Title: Monday, October 1, 2007 Community Services Committee
Date: 07/10/01
Time: 9:30 a.m.
[Mr. Marz in the chair]

The Chair: Good morning, everyone, and welcome to the public hearings of the Standing Committee on Community Services. I'd like to start today's hearing by thanking everyone here for their participation in this process. I know that we're all looking forward to a series of informative discussions today.

Now, to begin, I'd like to invite the committee members and staff at the table to introduce themselves. Starting with myself, my name is Richard Marz. I'm the MLA for Olds-Didsbury-Three Hills and acting chair of this committee. We'll start by going with my deputy chair to the right.

Mrs. Mather: Thank you. I'm Weslyn Mather, MLA for Edmonton-Mill Woods.

Mr. Lukaszuk: Good morning. Tom Lukaszuk, Edmonton-Castle Downs.

Mr. Lougheed: Good morning. Rob Lougheed, Strathcona.

Mr. Johnston: Good morning and welcome. Art Johnston, Calgary-Hays.

Mr. Backs: Good morning. Dan Backs, Edmonton-Manning.

Dr. Massolin: Good morning. Philip Massolin, committee research co-ordinator, Legislative Assembly Office.

Ms Dean: Shannon Dean, Senior Parliamentary Counsel.

Mrs. Kamuchik: Louise Kamuchik, Clerk Assistant, director of House services. Good morning.

Mr. Flaherty: Jack Flaherty, MLA for St. Albert.

Dr. Pannu: Raj Pannu, MLA for Edmonton-Strathcona. Good morning and welcome.

Mr. Johnson: Good morning. LeRoy Johnson, MLA for Wetaskiwin-Camrose.

Rev. Abbott: Good morning and welcome. Tony Abbott, the MLA for Drayton Valley-Calmar.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Thank you.

Now, before we get into the presentations, I'd like to make note of some important things that we need to remember. Each presentation should be 10 minutes, leaving 10 minutes for questions from the committee members. We'll have to stick to that because we have a full slate right till 9 o'clock tonight. At the end of the presentation or even before it, when 10 minutes are up, the chair will thank the presenter, and we'll go into questions. When 10 minutes are up in questions, then we'll move on to the next presentation. I'd like to ask everyone to ensure that any cellphone, BlackBerry, or whatever other electronic device you have is either turned off or in silent mode. For my colleagues at the table please do not leave your BlackBerrys sitting on the table because the vibrations from incoming messages interfere with the *Hansard* recording. Finally, for all members and staff and presenters there's no need to touch the microphone in front of you. The equipment is operated remotely by the *Hansard* staff.

Okay. Thanks, everyone, for your patience. Are there any questions or comments from the members?

Seeing none, we'll move to our first presentation, a video conference from the Canadian Civil Liberties Association in Toronto. Good morning, Ms Mendelsohn Aviv.

Canadian Civil Liberties Association

Ms Mendelsohn Aviv: Good morning. This is a very interesting forum. Thanks for having me. I'd like to say, first of all, good morning to you, Mr. Chair, and to members of this committee. My name is Noa Mendelsohn Aviv. I'm here on behalf of the Canadian Civil Liberties Association. Our organization has been involved in this issue, the issue of involuntary committal and forced treatment for people who are mentally ill, for a number of decades, and I think there can be little doubt why this would interest our organization. The bill that's before this committee today contemplates denying people their most basic rights and freedoms; namely, the right to dignity, privacy, and most of all liberty.

While it's clear that in our Canadian society we are willing to contemplate depriving certain people in certain circumstances of their liberty – in the criminal justice system, for example, we do so – we take great care and great precautions to ensure that we do not do so arbitrarily. We seek to ensure that an offence has been committed and one that we cannot live with.

Now, I don't want to make any confusion here. I'm not suggesting that mental illness is in any way linked to criminality. The realm that these two notions share is the realm of liberty and the question of when we in a free and democratic society are willing to take away someone's liberty. I'm here to suggest that in both contexts, the criminal justice system and the mental health system equally, we need to exercise a very exacting degree of caution to make sure that we have not arbitrarily or unfairly deprived someone of their freedom.

Unfortunately, it is our opinion that while this bill may have the very best of intentions and may be all about attempting to help people and even provides certain safeguards, it falls very far short of the requisite level of caution when we are talking about taking away people's liberty. If the bill is trying to help people, it is doing so by expanding the criteria under which a person can be taken and put in a psychiatric hospital, where there is a good possibility that they may be restrained, isolated, and quite likely forced to take medication, all of this against their will.

Now, as you're probably all aware, the current statute in Alberta, the Mental Health Act, provides that people who are a danger to themselves or to others can have their freedom restricted in this way for reasons of dangerousness that some of us can understand. This bill goes much further than that. It seeks to expand the criteria for involuntary committal and treatment to people merely because they have a mental disorder and are likely to suffer substantial mental or physical deterioration or serious physical impairment. The question I'd like to ask members of this committee is: what does that mean? The language is very vague and very broad.

If we take the simple meaning of the words, we can get to some ridiculous results. What if a person is suffering from anxiety, a recognized mental disorder, and has leukemia? Does this coincidence mean that this person should be a candidate for involuntary detention in a psychiatric facility? Well, you may say that that's ridiculous and that would never happen, but in the murky area of mental health diagnoses it is clear that the net has been cast too wide

when language could allow for such a situation. When we come to vulnerable people with mental illness, we cannot allow a net to be cast so wide that it would pull up people who shouldn't be there.

If we think that the answer lies in our psychiatric profession, that our psychiatrists know the difference and will know who needs to be detained and who not, that there are clinical definitions and diagnoses for these things, I would suggest and the academic literature would suggest that that is not the case. The primary diagnostic tool available to psychiatrics is the DSM, the *Diagnostic and Statistical Manual of Mental Disorders*. What the DSM offers us is a long and ever-changing repertoire of possible mental disorders, ranging from some that are very severe to some others such as insomnia, alcohol intoxication – who's never had that mental disorder? – voyeurism, and male erectile disorder. From one version of the DSM to the next hundreds of entries have been changed.

I just want to read to you a small bit from the *Australian and New Zealand Journal of Psychiatry*, which, if you don't want to take my word for it, will also verify that according to the academic literature diagnosis in psychiatry is not an exact science. It says:

> First, the introduction of explicit diagnostic criteria and new classification categories in psychiatry took place in the context of a discipline that still lacks conceptual coherence and hence remains easily influenced by ideological, political and market forces. Secondly, there are inherent shortcomings in the design of these classification systems which limit their usefulness and make them liable to misinterpretation or misuse.

Except for rare instances, according to this journal, hardly any DSM-IV diagnosis relies entirely or primarily on objective signs or tests.

So what does psychiatry have if not exact science? It's full of value judgments as to what is appropriate behaviour, feelings, and attitudes. Some authors note that defining a mental disorder requires finding where normality shades into abnormality. For example, psychiatrists have to decide how many days of sadness after the death of a loved one are appropriate. Where do we start to sink into depression? How much anxiety over job security is appropriate? How friendly or reserved should a person be at a dinner party? The value judgments that psychiatrists make about others have been given the feel of biomedical definition, but they don't change the fact that the behaviour labelled as deviant simply reflects social norms, not science.

Members of the committee, what about an individual who at the end of a long and productive life is diagnosed with cancer but refuses chemotherapy, such as the late, great June Callwood, if you're familiar with her? What about a health nut who wouldn't hear of taking antibiotics even for something like strep throat or something far worse or, more extreme, the Jehovah's Witness suffering leukemia whose life may be saved by a blood transfusion but out of faith refuses that medicine? Is this a rational choice, or is this an inappropriate, mentally ill response?

9:40

The answer may depend on the curability of the disease, on the aggressive nature of the treatment and its side effects, but it probably also depends on how one feels about life, about the medical system, and about who should be making the choices in these circumstances. Would we argue that these individuals' choices not to take medicine reflect a lack of understanding about the risks and consequences of their illness and treatment, or do we view this as a mere disagreement between the patient and her doctors? What would happen if this individual were also suffering from a mental disorder while they were refusing such treatment, a mild one or a severe one, and what were to happen if that patient's child, their family member, were devoted to the very understandable idea of keeping their parent alive? If involuntary commitment is a prison of the body, then involuntary treatment, especially in the case of mind-altering and behaviour-altering drugs, is a prison of the mind.

From the material that we have researched, there appear to be many good and logical and rational reasons for people refusing to take psychiatric drugs. The side effects have been described in some cases as devastating. The effects have been extreme and permanent. They have affected people's ability to do work. They have made people look strange and frightening. They've affected personal relationships. I won't go on in this vein because I understand that you're going to be here until 9 o'clock tonight, and I imagine that you will hear a lot more, but the details are important. If someone were to refuse to take drugs with this kind of side effect, it may seem perfectly rational and reasonable to object to receive such treatment. At least it may seem that way to everyone but the doctor and the family members who desperately want this person to get better, even if they think the drugs are worse.

Well, some people will say that we cannot possibly attribute the same kind of rational thinking to people who by virtue of their illness may be unable to make those kinds of decisions. That is an argument, but how do we know if the very refusal to take the treatment is the measure by which we assess the person's rationality? Members of the committee, I ask you: how can we know?

Moving on to a slightly different topic, I understand that this bill was put forward in an attempt to bring Alberta into line with several other provinces which have also expanded their criteria for coerced detention and treatment. One other province that did so recently is Ontario, and our organization had grave misgivings about what happened there. Even if there were an argument for the expanded criteria, the province still needs to do everything that it can to protect the liberty and autonomy of individuals who object to such treatment. In Ontario, for all of its issues, there are a number of qualifiers that make the situation a little less bad. Those qualifiers do not appear in this bill.

In Ontario it is required that the mental disorder will result in deterioration or impairment. There is no such link between the disorder and the impairment and deterioration in the Alberta bill as it now stands. In Ontario there is a notion of a revolving door and that the mental disorder for which a person may be detained is the same or similar to the one for which they have received treatment in the past. Furthermore, there is a qualifier in Ontario that they know that this person has improved clinically as a result of the treatment. That qualifier, too, is missing in this bill. So this bill would take people and lock them up and force treatment on them without actually knowing whether it's going to be effective but only because somewhere in some future possible eventuality they may suffer some kind of deterioration.

The Chair: Thank you very much for your presentation, Ms Aviv.

Ms Mendelsohn Aviv: Am I out of time?

The Chair: You're over time already. We'll move into questions.

Ms Mendelsohn Aviv: Oh, my goodness me. I didn't see the time signal. Could I beg your indulgence, then, for just one minute to mention two other issues that I think are hugely important? I won't go into detail, I promise.

The Chair: Well, we'll have to cut if off on the question side, then, if you do. At the pleasure of the committee we'll give you one more minute but one less minute for questions.

Ms Mendelsohn Aviv: I really appreciate it. I'm sorry. It's very hard for me to see you, and I didn't see any kind of time signal.

I just want to say two things that I think are very important. One is that this bill has not addressed what I think needs to be addressed in these circumstances, and that is the due process protections to make sure that a person gets a fair hearing. Those kinds of protections are available in the Newfoundland act. Since I don't have time to get into it, I suggest that you look at the act to see what kind of protections have been offered there but, in particular, questions as to who's making the determination, how much time, what kind of counsel is being offered, whether the Charter applies, and so forth.

The second one is that I understand that in Alberta, like in many places in this country, it's inadequate services that are responsible for many people's desperate situations, people who are suffering mental illness. In other words – and I will conclude with this – if we are going to contemplate such an enormous intrusion into people's liberty, privacy, and dignity, we need to be extremely careful about how we do this before we lock someone up and medicate them against their will.

I will conclude there. I thank you very much for your indulgence.

The Chair: Thank you for your presentation.

We'll move into questions. Reverend Abbott.

Rev. Abbott: Thank you very much, Mr. Chairman. Thanks for your presentation. As the sponsor of the bill I'm sure that you are aware of where the bill came from. It came from groups such as the Schizophrenia Society of Alberta. Other mental health groups have been lobbying the government for this bill to happen. We've also had, of course, the courts, through the Galloway inquiry, suggest that our government needs to do something to improve our Mental Health Act and possibly to include things such as community treatment orders and to expand the definition of the deterioration aspect, as you've mentioned.

We have tried to model this on some of the provinces that have been successful, such as Ontario, B.C., Saskatchewan, of course. I believe that today's public input will help us go a long way to shaping and making sure that we get this bill right when we do it. Again I want to applaud the Premier and the government on allowing this process to happen so that we can get public input and make sure, you know, that we haven't missed any pieces or gone too far or not far enough on other pieces.

I guess that my only comment, really, is that, you know, we have seen this bill work in other provinces. It's something that is definitely much needed. I have, like I said, many, many letters of supporting documentation in front of me, and I don't have the time to go through them all myself. I guess that I'm wondering: have you seen this bill or similar aspects to this bill work in other provinces? If you have, could you just comment on that as to how your group can partner along with us in order to make this a better bill?

Ms Mendelsohn Aviv: The Canadian Civil Liberties Association is not directly involved in providing service to people with mental illnesses. We're coming at this from a civil liberties perspective. What I can say is that I am aware of a great deal of the material that you're talking about, both in Alberta and in Ontario. I would say that, firstly, the mental health consumers seem to be taking a rather different approach, the people who are actually going to be the subjects of these treatments with these orders, many of whom feel that this is not an appropriate standard to be taking and that it is a risk and that there is a net that is being cast too wide. At the very least I would suggest to this committee to look at the qualifiers that were put in in Ontario and look into the due process protections that were put in in Newfoundland.

Rev. Abbott: Thank you.

The Chair: Mr. Flaherty.

Mr. Flaherty: Yes. I would like to just touch on your position on – you suggested medical diagnosis as being crucial in dealing with mental health patients. You seemed to be very critical of this in terms of the medical profession. Maybe I misread you. Have you any alternatives in terms of what you're suggesting there in terms of improving the medical diagnoses, that you seemed to be concerned about?

Ms Mendelsohn Aviv: No, I don't have suggestions for the medical profession on how to improve, but I do have suggestions for you the lawmakers. Given that psychiatry is not an exact science, my suggestion is: let's be as careful as we can. Let us not cast the net to include people who don't belong in psychiatric facilities, who don't belong with community treatment orders and coerced medication that they feel very strongly they do not wish to have and that feeling is being translated into irrationality. That's simply the point that I was trying to make. If we're going beyond dangerousness, if a person is a danger to themselves or a danger to others, we understand as a society why we may seek to lock up that person. If we're going outside of those areas, we need to be terribly careful how we proceed. Psychiatry does not have all the answers. That's all I was trying to suggest.

Mr. Flaherty: Thank you.

9:50

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. I heard you use the term "coerced medication" on several occasions. Are you suggesting that members of our medical professions are practising in an unethical manner? If there are, are there sufficient mechanisms within the college to address that issue?

Ms Mendelsohn Aviv: No, I'm not suggesting that at all. When I say coerced, I mean coerced in the eyes of those who have to take it. I'm certain that the psychiatrists in Alberta, like in Ontario, are good and decent individuals who want to treat and heal people and that that is their goal, a goal that they may take so far that where a person refuses treatment, they do see this as a further sign of their illness. But for the individual who under the terms of the act and under the terms of the bill as it's going to be expanded are forced to take medication with frightening and terrible side effects, who don't want that kind of treatment, who think that the remedy is worse than the disease, for those people this is coerced treatment, but it is lawful and lawfully applied. The question is: should it be? That is what you as lawmakers will have the opportunity to address. They're very difficult questions.

The Chair: Are there others?

Dr. Pannu: Ms Aviv, thank you very much for your presentation and being the first among the presenters to bring to us the concerns which the Legislature is aware of. Speaking on the bill, several of us did raise some of these questions about the civil liberties aspect that we have to address. I agree with my colleague Reverend Abbott that this committee's proceedings are really a good way of getting public input and valuable input such as yours.

My question to you is about the mental health science being an

inexact science. What's the degree of consensus on that assertion? That would be, I think, one question that will be raised. I'm sympathetic to the view, but is there some convincing evidence that we can rely on that this is, in fact, an inexact science?

Ms Mendelsohn Aviv: I believe that you can find online – and I'm happy to supply it to the committee as well – various submissions by our organization in Ontario on similar types of legislation. We go through some of the very serious psychiatric and psychological journals that do document this. Interestingly enough, one of these articles is written by the authors of the DSM, of this diagnostic manual, so they are aware of the changes.

Just to give you one example from I believe it's DSM-III to DSM-IV, there were over 200 – is that right? I'm asking my assistant here – changes in entries of mental disorders. When you think about it, by the time they got to the third and the fourth versions, they'd know more or less what a disorder is if it were so clear, if it were so obvious. Anyway, that's just one example. I will see if I can find that material to send to the committee. We can find your contact information.

Dr. Pannu: Thank you.

Mr. Lougheed: Thanks for your presentation. You talked about people who would choose to refuse treatment. Have you some advice for us and for others? How do you ascertain whether it's a valid decision in the best interests of that person if, in fact, they're having delusions of one sort or another, the different challenges they have? They may, as you said two or three times, not want the treatment, and it's coerced, forced upon them, and so on: words you used. What's the solution?

Ms Mendelsohn Aviv: I mean, obviously, you've asked the million dollar question. There are some civil libertarians, including my organization, who would argue that the risk is so great that if the person is not a danger to themselves or a danger to others, there is no justification for locking them up against their will. But even if one were to accept the argument that one could expand the criteria somewhat, again I would say that one has to be terribly careful about how it's done, make sure that the person has a right to counsel, that they know about it, that the patient advocate's office is involved with these people and is able to tell them what their options are, that the decision-makers are not just the psychiatrists, again, who desperately want to help and treat, but an independent, impartial adjudicator. The review panels right now only see a person after 21 days of their being in a hospital, and those review panels are heavily weighted in favour of the medical profession.

There are a number of different protections that can be brought in in addition to the bigger question of: should the criteria be expanded at all beyond what they are now? I think the short answer is that there are no easy answers. We are going to have to live with a certain element of risk, a risk that some people who need treatment may not get it and a risk that some people who shouldn't be locked up, who want their autonomy and their independence, may get locked up against their will. That is a very frightening prospect in a free and democratic society. We wouldn't consider it in any other context, not the criminal justice context or any other one.

The Chair: Do you have a supplementary, Mr. Lougheed?

Mr. Lougheed: No.

The Chair: Anyone else?

The chair has a question if you could briefly answer it. In your analysis of legislation in other jurisdictions which jurisdiction do you feel is the closest to getting it right, and what shortcomings of the legislation are there as you see it?

Ms Mendelsohn Aviv: Our organization takes the position that the Alberta legislation as it currently stands in terms of the criteria for committal actually has it closest. That criterion is one of dangerousness and perhaps an imminent dangerousness and perhaps includes an element of persons being able to care for their basic needs.

In terms of if one were to expand, then Ontario does have these additional qualifiers, but our organization opposed that expansion. In terms of due process protections it seems that Newfoundland, which has the most recent mental health act – they just brought theirs in last year – has the best due process protections. I think that if you put the committal criteria that Alberta has together with the process protections from Newfoundland, you are getting as close as one could hope to resolving a very difficult issue that doesn't have any easy answers, as we said.

The Chair: Well, thank you again very much for your presentation, Ms Mendelsohn Aviv. We will now be moving on to the next presenter. Thanks again.

Ms Mendelsohn Aviv: Thank you very much.

Alberta College of Pharmacists

The Chair: Is anyone here from the Alberta College of Pharmacists for the next presentation? Mr. Greg Eberhart and Ms Dianne Donnan. Welcome. We'll let you proceed with your presentation.

Ms Donnan: Thank you, and good morning. I am Dianne Donnan, the president of the Alberta College of Pharmacists, and with me this morning is the registrar, Mr. Greg Eberhart.

You will have a handout passed out in front of you that I'll refer you to – we won't go through everything, of course – as reference material. I do want to draw your attention to our mission, vision, and values of the Alberta College of Pharmacists, where you'll note that safety, quality, the public benefit from pharmacists' knowledge and skills are of utmost importance to our college. We are in place "to support and protect the public's health and well-being . . . by setting and enforcing high standards of practice, competence, and ethical conduct." You'll notice in our values that "the health of the client is paramount." We are all about continuous improvement, accountability for our professional conduct, partnerships, and teamwork. These demonstrate, we feel, that we are aligned with the values of the health minister and of Albertans.

10:00

A little bit about us. The Alberta College of Pharmacists has been the regulatory body who has governed pharmacists and pharmacies since 1911. We are the delegated arm of the minister, responsible for safe, effective, responsible pharmacist practice. The moral owners of the Alberta College of Pharmacists is the Alberta public. Our core businesses include registration and licensure, quality assurance, investigation and resolution of complaints, and contributing to health policy. These are all businesses established in legislation.

I'll draw your attention to the back of one page. This demonstrates elements that presently exist within the Health Professions Act, within legislation, where we are accountable and transparent to Alberta's public. Just a couple of items that I'll draw your attention to: 25 per cent of our council is appointed by the minister; all our

regulations are approved by cabinet; the minister has authority to request additional reports from the council at any time; decisions of the college are subject to review by the Ombudsman. Transparently, the constitution and registrants, standards of practice, and code of ethics are all reviewed and available. The code of ethics and standards of practice must be readily available to the public, and they are. The public may access information on the register about any of our registered members.

I just want to briefly touch on some of the things that the public has said about pharmacists in Alberta, primarily their trustworthiness. Building upon the credibility of the accountability and the transparency of the college, the Health Quality Council has survey highlights about patient safety, and any of these are available. I haven't provided more reading material for you, but for anyone who's specifically interested in some of these papers, I'm more than happy to provide Satisfaction with Health Care Services: A Survey of Albertans 2006, Health Quality Council, specific questions about pharmacists, governance, accountability. The Alberta College of Pharmacists in 2007 had Banister do surveys and focus groups to really tell us what Albertans are thinking and feeling about the governance of pharmacists and pharmacies in Alberta. In addition, what we've seen here is the trustworthiness and satisfaction that Albertans have expressed.

When we look at some of the sentinel events, safety events, that patients are concerned about, the Calgary health region's external review, the Health Quality Council review on the essential health infection processes, and the Red Deer event that happened recently are three big ones that come to mind. What they say over and over: it's the systems that break down, not individual people. Most common solutions, if you look at some of these reports that are presented by patients: improving the use of resources; striving for a team approach; system changes such as addressing fatigue, stress, workload; increasing communications; increasing the time that health care practitioners actually spend with their patients. Common to these sentinel events are system failure versus individual failure; failure in management, supervision and oversight within those systems; communication and reporting at both the management level and the professional level; and the need for training professionals, management, and unregulated workers.

With that background I'll pass over to our registrar, Mr. Eberhart, for some recommendations and our reasoning.

Mr. Eberhart: Thank you, Dianne. Again, our interest is Bill 41, the proposed amendments to the Health Professions Act. The recommendations that I'm about to provide you are supplementary to our written submission, but I will reinforce what was contained in our written submission.

First of all, we strongly endorse the desire of the minister and the department to enhance the quality of our health system and the accountability within it. To that end, we specifically endorse section 1.1(1), which deals with the reporting of the threat to public health. We believe that the public health of Albertans is of paramount importance, and where there is any such threat, disclosure needs to occur.

We also had the privilege of working with other colleges to propose amendments to the Health Professions Act, and we do support all of those submissions which were made by the federation of regulated health authorities. However, within the proposed amendments we do not support and we recommend that amendments to section 135.1, section 135.3, and section 135.4 be withdrawn from the legislation. I think I can say quite confidently that there was not substantive consultation about these proposals, and while we do agree or understand that the introduction of these sections has been to address accountability, we believe that there are other solutions to address them.

Colleges through delegated authority function as an arm of the minister and are committed to quality and public safety. The minister needs to facilitate and complement the roles of colleges. Sections 135.1, 135.3, and 135.4 do not address the problems consistently identified by the public through safety publications and through the reports of experts reviewing sentinel events, and I think those were outlined by President Donnan. These recommendations simply increase the authority and autonomy of the minister, potentially decreasing the accountability and transparency that is currently enjoyed within the legislative framework. The Health Professions Act already provides a rigorous framework incorporating processes to ensure accountability and transparency. The minister and the government are already empowered through transparent processes to ensure that standards are in place, to direct their expectations, and to ensure that colleges fulfill their responsibilities. We should all work together to ensure that these processes work well, and to that end I'd like to share with you some opportunities and solutions for your consideration.

First, it's important that the minister and the government facilitate the roles of colleges rather than directing the roles of colleges. Again, we have a long history, extending back to 1911, governing the profession of pharmacy and the activity of pharmacists. We have carried on that responsibility in the context of being an arm of the minister. We respect that privilege, and we look forward to the support of the minister in ensuring that we do it well.

Where provincial standards are required, we encourage the minister to collaborate with colleges and other stakeholders to develop the standards and collaborate and facilitate the deployment of the agreed-upon standards; for example, the incorporation of these into professional codes, the training of health workers, communication with regulated and nonregulated health workers and the public. Again, this demonstrates the will to fulfill the accountabilities and to achieve the goals of the minister, but we do not believe that these need to be achieved through a directed approach that is based on the opinion of the minister that lacks due process.

We recommend that the Health Professions Act and legislation governing RHAs be reviewed to better synergize the authorities, the responsibilities, and the accountabilities to ensure that they are complementary and that potential conflict is minimized. Today many colleges do not even have access to their own members who work within regional health authorities, and where they do have access, it's simply for the provision of reviewing competency, and that access is only granted through a request and approval.

We recommend that section 7(1) of the Government Organization Act be reviewed in context with the Health Professions Act to ensure consistent interpretation and application of supervisory requirements for restricted activities. Again, in reviewing the external reviews of sentinel events throughout Alberta in the literature, we find that often the issue is not about establishing standards but about management, supervision, authority, accountability, and how that is carried out. We want to make sure that as we look to restricted activities within the Government Organization Act and as we craft complementary legislation within the Health Professions Act or any of the regulations, they are indeed complementary and address the issue.

The Chair: Thank you very much for your presentation. We'll move on to the questions.

Mr. Eberhart: Could I indulge for one minute as per the previous presenter just to conclude? I'll make it quick.

The Chair: We'll just cut off the time for questions. Go ahead.

10:10

Mr. Eberhart: Next, we would recommend that the Health Information Act be amended to ensure that colleges such as ours have access to the necessary information about the performance of registrants, important to the college's role in quality assurance, quality improvement, and complaint resolution. Again, we suggest that the minister and the government have a role to play to make sure that all colleges have access to the information and the tools necessary to deal with prevention within the health system as compared to responding when things go wrong.

To that end, we would like to observe the strong relationship that we have developed with the Health Quality Council of Alberta through the health quality network and encourage the minister and the government to continue supporting the Health Quality Council of Alberta and resourcing the health quality network, a forum through which RHAs and colleges address safety and quality strategies and initiatives.

Thank you, Mr. Marz.

The Chair: Thank you for an excellent presentation.

Are there any questions from the committee members?

Mr. Flaherty: I have a question, if I may, and it goes back in history. Was there not, sir, somewhere in the recent past an evaluation tool, a team of people that moved across the province to look at hospitals and institutions to see if their systems were being applied properly and so forth; in other words, to see if standards were being kept? Was that system dissolved in the department of health within the last five to 10 years?

Mr. Eberhart: I can't speak to the breadth of your observation. I believe that most hospitals are accredited. That's not a role that our college is involved with. That's typically dealt with through the Canadian council on accreditation of – sorry; I can't remember the acronym or the name, but it's usually affiliated with the national process.

From our college's perspective the last really good experience we had in this area was in the early 1990s, when we developed a multidisciplinary team to review services in long-term care facilities, particularly with respect to the utilization of drugs and the prescribing of drugs. That was led by a member of our team. Again, it included a physician; it included administrators. We had huge successes with it, but unfortunately it disappeared with regionalization in 1995.

Mr. Flaherty: Thank you very much.

Dr. Pannu: Mr. Eberhart, you observed that your college does not have access to the members of your association who are employed by RHAs and that that creates certain potential difficulties, that the only access you have is in terms of being able to determine for the RHAs the competency of your members. What problem does it create, you know, not to have access?

Mr. Eberhart: If I can put this into context, if we discuss this in the context of the reports that have come out of sentinel events, again there's been an awful lot of discussion about systems and processes that include multiple health professionals, if it may be. If we look to the Health Professions Act and we look to the colleges, the majority of those colleges, yes, license their members, but in the context of the regional setting to go on-site and to do evaluation of members, they usually require permission to do that.

There are some colleges who have authority to license certain – I'll just refer to it as processes within the institutional setting. For example, I believe the College of Physicians and Surgeons has the responsibility around accrediting laboratories. Okay? In those cases my understanding is that they can look at systems and infrastructure and so forth to make sure that they work well. In our case we have access to pharmacists to deal with at the competence level. Until our new legislation, that is the Pharmacy and Drug Act, came into place – we do not have the ability to license hospital pharmacies. Our new legislation allows us to license hospital pharmacies who are billing third-party carriers in the context of providing community-based services, but in-patient services are not something that our college looks at, the processes that are undertaken there, because we don't have the authority in legislation.

The Chair: Mr. Johnson.

Mr. Johnson: Thank you, Mr. Chairman. I'm looking at the sheet you handed out. Under Opportunities and Solutions, in number 1 there, you mention the importance of collaboration between government and the colleges in defining roles and coming up with standards and so on. I appreciate that. I think that's very important. I'm trying to relate that to number 6, where you then go on and talk about the importance of educating the public about colleges, their responsibilities, and their accountabilities. I'm wondering if you feel that there's a weakness there now, and I wonder how educating the public is going to solve the initial problem or the initial point that you made about collaboration between government and the colleges.

Mr. Eberhart: I think they're related issues, but they're disparate issues also. I'm going to use an anecdote as an example to respond to your question. If we look at the past week in the media and the rebuttal that was going back and forth between the Alberta Medical Association and the minister, the context of the way that this discussion was framed was that this was about the regulation of physicians and surgeons. This discussion about Bill 41 is not about physicians and surgeons. This is about all health professions. I would suggest that the principles behind this have an effect on all professions, whether it be accountants, engineers, whoever, the context that is proposed here.

What we're citing here – and we've had discussions about this at the level of the health quality network – is the importance for the public to be empowered and to understand, when they have problems or challenges within the health system, who they go to. If they have concerns about the practice or the conduct of an individual health professional, who do they go to? What we're suggesting here is: does it make sense for 28 colleges to go separately and develop the tools, the communication plans, and so forth, to put in the hands of the public? Or is there an opportunity here for 28 professions to work together with the minister of health to come out with something that's really powerful and really meaningful so that we can provide direction to members of the public and support the members of the public in not only looking to expectations as to, you know, what they might do in accessing health care but, when things go wrong, what they should expect and where they should go?

The Chair: Are there others?

The chair has a question. Maybe the committee will think of some more. You talk about that the recommendations in sections 135.1, 135.3, and 135.4 have the potential of decreasing transparency and accountability by increasing the autonomy of the minister.

Could you comment? It says potential. Don't you think it could also increase transparency and accountability? Ultimately, at the end of the day, the minister has got to be accountable to the public on how all health care dollars are being spent.

Mr. Eberhart: I don't think that this is an issue just around health care dollars. I believe that this is about quality and safety and accountability. Again, we function as an arm of the minister. We take that responsibility very seriously. Legislation that's established today is created through the legislative process, which is transparent. It clearly is a delegated authority that is given to colleges, and as much as that authority is delegated, the government has authority through legislation to remove that power should it be required. What's being suggested here: the way these sections are written does not address a lot of process. It simply states that in the opinion of the minister if there's an issue around quality, safety, or otherwise, he can direct the development of standards, codes of ethics, bylaws.

We would submit, as per our written submission, that it's just totally inappropriate to direct any profession to develop anything within their code of ethics because a code of ethics is something that is very intrinsic and inherent to any given profession, whether you're talking about law, whether you're talking about the clergy, whether you're talking about accountants, pharmacists, physicians, whatever it may be.

Similarly, bylaws. Bylaws are about how we carry out our operations. They're not specifically about the care that is being received by the public. What we're suggesting is the opportunity that we have through process today. By looking at some of the suggestions that we've provided to you and the opportunities that we've suggested, we can make a really powerful system here that enhances quality, that improves accountability. There is not a need to have that autocratic, autonomous, top-down direction to do something. It's not to minimize the role of the minister but to clearly say: we recognize the responsibility – we are there to work with the minister – but there are better ways of doing this, and we are there to work with him.

10:20

The Chair: Reverend Abbott.

Rev. Abbott: Just on this point, Mr. Chair. You've just said that you're willing to work with the minister. Of course, you understand that the minister doesn't make these decisions or these moves in a vacuum, you know, that he also has some very excellent expert advice when he's making changes. Certainly, I see this as an evolving or as a growing of that partnership with the minister. I see this as an opportunity for the minister to perhaps have input from outside of Alberta when it's needed and to be able to make decisions accordingly, again, in conjunction with the college.

Mr. Eberhart: If I could respond to that, the principle is that that can already occur. There does not need to be a change in legislation in the context of sections 135.1, 135.3, and 135.4 to accommodate that, and if the minister was sincere about doing that, we should be getting on and doing that right now because I can assure you that the Alberta College of Pharmacists and, I believe, 28 other health professions are ready to do that. If we look to things like infectious disease control, I mean, if there was to be a forum or a proposal to address a provincial strategy and if there were expectations that come forward – I can speak for the Alberta College of Pharmacists – we'd be the first ones to the table to make sure that that's incorporated within our codes of conduct. We do not require additional legislation to do that.

We have to keep in mind that ministers change and governments change. When you look at the way the legislation is written, where it is so empowering without any description of process and transparency, there is a risk. It's not necessarily a risk to the professions, but it's a risk to the Alberta public because we cannot make these decisions evolve strictly through the political process. In fact, standards, codes of ethics, and bylaws should not be affected by politics. We need to make the right decisions for the right reasons, and that's why the comprehensiveness of the processes that already exist within the legislation.

The Chair: That concludes my speaker's list. I'd like to thank you both, Mr. Eberhart and Ms Donnan, for your presentations.

Ms Donnan: Thank you.

The Chair: Our next presenters are from the College and Association of Registered Nurses of Alberta. We have with us today Ms Margaret Hadley, Ms Mary-Anne Robinson, and Margaret Ward-Jack. Whenever you're ready, you can proceed with your presentation. The big clock on the wall will give you a rough idea. You have about 10 minutes for your presentation. That'll be a guide just by kind of glancing at that periodically.

College and Association of Registered Nurses of Alberta

Ms Hadley: Thank you, Mr. Chair and members of the committee. My name is Margaret Hadley, and I am the president of the College and Association of Registered Nurses of Alberta. CARNA is the professional and regulatory body for Alberta's 30,000 registered nurses, the largest health care profession in the province. We would like to thank members of the Standing Committee on Community Services for giving us this opportunity to speak regarding Bill 41, Health Professions Statutes Amendment Act.

Registered nurses recognize the importance of ensuring that the Minister of Health and Wellness has the tools required to address infection prevention and control and other risks to public health. For that reason, CARNA supports the proposed mandatory public health reporting mechanism outlined in section 1.1 of Bill 41. This section strengthens the role of the medical officer of health and reinforces professional responsibility with respect to infection control. It ensures that all regulated health professionals understand that the Public Health Act has precedence over other legislation, including the Health Professions Act.

CARNA also supports other provisions in Bill 41 outlined in sections 110, 113, and 114, which serve to protect the public by strengthening mandatory registration and reporting requirements for health professionals and employers and to clarify aspects of the Health Professions Act.

