Policy Brief: Addressing Involuntary Treatment for Substance Use in Saskatchewan

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Overview

Saskatchewan is facing increasing pressure to respond to the harms associated with substance use, particularly related to opioids and stimulants. Recent discussions in the three Canadian provinces of Alberta, British Columbia, and New Brunswick have addressed the possibility of involuntary treatment[1] for substance use. Involuntary treatment, enacted through medical assessment or court order has been utilized in Canada for mental health related concerns, but this is the first time such legislation has directly addressed substance use. Involuntary treatment for substance use is not supported by research evidence or expert opinion, these sources instead suggest the approach will not effectively address the root causes of substance use, such as trauma, poverty, and lack of access to care.

This document summarizes the **legislative approaches** of Alberta, British Columbia and New Brunswick to inform the discussion in Saskatchewan. The document then outlines current **substance use harms in Saskatchewan** and **evidence-based approaches to substance use treatment** are described. **Four policy options for Saskatchewan**, based on comparative provincial approaches and the summary of research evidence, are then provided. The document concludes with a **policy recommendation for Saskatchewan**.

Three key documents are appended to this brief for decisionmaker review:

1. Canadian Centre on Substance Use and Addiction (2025) Involuntary Treatment Evidence Brief.
2. Cattapan & McKenzie (2025, June preprint). Involuntary treatment legislation in Canada: Implications for pregnant people and parents. International Journal of Feminist Approaches to Bioethics.
3. National Mental Health and Substance Use Health Standardization Collective (2024). The mental health and substance use health standardization roadmap. Standards Council of Canada.

Item 1 provides a national-level overview of evidence regarding involuntary treatment for severe substance use disorders. Item 2 provides a legislative summary beyond that presented in the current brief with a focus on implications for specific population of pregnant people and parents. Item 3 provides a roadmap for decisionmakers to implement standardization across the substance use and mental health treatment systems in Canada.

[1] Involuntary Treatment is the term used in this brief to summarize the process of an individual being taken for involuntary assessment and admission to a health facility. This aligns with the stages of involuntary examination and admission as provided in Saskatchewan's Mental Health Services Act. Involuntary medical treatments, resulting from admission to a facility, should be governed by appropriate medical health regulatory bodies and not described in legislation.

Legislative Approaches: Three Cases (Alberta, British Columbia, New Brunswick)

Each province proposed distinct approaches to this topic. All refer to this approach as involuntary treatment.

1. Alberta

The Compassionate Intervention Act (Bill 53), passed May 2025, allows for involuntary treatment for individuals deemed a danger to themselves or others due to substance use. The legal framework established by the act aims to provide timely stabilization, assessment, and treatment while balancing individual rights and public safety (Compassionate Intervention Act 2025). The legislation provides for peace officers, family members, or healthcare professionals to apply to detain an individual without consent if they meet criteria for likely harm. Following apprehension individuals undergo assessment by a treatment team and if deemed necessary a care plan order can mandate inpatient or community-based treatment procedures. The legislation also provides a newly established Compassionate Intervention Commission to oversee decisions, including hearings and care plans. The criteria to determine 'likely harm' includes a history of overdose, deterioration in mental or physical health, inability to meet basic needs, or posing a risk to others. The Act includes specific mechanisms for minors, but these may not properly take account of existing youth protection laws.

The Canadian Bar Association – Alberta Branch (CBA-Alberta) raised several concerns about the legislation including use of broad definitions that are vague or non-specific (eg 'substance use' or 'family member'), the potential for the legislation to violate Section 7 rights due to lack of cross-examination and representation, resource strain (looking at existing unmet demand for voluntary services), procedural fairness (detention can extend up to 17 days before hearings), and conflict with existing laws including the Alberta Mental Health Act, Adult Guardian and Trusteeship Act, and Youth Criminal Justice Act. (CBA-Alberta 2025). Full implementation of the Act is anticipated in 2026 following construction of 'compassionate intervention centres' in Edmonton and Calgary (CRNA 2025, Farrell 2025).

