A Canadian Centre of Recovery Excellence Policy Whitepaper

Effective and Compassionate Intervention: Civil Commitment for Individuals with Severe Addiction in Alberta, Canada

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Day N[1], Bahji A[2], Tanguay R[3] and Adair CE[4]

1. Chief Scientific Officer, Canadian Centre of Recovery Excellence; Medical Director of Addiction, Recovery Alberta; Clinical lecturer, Faculty of Medicine and Dentistry, University of Alberta

2. Clinical Assistant Professor, Department of Psychiatry, University of Calgary; Psychiatrist, Addiction & Mental Health; PhD Candidate, Department of Community Health Sciences, University of Calgary.

3. Clinical Assistant Professor, Cumming School of Medicine, University of Calgary, Departments of Psychiatry and Surgery, Hotchkiss Brain Institute & Mathison Centre for Mental Health

4. Senior Scientist, MSc, PhD, Canadian Centre of Recovery Excellence; Department of Psychiatry, University of Calgary, Calgary, Alberta; Department of Community Health Sciences, University of Calgary, Calgary, Alberta

Key Messages

- **Urgent Need for Compassionate Intervention:** Severe addiction poses significant risks to individuals and society, with many unable to engage in voluntary treatment. Compassionate Intervention offers a structured, evidence-informed approach to assist those at high risk of harm.
- **Evidence Limitations and Opportunity for Leadership:** Existing research on civil commitment for addiction is of low quality, lacking robust comparison groups and randomized controlled trials. Alberta has a unique opportunity to lead globally by implementing and rigorously evaluating a best-in-class model applying learnings from other jurisdictions.
- **Effectiveness of Mandated Treatment Models:** Evidence from safety-sensitive occupations (e.g., physicians, pilots) shows high success rates for mandated treatment programs, highlighting the potential of structured interventions combined with long-term monitoring and aftercare.
- **Comprehensive and Evidence-Based Approach Required:** Effective Compassionate Intervention requires longer inpatient stays, use of long-acting medications, structured aftercare, evidence informed treatments like cognitive behavioural therapy, motivation enhancement therapy and contingency management, emphasizing dignity-centered and recovery-oriented care.
- **Highly Coordinated and Strategic Operations:** Effective and patient focused Compassionate Intervention will require strong collaboration and coordination between the mandated services and community-based recovery programs, Recovery Alberta addiction services and Recovery Alberta mental illness treatment programs. Additional coordination with legal decision makers for those who have lost capacity and proper long-term placement for individuals needing that level of care will be necessary.
- **Legal, Ethical, and Political Considerations:** Implementing Compassionate Intervention raises complex legal and ethical questions, including civil liberties, autonomy, and human rights. Transparent legal frameworks, procedural fairness, and robust ethical oversight are essential for public acceptance.
- **Strategic Recommendations for Alberta:** Alberta is well-positioned to implement Compassionate Intervention within its Recovery Oriented System of Care (ROSC), leveraging existing infrastructure and expertise. Rigorous scientific evaluation and stakeholder engagement are crucial to ensure policy effectiveness and social acceptance.

Executive Summary

Effective and Compassionate Intervention: Civil Commitment for Individuals with Severe Addiction in Alberta, Canada

Severe addiction is a complex condition that imposes significant personal, societal, and financial burdens. While many achieve recovery, others do not engage in voluntary treatment despite facing life-threatening consequences. In the context of substance use disorders, or addiction, civil commitment is a legislated process that mandates treatment for individuals who have severe addiction and are at high risk of harm. Civil commitment policies and practices vary widely even in other jurisdictions such as the US, Australia, and Europe and outcomes remain understudied. Civil commitment represents a potential avenue for intervention in cases where individuals pose a danger to themselves or others.

