BILL 48:
THE COMPASSIONATE INTERVENTION ACT FOR SUBSTANCE USE DISORDER

April 2026

This slide deck provides an overview of Saskatchewan's Bill 30-48. Any analysis of the bill is that of the authors and does not represent the views of any affiliated institutions or organizations.

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BACKGROUND

The sustained rise in toxic drug harms affecting individuals, families, communities as well as health and emergency services is a pressing and contentious public policy issue. The province of Saskatchewan is no different.

Honourable Lori Carr, Minister of Mental Health and Addictions, introduced Bill 48: The Compassionate Intervention Act on December 5, 2025. The second reading commenced on March 2, 2026.

Bill 48 proposes a **substance-use–specific law for adults** that includes:

- The establishment of a **Compassionate Intervention Board** with the authority to mandate both in-patient and out-patient **recovery orders**
- Expanded **apprehension and detention powers**
- Risk assessments on **likelihood to cause harm** based on a **balance of probabilities**
- Decision-making **capacity assessments** and substitute decision-making provisions

BILL 48 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*

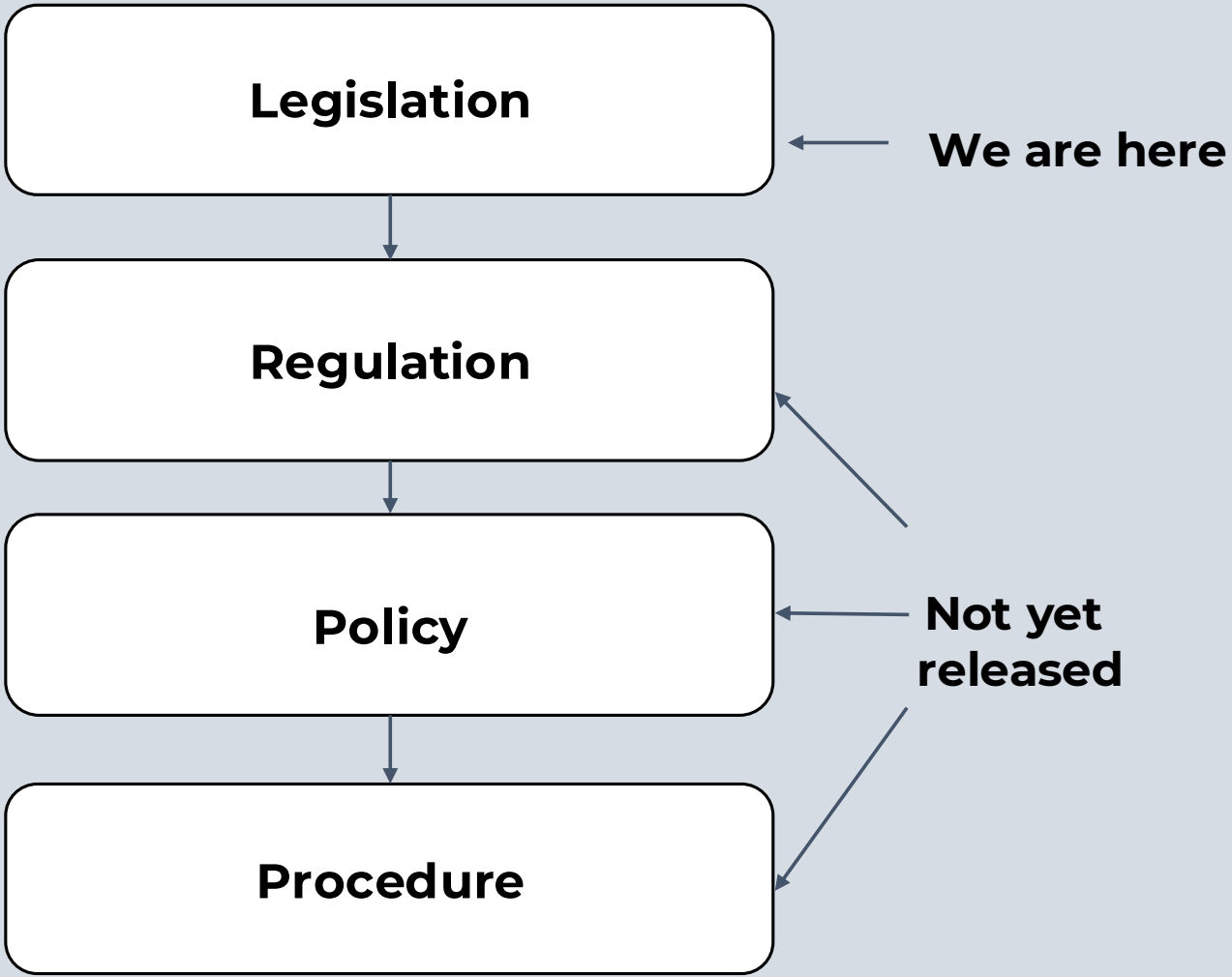
THRESHOLD FOR APPREHENSION & INTERVENTION

(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.