We are here today representing Alberta's 30,000 registered nurses to express our serious concerns with respect to section 135 of the proposed legislation. Section 135, specifically sections 135.1, 135.2, and 135.4, provides sweeping powers to the Minister of Health and Wellness and the Lieutenant Governor in Council to direct that a council of the college adopt a code of ethics, adopt standards of practice, adopt regulations, and carry out any power or duty of a council under the Health Professions Act in the absence of clear parameters for their use.

Registered nurses have five specific concerns about these provisions: these measures can erode self-governance for registered nurses, a model which has served Albertans well for nearly a century; the public policy intent of these sections is unclear;

provisions of the Health Professions Act already increase accountability and transparency; other mechanisms already exist to support smaller colleges; and there is a potential erosion of public trust in health professions, which is not in the best interest of Alberta's people.

Public opinion surveys have repeatedly shown that registered nurses are one of the most trusted professions. For nearly a century registered nurses, with the requisite skills and knowledge, have governed our profession in Alberta. The privilege of self-governance has been granted to professions like registered nurses because it is understood that we possess a specific, broad range of knowledge and that our actions significantly impact members of the public. Self-governance acknowledges that registered nurses are best equipped to develop standards of practice, a code of ethics, and disciplinary processes for ourselves.

We believe that the standards we have set for ourselves as registered nurses are high and, indeed, higher than others would set for us. Patients and the public benefit from these high standards that we expect of our members. Self-governance has created a professional registered workforce whose primary goal is to provide safe, competent, and ethical nursing care for Albertans.

CARNA does not understand the need to introduce legislation like Bill 41, which goes much further than other Canadian legislation in its potential to erode self-governance for health professions. The powers granted under Bill 41 would allow a minister or cabinet to impose direction on a college without going to the Legislative Assembly.

We have heard comparisons made between Bill 41 and the models used in legislation from British Columbia and Ontario. However, the legislation in these two provinces is different from Bill 41 on a number of levels. Under British Columbia's legislation the minister is authorized to initiate an inquiry if considered necessary in the public interest. Once the public inquiry is complete, the Lieutenant Governor in Council, not the minister, may issue a directive to the board concerning the matter examined during the inquiry. However, there are limits on the government's authority to issue directives to the professional college. The legislation specifically states that government cannot require the college to adopt standards regarding the practice of its members or their professional code of ethics.

In Ontario legislation the minister has a number of powers, but parameters are placed upon them. For instance, the minister may conduct an inquiry into the state of practice of a health profession in a locality or institution, ask a council to provide reports and information on its activities, or require a council to do anything required to carry out the intent of relevant legislation. It also gives the council of a college a time period in which to make, amend, or revoke any of its regulations if directed to do so by a minister.

However, it is extremely important to point out that Ontario's regulatory framework for health care is very different from the framework used in Alberta, just as their health care system is quite different. Ontario does not have a provincial system of regional health authorities, for instance. Their Regulated Health Professions Act of 1991 differs significantly from Alberta's Health Professions Act, establishing an official called the fair registration practices commissioner, which we do not have in Alberta.

10:30

Alberta is recognized as a leader in Canadian health care for initiatives such as establishing regional health authorities and spearheading the introduction of electronic health records. It seems to be a large step backward to be introducing legislation such as Bill 41, which would strip self-regulation from established professions such as registered nurses. In our opinion as registered nurses there is no justification for putting measures in place that can erode self-governance for 30,000 registered nurses when our long history within the Alberta government has been one of collaboration and a shared focus in serving the best interests of Albertans.

I'd now like to ask Mary-Anne Robinson to further discuss CARNA's concerns with Bill 41.

Ms Robinson: Thank you, Margaret. Legislation which grants such draconian powers to a minister to erode self-governance should have a clear policy intent. This is not the case with section 135 of Bill 41. If the intent is that section 135 would apply in the event of a public health risk, there should be clear and explicit language in the amendment to indicate this. If the intent of this section is to ensure uniform infection control requirements, other measures, including but not limited to new legislation, should be introduced to directly address infection control and further clarify the relationship of the Public Health Act to the Health Professions Act.

We also question the need to introduce the provisions of section 135 when the Health Professions Act already increases accountability and transparency for health professions. These measures include increased public representation on college councils, reporting obligations, and requirements to provide the minister with requested information as required.

CARNA strongly recommends that government remove section 135 from Bill 41 and focus resources on facilitating proclamation of the Health Professions Act for all health professionals. This brings us to our concern regarding section 135.2 of Bill 41. This section allows the Minister of Health and Wellness to appoint an administrator to take over the running of a college where requested by the college or where the minister is of the opinion that it is in the public interest or believes that a college requires support to carry out its duties.

The self-governing mandate of a profession can already be revoked by legislative amendment. There should be clarification of the type of situation which would justify allowing the self-governing role of a college to be revoked using a ministerial order. This section is extremely dangerous as it is worded now. It doesn't provide any direction as to how the public interest is to be defined. Clarification is clearly needed when sweeping powers are to be granted based on an individual's opinion of a situation with respect to a college. If this section is actually intended to support smaller colleges, then it should be spelled out in the wording. Otherwise, it could be used as a backdoor approach to interfering in the affairs of larger, more established professions with long histories of effective self-governance such as registered nurses.

There is also the question of liability in the event that an appointed administrator makes decisions affecting a college and its members. A college should not be held liable for decisions made by an appointed administrator, yet the proposed legislation is silent on the question of liability.

Our fifth area of concern regarding Bill 41 relates to the potential erosion of public trust if the provisions of section 135 were enacted. The foundation for public trust in Alberta's health system is confidence that public safety is the priority of both government and self-governing health professions like registered nurses. If governments enact the powers of section 135 without clear evidence of risk to public safety, the credibility of the profession would be seriously damaged, with resulting loss of public trust. Alberta's 30,000 registered nurses support legislation which strengthens public safety but does not potentially undermine the credibility of an entire profession in the public eye.

We also have to question whether or not it is even appropriate to have the standards of practice and ethical code for registered nurses

being decided in the political arena rather than in the realm of nursing expertise. We believe self-governance is the best means of assuring the public that we will receive safe, competent, and ethical care from registered nurses.

Margaret will conclude our presentation.

The Chair: The time is up, so it would be impinging upon the question period. If that's okay with the committee members, please proceed, but your total time is concluded in another 10 minutes.

Ms Hadley: Thank you, Mr. Chair. In summary, CARNA is deeply concerned with the provisions in section 135 of Bill 41 because they erode self-governance for registered nurses, a model which has served Albertans well for nearly a century. The public policy intent of these provisions is unclear, and the Health Professions Act already contains provisions which increase accountability and transparency. We do not believe that it is in the best interests of the public to enact legislation which has the potential to damage public trust in registered nurses. Professional self-governance allows registered nurses to focus on providing safe, competent, and ethical care without fearing potential political interference.

We would like to make three recommendations with regard to Bill 41. Remove section 135 and focus on bringing all health professions under the enhanced provisions for transparency and accountability of the Health Professions Act. Introduce other measures, including but not limited to new legislation, to directly address infection control issues and further clarify the relationship of the Public Health Act to the Health Professions Act. Finally, initiate further dialogue with the Minister of Health and Wellness to clarify public policy intent of Bill 41. CARNA believes that collaboration is the best approach to achieving a clear understanding of issues, co-operation from stakeholders, and the best results for the public.

Thank you very much for this opportunity.

The Chair: I have Reverend Abbott first.

Rev. Abbott: Thank you. I guess what I wanted to say, more than a question really, is just: thank you for having some recommendations. You've been sitting in on the hearings so far, and certainly we've had some groups that have pointed out some issues and some problems but not necessarily recommendations. So I guess I just want to thank you for that. It's very clear, and it gives us a lot of food for thought as we go into the discussion phase tomorrow because at least now you've given us some options as to how we can improve the bill with specific recommendations. Thank you for that.

The Chair: Mr. Backs.

Mr. Backs: Yes. Thank you for your very clear recommendations on the problems that might be seen with this act. The college for the pharmacists recommended that there might be some need for them to deal with their members by having increased powers. Is there some need on the part of your organization to see some increased powers to monitor your own members in order to properly execute your responsibilities?

Ms Robinson: Yes. Thank you for that question. CARNA, or registered nurses, have come under the Health Professions Act. Now we're into our second year of that, and we are implementing our program for continuing competence. Continuing competence allows us to ask registered nurses each year to set out what their goals are for their own professional practice in the year and to work towards those goals. We can audit our members to see that they are achieving those goals. We also have our professional conduct division, where unethical conduct or unprofessional conduct can be reported to the college. So those two pieces are in place, and I would suggest that the continued implementation of the Health Professions Act will actually give us more to work with as we develop our mechanisms to monitor our members, et cetera.

We do of course have the challenge that the majority of our members are employees of regional health authorities. They're not in independent practice. We do have to work co-operatively with the employers to both monitor and ensure that our members are in fact meeting the standards of practice and the ethical code for registered nurses. We enjoy a very good working relationship with the regional health authorities, so I think that as we work together, we can often sort through what some of the challenges are, ensuring that good practice is in place.

I think I agree with the College of Pharmacists that we could educate the public to a greater extent to understand how they can use the colleges and the regional health authorities and the minister's office in terms of any concerns that they have about the care that they receive. That is one area that I'm sure we could do more on.

Thank you.

10:40

The Chair: Mr. Flaherty.

Mr. Flaherty: Yes. Thank you, Mr. Chair. You talked about section 135 being removed. Can I just be bold enough to suggest that I'm the minister of health, and I'm very concerned about the well-being of patients in hospitals and specifically about medication. I'm wondering in terms of your presentation today: do you not see a time, where a patient's life has been endangered or taken away because of bad application of medication, where the minister should be allowed to have specific powers and to look at safety? Do you think it's beyond the college to make sure those standards and practices are safe for the public in Alberta? I'm just wondering where the trade-off is here. I'm just trying to suggest: are the public's hands in full safety in terms of standards being practised without the minister having some control in this?

Ms Robinson: Well, I would suggest to you that the minister has all of the tools that he already needs to ensure that patients are receiving safe and quality care. The Health Professions Act as it currently exists allows the minister to work with the colleges on any area of concern that he might have. There are also the Health Quality Council and the health quality network here in Alberta that take on a very good role in looking at the whole system in terms of protecting the patient. Then, thirdly, certainly we have through our own processes at the college ways to look at an individual member's practice. If somehow they have been part of the issue in terms of a medication error or anything else, we look at that very carefully against the standards of practice, and we can in fact remove someone's licence, to that extreme, if that's what's necessary.

I do think we have all the tools that are necessary. I think what we need to do is focus on getting those tools working, getting all the health professions under HPA, and getting all the elements of the Health Professions Act fully implemented so that we can enjoy what it has to offer. It is a very comprehensive piece of legislation that gives us a lot of tools to work with.

Mr. Flaherty: Thank you very much.

Mrs. Mather: Thank you for your presentation. I appreciate the detail that you've gone into. But I'd like to ask you if you could

maybe expand a bit on your comparison to Ontario's legislation and the regulatory framework that's there.

Ms Robinson: The Ontario legislation was developed in an environment where they, first of all, don't have regional health authorities in place, so they're really looking at a very different set of circumstances in that environment that they have to sort of manage their health professions. The information that I know about the act had more to do with issues around shortage of health professions and ensuring fair registration processes for health professions so that they could ensure that they were dealing with their supply and demand issues. It wasn't as specific as what we're talking about here.

The only reason we brought it up at all is because we have heard various comments made in various arenas that this is no different or no farther reaching than Ontario's or B.C.'s legislation, and we felt that it was important to speak to this committee about the fact that those pieces are much different and much more narrow in their application.

Mrs. Mather: Thank you.

The Chair: Are there others?

Dr. Pannu: Just a clarification on the issue of stripping of self-regulation. That's one of the concerns that you expressed if section 135 becomes law or becomes part of the law before us. Would you elaborate on that a bit, especially in reference to your comparison of this proposed act with the similar legislation in B.C. and Ontario, how those acts don't strip self-regulation requirements whereas this threatens to do that?

Ms Robinson: Yes. Well, certainly the sections of 135 that we refer to do allow the minister to appoint an administrator of a college, set the code of ethics, practice standards, et cetera, which are the fundamentals of a self-regulating or self-governing profession. When you start to set their code of ethics, that goes to the very heart of the profession. In B.C. there is a process laid out in legislation whereby the minister must consult with the profession, must work through various levels of the Legislature, et cetera, before any kind of measure like this would take place. Also in B.C. it's very clear in the legislation that the minister cannot invoke change in the code of ethics or in the standards of practice for that profession. It's much more specific to the minister being allowed to perhaps direct in the area of regulation but only after a very extensive process has occurred to make sure that that is, in fact, in the best interests of the public and the profession itself and that it's not subject to any sort of political interference.

The Chair: That concludes my speakers list. I'd like to thank you very much again for your excellent presentation.

I'd also like to point out to the public that's here that the presenters have provided some copies of their submissions on the ledge back there by the telephone, and you're certainly welcome to those as long as they last.

Ms Hadley: Thank you.

Ms Robinson: Thank you.

The Chair: We're going to take a break now, and I'd ask the committee to be back in the room about 8 minutes after 11. Thank you.

[The committee adjourned from 10:47 a.m. to 11:08 a.m.]

The Chair: We can get started. We have with us Ms Sandra Harrison. She is with the Alberta Mental Health Patient Advocate office. Sandra, welcome. Please proceed with your presentation.

Alberta Mental Health Patient Advocate Office

Ms Harrison: Thank you very much. Good morning. It's a privilege to have an opportunity to speak with the committee today about Bill 31. I am Sandra Harrison, and I am the Mental Health Patient Advocate for the province. I'm a social worker by training, and I have extensive executive experience working in corrections and in mental health. I have been appointed by the Lieutenant Governor in Council, and I report to the Minister of Health and Wellness on my statutory role.

In 1990 the government of Alberta had the foresight and wisdom to establish the office of the Mental Health Patient Advocate to create a voice for the most vulnerable patients in the province. As the mental health advocate it is my responsibility and my honour to work to ensure that the legislative rights of vulnerable, formal, certified patients detained involuntarily in any one of 16 designated mental health facilities located across the province under the Mental Health Act are promoted and protected, their needs are considered and met wherever possible, and they are supported to make responsible decisions that affect their lives.

Under Bill 31 it is proposed that the mandate of my office would be expanded to also provide these services to patients under community treatment orders. We believe this is the right thing to do.

In preparing for today's presentation, I thought about the important task facing this committee: to create a legacy relative to the management of people living with mental disorders. I thought about how the current Mental Health Act has been in place for almost two decades, and I wondered what this amendment will tell people in 10 or 20 years about the state of science, knowledge, and understanding about the optimal management of mental disorders in 2007 and about our priorities, compassion, and care for Albertans with mental illness.

I realize that your task is about more than tweaking a few words in the current legislation. It is about embedding principles in legislation that will govern for some time to come the provision of optimal care and safety of those people with and impacted by significant mental illness and mental disorders.

I previously provided a written submission to this committee, including a summary of recommendations, and I brought a few copies today just in case someone didn't have them. I will speak, however, today about what I know best: patient rights, advocacy, and the concept of recovery in the management of chronic illness and disorders.

Before doing so, I would like to set the stage by quoting from a submission to the World Health Organization.

> There is no more significant infringement of an individual's rights, freedoms and liberties than when they are involuntarily detained by the authority of the state. This is especially true if the individual is held in a mental health facility.

I believe the government of Alberta and this committee fully recognize that the changes proposed by Bill 31 have the potential to impact patient rights under the Canadian Charter of Rights and Freedoms, including the right to life, liberty, and security of the person and the right to privacy. If passed into legislation, it will broaden the criteria for involuntary admission and detention and provide for the implementation of community treatment orders. I also believe that this is the reason the government continues to affirm the statutory role of the Mental Health Patient Advocate: to

promote and protect patient rights, investigate and resolve complaints and concerns, help patients to self-advocate, and to educate the public and service providers about patient rights and about the application of the Mental Health Act.

My office is honoured to accept our role in the duty to protect and does so compassionately through advocacy that is independent from any person responsible for the patient's treatment or from those who have direct, indirect, or administrative responsibility for treatment decisions. We are partisan, ensuring that the patient's or the client's voice is heard. Unlike the review panel or Court of Queen's Bench, which are expected to be impartial, we are partisan. We are client centred. We are focusing on promoting the client's rights for and with the client. We are accessible to patients, their families, service providers, and the public in a timely manner to promote patient rights.

We are appropriate; that is, the advocates working in the Mental Health Patient Advocate office are knowledgeable and effective concerning patient rights and the application of the Mental Health Act. We take a proactive approach and pursue avenues of least contest; that is, we continue to explore options to ensure that we can be proactive rather than reactive and that we can look for solutions that meet the patient needs while minimizing the need to pursue legal remedies where appropriate and possible. We endorse the recovery model as being integral to chronic disease and chronic illness management, including mental disorders.

A sometimes misunderstood and controversial concept in some mental health circles, recovery does not necessarily mean a cure or absence of illness. To me it means that the patients feel supported, they know and exercise their rights, and they play a meaningful role in decision-making that impacts their lives in the management of their illness. This is not the same as having sole authority to give consent for treatment.

We believe in the patient's right to timely assessment and treatment, to optimal practices, and to community supports so that they can enjoy quality of life. Indeed, the success of CTOs is predicated upon having in place effective, accessible, and appropriate resources to address complex social determinants of health.

11:15

We believe that people with mental illness can move beyond the devastating effects of their illness and the stigma and discrimination they often experience and enjoy a sense of hope and a measure of control over their lives. We believe these concepts are consistent with the government's priorities to improve Albertans' quality of life, build a stronger Alberta, and provide safe and secure communities.

In closing, I want to recognize the Minister of Health and Wellness, the Hon. Dave Hancock, for boldly listing mental health as one of his ministry's key priorities and the government and this committee for establishing this timely and inclusive review of the Mental Health Act. I look forward to the outcome of your consultations and thank you for the opportunity to address the committee this morning.

Thank you.

The Chair: Thank you very much, Sandra.

Before I move on to questions, I'd just like to point out that aside from submissions by presenters on the back shelf, Albertans will be able to also access them on our website at www.assembly.ab.ca/communityservices.

With that, we'll move into questions. Reverend Abbott, please.

Rev. Abbott: Thank you, Mr. Chair. Again, thank you for a very clear and concise presentation and some very excellent recommendations. I see you have 11 here.

I have a couple of questions. First of all, just a general question: when we were putting the bill together, when we were building this bill, had you submitted some of these as suggestions from the Mental Health Patient Advocate? If not, that's fine. I'm just curious to know if you had input earlier or if this is your first time to have input.

My second question is with regard to recommendation 4, stating that your office should be notified when a patient is placed under a CTO. I think that's a good idea. I'm just wondering what kinds of systems you have in place to kind of keep track of that or what your thoughts are around that. How would you develop, I guess, a confidential filing system? What are your thoughts on number 4? Explain that one further.

Ms Harrison: Okay. I'll answer your first question about: did we have input when the bill was being drafted? No, we didn't. But we did get a copy of the draft, and we did make a written submission to the committee when you were requesting them.

Rev. Abbott: Okay. Good. Thank you.

Ms Harrison: Now, in terms of recommendation 4 we said that we think that our office should be notified when a patient is placed under a CTO and that we should then be required to contact the patient to provide them with rights information and answer any questions. Currently what happens is that our work is limited to formal patients who are detained in hospital under two certificates under the Mental Health Act, and they contact us. So we are very responsive to their calls. We also have treatment team members who refer them to us, and then we brief them on their rights and often maintain quite a dialogue with them through the course of their treatment.

This would be a new approach. The introduction of CTOs and the expansion of the role of our office into CTOs moves us into the community really for the first time. We have a confidential database and information system, which we are honing and improving even as we speak, and we would have the capacity to go out and meet with patients who are either being considered for a CTO or who are placed on a CTO.

Rev. Abbott: Okay. May I have a short follow-up? I'll go back on the list.

The Chair: Okay. I'll put you back on the list.

Mr. Backs: With the increased role of your office in terms of CTOs, will there be a substantial need for increased resources for your office to deal with this?

Ms Harrison: We, I guess, are as interested as anyone to know how many people will be impacted by CTOs if the legislation is brought in. We do not know what that number will be. I've heard speculation that maybe it will be 200 to 300 people, but I really have not been involved in those discussions.

We think we might have to expand our resources somewhat. We think that's doable. I believe that the minister would be open to that. I have great confidence in his understanding of the importance of patient rights and guaranteeing patient rights.

The Chair: Reverend Abbott, you had another question?

Rev. Abbott: Just a bit of a follow-up on my first question.

First of all, I was under the understanding of it being more in the neighbourhood of 50 or less, but again you never know until it happens.

At any rate, just a bit of a follow-up. I'm not concerned; I just want clarity. As of right now you had mentioned in your presentation that you're only involved if a mental health patient contacts you. You had mentioned something about possibly you do have some officers out there that are sort of keeping an eye on what's happening and that you do perhaps do some of that initial contact yourself, or do you do any initial contact yourself? If you don't, and again going back to number 4 as a follow-up, it seems that that's what you would like to do: be involved from the very get-go, right from the initial issuing of a CTO. Again, just clarify how the process is going to work if we follow through with this.

Ms Harrison: We have a very small office, a very small team. We're located in Edmonton, so most of what we do is responding to patients who contact us. That being said, we do go out and visit all of the facilities, so we do initiate contact with those patients who have not previously contacted us.

We feel that it's important that we would be involved with CTOs. Our thought is that if a patient is in the community, they may not know or recall or retain where they should go if they have a concern or complaint. We really feel that we can be supportive, but we need to be out there doing that.

Rev. Abbott: Great. Thank you.

The Chair: Mrs. Mather.

Mrs. Mather: Thank you. I apologize for coming a little bit late. I don't know enough about your group, and I wonder if you could tell me a little bit more about the types of individuals that are in your office that do the work.

Ms Harrison: The staff, you mean, or the patients we serve?

Mrs. Mather: The staff.

Ms Harrison: We are a four-person office. We have an administrative assistant. In addition to that, I am the provincial Mental Health Patient Advocate. We have an assistant provincial advocate, who is actually with me here today. We also have a new position that we recently expanded to: a patient rights advocate.

The Chair: Mr. Art Johnston.

Mr. Johnston: Thank you. I just wonder if you could clarify recommendation 8 for me. Give me an example to help me understand.

Ms Harrison: Certainly. I'm glad you asked. In the draft legislation it talks about the need for interpreters, and it talks about suitable interpreters. It's our experience that when we have both visited patients in hospital or have had some conversation with a patient whose first language is not English, often who interprets for them is a family member or a part of the treatment team. But we have found that when we have a one-off conversation, a private conversation, with those patients, what we are being told by the interpreter is not necessarily what the patient's position is. So we think it would be important that an interpreter would be independent, not a staff person or a family member, and that they would follow the code of ethics for interpreters.

Mr. Johnston: Sorry. Number 8 was the automatic application.

Ms Harrison: Oh, we've got two different copies in front of us, so I'll go with 7, then, which is the automatic application.

Mr. Johnston: Yeah. I had number 8 for that.

Ms Harrison: Sorry. Automatic application to review panel to hear and consider cancellation. The draft almost implies that CTOs could go on for a period of time if a patient is not asking for a regular review, and we're suggesting that's probably not a good idea, that there should be an automatic review built in after a certain period of time.

Mr. Johnston: Okay. Thank you.

Rev. Abbott: I guess that maybe I need clarification on number 7 as well because there is an automatic review. I shouldn't say an automatic review. It expires after six months, and you have to reapply, correct?

11:25

Ms Harrison: But it can go on for six months, six months, six months. It can go on endlessly for six months, and the patient may not be asking for an appeal or a review. So this really says that the patient gets a chance to come before and be heard.

Rev. Abbott: I see. So you're asking for some kind of a formal review at the end of each of those six-month periods before it's reinstated.

Ms Harrison: Or at some appropriate period.

Rev. Abbott: Okay. Thank you.

Dr. Pannu: Thank you for the presentation and a clear set of recommendations. I was most interested in your reference to the World Health Organization's position with respect to mental health issues and the rights of mental health patients. I was also interested in your observations on Charter rights and how any legislation must address that issue.

From your reading of Bill 31 and knowledge of the World Health Organization's position on mental health issues, do you think that the concerns expressed by the World Health Organization, the principles enunciated with respect to the treatment of patients, are well addressed in Bill 31, or are there some places where, in fact, Bill 31 falls short of those principles and expectations? Also, that applies to the Charter of Rights issue.

Ms Harrison: Well, as we always do, I should say that we're not clinicians and we're not lawyers, so I'm not speaking from that kind of a background. But in looking at 31, our recommendations really speak to how it could be enhanced from a patient rights perspective. Let me say that if the recommendations that we have made are incorporated, then we think that patient rights would be well protected.

Dr. Pannu: Do you have any concerns with the Charter of Rights and the potential risk that some of those might be violated by the provisions of the act, even when all of the recommendations that we make are accepted and made part of it?

Ms Harrison: Well, I will bow to the constitutional experts. I know

that they're wrangling with that and giving you good advice around that issue, so I'll actually bow to their advice on that.

The Chair: Well, I have no others on my list, so I'd like to thank you again, Ms Harrison, for an excellent presentation. I'd also like to thank you for the comprehensive list of recommendations. I'm sure the committee will find that very helpful. Thank you.

Ms Harrison: Thank you.

The Chair: Is Dr. White from the department of psychiatry here? Dr. White, if you're ready to make a presentation – Dr. White is here from the department of psychiatry at the University of Alberta – you may proceed. We are a little ahead of time, which is much better than being a little behind time.

Department of Psychiatry, University of Alberta

Dr. White: Mr. Chairman and members of the panel, thank you for the opportunity of addressing the panel. You would have already had a written submission from me, so I'll reflect a little bit on that submission. I come here at the outset as a full supporter of this change in legislation. I think it's probably one of the most important changes in mental health legislation for quite some time, and I'll give you my reasons why.

A bit of my background. I used to be a family physician. I've been a psychiatrist for the past 20 years. I've practised in Britain, I've practised in Australia, and I've been here since 1989. I come originally from Ireland. I had the opportunity of administering community treatment in the state of Victoria. I've also had discussions with psychiatrists from the state of Queensland in the last few months in relation to how the CTOs work in Australia. The uniform opinion from all psychiatrists is that this is a very important piece of legislation, and the majority of us, 98 per cent, are in favour. It has issues. It has concerns. There have been concerns about human rights, et cetera, and I will do my best to address those issues.

What we're dealing with here is a very difficult population. It is also a small percentage of the mental health population. Those who will tell you that it's dealing with all the mental health population are not correct. This is quite a small percentage of the mental health population, but it eats up 80 per cent of the resources and causes significant family grief. I in my job as a psychiatrist have worked with the police. I work with our police in-crisis services. I've been in homes dealing with patients who relapse on a chronic remitting basis. I've been in homes where I see damage from aggression. I see psychological damage to families and the burden on families of patients who, when they're admitted to hospital, are treated, stabilized, leave hospital, and they relapse within a short period of time. Then they're back in hospital, and the cycle begins again. Of course, we call this the revolving cycle. This piece of legislation is targeted to deal with that particular population, but I also think it can go further. In actual fact, we have a great opportunity to make this piece of legislation better, and I'll explain that further.

Let me back up here. Criteria 2, where we're talking about the issue of deterioration: we're fully in favour. We no longer have to wait for the patients to become dangerous. Waiting for them to become dangerous is actually a very dangerous exercise because it predicates the fact that you can only intervene when you feel harm is about to occur to an individual or others. We've been in situations where harm, unfortunately, belatedly has occurred. If we can intervene sooner, when we feel the patient is deteriorating both psychologically and physically, we get the patient into hospital quicker. We get them treated sooner. We get them stabilized quicker. Their quality of life improves, and we get them out of hospital quicker. The benefit to the population of intervening early and all research shows that early intervention equates with a better prognosis and a better outcome. So criteria 2: absolutely, totally in favour.

Getting back to the community treatment order aspect of the legislation, we will successfully, hopefully, deal with the revolving-door patients, where we have patients who are admitted on a revolving basis. When they're discharged, we can put them on a community treatment order, which will necessitate that they have to stay compliant with medication. Now, there's a bit of a misnomer that's thrown out here that, you know, we have pictures of psychiatrists running around the community with syringes about to inject people if they don't adhere to their medication. This is completely untrue.

How you operate a CTO is that every patient that's on a CTO will be seeing a community nurse twice a week as part of assertive community treatment, will probably see the psychiatrist weekly, two-weekly, three-weekly depending on how stable they are once they're back in the community. If we have an indication that a patient is not taking the medication, the nurse goes out to see the patient. Sometimes the physician, if available, will go out to see the patient with the crisis team, and the patient is given a choice: "Take your medication, and you stay at home; you continue to function. If you don't take your medication, well, we're going to have to bring you back into hospital so we can restabilize you." The patient is given a choice here.

Now, there's an issue of consent. There's an issue of competency. These are trickier areas, which still have to be worked out, but the issue here is that the patient is still given a choice. Okay, there's an element of coercion, but the element of coercion is for the better good of the patient. The benefit here is that for the patients who are chronically being readmitted to hospital, you break that cycle of chronic relapse.

What I'm seeing in my practice – I was on call yesterday. I saw three young people, early 20s, one young chap who's blown his brain with drugs, with crystal meth, coming back with a drug-induced psychosis. His level of functioning has deteriorated significantly over the past three years. If you have a chronic illness that's left untreated, the patient continues to be symptomatic, a continuous burden on his family and the community, a huge cost to the system. That patient's level of functioning decreases over time, which means that there's a lifelong dependancy on the system. The economic benefit here is tremendous.

Now I'll just move a little bit further. I also sit on the steering committee that's advising the minister. Some of the things we've been looking at – and I have this as part of my submission. We can go even further than this. Former patients with the in-patient criteria in place: we've proposed that the in-patient criteria should be shortened to be the same as Ontario's, but there should also be a capacity within these treatment orders to actually intervene in the community without the patient being admitted to hospital. In other words, we have proposed separate pieces of criteria based on illness, symptoms, deterioration, issues of risk. Where we identify somebody in the community, we can actually put them on the community treatment order in the community, and the purpose of this is to do all of the above of what I've just said but to actually keep them out of hospital. In the state of New Zealand the health act is very similar.

11:35

The benefit here is that you target a population that may not necessarily reach the criteria to be a certified formal patient, but still they're sick. They're relapsing in the community. They're not

taking treatment. You can intervene early and target this population, thus relieving symptoms, maintaining their level of functioning, and maintaining them in the community. So that's the one major amendment that we would like to see with this legislation so that we have flexibility and target two different populations.

A lot of issues that we're looking at are issues of rights, support issues, issues of education. I'll address the issues of rights. This piece of legislation has to have all the same legal support systems in place like it does have with the current Mental Health Act. The current Mental Health Act for in-patients has an automatic referral to a review panel after six months. That should be in place. So it would be similar to the current Mental Health Act. Review panels need to be set up, chaired by a lawyer, with a psychiatrist, a family physician, and a member of the public. Patients who appeal to this panel have to have the necessary legal support system, have a lawyer present, and the onus should be on the psychiatrist to prove that the patient needs to stay on the community treatment order. That is very similar to the current Mental Health Act. There is no reason why this should be different.

Coupled with that you need to have the administrative supportive system, and you also need to have the education system, because this is a big shift. It's similar to other provinces within the country but is a big shift for Alberta, so it has to come with the proper support system as well. It also has to come with the proper funding. We've talked to the minister about this, and the minister is quite receptive, but you need to have the proper community support systems in place.

Now, one might ask the question: could we put community treatment orders in place as of today? I would arguably state that that is a distinct possibility, but there are gaps in the system. There are gaps in the assertive community treatment system. Now, the reality is that the majority of CTOs are going to be operated within the major population areas. The geographic shift in chronic mental health is towards the major cities, where the services are available, with the result that we have a problem in the rural regions.

How do you administer a community treatment order in a rural region? Who supervises the community treatment order? It has to be a physician because the physician has the medical, legal responsibility for the patient. The issue then is: how do you liaise with family physicians in consultation with a psychiatrist? The steering committee is looking at the issue of using telepsychiatry: family physicians supervising the order in consultation with a psychiatrist. A lot of this stuff needs to be worked out, particularly in the rural regions.

In the urban regions it's not a problem. In the urban region I'm the psychiatrist, and I've got a team of nurses working with me looking after my patients. We liaise on a daily basis, sometimes twice a day depending on the severity of the patient. So the rural regions are a big problem. As Dr. Bland quoted to me a few weeks ago, you can't do heart transplants in High Level. So the reality with service delivery is that the majority of community treatment orders are going to be in the major population areas.

I'm fully in favour of this legislation. I've seen patients who have deteriorated significantly. The concern that we have in the mental health population right now is that our patients are getting sicker. They're younger. They're more aggressive. They're relapsing more frequently, at a huge cost to the system. We don't have enough beds. The reality is that this legislation will also help us with our bed delivery system.

Thank you, Mr. Chairman. I'll take questions from the panel.

The Chair: Thank you, Dr. White.

Rev. Abbott: Well, thank you very much, Dr. White. That is absolutely excellent. I completely agree with every word you said. In fact, I wish I had you with me when I was carrying this bill through caucus and through cabinet policy committee because you hit the nail right on the head. It's exactly why we need it.

Again I want to say thank you, even though this morning at 9 o'clock we found out from Civil Liberties that yours is not an exact science, and I say that facetiously. They're saying that, you know, we haven't proven yet that these things are necessary and that society as a whole really needs community treatment orders and needs to change the definition of harm to self or others, which, again, I would disagree with. Thank you for clarifying that, saying that if we do early intervention, which is really what Bill 31 is talking about, not really early but at least earlier, before there actually is harm occurring, then I think it'll be a safety issue and a benefit to all Albertans. So I completely agree. I thank you for your clear presentation of the bill.

I also agree with you that – originally it was my intent to have people put on a community treatment order while still in the community, to not have to do the hospital visit first. That's something that I would like the committee members to consider as we talk about this and how to improve the bill. You may want to comment on that again.

The question that stuck out from your presentation, Dr. White, was about the review panel. Just prior to you we had the mental health advocate asking for a very similar thing with regard to a review panel being involved, possibly, after the six-month CTO has expired. I didn't hear you put a time limit on it. Do you like the six-month time limit? When do you think the review panel should be involved? Could you elaborate a little bit on your thoughts around that, please?

Dr. White: Well, I mean, as I said, there have to be checks and balances to address some of the issues in relation to civil liberties. The patient has to have a right of appeal. Now, also coupled with that, when a patient is put on a CTO, the patient has to be informed that they have a right of appeal, and they have to be informed about how they appeal, the mechanism of appeal.

Now, just to comment on your feedback here on Civil Liberties. I get distressed when I get quotes like "not an exact science." I'll give you some figures from the state of New York in two seconds. The majority of people who bear the burden of patients with this illness are a hundred per cent in favour of this legislation. You will be hearing from the Schizophrenia Society. These are the people who live with this issue on a daily basis. I get upset when you have third parties talking about frivolous issues, about inexact science.

'Here are some figures from the state of New York. It's called Kendra's law. They reviewed 5,000 people on CTOs over five years, and here are some of the facts that they've found. In this population 74 per cent fewer experienced homelessness; 77 per cent fewer experienced psychiatric hospitalization; 83 per cent fewer experienced arrest, and 87 per cent fewer experienced incarceration over five years; 55 per cent fewer recipients engaged in suicide attempts or physical harm to self; 49 per cent fewer abused alcohol; 48 per cent fewer abused drugs; 47 per cent fewer physically harmed others; 46 per cent fewer damaged or destroyed property.