This policy white paper was developed by the Canadian Centre of Recovery Excellence (CoRE) following its creation in summer 2024, at the request of Alberta's Ministry of Mental Health and Addiction as part of the government's 2023 campaign commitment to introduce a made-in-Alberta Compassionate Intervention policy building off learnings from other jurisdictions. This white paper examines the potential role within Alberta's addiction treatment landscape of a best-in-class version of civil commitment, called Compassionate Intervention. The analysis incorporates a systematic literature review of civil commitment programs across comparable jurisdictions, in comparison with another mandated treatment model used in safety-sensitive occupations and insights from the addiction treatment literature.

Key findings include:

- **Effectiveness of Mandated Treatment:** Mandated treatment programs for professionals (e.g., nurses, pilots, physicians) demonstrate high success rates, with up to 90% completion, long-term abstinence and, high levels of return to work. Core components contributing to success include comprehensive assessment, intensive treatment, long-term monitoring, and structured aftercare.
- **Civil Commitment Literature Review:** The available research on civil commitment for addiction is of low quality, with no studies using an appropriate comparison group and no randomized controlled trials. However, key insights suggest that treatment duration and quality significantly impact outcomes. Short-term stays of less than one month appear ineffective, while structured, longer-term interventions may have benefits.
- **Treatment Approaches:** Evidence-based addiction treatments—including opioid agonist treatment, structured aftercare, mutual support, cognitive behavioural therapy, motivation enhancement therapy and contingency management—can enhance civil commitment models. Procedural fairness and a healthcare-centered approach improve engagement and perceptions of legitimacy.

Policy Recommendations:

1. **Extended Treatment Duration** – Civil commitment should incorporate longer inpatient stays based on individual need.
2. **Leverage Empirically Proven Long-Acting Medications** – Ensure access to long-acting opioid agonist treatments and other appropriate addiction treatment medications.
3. **Social Reintegration and Mutual Support** – Wherever possible and appropriate, incorporate evidence-based vocational interventions, structured return-to-work, and recovery-oriented peer mentorship, including structured mutual support participation.

4. **Structured Aftercare** – Programs should include the ability to offer assertive follow-up, evidence informed treatments including cognitive behavioural therapy, motivation enhancement therapy, and relapse prevention strategies, using contingency management principles.
5. **Anticipate Individuals with Permanent Cognitive Impairment** – Programs should anticipate a number of people with permanent severe cognitive impairments who may require ongoing structured supports on discharge from civil commitment.
6. **Anticipate Individuals with Severe Mental Illness** – Programs should anticipate a number of people with concurrent severe mental illness. Programs will require the ability to assess and treat these individuals and must coordinate with the broader mental health system to ensure appropriate aftercare, including the use of mental health community treatment orders on release.
7. **Dignity-Centered Recovery Approach** – Civil commitment should be framed as a healthcare intervention, emphasizing procedural fairness and recovery-oriented messaging. Dignity protecting appeals and review mechanisms will likely improve program and patient outcomes.
8. **Robust Scientific Evaluation** – Alberta should lead in evaluating civil commitment outcomes, with appropriate comparison groups, to assess effectiveness and inform global policy.

Alberta has a unique opportunity to implement a best-in-class civil commitment model, called Compassionate Intervention, which integrates modern addiction science. By adopting a rigorous, evidence-driven approach, Alberta can provide a compassionate, effective response to severe addiction while contributing valuable research to inform recovery-oriented policies around the world.

Introduction

Severe addiction is a complex and debilitating condition that poses grave risks to individuals, their families, and in many cases to others. Addiction has become a dominant social issue across North America.[1] The consequences of untreated addiction carry enormous financial costs.[2] Severe addiction carries substantial personal, family, and societal costs, penetrating far beyond its financial impact. Addiction's destructive power touches the lives of those around the one with the illness, left alone it can spread from generation to generation.

