Title: Thursday, October 11, 2007 Community Services Committee
Date: 07/10/11
Time: 1:30 p.m.
[Mr. Marz in the chair]

The Chair: Good afternoon, ladies and gentlemen and committee members. I'd like to call the meeting to order and welcome members and staff in attendance to this meeting.

Perhaps we'll start with introductions. I'm acting chair, Richard Marz from Olds-Didsbury-Three Hills. We'll go to deputy chair.

Mrs. Mather: Weslyn Mather, Edmonton-Mill Woods.

Mr. Backs: Dan Backs, Edmonton-Manning.

Ms Dean: Shannon Dean, Senior Parliamentary Counsel.

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

Ms Roth von Szepesbéla: Katrin Roth von Szepesbéla, legal research officer, Legislative Assembly Office.

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

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

Dr. Pannu: Raj Pannu, Edmonton-Strathcona.

Mr. Johnson: LeRoy Johnson, MLA, Wetaskiwin-Camrose.

Mr. Shariff: Shiraz Shariff, Calgary-McCall.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Welcome, everyone. I'd like to bring everyone's attention to the fact that today we are testing a new audio streaming. I'm told you'll be able to access the committee live on the Internet, just the audio part, not the video. Just to make everyone aware of that.

Also, Corinne will be handing out – she just did – a page from the Psychologists' Association of Alberta that was sent to us. They were one of the submitters. So you have that with your material as well.

We have some department officials here at the table: Martin Chamberlain, Fern Miller, and Karel Bennett. We'd like to invite you to join us at the table, if you would like to do that now.

I'd also like to note that the meeting agenda and supporting documents were posted online for printing and viewing yesterday, and the handouts from the public hearing were posted last week.

We have some changes to the agenda, which is basically amalgamating items 4 and 5. Could we have a motion to approve the agenda with those changes?

Mr. Shariff: So moved.

The Chair: Mr. Shariff moves that. Those in favour? Opposed? That's carried.

Approval of the September 14, 2007, meeting minutes. Has everyone had a chance to read them? If so, are there any errors, omissions, or corrections to be made? If not, a motion to approve? Dr. Pannu moves approval. Any discussion? Those in favour? Opposed? That's carried. Boy, we're making progress.

I'd like to remind committee members that our task now is to focus on the key principles of the two bills that we have before us. There are two key issues that arise out of the amendments to the Mental Health Act proposed by Bill 31. The first key issue concerns the broadening of proposed criteria for involuntary admissions. The second key issue concerns the proposed introduction of community treatment orders.

There are also two key issues that arise out of the amendments to the Health Professions Act proposed by Bill 41. The first key issue relates to the concerns regarding the proposed requirement for immediate disclosure of public health threat irrespective of governing privacy. You'll find this under item 5, under Introduction, if you want to follow along.

The second key issue speaks to concerns raised in respect of the proposed amendments that would potentially alter the existing medical health professions self-governance regime.

Essentially, the committee should be considering the key principles of each bill. Does the committee support those proposals at this time in principle?

Dr. Pannu: Mr. Chairman, do you mean in terms of the issues identified?

The Chair: Right.

Dr. Pannu: I think that's right. I think those two issues for each of the two bills are the central ones, don't you think?

The Chair: Okay. If the committee is in support of the proposal, the next question is whether additional issues need to be addressed or whether the current wording in the bill requires any amendments.

Ms Dean: Mr. Chairman, I believe you're just speaking to process in terms of the discussion that will unfold with respect to each of these key principles.

The Chair: You're right. Yeah.

Ms Dean: I believe what you're suggesting is that if the committee is in support of one of the proposals, then the next issue for the committee to decide is whether additional issues, criteria have to be addressed through the form of an amendment. It's sort of a flow chart of decision-making.

The Chair: We're not dealing with specific issues. We're just dealing with the process that we will follow. If there are no objections to that, are there any additional issues that anyone has to raise? If not, we'll continue on.

Before recognizing Dr. Massolin, unless there are objections from members, I'm going to make copies available of the focus issue documents to the media or public who are observing the proceedings today. Is that all right?

An Hon. Member: Yeah.

The Chair: Okay. I see some media here and some members back there.

I'd ask Dr. Massolin now to lead the committee through the two documents he provided, which summarize the focus issues raised during the public hearings and written submissions.

Dr. Massolin: Thanks very much, Mr. Chair. What I would like to do is just to, as you say, lead the committee members through the

issues that have come up with respect to the public consultation period on each of bills 31 and 41.

We'll deal with Bill 31 first, I think. I'd ask the committee members to refer to the document entitled Focus Issues Identified for the Standing Committee on Community Services, Bill 31.

The Chair: And that should be under tab 5 in your binders.

Dr. Massolin: Thank you.

What I would like to do just as you're finding that document is explain the structure of the document and its basic purpose and then go through the list of issues sort of item by item, allowing time, of course, after each item for committee members to deliberate because I think that the ultimate purpose here is that you deliberate on each discussion or focus issue and come to your resolution, and then we move on.

This document that we put together basically itemizes the Bill 31 issues based on those two fundamental principles of the bill that have been already mentioned: the changing of the proposed amendment to the criteria for involuntary admission as well as the introduction of community treatment orders.

What we've done is to put together a three-column document. If you can turn to page 4, I can illustrate what we've done here. The left column indicates the issues raised by submitters, and that means both in the written submissions as well as in the oral presentations, the public hearing.

The middle column deals with Bill 31 and the proposed amendments. Then the right-hand column is a listing of items for consideration and debate, so items that the committee members may want to consider and deliberate on. I'll go through those in just a minute or two item by item.

One other thing to point out before we start that is just at the very end of the document – and this is on page 11 – you have a list of submitters that are referenced in this document, and they're referenced specifically on page 12, where you have a list of end notes. So that's what that is dealing with.

Are there any questions before I launch into this? No? Okay.

1:40

The Chair: I don't see any. Everybody is on the same page as Dr. Massolin, are they? I believe I'm seeing from the chair that they are. Okay. Carry on.

Dr. Massolin: Thank you. On page 4 we'll deal with the first of the two major issues, and that is 2.1, the criteria for involuntary admission. We all heard and read the submitters' comments, and a large preponderance of submitters generally supported the amendment, as it is indicated in the second column there, with respect to widening the test or threshold for involuntary admission. However, a certain number of submitters indicated that the proposed language is too broad and that perhaps there is a need to reconsider the language there and that perhaps there may not be a need at all to consider an amendment in this regard. So I wanted to draw your attention to the submitters' comments.

In the second column there you can see the language of the bill as it is proposed here. You can see how Bill 31 proposes amendments to section 2(b) of the Mental Health Act, and you can see for yourself exactly how the act reads in that section and the proposed change. That's the second quoted section.

I believe one of the questions that the committee could consider is that the proposed wording obviously establishes a threshold that's different from the current wording of the Mental Health Act. Therefore, it expands the scope for the involuntary admission criteria. So the question is: is this expansion of scope appropriate? The other issue, of course, is whether or not it would raise Charter issues. But as we note there in the right-hand column, the proposed wording in Bill 31 parallels the wording used in other jurisdictions – namely, B.C., Saskatchewan, Manitoba, and Ontario – and Charter challenges have not to our knowledge been an issue there.

Maybe I'll send it to the chair for comments from the committee.

The Chair: Are there any questions on that particular proposal?

Mr. Flaherty: Mr. Chair, through you, could you just clarify what particular clause you've changed and you're suggesting? I'm not following you, to be frank. It's not your fault; it's my fault.