Ministry-Appointed **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

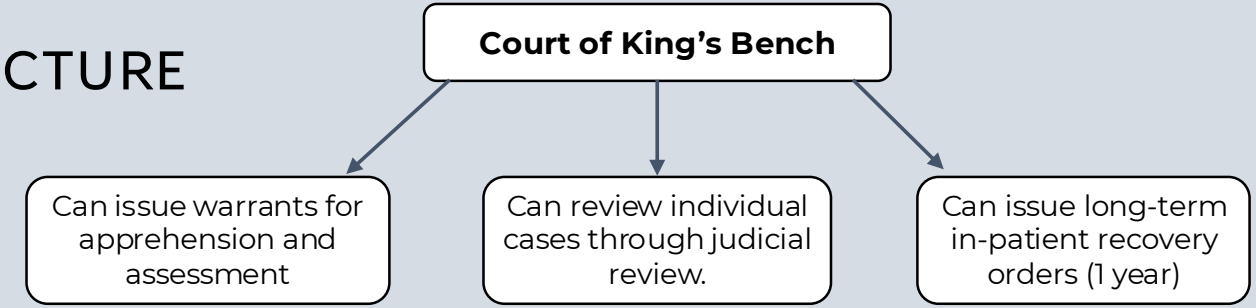
Health Director Appointed **OFFICER-IN-CHARGE (OIC)**

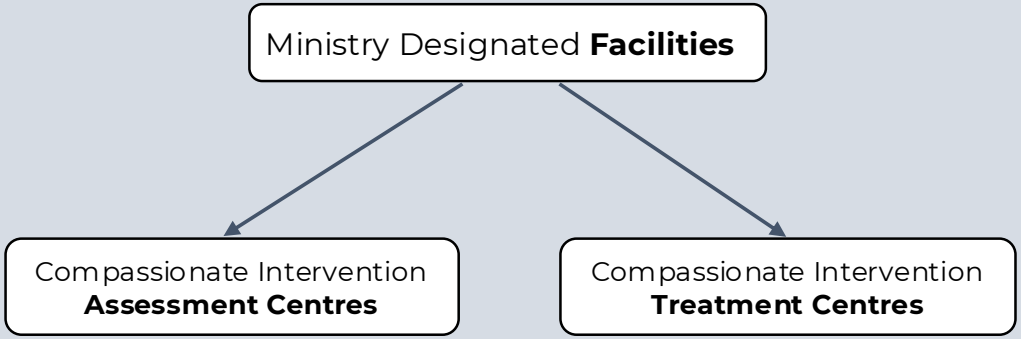
- One per centre, designated by the Health Director
- Oversees the administration of the Act within a designated centre
- Can recommend application to the Court for long-term order

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

OPERATIONAL STRUCTURE





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

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

PROCESS & PROCEDURE

Click here for the Flow Chart

SEVERE SUBSTANCE USE DISORDER

Subjects under Bill 48 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 bill.

The bill 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 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 assessment timeline and criteria are not clear within the bill.

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

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 bill 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 bill 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. However, patient relocations cannot be reviewed or appealed.
- Apply to the **Court of King's Bench for judicial review.**
- Access **legal counsel at no cost,** however timelines for lawyer–client contact are not defined, and 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.

FURTHER ANALYSIS

THE MENTAL HEALTH ACT V. COMPASSIONATE INTERVENTION

	Mental Health Services Act	Compassionate Intervention Act
Voluntary Treatment Access	Protected	Not protected
Service Delivery	Public	Possibly private or mixed
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. “Reasonably necessary” information can be shared.

PUBLIC V. PRIVATE SERVICE DELIVERY

Addiction treatment services currently involves **variable regulation with some 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 likely relies on some measure of **private sector service delivery**, raising questions about **the flow of public dollars**.

The ROSC framework (based on what is occurring in Alberta) involves large public investment with **likely low returns** on compassionate intervention specifically, if returns are clinical outcomes - given the lack of supporting evidence for involuntary treatment over voluntary treatment.

Concerns arise for **underfunding the public system** to protect or bolster private investments.

It is also unclear how **personal health data** will be handled by private service delivery providers.

DEFINING HARM

Bill 48 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 operating under the proposed Act.
- **“Inability to meet daily needs”** is also a challenge that can occur separate from substance use, especially preceding it, and 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

Bill 48 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.”

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

- 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, we expect this to **disproportionately target 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, **this bill 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.

DEFINING CLINICAL ROLES

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

The bill 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 oversight and a code of ethics. **Without this safeguard established in the law, compassionate intervention as a practice is at risk of not being properly monitored or held against ethical considerations.**

APPREHENSION POWERS

The proposed compassionate intervention process can be initiated through a peace officer or a police 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.**

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**.

Bill 48 does **not** offer:

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

RIGHTS & REPRESENTATION

Bill 48 promises access to legal counsel for patients. It is questionable whether the bill's design can reliably provide timely and meaningful access to counsel:

- 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) reappoint counsel**.

Taken together, legal representation could be quite limited for patients.

TRANSPARENCY & ACCOUNTABILITY

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

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

CONCLUSION

- Bill 48, the *Compassionate Intervention Act* is not like the *Mental Health Services Act*.
- Access to voluntary service is not protected.
- The omission of regulated professions in the legislation itself is concerning.
- With broad factors defining the likelihood to care harm, inconsistent application of the *Act* is a key implementation risk.
- It will disproportionately impact Indigenous people, caregivers and the unhoused.
- Indigenous representation is weak, possibly inconsequential.
- Legal representation may be limited for those who are deemed to lack capacity and doesn't appear to be guaranteed if a lawyer withdraws.
- Apprehension can be inappropriately granted to *any person with or without a warrant* if a patient leaves a treatment facility.
- The potential for private sector delivery raises concerns for the flow of public dollars, the underfunding of the public system, conditions in facilities, and data and privacy practices.
- The lack of mechanisms to report on and evaluate compassionate intervention, when implemented, flags concern for transparency and accountability

UPDATES

Bill Status

As of March 2, Bill 48 has entered the second reading. MLA Betty Nippi-Albright is set to respond, though the exact date is to be determined.

Recent Position Statements

Joint SMA/CPSS Statement on the Compassionate Intervention Act

Canadian Society of Addiction Medicine Position Statement on Involuntary Treatment