Many people recover from addiction and its consequences.[3, 4] Recovery is a real and profound process that at its heart involves significant changes in perspective and behaviour. Recovery is personal, and those in recovery can flourish with social and emotional support.[5]

While recovery is common and achievable, many other people do not recover and many die while suffering with addiction from overdose and other consequences of drug or alcohol misuse.[6,7] Families often feel helpless as they watch their loved one progress in addiction.[8] Addiction at its heart involves a loss of capacity, or a loss of ability to effect long term change to ameliorate the condition.[9] Addiction left untreated, often consumes the things that matter most to the person afflicted by it: spouse or partner, children, parents, siblings, friends, occupation, social standing, housing, dignity, and life.

In many jurisdictions families and communities have called on governments to legislate the power to intervene. Interventions for people with severe addiction, who have become a danger to themselves, or others have been applied in different ways, in different jurisdictions. Critics of these approaches talk about differences in outcomes between voluntary and involuntary treatment

outcomes, loss of civil liberties, absent medication treatments that could improve outcomes, limited aftercare, and involvement of the criminal justice system rather than the healthcare system in the implementation of the civil commitment response.

Some of these critiques are fair. It appears that voluntary patients seeking treatment may have better outcomes in some circumstances. However, no civil commitment intervention has had robust evaluation comparing conditions as usual (what the individual would receive without intervention) which is in our opinion, the most appropriate comparison group. Furthermore, evidence suggests that people engaged in voluntary treatment are known to be very different from those encountering civil commitment in some important ways.[10] Some civil commitment regimes have not had robust medical management,[10] including the provision of opioid agonist treatments, which are known to reduce all-cause mortality by as much as 50%.[11] It is known that opponents of civil commitment measures have actively discouraged clinician involvement in some jurisdictions, to the detriment of the programs and the people they serve.[12] In some other jurisdictions programs are structured, and individuals detained, in corrections settings.[13] Resources in the addiction treatment space have historically been scarce. It appears that providing short term interventions may not be particularly effective for people with the most severe illness.[13, 14] This finding should surprise no-one. A person with any severe disease is more likely to need more intensive treatments than someone with less severe disease.

While civil commitment could be contemplated as an arm of existing mental health act detainment, there is risk that without robust additional resources, individuals compelled into treatment using the existing mental health act may end up having shorter stays, in mental health focused facilities where treatment spaces are already pressured. Furthermore, many individuals have primary addiction illnesses that will benefit from comprehensive addiction and mental health assessment and treatment.

The civil commitment literature also provides important insights. CoRE reviewed the literature from the last decade to glean insights. The report can be found here. Short term programs appear to not have major benefits in populations with severe addiction who are involuntarily treated.[13, 14] Longer treatment duration is associated with better outcomes.[15-19] People who undergo civil commitment appear to have less psychological distress from the intervention than anticipated, and many appreciate that they were struggling and needed help as the intervention proceeded.[17] Opioid agonist treatments for those with opioid use disorder, and transitional supports are recommended.[20] Longer term, community follow up appears to provide other benefits.[15-17] Alberta can and should learn from these lessons. And, given the state of the literature, areas of significant research interest have remained unexplored.

There is strong literature that shows how robust treatment, with robust aftercare, can be tremendously effective for people who are mandated by their professional bodies to get care or lose their jobs. CoRE completed a rapid literature review on this subject that can be found here. In brief, comprehensive assessment, individualized treatment, longer-term intensive treatment, medication management when appropriate, and robust aftercare appear to provide exceptional outcomes in that population, even though the intervention typically did not start voluntarily.

Currently there are no definitive, randomized controlled trials or other research designs that are sufficiently robust, to definitively guide civil commitment policies. Individuals with addiction, their families, their communities, and society in general are suffering from the consequences of untreated severe addiction. There are potential risks and benefits that may come from effective and compassionate application of civil commitment. Alberta has a meaningful opportunity to learn from other jurisdictions and create the most advanced and comprehensive approach to both the application of civil commitment and its robust and thorough evaluation so that policy makers around the globe can know with unprecedented clarity what benefits and risks come with a compassionate intervention directed towards the renewal of a person's own ability to make rational choices for themselves.