Dr. Massolin: Okay. No problem at all.

Mr. Flaherty: If you could read it for me, I'd welcome that.

Dr. Massolin: Absolutely. Certainly. It's not my proposed change. It's what the bill is proposing, of course. As it's indicated here in the second column, currently section 2(b) of the Mental Health Act reads, "In a condition presenting or likely to present a danger to the person or others." So that's a necessary set of conditions to exist, among others, before an involuntary admission would be triggered, if I can use that terminology. The proposal is to repeal that section 2(b) and substitute the following language here. Instead of "in a condition presenting or likely to present a danger" and so forth, "likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment."

Mr. Flaherty: That's the proposal for a change that you're suggesting?

Dr. Massolin: Yes. Bill 31 proposes that change.

Mr. Flaherty: Thank you for clarifying that for me. Thank you very much.

The Chair: Dr. Pannu, did you have a question on that?

Dr. Pannu: Mr. Chairman, the language, obviously, is the key here. The proposed amendment, in other words, to that particular subsection expands the criteria to include specifically mental and physical deterioration, I think. Isn't that the case? That's the additional criterion there.

Dr. Massolin: Yes. In part.

Dr. Pannu: The first part of that proposed change seems to not differ substantively from what's there in the existing Mental Health Act. It's the second part of that statement that seems to add additional criteria expanding on what presently exists. Am I right about this? I saw that they had it going this way rather than this way.

Dr. Massolin: Yes. Maybe I'll defer to Shannon, Parliamentary Counsel, for greater clarification on that.

Ms Dean: If I may, Mr. Chairman.

The Chair: You may.

Ms Dean: I think one of the key points with this amendment is that they're removing the criteria for danger to be in existence. Basi-

cally, it's making it easier for involuntary admittance to occur by opening up the criteria. But if I may, Mr. Chairman, ask Mr. Chamberlain to perhaps provide a more succinct description of that proposal.

The Chair: You may.
Please proceed.

Mr. Chamberlain: Thank you, Mr. Chair and Shannon. You're correct. There are essentially two changes to this. The first is the removal of danger and the replacement with the concept of harm. That was to address the current practice, which is that there needs to be some sense of urgency, a sort of immediate danger that the person is going to cause harm to himself or others before they'll be admitted as opposed to somebody who is likely to cause harm, but it might not be right now, so it gets rid of that urgency requirement.

The second piece – you're quite right, Dr. Pannu – is an expansion of the test to include the physical or mental deterioration, somebody who is potentially cycling down for whatever reason who may not be a harm to themselves yet but if they don't get treatment will continue to cycle.

Dr. Pannu: Now, the concern that I think was expressed by a minority of presenters to us had to do with the change in language: likely to cause harm. The judgment will have to be made by somebody on this. The subjective element in that judgment I think was a matter of concern to those people, who felt that the proposed amendment will make things worse, not better, insofar as the application of this law is concerned.

Mr. Chamberlain: I would respond to that that it has always been a subjective test. Likely to present danger is already a subjective test. The tests that are in place are that you need two doctors, one who has to be a psychiatrist, and then there's an appeal process to make sure that that test is being applied properly. But you're right. There's always going to be a certain subjective element to: at what point are they likely to cause harm? That's why we've got the level of expertise, the two physicians, one a psychiatrist, making that assessment.

Dr. Pannu: I think that helps. The notion of urgency I think is the additional element here.

Mr. Chamberlain: Removing the requirement for urgency, yes.

Dr. Pannu: Removing the requirement. Okay. That's where I think the expansion does become a matter of concern. This no longer has to be a matter of urgent concern; it has to be just potential for a problem. Is that right?

Mr. Chamberlain: It's still likely to cause harm. There still has to be a reasonable likelihood that there's the potential for harm. It's just the immediacy of the harm. As opposed to somebody who's going to cause a problem within the next few hours, if somebody is getting to the state where they may cause harm to themselves or others in the foreseeable future, that would give the physicians an opportunity to detain them and treat.

1:50

Dr. Pannu: Mr. Chairman, it seems to me that it does cast the net a bit wider, and that is a matter of concern, but let's move on from there.

The Chair: The way I read it, to me it would mean a little more specific criteria than casting the net wider. It just specifies it a little narrower than it did before because even danger is a pretty broad net.

Mr. Chamberlain: Yeah. One of the real goals of trying to expand it is to allow for earlier intervention. Before a person gets to the point where there's an immediate danger, you're actually able to intervene at an earlier stage to prevent them from cycling down to the point where they're likely to cause themselves or others harm.

Mrs. Mather: I just wanted to reinforce what you just said, then, because I think that's one of the intents of this change. If we can do something that's preventative and act more quickly, then, you know, we are doing better for mental health. I really support that move.

Mr. Shariff: I just want members of the committee to be cognizant of the fact that this is dealing with people who suffer from mental illness and that the professionals who deal with them are by and large supportive of the amendment that is being proposed. I think this will help the people who are impacted by mental illness by allowing a much broader response rather than that confined in the previous section that we are dealing with, so I'm supportive of the amendment.

Dr. Pannu: The second issue related to that amendment is one, I guess, flagged in a sense in the third column there, that this provision that's being proposed parallels the wording used in similar legislation in three or four other provincial jurisdictions. Is there any information available with respect to Charter of Rights concerns that may have arisen in those jurisdictions? I don't know how long these pieces of legislation have been in force and whether or not, therefore, enough time has elapsed for someone to challenge those pieces of legislation on the grounds of the Charter of Rights. Is there any information available on that?

Ms Roth von Szepesbéla: If I may, Mr. Chair, this issue is very contentious. The amount of time available for legal research was, unfortunately, not sufficient to delve in depth into the issue. My understanding is that it comes down to a debate between what's referred to as a dangerousness or harm model and, on the other side, the treatment model. This new expansion of the section, as you properly pointed out, Dr. Pannu, expands it from a likelihood to present danger to "suffer substantial mental or physical deterioration or serious physical impairment." As we've heard from the department, that is intended to be a preventative measure. There has been sort of a discussion of this issue, but we're not aware of any particular case. That's something that perhaps the department can refer to in a moment.

However, the comment I wish to make at this point is that the concern is particularly with respect to section 7: life, liberty, and security of the person. The debate that I've discovered so far is between letting someone untreated or not admitted remain in the community who may harm either himself or someone else. If that's the case, then there are criminal law provisions that would come into play. From what I understand from the department as well, this is intended to prevent that from happening, that the injury, be it a deterioration of health or an injury to someone else, be prevented.

The alternative to admitting someone at this stage would then be what will be discussed a little later on, a community treatment order, which is an interim measure, so to speak, or if there's no involuntary admission at that point, there's a possibility of that individual deteriorating substantially and harming himself or others. If that's the case, like I said, criminal law may come into play, which then – I'm looking for a word here – entirely takes away that person's

liberty potentially because there may be jail. Involuntary admission would be an alternative to jail in many cases.

That's the ideological debate behind the two models. Is that helpful? Perhaps I may invite the department to speak.

Dr. Pannu: I think that the first part of your answer was important: that you haven't had enough time to research the particular question of whether or not Charter issues have arisen relative to similar legislation in other provinces. We don't even know how long they have been in force, you know, those mental health laws with similar provisions in them. If there are recent changes in those acts, maybe not enough time has elapsed, so the effects, the negative consequences of those acts, have not really become apparent or have not been challenged.