Now, one of the things that has been quoted here is that, in fact, the patients don't like this; they don't like the coercion bit. The satisfaction survey from patients in New York is 75 per cent. Patients initially don't like going on it, but they like the structure involved.

What it does, too, is that when a patient is on a community treatment order, it puts the onus on the system to provide service

because if I am administering a community treatment order, I have the responsibility to ensure that that patient has a nurse, is seen on a regular basis, and intervene when necessary. So the system has to step up to the plate and has a responsibility to provide the service. Thus the need for resources for assertive community treatment.

I hope that answers your question. A patient has a right to be well. You know, it sometimes gets misquoted that delusions and hallucinations in patients wandering in the community is a lifestyle choice. I get actually quite angry when I hear that kind of stuff because I see the dreadful consequences of mental illness. Depression now is the number one cause of disability world-wide; schizophrenia is number three. This is a very important issue.

I disagree completely: psychiatry is quite an exact science.

Rev. Abbott: Yes. Thank you, sir.

The Chair: Mr. Flaherty, followed by Mrs. Mather.

Mr. Flaherty: Yes. Thank you, Mr. Chair. Dr. White, you referred to the rural areas. In my experience in the rural areas when I was regional director of social services and health, the limitation of services for psychiatric people and diagnosis were big issues. Particularly, when you had a problem, you couldn't get psychiatric help. Are we suggesting in your model that when there's an issue, for example in Peace River, and there's no one available to do the assessment and diagnosis of people identified as a problem – I remember having them incarcerated in a jail on the weekend until we could get some service, quite frankly, because we as laymen anticipated that they were a threat to the community. So what do we do in the rural areas of this province, even in the area of Fort McMurray, for example, where you would tell us what kinds of services are available? I think this also talks about transportation and lodging if they're coming into an urban centre to be looked after.

11:45

Dr. White: A classic example. Last night I got a call from Athabasca, a patient who's depressed, suicidal, and in the local hospital. He had taken an overdose, and of course they said: can you make the patient medically stable? Okay. We'll make the patient medically stable. I get a call back at 1 in the morning from the family doctor. This guy had just left the hospital. He had run out. The cops had to arrest him and put him in a cell under form 10 under the Mental Health Act. I admitted him at 3:15 this morning. So that's a classic example of how the rural agents have difficulty with resources.

The reality of Alberta right now is that we need resources. We need community mental health clinics. We need secure facilities in the community. We can't find the people to man them. I mean, we could put a billion dollars into the system tomorrow, but I honestly can't say to you that I'll be able to man all those, no problem. Mental health care, all health care, in the community is an issue.

I've just come back from the Alberta Medical Association annual general meeting. We are going to have a crisis in rural family medicine in five years' time because a significant number of our GPs are going to retire, and there's going to be a significant reduction in the percentage of family docs available to do rural medicine. This is a crisis, and it's not a crisis of our own making. It's a crisis of circumstances. It's a crisis of opulence. I can't remember the report that talked about shutting down some of the places in medical schools 15 years ago. We're now paying the price, but that's a whole different discussion. I won't get into it.

In answer to your question, I mean, this is a difficult problem. What has happened in mental health is that there has always been this geographic shift to the cities. A classic example is I've had a couple of young patients from Fort McMurray, and I had one from Yellowknife, young patients abusing drugs. Seventy per cent of the mental health population are abusing drugs. The concordance right now with addictions is 70 per cent, and that's a whole other area of addictions.

A classic example is that they come to my unit. I run a rehabilitation unit at Alberta Hospital. We put these people's lives together. We get them social intervention, vocational intervention, occupational therapy intervention. We help them with their mental state. Some improve, but a significant number have developed chronic symptoms. The aim is to help their quality of life and increase their level of functioning. They go back to Yellowknife. There's no support system in Yellowknife. The group home system is very narrow. It's outside Alberta, but it's a good example. So what happens is we make the recommendation that, well, for good follow up, to be seen on a regular basis, we need to put you in a group home in Edmonton. You get good service and you do, hopefully, fairly well.

The rural areas are a huge problem. I get calls from GPs all the time about patients with mental health issues, and what it is really is not the problem with diagnosis from a family physician's perspective; it's the lack of support services. Now, a lot of these patients don't necessarily need a physician. They need a social worker. They need a community mental health nurse. They need a psychologist. We have a shortage of psychologists in this province. I would take two or three psychologists today in my service.

So it's a complicated issue. The solutions are numerous, but if we had a billion dollars tomorrow, I would be dishonest in saying that that would be the answer to the problem because it's not. It's a multiplicity of answers. Obviously, financing and support are very important. It's the most important part of the parcel, but it needs to come with manpower and resources as well, and that is a difficult issue.

Mr. Flaherty: Thanks very much.

Mrs. Mather: Thank you, Dr. White, for being here today and for clarifying so many points so well. I think the emphasis on the need to put onus on the system to provide service is very important. You have touched on it a bit, but I guess probably with some bias as a psychologist I would ask you – and you did suggest that perhaps a psychologist could be part of that community health team – could you tell us a little bit more about whether that is another tool that we should be looking at?

Dr. White: I have two psychologists on my team, and they're the core part of the team. There are two issues here. There are manpower issues and also the administration of CTOs. We need to keep it simple, and we need to keep the lines of responsibility very clear. I think it should remain with the physicians. We have adequate medical legal cover.

It's interesting. Now that the pharmacists have permission to write prescriptions, their medical insurance has gone up tenfold. That will happen in psychology as well. I think the strong emphasis here is the onus of responsibility because if we have other disciplines – and that's no disrespect to any other discipline – I think it needs to stay with the physicians.

The manpower issue. We have a huge manpower problem in psychology. Our psychologists go into private practice for financial reasons. They make more money in private practice. I mean, I've had discussions with Pierre Berube and with Stephen Carter of the Psychologists' Association of Alberta on this. There needs to be a

payment system so we can actually retain psychologists in the public system. We need to pay them properly.

I have two psychologists who are both what we call behaviouralists. I run a psychosocial and vocational behaviour rehabilitation program. My population average age is around 25, with significant levels of disability. I have two psychologists who are specifically trained in behaviouralism and how to work. These are the core members of the team. Both have their master's. They are going to leave and go into private practice because, you know, they've got families, they're aspiring to do better, whatever, and they make more money in private practice. That's an issue. If we had a better payment system in the public system for psychologists, we could entice some psychologists out of private practice, and maybe they could do half-time private, half-time public like a lot of our psychiatrists do. So that's an issue.

Mrs. Mather: Right. That's because at this time they can't bill under Alberta health.

Dr. White: You know, we can devise a system, but I think our psychologists are underpaid in the public system. I can't speak for the private system – I personally don't do private practice – but they are totally underpaid in the public system, and that has been an issue for a long time.

Mrs. Mather: Right. Thank you.

Mr. Lougheed: I appreciate your comments. They clarified and emphasized many things. I think it was Barer and Stoddard that went across the country 15 years ago telling everybody to reduce medical school enrolments and so on.

Dr. White: I get an instant bad feeling when I hear those names.

Mr. Lougheed: Luckily, they went across the country two years ago and told everybody to increase.

Dr. White: Yeah, we're trying to correct the problem now, but, you know, there's a lag time of 10 years or whatever.

Mr. Lougheed: A question with respect to community supports – and I especially appreciate that comment as well. As I understand it – and perhaps you can comment a little bit – things like the program that was set up for injectable Consta, where every two weeks, I believe it is, they come in and there's sort of a supervision that takes place there. My understanding from the people that are on this program is that it's very successful, and in all the things that you mentioned, I didn't catch that reduction in homelessness is one of the other things. Was that in that New York percentage reduction?

Dr. White: Yeah.

Mr. Lougheed: Those are all parts of this whole system working correctly. Just to clarify, when they're under CTO, the medication is provided by the system?

Dr. White: Yes.

Mr. Lougheed: Good. Have you done any work with a peer support model, where newly diagnosed or perhaps people that return to care when released are under any kind of a peer support system where somebody who has experienced this personally helps smooth the way a bit?

Dr. White: Yeah. A few points there. Let me say this. This legislation is just another tool. It's not the solution to inadequate community resource. It's just another chink in the armour that we can use for this difficult population.

One of your questions was in relation to patients with what we call first break. We have a first break clinic here where we have young people who have their first psychotic break. Most patients who come to the notice of the system are actually psychotic for a year before they come to notice it because there are changes in behaviour, hallucinations, delusions that begin to impinge on the behaviour of the patient. The first break system is where they're seen as quickly as possible, gotten into treatments as quickly as possible, and they're offered a various sort of community outreach program. There's a specific team that looks after these patients. So that's kind of the support module that is currently present in the community, but it does need more resources.

11:55

I will say that in order to administer CTOs, you need good community resources. One of the criticisms of CTOs that has been put out in the past is that CTOs will replace community resources. You can't do CTOs without the proper community resources because you need your team, you need your community psychiatrists, you need your nurses and your social workers. That system, as you had mentioned, is going on, is present. Again, if we have this legislation, that's just an extra bit. A classic example: a young person develops a psychotic disorder at the age of 19 or 20, goes into hospital, relapses, in and out. Of course, the level of disability goes down, as I already mentioned. If you have a CTO in place, and if the patient addresses the criteria, you can ensure that that patient stays on treatment.

I have patients on antipsychotic medication who've been out of hospital for 15 years with this type of system. What I've noticed is that their level of functioning gets better. They get a job. They get part-time jobs. They become productive in the community. They become volunteers. The evidence is that with continuous treatment, without an interruption – it's the interruption that does the damage because you get a significant drop in function.

The problem with our newer drugs – and I'll talk about Consta in a second; I'm glad you brought it up – is that they're not bound as strongly in the brain, so if you go off them, it's excreted very quickly, which means the relapse is very fast. The older drugs are dirtier, have a lot more side effects, but they cling to the brain much longer. That's why they don't relapse as quickly, but that's not a reason for using the older drugs.

Consta is a classic example of a shift in how we look after our patients. Consta is the long-acting form of risperidone, which is one of the newer drugs, which is lower in side effects. If a drug is lower in side effects, patients don't mind taking it, and compliance is better. Consta is used for those with a chronic psychiatric illness with multiple relapses. The joy of having them on an injection is that if they're due to come in tomorrow for the injection, and if they don't turn up, the nurse goes out after them. We have a clinic where we give our patients their injections, be it weekly, biweekly, or every three weeks. With assertive community treatment care goes out to the patient. It's the other way around. It's not like the traditional medical model.

Now, we have a problem with support for Consta. Consta is not funded at present under Blue Cross. I've been advocating for this for a long, long time. I know that there's been a significant interest in having it funded, and the reason why is that the feedback is that the research is not clear. That is true because the current clinical research is evolving and getting better. The clinical evidence is

overwhelming. All psychiatrists see significant benefit with this medication. Patients are more compliant. They're not as cognitively impaired as they would be with the older drugs, and their level of functioning increases. The evidence clinically is overwhelming. That is an issue. I want to see Consta funded in the system. Eli Lilly has a newer medication in the form of olanzapine coming out in a long-acting form as well. This has been a huge shift in how we treat our patients because we're giving them cleaner drugs, which means compliance will be better as well.

The Chair: We have enough time for one brief question from Dr. Pannu.

Dr. Pannu: Thank you, Dr. White. You bring to the table very extensive expertise, international experience. In particular, I commend you for underscoring the importance of community supports as a key element in this whole puzzle to deal with the issue of mental health and mental health patients. You are at the same time, of course, even if there is no community support system in place, very much advocating the CTO legislation that we've brought into being.

Two things here. Do you think CTOs will work without first putting in place the kinds of community supports that you are recommending? If we fail to put in place those conditions in the form of community supports, two things are likely to happen: the threat to civil liberties and, in fact, the erosion of the civil liberties of people who don't have the benefit of receiving support in the community, being against their will committed to hospital; secondly, the costs to the community of putting these people into the hospitals on a long-term basis rather than providing them with both an opportunity to improve, get jobs, get housing, get care and to improve if they can remain outside.

The issue here is whether you're trying to put the cart before the horse, what conditions we should put in place first before we bring in a more severe piece of legislation which will take away some of the civil liberties of these people yet will not lead necessarily to long-term improvement and rehabilitation of mental health patients into the community and to the improvement of their own lives.

Dr. White: First of all, I disagree. This is not a severe piece of legislation. We have legislation in place right now which gives us the authority based on the criteria to lock up patients, put them in a seclusion room, and keep them there until they're stable. The community treatment order legislation is actually less severe and more targeted to help patients than the current Mental Health Act. So I disagree on using the term "severe."

The mental health legislation has to have civil liberties addressed. All psychiatrists apply the current Mental Health Act with great scrupulousness. The idea that patients will be frivolously put on community treatment orders is completely untrue because we have to address our responsibility to a mental health review panel, and the onus of proof is on us.

Now, getting back to community resources. We already have good community resources. CTOs introduced with the current resources will be a significant help with this population. Okay; we have significant gaps in the system and particularly in the rural regions, where we do need more additions to the community mental health system. In fact, we need more money in mental health, full stop. I have a meeting with Mr. Flaherty in Ottawa on Thursday with the Canadian Psychiatric Association to address that very issue on a national level.

You need the support system in place. It's not an issue of the cart before the horse here. The issue here is an addition of a piece of legislation which will target a very vulnerable, difficult population, mainly young people, who are a huge burden on families, to themselves, causing significant disability, and also a significant burden on the system. This is an addition. It's not one without the other. You do need both together.

We have a developing community support system right now. The provincial mental health review has made several recommendations, issues on homelessness, et cetera, et cetera. We've had regional reviews on mental health, and we're rolling out some of those recommendations as we speak in relation to crisis services, police and crisis services, expansion in the suburban regions.

With respect to your question it's not that simple. I mean, this is just an extra tool which I believe will address the issue of the right to be well for our patients. We have patients who when they become so psychotic have the inability to make good decisions on their own behalf, where they have limited insight. Based on limited insight, they go off their medication, and they end up back in hospital. We need to help these people, and we have a duty to help these people. This piece of legislation is not the complete answer, but it will certainly help significantly for this population. We're not talking about an absolute utopia here. This is just another piece, a tool to deal with a very vulnerable and very difficult population.

The Chair: Thank you very much, Dr. White, for taking the time out of your busy schedule to make a presentation to this committee.

The committee will now break for lunch, and we will reconvene promptly at 1 p.m.

[The committee adjourned from 12:03 p.m. to 1 p.m.]

The Chair: Well, good afternoon, ladies and gentlemen. It's a pleasure to be here today at public hearings of the Standing Committee on Community Services.

I'd like to welcome Dr. Clark Mills of the Alberta College and Association of Chiropractors. Thanks for taking time out of your day to make a presentation to our committee. Would you please proceed?

Alberta College and Association of Chiropractors

Dr. Mills: Thank you very much. It's a pleasure to be here, and we do appreciate the opportunity to address your committee today. I'd like to just take a minute and introduce my colleagues. Dr. Brian Gushaty is the registrar of our college, and beside him is our CEO, Ms Deb Manz. My name is Dr. Clark Mills, and I serve as president of the Alberta College and Association of Chiropractors. We very much look forward to some dialogue following our brief presentation today.

I thought I would review, certainly for myself – you people don't need it – a little background. On July 24 you, Mr. Marz, acting chair for the Standing Committee on Community Services, provided notice that review of Bill 31 and Bill 41 was being undertaken. The Alberta College and Association of Chiropractors has indeed reviewed Bill 41 and has provided some written comment to the committee.

A search of the Health Professions Act on the Alberta Health and Wellness website provides a brief perspective on the role that that legislation is intended to play, and I'd like to just quickly review if I could. The Health Professions Act, or the HPA, establishes a common framework for the governance, the regulation, and the discipline of all regulated health professions in Alberta. Secondly, once all the regulations are approved, the HPA will govern about 30 professions through their 28 regulatory colleges. The HPA also provides health professions with a new flexibility. It effectively

eliminates exclusive scopes of practice and introduces the concept of complementary and overlapping areas of practice. This legislation with its regulations will allow the province to expand the role of health providers and make the most cost-effective use of health professionals in providing primary health care services.

The HPA has been a very, very long time in its evolution across all of these regulated health professions in Alberta. Much sober thought, innovation, and effort has gone into the legislation on the part of government for sure as well as the professions that are or will be governed by the act, and, not like any legislation, implementation provides an opportunity for all professions and stakeholders to review the act and modify it for clarity and consistency.

Just addressing some of the amendments, I'd like to speak about the risk to self-regulation and the need for accountability. Notwithstanding a critical need for public accountability the ACAC is concerned that the proposed amendments in Bill 41 related to self-regulation may have been proposed as a response to several specific circumstances that have risen within certain health regions as well as with individual professions. Not at all to minimize what were very disconcerting circumstances, it is our opinion that it would be more appropriate to deal with these situations directly with the profession or professions involved rather that attempt to address them via amendments that, frankly, we believe have the potential to threaten the very essence of self-regulation as well as even how legislation is constructed in Alberta. We are uneasy that a systemic solution is proposed for essentially focal challenges.

The recommended legislation has a potential, in our opinion, to undermine the principles of self-governance, and now accountability is absolutely crucial to ensure public safety and protection like never before. However, in the event of identifiable concerns this accountability should be made to rest squarely with the profession or health region in which there is a recognized or demonstrated issue. Holding all self-regulated professions hostage to what amounts to unilateral ministerial oversight in the absence of Legislature support would be seen as a significantly regressive proposal and causes our profession some considerable consternation.

Let me talk briefly if I could about section 1.1, the mandatory reporting obligation. Within the definitions in the Public Health Act applying to this proposed amendment, section 1.1 creates a mandatory reporting obligation to the medical officer of health. Now, there's no reasonable argument against the idea of reporting matters of concern related to public health, but this proposed amendment poses two significant areas of concern to the ACAC. First, the legislation provides somewhat vague and even possibly misleading definitions of exactly what should be reported. With the opportunity for such broad interpretation the potential for imprecise or even nonreporting, in our opinion, remains great. As well, misdirected or malicious reporting is almost assured with the current Public Health Act definitions.

Also of concern is the issue of reporting to an appointed medical officer of health. This, in essence, leaves a sole profession, that being the medical profession by virtue of the appointed individual, to adjudicate the issue of what may or may not constitute a threat or a nuisance. Reported issues may be reviewed and arbitrated with insufficient understanding or knowledge to appropriately appraise the circumstances at hand.

This structure is contradictory to the entire premise of self-governance and the notion of each profession being held accountable for ensuring that its members are compliant with matters of public safety. Alternatives to this amendment – we're speaking, again, of section 1.1 – can still certify effective reporting mechanisms while at the same time remaining appropriately anchored in the obligations of each regulated profession. For example, where concerns are identified, a joint review could be structured between the profession in question and the government or health authority as appropriate. Expert autonomous advice could be sought as required.

In any review process and certainly as a minimum requirement the inclusion of the profession in question is essential. The anticipation of accountability cannot be expected to succeed without the full knowledge and commitment and participation of that profession at the table. Mandating collaboration between specific professions and the government is critical to ensuring that issues are addressed, changes are embraced, and modifications are sustained over time. Arbitrary intercession, we believe, is a very short-sighted approach. Other equally effective mechanisms are available.

If I can speak about section 134 and the powers of the Lieutenant Governor in Council, the proposed amendment to section 134 that addresses powers of the LGIC is troublesome for us as well. The amendment allows for virtually any action desired. The current legislation provides clearly defined authority in this area. The proposed amendment would allow any contemplated regulation to be addressed by the LGIC. Again, any proposal that would see the current standard of developing and approving legislation disregarded in favour of a potential unilateral direction to the LGIC by a single ministry is counterintuitive if not alarming. This amendment of section 134 is clearly intended to support the changes proposed in section 135.

The current process for legislative change is based on a system of parliamentary procedure that has stood the test of time and has embedded within it the checks and balances of a corporate body of elected officials representing the interests of the very people that elect them. To vacate this process and place legislative change in the hands of a single minister regardless of the situation undermines the entire democratic parliamentary system and throws its veracity into question. Albertans know that legislative change should remain firmly anchored in the current process, which will in fact provide far broader safeguards for the public than those proposed changes could ever address.

Ministerial intervention. This is section 133. This section is related to proposed amendments that would provide the ability for the minister of health to subjectively intervene in the affairs of the regulated health profession. Most specifically, these would allow the minister of health to make, amend, or delete bylaws, standards of practice, codes of ethics, or any of its practices. As drafted in this legislation, all of what I have itemized could occur at the sole discretion of the minister of health with the full force of the Legislature behind him. The LGIC, too, on the recommendation of the minister can vary any provision of the HPA as the provision applies to any college and its council, its officers, or its committees. Thirdly, the minister of health could appoint an administrator to carry out any of the powers and duties of the college and its council, its officers, or its committees.

1:10

So, in essence, these proposed amendments provide the mechanism to have the privilege and right of self-governance withdrawn and the potential for total oversight by a single ministerial office in its place without any action or consideration by the elected representatives of the Alberta Legislature. This is imprudent. No provision for the identification of specific concerns or dialogue with the appropriate profession or any joint agreement to an intervention strategy appears to have been considered. Self-governance as we know it would become a total facade, supplanted by this potential for government intervention and oversight at any time.

I think collective accountability is more effective. It's more appropriate that dangers or concerns of public safety and public

health be considered the collective responsibility of regulated health professions, provincial health authorities, and government working together. That being said, concerns of a specific nature relative to any profession or health authority should be addressed as such in the appropriate forum, a focused solution for a focal problem.

Accountability and responsibility must reside with each individual regulated profession. The role of government for the people of Alberta is to ensure this accountability by government, not by a single ministerial entity. The challenge is this: to see to it that all health professions demonstrate to government and to the citizens of Alberta their commitment to professional integrity and accountability. We accomplish this via the discharge of our self-governance mandate in a diligent, consistent, and transparent manner.

That's kind of the summary of how we see the world related to Bill 41. Thank you.

The Chair: Thank you very much for the presentation.

Are there any questions from the committee?

You must have been very thorough in your presentation.

Dr. Mills: When you speak like an auctioneer, they probably missed half of it.

The Chair: Mrs. Mather has a question.

Mrs. Mather: Thank you for the presentation. It is quite clear and well said, but I would like you to expand a little bit on this part where you said: "misdirected or malicious reporting is almost assured with the current Public Health Act definitions."

Dr. Mills: Could I defer to my registrar? We've had this conversation many times, so I'll invite up Dr. Gushaty. He can explain our concern in this area.

The Chair: Could you come to the table, please?

Dr. Gushaty: Sure. Our concern with this issue is with the broad definition that's found in that piece of legislation that defines those particular issues that require reporting. The perspective on health issues varies from profession to profession, and our concern is around the perspective of the single or sole governing profession, the medical profession, in the appointed position of a health officer interpreting issues that may be profession specific or particularly profession significant.

Mrs. Mather: Okay. Thank you.

The Chair: Any others?

Dr. Pannu: Just a comment, Mr. Chairman. Dr. Mills, your organization's concerns reflect, broadly speaking, the concerns of all professions, I notice. Are there any unique concerns that you have? We had the nursing representatives come before us. We'll be hearing from the Alberta Medical Association this afternoon or later in the evening. Are there any specific concerns that pertain to your particular circumstance?

Dr. Mills: I think you're quite right. I think the concerns about this are generally held by all regulated health professions. Brian has outlined that our major concern is, for instance, where a medical practitioner may be the sole arbitrator of health issues. We think that's short-sighted and narrow in terms of the entire scope of health care in Alberta. So that's an issue that might resonate particularly for the ACAC.

Dr. Pannu: Thank you.

The Chair: Seeing no others, thanks again very much for your presentation.

Dr. Mills: Thank you for your time.

The Chair: The next presentation is from the College of Physicians and Surgeons of Alberta, and we have, I believe, Dr. Trevor Theman and Dr. Jim Bell. Are they here? Okay. You may take your seats at the table. I'd just point out that you have 10 minutes for a presentation and 10 minutes for questions from the committee. We've been flexible with the amount of time on the presentation, but the total amount of time between the presentation and the questions is strictly enforced. You have the clock on the wall to give you an indication of how the time is slipping by.

I'll let you proceed from this point. Please, go ahead.

College of Physicians and Surgeons of Alberta

Dr. Theman: Thank you, Mr. Marz and members of the committee. This should take me nine minutes, so we should be okay.

Good afternoon. My name is Trevor Theman. I'm the registrar of the College of Physicians and Surgeons of Alberta, and I'm accompanied by Dr. Jim Bell, who is the president of the council of the college. We're pleased to have this opportunity to present our position to you with respect to Bill 41, and we understand the time constraints.

As you've heard – and I listened this morning to the presentations by CARNA and the ACP – many, if not all, of the health professions are opposed to some specific amendments relating to section 135 contained within Bill 41, which is a series of amendments to the Health Professions Act. These amendments are not only a direct threat to self-regulation of the health professions, they are, in our view, unnecessary, they risk the collaborative relationship we have with government in Alberta, and they may pose a risk to the well-being of Albertans.

We recognize the public need and the public's desire for greater transparency and accountability of all the health professions. We in the College of Physicians and Surgeons of Alberta are committed to making necessary change to ensure that those objectives are met. I want to let you know that we have public members on our council, on our hearing tribunals, and on many of our committees and have had public representation for at least 25 years even though we remain under the Medical Profession Act, not yet under the Health Professions Act.

We believe that the powers that the minister and cabinet would be given if these amendments are passed are not only unnecessary but extreme and not in the public interest. The Minister of Health and Wellness has been quoted in the media as suggesting that we – that is, the college and the medical profession – are overreacting to his proposals. My response would be that we know what we are reacting to, and others can judge whether our reaction is appropriate or not, whereas the minister has crafted very intrusive legislation in response to an unidentified policy issue.

This legislation is unnecessary, in our view, because there has never been to our knowledge an issue that the medical profession and government, when it's related to those two parties, have been unable to resolve – this includes the recent breach of infection control practices in Lloydminster – and unnecessary also because the

better alternative to this legislation is for government to consult more regularly and more openly with those health care organizations, like the health care regulators, that have the expertise and knowledge to help them solve problems.

I am convinced that consultation and discussion with the regulators could have avoided these threatening amendments, but such consultation did not occur. Let me emphasize. If Lloydminster is the spark for this legislation, then I ask: why was there no consultation with the College of Physicians and Surgeons of Alberta? Why were our requests to meet ignored until the middle of August of this year?

Why do we see these amendments as a threat to the public? Well, you've heard from others: because these broad powers would allow the minister or cabinet to do the following, if they so chose, without the need for public or legislative debate. We understand that as regulators if we are not responsive to the public or to government, government always has the power to introduce legislation to force our college or any regulatory body to get in line, but to introduce legislation requires openness, public scrutiny of the use of government's power, and the opportunity for debate and challenge. What we are facing, we being all the health professions, should these amendments be passed is the opportunity for the minister or cabinet to act without that level of scrutiny and public exposure.

1:20

What risks do we foresee? Well, I'll offer a couple of examples. We the College of Physicians and Surgeons are responsible for the licensing and registration of physicians, and despite our efforts to explain the standards that we have set and the efforts we expend in trying to ensure that as many qualified physicians as possible are licensed in Alberta, we're still seen as a barrier to the registration and integration of internationally trained physicians or international medical graduates, known as IMGs. So in this case the minister or cabinet could, if they chose, impose on us lower standards that perhaps would lead to there being more physicians licensed in Alberta, but in our view that would compromise public safety by letting unqualified physicians practise on Alberta's patients.

We also run the Research Ethics Review Committee, which reviews all physician-led research that doesn't qualify for research ethics review by one of Alberta's universities. This is essentially research done by community physicians. We hear rumours that Canada's major pharmaceutical companies see us as a barrier to getting research done in Alberta. While we categorically reject this view, we understand that the minister or cabinet could disband our Research Ethics Review Committee and allow unregulated research on Albertans for the economic benefit that such research would bring but to the detriment of patients and research subjects.

We also believe, as do our colleagues in the Alberta College of Pharmacists, that Internet prescribing, whereby a physician or other prescriber issues a prescription for a patient he or she has never seen, is bad practice, unsafe practice for patients. In Manitoba Internet pharmacies are big business, supported by the Manitoba government but opposed by the pharmacy and medical regulators. Our minister of health or cabinet could impose changes to the regulations, standards, or bylaws of the College of Pharmacists to allow Internet pharmacies to operate more broadly in Alberta and could allow Alberta physicians to issue such prescriptions by altering the standards and policies of our college. Such changes would detract from the safety and quality of care for Albertans and for patients beyond our borders. Writing a prescription for a patient the physician has never seen is bad practice.

Am I simply fearmongering by raising these examples? I think not. While unlikely, they are possibilities. Let us not forget that chelation for the treatment of hardening of the arteries, atherosclerosis, while completely unproven scientifically was supported by the government of the day. We now have an amendment to the Medical Profession Act that prevents us, the regulatory body, from taking action against a physician who practises such nontraditional but unproven and unhelpful therapies.

We believe there is value to professionally led regulation, justification for the trust that the public and government has granted to us. We regulators, while respectful of the political realities of the day, can do the right thing without concern for the political exigencies that affect governments regularly.

I just want to give you a couple of examples of the sort of standard-setting that we do in Alberta that ensures the safety of Albertans. I'm sure all of you are aware that a young woman died recently in Ontario following a liposuction procedure, and there are questions about the qualifications of the physician who performed the procedure. In Alberta our college has regulated such practices since private surgical centres were first opened about two decades ago. We define what procedures, including liposuction, can be performed only in an approved hospital or an accredited facility rather than a doctor's office. We set standards for those facilities, and we set rigorous qualification standards for physicians who wish to offer such services.

We also created the PAR program and lobbied government to provide us the authority to mandate participation in this program by our members long before the Health Professions Act was passed by the Legislature. This program requires that all physicians undergo a review of their practice by patients, peers, and co-workers every five years. We were the first jurisdiction in the world to introduce such a program.

You have heard from CARNA about the differences between the amendments contained in Bill 41 and the legislation in B.C. and Ontario. I want to emphasize that the environment, the social milieu, in both B.C. and Ontario is far different than it is in Alberta. In Alberta we have a long history of co-operation and consultation with respect for each other's roles and responsibilities. We should not be trying to emulate Ontario or B.C. Rather, they would be far better off if they could create the kind of collaborative environment that Alberta and Albertans have enjoyed for many years.

The amendments that Minister Hancock has introduced will only interfere with the very healthy, collaborative, open relationships we have all enjoyed in this province. There is an alternative to this legislation, and that is enhanced discussion and collaboration. Albertans have benefited from a very collegial and co-operative health care environment. This bill, in our view, is a large step backwards, one that should be rejected, at least those specific amendments. I urge you to recommend that the offending sections, those that offend and threaten self-regulation, be removed.

I thank you for your time.

The Chair: Thank you for the presentation.

We have some questions. Reverend Abbott.

Rev. Abbott: Thank you very much, Mr. Chair, and thanks for the presentation. We're certainly hearing a theme here from the different health professions. You're right: you guys seem to be in unison that nobody likes the changes that are being proposed.

I have a little bit of an issue with some of your presentation. You talk about that no consultation was taken with the health professions prior to the introduction of these amendments. I guess I would submit to you that this is that consultation. You're kind of thinking of the old way of legislation versus the new way. As you know, we have a new Premier. We have a new way of doing things. The

whole purpose of having these public meetings is to have consultation with the different professions, with the public, with all interested stakeholders instead of just one or two in a room as we try to draft legislation and get it on the floor of the Legislature. So I would say to you that this is the consultation phase. You guys have made a very, very strong argument as a collective group, and certainly I'm hearing your message, and I'm sure my colleagues are as well.

You've all come in with pretty much the same thoughts and the same notions, saying: we can do this ourselves. I guess my question for you, then, doctor, is this. You talk about the infection control challenges that have arisen out of Lloydminster and Vegreville. So far, what have CARNA and the College of Physicians and Surgeons done in a proactive way to address these concerns without the prompting of the department?

Dr. Theman: I can't speak for CARNA, but I can tell you that after months of trying, we were finally able to meet with the minister and then with provincial public health officials with respect to the issue in Lloydminster, and in an hour we had solved our problems.

There is one piece of this legislation that we strongly support, and this has to do with the addition of the explanation that I, for example, as the registrar have a duty to report. That was not clear in the Public Health Act. In fact, I think it is absent. On the other side, of course, I have other duties and obligations of fairness. I have to make sure that I do things by due process and such. So we have, I believe, resolved that.

Our council only a couple of weeks ago passed an amendment to our bylaws under the MPA which allows us to do the reporting that public health would like to see, and we've also created an infection prevention and control committee – that's a committee of our council – to look at infection prevention and control practices in physicians' offices.

I think it's important that you understand that we regulate many facilities in this province. We regulate nonhospital surgical facilities. We inspect and regulate private laboratories, diagnostic imaging facilities, and others. We have very explicit standards there, and we do inspections, but we don't inspect physicians' offices. We recognize that there's some risk here. We need to do better. We've taken action on that.

Rev. Abbott: Thank you.

Dr. Theman: Could I add one more thing, Reverend Abbott? I'm not sure if this is old way or new way, but it strikes me that the first issue before you introduce legislation of any kind would be to understand what the issue is, and frankly we don't understand the issue. If it is infection prevention and control, I would submit to you that that could have been solved without having to introduce legislation. To me this is a difficult way, frankly. Rather than seeking understanding as to the problem and a solution, we're now faced with attempting to convince you and the minister to make changes to this, which, I would submit to you, is a far more difficult process.

The Chair: Reverend Abbott on this point.

Rev. Abbott: Okay. If I could just comment on that. I hear what you're saying, but again my personal belief is that when we look at this, it's a much more open process than that. It's not a matter of: we've made up our mind, and you have to convince us to change it. It's a matter of: we have set out in a direction, and we're now asking for input to see where that direction needs to lead. I do feel that this is a very collaborative and a very consultative process, and I do feel that this is the opportunity to fix some of the problems in the legislation, and I personally foresee that happening.

I guess what I'm just saying maybe: new versus old. I don't know. It's different. It's a different way than we've done it before. It's including all parties, as you can see from around the table, and it's definitely more of a publicly open process. These are the kinds of things we used to do before in private. Now we're doing these things in public. I have a strong feeling that we will get to the same co-operative, collaborative end result. It's not really, you know, a versus situation; it's more of an open collaboration.

1:30

Dr. Theman: Thank you.

The Chair: We have Mr. Lukaszuk, followed by Mr. LeRoy Johnson.

Mr. Lukaszuk: Thank you, Mr. Chairman. Doctor, listening to your presentation and the one prior, a common theme emerges. It touches the issue of dispensation of authority, particularly in your presentation, which was fraught with innuendoes and, as you referred to it, fearmongering. An uninformed listener would conclude that somehow the authority to ensure quality delivery of health care in this province is dispensed from self-regulated bodies unto the minister and then handed on to the public.

We all know better than that. We know that the dispensation of authority actually is from the minister, and you're acting on behalf of the minister with a limited margin of authority that has been granted to self-regulating bodies by the minister. The actual, direct responsibility to the customer, to the public, to the voter is that of the minister to Albertans.

What I'm hearing in your presentation is that somehow in the absence of the self-regulating bodies there is ill intent on behalf of the minister and that the minister has no vested stake in ensuring that quality care is being delivered to Albertans, that it is only thanks to the self-regulating bodies that there are any standards in place to begin with, that otherwise the minister would have political agendas that would definitely take priority over quality of service to Albertans.