2. British Columbia

In March 2025, British Columbia released new clinical guidance (Vigo 2025) authored by Dr. Daniel Vigo, chief scientific adviser for psychiatry, toxic drugs, and concurrent disorders, addressing the use of involuntary treatment under British Columbia's Mental Health Act for individuals with substance use disorders. These updates do not change the legislation itself, but clarify when and how involuntary care may be applied in cases involving concurrent mental health and substance use challenges (Government of British Columbia 2025).

The clinical guidance does not amend British Columbia's Mental Health Act, rather it clarifies existing provisions and corrects misconceptions about involuntary treatment, noting this is legally permitted. However, involuntary treatment may only be considered when substance use is accompanied by mental impairment including; when substance use co-occurs with a diagnosable psychiatric condition, when there is an acute and severe psychiatric syndrome (even if the cause is unknown but includes substance use), and when there is ongoing mental

impairment for an individual following remission from an acute state if the individual is unable to care for themselves. Importantly the clinical guidance emphasizes that risky decision-making alone (such as using drugs in dangerous ways) is not grounds for mandated treatment unless this behavior stems from mental impairment.

The guidance released is intended to address a growing concern about a small segment of the population who experience overlapping mental health concerns, substance use disorder, and brain injury from repeat overdose events since this may render the individual unable to make decisions about health care or if they pose a risk to themselves or others. The guidance emphasizes clinical judgement, the protection of rights, and the need for appropriate supports. Overall reinforcing a narrow and cautious approach to involuntary treatment.

Two treatment facilities are opening for involuntary treatment, one for individuals in contact with the justice system at the South Fraser Pretrial Centre and the other for individuals external to the justice system in Maple Ridge.

3. New Brunswick

In 2024 Premier Blaine Higgs' Progressive Conservative government announced their intention to put forward Compassionate Intervention Act legislation, stated to be similar to the province of Alberta, and aiming for implementation in the spring of 2025. Media coverage noted leadership would consider use of the notwithstanding clause to avoid charter challenges to the legislation (Poitras 2024). However, this legislation was never tabled. The Liberal Party, with Susan Holt as Premier, won the fall 2024 election by a wide margin. Since the election there has been no movement regarding involuntary treatment.

Substance Use Harms in Saskatchewan

The current state of knowledge about substance use harms in Saskatchewan is limited but the impacts of substance use (SU) are a province-wide concern, costing 1.8 billion in 2020 when taking account of lost productivity, health care, criminal justice, and other direct costs (CSUCH, 2020). Saskatchewan is among the top provinces for impaired driving, with 539 incidents per 100,000 population, significantly higher than the national rate of 228 incidents (Statistics Canada, 2021). Alcohol was the primary driver (59%) of hospitalizations related to substance use in 2021-22 (CIHI, 2022) and 2.1% of all hospitalizations in 2022-23 are attributed to substance use disorders, the seventh of the top ten reasons for hospitalization in Saskatchewan (CIHI, 2024). Additionally, Saskatchewan's new HIV infections, 19.4 per 100,000 people, far surpass the national rate of 6.1 (PHAC, 2024) and the primary means (62%) of transmission in 2020 was related to intravenous drug use, with Indigenous people over-represented in this data (Challacombe, 2025). Data gleaned from the Canadian Wastewater Survey indicates that methamphetamine and amphetamine use levels are consistently higher in the prairie cities than other participating cities, with Prince Albert having the highest average levels in 2022 and 2023 (Statistics Canada, 2023).

Saskatchewan's health care system, defined as health service sites operated by the Saskatchewan Health Authority (SHA), is strained (Smith 2024). Services related to substance use are often focused only on acute care needs and are often over-capacity, operating with long waitlists and gaps in support when patients transition between services, such as moving from withdrawal management to treatment admission (Maess 2022). Additionally, the scope of services and support available through the SHA are also limited, failing to meet the stated needs of people who use substances (PHR 2021) or to take account of additional challenges related to broader social determinants of health like housing or food security (SCAA 2020). Despite these barriers, the budget percentage to support mental health and addiction services (MH&A) has remained between 7.3% and 7.8% of the total health budget since 2021 (See Table 1 below). The Canadian Mental Health Association recommends 12% of provincial and federal health budgets be allocated to MH&A services (Lowe et al 2024).