Ms Dean: Mr. Chairman, if I may. To our knowledge the legislation that is in place in B.C., Saskatchewan, Manitoba, and Ontario is valid legislation. It has not been struck down on the basis of a Charter challenge. I would defer to Mr. Chamberlain if he has any further information on that point, but, again, to our knowledge that legislation is on the books. It's still valid and operative.

The Chair: Mr. Chamberlain, do you have any comments on that?

Mr. Chamberlain: Yeah, just to add a little bit, Mr. Chair. I can't advise off the top of my head how long some of this legislation has been in effect. Obviously, the different statutes have been in effect for different periods of time. Newfoundland's, which is the most recent one which has a similar test, doesn't come into effect until next year. My understanding is that some of the legislation, just on a quick flip through of my copies, actually goes back to the '90s, possibly even the '80s, with a similar test. To our knowledge, we're not aware of any specific Charter challenges that have been brought in the courts. It's obviously a topic of discussion, but I'm not aware of any Charter challenges and certainly not aware of any successful Charter challenges.

The Chair: Mr. Lukaszuk, you had a question, followed by Mr. Backs.

Mr. Lukaszuk: Thank you. As Mr. Shariff has indicated, this is a very important piece of legislation. I'm not sure if we should be awaiting whether there will be a Charter challenge. You know, every statute that we have on the books is subject to a Charter challenge. It's just a matter of time when somebody chooses to challenge it.

My question would be to our legal counsel. Have courts decided on what test is applied when challenges are brought forward, not to the Supreme Court level but to lower levels, appellate levels? How are they balancing the limitation of liberty versus the benefit to society? What test is being applied when challenges of this nature arise, when someone's liberties may have been limited but to the benefit of a greater good or that person's long-term benefit? Is there a common challenge that usually is being applied?

Ms Roth von Szepesbéla: If I may, Mr. Chair. The nature of the challenge usually depends on the facts of the case, which will trigger one test or the other. Generally, the debate that has made it to the Supreme Court in a criminal context has been criticized in that the Supreme Court has decided, for example, that in a criminal context – and it's under the Criminal Code, which isn't as applicable because this is civil context – a patient has a right to refuse consent and not to be admitted against their will or to be admitted for mental treatment if they have the capacity to recognize what it means and are competent to say so.

However, on the other hand, this case in a criminal context, for example, has been distinguished in the sense that if we're talking about a section 7 Charter challenge, the issue turns on whether or not there's danger or whether or not there's harm to the community. The test that I think you're asking about is to balance between the life, liberty, and security of the individual that suffers from a mental health issue and the public at large, that may be subjected to this person with a mental health issue. There's no one test that has been proven to be standing out as the test to be applied.

Again, those cases are not decided in a vacuum, and there's a difference between the criminal and the civil sides. However, in these cases it's easy for the mental patients to be subjected first to the civil side, and if that person falls through the cracks on the civil side, that person will find themselves likely on the criminal side, and the law is inconclusive.

2:00

Mr. Lukaszuk: Thank you.

The Chair: Mr. Backs.

Mr. Backs: Thank you, Mr. Chairman. My question is to Mr. Chamberlain, I think, in the department. It's in regard to the application of these amendments. We seem to have some general agreement that this applies very well in the case of schizophrenia, and we have a lot of lobbying from people around that. But in terms of other treatments, especially where the treatment is methadone, there seems to be less agreement. How do you see this applying in that second class of perhaps CTOs for, you know, a drug addiction or some other thing where you might see a methadone treatment come into play?

Mr. Chamberlain: To be honest, Mr. Backs, I'm not entirely sure how to answer that other than to indicate that the Mental Health Act and the bill are really neutral on treatment. It's up to the clinicians – the doctors, the psychiatrists – to determine what appropriate treatments are.

One of the criteria for formal patient admissions and CTOs, for that matter, is that there is, in fact, a need to admit them. They can't be treated properly otherwise. Their condition, their potential treatment would be something the physicians would have to take into account in determining whether or not admission as a formal patient made sense in their particular circumstances and, if you got down to CTOs, whether or not it would make sense and a CTO is actually workable. So treatment options would certainly come into account when they were considering those facilities. If a person couldn't be treated in a hospital setting, then there may be no point in admitting them. That would be something the physicians would have to take into account. But the bill and the current act are neutral on specific treatment options.

Mr. Backs: Section 29 of the Mental Health Act, the objection to treatment: how would that impact this amendment if there was an objection to treatment?

The Chair: Dr. Massolin, you have a comment on this?

Dr. Massolin: Thank you. I just wanted to point out, Mr. Chair, that we do deal with that issue a little bit later on in the process, so I don't know if it's necessarily germane here. Do we want to wait? That's my only suggestion.

Mr. Backs: If that's what he recommends, I'll go along with it.

The Chair: Okay. That will be brought up later.

Mr. Johnson: I think this change is quite satisfactory. I just want to make sure that I understand totally what's happening here. My understanding here is that a large number of submitters supported the amendment initially but that others felt that it was too broad, so now we're coming forward with this to broaden the original amendment. Is that right?

Mr. Chamberlain: I'm sorry, Mr. Johnson. I missed the question.

Mr. Johnson: I understand that most of the submitters supported the original amendment here but that some of them felt that it was too broad; therefore, we are coming up with something that is broader to support them. Can you clarify that for me?

Dr. Massolin: Yes, I certainly can. Mr. Chair, the clarification is that submitters certainly were of two minds, if you will, on this issue and that the first general sort of category of opinion was that this proposed amendment is a good one and that broadening the tests is a good measure to undertake.

The other line of thought was that the current standard is good as it is. The submitters were commenting on the proposed amendment, so nothing has happened as a result of what the submitters have done. They were just simply commenting on the proposed amendment as it stands.

Mr. Johnson: Okay.

The Chair: Okay. Before we move on to 2.2 in the document, could we get agreement of the committee, then, to go along with this amendment? Is that agreeable? The committee agrees with this 2.1?

Mr. Shariff: Do you need a motion?

The Chair: Yes, I think so. Mr. Shariff. Any discussion? Those in favour? Opposed? That's carried.

Okay. Dr. Massolin, you may continue.

Dr. Massolin: Thanks again. The next major issue that Bill 31 proposes has to do with community treatment orders. Now, Bill 31 under section 8 proposes the addition of section 9.1 to the Mental Health Act, and if that proposed amendment were adopted, it would introduce community treatment orders to Alberta. Now, we've received a large number of comments in the submissions on this issue, and I'll point out that the majority of invited stakeholders supported CTOs. However, there were a good number of submitters generally that opposed CTOs, community treatment orders, and they opposed them for a variety of reasons, which I'll not get into right here.

The other thing to point out is that just for your information and as you've seen through a previous document, the cross-jurisdictional analysis that was provided to this committee, other jurisdictions, including Ontario, Saskatchewan, Newfoundland and Labrador, have enacted legislation that allows for CTOs, and Nova Scotia has a similar bill that is awaiting royal assent.

I think the basic issue in terms of CTOs is whether or not the committee supports CTOs in principle, and if they do, then I guess the next set of questions would be what the criteria should be in terms of the issuance, renewal, or cancellation of community treatment orders.

The Chair: Dr. Pannu with a question?

Dr. Pannu: Yes. Thank you, Mr. Chairman. Dr. Massolin, you did some interesting review of some research with respect to the effectiveness of CTOs, and I think that review might be germane here for us to look at. Would you like to comment on the results of your review of the research relative to the effectiveness of CTOs so that we can take that information into account when discussing this?