I would want to hear you comment on that because you definitely were implying that throughout your entire presentation. I would like to hear you address it perhaps more directly.

Dr. Theman: Well, I suppose, like any message it is in the ears of the listener. Certainly, it's not my intention to imply that the minister has no role here or that he has no interest in health care safety and quality. It was an intention to offer to you and to those listening the risks that are inherent in this legislation.

I have no doubt that the minister wants us to have the best quality care system in the world, and frankly so do I. I've heard the minister say that ultimately responsibility is his and the buck stops here. There is some truth to that, I suppose, but as a citizen, in fact, I think that that's not completely accurate. I have a role. I'm responsible to Dr. Bell and my college for the practice of physicians. I suggest to you that the minister can't and shouldn't probably be held responsible for everything that happens in the health care system because he can't. That's why he has a department. That's why he has regional health authorities. That's why he has health professions who have some unique expertise and knowledge and ability to undertake certain actions. I was attempting to point out some of those things that we do.

If I look at, say, the registration of physicians, I have to tell you that this is very complex. I have had the chance to speak, I guess

under the old system, to a cabinet committee with respect to that, and it's highly complicated. Frankly, I would submit that the minister of health needs to involve the health professionals and health professional regulatory bodies who work in the public interest – the public is our moral owner – to ensure that we have properly qualified physicians working in this province.

Mr. Lukaszuk: I appreciate the fact that conclusions are drawn by he who listens and not he who talks, but if that is the case, am I to disregard your commentaries relevant to the possible pressures on the minister by pharmaceutical companies or the registering of undertrained foreign-trained physicians or the prescription of drugs via the Internet? Are you not suggesting that if it was not for your role, the minister would definitely give in to those pressures and allow for those practices to occur?

Dr. Theman: No, sir. I'm merely suggesting that those pressures are on the minister and that, obviously, he needs to consider those pressures as he listens to all of his constituents, just as he listens to us.

Mr. Johnson: To follow up on your alternate suggestion which, as I heard it, was enhanced discussion. I suppose that some of my questions have already been answered in Mr. Abbott's comment regarding the consultation phase. As he had indicated, we're kind of in that right now. In regard to your comment about enhanced discussion, I know what's going on now, but are you telling me that there has been no discussion to this point? Can you just clarify?

Dr. Theman: Yes, indeed. The specific amendments to section 135, with the exception of the amendment that would allow the minister to appoint an administrator to assume any or all functions of a college or council, were never distributed for comment by the health professions. When that one was distributed, the pretty much unanimous response was that we thought that was acceptable if a college sought such assistance from the minister. We recognize that there are some small professions that may require that assistance.

The other amendments were not communicated to us. I believe the bill was introduced about June 12 or June 13, and I think about June 5 or 6, give or take, a week prior, the minister held a consultation session at which the health professions were invited. He did not share the wording. He merely said: I am going to introduce legislation that's going to increase transparency and accountability. That was the only consultation, if you can call that consultation, that occurred.

Mr. Johnson: Thank you.

The Chair: Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. Dr. Theman, you made some very strong and serious observations with respect to the impact that this will have on the ability of your profession and perhaps some others to continue to exercise both self-regulation in its fullness and self-governance. You know, self-governance/self-regulation is part of a pluralist model of democratic government, that some of the powers are devolved to specific groups so that they can make important decisions where the Legislature recognizes that they have the expertise and that they should be given the authority to do so. To change this particular model would be to the detriment, I think, of good governance, I would generally agree in principle.

You also draw attention to the question of the executive branch of the government almost usurping some of the powers that should be, in fact, in the purview of the Legislature. The Legislature will be excluded from making any major changes in regulating professions or whatever have you. I have concerns about this. As a member of the Legislature I very jealously protect the powers of the Legislature vis-à-vis the Lieutenant Governor in Council or the minister. So I think I share some of your concerns there.

Two other issues. You said that the minister is seeking, perhaps, some of these extensions of his powers in order to push forward with his policies for including foreign-trained doctors, licensing them. Do you agree that there's a need for some changes in the way we deal with foreign-trained professionals in this province at the moment, or do you simply say that things are okay as they are? There's widespread concern in the public that while there's a looming shortage of physicians in this province, we are not taking advantage of the presence of reasonably well-trained doctors who might need some further training. We need to provide those opportunities and fund those opportunities publicly in order to increase the numbers of those members of your profession so that we are not faced all the time with a serious shortage of doctors. So I ask you: what's your position on that?

1:40

Dr. Theman: I agree with everything you said, Dr. Pannu. Frankly, I mean, it's not even a looming shortage. We believe that we're short about a thousand physicians, which probably translates into 1,300 real bodies, right now, and that that number is only going to grow. We work really hard to register and allow to practise every qualified physician that we can. Somewhere between 25 and 28 per cent of Alberta's physicians are international medical graduates. Over the last five years somewhere between 25 and 33 per cent of every new registrant in the province was an international medical graduate. We are reliant. We will not in my lifetime produce enough doctors. I applaud government for increasing medical school positions, but we will not produce enough doctors in this province to be self-sufficient. We will rely on immigration from the rest of Canada and internationally.

It's a very big problem, and frankly I'd appreciate the opportunity to explain more fulsomely to you or to whoever that an MD is not equivalent to ability to practise. If you train in Alberta, you get your MD from the University of Alberta, University of Calgary. Then you do a minimum of two years of postgraduate training to be a family doctor, and you do a minimum of four years of training to become a specialist, say a psychiatrist or pediatrician or neurologist. Frankly, that's the biggest barrier we see. That's barrier number one.

Another huge barrier is that we see applications from individuals who may well be qualified. The challenge is that we don't know what the training is like and how it compares if you trained in eastern Europe or in Pakistan or virtually any other part of the world, with rare exception. For those individuals they may well be qualified if only we could get them assessed, some assessment process. There are a number of individuals who are able to get assessments, but it is small. We have been working very hard with the department, with the minister, with the medical schools, with regional health authorities to try to expand the assessment capabilities in this province because, frankly, we have a huge doctor shortage in some places like Grande Prairie, Fort McMurray, and Calgary. It's a crisis.

Dr. Pannu: Are you are telling us and the minister that you are not a barrier to the inclusion of foreign-trained doctors in your profession?

Dr. Theman: Absolutely. I'm telling you we're not a barrier. We're a barrier only to the registration of those who would be unqualified.

Dr. Pannu: Well, you recognize that there is a perception about that, and the minister, you said, is influenced by the perception. Is it entirely without any basis in reality, then? Is that what you're suggesting? It's a categorical kind of statement that you're making.

Dr. Theman: I understand. We were part of a process. It was called the Western Alliance for the Assessment of International Physicians. We assessed about 40 candidates. These were physicians who were not eligible for full registration based on their criteria and qualifications or for entry into the Alberta international medical graduate program, which is a training program. But we assessed them, as did our colleagues in Manitoba and Saskatchewan and British Columbia. Out of that, using very liberal criteria, we were able to identify three individuals who we thought might be eligible for practice. Of the three, they then went through a knowledge-based examination, and those who were successful went through a three-month clinical practicum. We have one registrant, one of 39. So I would suggest to you that there is a large pool of people who have an MD but who for a variety of reasons would need to go back to school at some level in order to be able to qualify to practise in the province.

Dr. Pannu: I want to switch to my second question but, you know, there is a difference in the U.S. The same people with the same qualifications have a much easier time, I understand, getting in than here.

My second question to you is another important statement that you made about the influence of pharmaceutical companies trying to change rules, you know, by which they want to commission research and all of that. Pharmaceutical companies are a very powerful, well-resourced lobbying group. It's known. There are tonnes of books written on it, articles written on it, press reports on it. I can't challenge you on that. Now, what basis do you have to say that pharmaceutical companies are indeed attempting actively to get this minister and this government to go down the road that they would like to proceed?

Dr. Theman: Thank you, Dr. Pannu. I don't believe that I actually said that. I just simply said: here are possibilities. I have no question, from speaking with individuals in the ministry, that large pharmaceutical companies do lobby government members and probably members in all parties, and I have no doubt that they do express their view that the College of Physicians and Surgeons and our Research Ethics Review Committee are barriers to performing research. That much is true. Finally, if I may.

The Chair: Briefly.

Dr. Theman: An international medical graduate going to the U.S. has to do postgraduate training before he or she will be allowed to practise. We don't require that. Okay? That's a huge difference. I mean, it says that everybody who's going to come from the Philippines to the U.S. to practise medicine first has to do a minimum of two years of extra training. We neither have the capability nor the requirement for that, so I would argue that, in fact, it is not as great a barrier in Alberta.

The Chair: That concludes our time for this presentation. We thank you very much.

We'll take a two-minute recess for the staff to set up equipment for a PowerPoint presentation for the next presenter.

[The committee adjourned from 1:46 p.m. to 1:49 p.m.]

The Chair: Okay. The next presentation is by the Schizophrenia Society of Alberta. I'd like to welcome Mr. Giri Puligandla and Ms Anne Packer. Please proceed. You have 10 minutes from now for your presentation.

Schizophrenia Society of Alberta

Mr. Puligandla: Okay. Thank you. First of all, I'd like to thank the members of the Standing Committee on Community Services for giving us this opportunity to speak to you about Bill 31 and our hopes and prayers as far as that goes.

I'll just give you a really quick background about schizophrenia. Schizophrenia is a disease of the brain. It's often called a mental illness, a biochemical brain disorder. It most often develops between the ages of 15 and 25. If you think about that time period, that's when people are basically making that transition from childhood to adulthood. They're learning life skills, and they're getting social networks. Schizophrenia can be quite disabling in terms of basically precluding that development of social networks and life skills.

Some of the symptoms associated with schizophrenia include difficulties with thinking and speaking, hallucinations and delusions, often termed as psychosis, a need to withdraw from any kind of social contact, problems performing routine activities, whether that's going to work or brushing your teeth or putting on clothes. In many cases there's a lack of insight into their own mental state, and this is actually where involuntary treatment and community treatment orders in particular come into play. Now, no two people with schizophrenia experience the same sorts of symptoms, and that also creates great difficulty for clinicians in not only diagnosing the disorder but also treating it.

That little pie chart there basically demonstrates the disparity between, you know, the outcomes for people diagnosed with schizophrenia. If you look at the green section, 1 in 3 people diagnosed with schizophrenia will recover completely, so they can basically look back at that time and be thankful that they got past it. Another third, that yellow area, recover substantially. They may need medication. They may need supports, et cetera. In fact, it's a small group in that yellow area for whom community treatment orders would be used. In the last third for 23 per cent for some reason no treatment seems to work quite effectively. In a lot of cases hospitalization is the only solution. Then you see the 10 per cent for suicide. In fact, 40 per cent of people with schizophrenia attempt suicide, whether it's because of their psychosis or whether it's a loss of hope. Basically, it's possible to say that schizophrenia can be a fatal disorder.

Schizophrenia is also the most common diagnosis of people admitted involuntary to psychiatric units, and that's the reason why the Schizophrenia Society is here today.

The Schizophrenia Society was started in 1980. We are Alberta's only family-based provincial organization dedicated to helping people overcome severe mental illness, so not only schizophrenia but bipolar disorders, severe depression, anything that basically severely disables people. We provide information, individual and family support, public education outreach, and advocacy for family members and people living with the illness. When I say family based, we were started by family members who decided to be active and take on the mental health system in order to improve it for their

loved ones. We are also strong believers in peer support and the power of the health promotion framework.

It's not an exaggeration to say that many of our families have been in despair for many years due to the inadequacies of Alberta's Mental Health Act as well as the mental health system, including access to medications, access to community treatment, et cetera. So there's no doubt that the current Mental Health Act needs to be changed, and that's why we're very happy that Reverend Abbott did present that bill with Minister Hancock. Frankly, under the old bill family members just couldn't help loved ones who were so obviously deteriorating, and anyone who's a parent can understand that sense of frustration when you see a problem and you want to do everything you can to solve that problem but things are getting in the way. Your loved one won't start treatment, and no one can get them to take their treatment.

The wording in the old Mental Health Act about dangerousness is quite stigmatizing. In fact, if you look at it this way, people with mental illness are about 2.5 times more likely to be victims of violence, yet in the wording used in the Mental Health Act, they are defined more in terms of their potential for dangerousness rather than for their likelihood to be victims of their own mental illness, whether that's through abuse by others or from deterioration of their lives.

1:55

Obviously, people want the least restrictive method of treating people. Frankly, a hospital is far from being the least restrictive. That's why we're in support of community treatment orders and that sort of thing, to allow for similar levels of supervision in the community so that people can remain within their social networks, especially young people, and they can basically continue their lives while they're undergoing treatment. I'm sure that we've all heard about this revolving-door syndrome, where people are admitted to hospital, kept there for a few days, discharged, and then, you know, once again they come back in and are discharged, and that goes on for years, sometimes decades, as many of our families will attest to.

Bill 31 would remove barriers to care for people with mental illness. There's no doubt about that. It can change the way people look at mental illness. Instead of defining people by dangerousness, we're indicating and recognizing that people with mental illness are vulnerable to decline, and that should be the focus of any kind of intervention.

To make sure that information follows the patient, in Bill 31 there is a requirement for information sharing between the hospital and family physician. There's, I guess, a buzz term, continuity of care, that's thrown around a lot. For people with mental illness it's a dream. Once they're discharged from hospital, the supports, the treatment, all that disappears, and they're left kind of scrambling, trying to find a way to recover. Hopefully, we won't get any more situations of parents turning up at their homes and finding their kid there with a garbage bag after just being discharged from hospital, and hopefully their family physician will know as well.

It could introduce tools for supporting community living. The introduction of community treatment orders is wonderful; however, we strongly believe that the eligibility criteria for CTOs are far too strict to be useful. Under Bill 31, if it passes, the following must be fulfilled for a CTO to be issued. First of all, they have to be admitted to hospital as an involuntary patient. They have to fulfill these criteria that basically say that the safety, health, or welfare of the person is at risk and that without treatment they're likely to deteriorate further. The care has to be available in the community, and the person has to be able to follow the prescribed treatment.

Then this fourth one: "during the immediately preceding 2-year period . . . has been detained as a formal patient for at least 60 days " or "on 3 or more separate occasions." This fourth point is what we have concerns about. We feel that we shouldn't have any kind of previous hospitalization requirements. There are six reasons for this. Number one, relatively few people could benefit if the preconditions remain. If this bill gets passed – and we really hope it will – we want this to be effective immediately for all the people who have been going through the revolving door for years. The requirement for 60 days is, you know, far too strict. Very few people are detained involuntarily for more than just a few days.

Secondly, the three admissions have to be involuntary. In fact, most admissions are voluntary. The reason why "voluntary" is in quotes is because most mental health workers quite rightly will, to use the word, coerce the person to admit themselves voluntarily instead of having them involuntarily admitted. That's why a lot of people who could benefit from a community treatment order right away would probably have to wait for a few more admissions before that could be possible. That's the revolving door spinning and spinning again.

Waiting so long makes recovery much harder. Psychosis, essentially, causes brain damage. The longer a person is in a state of psychosis, their brains are being destroyed, and it becomes much harder for them to recover, especially young people. When we're talking about disability, if we want to prevent people from being disabled and we want them to remain productive members of society, then we need to intervene quickly so that they can get back to life right away and they can continue developing and growing and contributing to our society.

Also, you know, if there was an option between hospital or treatment in the community, I think most parents, most people would choose to be treated in the community. For one thing, being in hospital is quite isolating, especially for a young person. You take them out of their group of friends, drop them in hospital for a little while, and when they come back, those friends are gone. That's quite traumatizing, and it has long-lasting effects. It's also quite stigmatizing. You tell anyone that you spent a week in a mental hospital, and you'll see the full brunt of the stigma.

Now, in other jurisdictions there's always a tragedy that kind of spurred or acted as a catalyst for changes to mental health acts. In Ontario it was Brian's law, in New York state Kendra's law. Mr. Ostopovich and Constable Galloway, that tragedy that happened a few years back is basically the catalyst for this, as far as we're concerned. In fact, Judge Ayotte, who led the public fatality inquiry, did indicate that with CTOs, in his opinion, tragedy might well have been avoided. Well, under Bill 31's criteria for community treatment orders Mr. Ostopovich would not have been eligible for a community treatment order. He only had one admission of 14 days.

Most jurisdictions in the world do not require previous hospitalization. England, Scotland, New Zealand, all of the states of Australia, and many U.S. states basically regard community treatment orders as an alternative to hospitalization, and that's the way we see it as well. In fact, one thing that defines these states and countries is that they are strong believers in the least restrictive philosophy; basically, that you want to treat someone in the least restrictive environment possible. Obviously, like I said before, treatment in the community is way less restrictive than treatment in a hospital.

The Chair: Perhaps we could deal with some of the rest through questions. The time for the presentation is over.

Mr. Puligandla: I'm almost done.

The Chair: Okay. Proceed.

Mr. Puligandla: Basically, Alberta is proposing very strict criteria. We believe that there are safeguards built into Bill 31 to address any issues about human rights. Like I said, CTOs should be an alternative to hospitalization if intervention is necessary, and a CTO could ensure effective care. Basically, we're looking at CTOs as an alternative to hospitalization. That's just a recap.

I'd like to thank you for this opportunity. I really hope that these amendments will be made to Bill 31 to make CTOs an effective option for people living with mental illness.

The Chair: Thanks very much for your presentation.

We have Reverend Abbott.

Rev. Abbott: Thank you very much, Mr. Chair, and thanks for the great presentation. That's excellent. Again, I definitely support your amendments that you'd like to make. They are actually fairly similar to the ones that were presented earlier by Dr. White from the department of psychiatry at the U of A. He also agreed with you that perhaps CTOs should be able to be issued without previous hospitalization so that people could be treated in the community. I would, I guess, wholeheartedly agree with that.

Again, I just want to thank you for being very, very clear. When Dr. White made his presentation, he didn't quite give us all the reasons why we should be able to do this, you know, without prior hospitalization. You've given us some very good reasons as to why we should consider this. You're right: if we were to pass this bill tomorrow, it would be quite a long time before we could use it because people would have to sort of build up a record, so to speak, whereas we know that there are some people in Alberta right now that could use this legislation right away.

I guess just more of a comment to say thank you for a thorough presentation to give us some good food for thought here as we move forward with the bill and, again, to encourage my colleagues to consider some of these amendments that the Schizophrenia Society is proposing.

Mr. Puligandla: Thank you.

The Chair: Are there any others? Mr. Backs.

Mr. Backs: Yes. Thanks. Thanks for your presentation. I was just wondering if you have any sense of the numbers of CTOs that we might expect in, say, the first year.

2:05

Mr. Puligandla: I don't think it's possible, really, to predict that. Really, it's at the discretion of the clinicians. We know just anecdotally from all the family members who have been trying to get their loved ones to accept treatment and also from the number of people who have moved to other provinces and had their children on either conditional leave or community treatment orders that it would be of great use to a lot of families right away. But in terms of giving you any exact numbers, I don't think I could predict that.

Mr. Backs: Do you have any sense of the frequency that we see in other jurisdictions, such as Australia?

Mr. Puligandla: In Australia, no. I know that in Saskatchewan they saw maybe 10 or 20 community treatment orders in the first couple of years that they were implemented. In Ontario it was much, much greater than that, I believe hundreds, close to a thousand. In New York state, of course, the population is much higher, so you see a lot more there. What I do know is that in New Zealand and other jurisdictions that do follow that least restrictive philosophy, there are more people on community treatment orders, but related to that, there are far less people in hospital.

Mr. Backs: What do you see as the role of the Alberta Mental Health Patient Advocate?

Mr. Puligandla: Well, the patient advocate is meant to be the advocate for patients in terms of letting them know their rights. Unfortunately, you know, mental health does not have a very good history over its many decades of existence. In fact, during the dark days we saw forced sterilization and lobotomies and such.

Sorry. If you could repeat the question.

Mr. Backs: What role do you see?

Mr. Puligandla: I think that the patient advocate needs to ensure that each patient is not only aware of their rights but able to, I guess, use their rights to protect themselves in cases of frivolous or vexatious sorts of actions against them. I think that's a role that's very important. You know, if we're going to impose mandatory treatment in the community, people need to be protected in case these sorts of frivolous or vexatious acts occur.

The Chair: Mr. Flaherty.

Mr. Flaherty: Yes. Thank you, Mr. Chair. I was very interested in your presentation. I was looking at your five to 25 that you suggested.

Mr. Puligandla: Fifteen to 25.

Mr. Flaherty: Fifteen. That changes it a little bit, but I'm just wondering about the schools. Particularly, I notice that Ontario is doing some screening at an early age for these children. Is there anything you could suggest that we could do in schools across the province to help identify these people with illness earlier, and would early intervention be of much value to us?

Mr. Puligandla: Well, I think that there's no doubt that early intervention would be very helpful for a lot of people. In terms of how to identify people early, I think that's only one part of it. By educating, you know, people in high schools and maybe even in junior high, letting them know about the early warning signs of psychosis and also letting them know how important it is for social support and support from family members and from people in the community – I think that that's crucial.

In fact, the Schizophrenia Society speaks to literally thousands of students every year in CALM classes. It's amazing. You give a presentation, and at the end of the class every now and then someone will stand up and say: "You know what? I live with a mental illness," or "My father has a mental illness, and I've been estranged from him." We see the benefits right away. So continuing to do that sort of public education, properly funding organizations that do that, I think is the first step that we need to take.

Mr. Flaherty: Thank you.

The Chair: Time for one quick question. Mrs. Mather.

Mrs. Mather: Well, thanks. I wanted to ask if you are confident that we have the resources that we need in this province for CTOs?

Mr. Puligandla: Well, there's no doubt that Alberta has enough revenue to fund appropriate community services. Whether we have enough human resources right now – I think there's no doubt that we could use more, a lot more. I think it's also about how those human resources are used. We need to use more of a case management approach. Everyone who is fairly severely affected by mental illness should have someone that they can rely on who can co-ordinate their care, and that needs to follow them from the hospital into the community and back into the hospital if necessary. Also, there's the need for shelter and supported housing especially. I think that's crucial.

The Chair: Well, again I'd like to thank you very much for your presentation.

Mr. Puligandla: Good. Thank you.

The Chair: It's time to move on to the next presenter, from the Alberta Alliance on Mental Illness and Mental Health. If Ms Sharon Sutherland is here, please find a seat at the end of the table. You may proceed whenever you are ready.

Alberta Alliance on Mental Illness and Mental Health

Ms Sutherland: Thank you, Mr. Chairman and committee members. Thank you for giving us time to present to you. I'd like to introduce Mr. Pierre Berube, the vice-chair of the Alberta Alliance on Mental Illness and Mental Health and also the executive director of the Psychologists' Association of Alberta. Mr. Tom Shand, to my left, is the executive director for the Canadian Mental Health Association. Myself, I'm the chair of the alliance, past president of the Schizophrenia Society of Alberta, and a past national board member of the Schizophrenia Society of Canada. The Schizophrenia Society has just done a very wonderful presentation.

Our goal here today is to encourage the ongoing work of this government re the amendments for the Alberta Mental Health Act. We're a diverse coalition of 10 provincial organizations created in 1999. We represent families, persons suffering with severe and chronic mental illness as well as service providers and professional bodies. In your handouts we've provided our current membership list as well as a handout about our issues and our work.

We want to again applaud the provincial government for making this very, very strong effort to consult with the voices of community service providers and professional service deliverers. Currently the alliance sits on the implementation steering committee for mental health community supports and community treatment orders. We also have representation on two task groups, one being on community services and the other on legislation.

[Mrs. Mather in the chair]

You'll be hearing from several of our member organizations today. We're here to add our collective voice to this process and to show support for our members' positions. We strongly support the change of criteria in community treatment orders in the proposed amendments. Our approach within our coalition reflects a majority response.

The first issue: changing the criteria beyond dangerousness. If I can be a little careless and say hallelujah. Parents such as myself have been waiting for this for a very long time. We've grown very tired of having to call 911 and lie to the police about the extent of our children's paranoia because of the very strict restriction of dangerousness.

[Mr. Marz in the chair]

So the first thing I see is that we're decriminalizing this situation. Police have always been our first responders.

The need for enhanced community services and resources to ensure both CTO effectiveness and lessen the need for their use. This is going to be so very, very important: the continuity of care, how to move patients from care into the community. It's just going to be so very, very important to ensure that enhanced community services are there not only for the people under CTOs but for all people suffering with severe and chronic mental illness.

2:15

We agree with the Schizophrenia Society of Alberta's position that CTOs should not be restricted to formal patients, and Giri provided some very good examples. A treatment plan must be in place and appropriate services available and accessible to the individual before a CTO can be issued. This is a very complex part of the process. We're going to have to consider addictions, the ability of the patient to comply, the sharing of plan and information with both the family physician and the family. We also agree that we should have access to the most effective medications. We're not talking about the best and the newest but the most effective because medications are not a one-size-fits-all. There are some very new medications out there that are not approved yet and that I understand are very costly, but I would like the government to please consider that if we must use these very expensive medications, the costs in the long run will certainly prove beneficial.

There are other things that we are concerned about. The alliance has a huge list of issues that we're working through, about 16 of them to be exact, and because we haven't reached a consensus on all of them or had an opportunity to have a full discussion, we will just simply supply that information to the committee as it happens.

We have great confidence that you'll take patient rights into consideration. I had the pleasure of listening to Sandra Harrison, the patient advocate, on Saturday night. We're very supportive of her hopes to expand the role of the patient advocate. They need to be there for everyone, not just formal patients.

Education is going to be very important. You're going to have to educate the professionals. You're going to have to educate the people that are suffering with mental illness, and you're going to have to educate families such as mine. What are our rights? What can we do? How do we access services? All of those things are so important, and it will help reduce stigma.

The last thing I'd like to make comment on is that you're going to need an evaluation process. You have groups such as the Schizophrenia Society of Alberta. You have the psychologists, the psychiatrists, the social workers, the OTs, the consumer network, the alliance. We can be invaluable in providing input as to the effectiveness and where some of the pitfalls are down the road.

I think that's all I have. Thank you.

The Chair: Thank you very much for a very good presentation. I don't have anyone on the speakers list yet, but I have a question myself. You talked about having access to the most effective drugs. The current situation in Alberta is that we have a professional panel that reviews all drugs a couple of times a year to decide which drugs are approved and to be paid for and which ones should be taken off. I believe that system has served us very well. It's not perfect, as

there have been drugs that have been approved where after a couple of years of use have had to have been taken off because of patient safety. Do you have another way of doing this or some suggestions to improve upon the current system of approval of drugs?

Ms Sutherland: Well, I wish I did. I will say this. Alberta is recognized throughout Canada for having one of the best pharma programs for people suffering with mental illness, and we've always greatly appreciated it. Every time we hear about pharma plans, et cetera, we realize that this type of access to good medication may be diminished. There are a couple of drugs that are out there that are being approved on an individual basis, either through persons like Dr. Allan Gordon – I forget the other gentleman who is approving – and AISH. They're doing everything they can to make some of these injectables available, despite the very high costs of them.

I'm not here to promote any pharmaceutical. All I'm suggesting is that if there are injectables that are not yet approved, we shouldn't hesitate about using them despite the very high cost because it gives quality of life, and it just makes complying with the CTOs so much more effective. In all other illnesses, physical, et cetera, we try in Alberta to give the very best treatment available, and our community wants that too.

The Chair: I don't believe cost is a factor so much as patient safety, and I think patient safety has to be paramount in any decisions for approval of new drugs. Would you agree?

Ms Sutherland: Yeah. I'm speaking specifically at the moment and probably Dr. White spoke to you this morning about Risperdal Consta. That's $500 an injection.

Mr. Lougheed: Well, our chair was so restrictive he wouldn't let me make this comment with the last speaker, but he has given me the opportunity now, and maybe it's even more appropriate. I just want to comment that I really appreciate Giri's and your presentations. We've got more coming in the next few presentations from family members and consumers. I really appreciate your insights. Thank you for being here.

Ms Sutherland: Thank you, Rob, and thank you for being such a good friend to all of us.

The Chair: I believe Mr. Lougheed will be very thankful about 9:30 tonight that the chair was restrictive.

Mr. Johnson: I just wanted to follow up on one of your last comments about education and reducing stigma because you seemed to indicate that you feel that's pretty important. Do you feel that by implementing Bill 31 we would be reducing the stigma? In other words, is education inherent in that, or were you thinking that we should be doing something in addition to that, such as maybe education through our schools? I don't know just what you may have had in mind.

Ms Sutherland: I would like to make note of the fact that over the last five, six, seven years the Alberta government embarked on, well, a five-year program on stigma, if I'm not mistaken, Sandra, and they did very well. Canadian Mental Health have just finished an across-the-province, very intelligent, very clever campaign.

What I'm speaking of as far as Bill 31 is the fact that you're removing that criteria of danger. In my community I'm hoping that that will help remove some of the fear and the barriers and the stigma within the community because we're using it as a useful tool, not waiting until someone thinks that my son who lives next door to them is dangerous, thereby perpetuating this horrible stigma.

I'd like to add here – it's probably not a good place to say this – that the World Health Organization embarked on a five-year study. It seems like I've been here forever. It was about eight or nine years ago, and it was a pilot project in Drumheller and Calgary. The biggest stigma was among the medical profession and businessmen and people over 50 years old, which astounded me. So we always have stigma. By being open and transparent and showing that we're taking care of our people before they disintegrate so horribly, hopefully that in itself will help stigma.

2:25

The Chair: Mr. Backs and then Dr. Pannu.

Mr. Backs: Thanks, Mr. Chair. Certainly, the human element is paramount in how we look at all this legislation. One thing that all legislators, I think, hear a lot of is cost. We see the burgeoning increase in our budgets, the fact that we're being told time and again that the increases in our budgets are unsustainable. Many would argue that the CTOs in this legislation might decrease costs in the long run. Having heard the problems, you know, that we've seen in New York, and the decrease that CTOs had in the homelessness of patients, the decrease in incarceration, the decrease in many of the issues that are very expensive to society, do you have any sense of the cost savings that we could somehow estimate that would come from this legislation?

Ms Sutherland: Considering that mental health as an illness is in cost and burden to the people second only to cardiac, I'm not sure that I can answer that question. I will tell you that around some of the tables – and we've had discussions with very prominent people, knowledgeable in this – they feel that to bring in community services and provide the quality of care that is needed and to do all those things and have a super-duper model, we're talking millions of dollars.

You know that mental health has traditionally always been underfunded, and maybe it's time that we could put a few more dollars there. I agree with you. I think that there will be cost efficiencies whereby you'll be saving on hospitalization, and you'll be saving in all those other areas. There's a horrible tragedy of the cost of this illness. Those savings will have to be transferred over into providing appropriate and accessible community services.

Mr. Backs: You would say that, you know, on a global scale this would be a good investment.

Ms Sutherland: I would most definitely as a mom say that.

The Chair: Could we just back up for a moment? Was one of the members from your panel wanting to supplement the previous question?

Mr. Berube: No. That's fine. It was taken care of.

The Chair: Okay. I apologize for that.

Dr. Pannu: I'm very impressed with both your personal and family experience, of course, as an advocate for mental patients with your concern and compassion both for people who suffer from mental illness and for families who have members who are ill in this way.

When I look at the issues that you have raised here, I have questions about numbers 4 and 1 – they're quite related – to change

the criteria beyond dangerousness. For commission to CTOs: is that what you mean?

Ms Sutherland: Yes. I'm sorry if I didn't make that clear.

Dr. Pannu: Okay. I'd like you to talk a little bit about what you mean by going beyond that, because CTOs do involve involuntary commitment and treatment. Even in our criminal system just being dangerous is not good enough grounds for police to intervene. We all know this. The probability of committing a crime itself is not, you know, grounds for arrest, for example. So there is a problem here that we need to address. How do we deal with people who are innocent, who are not criminals, who are ill? We are advocating measures which go beyond those that we presently use to deal with people who are likely to commit serious crimes. So that's one.

The second question is related to number 4: "A treatment plan must be in place and appropriate services available and accessible to the individual." Are you suggesting that this should be made a condition explicitly stated in the legislation, that no one should be involuntarily committed to community orders unless there is in place the kind of facilities that are needed for this person to go to to seek treatment?

Ms Sutherland: I apologize if I haven't been clear. The issues stated are dealing with the proposed amendments that are already out and printed. It is our organization's understanding that a CTO will not be issued unless the appropriate and effective treatment for that patient is in place in the community, whatever treatment is required as deemed by the issuing physician.

Dr. Pannu: I do appreciate your understanding of what will happen, I guess, through regulation. The point is: would you like that to be entrenched in the legislation itself?

Ms Sutherland: Yes, definitely. There are so many aspects to a community treatment order, and it's going to be a struggle, I know, to refine it. There are social issues. There's housing, all of those things.

Dr. Pannu: You touched on that in number 2. That's why I was going to draw your attention to it. Can we legislate that the government, in fact, does put in place the facilities before it implements CTOs?

Ms Sutherland: Well, from the broad amendment that is there now, we're taking that to interpret that that's what that means. There is an amendment in place. It was going to be in third reading, I hope, in November, the first of November. I don't have the section number. I'm sorry. I don't have it handy.

Dr. Pannu: That's all right.

Ms Sutherland: It says, as I say, from my understanding, that a CTO will not be issued, cannot be issued unless the appropriate community treatment services are in place in the community and are accessible to the patient.

The Chair: Other questions?

Mr. Berube: If I may make a comment. I don't think that we are assuming that having community resources available and in the ideal world having the perfect services can be equated with having a good plan in place, so we see these two clauses as quite separate. We do understand that if you issue a community treatment order, there has to be a plan in place for the treatment of the individual. We don't quite equate that with number 2, where you're talking about having the best community resources available in all cases. We also believe that you need to have those, but I'm not saying that we're saying that the passing of the CTOs should be contingent on having everything in order, like in a perfect world, at this point.

Ms Sutherland: Dr. Pannu, excuse me for a moment. It is section 9 under part 8. It says under (c): "The treatment or care the person requires exists in the community, is available to the person and will be provided to the person." I hope that helps. I'm sorry if I've muddied the waters.

Dr. Pannu: Thank you.

The Chair: Well, thank you very much, Ms Sutherland, for an excellent presentation.

The committee is scheduled to take a break now, but seeing both Mr. Berube here as the next presenter and Mr. Tom Shand, the next presenter after that, in the interests of your time and helping you get on with your day, with the approval of the committee we would maybe have the break after that. I think it would be a little more efficient use of your time.

2:35

Mr. Berube: Sorry. I am waiting for our president to join me in our presentation.

The Chair: What about you, Mr. Shand? Are you prepared?

Mr. Shand: I'm prepared to proceed at your leisure, at your will.

The Chair: Why don't we go to the Canadian Mental Health Association presentation, then. Mr. Shand, please proceed when you're ready.

Mr. Shand: Okay. Thank you very much. I do have, actually, the text of my presentation here, which I'll hand around.

The Chair: We can do that for you, sir.

Mr. Shand: Okay. That's great. I also have actually a copy, two days old now, I think, hot off the presses, as it were, of our last annual report just for your information. It gives a little bit of background on our organization and our views.

The Chair: Okay. You may proceed, Mr. Shand.

Canadian Mental Health Association, Alberta Section

Mr. Shand: Thank you very much, Mr. Chair. Good afternoon. My name, as you've now heard, is Tom Shand. I'm here today as executive director of the Alberta division of the Canadian Mental Health Association. I'm speaking on behalf of CMHA across Alberta, including eight regional offices, a provincial suicide prevention centre as well as our provincial board, which has representation from each of those entities.