Definition of Civil Commitment for the Alberta Recovery Oriented System of Care (ROSC): Compassionate Intervention

While civil commitment has been applied in different ways, in different jurisdictions, including at a minimum some form of incarceration - with no evidence informed treatments, to apprehension and detention in medicalized environments for limited time frames. For the Alberta context, we define civil commitment as having the following components and can be labelled as Compassionate Intervention:

1. Initial involuntary detainment for stabilization and thorough assessment in an addiction assessment and treatment facility facilitated by legislation separate from the mental health act
2. Determination that the person poses a risk to themselves or others by a commission that is independent of the Government
3. Use of most appropriate evidence informed treatments for the reduction of suffering, reduced relapse rates, and avoidance of overdose on release
4. An individual right to dignity protecting representation, review and appeal
5. Development of a personalized, principled and evidence informed treatment order
6. Appropriate individualized timeframes for treatment with transition from most secure settings to less intense community-based treatments
7. Programmatic ability to transition from involuntary to voluntary treatment pathways when appropriate

Literature Review of Civil Commitment

The Canadian Centre of Recovery Excellence (CoRE) completed, in collaboration with partners, a systematic literature review of the evidence on civil commitment. The review looked at data from jurisdictions similar to Alberta from 2016 to 2023. The evidence review can be found here.

Methods

There have been other literature reviews completed in the last several years on this topic. Some reviews included studies of involuntary care that included populations receiving civil commitment through mental health acts, or through drug courts or in the context of "prison or probation." Prior reviews have often included data from countries with dissimilar civil and human rights standards to Canada. Additional concerns with this literature are studies with little to no description of what treatments were used, or little to no description of the judicial process used. These issues limit our ability to understand the intervention or interpret its results. Most prior research was completed before the widespread availability of opioid agonist treatment (OAT), medications that are known to substantially improve outcomes including all cause mortality.

Our review looked at studies completed in similar jurisdictions to Alberta, Canada. These jurisdictions spanned several states in the USA, Canada, Europe (Norway, Switzerland, Sweden, Netherlands), and Australia. We elected to review only research articles published in the last decade (2014-2024) to reduce bias associated with outdated treatment approaches.

Reported treatments ranged from basic inpatient care to extensive multidisciplinary and multi-modal approaches with and without aftercare. The length of compulsory treatment intervention ranged from **3 days to 4 years.**

Study designs ranged from qualitative to prospective cohort studies. No randomized trials were found. Only five studies of thirteen had comparison groups and all comparison groups were

non-equivalent.[1] Unfortunately, individuals who are this ill rarely engage existing voluntary treatment, which often results in them receiving 'no treatment'. More appropriate comparison groups can be included in strong study designs, including comparisons using administrative data. All studies were rigorously assessed for quality using the 36-item Methodological Standards for Epidemiological Research (MASTER) checklist.[21] Overall quality assessments showed that the research was of low quality. It must be noted for all readers that this does not mean that the research was poorly done relative to similar study types. Rather, *the quality assessment of each study was in terms of its ability to answer the question of effectiveness (outcomes) of civil commitment in an unbiased way.*

Findings

The current literature is not adequate to determine the effect of civil commitment in general or determine which interventions are beneficial and to what degree. Authors noted that people engaged in civil commitment were different from people engaging in voluntary treatment in important ways, for example noting key differences in motivation, medical, psychological, or social complexities.[19] Authors noted that civil commitment participants would not have otherwise received treatment.[22, 23]

Modern treatments, and in particular opioid agonist treatment and anti-craving drugs for alcohol were not described as having been used in most studies. Even so, authors identified them as being very promising for improving outcomes.[20] Mortality was high, ranging from about 5% to 10% in studies that reported post-civil commitment deaths.[13-15, 19, 20] These results, in the absence of OAT are not unexpected.