The Chair: Would you like to comment on that, Dr. Massolin?

Dr. Massolin: I certainly can right now. I think you're referring to a couple of documents. There's one document that pertained to the statistics that were provided by a particular submitter to the committee, and they pertained to the effectiveness of community treatment orders in the state of New York. I'll comment on that one first, and then I'll pass it over to my colleague for the comments on the legal ramifications of community treatment orders. That was the other research document that was presented.

Just very briefly, our findings were that those statistics that were provided did accurately reflect a New York state government report on Kendra's law, which is sort of the informal, colloquial name for community treatment orders or outpatient treatment orders I believe they're called in New York state. The numbers were accurately reflected. Our findings, however, indicated that the data was a little bit skewed.

There was a basic problem in terms of an analysis of how homelessness and criminal behaviours were assessed. The time period, specifically, was not the same in terms of criminal or antisocial behaviour before community treatment orders and the same sort of measures afterwards. They were unequal periods. That caused a problem in terms of a valid conclusion that CTOs actually reduce the rates of things like homelessness or perhaps other antisocial activities, including arrest rates. So that was our first finding.

2:10

Another finding was that a subsidiary study looked at this Kendra's law report that the state of New York did and basically said that it was not a controlled study. In other words, it didn't have a scientific basis to it. Then the same study cited other studies which were, in fact, controlled scientific studies which indicated that there were no statistically noteworthy sorts of benefits to patients who are under CTOs in terms of those antisocial measures that I've indicated. Homelessness, as well, is part of that. So that was the finding.

Just in conclusion, the numbers were correct. They were correctly cited. They are indicative of some sort of effect on CTOs, but perhaps they're not indicative of the effect as was presented to this committee.

The Chair: Your colleague was going to comment further?

Dr. Massolin: Yes, just on the other report in terms of the legal. I don't know if there are any questions on what I've just said.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. So that's sort of the longitudinal effect of them or the efficacy of them, but is there any research showing what the immediate benefit or lack thereof was by way of preventing imminent danger that may have otherwise occurred to the patient?

Dr. Massolin: Mr. Chair, if I can respond to that.

The Chair: Go ahead, please.

Dr. Massolin: It's a very good question. I think that's exactly what this New York study does. It shows you that CTOs have a very profound immediate effect. Those numbers shoot way up in terms of reducing homelessness and so forth, so there is a profound immediate effect. The question is whether or not, you know, when you look beyond sort of the immediate period and into the longer term, comparing that with the time period prior to the CTO, that pronounced effect is maintained over the longer term.

Dr. Pannu: Your review – you know, the two pages or three pages that you have done – is very helpful, particularly because we had the benefit of receiving oral submission from one of the authorities in the area of psychiatric treatment here, Dr. White. I just was looking very closely at the conclusions that you have drawn from the review of a handful of studies. There are not 200 of them but three or four or five studies that you've looked at. Mr. Chairman, Dr. Massolin's conclusion is something that's important here. It says:

> The information cited by Dr. White – derived from the New York study indicated above – would appear to require careful re-examination in terms of the way that the statistics on the effects of AOTs are presented and with respect to the conclusions drawn from this information. Additional clinical literature on the issue of outpatient treatment appears to be much less optimistic than the New York report concerning the effectiveness of involuntary outpatient treatment. It is apparent . . .

And this is the concluding sentence of your conclusion.

> . . . that further research and study are needed to determine whether involuntary outpatient treatment is effective.

Right? So I kind of thought that that was an important statement that you made here.

The Chair: Thank you.

Mr. Lukaszuk: In follow-up to Dr. Pannu's comments I'm wondering if we're not sidetracking and if we're not discussing the possible efficacy of two separate processes. There's the one process of involuntary commitment to treatment, which is sparked by imminent danger to the person. The efficacy of that process you would measure by way of establishing whether you have indeed saved the person's life or prevented them from seriously harming themselves at that moment in time or perhaps in a very short time from the moment you apprehended the person.

Now, what Dr. Pannu seems to be referring to is the long-term efficacy: have these individuals then somehow regained their long-term mental health, or have they desisted in engaging in criminal activity or anti-social activity? Now, when you're assessing that long-term efficacy, what you are really assessing is not the effectiveness of involuntary confinement but the well-being of the mental health system and care in the state of New York. The order may have been very effective and achieved its purpose, but if there's no follow-up, if there's no proper care and medication provided to the individual, he may not recover in the long term. Yet the order was effective: he did not freeze to death, did not die of malnutrition, or commit suicide.

The Chair: You wanted to respond to that?

Dr. Pannu: I don't want to continue on this, Mr. Chairman. The only point I wanted to make was that Kendra's law, the assessment of it, is with reference to outpatient commitment, which is similar to CTOs. It's not involuntary commitment but outpatient commitment, which is another term for CTOs. So it speaks directly to the effectiveness of CTOs in New York state.

The review done here casts serious doubt on the validity of the conclusions drawn from the study for reasons primarily methodological, I think, more than anything else. These studies have to be carefully scrutinized because if appropriate methodology is not in place, then they produce results which we cannot depend on. That's the issue, and that's why I think that the review done here does speak directly to the effectiveness of CTOs rather than just involuntary treatment.

So just clarification that the issue reviewed here does speak directly to CTOs and their effectiveness.

The Chair: Dr. Massolin, do you want to respond to that?

Dr. Massolin: Yeah. I guess there are two points, and maybe a question can come out of this. I agree that there is doubt cast on the numbers that were presented because of methodological inadequacies. It wasn't a scientific study. That's what other studies that review this New York state study have indicated to us, and we're basing our conclusions on those studies. Of course, you know, we're not experts in the field ourselves, and this is, therefore, the reason to indicate as well that further study is needed not only to assess the effectiveness of CTOs, or outpatient treatment orders, generally but also to understand the issue more in depth. That's the first point to be made.

I suppose the other point to be made is the issue of the effectiveness and the duration of a CTO. Perhaps this is a question for the department. What is envisioned by the CTO in terms of its duration? Is it supposed to have an immediate effect, or is it supposed to have a longer term effect?

The Chair: Was there anything else? Do you want to continue on this?

Dr. Massolin: No. I misunderstood. I think Dr. Pannu was only referring to this New York state statistical information. That was about it.

The Chair: Any other questions from any of the panel members up till now?

Did you wish to proceed, then, on 2.2?

Dr. Massolin: Well, I guess that the other question before the committee is pertaining to community treatment orders and whether or not they're desirable, necessary, or appropriate and whether or not this amendment, therefore, should stand.

The Chair: The question before the committee now is, I guess, a two-part question: 2.2 is whether we want to engage the use of CTOs in Alberta, and if so, under what criteria should we be using them? I think we should ask the question in two parts. Is the committee agreeable to the use of CTOs? Maybe we should have a motion on that.

2:20

Dr. Pannu: The review done by the legal staff is very good, Mr. Chairman, and I think we should perhaps review some of the recommendations or observations made here in column 3. For example, on the issuance of the CTOs, whether the patient was subject to previous CTOs is important. There's a recommendation made here by the review. "The Committee Members may wish to elicit input from the Ministry on the choice to limit CTOs to formal

patients [only], as opposed to making them available to outpatients." That to me is an important issue, whether we agree on the use of CTOs: whom should it apply to? Only to formal patients or also to those who are outpatients?