Year	Total Health Budget	MH&A Budget	% of total budget for MH&A	Change from last year
2021-2022	6.12B	458M	7.5%	---
2022-2023	6.44B	470M	7.3%	0.2% decrease
2023-2024	6.867B	518M	7.5%	0.2% increase
2024-2025	7.59B	574M	7.56%	0.06% increase
2025-2026	8.07B	624M	7.79%	0.23% increase

Table 1: MH&A Budget Allocations 2021-2025 (Government of Saskatchewan 2021a, 2021b, 2022a, 2022b, 2023a, 2023b, 2024a, 2024b 2025a, 2025b).

Saskatchewan may be seeing a greater manifestation of substance use related harms in 2025, but this development has a longer trajectory. Following a year-long consultation with multiple communities and stakeholders across the province, "Working together for change: A 10-year Mental Health and Addictions Action Plan for Saskatchewan" was released in 2014. This 76-page document highlighted systemic gaps and provided responsive approaches to care that could be offered cohesively across the province (Stockdale Winder, 2014). However, very little identifiable action resulted from this document. In the fall of 2023, as the prior plan was coming to a close a new approach was produced unilaterally by the Ministry of Health (Government of Saskatchewan 2023c). The ten-page document included a cover page, a message from the minister, and a broad description of three pillars that aim to support a "recovery-oriented system of care" that focuses on enhancing treatment provision through emphasis on financial investments.

Unfortunately, the new plan appears to misrepresent the phrase 'recovery-oriented system of care' because this terminology is meant to describe a system that provides support beyond acute care models (Davidson et al 2021). The current action plan does not appear to support a

full continuum of care with its strong emphasis on additional acute care treatment beds. Data regarding wait times for admission to withdrawal management or publicly funded treatment facilities is not available, but media reports note admission for withdrawal management support can range from 24 hours to five-days (Vescera 2021) and waitlists for treatment admission range from two-weeks to 45 days (Holowaychuk 2025). Additionally, vital health supports to reduce substance use related harms are no longer funded or have never been provincially funded in Saskatchewan. For example, no funding for supervised consumption services (SCS) has been provided by the province since the first Health Canada exempted site opened in October 2020 (Gagnon 2025), despite strong evidence that supports this evidence-based health service (CCSA 2024, Hyshka et al 2021). More recently, January 18, 2024, existing provincial funding for harm reduction supplies and supply distribution costs were removed across the province (Langager 2024) inducing additional risk for people who use substances (Strike et al 2021, CATIE 2024). Saskatchewan also returned to a 1-for-1 needle exchange approach; this is an outdated model shown to be ineffective at reducing the spread of bloodborne infection (CATIE 2024).

Drug toxicity deaths (confirmed & suspected) have been growing in Saskatchewan since 2017, with a slight decrease in 2024 from the record-breaking number in 2023. As of August, it appears 2025 will be another devastating year for the province (See Table 2: Confirmed & Suspected Drug Toxicity Deaths by Manner of Death, 2016 – 2025).

Confirmed & Suspected Drug Toxicity Deaths by Manner of Death, 2016 - 2025											
		2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Confirmed Cases	Accident	92	95	139	155	306	383	335	420	277	89
	Suicide	13	16	27	21	18	16	25	22	15	6
	Homicide	--	--	--	--	--	--	--	--	--	--
	Undetermined	4	8	6	4	1	8	3	4	1	1
Suspected Cases	Suspected	0	0	0	0	0	0	2*	10*	49*	114*
	Total	109	119	172	180	325	407	365	456	342	210

Table 2: Confirmed & Suspected Drug Toxicity Deaths by Manner of Death, 2016 – 2025. Last updated July 31, 2025. (Saskatchewan Coroners Service 2025).

Deaths and additional harms (e.g. acquired brain injury) reflect a lack of resources to address substance use directly, with SHA facilities and community-based organizations routinely overcapacity, but these harms are further exacerbated by a shortage of resources in other sectors including housing/shelter, food security, and mental health support among others (Lin et al 2024). Many people who use substances are hesitant to access support, even when available, due to perceptions of stigma (PHAC, 2019). This means, many people who use substances often begin their journey to care through the support services provided by community-based organizations (CBOs). CBOs facilitate enhanced engagement and referral to the formal health care system (Bartlett 2013, Wilson et al 2012, De Maeyer 2009). CBOs also provide enhanced reach across marginalized communities and advocate for services beyond addressing substance use, connecting individuals with housing, food, or employment to support immediate quality of life improvements (Alegria 2023, Russell et al 2021, Palis et al 2020, Ormond et al 2019).