The quality and length of treatment appear to be critical factors for successful civil commitment interventions. Short stays of less than one month do not appear to be beneficial.[13, 14] The literature review found that civil commitment may improve short-term treatment engagement. Motivation to change also increased over time [24] in civilly committed individuals where it was measured, suggesting that structured treatment may help overcome impaired decision-making associated with severe addiction.

Studies highlighted the need for procedural fairness.[14, 15, 24-26] People who perceived the process as fair appeared to be more likely to engage in treatment.[25] The literature suggests that civil commitment should be framed as a healthcare intervention rather than as a criminal justice response.[14, 15, 24-26] Healthcare providers should take on the care of individuals facing a compassionate civil commitment process as early as possible in any intervention.

Literature Review of Mandated Treatment in Safety Sensitive Occupations

The Canadian Centre of Recovery Excellence (CoRE) completed a rapid literature review of the evidence on mandated treatment programs for people working in safety sensitive occupations. The review looked at health program data for people in the aviation industry and healthcare industries (e.g. nursing, physicians, pharmacists, dentists) from jurisdictions similar to Alberta from 2008 to 2024. The evidence review can be found here.

1 There were no studies that used a "treatment as usual" comparison group. By 'treatment as usual' we mean any existing, voluntary services that could *be offered* to an individual.

Findings

This review found that mandated treatment approaches are highly effective for professionals with substance use disorders. Studies consistently demonstrate positive outcomes, with participants maintaining high rates of abstinence and successfully returning to work.[27, 28] These results significantly exceed typical recovery rates in the general population.[29] Key factors contributing to program success include comprehensive assessment, intensive treatment, long-term monitoring (often for several years) with frequent random drug testing, and use of evidence informed treatments such as cognitive behavioural therapy, motivation enhancement therapy and contingency management.[27, 28]

Across all professions, from pilots and flights attendants to physicians and nurses, to pharmacists and dentists, program completion was very high with completion rates between 60-90% depending on the study.[30-32] Two evidence syntheses and six individual studies reported high rates of work retention, typically ranging from about 70% to 95% of individuals returning to work in concert with completion of addiction treatment and aftercare.[32]

The literature suggests that mandated treatment in this context also shows improvements in mental health outcomes.[33] Majorities of treated individuals had no relapse events.[32, 34] Large percentages, between 70-90% sustained abstinence from substances.[32, 35] These remarkable outcomes must be considered in the context of the unique advantages and resources available to professionals such as employee assistance programs (EAPs), coverage for treatment costs, relatively quick access to care and an assumption that a person who has been maintaining employment likely has reasonably high recovery capital. The successes are also likely dependent on long-term multiyear follow up and engagement.

There were three studies that measured patient satisfaction, two in physician treatment groups and one in flight attendants.[28, 33] All three studies measured very high satisfaction rates overall, with scores above 90%. Of interest, in Brooks et al (2013) there was high satisfaction at 8 weeks (91.8%) which rose to 98.6% as treatment progressed at 26 weeks.

Three studies reported on factors that influenced outcomes.[28, 36, 37] Smiley et al (2021) found that nurses who spent more time in group meetings and who checked in the most frequently were more likely to complete the program. Bruguera et al (2020) found that good adherence to follow-up therapy groups predicted lower relapse risks and higher rates of abstinence. The National Academies of Sciences, Engineering, and Medicine (2023) reported that pilots and flight attendants had enhanced accountability, reduced stigma, and improved long-term success when there were peer and professional support networks available.

Common Components of Care

Our review of the literature yielded insights into common components across these types of programs. It may be that applying these principles to a compassionate and effective form of civil commitment would yield improved outcomes for participants.