The next sentence here says, "Specifically, the Committee Members may wish to consider whether there ought to be a requirement that patients be hospitalized before a CTO is issued." I think that's an important question for the committee to consider. I certainly would think that we need to be very careful with respect to who would be subjected to a CTO. If it applied to someone who has been hospitalized before the CTO is issued, I think that would help narrow the scope of the application of the CTO, which is what I favour personally very much.

The Chair: I have Mr. Lukaszuk and Mr. Shariff. But before I recognize them, I think that if we find out that the committee is not in favour of CTOs at all, the rest becomes redundant. What I'm asking for in the two-part question is: does the committee wish to approve of CTOs? Then we get into the discussion of under what criteria they would be used. If we don't approve of CTOs, then we're on to the next issue, and we don't have to bother discussing it.

Mrs. Mather: Do you need a motion?

The Chair: Yeah.

Mrs. Mather: I'll make a motion.

The Chair: Mrs. Mather moves that we approve of CTOs in Alberta.
Any other discussion?

Dr. Pannu: Mr. Chairman, I very much respect our wish to proceed with some decisions so that we make progress. Approving in principle and then defining the circumstances under which and only under which circumstances CTOs would be applicable would seem to be one way to go. The other is to discuss the various issues that are raised by the review and then come to the conclusion whether we need to proceed with the CTOs. There's good information here. Some suggestions are made. Some of it has to do with legal advice, that we should seek, perhaps, further information from legal resources before proceeding with it. If you make the decision, then you have made the decision. Then all you are trying to do is to limit the damage that might happen. There is a very extensive review here, about 10 pages.

The Chair: I've read it.

Dr. Pannu: Would it not be useful to discuss some of the issues and questions raised by the review before voting on the motion? That's all I'm asking the committee to consider.

The Chair: Did you have a question, Mr. Lukaszuk?

Mr. Lukaszuk: No. I'm ready to vote.

The Chair: Well, we have a motion before the committee.

Mrs. Mather: It doesn't limit discussion later.

The Chair: There's more room for discussion if anyone else wants to discuss it.

Mr. Lukaszuk: I have a question relevant to criteria, but it would be inappropriate for me to raise the question now. Once we establish whether there is criteria to be set to begin with, then I'll ask my question.

Dr. Pannu: The motion is before the committee. Given the information that's provided here and the questions that are raised, I will have to vote against the motion based on the process that we are using, Mr. Chairman. That's what I want to say.

The Chair: Well, the committee is open for suggestions on process. It's whatever the committee wishes. We do have a motion before us. You can defeat it if you wish.

Mr. Lougheed: I'm just curious if Dr. Pannu would illuminate us about the process that he's concerned about right here.

Dr. Pannu: As I mentioned, I'm looking through column 3 here. I spent some time this morning reading the material, and I can only cite a few examples here as to the matters that need to be considered before we say CTOs are fine, I think. Our answer should be subject to satisfactory answers that we get to those questions or not. Whether we approve the CTO or not should be subject to whether or not we get the answers that satisfy us. The staff have done the work. They've raised the questions for us. It's up to us to then satisfy ourselves that those questions have been addressed in a satisfactory way for us to proceed with the CTO. I can mention a few more, but it's a fairly detailed document here that I am referring to.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you. Well, I want to make sure that all members of this committee are satisfied with the process because we are here in a new forum, and we want to make sure that everybody walks away from this table – you don't always win votes, but you want to make sure that even if you didn't win, you didn't win in a process that you agree with.

In this case I find that it's a bit of a catch-22. All this research is available to us, and I assume that everybody has read it, so the question one has to ask himself or herself now is: are you in principle in favour of CTOs? You may be in favour of them under certain circumstances. That is the second vote. We will hammer out the circumstances under which they can or cannot occur. In general, do you see that there is any purpose or reason to implement CTOs? If the answer is no, then you don't have to worry about circumstances because there won't be any. If the answer is, "Yes, in general I think it is a good idea, but we need to now work out the parameters under which they can occur," then that will happen in the second vote. I'm not sure what the point would be of voting on the second one first.

Mr. Flaherty: Mr. Chair, could I go to the hon. Member for Edmonton-Castle Downs and ask him a question? When you say yes on accepting CTOs – we had Dr. Massolin present the position on methodology earlier. We moved on from that, and I agree that we've passed it. Now, when we're doing this to get a larger scope of what should be included and the proper way of doing business in terms of implementing this particular bill, is methodology one of those criteria that we should go back and look at and say, "This has to be looked at from the beginning," with the idea of being able to tell us how it was impacted and what would be the result of giving us some direction in the future? Would that be part of something you would enclose in the criteria after we said yes?

Mr. Lukaszuk: Well, I'm sitting here under the assumption that the Member for St. Albert has already done that research for himself and should be at this point comfortable with whether or not in general he feels comfortable with the concept of CTOs. Now, if the member hasn't done that research for himself up to this moment, then I can understand his hesitance in voting one way or the other. But that research should have been done up to now. It has been definitely available to us, and the resources have been available to us. The question now that is before us is: are there any circumstances out there under which we would feel comfortable with a CTO? I know what the answer in my case to that question would be. Then question 2 would be: what are those circumstances under which you are comfortable or not comfortable? The question you should ask yourself is: are there any circumstances under which you could support CTOs?

The Chair: Rob Lougheed, do you have a comment?

Mr. Lougheed: Yeah. We've got a motion on the floor, and Thomas is making some good points here. I believe I understand where I want to go with this vote. Right now we've got a motion on the floor that we can discuss. Perhaps Dr. Pannu has uncovered something that is worthy of us to consider before we say yea or nay with respect to having CTOs in this province. Why doesn't Dr. Pannu, as part of the debate here, bring up the two or three things that you have highlighted there? You may convince all of us, or the majority, to your way of thinking.

2:30

Dr. Pannu: Fair enough. Mr. Chairman, there are two issues. Let me bring those up quickly. One is the issue of a mandatory review after six months. What happens after six months? Is it automatic renewal in six months? Are there issues raised with the presenters? Then in the review the Newfoundland legislation, particularly, has been the focus of the review. It suggests that there must be a mandatory review, particularly at the time of the first renewal. The renewal should be subject to that mandated review that must take place before CTOs are renewed. That's one issue.

The other one is apprehension for noncompliance with the CTO. I find, again, the review here very helpful. Attention is drawn to this and some very constructive suggestions made in the way to proceed with it.

> The Committee Members may wish to consider introducing a less intrusive interim measure intended to bring the patient into compliance prior to the issuance of an order for the non-compliant patient's apprehension.

That's another important issue, dealing with the liberties of people where they are people who are not entirely capable of looking after their own affairs. They need help. That's why they are in this treatment. We do talk about striking a balance between the liberty of the individual and liberties of all of us as individuals and the threat and the danger in which you might put others or ourselves.

The Chair: Dr. Pannu, in the interest of time for the committee it seems that we're going down this road anyway. It seems that there's a desire to debate the criteria for issuances of CTOs rather than to debate the principle of whether or not we have CTOs. If that's the desire of the committee, we can either see if the mover wants to withdraw the motion and go down that road or have the vote and have that discussion afterwards because we're having it regardless of the fact that the motion is on the floor. We're debating not this motion; we're debating what I see as probably a subsequent motion that hasn't been made yet. So what is the desire of the committee? Do we want to debate the criteria for the issuance before we make the decision on CTOs or not?

Dr. Pannu: Mr. Chairman, that was my proposal, but obviously it's up to the committee.