As you may be aware and certainly people within CMHA are aware, community treatment orders have been a very difficult issue for CMHA to come to grips with not only here in Alberta recently but across the country, and this is in part because there's risk that people living with mental illness will not be afforded the same human rights and freedoms as other people and in part because

there's not overall confidence within our organization and the people, the staff and volunteers, involved in the organization that the health care system can manage CTOs effectively.

We see Bill 31 not only as a means to address the legislative content of the bill but to encourage the government and the public you so well serve to take a closer look at the overall needs of those living with mental illness in Alberta and provide more support to this area. These situations need to be addressed not only as a prerequisite for Bill 31 to be effective, as was just spoken to in Dr. Pannu's comments, as it's presented in the current proposals for the act changes, but more importantly to improve the quality of life for the vast majority of those Albertans who live with a mental illness but are not likely to be and hopefully will not be directly impacted by Bill 31.

We thank you for providing us an opportunity to share, however briefly it may be today, our views with you. As a health and wellness organization the Canadian Mental Health Association in Alberta supports Bill 31, and I must tell you that it was not without long deliberation and heavy consultation throughout the province with our various boards, with our staff, and with others. It is not an opinion that we render to you lightly here today. We do support Bill 31 because we recognize that there's a small group of individuals who may benefit from a community treatment order, that part of the bill in particular.

However, CMHA recommends the following additions and/or amendments to the act. One, that a date be set for review of the act within five years. We say five years, and that may not be a time frame which is possible or feasible for you. We're making that as a suggestion, but certainly that there be a review of the act and something in place to do that as best as can be done without undue problems in doing so. Two, that the clause under 9.1 of the present Bill 31 dealing with the issuance of CTOs if the person has been previously subject to a CTO be amended to add a time frame of within the past two years. Otherwise, people may see this as hanging over them for the rest of their lives, regardless of how things may change for them since they were at one point in time issued a CTO, if the renewal process is that simple for somebody who has had a CTO at some point in time. We would like some rigour inserted into that unless it's within a fairly small time frame. We're suggesting two years.

Again, referring to the act as it's presented to us, there's a clause 9.7 and clauses (1) and (2). We would like it added that – and we believe that this is essentially very important, and I think it will be a fundamental thing that you will need to be making a decision on within the wording of the act – a client must have access to a psychiatrist within 48 hours of issuing the CTO. We believe that it's discriminatory to those living with mental illness to not have these people seen by the appropriate specialist for such a critical assessment. You will note that in the present act there are contingencies by which a psychiatrist would not be involved, by which it might be general practitioners or others in the community if there's not a psychiatrist in that particular community. I would suggest to you that if there's not a psychiatrist in that particular community, it would be very hard to fulfill the ongoing treatment that a CTO requires and the services which are built into the act now as a necessity or prerequisite for giving the CTO.

It also leads, I believe, to inequitable access to quality health care for those living in rural areas and northern communities. I expect that by this point in time you've probably become familiar with the scenarios such as those in Grande Prairie, where at times they've not had a psychiatrist in the city at all. At the present time I believe that they have one. Clearly, that's not a situation that is adequate for mental health services, let alone for mental health services in the community. We have concerns in those areas existing now, let alone adding different layers that may make it more difficult to get service in some places.

We're very pleased to see that Bill 31 says that CTOs can only be issued when adequate resources exist within the community, and I refer to the phrase that Ms Sutherland just read to you a few moments ago stating that fact. As you're no doubt also hearing from other sources, quite often it's not currently the case that there are adequate resources in every community to treat the needs of people with mental illness, let alone those with a serious type of mental illness that you may be dealing with within the structure of this act.

In the written submission we gave to you earlier, we outline some of the direct and indirect needs and shortfalls. I'm certainly not going to go into great detail on all those. There are a couple of pages, probably, in each area. As Mr. Backs just pointed out, I think it is difficult to measure specifically within one department what some of the benefits may be to taking a certain act within another department. I certainly would support Sharon's comments to you, Mr. Backs, in terms that the benefits will be very widespread. At the same time, the investment into enhancing the community in order for these to be effective, in order to improve mental health will also be widespread. In the long term will you have savings? I think absolutely, but you'll also have had an investment into the health of people in Alberta that are not always able to take care of their own health now and who tend to be victims within a province that overall is doing very well.

I would like to highlight four of the areas of significant concern that we have expressed. One is adequate housing. It's certainly an issue we don't have to go into great detail on. You see it every day on the front pages of the paper. If you walk by certain areas where there are tents, you're very much aware. You see people sleeping in the front of police stations. You're aware of the issue, and it's a big issue in Alberta right now. There are many things involved with it for people living with mental illness. It is one that can be addressed, though, and it's not always just money. Sometimes it's just different ways of doing things.

We had a conference in Red Deer this summer that was an excellent housing conference. The title of it was Housing First. People need that. It's one of Maslow's basic needs. They need to have safety, security, and shelter. I think that's well recognized.

2:45

Secondly, we have an area of concern now that there's not adequate access for all people to medical services, including medication – Sharon spoke to that somewhat – including psychotherapy and psychiatric assessments. There are not adequate resources in place to fully support that area now.

Third is that community supports are necessary to enhance people's independence and their opportunities for recovery. Certainly, that's an area that CMHA works very heavily in. We represent community services on a widespread basis and provide a linkage for people that are coming out of hospital and other people to getting access to some of those services.

The fourth area where we have some significant concerns is in the area of guardianship and trusteeship. In certain areas of the province at certain points in time it has not been adequate for the needs of people with mental illness. There aren't enough resources there. Sometimes it's, as in many other things in this province right now, a question of not having enough manpower. In some cases it's not enough budget. In some cases the system doesn't quite work for people. I'm not an expert in that area, but I certainly pass that along to you.

In closing, in the couple of minutes I believe I have left, I'd like

to share with you a story, which I think will provide some perspective to this legislation, again relating to the overall needs of those living with mental illness. About a year ago I shared a ride home from a conference with the mother of a teenaged daughter, the daughter living with a mental illness. The mother shared a very personal story with me of how her daughter confessed to her that she had lied to doctors about her intent to commit suicide in order to be admitted for treatment that she knew that she needed at that time, and this was the only way she could figure out how to get it.

That story has weighed on me heavily for the past year, and I'm glad to be able to have a chance to share it with you because it means a lot to me that it really is a reflection of where our mental health system is today, that a daughter would have to go to that extent and have the pain of revealing to her mother, which at least she had the courage to do and many would not. I'm hopeful that the expanded criteria for admission, which were dealt with at the beginning of the proposed act, will soon prevent this type of scenario from taking place.

At the same conference – it was one hosted by AMHB, a wonderful conference dealing with medical research, in Banff, actually, which isn't all that hard to take either, very well done – there was a panel discussion at the end on community treatment orders, with an open mike. As you know from your experiences out on the campaign trails, if you have an open mike, you never know what you're going to fully get. In this case we got from the experts kind of what we expected with regard to CTOs. They exchanged all sorts of various views about the research, about some of the other provinces and other countries and states in the United States that are using it and whether the research was good or not. There were all those types of things that you would kind of expect. But far more telling were the very personal questions that came up from those attending, many of whom had lost a loved one to suicide. However – and I sat through to the end of this and heard all of the speakers – I don't recall one where there was a single circumstance where the proposed CTO legislation would have saved that life of the loved one of those people speaking.

I reinforce Sharon's concern about education, education, certainly, of people like yourselves and others that are in the decision-making capacity but also of the families. This is not being seen as a save-all, as a panacea for mental health. As it stands now, it would not necessarily save that many lives. It would be good for certain situations, and we endorse it as being good for certain situations, but unless some amendments are made, unless some improvements are made in the community health systems that support it, it really is not going to do what you really would want it to do.

As I said, this proposed legislation would not have saved those lives. The circumstances didn't apply. Each life was lost, essentially, because that person wasn't able to access the level of service they required, whether it be in an institution or getting into an institution or, certainly, in the community or sometimes coming out of an institution and having no one there to properly support it, the level of service they required when they needed it. So those lives were lost. Those are very personal stories, and I'm sure you're hearing many of them today.

We very much appreciate not only your thoughtfulness and the work you've put into putting this bill together, Reverend Abbott's passion in presenting it in the first place. We know that you want to do the best for Albertans that you can with this. We hope that when you're doing so, you'll be able to influence not only those putting this legislation together but others that are in the position to impact, as Dan Backs had spoken to, some of the things that are far ranging beyond the context of just this bill in terms of improving community services. You can be assured that CMHA supports you in your efforts to improve life for those living with mental illness, and we will continue to act as community advocates and support programs that promote the quality of life for all people with mental illness and mental health concerns.

I thank you very much, ladies and gentlemen, for allowing me this presentation. I'll entertain questions as best I can.

The Chair: Okay. We have a number of questions. Reverend Abbott, followed by Mrs. Mather.

Rev. Abbott: Thank you, Mr. Chairman. Thanks for your comments. I have to say at the outset that it certainly has been a collaborative and collective effort on behalf of many of my colleagues. In fact, even colleagues from other sides of the House have been supportive and encouraging of this bill. Mr. Hancock helped me with this several years ago, when he was the Minister of Justice, so I agree with you that it has been a long time coming, but it's great to see it here and to this stage. Certainly, it's been a great collaborative effort. Your various different organizations have had a lot of input over the year and a lot of encouragement over the years. So it's definitely a team effort to get us to this point.

I have a couple of questions with regard to your point about within the last two years, on 9.1(1)(a)(iii). I'm wondering where you got the figure two years. I'm wondering why it wouldn't be, say, five years or something like that, if there's any research behind that.

Secondly, with regard to your number 3 there, talking about a psychiatrist in 48 hours, I totally agree with you. I'm from Drayton Valley, which is rural Alberta. We don't have a lot of access to psychiatrists. We certainly do have access to family doctors. I'm wondering if you feel that a family doctor could possibly take the place in the absence of a psychiatrist. Or do you feel that that person should be required to find a psychiatrist, say, in the city or something like that?

Mr. Shand: Yeah. They're two, certainly, separate questions. On the first one relating to the two years, just a tiny bit of background. My board is made up of people that have an extensive amount of experience similar to Ms Sutherland's in terms of personal experience but also often working within the mental health system. That was a figure they put forward with their combined wisdom. I don't think it's a figure that they're going to say: "Reverend Abbott, we said two years. You've got it at 18 months," or "You've got it at three years," and they're going to come a complain to you and say: "weren't you listening?" The fact is that there is a time frame within a reasonably short period of time that people aren't – and I use the term, and it's my term, and I apologize to my board, perhaps, because it may not be a fair term – hanging over your head. But in essence in some ways it does. Part of that relates to stigma. Part of it relates to the emphasis.

Again, we were pleased to hear Sandra speak about moving towards modes of recovery. We believe that people do have the opportunities to recover and do have some success in recovering. If so, they shouldn't be in some ways not given some release in some respect for having achieved certain changes in their life when it's possible to do so. That I hope answers that aspect of the thing.

The second part of the question was relating to? I'm sorry.

Rev. Abbott: Just the rural family docs.

Mr. Shand: Oh, yeah. That's probably the most important point, I think, that we have to make. I endorse personally and I think our CMHA would endorse most of the views taken by the Schizophrenia Society. We've taken a little bit different emphasis than some of the

things have. This is one area where we believe fairly strongly that if you had a person going in for open-heart surgery, you wouldn't recommend them to your GP to do it because they would have to be transported to Edmonton or Calgary or somewhere in order to get assessment.

In speaking with Dr. White, who spoke to you earlier, he might have been able to answer the question better and probably did answer as to how many cases. I had Dr. White come in to speak to the CMHA Edmonton board because they were dealing with various issues, as you'll hear from them later, I think, about: what is this legislation about? There were many fears relating to it and that type of thing. He indicated to us that he did not believe the CTO part of this was going to be really widespread. Specifically, as the criteria are now, it's going to deal with a very, very small number of people, people that desperately need it. It's a great resource to have, and if you expand the criteria a little bit, as the Schizophrenia representative spoke of a little bit earlier, you're obviously going to have more people, and it will probably be a better bill.

At the same time, it's not demeaning whatsoever the value of well-trained people in the community. They're going to continue to work with these individuals. Whether they be GPs or psychologists or others, social workers, psychiatric nurses, all those people are wonderful assets. But when you come down to the initial assessment of somebody to say, "We are going to do this, and it requires medication," which they're usually the only ones really able to properly designate in the first place, we believe that the presence of a psychiatrist very early on, before the person is released into the community, is extremely important.

2:55

Rev. Abbott: Okay. Thank you.

Mr. Shand: Thank you for asking that question.

The Chair: Mrs. Mather, followed by Mr. Flaherty.

Mrs. Mather: Well, thank you. I think you've answered my questions, actually.

I wanted to point out the need for a multidisciplinary team and again mention that there are psychologists who are appropriately trained that could work in consultation with a psychiatrist from a distance perhaps.

Mr. Shand: Absolutely. The multidisciplinary team is a wonderful thing. The psychiatrists alone are not going to provide all the supports that you need anyhow, but there's a reason they're trained to do what they do. This is the very type of thing that, really, only they can do as being one of the fundamental people, you know, whether you bring a psychiatrist in to see somebody in Drayton Valley or in Grande Prairie or somewhere else – Grande Prairie is a large community, and I shouldn't have to be saying Grande Prairie, but the reality is right now that it might be the case – or you need to bring that person into Edmonton or Calgary or somewhere else where they are.

Right now, actually, we have regional offices, as I mentioned, in eight different locations. Often people will come in and actually relocate to those locations, in Lethbridge and other places, simply because even the services our organization provides and the hospital services are larger there. People may need to be brought to a place to get properly assessed, I guess, is what I'm saying, and whether they can survive on a CTO in some smaller places where there really aren't support services I think would be questionable. You know, as opposed to living in a hospital, it's certainly a better scenario for most people, but it's questionable in really small places where you don't have a professional support network or, as you said, a multidisciplinary team.

The Chair: The last question. Mr. Flaherty.

Mr. Flaherty: Thank you, Mr. Chair. One of the questions that I was going to ask was already answered. But I was wondering about your list on the back page. I was going to add a fifth point. I think you're a very smart man. You showed us your budget, and it showed that the last two years, '07 and '06, you were in a deficit.

Mr. Shand: That we're in a deficit. I didn't bring that up in the presentation. I didn't want that in the *Hansard*, but thanks.

Mr. Flaherty: Well, you're too smart. You did it subtly through various secret messages to me. Anyway, I put down costs of operation. I'm wondering: with the CTO, the community treatment order, would your costs be changed, and would you be subject to more costs to provide the services and advocacy that you do so well across the province?

Mr. Shand: It's probably a very long answer to a very good question, and I'll try to confine it to relating to the CTOs themselves. I think you'll find that the entire industry now in not-for-profit organizations, particularly in health care and particularly in mental health, is very hard-pressed, as are many other areas of the province, to maintain staff, and our salaries are not, to be honest with you, for the most part competitive with people that are even providing contracts to us. That's another discussion for another day, but it actually has very real implications here. In the regional hospital districts, even the Alberta Mental Health Board, which is a great partner and provides some funding to us provincially, we lose people to them because we can't compete financially. So, yes, we are under pressure financially. We're not particularly complaining about that, but that is the reality for us to be able to deliver some of the kinds of services that we believe we can do.

We believe we're in a really good position, the Canadian Mental Health Association particularly, because we're active, you know, in a broad span of activities across many communities in the province to provide a liaison for people coming out of hospital to the types of community services that they need access to and to work hand-in-hand even with the hospital in areas like – and I think you heard the term – ACT, assertive community treatment, those kinds of things. We have, certainly, things that we can add to that. We have people and resources that are well connected to the community that have the trust of some of the people that are potentially subjects of community treatment orders.

Yes, we would need more funding in order to be able to do it properly. We see that as an opportunity, though, to come and take a more active role. To be honest with you, Mr. Flaherty, we've been swayed to a great extent not only by some of the people around this table. We have a real belief that Minister Hancock gets it when it comes to mental health, that he has a feeling for what needs to be done and is a person of enough respect with his colleagues that he's going to be able to help leverage some extra funds out of the Treasury Board instead of, perhaps, going into some other areas and really make a difference in the area of mental health services in the community. Should CMHA be fortunate enough to be a part of that, I hope that we would be.

Mr. Flaherty: Thank you.

The Chair: I'd like to thank you, Mr. Shand, for a very good presentation. In keeping with our tight schedule, I'd now invite Mr. Berube and Dr. Stephen Carter back up for their presentation representing the Psychologists' Association of Alberta, and then we'll have a quick break.

Corinne will be bringing the presentations around, so you may proceed right away.

Psychologists' Association of Alberta

Dr. Carter: Good afternoon, and thank you for the opportunity to speak to your group. I'm Dr. Steve Carter, president of the Psychologists' Association of Alberta. Mr. Pierre Berube is our executive director, and we're both registered psychologists. To start with, the Psychologists' Association applauds the expanded definition of mental disorder as well as the introduction of the community treatment order.

We're going to focus our presentation on two aspects related to Bill 31. First of all, who can issue a community treatment order? Secondly, how can the government ensure that the most appropriate and effective community treatment services will be in place?

Finally, we'd like to propose some solutions that we feel can be readily and quickly implemented to increase the standard of mental health care in the province. We'll start with Mr. Berube speaking about who can issue a community treatment order.

Mr. Berube: Thank you. We do support the notion that is in the proposed bill that requires two separate examinations prior to a community treatment order being issued. We do however think that one of those examinations could certainly be provided by a psychologist as one of the two parties. Mental illness is not just another physical ailment. It is a psychological/mental factor. I think that patients with mental illness do deserve the most appropriate, the most effective treatment available and that that treatment should be provided by the most qualified professionals available.

Then it brings us to the question: who has that expertise and training? Psychiatrists do. We know that. Psychiatrists are trained in the physical aspects of health. They're also trained in the psychological/mental aspects of health. We know that family physicians are well trained in the physical aspects of health, and they get very limited training in the psychological/mental health aspects. Psychologists are trained in the mental health aspects, and they get also limited training in the physical aspects of health. If you put together the psychiatrists and the psychologists, you have the two professions that are the most qualified and the most trained and the only two professions that have the senior academic training to deal with the mental and the psychological aspects of mental health.

We can certainly have the family physicians with the psychiatrists issuing community treatment orders. We certainly respect that. That's totally viable. If you have a psychologist with a family physician, you also have the balance of the two, the expertise in both domains. We don't think, certainly, that just having family physicians issuing community treatment orders would make sense. I think it's similar to Tom Shand's comments about heart surgery. You wouldn't send a patient who needs heart surgery to a family physician simply because the experts aren't around. Well, I think, quite frankly, that that has been happening in the field of mental health, and we need to recognize that.

We have in Alberta, according to Alberta Health statistics, 352 psychiatrists. We have 2,138 psychologists. The necessary resources are there. I think it's a matter of making use of them.

3:05

Dr. Carter: Addressing our second point of ensuring the most appropriate and effective community treatment services, first of all, community treatment orders are not services. It's the beginning. It's identifying that there's a problem. We need the experts implementing the treatment, and we need the treatment readily available. We do have a shortage of community supports and a need for assertive community treatment that can't be downloaded onto community and paraprofessionals. We need better access to psychological services, which will give tangible results and an immediate solution to the problem.

We have a shortage of psychiatrists. We do not have a shortage of psychologists. But one of the issues right now is that there is no appropriate public funding, so in fact psychology is very much a two-tier system. We have psychologists working within select government and community agencies, but at least half of our members are in private practice, which provides some interesting opportunities. They have offices. They have clerical staff. They have everything it takes to accept patients right away. So in looking at making better use of psychologists, we're not talking about a penny for infrastructure. We're talking about using professionals that are in place.

Looking at the health workforce action plan, talking about making better use of the resources we have and for health professionals to make use of their skills and abilities, we have a wide team of people working within mental health, which includes the psychiatric nurses, the social workers, the psychiatrists, the psychologists, and we feel that it's the psychologists that are definitely well trained to be leaders in this field. Looking at a psychologist with a master's degree having the equivalent of seven years of training, PhD level, you're looking at nine years of university graduate internship training.

Treatment is not just prescription of medications. Many drug companies have done studies for a very long time. The best they come up with is that a combination of treatment and medication is better than just medication alone or just treatment alone. We also have studies saying that there's a huge placebo effect in medication, so perhaps it's really the treatment. Now, obviously, the medical component with severe mental illness such as schizophrenia, a biochemical problem, cannot be left undone, but we have other people that are equally incapacitated through severe anxiety and depression that psychologists could also help meet the needs.

Mr. Berube: I want to talk about some possible solutions. We have two which we think are very tangible and possibly fairly immediate solutions to this. First, the whole primary care system. I imagine you're aware that the whole primary care system is being reorganized in Alberta, I think in some ways fairly effectively. The doctors are coming together, signing agreements to provide services for catchment areas, where they agree that they will provide the total medical services for a geographic region, and that includes mental health services, supposedly.

In spite of many, many efforts on our parts, to date none of those primary care networks have included psychology, to our knowledge, and I think that's a fascinating realization when considering what we've just said about who has the expertise and the training ethics expertise to provide for the psychological medical health well-being of Albertans. This is not because the doctors don't want us. I have been in contact with many of the doctors in these primary care networks. The response I get is always the same. They say: "We agree with you, Pierre. The problem is: who's going to pay for this?" The doctors' fees are all paid by Alberta health care. Psychologists' fees are left to the individual, and many of their patients are simply not able to afford those services.

The Faculty of Medicine at the University of Alberta has also

fairly recently done a study where they asked their own physicians about their interest in networking and referring to other professions, and they made a strong point for the need to refer to psychologists. As a matter of fact, after dieticians that was the most important group they wanted to be able to refer to. Then they looked at how many of them actually do it, and the stats go way down. Again, it's the same thing. The funding mechanisms aren't there.

We believe very strongly that when it comes to the primary care network budgets, there has to be an allocation in there that is earmarked for psychology because it won't happen otherwise. The doctors tell us that they've hired social workers. It's absolutely necessary; it makes a lot of sense that there's case management They've hired LPNs to work with them. But, again, none of them hired psychologists because it's just too expensive for them. We have to find some mechanism for that. They want the psychologists involved, but the system isn't such that they can be involved.

There are various models for that. Australia has found a way. Australia has recently started paying for psychological services. So that's one mechanism. We think that there's a lot of evidence that the best model is for the actual psychologist and the physicians to be collocated, not to necessarily hire a psychologist to go work in the offices. They can collocate in their own private practices. That's one model that would work very well. I hope that it's within the scope of this committee to look at the whole funding for services that are so much needed.

The second issue is another model that we've talked to both most recent ministers of health about: a possibility of a psychology aid program in Alberta, just like we have a legal aid system, a parallel system to that. Legal aid is there to serve those who need legal services but can't afford them. We could have a parallel system on psychology aid. The government in the documents we handed out said that they spent over $28 million a year – Steve tells me that the recent figures are $40 million a year – to fund legal aid. Legal aid is also funded by other sources.

In the Alberta health care billing records for 2006 you spent 35 and a half million dollars a year funding family physicians to do counselling psychotherapy. We don't know where the training comes from for family physicians to provide that service. We do know that psychologists have the training and the expertise to provide that service, but they're out of the loop when it comes to private-practice health care particularly.

Dr. Carter: That covers our points. We'd be happy to answer any questions.

The Chair: Well, thank you very much.

We have Reverend Abbott, followed by Mr. Lukaszuk.

Rev. Abbott: Thank you, Mr. Chair, and thanks, gentlemen, for your presentation. Unfortunately, funding for mental health is not within the scope of this committee. Otherwise, I'm sure we'd all give it a hearty increase. At any rate, we are talking about Bill 31, and you have put forward some proposals which are very interesting, to say the least.

I guess that my question is with regard to your first proposal: who can issue CTOs? You mentioned psychologists. My question is really for clarification. It's not in any way a run at your association. It's truly for information purposes. I'm wondering: what criteria must be met in order to become a registered psychologist? The reason I'm asking you that question is because I'm looking at both of your credentials, and I see, Dr. Carter, that you have a PhD, and I see, Mr. Berube, that you have a master's of education, and you're both registered psychologists. I'm just wondering what criteria are necessary to become a registered psychologist and how you feel this would qualify individuals to issue CTOs.

Dr. Carter: In Alberta the minimum standard is a master's degree in a psychology program. So you have to have a bachelor's degree to enter, a master's degree, typically at least a two-year program, followed by a 1,600-hour internship under the supervision of an experienced psychologist as well as writing a test standardized across North America and doing an oral examination. Following that, psychologists also are under the Health Professions Act as a regulated profession and have a very stringent code of ethics and code of conduct. We do training on personality, behaviour, development, intelligence, psychopathology, and assessment.

Rev. Abbott: Okay. In other words, in your professional opinion, then, you feel that any one of your couple of thousand registered psychologists would be qualified to issue a CTO as one of two signing authorities.

Dr. Carter: Absolutely not. Some of our members are just counselling psychologists. Others are clinical. We have different designations and specialities. A very large number work in this field, but those who only do counselling, through our ethics, would not put themselves forward.

Rev. Abbott: I see. Okay. Good. That's what I needed for clarification. Thank you.

The Chair: Mr. Lukaszuk.

3:15

Mr. Lukaszuk: Thank you, Mr. Chairman. Much along the lines of Reverend Abbott's questions, we're looking here at a form of expanding the scope of practice if issuing of CTOs would be allowed. A parallel that comes to mind as of recently is the one with pharmacists who may be allowed to do some prescribing, but to do so, they would have to return to some learning institution and upgrade their credentials in that particular area of practice. I'm wondering: would it be appropriate to require our clinical psychologists to undergo some form of academic upgrading in order to enter into that scope of practice?

Dr. Carter: Many of our clinical psychologists have had experience working in settings such as Alberta Hospital, various agencies where they're doing just that. It's within our scope of practice for doing both diagnosis and treatment. Obviously, we do not have prescription authority, and that's a totally different debate that's going on within our profession as well. We also welcome the opportunity to provide professional education opportunities to ensure that we are meeting the highest standards.

Mr. Berube: There is a difference in that the prescription of medications is a restricted activity under the Health Professions Act. This is a different basis here.

Again, it's certainly true. I, for example, am a masters in counselling psychology. I probably wouldn't touch this CTO. It's not my field of expertise. We have many psychologists who are very much experienced and involved in that, and it's not like they need more training for it. Of course, if this happened, we certainly would make sure that we'd put on some additional training to that end, but it's not like we don't have people who are ready to do that now.

Mr. Flaherty: Mr. Chair, maybe you'll rule me out of order on this one. I'd just like to put it on the record. Maybe it's not within the frame of reference of your spectrum, but I believe that funding is an issue regarding this particular act and the implementation. I think this committee is going to have to address that, maybe not here this afternoon. But I want to go on record as saying that funding is an issue. You heard Dr. White, and you heard some of these experts. They talked today about the necessity of having new resources. We would be as a committee, I think, very neglectful and not up to task if we did not address this issue.

The Chair: I would remind the member that this bill is in second reading, so the principle of the bill has already been addressed in the Legislature and passed in second reading. We have to deal with the bill and make recommendations in that light.

Mr. Backs.

Mr. Backs: Thank you, Mr. Chair. In looking back to the issue of the use of psychologists and CTOs, the fatality inquiry by Judge Peter Ayotte into the deaths of Martin Ostopovich and Corporal Jim Galloway recommended a CTO process where there would be two psychiatrists looking at his particular type of case, and his was one of paranoid schizophrenia. Would there be an application for a psychologist in this particular instance if that was one of the two professionals?

Dr. Carter: Yes. Psychologists that are working in this field are well trained in risk and threat assessment as well as mental health diagnoses. Actually, a component of psychological training – and I also instruct it at the University of Alberta – is the use of standardized assessments. There are many psychological assessment measures that are utilized by psychologists that are commonly not used by other professions, including psychiatry, or at least only in consult with a psychologist to do the interpretation. Rather than looking at an individual through one lens such as an interview, we get multiple views of that individual and, in fact, can build a better picture of where the person is at and what risk of threat they may present and the need for treatment.

The Chair: Mrs. Mather.

Mrs. Mather: Thank you. Thank you for your presentation. It's nice to have the written presentation as well. I just want to go on record supporting MLA Flaherty in terms of looking at what it is we can actually do through this committee with recommendations. It's foolish to be supporting something if we actually believe the resources aren't in place to implement. I'd like to have consideration given to that.

The Chair: Reverend Abbott on this point.

Rev. Abbott: Thanks, Mr. Chairman. I agree. As I said, if we were a funding body, we would I'm sure give mental health a hearty increase, but again we're not a funding body. We could all go on record saying that we want to improve and increase funding to mental health. Certainly, I'll go on record saying that. Of course, it may help. There are some departmental staff here as well listening in, and I'm sure the *Hansard* will be read by all. But, again, I think that we really do need to focus on improving the bill.

What I would say is that if we can get this bill done right and get it passed in the Legislature, it may be the impetus for increased funding. So let's make sure that we put this bill forward with the right revisions, and let's make sure we get it through the Legislature. Then maybe we can also see some funding. It's not uncommon to see that when a bill is passed, funding comes along with it.

Mr. Lukaszuk: I just wanted to comment on it. From a policy perspective it may turn out that this bill may require additional mechanisms to be put in place, but it would be a great disservice to the passage of this bill, which I find to be of paramount importance, to derail it by budgetary discussions. Mr. Flaherty is well aware of the fact that pretty soon we will be going into budget discussions in the Chamber, and he will have ample opportunity to argue health care budgets in the vein of this new legislation at that time and in that place.

The Chair: The next person on the list was the chair. My question is: of the 21,038 psychologists in the province, how many of them are operating outside of the major cities of Calgary and Edmonton, and how many would be operating out of the small cities like Grande Prairie, Red Deer, and Medicine Hat, for example? How much access would there be in rural Alberta to psychologists if they were to be included in this legislation?

Mr. Berube: Yes, we have that data. I don't have it in my head, unfortunately. Approximately a third, I think, would be in the rural areas. Certainly, Medicine Hat, Grande Prairie, Lethbridge: we have several psychologists there or groups of psychologists. I can get that information for you, but I don't have it at the top of my head.

The Chair: Outside of those what we refer to as small cities, like Medicine Hat, Red Deer, and Grande Prairie, how many would be operating in even smaller centres than those? I think that would be helpful to the committee as well if you could provide that information.

Mr. Berube: Yes, we can do that. We have that information.

The Chair: If you just provide it through Corinne, she'll distribute it to all the members.

Mr. Berube: We can do that. Thank you.

The Chair: Dr. Pannu, you had one last question.

Dr. Pannu: It's essentially an additional information question. Are clinical psychologists employed by regional health authorities and in particular hospitals, and if they are employed in a hospital context, are their services paid for from the medical budgets?

Dr. Carter: Yes to both. There are clinical psychologists within our health care system in the hospitals that would come out of the hospital budget. Alberta mental health also has some, and they would be paid there. There are also many clinical psychologists that are in private practice.

Dr. Pannu: Are there clinical psychologists employed by hospitals?

Dr. Carter: There are some, yes.

Dr. Pannu: Any idea how many?

Mr. Berube: Well, as a rough figure there are about 20 at the U of A hospital.

Dr. Pannu: Second question: have you been in consultation with

specialists in psychiatry, and what's their view with respect to your role in addition to what they see as their role in this area?

Dr. Carter: In a conversation we had with Dr. White recently, we talked about it. In fact, one of the ideas came from a discussion I had many years ago with Dr. White when he was describing his training in Ireland as a psychiatrist, where he would go to a rural location one day a week. The general practitioner would have all mental health clients booked on that day, and the two of them together would deal with the population there. That's a very good, complementary way of doing it.

My understanding of our discussion with Dr. White – and we had some of the people at the table here during that discussion – is that he was supportive of it.

Dr. Pannu: Is the College of Physicians and Surgeons supportive of it too?

Dr. Carter: We've not had those discussions.

The Chair: Well, thank you very much, gentlemen, for your presentation.

The committee is going to take a break, but before we do, I just want to mention that presenters have been leaving extra copies of their presentations on the back shelf by the telephone. You're welcome to those, and they're also posted on the committee's website.

The next scheduled appointment is at 3:50. We'll try to start a little bit early, at 3:45, if we could get members back here by 3:45. We'll take a short break until then.

[The committee adjourned from 3:25 p.m. to 3:47 p.m.]

The Chair: Well, good afternoon again. I would like to welcome Ms Carmela Hutchison, who represents the Alberta Network for Mental Health. Welcome, Carmela. I would invite you to proceed with your presentation.

Alberta Network for Mental Health

Ms Hutchison: Thank you very much. As most of you who I've presented to before know, the Alberta Network for Mental Health is an organization that represents mental health consumers across the province of Alberta, and we have 2,200 members. We try to help mental health consumers navigate through the mental health system, and we also answer inquiries. You know, somebody may say: I've just been diagnosed with bipolar illness or schizophrenia or depression, and I want to know about medication. Sometimes we get phone calls from people who may have been hospitalized, and other times we get inquiries for support groups and things of that nature. We also do a lot of assistance with helping people fill out forms that they need to apply for their benefits.

I'm hoping to keep my presentation as brief as possible so that the time allotted can be used for dialogue. I'm just going to cover basically five points. One is around the issues of voluntariness. Two is around recovery. The third is around access to all of the allied health professions. The fourth is some vision that we'd like to see with respect to issues with the way that the Mental Health Patient Advocate's office could be enhanced. The fifth is the need for mental health consumer representation, which we'd like to offer, on the implementation committee. We believe that that's also very essential.

With respect to voluntariness you may be quite surprised to learn that upon a vote of our board, we actually do not want to see a model like Ontario has. Ontario has a model where the patient has to agree to a community treatment order, and we are not in agreement with that stance. Everyone is very realistic about the fact that there are times when someone is not able to manage their mental health, that they will need to be treated in an involuntary way in order to save their life. So we're very concerned that that be kept the way it is.

Having said that, we're very concerned about rights, and we're also very concerned about protection of patients from abuse that can occur in any system, whether it be, you know, people who are receiving government programs or people who are being treated at the hands of government programs. One of the concerns that I have that is already addressed in the Personal Directives Act that I want to see brought over to Bill 31 is the issue that forced treatment cannot be experimental in nature, that it cannot be forced psychosurgery, and that there cannot be an ECT done on an involuntary basis. I would like to see that brought over and enshrined in this act in terms of protection of patient rights. I think that that's a very important issue.

There also has to be a real enhancement of the ability for patients to have access to information about their rights and responsibilities under the act when they're under a community treatment order. I think that's very important, to engage them and be very open about the process that they are involved in.

With respect to how a community treatment order is instituted, we think it's very important that it does come from a formal patient setting as opposed to just being issued from within the community. The reason for that is that we don't want to see downloading of that kind of service. When someone is sick enough to be on a community treatment order, they're sick enough for a period of hospitalization to be stabilized. Once stable, the community treatment order will then follow them. We are very concerned about proper oversight and monitoring of the patient's condition. We think that's absolutely vital. We also believe that a psychiatrist, in terms of monitoring of the medications, must be involved in some level of oversight of the medical condition of the patient who's receiving psychiatric medication.