Evidence-Based Approaches to Substance use Treatment

What is meant by the term 'treatment' regarding substance use disorder, or for those experiencing substance use related harm, can vary widely. Treatment, for substance use disorders, is a broad term that may encompass multiple approaches. Many supports or services can be classified as 'treatment' including rapid access models, residential or community program models, gender specific and integrated models, medication-assisted therapies, and more (CCSA 2020, CAMH 2021, Johnstone 2023, Health Canada 2024). Some of the first supports available to people who use substances came from peers, or people with lived/living experience of use, in the form of mutual aid support groups like Alcoholics Anonymous. Over time, additional research and policy advocacy has resulted in knowing more about what treatment 'should mean' in Canada. This is articulated through guidance and framework documents like the National Treatment Strategy (CCSA 2008) and National Treatment Indicators (CCSA 2021) to improve data collection and inform the development of services and supports. It was only in June 2023, that National Standards for Mental Health and Addictions Services (HSO 2023) in Canada were released. Implementation of these standards will take time. In October 2024, The Mental Health and Substance Use Health Standardization Roadmap, supported by the Standards Council of Canada, was also released, providing clear steps for appropriate systems implementation of standards (NMHSUHSC 2024).

This diversity in what treatment means has also made the study of voluntary and involuntary treatment challenging for researchers. The Canadian Journal of Addiction published a comprehensive synthesis of evidence "to inform the effectiveness of involuntary treatment for persons with substance use disorders" (Bahji et al 2023 p.13) that included 42 studies. Of these studies, only 22 compared involuntary and voluntary treatment, with 10 reporting negative outcomes, 7 reporting improvement (but this was largely in treatment retention), and five reporting nonsignificant findings. The authors note "the overall data neither supports nor is against involuntary treatment" calling for more research to be done, since the quality of evidence is lacking; "the treatments for 31 of the 42 studies were either not evidence-based or simply poorly defined, it is impossible to meaningfully interpret the relationship between the reported outcomes and the fact that the treatments were involuntarily provided" (Bahji et al 2023 p.14).

There is no single standard pathway in the Canadian health system for the treatment of a substance use disorder. Instead, treatment for substance use disorder means trained health practitioners take account of individual factors, and tiers and types of health support available in the treatment of substance use disorder. Most people will navigate various tiers and types of support based on factors that are underlying their substance use (CCSA 2008, CCSA 2013). (See Appendix A: Factors, Tiers, and Types – Informing Substance Use Treatment for additional detail). The most important idea to retain when thinking about 'treatment' is the diversity and range of approaches this term may encompass for health practitioners. This is why emphasis on involuntary assessment and admission parameters can be a legislative question, but treatment practices must remain with professional health practitioners and their regulatory bodies.

Four Policy Options for Saskatchewan

1. No Change

In this option, no changes are enacted, and current trends are likely to continue.

Pros:

- Avoids ethical and legal concerns around coercion.
- Maintains focus on voluntary treatment and recovery-oriented care.

Cons:

- May be perceived as insufficient in addressing growing acute health and public safety concerns.
- Existing barriers to care remain or worsen over time.

2. Enhanced Funding and Access to Voluntary Services in Saskatchewan

In this option, the province increases direct funding for publicly run mental health and addictions services, moving beyond the 7.5 - 7.8% annual health budget allocation and attains the 12% recommended by the Canadian Mental Health Association. This increase could be distributed across the continuum of care in the Saskatchewan Health Authority (SHA) to prioritize primary care screening and early intervention activities, reduce waitlists for withdrawal management and treatment admission, reinstate funding for harm reduction supplies and supply distribution programs in the SHA and at partner CBOs to alleviate secondary harms from substance use, and provide outreach and system navigation supports before an individual experiences severe or debilitating harms. The approach exemplifies a health focused approach to addressing substance use harms.

Pros:

- Aligns with evidence-based practices and public health recommendations.
- Addresses systemic barriers to care, especially in underserved communities.
- Respects individual autonomy and promotes long-term recovery.