The Chair: If I could have some consensus. The mover has made a motion. Mr. Lougheed, do you have a comment on this?

Mr. Lougheed: Having heard the comments that Dr. Pannu has just made here, I would prefer to vote now rather than to discuss them because they are part and parcel of how to approach the whole CTO once it has been decided that we would go ahead with it. I would ask for the vote, from my perspective.

The Chair: Are there any other questions on the issue of issuance of CTOs? The motion is that

> we do have CTOs.

Is there any other debate on that motion without going into debate on a motion that hasn't been made yet?

Mr. Shariff: Question.

The Chair: Those in favour of the motion as proposed by Mrs. Mather? Those opposed? That's carried.

Now we'll get into the discussion of under what criteria CTOs would be issued and renewed or cancelled. Do you have any further comments on that, Dr. Massolin?

Dr. Massolin: Yes, I do. I think we can move on to a discussion of the criteria for issuance of CTOs and go sort of item by item as the bill lays out.

The Chair: That's 2.2.1.a.

Dr. Massolin: Yes, exactly, the medical authority required for the issuing of CTOs. You can see that in the second column there the second bullet point shows what section of the bill, 9.1(1) and (b) specifically. It explains what the current requirements are; that is, that a psychiatrist and another physician can issue a CTO, so on and so forth. It explains what those conditions are so that a CTO can be issued.

Just to point out that we received some comments from submitters that said that perhaps you might want to consider other mental health professionals, including psychologists, to be a part of the process here. So I think perhaps you might want to consider as committee members the question of what types of medical professionals and how many medical professionals ought to be responsible for issuing a CTO.

Mr. Shariff: My question pertains to Small Town, Alberta, which may or may not have accessible psychologists or psychiatrists within that time frame of 72 hours, I believe. What happens in those scenarios? It may not be practical to have somebody physically give a second opinion within that 72-hour time period.

Dr. Massolin: I cannot speak to what happens in lieu of that, if there's a specific provision, but perhaps my department colleagues here can enlighten.

Mr. Chamberlain: I think the answer to your question, Mr. Shariff, would be twofold. Obviously, a patient could be conveyed for examination, and in a serious case that's what would happen. The

other provision which is in Bill 31 which may be of assistance is section 9.7, which authorizes health authorities to designate physicians in accordance with the regulations to serve the role of the psychiatrist where a psychiatrist is not available. So there was some contemplation of that when the bill was drafted.

Mr. Shariff: Then my further question is this. A community treatment order is issued if there is a concern about the patient's safety to himself or to others. The system that is being proposed will prolong that decision being made until the patient can be conveyed to a different venue. So my thoughts are: could there not have been a process whereby a physician could have issued a CTO and then have a subsequent re-examination whether that decision was valid or not in situations such as Small Town, Alberta, which may not have a psychologist or a psychiatrist accessible to them?

Mr. Chamberlain: Yeah. I think that there are various answers to that, obviously. Generally speaking, when a patient presents, there is a history of conditions, treatment, and that may ease where they're being conveyed or what treatment is required. We have made provision for the physician to act in place of a psychiatrist. We're also considering some regulatory amendments that would facilitate telehealth examinations to try and ease some of these issues.

So it's a legitimate concern, that patients have access to these things. One of the aspects of the back end of the CTOs which relates to this issue a little bit is that the CTO can only be issued where the physicians who are issuing it are satisfied that, first, the person's going to be able to comply and that the resources in the community are going to be available to address whatever treatment requirements they need. I don't know if that answers your question, Mr. Shariff.

Mr. Shariff: Well, it clarifies it. Let me just reclarify. What you're saying is that there will be mechanisms in place that may not require a face-to-face visit between a psychiatrist, psychologist, and a patient. Correct?

2:40

Mr. Chamberlain: That's what we're contemplating and considering, yes.

Mr. Shariff: Okay.

Mr. Backs: The Psychologists' Association of Alberta has provided us here today with a list of the communities in 2005 that had psychologists, and there are quite a few, I think over 75 just at a quick glance. A question, Mr. Chamberlain and to the department: is there a reason why psychologists aren't included in the criteria for the issuance of the initial community treatment order?

Mr. Chamberlain: The short answer, Mr. Backs, is that the current scheme of the act, which is consistent with most of the legislation across the country, is that two physicians issue formal patient orders – and that same model was used for CTOs – and that one of those physicians has to be a psychiatrist. So this was not really a matter of changing; it was a matter of looking at the status quo, which is that a psychiatrist is being involved but making some room in the regions for the community treatment order issue to allow a physician to take the place of a psychiatrist where a psychiatrist wasn't available for issuing CTOs. Quite frankly, it's as simple as that.

Mr. Backs: So in the initial issuance of a CTO it is thought that psychologists should not be a part of that as one of the two people.

Mr. Chamberlain: The answer, I'm afraid, is the same. We haven't really considered whether that could be expanded in drafting this. It was a matter of maintaining the status quo and trying to make it as consistent as possible with other legislation. Recognizing the risks and the Charter risks that this kind of legislation brings, we didn't make changes that we didn't think were necessary at the time, but that's certainly something the committee can consider, whether there are psychologists or, in fact, other health professionals who may be able to fill that role.

Mr. Backs: Would that in the view of the department be a workable amendment?

Mr. Chamberlain: I can't answer that at this time. I'd have to consult with my colleagues.

Dr. Pannu: Mr. Chairman, the issue is one of professional competence to make judgments which have consequences. My question at this stage, whether the department can answer it or someone else around the table, is whether or not family physicians or even clinical psychologists have the competence to make decisions with respect to mental disorders which are likely to lead to the issuance of CTOs. My understanding at the moment is that psychiatrists would claim that they are the only ones who have the competence, and the College of Physicians and Surgeons has some, I think, role in determining, therefore, who has the authority to make these authoritative decisions about mental disorders, based on which, then, one could be subject to a CTO.

So my question is: are family physicians deemed competent to make the decisions regarding the issuance of CTOs, assessment of patients, you know, who would be subject to CTOs? There's no such reference, I would guess, in the bill here which clearly states that there is a provision in the bill, in the way the bill is written, which would in fact empower or authorize family physicians to be able to make the kinds of judgments that normally psychiatrists make.

Mr. Chamberlain: You are correct, Dr. Pannu. There isn't anything in the bill that addresses that, and as I indicated, the bill was drafted primarily on status quo because the determination across the country has been that psychiatrists are able to make that kind of determination.

At what level other health professionals might be competent is really a question for the health professions themselves to address. I understand that representatives of the Psychologists' Association did present and did express some comments about whether certain psychologists would be competent to do this and what their expertise was. Certainly, part of the concern is that even if psychologists were to be granted the power of psychiatrists, is it all psychologists or is it subgroups, and what would the specialities be? Quite frankly, the legislation was drafted as the status quo. I won't pretend it's more than that. It was that psychiatrists have been accepted as having that power and that role. We are preserving rights, and there was no change contemplated at the time the bill was drafted.

The Chair: Any other questions?

Mr. Johnson: Well, on the basis of what I've heard and what I know, I would have no reason to recommend any changes than what exists now. I think we would have to have more information, either a recommendation from the medical community or whatever. In answer to the questions in the right-hand column I would say: no change.

The Chair: Anyone else?