Having said that, there is a vital place for every member of the allied health professions to be part of the tier team, and that really needs to be funded. Psychiatry and social work have better skills with trauma and addiction and also with nursing, who can help monitor, so they can enhance the psychiatric role by helping to monitor a patient's response to medication in a week-to-week or daily, if they're being more intensely supervised, way. So that's an important thing to keep in mind when you're designing your community supports. Community supports are absolutely essential. No treatment can function at all without the determinants of health. If people are homeless and don't have proper food to eat or are living in constant distress or if they're being abused in any way, either in the system or outside of it, treatment is not going to be effective, and it's not going to reach the goal that you desire to reach.

That brings us to recovery. It's very important as we walk with a person who's mentally ill towards their recovery that we understand that recovery is individualized for every person. The level of recovery that we want to seek for them is the highest possible that they can achieve. It is also crucial that people have access and support to navigate through the system. Families also need information and support. Even sometimes in the consumer network, when we're trying to work with somebody, we run up against the same issues that families come into play with, where we can't get information or we're trying to give information. So that's one other thing that's very important.

3:55

The last piece that I also wanted to talk about. Again, this may also shock and amaze people, but a lot of times in rights legislation government has legislated away some of its powers in order to uphold and protect people's rights, and it's really important that you take that power back. I think that it's absolutely crucial when we have appeals. For example, if you have somebody who's appealing their certification or they're appealing their community treatment order, because the health system doesn't want to be bothered with the appeal, very often they'll revoke the order or they'll revoke the certificate even though the patient probably still needs it, and they'll revoke it in advance. That sometimes makes it very difficult for those of us who are supporting people in order to have the treatment that they need stay in force.

The last piece that I'd really like to advocate is that we're very interested in working with the office of the Mental Health Patient Advocate in order to enhance the role of consumers to be able to assist in the process of working with and advising the system. In order to assist and advise you, I think one real key piece that is definitely missing is having a mental health consumer on the implementation committee for Bill 31.

That concludes my presentation. I want to keep it as short as I can because I hope to maximize the dialogue that we might have. Thank you.

The Chair: Thank you very much, Ms Hutchison. I don't have anybody on the list right now, so I have just a quick clarification. You brought something forward that I don't believe any of the others have thus far, and that is that forced treatment cannot be experimental in nature or a surgical treatment. Was it just the two, or were there more in there than just those two that couldn't be forced?

Ms Hutchison: I believe that it's experimental treatment and psychosurgery. ECT is not under the Personal Directives Act. I think those are the three elements that are the ones. They are in the Personal Directives Act as well, and I'd like to see them brought over. ECT is not in the Personal Directives Act, but I think it's really important because its effects are not known, and it is controversial that a person's consent should be obtained before that treatment is put on them.

The Chair: Those are very good points. Those rights should be preserved for the patient; that's for sure.

Any questions from the panel?

Mr. Flaherty: Just a definition. Maybe she could help me. I don't know if I can pronounce it properly. Psychotropic medications?

Ms Hutchison: Yes. Psychotropic medication is any medication that is given to enhance a person's mental health. In other words, if it is a medication such as an antidepressant, then it's changing a person's mood. If it's an antipsychotic medication, it's to treat a thought disorder. If it's an attention deficit disorder treatment, a person is receiving Ritalin, that helps them with their behaviour. So any medication that helps with a feeling, thought, or behaviour, which is basically the essential definition of mental health.

Mr. Flaherty: Thank you very much.

Mr. Johnson: You made an interesting statement there. You said that government often legislates away some of its powers and that we need to get that power back. I didn't really get the point there as to how that relates to this bill. Can you just go over that again with me?

Ms Hutchison: Certainly. There is an ombudsman that a person can approach, but they can only recommend. They cannot compel. There are human rights commissions, and they can compel to a certain extent, but we don't see as much of that as we might otherwise. I think it's really important because government is here to uphold people's rights as much as it is to make rules and enforce legislation. If people are circumventing appeal processes by simply cancelling hearings, that also doesn't allow for a situation to be fully investigated and inform government to make decisions that it might make differently. It might also make a patient think about things differently. If a patient goes to a hearing and feels that they've been heard and their certificate is upheld, they know at least that they've been through a process, but it might also help them come to accept that it's not just the doctor but that it's the community that's saying: you need care; you need treatment. I think that it's very important.

There may be other times when some other issue may be raised as the point of having that investigation, so it's very, very important. Everyone in the mental health consumer community wants what's best for people who are mentally ill and wants treatment that works, wants people to be well, wants people to be cared for and happy.

I mean, I've sat on other committees and at round-tables with some of the MLAs here over a period of several years, and I believe that you are sincerely interested in what is the best possible outcome for the people that we all serve, but without the legislative support to uphold rights, without the legislative support to uphold a treatment order that families have struggled for months to get, it's very difficult.

We had a situation once where a gentleman in the gallery and I were assisting a gentleman who was addicted and had bipolar illness. He was certified in the hospital, and as caregivers we were just so relieved because finally there was going to be help for him. Because he appealed the certificate, they cancelled him at 15 days. If he'd stayed 30, would he have been able to avoid the alcoholic psychosis that then ensued? We're never going to know.

Mr. Johnson: Thank you.

Dr. Pannu: Carmela, in the very first part of your presentation you said that you'd like this legislation to make sure that involuntary treatment must not allow the use of experimental medication.

Ms Hutchison: Experimental treatment of any kind, psychosurgery, any other kind of treatment that isn't proven, any kind of experimental or research project should not be forced on a patient.

Dr. Pannu: But you would not be opposed to the use of this kind of treatment if there is informed consent?

Ms Hutchison: Yes.

Dr. Pannu: Are mentally ill patients who are under involuntary orders able to give that kind of consent? That's the issue.

Ms Hutchison: Yes. There are many times when they are. I used to work in mental health before I was ill, and there are many times when a patient has to be certified in order to stay in treatment. But if you engage them – and that's the other thing. We have to engage the patients in the process of their care. A lot of times what happens is that they're confused and frightened when they come into hospital. They don't know why they're there.

My first job, actually, in mental health was in Nova Scotia. I was in an institution there where a man, you know, came in as a teenager. He had been in and out of hospital for 47 years and did not realize

that he had schizophrenia and broke down in tears when I explained his diagnosis to him. No doctor had explained it to him. No other nurse had explained it to him. How can you have somebody engaged in a treatment process if they don't have informed consent?

A lot of misconception and stigma around mental illness is that mentally ill people cannot make those decisions, that mentally ill people are somehow unable to have informed consent. They actually can and do in many cases. There will be some who will resist medication. They will have to be medicated against their will. I did say in my written submission that established medication, of course, is the one involuntary treatment that will be given – we all know that, and we understand that – but I would not want to see people on experimental, unapproved things without their consent.

Even as a patient I had to undergo a medical surgery. In that procedure, from what the doctor wrote, I was feeling very nurtured because this man was very holistic, and he said: "Carmela has a mental illness, but she understands the nature of this surgery and its effects, and I believe that she is making an informed decision." He took the time to find out that I had a therapist. He took the time to see, in his opinion as a surgeon, that I really understood my surgery and that I was making the decision with my husband and with my therapist and that I was, you know, on track with my decision-making process. We can do that with every person who comes in. We can at least make the attempt. I would probably tell you that 90 per cent of the time you would have somebody who was capable of consenting to those things.

4:05

The Chair: Are there other questions?

Seeing none, I'd like to take this opportunity to thank you very much, Ms Hutchison, for an excellent presentation, and I'm glad we were able to get you in in a timely manner.

Ms Hutchison: Thank you. My contact information is on the written submission, and I look forward to ongoing dialogue.

The Chair: Thank you.

The information on the handouts that people present will be on the website at www.assembly.ab.ca/community services, but it will take a number of days for staff to do that. It'll eventually be there but not immediately.

Our next presenter is Mr. Richard Dougherty. Is Mr. Dougherty here? Welcome, Mr. Dougherty. I understand that you're a volunteer with the Citizens Commission on Human Rights.

Mr. Dougherty: Yes. Thank you very much. I left 25 copies of my oral presentation with a gentleman outside the door. Has he given them to you yet?

The Chair: We have them here. I'll distribute them right now.

Mr. Dougherty: Okay. Good. Thank you.

The Chair: Just give them a moment to distribute them.

Mr. Dougherty: Sure.

The Chair: Okay. You may proceed. The committee members will have them within a few seconds.

Citizens Commission on Human Rights

Mr. Dougherty: Thank you very much. My name is Richard Dougherty. Although I am a volunteer with the Citizens Commission on Human Rights, as a private citizen I wish to refer to my original submission, dated August 19, as to why I have concerns about Bill 31 and the document submitted on October 26* to the committee entitled Effective, Safe, Healthy, Optional Approaches to Emotional, Mental, and Behavioural Problems and Learning Difficulties. As I understand it, the committee has electronic versions of both documents, and I have some hard copies here if the media would like to have a look at those documents. I also have hard copies of my oral presentation as well for the media.

First of all, I'd like to thank you for inviting me to make this presentation. On June 30, 2006, in an historic and precedent-setting decision the Alaska Supreme Court in Myers versus the Alaska Psychiatric Institute affirmed that the forced administration of psychotropic drugs to patients is unconstitutional. The court's thoughtful, clear, and informed ruling took into account both the constitutional right to personal freedom and privacy. The court addressed a distinct class of drugs called psychotropic medications and also took note of these drugs' profound adverse effects, effects that are not in patients' best interests, which legitimize patients' refusal to ingest them when there are less restrictive alternatives available. I would like to mention just a few of these effective, safe, and healthy common-sense solutions and options, most of which are medically endorsed, which fall into the category of less restrictive alternatives.

No one denies, of course, that people can have difficult problems in their lives and that they can become mentally unstable and, of course, even psychotic. There is no intent in my documents or oral presentation to downplay the seriousness or the pain of emotional suffering caused by mental problems. However, mental healing methods should result in recovered individuals, and there are many safe and healthy things that one can do to facilitate mental healing. We do not refer to the options below that I will discuss as treatments as such because alleged mental illnesses are not real diseases. Although many theories have been proposed, there simply is no absolute, confirmatory proof by way of objective findings that the 374 mental disorders described in psychiatry's billing bible, the diagnostic and statistical manual, or DSM, are due to chemical, genetic, or any other physical abnormalities. Instead, we refer to these solutions as workable options.

Consider the following basic criteria for the creation of real mental health: (a) effective mental healing options which improve and strengthen individuals and thereby society by restoring individuals to personal strength, ability, competence, confidence, stability, responsibility, and even spiritual well-being; (b) highly trained, ethical practitioners who are committed primarily to their patients and to patients' families' well-being and who can and do deliver what they promise; (c) mental healing delivered in a calm atmosphere characterized by tolerance, safety, security, and respect for people's rights.

Identified by the paragraph number in the second document, I will now refer to portions of my second document, entitled Effective, Safe, Healthy, Optional Approaches. In paragraph 1 Dr. Peter Breggin, MD, psychiatrist, and David Cohen, PhD, refer to 12 principles for helping people without resorting to psychiatric drugs in their book *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications*.

In paragraph 2 of that second document – I'm talking about the big 21-pager that you received on October 26 – Dr. Grace E. Jackson, MD, psychiatrist, in her book *Rethinking Psychiatric Drugs: A Guide for Informed Consent* says that as alternatives to antidepressant drugs, nonpharmaceutical approaches like cognitive behavioural therapy, interpersonal therapy, and aerobic exercise are not only more effective than pharmaceutical approaches but have been especially impressive in the prevention of relapse and recur-

*See p. CS-74, right col., para. 15, line 1

rence. She refers to the moral treatment movement, being the work of practitioners who introduced humane approaches in the care of the insane during the late 18th century. Although the moral treatment movement was replaced in the late 1800s and early 1900s by biological psychiatry using psychotropic drugs, some of its elements were regenerated in the theory and practice of various psychosocial therapies and other methods. She mentions a few of them. She refers to them as client-centred therapy, psychodynamic therapy, humanistic-existential therapy, peer counselling, vocational rehabilitation, pretherapy, psychodrama, exercise, cognitive remediation.

The superiority of these psychotherapies and methods over psychiatric drugging is illustrated in a number of studies and projects, including the preneuroleptic outcomes in Massachusetts; the Vermont longitudinal study of persons with severe mental illness; the Michigan State psychotherapy project; the Colorado experiment on humanizing a psychiatric ward; the Soteria project of California, conducted by Dr. Loren Mosher, MD, psychiatrist; and in Finland the acute psychosis integrated treatment project.

In paragraph 4, in looking for the obvious, a number of underlying physical and medical problems are identified in detecting the causes of emotional and social stressors in people's lives.

In paragraph 5 of that larger document five social factors and situations in a person's environment are identified in detecting the causes of emotional and social stressors.

In paragraphs 3, 16, 17, 18, and 19 improved diet, judicious nutritional supplementation, and even pure water fasting are identified as factors in solving mental, emotional, and social stresses. For example, in paragraph 3 we learn from a Dr. Michael Lyon, MD, of British Columbia that optional nutrition and essential fatty acid supplementation safely helps people overcome ADHD and other behavioural difficulties.

In paragraph 17: Dr. Joel Fuhrman, also an MD, has had much clinical experience and has documented the value of fasting to improve the function of the entire body, including the brain. Fasting has been repeatedly observed to alleviate neuroses, anxiety, and depression.

4:15

Paragraphs 21, 22, and exhibit B refer to the effectiveness of common-sense counselling, caring, and drug-free therapy. Reference is made to a Dr. Ralph Cinque, a doctor of chiropractic, in an article he wrote called Mental Health: A Hygienic Perspective.

In paragraph 23, which I find most impressive, the late Dr. Loren Mosher, MD, psychiatrist, opened Soteria House in 1971 in California as a place where young persons diagnosed as having schizophrenia lived drug free with a nonprofessional staff trained to listen, to understand them, and provide support, safety, and validation of their experience. At two years postadmission, Soteria-treated subjects were working at significantly higher occupational levels, were significantly more often living independently or with peers, and had fewer readmissions. Clients treated at Soteria House who received no antipsychotic or neuroleptic medications over the entire two years or were thought to be destined to have the worst outcomes actually did the best as compared to hospital- and drug-treated subjects. In the Institute of Osservanza, observance, in Italy Dr. Giorgio Antonucci, MD, psychiatrist, adopted similar methods to what Dr. Loren Mosher did with success with dozens of so-called violent schizophrenic women.

In my first document, dated October 19, I make note that biological psychiatry has a dismal record in the field of mental health. I itemize over a dozen treatments as being unscientific and experimental, all of which have been discredited. Biological psychiatry's most recent innovation in experimentation, psychotropic drugging, is also unscientific and a highly charged, controversial, and highly questionable practice. It has been accurately described by some authorities as nothing more than a chemical lobotomy.

I would like to conclude my presentation by referring to a statement by Dr. Grace E. Jackson, MD. In her book she says that informed consent is about the right to make choices and the right to refuse consent, that it is about the right of individuals to preserve their integrity and dignity, whatever physical and mental deterioration they may suffer through ill health, that it is about our duty always and in all circumstances to respect each other as fellow human beings and as persons.

Thank you for your time today.

The Chair: Thank you, Mr. Dougherty, for your presentation. Just a first question: how prevalent are alternative therapies being employed in treating mental illness in Canada, and do you have any comparative studies that have been done between the alternative therapies that you speak of in your report and traditional therapies as far as outcomes go?

Mr. Dougherty: Yes. As far as the second question is concerned, the book that I have referred to the most or the one area that I have seen quite a bit of on comparable studies in is that Dr. Grace E. Jackson book *Rethinking Psychiatric Drugs*. In three chapters she deals with antidepressant drug treatment, with antipsychotic drug treatment and, of course, psychostimulant drug treatment. At the end of each chapter she has a section called alternatives to these kinds of treatments, in which she outlines comparable features of the alternative therapies compared to traditional drug therapy.

The Chair: Have these been written up in any medical journals?

Mr. Dougherty: Yes. She refers to them in her book. They're in the footnotes at the back of her book.

The Chair: The first part of the question: how prevalent are these alternative therapies in Canada compared to the more conventional therapies?

Mr. Dougherty: To the best of my knowledge they're almost unheard of.

The Chair: Okay.

Next question, Reverend Abbott.

Rev. Abbott: Thank you, Mr. Chair. Thanks for the presentation. I'm actually just wondering. First of all, on the first page of your document that you just gave us, you mention a document submitted on October 26, 2007, which hasn't occurred yet.

Mr. Dougherty: Yes.

Rev. Abbott: I'm assuming that means September 26.

Mr. Dougherty: I'm sorry, September 26.* Yes, I'm sorry. That's my error.

Rev. Abbott: Okay. Then I'll fix that.

Then also I guess I'm wondering – it's not very clear in your presentation – if there are any parts of Bill 31 that you support. The reason I'm asking that is because I'm almost hearing that you would advocate for some kind of a community treatment order except that

*See p. CS-73, right col., para. 1, line 2

in the case of drugs being prescribed, you would prescribe a special diet or some kind of special, you know, care for that person other than drugs to make sure that they can maintain mental health.

Mr. Dougherty: As I understand it, in biological psychiatry usually the first method or the main method that is employed is to administer some sort of psychotropic drug, and I think that is perhaps what I object to the most. I'm not saying that drugs aren't useful in some instances, like, for example, in the here and now, when someone is imminently going to harm himself or harm others. But I don't know if that would provide an excuse to continually drug that person day in and day out, month after month, year after year.

Rev. Abbott: I understand that, and that's not my point. My point is: what part of Bill 31 do you think would fit in with your understandings of how to protect the community or to help people who have mental illness? What parts of Bill 31 do you feel are appropriate or perhaps inappropriate? I'm not talking about treatment. I'm talking about the bill.

Mr. Dougherty: The actual bill itself?

Rev. Abbott: Yes.

Mr. Dougherty: Well, I would have to agree that society has to be protected from people who are mentally unstable, but I also think that we should be considering how we can help them long term in a very functional way and in a way that's long lasting.

Rev. Abbott: Okay. Just if I may, Mr. Chair. I guess what I'm hearing you say, then, Richard, is that you feel that the bill doesn't go far enough or that the bill needs to have some supplemental legislation in it that talks more about the treatment side rather than just a strict, say, community treatment order or changing of the definition of a danger.

Mr. Dougherty: That would be correct.

Rev. Abbott: Got it. Thank you.

The Chair: Thank you.
Are there others?

Dr. Pannu: Mr. Dougherty, on page 2 of your handout, the very first top few lines, you cast lots of doubt on the science of biological psychiatry and, in fact, say:

> There simply is no absolute confirmatory proof . . . that the 374 mental "disorders" described in psychiatry's billing bible, the Diagnostic and Statistical Manual . . . are due to chemical, genetic or other physical abnormalities.

Now, this statement, obviously, is highly controversial, and I suppose that professionally trained psychiatrists – Dr. White was here this morning – will find the statement highly provocative and, of course, inaccurate. Dr. White is a very strong supporter of the bill before us, Bill 31, which permits the issuance of CTOs. What would you have to say to him for his enthusiastic support for the bill, and what would be your position with respect to involuntary commitment and involuntary treatment given the nature of the science that you have described here?

Mr. Dougherty: Well, in real diseases like asthma, heart disease, and cancer there is an objective finding – there is some sort of examination of tissue, an X-ray, a blood test that is done to identify some dysfunction in tissue – whereas in the disorders listed in the DSM, there are no laboratory tests which confirm an objective finding, unlike in a pathology textbook, where we find other diseases listed like asthma and diabetes and that kind of thing.

I suppose I would challenge him to produce one piece of scientific literature that actually proves definitively that there is an actual physical, chemical, genetic abnormality that can be effectively treated with drugs because in the absence of a physical abnormality I would say that there is no reason to drug a person. I know that there are theories that are out there, but there's nothing in the scientific literature that actually proves a physical abnormality.

4:25

Dr. Pannu: Then this bill, which will permit CTOs: under those orders compulsory or mandatory ingestion of psychotropic drugs – others would become obligatory, you know, in reality. Given what you know, based on your own studies and other things that you read, would you support a bill that makes legal mandatory administration of psychotropics for patients even when they're not willing to take them?

Mr. Dougherty: Absolutely not. I would not be willing to support that bill. I would take the position of the Alaska Supreme Court. That would be the position I would take. That's why I mentioned that in my opening statement, to give a reference to an actual court decision.

The Chair: Are there others?

Seeing none, I'd like to thank you again, Mr. Dougherty, for your presentation and taking the time to come in here and doing your research and presenting it to the committee. Thank you.

Mr. Dougherty: Thank you very much. I appreciate you giving me the time.

The Chair: Our next presenter is here, Dr. Peter Doherty, and he is with the Alberta Association for Marriage and Family Therapy. Welcome, Dr. Doherty. You may proceed any time you're ready.

Alberta Association for Marriage and Family Therapy

Dr. Doherty: On behalf of the Alberta Association for Marriage and Family Therapy, AAMFT, I'd like to take this opportunity to thank you for this opportunity to speak to the Standing Committee on Community Services. On behalf of the association I wish to congratulate this government for its attention to and current review of the Health Professions Act, Bill 41, with the attempt to provide increased support for small professional colleges. This is an opportunity for me to introduce to this committee two important issues related to marriage and family therapy for Albertans that impact community mental health services to the public.

The Alberta Association for Marriage and Family Therapy is a professional organization which is committed to the practice of individual, couple, and family therapy as it seeks title under the mandate of the Health Professions Act of Alberta. Recognition under such legislation is a future endeavour for the family therapists, and I'm looking forward to the increased number of mental health groups listed.

I'd like to highlight to the members of this present committee the importance of such recognition for registered marital and family therapists. Presently anyone can call themselves a marriage and family therapist and attempt to conduct therapy with couples and families without training or experience in this field. This became, actually, quite clear to me when I was supervising an intern, who

asked to borrow one of my textbooks on family therapy. When I explored as to why this sudden interest, he had decided to see a family as part of his practice, assuming that his training in individual therapy would be enough to deal with the complexities of several members of a family.

Albertans seeking help for their families' problems in mental health are at risk. Marriage and family therapists are mental health professionals trained to diagnose and treat mental and emotional disorders. They specialize in treating mental disorders in the context of their individual relationships. The goal is to work in the most time-efficient manner possible. Marriage and family therapists work with the individual, the couple, and the family to change behaviour patterns so that problems can be resolved. Qualified marriage and family therapists have specialized training to help with this process.

The second issue I wish to outline is some of the challenges of membership in this professional organization, which is committed to the practice of individual, couple, and family therapy. The training and clinical work in the area of marital therapy and family therapy is recognized for its creative research, contributions to the advancements of the change-orientated therapies, for dealing with the family as a system, and dealing with the different complexities of the system as they interact on the individual.

Marriage and family therapy has become a distinct professional discipline with graduate and postgraduate programs. Marital and family therapy programs are getting recognition in university training programs across North America, Australia, New Zealand, and parts of Europe. Degrees are being conferred specifically in the distinct discipline of marital and family therapy.

To become a marriage and family therapist, an individual must obtain at least a master's degree or complete a doctoral program in marriage and family therapy. Graduate studies are rigorous, involving individual and group supervision, course work in human development theory, assessment, treatment, ethics, professional studies, and research. Postgraduates go through 1,000 direct client hours and 200 hours of supervision before clinical membership can be considered. Continuing education is ongoing. The AAMFT Commission on Accreditation of Marriage and Family Therapy Education is designated as the accrediting agency for academic institutions providing master's, doctoral, and postgraduate training in marriage and family therapy.

As a professor teaching students in family studies, as a family therapist myself, and as the newly elected president of the Alberta Association for Marriage and Family Therapy I believe regulation and protection under provincial legislation offers essential recognition and understanding of registered marital and family therapists as a stand-alone profession. Inclusion would acknowledge the enormous thoroughness of the training this professional designation would require. It would further help the public at large to have access to service excellence under provincial statute.

Other provinces are making headway in this regard. Ontario and Quebec divisions have gained recognition under provincial legislation, and British Columbia is attempting to seek recognition under a group umbrella supporting a profile of specialized competencies.

In closing, the Alberta association is a division of an international body. The challenge of our group is the recognition under the Health Professions Act, recognition of the contribution that we make, and a struggle to be recognized as a profession under it. As this committee reviews the current statute, my intention with this presentation is to raise awareness of registered marital and family therapists and highlight the issues relating to regulation.

Thank you very much for your time.

The Chair: Thank you, Dr. Doherty. There's usually opportunity during the course of a day's public hearings to ask a question a bit on the lighter side. I'll start it off. To be a professional lawyer you have to article for a period of time. To be a doctor you have to serve an internship for a period of time. To be a professional marriage and family therapist, do you have to be married with children for a period of time?

Dr. Doherty: That could be a liability, actually. No, you don't have to be. I do substance counselling too, and I don't drink.

The Chair: Reverend Abbott.

Rev. Abbott: Thank you very much. I guess what I'm hearing you say, then, is that you're supportive of Bill 41.

Dr. Doherty: Yes, very much so.

Rev. Abbott: Okay. Good. You're the first one today, so thank you for that.

Secondly, you would like to see the Alberta Association for Marriage and Family Therapy included as one of the health professions in that act. That's essentially your ask this afternoon, is it?

Dr. Doherty: Yes, recognizing that and recognizing the importance of the revisions that are being made or considered.

Rev. Abbott: Okay. Great. What you're saying, then, is that with your association you feel that you do have the education, the accreditation, the self-governance, and the discipline to make sure that your members that are certified are in fact able to perform the function, you know, of your title. Just to be clear, then, do you do that now, where you get this certain clinical designation, and do the people that are in your organization have something that will sort of set them apart currently from the other perhaps less qualified or unqualified marriage and family therapists?

Dr. Doherty: At this time, no. I guess the closest we would have is to use the logo, which we have a copyright of, but that's it. I don't think the public would necessarily recognize that distinction.

Rev. Abbott: Okay. So there's definitely a gap here. There's definitely an issue here.

Dr. Doherty: Yes, there is.

Rev. Abbott: Okay. Thank you.

Dr. Pannu: Dr. Doherty, how many members does your organization have at present? You say it's a small group.

Dr. Doherty: Yes, it is. We have 205 members at the present time.

Dr. Pannu: And are they all in private practice? Are most of them?

Dr. Doherty: To the best of my knowledge, I would say that maybe about a third of them would be in private practice. The other two-thirds would be involved in different community agencies.

Dr. Pannu: It is true that today most of the professional organizations that have come before us to make a presentation have expressed very serious concerns about one particular section of Bill 41. I think it's section 135.

4:35

Dr. Doherty: Could you say something about it, sir? I don't have it with me.

Mrs. Mather: It's about the erosion of self-governance.

Dr. Pannu: There was very serious concern expressed about the provisions that will erode both their ability to self-regulate and self-govern.

Dr. Doherty: I have not taken that question directly to the board. I would estimate and believe that we'd probably lobby for more once we are in. I think that's an issue that can be resolved. I don't think that that is something that would stop our support for this bill.

Dr. Pannu: You haven't had a close look at that particular section.

Dr. Doherty: Not a close look. I'd like to discuss that with my board at this point.

Dr. Pannu: Okay. I just want to ask you what types of psychosocial disorders your specialty deals with and provides healing for. How is it different from, perhaps, the class of illnesses and mental and psychological disorders that psychiatrists might deal with?

Dr. Doherty: Well, I think I will look at strictly what we deal with, a lot of examples with different forms of addictions. Oftentimes one person will come in, and you find out that the whole family is experiencing different forms of the addiction as well. Spousal abuse would be another situation in terms of that dynamic. You're more likely to have success if you deal with a couple rather than just dealing with one individual, the offender. Dealing with child abuse issues as well, family incest, dealing with it from a family perspective often brings about change.

Dr. Pannu: So it's more of a class of difficulty that you might call family dysfunction or disorders rather than psychiatric or psychological?

Dr. Doherty: That's a very good question. I think that from our history, though, ironically marriage and family therapists, the grandfathers and grandmothers of marriage and family therapy, dealt with schizophrenia. I'm not quite willing to give up part of my history here. I would not see that the marriage and family therapist would be the primary source of therapy in a schizophrenic family, but I could see the family doing some family therapy. Dealing with a family member with schizophrenia would certainly impact the family and could lead to dysfunction within the family. There is some evidence indicating that it's a two-way street, I guess.

Dr. Pannu: You were sitting there and listening when Mr. Richard Dougherty made his presentation. I wonder if you have any observations or any advice to give us with respect to some of what he had to tell us because you are a specialist in the, sort of, nonpsychotropic drug therapies, if I might call it this.

Dr. Doherty: I think there are many causes to mental health issues. I think he was dealing with specifically one, and I'm dealing with a whole other set of possible causes and contributing contraindicative therapy, so I would be reluctant to speak specifically on his. I think it's different, apples and oranges almost, what we're offering.

The Chair: Dr. Doherty is presenting on Bill 41, not Bill 31. Could we keep our questions to Bill 41?

Dr. Pannu: But you see a relationship, Mr. Chairman, between these two presentations. I think it's important to take advantage of advice.

Rev. Abbott: A supplement. We did have the Psychologists' Association of Alberta earlier this afternoon, Mr. Pierre Berube and Dr. Stephen Carter. Again, they were presenting on Bill 31, which is about Mental Health Act amendments, but I did ask them some questions about the criteria for becoming a registered psychologist, so I'm pretty comfortable I understand that. I see that you also are a registered psychologist. My question for you is very simple, and that is: are all the members of your association registered psychologists? In other words, do they also go through that scrutiny of the Psychologists' Association of Alberta?

Dr. Doherty: We don't have an EPPP exam, you know, the 200-question exam. We don't have licensure yet. This would be something moving towards that. In terms of the clinical hours that are supervised out in the field, psychologists require 1,600 hours; we're requiring 1,000 hours. We're considerably less.

Rev. Abbott: Okay. So if I may ask, then: what would you say, just ballpark, would be, roughly, the percentage of your members that would be registered psychologists such as yourself?

Dr. Doherty: I'd say about a third.

Rev. Abbott: A third? Okay. Thank you.

The Chair: Are there others? If not, thank you very much for your presentation, Dr. Doherty.

Dr. Doherty: Thank you very much.

The Chair: The next scheduled appointment is at 6:05, unless Dr. Austin Mardon is here and is prepared to make a presentation now. Not prepared? Okay. Is there a Ms Ione Challborn here? Okay. What about Mr. Merle Schnee, scheduled for 7:20? You're not prepared yet? Okay.

Is there anyone here that's presenting later on that would be prepared to present now? Seeing none, then we will adjourn until 6 o'clock. I'd ask the committee members to be in their chairs at 6 o'clock. We'll break for dinner.

Thank you.

[The committee adjourned from 4:41 p.m. to 6 p.m.]

The Chair: I guess you can go ahead and proceed, Dr. Mardon.

Austin Mardon

Dr. Mardon: Good evening, members of the Legislature. I would like to start by stating that I'm here as an individual. My comments should not be construed or interpreted as representing the views of any organization. I come here today simply as a person that has lived with schizophrenia for the last 15 years. Those with schizophrenia are potentially one of the major groups that will be affected by the most controversial element of Bill 31, that being community treatment order provisions.

I have never consciously decided to stop my psychiatric treatment. That puts me in the 20 per cent of the population of persons with schizophrenia that co-operate with treatment. I still suffer from the effects of the illness but at least have been gifted with insight to understand my disease. Many people with schizophrenia are not

blessed with the insight to know that they are ill with a chronic disease that will require a lifetime of treatment. In those individuals with serious cases of schizophrenia who have the lost the ability to know that they need to remain on their medication, in my opinion this necessitates their being under supervised treatment.

I do believe that serious checks and balances need to be in place to avoid potential abuse of this process. There is no question that the province has the power to enact laws to protect those citizens most vulnerable and unable to take care of themselves, but with great power comes great responsibility. I think one issue that hasn't been addressed is that if the province forces an individual to take medication, who, then, bears the cost of this medication? Some of these medications are not covered by the formulary, neuroleptics, I mean, and can cost several hundred dollars. That includes the medication that I take that has made me capable of even being in your august presence today.

The focus of this legislation is the perception that those who suffer from schizophrenia are all potentially violent. This is an unfortunate misconception. While it is true that there have been several well-publicized incidents of violence perpetrated by individuals off their medication, the truth is that a schizophrenic is much more likely to be a danger to themselves. The implementation of CTOs will actually save more lives that are potentially at risk from suicide. A person off their medication in the grips of psychosis is not just a danger to the public, but they are a danger to themselves and potentially their loved ones.

I'm not an expert on the legal or clinical aspects of CTOs, but I do know for myself and for my family I take comfort in knowing in the future that if for some reason I become ill or have a serious relapse, then this legislation offers the chance that I will receive humane treatment even if I'm too ill to know that I need treatment.

It is important for the members of this body to understand that enacting this legislation will mean that the treatment most likely to be used will be an injectable neuroleptic administered once or twice a month. It is a fallacy to believe that CTOs can be enacted with traditional daily medications. It will be logistically impossible to follow individuals, many of whom may be homeless, around on a daily basis to make sure they have taken their pill. The more expensive injectables and also cheaper injectables that are of older birth are the only way for a doctor to know absolutely that the person has had their medication.

I would like to note that for the general population approximately 40 per cent of people do not take their medication that has been prescribed to them by a doctor in the prescribed manner. So it is not surprising that people miss taking their neuroleptic pills correctly.

Of course, taking medication is only the first step. Housing, employment supports, social supports, and general psychosocial support are necessary to ensure that when the medication kicks in and the person leaves an extreme psychotic state these people will have a reason to stay well rather than living a life of quiet desperation.

In summation, as a person who may one day be the subject of a CTO, I support them for my personal safety and well-being and for the peace of mind of my family, and I thank you for allowing me to speak to you today.

The Chair: Thank you so very much for your presentation, Dr. Mardon.

We have Reverend Abbott first.

Rev. Abbott: Yes. Let me echo the chair's thanks for being here. It's very, very important, as you say in your handouts that you've given to us, to hear directly from somebody with schizophrenia. We did have the Schizophrenia Society in earlier, and they were also very strong in advocating for the passage of Bill 31. As well, we had a Dr. White from the U of A, a psychiatrist, who was also a strong advocate of Bill 31.

In fact, Dr. White presented some statistics to say that I believe it was 70 per cent of people who have been subject to a community treatment order support them. They actually agree with them. He said that quite often there's a resistence at the outset of people going on them, but he said that once they get on them, they're actually very supportive of those. I guess I'm essentially hearing the same thing from you, and obviously, being from Alberta, you've never been on one.

Dr. Mardon: No, I've never been under a CTO.

Rev. Abbott: Okay. Are you familiar with anybody that has, or can you give any personal comment on that?

Dr. Mardon: Well, I've never met anyone that has been under a CTO. I've only read anecdotal material that I've come across over the last 15 years. It's quite a drastic move, obviously, to interfere with a person's right to administer medication to themselves, but it does seem to be appropriate when one considers that the part of the body that's broken is the brain. The actual ability to have insight is broken in this illness's case. It would be similar to Alzheimer's and certain types of dementia, where the person's ability to make a decision about treatment is interfered with.

Rev. Abbott: Okay. Excellent. Thank you.

The Chair: Mr. Flaherty.

Mr. Flaherty: Thank you. Dr. Mardon, I respect your sincerity in the presentation very much. I wanted to ask you something. This morning a lady from Toronto, the very first, raised medical diagnosis of the mental problem. I was wondering: could you share with us in terms of your own illness and working with physicians, was a medical diagnosis a good experience for you? I guess I'm trying to understand what your feeling about the medical profession has been in dealing with your illness. I'd be very interested in your comments on that relative to diagnosis.