Cons:

- Requires sustained investment and coordination across sectors.
- May not immediately alleviate crisis for individuals at high-risk.

3. Utilize Existing Legislation for Involuntary Substance Use Treatment in Saskatchewan

In this option, Saskatchewan decisionmakers would utilize Saskatchewan's Mental Health Services Act to inform health practitioner guidance to implement involuntary treatment for substance use. Following the approach of British Columbia, health leadership could develop a new guidance document providing interpretation that guides the application of the Act to concerns regarding substance use disorder.

Pros:

- Clarifies existing mechanisms to intervene in high-risk cases.
- May appeal to public concerns about safety and visible substance use.
- Builds on established frameworks for involuntary intervention and aligns with existing legislative frameworks.

Cons:

- Evidence shows mixed or negative outcomes from involuntary treatment.
- Risks undermining trust in health systems and health providers.
- May divert resources from voluntary services that are more effective.

4. Enact New Legislation for Involuntary Substance Use Treatment in Saskatchewan

In this option, Saskatchewan decisionmakers would develop and implement new and specific legislation to enable involuntary treatment for substance use. Following the approach of Alberta, elected leadership could introduce legislation similar to the Compassionate Intervention Act discussed above.

Pros:

- Offers additional mechanisms to intervene in high-risk cases.
- May appeal to public concerns about safety and visible substance use.

Cons:

- Evidence shows mixed or negative outcomes from involuntary treatment.
- Scope of legislation is not well defined and may be subject to court challenges.
- Risks undermining trust in health systems and violating individual rights.
- May divert resources from voluntary services that are more effective.

Policy Recommendation for Saskatchewan

Option 2: Enhanced Funding and Access to Voluntary Services in Saskatchewan is the preferred policy direction. It aligns with evidence-based practices in public health, addresses the root causes of substance use, and respects individual autonomy. While involuntary treatment may seem appealing in crisis scenarios, this approach lacks robust evidence of effectiveness and poses significant ethical concerns. Increasing overall funding to substance use related health services and reinstating funding for the reduction of substance use harms (supply provision and distribution) best facilitates a Recovery-Oriented System of Care in Saskatchewan.

If policymakers pursue involuntary treatment, the stronger pathway is option 3 for Saskatchewan. Following the approach of British Columbia, issuing guidance to health professionals regarding how involuntary treatment for substance use may be enacted under the Mental Health Services Act is the most straightforward option with less potential drawbacks. Any newly proposed legislation should avoid the pitfalls of Alberta's approach and include clear parameters regarding due process, defined language, procedural direction, time limitations and requirements, and routes of appeal.

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Appendix A:

Factors, Tiers, and Types -Informing Substance Use Treatment[2]

Factors informing individual pathways often include experiences of acute harms (e.g. injury resulting from intoxication), chronic harms (e.g. repeat absences from work, liver disease, family conflicts), or complex harms (e.g. social factors like housing status, mental health concerns, or trauma). Often in health care system terminology, the word 'complex' is used to describe situations that have more than one factor causing or influencing ill health.

Tiers of service and support options can be grouped into five categories. However, most people will move between different tiers during their treatment journey. Each tier provides a differing level of support (often medical services) that an individual may need to assist their health outcomes.

- **Tier 5** provides the most intensive and specialized services available. Often provided in a hospital or other institutional environment and addresses only the most complex and chronic care needs for an individual. A team of trained medical professionals would typically provide these services.

- **Tier 4** provides intensive and specialized services including structured residential environments and specific mental health support services. There is ongoing case management, structured treatment planning with a care provider, and intensive day programming engaged at this level of care. This tier also includes targeted services in hospitals, shelters, or correctional facilities.

- **Tier 3** provides structured support services targeting people who are at risk of secondary harms due to substance use (e.g. contracting HIV). These services can provide access to higher tiers as needed, and often assist with managing additional health concerns or navigating additional health services. General outpatient counselling may be available at this tier of service and home-based withdrawal management guidance could be provided as well. Needle exchange or distribution programs, along with medication assisted therapy programs (methadone or suboxone) are examples of tier 3 services.