Comprehensive Assessment, Longer Term Treatment

All programs require comprehensive assessment on entry. These assessments include medical, psychiatric and addiction specific assessments.[34] Participants in physician programs are typically required to attend abstinence focused, bed-based treatment for an initial period of 60-90 days.[34] Pilots are offered 30-90 days of initial treatment.[28] Programs generally appear to adapt their treatment recommendations to individual circumstances but favour longer treatment periods and sustained aftercare.[36, 37]

Biologic Monitoring and Contingency Management

Random drug testing, or toxicology screening, is a key component across programs.[38, 39] There

is some variation in testing frequency. It is anticipated that in addition to early, and rapid intervention, as well as benefits to the individual in sustaining abstinence, that the need to protect the public informs testing frequency.

Work restrictions are common, especially in early recovery. Gradual return to work programs is offered.[28] This approach recognizes that work is inherently dignifying and meaningful for most people and work strongly supports recovery efforts for most people with addiction illness. There is also a contingency management element to this testing with real consequences to a return to drug or alcohol use and the incentive of return to work, or continuation of work by demonstration of abstinence.

Mutual Support and Peers

Participation in peer support programs was emphasized across programs.12-step or other support programs are a component of nearly all programs across sectors.[35] A recent systematic literature review on the effectiveness of 12-step or peer focused recovery movements for alcohol use disorder found benefits similar to cognitive behavioural therapy.[40]

Evidence Based Treatment Medications

Russell (2020) reported that 18/27 programs used mood-altering medications for psychiatric or medical conditions. Regarding opioid agonist treatments 10 programs reported information on buprenorphine use and 7 programs reported on naltrexone use.

Overall, most programs share core elements of early detection, comprehensive evaluation, abstinence-based treatment, and long-term monitoring with contingencies. High quality addiction medicine practices including cognitive behavioural therapy and motivation enhancement therapy are utilized. Use of effective treatment medications appears to be emerging as a current treatment practice.

Additional Considerations for Compassionate Civil Commitment

Given public concern for vulnerable family members and loved ones struggling with severe addiction, it is sensible to seek best practices in other areas of addiction medicine treatment to inform compassionate civil commitment interventions to achieve optimal outcomes. We believe that there is little political or social appetite for half measures that will not lead to successful outcomes.

Although there will be notable differences between individuals mandated to treatment under threat of losing their professional status and employment, including anticipated large differences in baseline levels of function, histories of trauma and baseline recovery capital scores, compared to those likely to receive civil commitment orders due to severe addictive illnesses, there are opportunities to explore treatment interventions that have long been determined to be effective. It stands to reason that people without the robust resources of employee assistance programs, could benefit from some of the same interventions that appear to help so many of the people who do have access to those services. In a country that prides itself on equitable access to healthcare services, Canada has an opportunity to “walk the talk” in this space.

Other research not included in these literature review shows that efforts to divert people from the criminal justice system in treatment or jail diversion systems can have very good outcomes.[41] Additional research shows that people involved in intoxicated driving, often with multiple convictions, have had remarkably good outcomes with systems that require daily alcohol testing or face immediate, certain, and short, one day stays in police custody. This method of swift, certain, and fair interventions has led to marked improvements in outcomes in the jurisdictions that have used it.[42] It is important to note that these interventions have been applied to general populations and are not restricted to people in professional or safety sensitive programs.

There is substantial research to support mutual support groups in the treatment of alcohol use disorder. It has been shown that manualized twelve step facilitation and non-manualized twelve step facilitation was both effective and cost saving.[40] There is growing evidence to support mutual support groups in the treatment of various drug use disorders, including methamphetamine use.[43]

There is strong evidence from decades of research to show that medication management, particularly in the context of opioid use disorder, reduces all cause mortality, or in other words reduces all causes of death, including overdose, by as much as 50%.[11] Many people, despite having an opioid use diagnosis (OUD) do not receive these medications.[44] Alberta is an international leader at improving access to OUD treatment medications, currently with same day access in every community at no charge through the virtual opioid dependency program, an Alberta initiative to deal with this problem.[45] Virtual care improves access and improves outcomes. Many people, despite having an OUD do not receive these medications.[46] It would be a missed opportunity to intervene in this hard to reach population without a robust effort to engage individuals with OUD in this life saving care.