Dr. Mardon: Relative to diagnosis. Well, I had a prodromal, which is the preschizotypal personality, before I became floridly psychotic in 1992. I had a type of personality that is susceptible. My mother had schizophrenia, so there's that genetic link, and I had a great-grandmother and several cousins that have it. So it wasn't too difficult for the doctors to make that link.

I found that they generally don't diagnose you very quickly. They usually err on the side of caution. First of all, when you get hospitalized, usually the first thing they assume is that you're on drugs, so they do a tox screen to filter out whether you're on LSD or some sort of hallucinogenic. Once they've taken that out of the equation, then they can look to see what type of schizophrenia you have if they diagnose you.

I found that the doctors generally don't want to diagnose you, actually, because they understand that it's a pretty drastic label to be diagnosed that way. You know, it has very big implications for your future employment; for example, public life or private life, self-esteem, the way family members react to you. They don't usually want to diagnose you. From what I understand, usually the average length of time between first seeing a doctor and diagnosis is about six months. I read that about 10 years ago. Have I answered your question?

6:10

Mr. Flaherty: Well, no, that's fine. I just wanted to get your feeling on that, sir, and I appreciate your comments. Thank you very much.

Mr. Lougheed: Good evening, Austin. Thanks for being here. I have in the past appreciated your counsel. Congratulations on your award this past weekend in Ottawa.

Dr. Mardon: Thank you. It was actually in Toronto. The Order of Canada happens next.

Mr. Lougheed: Ottawa is next for the Order of Canada. Congratulations on that as well. Your work is appreciated. Your comments today helped to illuminate this more than we can get out of briefings and other things, so your contribution is important.

A question was asked earlier today about people who are on community treatment orders, and yes, the ministry or the department, the government would be providing the cost of the Consta or whatever it might be under the treatment order.

Dr. Mardon: Well, one thing to talk about neuroleptics is that there are other neuroleptics that are in the tube that are being tested right now that are injectable for the latest generation of antipsychotics. The way schizophrenia medication works, it's not one medication for everybody. You have to try different kinds. Also, they do wear off after time.

I do know that it's expensive, which is a factor. I think that the savings to the criminal justice system, the mental health system, just the wasted lives – people can be rehabilitated from a state of psychosis. I've seen figures that approximately 600 out of the 3,000 homeless people in Edmonton are homeless schizophrenics. It's a very large problem. It's a medical problem. It's not a legal problem. As such, it should be treated as a medical problem.

It might not necessarily be true, but I believe that if I was not on medication, I would be similar to my great-grandmother, who in the 1890s developed schizophrenia and was institutionalized for 20 years straight until she died in an asylum. The medication really can give you back a life just as the triple cocktail gives people with AIDS their lives back. You know, they would be dead if they didn't have this. The latest generation, the atypicals, neuroleptics, have been around since the early '90s, mid-90s, and they've been a dramatic increase in the effectiveness of treatment in terms of schizophrenia and some other forms of bipolar and psychotic illnesses.

I've rambled a bit.

Mr. Lougheed: Good information. Thank you.

The Chair: Tony, on this point?

Rev. Abbott: Thank you. Yes, just on this point. Rob's comment is reminding me also of a proposal that was put forward this morning, or it could have been this afternoon, from one of the presenters that was talking about the possibility of the community treatment order, the record of it, the record of having been on a CTO, elapsing after possibly two years. I'm just wondering if you have any comments that you would like to add with regard to the possibilities of adding in some kind of a statute of limitations as to how long we should keep a record that a person has been the subject of a CTO.

The other, just tied into that, is with regard to the CTOs named in this bill lasting up to six months. I'm wondering about your comments or your thoughts on that as well.

Dr. Mardon: I think that under no circumstances should a CTO appear in the criminal justice record system. I honestly believe that. This is not criminal activity.

Rev. Abbott: Actually, I'm referring more to a health record.

Dr. Mardon: Oh, okay. I believe that two years might be appropriate. The length of time might be a problem in terms of renewing it, you know. For the refractory patients, those patients that don't respond, it can take up to one year initially to respond to an atypical antipsychotic if you've been off it or if you've been on the wrong type. So it can take a very long time for it to kick in.

Rev. Abbott: Good information.

Dr. Mardon: Have I answered your question?

Rev. Abbott: Yes. You did very well. Thank you.

Mrs. Mather: I, too, want to thank you for being here and presenting your perspective, which is really valuable to us. So far you're talking about the administration of drugs to help. It's my belief that for CTOs really to be worth while, they have to be multidisciplinary. I'm wondering if you would comment on that and what other aspects of treatment you have found to be worth while.

Dr. Mardon: Well, I believe that medication is a very important first step, as I said, and that one needs what is called assertive community treatment, a treatment team that deals with a limited number of people that are under a CTO or are really needing intense care, for example psychosocial support. They would need the support of a multidisciplinary team of social workers, psychiatric nurses, possibly employment counsellors, employment support people if they wish to get back to part-time work.

One thing I found is that the idea that people could necessarily go back full-time might be counterproductive, but I do believe that people that are mentally ill should be active in some way, should participate in society. Many volunteering positions in Edmonton are filled by people on AISH and actually by mentally ill in many different societies. There are organizations such as the Clubhouse, which reintegrates people coming out of hospital. There are the outreach clinics.

It's not a simple thing of just administering medication. Once the person gains insight, they might realize what it means to have that label and to take these medications and so therefore actually has to have a meaning to their life, and because of their social impairment, they really do need help in getting back to a point where they can function as independently as they can and, hopefully, in a healthy manner. I think health would be more important than normalcy, you know. The person under a CTO or who is severely mentally ill might not necessarily be normal per se for the rest of their life, but they might attain a level of health that is quite good within the context of their illness.

Mrs. Mather: Okay. Thank you.

The Chair: If I could expand on that just a bit, Dr. Mardon. I thank you for coming here. I think the committee really needs to hear first-hand how this legislation can affect actual patients, and we need to hear from people that may be directly affected by it. Expanding on some of the ideas that Mrs. Mather brought up, earlier today we heard a presentation on alternative therapies as a replacement for the more pharmaceutical therapies. In your experience what is the value

of some of those alternative therapies as a substitute for the pharmaceutical treatment or as an addition to?

6:20

Dr. Mardon: Well, if I could digress a bit. One of the groups that Mother Teresa in India took care of were schizophrenic people that were off the street. She had some success with treating them without drugs because she couldn't afford it. She couldn't even afford the old generation medications. These people were very poor. They achieved a level of normalcy, but it was after a very long period of time. They were never able to work again. They lived in a very structured, agricultural setting, so that was not in a normative society context. They were sheltered away, but they were able to function fairly well.

To be honest, to live in our modern society there is stress. Everybody here knows that there is stress. You have to deal with that. Medications are a first step. All I know is the experience of my family. In the 1890s, when my great-grandmother got sick, there was no access to medication. Her prognosis was illness for the rest of her life and social isolation. In the case of my mother, she had access to the old generation medication. Her prognosis was that she never worked again, but she was able to function somewhat. In the case of my generation, my cousins have survived to the point where they were put on the latest generation antipsychotics. They are able to work part-time, not full-time, and are able to contribute to society in various volunteer capacities. So it's not back to the level that it would have been if I and the others had not gotten ill, but it is back to a more measurable level.

Obviously, Freud and psychiatry have elements of alternative therapy. It's intrinsic in psychiatry, but we entered an age back in the 1950s of a type of treatment of psychiatry, of brain chemistry, looking at it from a chemical point of view. It's important to go along those two tangents: first, the chemical interventions, medication, to rebalance the chemical imbalance in the brain, and at the same time use psychosocial support in therapy to support the individual so that once they get back to a modicum of reality, then they can try to come to grips with their new reality, their new social environment.

The Chair: Thank you very much. I'd like to thank you once again for coming in and making this presentation. I'm sure your answers will be most helpful to the committee.

Now we will move on to the next presenter – and Corinne will be circulating a handout – and that will be the Canadian Mental Health Association, the Edmonton region, Ms Ione Challborn. And you are accompanied by?

Ms Challborn: I'm accompanied by Valerie Wright, the president of our board of directors.

The Chair: We'll just wait for another second or two until everyone has their handouts.

Okay. Ms Challborn, you may proceed.

Canadian Mental Health Association, Edmonton Region

Ms Challborn: Thank you. Good evening, everyone. My name is Ione Challborn, and I'm here this evening in my role as executive director of the Canadian Mental Health Association, Edmonton region, an affiliate of the Canadian Mental Health Association, Alberta division. I'm joined by Valerie Wright, president of our board of directors.

I've only very recently joined the Canadian Mental Health Association, and I'm thrilled to be able to present here to you tonight on behalf of our agency. Much of my past work in the not-for-profit sector relates to the field of family violence, and as such, I know how important it is for all to find workable solutions to complex medical, social, and legal problems. A small package has been distributed to you that includes a description of our organization, a booklet which explains our agency programs, as well as our thoughts on Bill 31.

I was here this afternoon for a while, and I know that you've been hearing many presentations from many different groups and individuals who have praised and encouraged the government for striving through amendments to the Mental Health Act to improve the quality of life for people who are experiencing a mental illness and who also have thoughts on how to strengthen Bill 31, and we're very pleased to add our voice to this discussion. The social action committee of our board of directors reviewed similar legislation from other jurisdictions, and the board as a whole had discussions with other community professionals in order to best appreciate the intent and the ramifications of Bill 31.

Our board supports Bill 31 because a community treatment order is a tool that's designed to get services quickly to those who need it. Our support is predicated on these conditions: that a case manager is assigned within 72 hours of the CTO being implemented and that case manager would have the responsibility to develop, co-ordinate, and monitor an individual treatment plan; that significant additional community-based support for all people with mental illness be provided. Bill 31 is a medical-legal solution to complex, medical, legal, and social problems. We advocate that in order to achieve the desired benefits of such legislation, resources must be available and accessible to people experiencing a mental illness, to the community, and to the care team.

We also think that early intervention programs be mandated as part of the continuum of care. Early intervention programs are effective in helping people adjust to mental illness, function effectively, and thereby reduce the need in the end for community treatment orders. Important early intervention programs are bridging programs from hospital to community, outreach programs, school-based education programs, and early psychosis intervention.

We also recommend the immediate addition of Risperdal Consta to the Alberta health pharmaceutical formulary.

Many will say that appropriate and readily accessible community-based supports are hard to come by. Further investment in these supports will likely be required to ensure that the requirements of community treatment orders can be met. I was heartened to hear that two committee members spoke to that fact this afternoon.

Thanks very much for the opportunity to speak with you today. We want to be a partner in any initiative which improves the quality of life for people with mental illness, which supports recovery, and which reduces the shame and stigma of mental illness. We're ready to respond to any questions that you may have. Thank you.

The Chair: Thank you very much.

Are there any questions from the committee members?

Rev. Abbott: I guess I'll start it off again. Well, again I just have to say thank you for your comments and for this handout. It's very good. I like your three points. I feel this is a very important process of kind of fleshing out the bill and how we would like to see it go forward. Some of these things could be possibly included as part of the, you know, regulations side of the bill rather than the bill itself.

Number 1 I think is brand new, but it's very good. I support that idea. Number 2, the increased funding part, I completely agree with. Then the early intervention programs – again, as I was mentioning earlier, this bill may be the impetus to trigger some of that and

perhaps get us some increased funding for this whole field of mental health.

I just want to thank you for coming in and making your comments known and for adding some new stuff at the end of a long day. It was very good.

6:30

Ms Challborn: Thank you.

The Chair: Do you have any response to that or more of a comment than a question?

Ms Challborn: From me? No. When I was listening this afternoon – I was also here on Friday, and I know that some of you were here too – what struck me in the presentations that I was hearing is that you're receiving a lot of comments that are on the same page, that a lot of people are in agreement with the intention of the amendments to this act. Again, like anything, how does it fall out in the community with the protocols?

Though I'm here for the Edmonton region, I know that with any provincial legislation there are differences between sometimes what can be possible in a rural area and what can be possible in an urban area. I know that you've heard a lot about that today too. It's how to get equity for all people who are experiencing a mental illness. I know that in Edmonton or in Calgary people would always say that there aren't enough supports, right? Like, everybody says that. That's just a bigger issue in other parts of the province.

Rev. Abbott: Can I ask a short follow-up, Mr. Chair?

The Chair: Yes, you can.

Rev. Abbott: We had heard something a little bit about telehealth, the possibility of the rural areas connecting in through telehealth or through, you know, some other form. I'm just wondering: does the Edmonton region have clients from outside Edmonton? Like, do you help people in the rural areas? Tell me a little bit about that.

Ms Challborn: We work with people who are in Edmonton.

Rev. Abbott: Okay. Your mandate is fairly strict that way?

Ms Challborn: Uh-huh.

Rev. Abbott: Okay. Thank you.

The Chair: I thought I saw a hand go up.

Mr. Johnston: I just need a clarification. You're recommending the immediate addition of Risperdal Consta. Could you explain what that is?

Ms Challborn: My understanding is that it's an antipsychotic drug that is not currently available as a matter of course for treatment for people because, I think, of the expense per injection, but the benefits of it are great because it balances out, you know, the chemicals in the blood and helps people stabilize faster. So if it was regularly available for people who required it, that is our recommendation.

Mr. Johnston: You got this information that you have on it from somewhere else where they use it? I'm just wondering where this comes from.

Ms Challborn: My understanding is that we heard it from Dr. White.

Ms Wright: Yes. Dr. P.J. White.

The Chair: Did you want in on this point, Mr. Lougheed?

Mr. Lougheed: Just to comment about what Dr. White was speaking of. He didn't talk specifically about the Consta but about the injectable that was every two weeks for – I forget what the bill was – $200 or $300 a shot. That was what he was talking about earlier today.

The Chair: Were you done, Mr. Johnston?

Mr. Johnston: Yes, I was. Thank you.

The Chair: Mr. Backs.

Mr. Backs: Thank you, Mr. Chair. Thank you for coming today. It's important that your organization presents here and gives us your views.

I'm looking to the second page, point 3, the early intervention programs supporting the CTOs if there are these in place. I'm looking to the last sentence on school-based education programs and early psychosis intervention. What are you looking for in those areas?

Ms Challborn: Currently we have staff who do a number of presentations in schools to talk about mental health and signs of mental illness so that young people have an understanding. Then if they see it for themselves or somebody they know, they know where they can go for help and get help immediately so that they're not waiting for something very serious to happen down the road but that they can get help immediately.

Mr. Backs: Are you looking for identification on the part of educators as well to try and help those that they may identify?

Ms Challborn: Well, the more people who have information and can support anybody – but in this case we're talking about young people, of course – yes, and get them the help that they need.

Mr. Backs: Okay. Thank you very much.

The Chair: Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. My own congratulations on your debut. I think this is your first presentation after your appointment.

Ms Challborn: It is. Thank you.

Dr. Pannu: I'm pleased to see you in this role.

Your endorsement of the community treatment orders, of the implementation conditional on these at least three things that you've identified I think is a very positive intervention, a very positive contribution. I think that these three recommendations or suggestions address some of the concerns that we heard from several people who may like the idea of the community treatment order but have concerns about its enforcement, implementation, and I think this focuses on the implementation level.

But in number 3 I think you hit another concern that I have had,

which is to reduce the need for community treatment orders. I think that's a very important sort of prevention level. Sometimes in a great rush to address a problem that's serious or perceived to be serious, we lose sight of the determinants of why things happen in the first place, and point 3, focusing on early intervention, I think draws attention back to that we need to work at these different levels simultaneously. So that fits really well.

One last question that I have on your comments. You said that you had done some study for legislation in other provinces.

Ms Challborn: Our social action committee. Yes.

Dr. Pannu: The social action committee did. I understand that Newfoundland has a piece of legislation that also deals with CTOs, but it has some special features to it. It focuses on due process and its availability to patients who might be receiving these orders, might be the subject of these orders. Is there any information that you can share with us on that?

Ms Challborn: I'm just looking to see if Newfoundland was one of the provinces, and it was not. It was compared to Saskatchewan and Ontario, so I don't have that information. But I agree with your earlier comments. It's part of a broad-based health promotion strategy – right? – and investing in that.

Thank you.

The Chair: That concludes my question list, so thank you again very much for participating in this public hearing process. We thank you for your time and efforts in contributing in this way. Thank you.

Ms Challborn: Thank you very much. Thank you, everyone.

The Chair: Ms Odette Boily, you're welcome to come to the end of the table. As soon as the handouts are distributed, you can proceed. Welcome. You may start your presentation.

Odette Boily

Ms Boily: Thank you, Mr. Chairman. Good evening, ladies and gentlemen of the Legislative Assembly of Alberta. Many thanks to the Standing Committee on Community Services for allowing me to express my thoughts and concerns regarding Bill 31, Mental Health Amendment Act. As a town councillor I understand the challenges government faces to serve and improve the quality of life of its citizens, specifically those requiring specialized services to meet their needs, such as individuals suffering with mental illness or mental disabilities.

Along with the Canadian Mental Health Association and as a lifestyle educator on health and wellness I support Bill 31. However, there are areas of concern I would like to address. The first one is the service in the community. The second one is adequate housing. The third one is medical services, including medication. The fourth one is mentally ill people and the criminal justice system. The fifth one is community committal. The sixth one is suicide prevention, and then I give my recommendations and conclusions.

6:40

The first concern: the services in the community. It is sometimes the case that laws are passed before proper services can be offered to those who are directly affected by these laws. Such was the case in the 1980s when the Young Offenders Act was passed and hardly any services were in place to meet the challenge of young 16- to 18-year-olds ending up in correctional services facing criminal charges. I know first-hand of these challenges as I worked in implementing assertiveness training programs at detention centres in Ontario during that era at the request of the Ontario Correctional Services. Bill 31, mental health amendments, seems good in theory, but communities will be facing the same challenges unless services are in place to meet the needs.

Another example I witnessed in the 1980s while living and working in Toronto was to see mental patients dressed in pyjamas and slippers walking on Queen Street, downtown Toronto, after being dismissed from Clarke mental institute once it closed its doors, which brings me to my second concern: adequate housing.

Because of a lack of social skills and life skills mentally challenged people often live a life of poverty and homelessness. The problem resides at that level more than the lack of adequate housing or shelters. It's a very difficult problem to resolve since society in general and those who serve these clients in particular concentrate much effort and money to provide adequate housing and shelter while the client seems to prefer living on the streets and warming up themselves on subway heating vents, as can be seen in Toronto or New York. This is a phenomenon I directly connect to the closing of mental institutes and hospital services and attempting to serve these clients in the communities. These people are not all alcoholics and drug addicts, contrary to common public opinion, which brings me to my third concern: medical services, including medication.

As a certified massage therapist and lifestyle educator I often have the opportunity to serve clients who face stress, depression, and even crisis in their lives. Many of them do not want to take medication, and it is comforting for them to know that other methods are available. Massage, hydrotherapy, nutrition, exercise, and other natural methods have been used and are used today without the help of medication to successfully help people suffering with addiction, depression, mental illness, and other challenging sicknesses. Education and government support in this area should be another available and accessible option and, hopefully, one recommended by physicians, social services, and families of the suffering ones. The families would do well to appropriate these services for themselves as well, as they are facing many challenges as they attempt to assist their loved ones on their journey, which brings me to my fourth concern: mentally ill people and the criminal justice system.

During the years I worked in a maximum security institution in Toronto, it was not unusual to meet inmates charged with murder or other crimes while demonstrating evidence of mental disorders of some kind. Last year here in Edmonton I met a similar case. This young man, who I met while he lived on the street, was in a major car accident in 1996. Part of his frontal lobe had been removed, and he suffered mental challenges. Unhappily, after being on morphine for many years and his mental challenges not being addressed, he fell into street drugs, homelessness, and facing criminal charges.

This young man came from a well-off, hard-working family in Alberta. In November 2006 I had an opportunity to meet them in court with their son facing minor criminal charges. After talking to the Crown attorney, she was convinced like us that Martin should go to a rehab centre rather than prison and presented the case to the judge, who agreed to recommend community hours and rehabilitation. This was followed by six months at an Edmonton rehab centre and two months in three-quarter house residency, which brings me to my fifth concern: community committal.

As defined from the discussions at the CMHA national board and Consumer Advisory Council and CMHA, B.C. and Alberta divisions, community committal is a legal mechanism to enforce compliance with community services and treatment. It is a compulsory psychiatric treatment in those cases where legal authority is required to give treatment without a person's consent, but the person does not need to be detained in hospital for the treatment. The report

adds that community treatment in Saskatchewan, as an example, can be ordered by a psychiatrist under prescribed conditions and comes into effect if there is agreement from a second doctor. These orders are generally intended for people with long-term, disabling mental illness who may have responded well to treatment in hospital but failed to comply with prescribed treatment in the community and who tend to be frequently in and out of hospital. People given a community treatment order must submit to treatment and attend medical appointments in the community or face hospitalization, which you probably know of.

While Martin was not under a treatment order, he was under methadone treatment as recommended by a physician. He was also given two antidepressants for anxiety by a psychiatrist. At the end of the eight-month rehabilitation in three-quarter house residency Martin had become incoherent, withdrawn, and was worse than when I met him on the streets, which brings me to my sixth concern. As I saw Martin going from bad to worse, I became very concerned about his behaviour. Unhappily, Martin confirmed my concern on July 23, 2007, when he jumped from the High Level Bridge in Edmonton and took his own life at 31 years old. He would have been 32 on September 8, this past month.

I spoke to his parents again Saturday, September 29, and we tried to comfort one another with the thought that Martin is finally resting from all the pain and aches he went through since 1996 after his car accident and the head injury that he suffered from since then. Martin was a very talented young man and enjoyed skiing, sailing, biking prior to that accident. Martin did not really kill himself. I believe he was a victim of a society who has problems facing situations where no solution seems to be adequate to resolve such a great challenge. I include myself in that society and wonder, with his family, social workers, doctors, what else could have been done to help Martin.

My recommendation. All those still troubled with Martin's decision in July have remained hopeful that others like Martin can be helped and recommend further studies before implementing Bill 31, Mental Health Amendment Act. As government officials it is not enough for us to write laws, amendments, or bylaws, especially when it involves real life and real people.

After reading the well-prepared top priorities of the Canadian Mental Health Association, I recommend major studies and research on medication for mental health patients, restricted power given to doctors and psychiatrists in administering these medications, and more co-ordination, closer follow-up of patient behaviour: drug intake, life skills, and social skills. Scrutinize the methadone private clinic services. Recognize other valuable methods of treatment such as natural biotreatment, without drugs and negative side effects on behaviour and long-term deterioration of the nervous system. These recommendations are based on 25 years of experience and more in dealing with drug addiction, alcoholism, and mentally challenged clients and personal friends.

My belief and hope are best expressed in the words of the wise: my people are dying for a lack of knowledge. That is why I believe in education, knowledge, and understanding of all factors involved. My faith and strength are not shaken. I still believe in people who are trying their very best to help those who can hardly help themselves and a government who cares in establishing fair and just law to protect even the most feeble in society.

I thank you once again for this opportunity to express my concerns. For those who are interested, I have prepared a paper on methadone treatment. My training in chemistry and biochemistry led me to research the contraindications that should be strictly known and respected in the case of methadone treatment, which I believe in the case of Martin were overlooked.

Thank you very much. If you want to look in the back, this is Martin's photo.

The Chair: Thank you very much, Ms Boily.

Questions from the panel?

Rev. Abbott: Just a comment, Mr. Chairman. This is extremely well written, very excellent points that you make. Some points have already been made, but I see a few new issues here for us to discuss and talk about when we go through these. Again, thank you very much for giving us a hard copy of your presentation and just for being here today presenting and supporting what we're doing with Bill 31. There are some great recommendations here that we'll definitely take under consideration.

Thank you.

Ms Boily: Thank you, Reverend Abbott.

6:50

The Chair: Mr. Flaherty.

Mr. Flaherty: Thank you, Mr. Chair. Could I ask the presenter if she could just straighten me out on the scrutinized methadone private clinic services? Could you just explain that to me? I'm sorry, I don't quite follow what you're after there or you're stating.

Ms Boily: Yes. I have done a paper on methadone, sir. I'm a chemist by profession. I have never consumed any drugs. My training is industrial chemistry, so I have not done pharmacology except biochemistry. After Marty died, I was surprised that most people think that methadone is a byproduct of opium. So I did research on methadone, wanting to know the chemical formula of it. I have made copies, actually, if you care to have it. The formula for methadone is actually synthetic. The formula itself, if you're interested, is carbon 21, hydrogen 27, nitrogen, oxygen, and chlorhydric acid. This methadone hydrochloride is actually at a ratio of 1 to 100 in water of a pH of 4.5 to 6.5. You know, 7 is neutral, but when you get to 4.5 it's pretty acidic.

The problems with methadone, the reason why this is my little campaign, is that I went personally with Marty to his methadone treatment clinic here in Edmonton, and as a chemist and as a lifestyle educator, this did not look like a professional clinic to me. I know for a fact that there is a gentleman in Toronto who overdosed on methadone because they made a mistake when it was time to give him his diagnosis in clinic. They gave him the wrong diagnosis. When Marty went to those clinics, he would come out basically sicker than when I had seen him on cocaine on the street last year. The problems with methadone that I see here – for example, right now there is a group of parents in Oregon. I wish I lived in Oregon because I would join them. There is such a major problem with overdose on methadone prescription – it's prescribed – that they are rating it higher for suicide compared with cocaine and heroin combined.

You see, the problem with methadone as I explain here – and that's scientifically proven – is that you cannot have any additive with it. You cannot take antidepressants. You cannot take street drugs or recreational drugs because it's very potent. When I met Martin before he died – I wish I would have known he wanted to kill himself; I would have done something – he was shaking like this.

Last year on the street when I went to my AUMA convention, I met Marty at the Westin hotel, and he was in better shape than when he was following those treatments. I asked him: "What's going on with you? You're not functioning. What's going on?" He said: I'm

on two antidepressants. I know the place where he was, and they told me which one it was. I said: "You shouldn't even be on antidepressants with methadone, Marty. It's an additive. It's not a complement. It's too strong for you." I'm not accusing anybody. I mean, I'm not here to charge anybody, but I'm very concerned that Marty was not tested like they recommend when you read. Even the FDA in the United States recommend that they have urine tests each time they take their in-clinic because it's a day clinic where they go every day. Marty did not receive that.

The day I went with him, he had no money, and he had forgotten his welfare. I said: we'll go to welfare and get you your card or whatever. They just took the methadone and gave it to him. I said to myself: "What if he had something in his body? How do they know?" No tests. Nothing. So that's why this paper was prepared just after Marty's death.

I talked to Mr. Stelmach – he's my MLA – and I talked to people that I know in the government, who are very understanding of the situation. I would like to see more testing on it. I also talked to Recovery Acres, where Marty did his rehab, and Jellinek. I was at their meeting last week with the director of the rehabilitation centre. I'm not going to name anybody, but they encouraged me. They said: "Odette, speak. Do something." It takes two months to clean somebody from methadone, where it takes only one month to clean them from cocaine. There is something wrong here, very wrong.

I really appreciate your allowing me to speak today.

The Chair: Any other questions? Dr. Pannu.

Dr. Pannu: Thank you for this very persuasive presentation. You bring experience, scientific knowledge, poignancy, and passion to what you have to say, so it's very, very good.

Under the recommendations you urge, of course, major study and research in medication for mental health patients. There have got to be studies available all over the place on this. The pharmaceutical industry trying to sell these drugs does research. The medical profession from the other side, as clinicians, must engage in research. Is there really a scarcity or dearth of scientific research on this issue? That's one question.

Let me go on to the second one. The second recommendation that you made has to do with restricted power given to doctors and psychiatrists. Now, if you have looked at Bill 31, do you have concerns that it gives too much power to psychiatrists? Is that why you made this recommendation? Elaborate on that if you would.

Ms Boily: I think it's the experience that I've had with Marty and also because I have worked in prison. That's mainly my experience. I worked at metro residential centre for five years with young offenders when the Young Offenders Act had just come out. What I found, for example – and I can just give you an idea; I'm not against medicine or anything – is that what happened in the case of Marty is that the doctors that gave him the methadone treatment and the psychiatrists, I know for a fact, were not even from the same city. You know, Bill 31 is recommending that both should work together.

You know, when people have an addiction, whether it's with prescription drugs or drugs from the street – I had a home for teenagers with the Children's Aid Society in Toronto for a number of years in the 1980s. These kids are nice children. They're 16-, 17-, 18-year-old girls, and they're on drugs. They come to you and they say: I would like some Midol. It's for their monthly period. I didn't know that they were like that, so I gave them seven Midols for their seven days. Well, I don't know if they still exist, but in the 1980s they used to give that for periods, cramp, and things like that. Anyway, this kid came back two days later, and she wanted more. I said: I gave you enough for seven days. She said: oh, I thought you wanted me to take them all at the same time. I said: yeah, whatever.

I'm not against the approach of if the doctor and the psychiatrist want to use medication. This is not what I use. I use natural remedies. I believe that there is not enough rapport and there are not enough connections. So if I ever even went with the CTOs, as you call them here – you know, the orders – it has to be co-ordinated because these people will con you. You can ask anybody in rehabilitation. They'll go to three doctors to get three different prescriptions, and they'll take them all at the same time. You're not always dealing with balanced people here. So this is where medication to me is: you really have to be very careful with that because they con you that they're getting better.

I know for a fact with Marty that he had to be followed up very closely. I mean, these kids come off the street, they have been on hard drugs, and now they're going to be on methadone? Come on, it's just another drug for them. They're not seeing it as a treatment, you know, they just want the high.

That's a strong treatment. It's a painkiller – I don't know if you know the background of methadone – that was invented by a German chemist during the Second World War because the allies had cut away the opium. They basically created a painkiller. So my question is as a lifestyle educator: why does a drug addict need painkillers? He's not sick. He's addicted. He needs out of drugs, not into drugs. That has been my puzzle in 25 years of working.

I've worked in Chicago in a cocaine addiction centre. I've worked in Toronto. Each time I'm hired to do my treatment, like with massage and hydrotherapy, you know what my first demand is, even if I'm paid? I say: if you give these clients medication, I'm not coming. Give me 10 days, give me a doctor that believes in what I'm doing, and I will show you that you can clean up somebody from cocaine in 10 days by using natural remedies. You don't need medication. That's where I come from, and that's what I believe.

The Chair: Okay. I have no other questioners on my list. Thank you very much for your presentation.

Ms Boily: Thank you so much. I appreciate your time.

The Chair: Is Mr. Merle Schnee in the crowd? Would you like to come up and start your presentation?

Mr. Schnee: If I can get organized here.

The Chair: Do you have some handouts?

Mr. Schnee: Yes, I do.

The Chair: We'll distribute those for you.

7:00

Mr. Schnee: Can I stand?

The Chair: You can stand if you like.

Mr. Schnee: I will do that.

The Chair: Just give us a moment until we get your handouts distributed.

Mr. Schnee: I will do that.

The Chair: Whatever makes you feel more comfortable. You can go ahead and proceed, sir.

Merle Schnee

Mr. Schnee: Hon. members of the committee, staff, presenters, ladies and gentlemen, Mr. Chairman, I want to thank you for the opportunity for presenting a case today. We were at your meeting a couple of weeks ago, I think it was, when Dr. Pannu made a motion that we have some more hearings, and I thank him for that, and I thank the committee for voting for that.

I see this bill as a bad bill, as a violation of my human rights. If I could get you on that first document we have, it's a Supreme Court case of 1950. The Attorney General of Nova Scotia and the Attorney General of Canada and the Lord Nelson Hotel Company in Nova Scotia. This was a Supreme Court case in 1950. It was a constitutional case as well, and out of that we were talking about whether section 91 and section 92 overlapped or whether the government could trade and give off their responsibilities.

What was good in that bill and what I feel was really the outcome for me, anyway, was: "The Constitution of Canada does not belong either to Parliament, or to the Legislatures; it belongs to the country and it is there that the citizens of the country will find the protection of the rights to which they are entitled." Now, that to me is important. It'll protect the rights to which I am entitled. I think that what we've done in many cases is given up those rights. It's my submission and my belief that this bill is also a violation of the Canadian Charter of Rights, the text of the Magna Carta, and the Canadian Bill of Rights in 1960, the Bill of Rights that John Diefenbaker got for us, of course, as well as the United Nations declaration of human rights. It is my belief that they are in violation of those bills.

I have to apologize because, you know, there is just so much to talk about, and what I really want to say is that what I heard this morning is that we're too narrow. We're talking about drugs and pharmacists and doctors and psychiatrists. I second the motion of the previous speaker. While I don't agree with Bill 31, I second the motion. We have to expand this thing. We have to expand it. How do they get sick in the first place? What caused them all this? We could go on for days. I took a little bit of exception when I heard one member here say: well, we're going to get this bill pushed through the House, and then we're going to go work on the finances. I would hope that we don't do that. That was before I was speaking. I would hope that you would say: I at least want to hear what this guy has got to say before I make up my mind.

Anyway, I want this committee to slow down. It's better to get it right. It's better to do the things that are right. From what this previous speaker said, there's lots to look into and lots to check out. So I'm going to introduce this document, Psychiatry: An Industry of Death. It's been presented by the Citizens Commission on Human Rights. I understand that everybody was supposed to get a copy of this. Now, I don't know if you have or not, but I want to say that this document should be seen by everybody before you vote. This is a document that's quite hard to digest. It's tough. Somebody mentioned this morning a little bit about how he thought that maybe that was, you know, from the old days, when they were bloodletting and all that kind of thing. Well, today it's electric shock treatment. Is that any better? Is that good? Is that bad?

I'll read what they say in Psychiatry: An Industry of Death. This document presents the history of psychiatry from its beginning in the 18th century as a fringe industry housing the disfigured and retarded souls of society to where it is now, a deeply corrupted marketing arm of the pharmaceutical companies. The goal is to make everyone on the planet dependent on psych drugs supposedly to control mental disorders such as attention deficit disorder and shyness syndrome that in reality do not even exist. When psychiatry and totalitarian governments join forces, as they now have, political dissidents can be involuntarily imprisoned, medicated, and given shock torture, called therapy, to cure their dissidence. It will take a grassroots awakening to dismantle this evil mechanism. Acquire this video, show it to your friends, and help to create that awakening.

I'm going to do that. I'm going to do all that I can. All I'm saying is: hey, let's look at it; let's look at everything. What this document says is that the psychiatrists themselves cannot tell you whether you're incompetent, whether you're medically fit or unfit. There's no yardstick. I'm not saying that. I'm just telling you that. They're saying that there is no yardstick. Now, with there being no yardstick, they're going to go out and grab me if somebody should say that I'm a little bit off, put me in a hospital, and give me drugs that I don't want. The drugs that you've heard are harmful. The side effects are killing people.

I have here the documents of some of the people that are suing these various companies – that was done a bit this morning, so I'm not going to go into that – the case in Alaska this year, for example, Florida, Illinois, Louisiana, Mississippi, New Mexico, Ohio, Oregon, Pennsylvania, South Carolina, Utah, Vermont, West Virginia. The UFCW: that's my area; I'm labour. The United Food and Commercial Workers, local 1776: they're suing Lilly. Most of the suits are because of things like elderly patients with dementia-related psychotic treatments at an increased risk of death compared to the placebo. These are lawsuits.

I hope this committee and we in our government aren't going to adopt this whole thing hook, line, and sinker and get it over with in a big hurry just so that we can please somebody. I hope that isn't the case. The committee can have this material. I didn't have enough copies for everybody, but they can definitely have that.

