Capacity can fluctuate over time and according to levels of intoxication. Yet, the Act **does not establish a timeline for re-evaluation.**

In committee, an amendment was introduced to include re-evaluations timelines. This amendment was defeated.

SERVICE DELIVERY

According to the Committee, the first Compassionate Intervention site will be in North Battleford, under the direction of the Saskatchewan Health Authority.

However, **the addiction treatment sector** currently involves **variable regulation with many unregulated areas.**

Saskatchewan has signed onto an interprovincial partnership to implement **a "Recovery-Oriented Systems of Care" (ROSC)** for addictions services.

ROSC Solutions Group and *Recovery Alberta* have led policy development and implementation. This framework relies on a mixed **public - private sector service delivery model**, raising questions about service delivery for involuntary treatment, evaluation, and the flow of public dollars.

In committee, Minister Carr was asked to amend the bill or promise on record to prohibit expansion of compassionate intervention into the private sector. No agreement could be reached.

DEFINING HARM TO SELF

The Compassionate Intervention Act casts a wide net.

The criteria for assessing the risk of **harm to self is overly board and not sufficiently constrained**.

- **“Negative impacts on health, employment, or relationships”** can mean different things to different people.
- **“Inability to meet daily needs”** can occur separate from substance use, especially preceding it. This risks punishing poverty when broader life circumstances are not considered.
- **“Any other prescribed factor”** authorizes significant discretionary power in addition to the broad criteria.

DEFINING HARM TO OTHERS

And it has targets.

Likelihood to cause harm to others **targets caregivers and anyone posing a risk to community safety** in addition to "any other prescribed factor."

In committee, an amendment was introduced to include domestic violence and impaired driving as risk factors for assessing harm to others. This amendment was defeated.

Targeting these categories of people directly, without offering a fuller list of possible substance use harms signals who legislators imagined will be subjects of compassionate intervention.

- For caregivers unable to provide care, questions arise **concerning the apprehension of both the caregiver and the child**, sent to separate places.
- For those posing a risk to community safety, this **targets the most visible of people who use substances, the unhoused**, since those who can use in private residences are less likely to be seen as impacting community safety.
- Given the known overrepresentation in these groups, **compassionate intervention is likely to disproportionately target Indigenous people, particularly caregivers and the unhoused.**

BOARD DECISION-MAKING AND STANDARD OF PROOF

Decisions of the Compassionate Intervention Board are made **by majority vote** and not unanimously. A proper alternative to the removal of personal liberties would require **unanimous decision**.

The standard of proof for “likelihood to cause harm” is set to **a balance of probabilities**, meaning – *more likely than not* to cause harm. This bar is low – especially when considered along side broad factors defining harm. **Beyond a reasonable** doubt was suggested as the proper standard of proof when removing personal liberties.

Both unanimous decisions and beyond a reasonable doubt were brought forward as amendments and were defeated in committee.

APPREHENSION POWERS

The proposed process can be initiated through a peace officer **with or without a warrant**.

Given that the threshold for intervention includes severe substance use disorder with reference to comorbid medical conditions and concerns regarding capacity, questions remain about how such assessments will be applied in practice:

- **How can apprehension powers be applied consistently?**
- **How will immediate medical needs be assessed at apprehension,** especially in cases where withdrawal can be fatal (i.e. alcohol and benzodiazepines)?

Under section 6-2, the officer in charge can the transfer of apprehension powers *to any person* following a patient's departure from a compassionate intervention facility and does not require a warrant. **"Any person" without a warrant is dangerously inappropriate for apprehension powers that require specialized training.**

In committee, an amendment was introduced to remove this subclause, and it was defeated.

INDIGENOUS REPRESENTATION

One member of the Compassionate Intervention Board must be of Indigenous ancestry, however:

- The Board's decisions by majority vote and not by consensus, has the potential to **limit Indigenous representation and decision-making.**
- The Indigenous member is **not required on hearing or review panels**.

The Act does **not** offer:

- Protections for cultural programming
- Duty to consult or otherwise engage elected First Nations leadership.

In committee, amendments were introduced to require the Indigenous board member on decision-making panels for Indigenous patients and to offer Indigenous programming as a service delivery option. Both were defeated.

RIGHTS & REPRESENTATION

The Act promises access to legal counsel for patients.

- The registrar will compile **a list of all lawyers** in Saskatchewan. Those who do not wish to be on this list, can ask that their name be removed.
- Legal representation may be **limited for patients deemed to lack capacity**.
- Should legal counsel withdraw or be unable to represent the patient, the registrar ***may*** **(not must or shall) reappoint counsel**.

Taken together, legal representation could be limited for patients.

In committee, an amendment was introduced to require continuity of legal representation should a lawyer withdraw. This amendment was defeated.

TRANSPARENCY & ACCOUNTABILITY

Though facilities are subject to inspection, there are **no required timelines** in the Act.

There is also **no mandate on the reporting of aggregate data,** which will make implementation challenging to evaluate and accountability challenging to enforce.

In committee, amendments were introduced to require yearly facility inspections in addition to public reporting provisions. These amendments were defeated.

The Compassionate Intervention Act passed on May 5, 2026.
See: Legislation Passes for Compassionate Intervention for Additions Treatment

Recent Position Statements

The First Nations Health Ombudsperson Office: *FNHOO Finds Systemic Failure in Saskatchewan's Compassionate Intervention Act*

Joint SMA/CPSS Statement on the Compassionate Intervention Act

Canadian Society of Addiction Medicine Position Statement on Involuntary Treatment

John Howard Society's Joint Statement on The Compassionate Intervention Act and the state of voluntary care in Saskatchewan

Moms Stop The Harm Involuntary Care Position Statement