Mr. Shariff: You know, this point is raising a number of issues, and I am not very sure whether we're capable of voting right now although I support it in many ways. I'm looking at it again from smaller centres which do not have professionals available to them. I don't think it will necessitate our having it as part of the act. I think a regulation that indicates that the professional body certifies certain professionals within their jurisdiction as being capable of issuing a CTO may suffice for our needs. I'm wondering whether the department can answer this: would you make sure that the regulation reflects that the psychologists or family physicians or whatever other category of physicians are considered do have the authorization from their professional bodies certifying that they are capable of issuing a CTO?

Mr. Chamberlain: Obviously, I can't speak for the colleges, Mr. Shariff. What I am hearing and what I think you might have been suggesting – and correct me if I'm wrong – is to move the designation of the person who is qualified to certify a CTO or issue a CTO into the regulations. The statute currently provides for two physicians, one of whom is a psychiatrist. In theory you could accomplish the same thing by providing for the regulation to specify who's certified and then having that same provision in a regulation, which would give you the flexibility down the road to move to a psychologist if you could determine which ones had the necessary expertise. That's not something that we've considered or that I have instructions on, quite frankly, but that's what I think you're talking about when you indicate moving the expertise competency level into a regulatory power and taking it out of the statute.

Mr. Shariff: That's right. Yeah, that's what I'm suggesting. If it's possible, then we can proceed with the rest of the questions with an understanding that this will be moved into regulation.

The Chair: Mrs. Mather, you had a question?

Mrs. Mather: I really wanted to support what you've been saying because we heard from the Psychologists' Association certainly that the minimum standard is a master's degree and that they have a very stringent code of ethics. Depending on the qualifications, I would suggest that some would be better able than family physicians to take on this role, so I would really support an expansion through regulation of who is actually qualified to do this work.

Mr. Lukaszuk: I would have to echo that. Normally I'm not a big fan of moving anything from legislation to regulation if it doesn't have to be, but in this case the argument that was presented to us by the college of psychologists I found to be a rather compelling one. I did a little bit of follow-up research of my own, and I am satisfied to a large degree that a clinical psychologist with appropriate education, being a minimum of a master's degree in the art, may often be in a much better position to make a determination on a person's mental health by virtue of the academic background that they receive than a general practitioner, whose background on mental health is rather limited compared to those clinical psychologists.

Perhaps in this case it would not be a bad idea to move this into regulation and then have the professional bodies hash this out with the oversight of the minister. I'm sure this will not be an easy undertaking. There will be some territorialism, as there normally is, but then we can make the best decision through the minister's office for what is best for the patient and who is really best qualified.

2:50

Dr. Pannu: It's an important issue that we're discussing now; you know, who is qualified and legally authorized to make these important decisions on mental health. Psychologists clearly stated before us that they are capable of doing it, that they have certain educational qualifications, requirements, that those who meet the requirements are the only ones who are members of the psychological association, and that therefore they are able to do this. Psychiatrists may or may not agree with it; we don't know where they come from. At the moment is there anything in the Medical Profession Act that will not allow this to happen; that is, for psychologists to be able to play the role that psychiatrists currently are playing? Would the Medical Profession Act have to be changed before any regulatory changes can be made to authorize new practitioners, professionals to make the kind of judgments which to this point only psychiatrists may be the ones who are authorized to make?

Mr. Chamberlain: I'm not aware of any changes that would be required to the Medical Profession Act, Dr. Pannu. I can't give that advice firmly, but I'm not aware of any changes. I would note that the plan is that the physicians and surgeons will be moving over to the Health Professions Act, hopefully in the next few months. Then the Medical Profession Act will be repealed, and all the professions – psychologists and physicians – will be under the same enabling legislation, which is the Health Professions Act.

Mr. Backs: To echo some of the previous speakers, I often have some concerns about moving things out of statute into regulation, but I think there is good cause to do so in this case because of the representations we've had from the Psychologists' Association and what they've told us about their expertise. Correct me if I'm wrong, Mr. Chairman, but can I make a motion to that effect, to just add in section 9.1(1) that after the further issuance of CTOs there be a psychiatrist and another physician or another medical health professional as established by regulation, or some wording to that effect?

The Chair: You're making a motion?

Mr. Backs: Yes.

Ms Dean: Mr. Chairman, if I could just get some clarity. Is the proposal that the committee supports the concept of one psychiatrist approving the CTO but that with respect to the second medical official, that be either a physician or a psychologist or somebody who is meeting the requirements as spelled out in regulation? Am I understanding the intent of the committee?

The Chair: Yes.

Ms Dean: Thank you.

Mr. Shariff: So psychiatrists are included, but this is the second person.

Dr. Pannu: Mr. Chairman, we are discussing the contents of Bill 31, which has received second reading approval by the Legislature.

The Chair: Yes. The principle has been agreed to.

Dr. Pannu: I'm wondering if the motion that's been proposed or

suggested, at least, really is in order given the contents of Bill 31. Are we, in fact, trying to do something that's not part of the bill and the bill doesn't address that issue at all?

The Chair: Well, we do have a mandate to recommend amendments, but I'll defer that question to Shannon Dean, our legal counsel.

Ms Dean: Thank you, Mr. Chairman. I would view that type of amendment as certainly in keeping with the principle of the bill and would approve it for the purposes of Committee of the Whole.

The Chair: Okay. Does that answer your question?

Dr. Pannu: It does. There'll be a particular section, I guess, in which that amendment would have to be addressed.

Ms Dean: If I may just make a suggestion, Mr. Chair. There may be corollary amendments associated with this concept that will impact other sections in the bill, and perhaps in preparation for the next meeting I may be working with department officials on the appropriate wording for consideration by the committee.

If I can just be clear, 9.1 may be amended, but 9.7 may also require an amendment.

The Chair: I have a question from Mrs. Mather.

Mrs. Mather: I'd like clarity on the motion because I think that part of the reason we were considering the role that appropriately trained clinical psychologists could play with CTOs would be that they might be more available in this province than psychiatrists, especially in the rural areas. If there's a clinical psychologist who's trained and capable and a physician, would that be sufficient for a CTO, or are we saying that there must always be a psychiatrist?

Ms Dean: Mr. Chairman, if I may. We're just moving around in the bill in a few different spots at this point. Section 9.1 deals with that initial proposal. Section 9.7 deals with the scenario, which I think you're addressing, where the psychiatrist is not available. What I would propose is that we come back next week with an amendment that would take that concept and import it to both 9.1 and 9.7. Section 9.7 is the scenario where the psychiatrist is not available, so a physician is allowed to issue the CTO as well as another physician that's been designated by the RHA. We could build in the alternative designated official in that section as well, but again I think this concept requires just some further discussion with the department. If we can bring that amendment back perhaps next week, or if the committee can direct us to draft an amendment with respect to those issues.

Mrs. Mather: I would like that.

The Chair: You mean in respect to the motion that Mr. Backs has proposed?

Ms Dean: Yes.

Mr. Shariff: I just have a question. I just want to make sure that I follow through with the question put forward. My understanding was that a psychiatrist is automatically considered capable and has the credentials to be able to be a participant in issuing the CTO. This pertains to a physician or a psychologist or maybe any other health professional that may be designated. This would then come into play if a psychiatrist is not available and there are two medical professionals coming together: one is a physician, and one is a psychologist.

Mrs. Mather: That was my question.

Mr. Shariff: Well, I presume that a physician and a psychologist coming together would be able to issue a CTO as we are discussing it right now.

Ms Dean: I understand the intent there, and I think the appropriate section that would require amendment would be section 9.7.

Mr. Shariff: Okay. Fair enough.