I had some experience because I was president of the EDTA Chelation Association of Alberta. This is after we got the bill through the House. It was called Bill 209. That's when our College of Physicians of Surgeons were after us big time. They were suing our doctors. When I say doctors, I mean the doctors that were doing alternative therapy. We had to go to the States to get it. Then we had to go to B.C., and then finally we got a bill through. You know, the reason we got that bill through is because the people in the Legislature, the ministers, and the deputy ministers all understood it, and a lot of them had those treatments and were using that EDTA chelation. Regardless of what the medical industry said, they put that bill through. That saved us. In B.C. the New Democratic Party put one in. It was a hell of a good bill. The Liberals got in, and they took it out.

Now, what's the fight here? Why are we fighting? Why are we fighting with these doctors? What is it about these doctors that they don't want us to know or to get ourselves healthy? I can argue till the cows come home about alternative health and chelation. It's there. To me the pills and the drugs are not the answer, but that's all I've heard today. It seemed like this room was stacked with those people that want to give drugs.

7:10

The next one is *The Trial of the Medical Mafia*, Dr. Guylaine Lanctôt. Here's what she was fighting for. This is why in Edmonton we got Bill 209 through. It was the Helsinki declaration: "In the treatment of the sick person, the physician must be free to use new diagnostic and therapeutic measures, if in his or her judgment they offer hope of saving life, re-establishing health or alleviating suffering." That's why we got Bill 209 through the House, the Legislature, here in Edmonton. It was a good bill. The people understood it. We must have been lobbying for it for two years. We had hundreds of people in there. We got to the people, and they

understood because they read what we were doing. That's what I would hope would happen here. I want to say right off the bat: I don't like the direction we're going right now.

I've not stuck to this thing greatly because I wanted to expand it. Now, I've got a book here called *The Cancer Cure That Worked!,* by Barry Lynes.

The Chair: We've been going with 10-minute presentations.

Mr. Schnee: How far have I gone?

The Chair: Twelve minutes.

Mr. Schnee: Oh, geez.

The Chair: We want to have most of 10 minutes for questions.

Mr. Schnee: Okay.

The Chair: Unless you're just about done.

Mr. Schnee: Listen. There is one thing that I would like to read from here, or maybe I can just explain it to you. Gaston Naessens was from France. They kicked him out of France. He came to Canada. He was curing cancer. When he got here, this democracy of Canada was going after him as soon as he got here, so he had a case at trial. What came out of that – this book was written by Christopher Bird, the same one that wrote *The Cancer Cure That Worked*! Perhaps what's really interesting and probably is the best of all is this, and I wonder if I can read it.

> I was deeply moved by this physician's plight, and by his honesty, for over the months since this book has appeared, it has been my privilege and my pride to meet – either face to face or over the telephone – with dozens of doctors who would like nothing more than to become better informed on new medical discoveries. But they are prevented from doing so by the medical establishment, dictated to by a multibillion-dollar drug industry.
>
> Thirteen of the doctors who called me were eager to know how they could get access to treatments such as those devised by Gaston Naessens for themselves, their wives, or their relatives to treat grave cases of cancer with which they had become afflicted.
>
> In each case, I interjected my own question: "Doctor, how come you're not advising yourself (or those close to you) to go the same prescription route you've been recommending for so long to your patients? Chemotherapy, or radiation, or the like?" And each time, though phrased slightly differently, the answer came back: "Because we know it doesn't work!" When I heard this answer, sometimes voiced late at night, I wondered if I were living in a world gone medically mad.

I don't want anybody to come and pick me up and tell me that I have to take any of these treatments if at all, you know, under compulsion.

I'll quit right now. We all know about *Years of Sorrow, Years of Shame*, what they did to the Japanese in Canada. They were Canadians. We went out there. We gave them seven days – seven days – to get their stuff together and to get out. We didn't tell them why, who, or what. A disgrace, a black mark on all Canadians. I don't know. I think they've been apologized to today, but it took a long time. I don't want to have this happen again.

I appreciate it. Thank you.

The Chair: Thank you very much for the presentation. Just a clarification, Mr. Schnee, on your comment about the room being stacked with presenters with a particular bias. The committee accepted all requests without any previous knowledge of which bias they may have had.

Mr. Schnee: I understand. Personally, it seemed like that. I didn't say it well.

The Chair: We accepted all that requested within the advertised time frame.

Mr. Schnee: I'll tell you what happened. They've got more time and money to get their stuff together. I had to get this together myself. The people that I'm trying to tell to come here and do this, they're out there working, making a living. They don't have time to come down here, which is unfortunate, really.

The Chair: Are there any questions from the committee?

You must have been very thorough, Mr. Schnee.

Mr. Schnee: No. I know that it's the other way around. Hey, I'm an old NDPer. When you go to a convention and you're out there, you get the people to ask you questions. The Conservatives, they know to sit back. They don't ask any questions because that would give me an opportunity to tell it again. Let's put that on the record. Put that on the record. I was raised that way. But I didn't get to Raj and say: Raj, now ask me some questions. I didn't get to tell him that. Listen, Mr. Chairman, that's okay. You'll be hearing from us as we go along.

Dr. Pannu: Merle, thank you for your presentation.

Mr. Chairman, I just have one concern that I expressed earlier with respect to . . .

The Chair: Reverend Abbott did have a question before you.

Rev. Abbott: No. I'll let Dr. Pannu go ahead first.

The Chair: Okay. You go ahead.

Dr. Pannu: Okay. Newfoundland legislation does address to some extent that issue that Merle has raised, the due process; you know, how people who do get subjected to psychiatric treatments against their will still have access provided legislatively, through legislation, to have legal representation, a lawyer representing them, to be able to call someone, if they can't plead their own case, and have someone represent them. I think we need to look at those provisions to see if we can bring in the due process guarantees that people are protected when they feel that they are being treated against their will.

The Chair: That was a comment more than a question.

Dr. Pannu: Well, yes.

The Chair: We'll be discussing as a committee all of the submissions in due course.

Mr. Schnee: Mr. Chairman, I can leave you these three documents if you want. They're all mine, and I'd leave them with the committee if they want to read them or whatever for a length of time if you wish.

The Chair: Did you need them back?

Mr. Schnee: Well, now, just a minute. These are precious. I would loan them to the committee, but I would definitely need them back. I think these are the only ones that we've got.

The Chair: If those are the only ones you've got, we can probably find copies on our own.

Rev. Abbott: We can get them through the library.

Mr. Schnee: Yeah, the library does have it.

The Chair: Reverend Abbott.

Rev. Abbott: Yes. I do have a comment, Mr. Schnee. I don't want you to feel left out because I know I've been the guy asking all the questions all night. At any rate, I just want to say the same thing to you that I've said to the other presenters, and that is: thank you very much for your comments and your input. Of course, yes, we will take this into consideration.

The other thing I would simply say is this. Those who are out there working, et cetera, who would still like to give input on this can certainly do so through written submissions, also through their MLA. Again, if they don't feel that their MLA will listen or will forward their concerns, then they can do it through either the Premier's office or through opposition MLAs. There are many, many ways of getting the message through to this Legislature. I want to encourage everybody to use all of those methods available.

Mr. Schnee: I do want to thank the Premier and the Conservative Party and the House for putting in this new method of having communications with the people. I back that a hundred per cent.

Rev. Abbott: Thank you.

The Chair: Thank you very much, Mr. Schnee.

Is Mr. Paul Greene here? Welcome, Paul. Do you have any handouts?

Mr. Greene: No, I don't.

The Chair: In that case, you may proceed whenever you're ready.

Paul Greene

Mr. Greene: I'm a long-time educator. I spent some 20 years in the education . . .

The Chair: You can sit down if you wish.

Mr. Greene: Oh, I love standing. I'm a schoolteacher.

I want to thank the committee here for having these reports given to them. What I find appalling is that it has taken past second reading to allow the citizens of this province to have their voice on, to me, an exceptionally important document changing mental health in Alberta. I want to thank Dr. Pannu, who is the former leader of the NDP, because I sat in that corner when he made the motion that we have this, and it was only because you people got pressured by Dr. Pannu that you had to vote with him for once. Thank you very much, Dr. Pannu, for allowing us to get this on the proper track, where the people should be speaking about changes in things such as this.

Now, let me be clear. I suffer from depression, and I've suffered from depression for a long, long time. When I took my leave from teaching because I was very, very ill, very soon after that the psychologist at the school board – and I will not give his name – was asked by the superintendent to give all the medical bills of all those teachers that were ill, no matter what kind of illness they had. They wanted all the folders for those people who took leave for medical purposes. That psychologist did the right thing. He burnt all those files so that the superintendent – and I'm not going to name him – and his associates at that time would not have a look at the people who have suffered because of depression or any other things, so that they could use those things against those people, those teachers who put in valuable time to teach our children, to use them to get rid of them in any manner or what have you.

7:20

Now, a second thing. This is the psychiatrist's strength, in whatever matter you want, and that is that when they hospitalized me, in my medical forms folder was – and this was found by my daughter, who was very upset, when I was in the hospital for another matter – that I was suicidal. Never in my life was I ever suicidal, but the psychiatrist had the right to put that into my document, and I find that horrendous. I find that leaning towards what happened in some of our Eastern bloc nations, where psychiatrists had the control of the people and the control of the system. Absolutely they had the control. This document, the way it's going right now, is very, very scary. I have relatives in Ukraine, and I know what they have gone through. This is a very, very scary document that you're changing and giving the rights to the psychiatrists to do as they please, the right to keep them there for six months and then perpetually keep them there till time immemorial.

Imagine me, a political activist who worked here at the Legislature for 10 days to kill Bill 11. Imagine what they would do to me if they tapped me on the shoulder and said: "You know our neighbour there? Something is really wrong with him. I think we have to have him assessed." How long will they take to assess me? We're assuming that things like in Burma will never happen here. There are people that are loose cannons in our society. They are here, and they are maybe in the Legislature. I don't know. I don't attend the Legislature very often. I do believe in the democratic process. I believe that this kind of act that is being proposed should have been brought to the people. It should have been explained to the people what is happening so that they would have more input into something that you're going to change as massively as this.

This breaks the Bill of Rights, which I strongly believe in. It breaks the Alberta human rights code. It breaks the Canada Charter of Rights and Freedoms: "Everyone has the right to be secure against unreasonable search or seizure." That is one of my rights. You are breaking it by this act. "Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

Even though I'm on antidepressants, I have the right to refuse at this moment to take them because in my studies – and this is where I've had disagreements with my doctor, and he's a psychiatrist. We have disagreements because, you see, I have seven years of university education, which is as much as he has, and I can read the documents that he passes out on medication just as well as he does. When he found out that I was researching mental problems – depression, all these things – you know what he said to me? "You know what, Paul? You read too much." He wanted me to cave in to his healing process without questioning or without knowledge of what is happening to my body and why.

None of this was ever explained to me. They just threw pill after pill after pill after pill, and I kept on getting sick from every pill that they threw into me because I was like a guinea pig there. Like a guinea pig. They were throwing pills at me like you wouldn't believe till they finally said: "You know what? We don't have any pills that will help you. We suggest" – the horrifying word – "shock treatment." Yes, twice I went through shock treatments. Ten shots the first time, every second day. Was I sick? Yes, you're darn right

I was sick. You're darn right. It does something here. The second time was about 10 years later. I relapsed into a depressive state, and I think it's because of certain things that happened in my teaching field that I ended up in the hospital again, and again shock treatments.

Would I say that shock treatments are good? Not from what I have seen and read. Not from when Dr. Cameron was working in Quebec on the people and destroying their brains. Yes, we know those things, and if you give the control of mental health completely to the psychiatrists and the police, then we are in a major problem.

Now, let me explain about the police force while I throw it in here. I got a small $50 parking ticket. Going through Banff, I parked at about 12 midnight for an hour's snooze because I was headed to Kelowna. I got the door open, and he gave me a $50 ticket because it was a parking lot you're not supposed to be parked in. I forgot about that ticket. About three or four years later I got pulled over. I don't usually speed, but I did at this time. I got pulled over. The policeman looked up on his computer, and I'm supposed to be arrested for a $50 ticket. Not only that, but I suffer shoulder problems, and I said: well, if you're going to put those cuffs on me, please put them in the front because if you twist my shoulders back, I'm in full pain. Not a chance. Would he listen to me? He then took me to the police station, took me out of the car and said: I'm unlocking these cuffs for you, but don't you dare run, or I'll shoot you. That's what the police mentality in this city is right now. I'm sorry, but it's that way. It is.

Now, in my hurry to go and pay this ticket in Banff, I got into a major accident at nighttime where I almost got killed. I didn't get there to pay that ticket. I forgot about it again. About a year later I had another policeman stop me, this time for going through a red light. I said: put them on here. He wouldn't do it. But as we're going into the police station, he said: "You made enough noise while we were out in the street. Shut your mouth when you're going into the police station because we know how to handle you." That's what we have in our cities right now. That's what we have. Somebody who is law abiding is going to get shot at or beat up by the police. I am talking about my human rights.

Now, I read Laurie Blakeman's report. It's an excellent report, and where I agree with her a hundred per cent is on page 5 of her report. One of the things that this bill does not encourage: it doesn't do anything to improve medication. Why do so many people get in trouble where they're in that situation where somebody would want to be committing them or where they'd be considered in a deteriorating situation or maybe just imminently a danger to themselves and others? A lot of it is because the meds are terrible, and believe me, I'm a good example to tell you how terrible the meds are.

I was a young man, probably 38, when I first got sick. The doctor never told me what side effects antidepressants have or anything of that sort, what it will do to my body. Suddenly I had no sexual drive at 38. Have any of you gone through that? It's a major thing in humanity to lose your sexual drive at the age of 38. I went around trying to find out why, why, why. I was crying. I was going to lose my wife because there was nothing compatible happening in the bedroom. I'm sorry to talk like this, but I have to tell you the truth. Only later did I find out that that antidepressant and all antidepressants for that matter have that side effect. It cuts down on your sexual drive.

7:30

The Chair: Mr. Greene, are you. . .

Mr. Greene: Yes. I'll be finished. One more thing.

The Chair: Okay.

Mr. Greene: The second side effect of those drugs is major constipation. You can't get rid of what you've taken into your body easily. I had to be on major, major fibre laxatives to have just a little bit. I have to have a colonic cleanse every three months to get rid of what is poisoning my body with toxins.

These are the things that I want to plead with you people. Do not do as you have done up to now, gone through second reading, because there are some people that are interested that you don't make the mistakes that have been made in other countries, that you deal with the people of this province. There are 2 million or 3 million of us that have the right to be told what we take and to not lose our human rights.

The Chair: Thank you very much.

Mr. Greene: I've got lots to say, but I'm also getting a little emotional because I've gone down that track.

The Chair: We're trying to restrict the presentations to 10 minutes so that there is time for questions.

Reverend Abbott, you had some questions.

Rev. Abbott: I just wanted to make one comment, Mr. Chairman, and that was with regard to one of your very opening statements saying that Dr. Pannu made a motion that we were all pressured into supporting. That's completely untrue. Every member on this committee, or at least myself anyway, votes independently, according to what we feel are the wishes of our constituents or what is best for Albertans. To say that Dr. Pannu made a motion that I was pressured into supporting is completely untrue. I don't know how my colleagues feel.

Mr. Greene: I'm sorry. That's the way I saw it.

Rev. Abbott: We had always intended to have public hearings. We had always intended to open those to private citizens as well as to organizations. Again, that was part of the Premier's vision of these all-party committees. That's why we're here today, and that's why you've had your opportunity to present. Again, I want to thank you, as I did the other presenters, for bringing forward your views. Certainly, again, we will take those under consideration.

The Chair: Okay. Anyone else?

Mr. Greene: I'm not finished. The other thing, since he's brought that question up. When I was here, it wasn't the elected officials that were deciding on whether we're going to have two days or one day. There were people that were the bureaucrats who were saying, "We will put ads in the paper, but we'll only make it from 9:30 and open ended, no time ending of it," not telling people, "Yes, we will have a second day." That is the wrong way for a bill as important as this to be advertised in our papers. I would never do anything like this. In my teaching career if I pulled a stunt off like that, I'd have every parent down my back. Mrs. Mather knows that. She's been there.

The Chair: Just a matter for clarification, Mr. Greene. That decision on the advertising was made by the members of this committee in this committee room.

Mr. Greene: I agree. I saw it, and they pushed that. The bureaucrats pushed it.

Thank you.

The Chair: The decision was made by the elected members voting on it.

Mr. Greene: Thank you.

Dr. Pannu: Mr. Chairman, I want to thank Mr. Greene for his presentation. But I want to assure you, Paul, that for this committee it's the first experiment that we are having with these public hearings. It's a very important first step, and the committee has been very open and transparent about how it has conducted itself. I like to take credit for things, but what you have said about my motion creating the pressure is not the case. I think we have worked very hard, all of us, to be open to ideas. We'll prepare a report, and we'll see where we go.

The point, however, that you make about the bill coming to the committee after second reading is something that we need to reflect on. I think Bill 1 has not been through that process. After first reading it came before the committee. I think there's something to learn from it. You know, once you approve a bill in principle, it restrains you from what you can do to it in order to change it, so I take your point. That's a very important point that you have made here, and I think we as a committee take note of it. I do take note of it, and I hope the whole committee does. We agree with that point.

The third thing that I want say – and I will say it briefly – is that I want to thank you for the openness with which you have told us your own life story. Sometimes your telling these stories about yourself persuades people who otherwise might not be open to persuasion on particular issues. You have done a wonderful job on it. Thank you.

Mr. Greene: Thank you.

The Chair: If I may just expand on Dr. Pannu's comments about when a bill is referred to committee, either first or second reading, that decision is made by the Members of the Legislative Assembly and voted on at that point in time. A motion can come forward at any time during first or second reading, and it's the Legislature that decides that.

Thanks again for your presentation. I don't have any other questions.

I guess we're moving on to the next presenter. Is Mrs. Ruth Maria Adria here? Probably not yet. What about Mr. Murray Schneider?

Mr. Schneider: Yes, I'm here.

The Chair: Are you prepared to make your presentation now?

Mr. Schneider: Yes, I could.

The Chair: Please join us at the table. You have some handouts, do you? Oh, we got them electronically. Okay. Thanks very much. You may proceed, and you can sit down or stand up, whichever you prefer.

Citizens Commission on Human Rights

Mr. Schneider: Okay. Thank you. My name is Murray Schneider. I am a volunteer from the Citizens Commission on Human Rights. I'm here to give you some facts about community treatment orders that may not have been covered so far. I'm hoping that this will be a bit of a wake-up call.

Point one, the drugs prescribed in CTOs are proving to be dangerous. The three most popular drugs approved for schizophrenia and bipolar disorder are among the top-selling medications in the world. Eli Lilly's global sales of Zyprexa were $4.36 billion in 2006, which made it Lilly's top-selling drug. Risperdal sales were $4.18 billion, making it Johnson & Johnson's second-best selling drug. AstraZeneca's drug Seroquel had world-wide sales in 2006 of $3.4 billion. I would also like you to know that according to their website the Schizophrenia Society of Alberta receives funding from all three of these companies.

Eli Lilly agreed on January 4, 2007, to pay up to $500 million to settle 18,000 lawsuits from people who claimed they developed diabetes or other diseases after taking Zyprexa. Including earlier settlements over Zyprexa, Lilly has now agreed to pay at least $1.2 billion to 28,500 people who claim that they were injured by the drug, and at least 1,200 suits are still pending, the company said.

Although Zyprexa is still used frequently here in Alberta, in the U.S.A. nine states have sued Eli Lilly regarding this drug. These states include Alaska, Louisiana, Mississippi, Montana, New Mexico, Pennsylvania, South Carolina, Utah, West Virginia, and Arkansas will be added to the list in two weeks. If Bill 31 is passed, there will be no choice. A patient will be forced to take these drugs by law if they are prescribed.

7:40

Four U.S. states have sued Johnson & Johnson so far regarding Risperdal for similar problems with that drug. Those states are Louisiana, South Carolina, Texas, and Pennsylvania. There are also class-action lawsuits regarding this drug. Two U.S. states have sued AstraZeneca regarding Seroquel for similar problems. Those states are Pennsylvania and South Carolina. Again, there are also class-action lawsuits regarding this drug. With community treatment orders in place a person would have no right to say, "No, thanks" to the use of these drugs if they are prescribed. It could well be a life sentence to an enforced dependency on medications which are proving to be a hazard to one's health in many cases.

Point 2. Community treatment orders have had poor reviews in other studies. The Institute of Psychiatry, King's College, London, concluded, "There is very little evidence to suggest that CTOs are associated with any positive outcomes and there is justification for further research in this area."

[Mrs. Mather in the chair]

The National Association of State Mental Health Program Directors in the U.S.A. concluded:

> Current interest in involuntary outpatient commitment,

another name for CTOs,

> also stems from concerns about individuals with mental disorders going untreated in the community. IOC, [involuntary outpatient commitment] however, should not be regarded as an alternative to adequate community mental health services. Current research fails to provide strong evidence of success with IOC programs. It is clear that IOC will not accomplish its objectives without a strong community-based service provision system. Some posit that if comprehensive services were readily accessible in the community, there would be no need to use a more coercive mechanism like IOC to engage consumers in treatment.

July 2001, Bazelon Center for Mental Health Law:

> Based on current evidence, community treatment orders may not be an effective alternative to standard care. It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness. People receiving compulsory community treatment were, however, less likely to be victim of violent or non-violent crime. It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest.

There are many more studies that can be found with a quick

Google search that indicate similar results to the ones listed here. In practice community treatment orders have simply not been the boon they were advertised to be. As the Romans used to say: cui bono? Who benefits? It isn't the patients who with the passage of this bill will have fewer rights than felons. It isn't the community as there are many studies to show that after CTOs were enacted there were no significant differences in service use or cost-effectiveness. In Western Australia their conclusion was short and sweet: "The introduction of compulsory treatment in the community does not lead to reduced use of health services."

Psychiatrists will gain even though they still cannot give solid definitions for the terms "sane" and "insane." Psychiatrists can be found in courtrooms on a daily basis, one working for the prosecution and swearing that the defendant is sane and one working for the defence to prove that the same defendant is insane, yet we take what they say as fact when it is only opinion and can be debated by the next mental health person that comes along. They are the ones that will gain power.

Finally, the pharmaceutical industry will gain. Sales of the above three medications were over $11 billion in 2006 alone. Laws that force the use of these drugs through CTOs will give the industry even more profits and even more power.

[Mr. Marz in the chair]

To conclude, I would like you to know that a similar bill was defeated in New Mexico in February of 2006. Michael Allen, an attorney at the Bazelon Center for Mental Health Law, said:

> New Mexicans have turned the tide on forced treatment, and rejected the simplistic approach represented by Kendra's Law. This victory for a sane mental health policy will resound across the country, refocusing public attention where it should be – on adequate funding for the services and supports needed by people with mental illnesses.

We have also provided you with a written submission that goes into these issues in far more detail, and I urge you to make time to read that as well.

Thank you for your time.

The Chair: Thank you very much for your time and making your presentation.

Reverend Abbott, do you have a question?

Rev. Abbott: Yes, I do. Actually, I have a question with regard to the Citizens Commission on Human Rights. I'm wondering, Murray, if you could tell us more about that. I did have a little bit of time to look up from some of the appendices in Mr. Dougherty's articles about the Citizens Commission on Human Rights. I'm wondering if you could tell us about that and if it's connected in any way to the Church of Scientology.

Mr. Schneider: Thank you, Reverend Abbott. The Citizens Commission on Human Rights was established in 1969 and cofounded by the Church of Scientology and Dr. Thomas Szasz, who was professor of psychiatry emeritus from the State University of New York. It has been an international human rights organization dedicated to exposing and investigating human rights abuses and abuses in the mental health profession. The whole purpose of this is to help clean up the area of mental health and make it a more workable system, where people can benefit from the services that should be provided.

Rev. Abbott: Great. Thank you.

Dr. Pannu: Mr. Schneider, you stated that the Alberta Schizophrenia Society receives funding from three major drug companies, each of which has benefited enormously from the sale of their drugs because they've been prescribed on a very large scale.

Mr. Schneider: Correct.

Dr. Pannu: Any proof of this?

Mr. Schneider: Well, what I'm going on at this point, although there may be more, is that if you go to their website, the logos of five drug companies appear on their website. I'm assuming that they receive funding from these drug companies as a result of advertising their products on their website.

Dr. Pannu: Essentially, at this stage you're alleging that that's the case, that the logos being on their website suggests some close relationship. Is that right?

Mr. Schneider: That's what I'm saying. I believe that there are five drug companies that are represented.

Dr. Pannu: You have also stated that many states in the U.S., not individuals in those states but states as governments, have sued these three companies.

Mr. Schneider: This is correct.

Dr. Pannu: What's the nature of these suits? Why would a state, in other words, take this kind of legal action unless these drugs are a draw on its treasury or something?

Mr. Schneider: Well, I mean, there are 28,500 individual lawsuits that have been settled already by Eli Lilly. As far as the states are concerned, to my knowledge the states have funded the use of these drugs through their medical systems. As a result, they are trying to, you know, collect compensation for the fraudulent use of these drugs, which have actually caused damage rather than helped people.

The Chair: Any other questions?

Dr. Pannu: One more question, more for information. Who runs the Bazelon Center for Mental Health Law?

7:50

Mr. Schneider: I believe it's a national mental health law advocacy agency that's in the U.S., I believe, primarily. They are, you know, overseeing the rights of mental patients and standing up for the rights of mental patients.

Dr. Pannu: It's a nongovernmental agency, is it?

Mr. Schneider: I believe so.

Dr. Pannu: Thank you.

Mr. Schneider: Okay. Thank you.

The Chair: No other questions? Thanks again, Mr. Schneider.

I understand that Mrs. Ruth Maria Adria is here. Welcome. Please join us at the table there. You have 10 minutes to make your presentation, and then we'll have 10 minutes available for questions and answers.

Mrs. Adria: I brought a copy.

The Chair: Oh, that would be good. Just give us a second to get those passed out.

Okay. You may proceed.

Elder Advocates of Alberta Society

Mrs. Adria: Thank you. My name is Ruth Maria Adria from Elder Advocates of Alberta Society. I'd like to tell you this evening about Anne. Anne became part of our extended family through marriage. After some years it became obvious that she suffered from serious mental illness. She often told me how difficult it was to take the pills. She said: "Ruth, I can't take these pills. They hurt my stomach. They make my head ache." Sometimes she took the medication, sometimes not. The police arrested her a number of times. I visited her at the remand centre. She was humiliated. It was awful. She didn't belong there. She was a good person.

Many times she was committed to Alberta Hospital and detained behind heavy, locked doors. The hospital social worker withheld her comfort money, which meant that she could not buy smokes, which was torture for her. She told me of intimidation by injection, which translated means that if you are not co-operative or refuse to take your medication, perhaps six staff will hold you down and put a needle in your backside. As a result, you may be drugged for several days. Her husband divorced her. Her family abandoned her. I continued to visit. She had an apartment but ultimately became somewhat of a street person, a social outcast. Nobody understood her pain. They had judgment and abusive treatment for her. She died at Alberta Hospital with cigarette burns on her chest and abdomen. Throughout her life her rights were violated by those who were mandated to help her.

That was 1993. Nothing has changed. Frail, elderly seniors who do not meet the criteria of being a threat to themselves or a threat to others are being committed to Alberta Hospital in breach of the Mental Health Act. One such senior we visited on September 7 was restrained. He was hanging forward out of his chair. During the two hours we were there, he was totally medicated. He was totally drugged. Periodically his entire body would jerk. We took a photograph of fingernail pick marks and abrasions on his right arm, which has been submitted to the College of Physicians and Surgeons. Why is this old man at Alberta Hospital? He's not a mental patient. He's an old man who has needs and deserves compassionate care. His family are trying to remove him from Alberta Hospital. Wednesday there will be a review panel hearing, but they find it impossible to get him out of there. He's detained behind locked doors. If you knew his name, you would know that he was a prominent businessman here in Edmonton.

Similarly, on a Sunday evening we visited Alberta Hospital. There was a whole row of old men in nightgowns. It was cold. They looked cold. They were uncomfortable. They were physically and chemically restrained. Often persons detained under the Mental Health Act are relegated to group homes, where there is little or no supervision. Staff have no training. Patients languish because there are no activities. Some have been known to wander away, perhaps escape, die of exposure, freeze to death. This year a person burned to death in a Capilano group home. The fire was spotted by joggers. What kind of fire safety was in that home? To date there has been no fatality inquiry, no accountability.

Mentally ill persons are sometimes restrained, pepper-sprayed by police who have no training, no understanding of the persons they are apprehending. When these persons cry out for help, often they don't get help. There was a Mr. Harrold of Lamont, who begged for help, and ultimately he took his life when he was turned away from an emergency ward.

Last week we visited a group home, a house with plastic flowers on the deck, where residents have to go down the hall to the toilet for toilet and shower. A resident is being charged $2,600 a month for an eight by 10, poorly lit room. The public guardian, the Public Trustee, the psychiatrists, the chairman of the review panel are aware of this abusive situation, but she is helpless and perhaps fearful to complain because she has been stripped of all rights under the Mental Health Act and the Dependent Adults Act.

We the Elder Advocates of Alberta Society are an anomaly across the province and even across the country in that we not only speak out for justice and the rights of seniors and vulnerable persons, but we maintain an office and accept and investigate complaints. It is very labour-intensive work. We work 12, 15 hours a day.

In our long experience we have documented a litany of untrustworthy, unprofessional assessments and declarations of incompetency. No one has been held accountable. With a few strokes of a pen professionals can strip a citizen of all rights, deny them the right to their bank accounts, their homes and belongings. Similarly, professionals can medicate, humiliate, detain behind locked doors. There is no viable appeal. In most instances there is no accountability.

We have documented instances where no testing, assessment, or even interview was carried out prior to filling out declarations of incompetency or mental health certificates. Within the existing legislation no action lies against those who issue flawed, untruthful declarations. The present legislation gives professionals incredible power over lawful citizens and is a blatant violation of constitutional and Charter rights. Professionals are not held accountable by any court or authority. Because of these troubling irregularities, in August of this year we made a formal request to the Minister of Justice to convene an inquiry into this entire process of how Alberta citizens are being declared incompetent and how their rights and assets are removed.

Finally, we want to say that mentally ill persons are still persons.

To the committee. We urge you to not grant anyone any more power over vulnerable persons – the track record of professionals and others has not been good; we must remember that it was physicians and psychiatrists who facilitated and carried out the sterilization act here in Alberta – until a province-wide inquiry has been held to examine the standards and protocol that exist in the issuance of professional certificates and declarations of incompetency; until those would-be enforcers have received education and relevant training in this regard, such as policemen and social workers; and until a protocol of accountability has been established.

That's what I've got to say.

The Chair: Does that conclude your presentation?

Mrs. Adria: Yes, it does.

The Chair: Well, thank you very much.

Questions?

Dr. Pannu: Mrs. Adria, thank you for your presentation and the work you and your organization have been doing for many years advocating for the elderly in this province. I have had the occasion to meet with you many times over the years. You, in fact, invited me once to – it wasn't Spruce Grove. It was the next community, I think.

Mrs. Adria: Stony Plain.

Dr. Pannu: That's right. One of the ministers, Stan Woloshyn, who represented the constituency, appeared with me at the forum, and there were about 200 people at the forum. So you have indeed

provided an enormously valuable service. Taking a dissenting view requires courage, requires conviction. It's not easy to stand up and say things which clearly look like swimming against the tide, and that's what you have done and your group have done, and I really compliment you for that.

8:00

On the issue of the fallibility of medical experts, particularly psychiatrists, physicians, you drew our attention to the Sterilization Act of Alberta. In my comments during second reading on this bill, I referred to that as a reminder that all of us need to learn from history, from our own history, from our mistakes made in this Legislature in good faith but nevertheless mistakes that represent terrible injustice against our fellow human beings who are co-citizens. I thought it was a legitimate reference to make, but one of the speakers who rose after me to comment on what I had said called it a red herring.

I think it's important that we draw some lessons from the experiences of our own Legislature – 30, 40 years later we did that – but these victims had to go all the way to the Supreme Court. The Supreme Court ruled in their favour, and we as a province had to compensate for people who are still alive, and many had died long before the Supreme Court could make this judgment. So I think the message that you have here is very, very important, and I think it's worth our time to listen to you and pay attention to it.

Thank you for being a presenter.

Mrs. Adria: I just want to say that because we are grassroots people, we see the tears or the anguish of these people whose rights are denied, who are detained unfairly. There is an epidemic out there of persons being unfairly detained in hospital. Seniors: their rights being taken away. We will not be silent. We have filing cabinets. We have a basement with 24 bank boxes of information. It is terrible what is happening to frail and elderly Alberta citizens.

The Chair: Anyone else?

Mr. Backs.

Mr. Backs: Yes. Ruth, thank you for coming today. You know, it's very important that there are advocates for our seniors such as yourselves. There are many people that may not agree with you, but it is obvious that there are seniors in many of our institutions, in many of our homes that are drugged to be compliant, drugged to be quiet. Some of it is because there's a lack of people to work in those homes. There's a lack of people training up to actually do that, and it's totally unfortunate. Many people would like to find a solution for that, and some are seeking that.

I thank you for your work, I thank you for your concern, and I thank you for coming here today.

Mrs. Adria: Thank you.

The Chair: On behalf of the committee I, too, would like to thank you for your presentation today. Certainly a different perspective again. I believe that all the presenters today brought forward a lot of knowledge to the members of the committee. Probably some more questions as well that the committee will be charged with mulling over over the next period of time in trying to sort out and trying to find some solutions to this problem that we have in our society. Hopefully, we will come up with the best solution that we possibly can. So thank you again very much for taking your valuable time and sharing it with us. Thank you.

Mrs. Adria: Thank you.

The Chair: Members of the committee, that concludes the presenters for today. We will be meeting again at 9:30 tomorrow morning. I'd like to discuss the process for that meeting. We already know that Philip Massolin will be preparing a summary of the presentation for our review at our October 11 meeting. I felt that it would be valuable to have officials from Alberta Health and Wellness here tomorrow to assist us, so I've taken the liberty as chair to send a letter to the deputy minister requesting that assistance.

I also would like to say that Corinne just circulated this letter, that was requested by Reverend Abbott from the College and Association of Registered Nurses of Alberta, so we will have that as well as the agenda for tomorrow morning's meeting. Is there any discussion on the agenda tomorrow or anything else you wish to bring up?

The next meeting is scheduled for tomorrow, 9:30 a.m. till 11 a.m.

Rev. Abbott: I've got a question, Mr. Chairman. Can we leave our books here overnight? Is the room secure?

The Chair: Yes. The room is secured, so you can leave everything right here as it is, including your coffee if you like it cold.

Dr. Pannu, you had a question.

Dr. Pannu: About the agenda, Mr. Chairman. I sat for Brian Mason for another committee for two days just last week, Government Services Committee I think it was, and the meeting of the committee subsequent to the completion of the hearings had to deal with the question of whether we deal in that meeting with the substance of issues or whether we deal with the process. I think it would be good for us to be clear on exactly what we'll be doing tomorrow. Number 3, I think, is Discussion on Oral Presentations and Written Submissions. I guess we can have general discussion, but I don't think we'll be engaging in any voting on anything tomorrow.

The Chair: My understanding is that we'll be dealing with the process tomorrow morning.

Dr. Pannu: Okay. Good. Thank you.

The Chair: Thank you very much for everyone's attendance. We stand adjourned until tomorrow morning at 9:30. Thank you.

[The committee adjourned at 8:08 p.m.]