There is significant evidence for the benefits of cognitive behavioural therapy and motivation enhancement therapy. Evidence informed treatments must be at the heart of treatment offerings in any compassionate intervention regime, avoiding treatments that have not been properly assessed in the addiction setting.

Contingency management is an evidence-informed intervention where patients are offered or not offered rewards related to desired treatment outcomes. Access to employment, and other offerings can have powerful reinforcing effects that promote engagement, medication adherence, and recovery. Research on contingency management has shown benefits in multiple substances, over many years, and is now considered a standard of care intervention in the treatment of stimulant use disorders by the American Society of Addiction Medicine.[47-58]

Our systematic literature review did not consider the grey literature on civil commitment. The State of Massachusetts has implemented civil commitment and has completed evaluation that is not peer reviewed but is informative. The Massachusetts programs are dissimilar in some important ways from what is recommended for Alberta's model of Compassionate Intervention. Massachusetts showed that those released from a Section 35 commitment had significantly greater odds of experiencing a nonfatal opioid overdose in both the 30- and 90-days following Section 35 as compared to the 30- and 90-day period following voluntary treatment, though there was no statistically significant difference in overdose mortality.

Patients receiving opioid use disorder medications in the Massachusetts model were 4 times more likely to receive naltrexone over buprenorphine or methadone compared to voluntary patients.[59] Authors of the legislative report stated "this is not necessarily a positive finding. Naltrexone is only effective for reducing use among patients who are not tolerant to opioids and does not address withdrawal symptoms. Adherence to naltrexone is worse than for methadone or buprenorphine and is especially poor for daily oral naltrexone." This finding highlights the importance of thoughtful medical oversight of programing to ensure that medical decisions and pathways support optimal patient outcomes not only during their time in a Compassionate Intervention facility but also with serious consideration to outcomes on release. Community addiction providers who receive patients from Compassionate Intervention facilities must facilitate ongoing medication treatment for opioid use disorders to prevent unnecessary overdose and death.

Evaluation and Research Implications for Alberta's Recovery Oriented System of Care (ROSC)

Alberta is a leader in Recovery-Oriented Systems of Care (ROSC). In Alberta, any implementation of civil commitment should use empirically proven addiction treatments. Alberta can lead with robust evaluation and research providing meaningful insights to the global knowledge base on this issue.

We recommend that Alberta work with experts to design and implement robust, high-quality research designs with more equivalent comparison groups such as people who have been referred but deemed ineligible, among other options.

Long-term outcomes, including reduced substance use, relapse rates, mental health status, changes in social functioning, mortality, procedural fairness, and personal benefit should be prioritized.

Family and community outcomes should also be measured. These could include measures of relevant family perspectives on the intervention, procedural efficacy, and family benefit.

Society-level outcomes should be measured including healthcare, justice and social involvement.

Recommended Strategies for Compassionate Intervention

CoRE recommends the following strategies to optimize outcomes for people subject to a compassionate intervention.

1. Extended Treatment Duration

The Compassionate Intervention model should incorporate longer inpatient or bed-based treatment options with structured discharge planning. Stays should be determined based on need, not predetermined program lengths. Decision makers with authority to prescribe treatment duration should be knowledgeable about the relatively high risk of relapse, overdose, and death after brief stays.

2. Leverage Empirically Proven Long-Acting Medications

Alberta has dramatically and effectively expanded same day access to opioid use disorder treatment medications in virtually all settings.[45] To further augment this strategy, long-acting buprenorphine formulations and other proven treatments should be integrated across inpatient and outpatient phases of care. The Government of Canada should work with the provinces to expedite access to injectable long-acting naltrexone, which is currently not available here despite long-standing high-quality evidence to support its use in the treatment of substance use disorders.[60]

3. Social Reintegration and Mutual Support

Whenever possible and appropriate, programs should develop and offer structured return-to-work and other life skill development strategies. Vocational training or retraining and evidence-based vocational programs, as well as skill development should be considered part of treatment providers' recovery curriculum. Programming should, wherever possible, encourage family recovery alongside the individual.