- **Tier 2** provides early identification and intervention for those who are at risk of harms or are experiencing harms from substance use. These services are typically open to everyone and may include screening and referral for other service tiers. Employee assistance programs, family doctors, or community-based programs for mental health and substance use support would all be good examples of this tier.

[2] This material is synthesized from documents produced by the Canadian Centre on Substance use and Addiction in 2008 and 2013. Citations are provided in the policy brief reference list.

- **Tier 1** provides community-based services that are open to everyone and may provide referral to higher tiers of service. Health promotion or prevention programs would be grouped into this tier. This tier could also include education programs in schools, or websites providing substance use information. Peer support groups and books to facilitate self-directed change are also part of this tier.

Types of treatment can be provided across multiple tiers. For example, peer support is available to anyone and is generally considered a tier 1 support, but peer groups are also often offered as part of tier 4 residential environments. Additionally, individual counselling supports could be engaged in alignment with any tier of service, as part of a medical facility or in the general community. There are generally six types of support that encompass a range of services available in multiple tiers. These common types include:

- **Medical Withdrawal Management** - This is a medically supervised approach to reducing the use of a substance where the individual is monitored for changes in health status throughout the withdrawal process and supported for additional medical needs that arise. This approach often includes medications and/or psycho-social supports to safely reduce the individual's physical (and/or psychological and social) dependence on a substance of use. This approach is usually completed in a medical setting with trained practitioners of various health backgrounds including doctors, nurses, social workers, addictions counsellors, paramedics, or psychologists. Sometimes this is called 'detox' in popular culture, but the preferred terminology is now 'medical withdrawal management.' The term 'withdrawal management' is also used. This generally means the same as above, but without intensive medically-based monitoring of the individual. Sometimes it is safe for an individual to engage community-based or home-based withdrawal management. The decision about what type of withdrawal management is best for an individual should be made with the support of a trained practitioner.

- **Bed-Based Treatment** - This is the creation of a community and environment where individuals can address substance use through various program and service options. These programs are often highly structured and are scheduled to provide daily program engagements through a set a routine for participants. Bed-based treatment (also sometimes called residential treatment or in-patient treatment) can vary in length from a few days to over a year, depending on the program. There are also 'outpatient' or 'day-based' treatment programs (also known as 'day programs') that operate according to a similarly structured daily schedule, but those in the treatment program return to their home environment each evening.

- **Group Counselling and Therapy** - This is an approach to providing support that is often part of treatment programming, whether a program is bed-based, outpatient, or in the community. Groups are usually facilitated by a trained health professional like a social worker or psychologist and aim to assist participating individuals with defining and reaching their treatment goals. There are many models or types of group therapy or

counselling that may be engaged according to practitioner expertise and group focus aims.

- **Individual Counselling and Therapy** - This is an approach to providing support that is often part of treatment programming, whether a program is bed-based, outpatient, or in the community. Individuals are supported by trained health professionals, like therapists or counsellors and the aim is to assist individuals with defining and reaching their treatment goals. Individual sessions are usually facilitated for approximately one-hour per week or the schedule is determined according to individual need. There are many types of counselling and therapy that may be engaged according to practitioner expertise and participant need.

- **Mutual Aid** - This is an approach that provides a supportive environment and social network for people seeking to change substance use patterns or behaviours. This might also be described as peer support. People belonging to these groups seek to support each other by sharing experiences and wisdom gained in those experiences. The majority of the time an individual does not need to be engaging a formal or professional treatment program to join a mutual aid/peer support group. These groups are usually open to anyone who would like to change their relationship with a substance of use. Mutual aid may be part of bed-based, outpatient, or community-based support systems. These groups often serve an important role in bed-based treatment after-care and in transitions to community-based supports from institutional settings. They may also be the first point of contact for an individual seeking to engage additional tiers of care.

- **Self-Directed Change** - This approach is about an individual enacting an intentional change in their life and may encompass a range of tools and resources that assist or support that individual to make the identified change in their own life. This approach may be successful for individuals who have access to the tools and skills suited to the changes they desire in their life. However, it is important to emphasize that the majority of individuals who are enacting a self-directed change will still seek out external supports for guidance on making and sustaining the changes they have identified.

These factors, tiers, and types are all important elements in substance use treatment planning and program delivery. The elements mentioned here are also not an exhaustive list.