All services should include structured provision of empirically proven treatment including mutual support groups.

4. Structured Aftercare with Embedded Contingency Management

Professional programs provide years of structured follow-up. Civil commitment models in some jurisdictions use assertive outreach teams such as Assertive Community Treatment, and other supports to maintain engagement. Compassionate Intervention policies should learn from these models, incorporating regular check-ins, mutual support, peer-mentorship, and relapse

prevention strategies. Evidence informed treatment modalities like cognitive behavioural therapy and motivation enhancement therapy will be of value. Appropriately designed and implemented contingency management programs will also be of value in the population who have successfully transitioned to community care.

5. Anticipate Individuals with Permanent Cognitive Impairments

Services should anticipate a number of people, yet undetermined, who despite significant improvements in the absence of substances, have permanent cognitive impairments, including acquired brain injuries. Others may have severe and persistent mental illness, or both. Services will likely be well served to work with the office of the public guardian, continuing care, and other appropriate placement service providers to ensure appropriate ongoing care for these vulnerable people.

6. Anticipate Individuals with Severe Mental Illness

Programs should anticipate a number of people with concurrent severe mental illness. Programs will require the ability to assess and treat these individuals and must coordinate with the broader mental health system to ensure appropriate care while in civil commitment as well as discharge aftercare, including when appropriate the use of mental health community treatment orders on release. It should be anticipated that some individuals will have mental illness of a severity that prevents independent living in some circumstances. There may be benefits to designating Compassionate Intervention facilities under the mental health act.

7. Dignity-Centered, Recovery Approach

Compassionate Intervention should be framed as a healthcare intervention, ensuring treatment environments are therapeutic, not punitive. Procedural fairness is likely to enhance engagement and outcomes. Dignity protecting appeals and review mechanisms will likely improve program and patient outcomes.

Involvement of peers who are in long-term established recovery also holds potential to emphasize the dignity of change and the message that recovery is both desirable and achievable. This messaging is inherently de-stigmatizing.

8. Robust Scientific Evaluation

Alberta has public support and policy levers to implement a best-in-class, rational approach to Compassionate Intervention. Robust evaluation that bravely assesses comprehensive outcomes, particularly against treatment as usual arms can provide valuable insights. In this way, Alberta can improve the quality of care and outcomes for vulnerable people in its own jurisdiction and around the world.

Conclusion

Addiction and its consequences continue to harm individuals, families, and communities across North America, including Alberta. Interventions to date, while useful and helpful for many people have not adequately reached those with severe addiction illness who have not been willing or able to engage voluntary care services and are a danger to self or others.

The evidence for civil commitment for addiction is limited, yet it offers important insights. Learning from other areas of best practice addiction care, including mandated treatment for people in safety sensitive occupations can also yield insights. Integrating Compassionate Intervention with Alberta's modern, evidence-based addiction treatment system, and engaging

long-term supports may stabilize individuals in crisis, help them regain agency, and help them move towards recovery.

Alberta can lead unequivocally with a message that every person with addiction can, with dignity, receive high quality, meaningful care that can restore autonomy against the manipulation and coercion that alcohol and addictive drugs have inflicted on them.

In advance of further evaluation and research, given the evidence before us, we recommend serious consideration of longer bed-based treatment, using empirically proven long-acting medications, effort to facilitate social reintegration, use of empirically proven mutual support interventions, and structured aftercare with contingency management. This all can and should be offered in a dignity-centered way, framed as a healthcare intervention first. Scientific evaluation of these components of care is an opportunity for Alberta to showcase its Recovery Oriented System of Care. This evaluation is an opportunity for Alberta to add clear evidence on interventions that may be of critical importance to people suffering with addiction around the world.

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