The Chair: Do you want to vote on the motion as Mr. Backs presented it, or do you want to table it to legal counsel to be brought back, to be drafted up for next week?

Dr. Pannu: I think the latter, Mr. Chairman.

The Chair: A motion to table the motion till next week? Or do you just want to withdraw it?

Mr. Backs: I agree that it be tabled.

The Chair: Okay. Mr. Backs withdraws his motion. Is it agreed that we refer this to legal counsel to bring back a draft motion?

Hon. Members: Agreed.

The Chair: Opposed? Seeing none, it's unanimous.

Okay. If we can move along, Dr. Massolin, to the next issue.

Dr. Massolin: Yes. Thank you, Mr. Chair, again. I guess we're on 2.2.1(b), under the category Patient History or Previous CTO. The basic issue here that I'd like to highlight is the issue of prior hospitalization being a condition or a criterion for admission under a CTO. Now, we received a fair bit of feedback on this issue, both in favour and opposed to that condition: prior hospitalization. One example of a reason in favour was that a CTO ought to be issued only if a patient is stabilized, and the assumption is that that stabilization would occur in hospital.

3:00

There are others, however, who are opposed to this prior hospitalization condition. One of the arguments was that you might have a so-called silent population out there who exhibit symptoms and require help but who are not subject for whatever reason to hospitalization and, therefore, would not be admitted under a CTO.

I guess the first consideration here is whether or not prior hospitalization is appropriate or whether a CTO should be made available to so-called outpatients as opposed to formal patients. There is another sort of consideration as well to throw in here, and that is the last bullet point on the first column here. That exists on page 6, that this provision is actually too restrictive, the immediately preceding three-year period. There should be sort of a lower standard attached to admission, in summary. So that's another consideration that the committee may want to engage.

The Chair: Dr. Pannu, you have a question?

Dr. Pannu: Mr. Chairman, I'm ready to make a motion on this issue

that the bill be amended to say that there ought to be a requirement that patients be hospitalized before CTOs are issued. This is on the top of page 6 in column 3. This is suggested as a possibility.

Dr. Massolin: I just wanted to point out to the committee members that that is already the case, that prior hospitalization is, in fact, a prerequisite before a CTO can be issued.

Dr. Pannu: Oh, okay. All right.

What's the difference between someone being hospitalized for a mental illness and being a formal patient? Is there a difference?

Dr. Massolin: No.

Dr. Pannu: They're the same, right? The same thing. Okay. All right.

The Chair: Does that answer your question?

Dr. Pannu: It does, yeah.

Mr. Lougheed: Can you repeat that comment again?

The Chair: Dr. Massolin, do you want to repeat that?

Dr. Massolin: Yes. Prior hospitalization is a necessary precondition to be considered before a person is considered to be eligible for a CTO.

Dr. Pannu: Mr. Chairman, I have a question on that one now. The next question that raises is: is there any time limit on it? Three years ago, two years ago, six months ago? When? That to me is the other critical issue, then. How long ago should one have been committed to a hospital?

Dr. Massolin: Yes. If you look at the middle column there, you've got section 9.1(1)(a)(i) and (ii) and then 9.1(1)(a). You can see the provisions set out there. It's within two years of a patient's single detention "for more than 60 days or 3 or more detentions." That's kind of the standard that is used.

Dr. Pannu: So the question is: is that a reasonable time limit? That's the main thing.

The Chair: Is that consistent with other jurisdictions?

Dr. Massolin: The other jurisdictions vary. Saskatchewan, I believe, has a similar set of parameters. Ontario, as an example, has a slightly different standard in terms of indicating only a cumulative period of 30 days as opposed to 60 days, as one difference, just to pull out two examples. So, generally, yeah, there's a bit of variance among the jurisdictions, but Alberta's is not that far off what other jurisdictions have done in general terms.

Dr. Pannu: Could you comment, Philip, on what the Newfoundland legislation has? That seems to be the latest one, and it seems to have some more provisions in it to protect patient rights and others.

Dr. Massolin: Sure. Well, I'll just read to you from the cross-jurisdictional analysis that was provided. In Newfoundland this is the standard, and I'm just paraphrasing. During the immediately preceding two-year period the person has been unvoluntarily detained in a psychiatric unit on three or more separate occasions, and then there's the other consideration: or has been the subject of a prior CTO. That's something that we'll get to in our discussion in a moment or two, I guess.

The Chair: Corinne is handing out a document that gives a cross-jurisdictional comparison. We've had it before. You'll have it handy now.

Mr. Lukaszuk, you had a question?

Mr. Lukaszuk: More of a comment perhaps, but maybe the department can comment on it. When I look at this Bill 31, I see it as a piece of legislation that is aimed at assisting those who are suffering from a mental health disorder and obviously find themselves in predicaments where they cannot at that moment in time make what we would consider to be a prudent decision to submit themselves into care. Our researcher says that there may be a silent population out there who has never been hospitalized. Who are we kidding? We all know that there is a population out there, and it's not so silent. Those are a large percentage: the homeless that we encounter on the streets and those who freeze to death in Edmonton every year, about whom we are very concerned. So we need not pretend that there is a silent population.

This bill is aimed at helping those very people, putting them into care so that they can be treated, and then they can make prudent decisions and take better care of themselves. If you put stringent restrictions on it that they have to have prior hospitalization, well, the fact of the matter is that they are not amicable to treatment to begin with. Many, not most of them, would never have been hospitalized. This is the population we're dealing with. The only time they end up in the hospital is if they're picked up by an ambulance and are provided with acute care and then released, but rarely ever are they checked into hospital because they don't want to be in the hospital in the first place. If they wanted to be in the hospital in the first place, you wouldn't have to issue a community treatment order.

This motion, what it says to me, is a vehicle by which one could agree to something, but then you will make it so ineffective that you might as well not have agreed to it in the first place. You know, it's almost like voting yes and no at the same time. On the record you're in favour of it, but if we were to pass this motion, then it will never be implemented for those who actually really need community treatment orders. That's my concern.

Maybe the department can comment on it, or maybe there is some further information that would change my mind. But if we make this that restrictive – and I fully appreciate and I'm cognizant of the implications of liberty and human rights. Our Charter in section 7 is very clear on it. Where there is a greater benefit to society or if there will be greater benefit realized to the person, then those are the decisions that we make as politicians. It's one of those cases where you can't have a cake and eat it too.

Mr. Johnson: I wonder, Dr. Massolin, if you could give me some idea as to how strongly those people that made submissions felt about this and how many. I notice that it says here in the first column that some said, "'Delete' previous hospitalization requirement, two-physician assessment suffices." You know, these are points made. Were they made by a lot of groups? Can you give me some idea?

3:10

Dr. Massolin: Yeah. It's difficult to say with a lot of certainty, like give you numbers and do the analysis that way. I can tell you, though, the reason why this issue has been pulled out. Well, there

are a variety of reasons, but from the standpoint of the submitters there was a fair bit of comment on this issue, so they isolated the issue of prior hospitalization as being an important one, whether they agree with it or whether they debated it or what their recommendations were on it. These bullet points reflect a number of those comments and not necessarily a groundswell behind each one of them but maybe, you know, a variety of comments on the general issue. So just to recap. Yeah, lots of interest on the issue of prior hospitalization, and here is some of the rationale why that's an important issue.

Does that answer?

Mr. Johnson: Yes.

I have to kind of agree with Mr. Lukaszuk's points here. I can think of a couple of cases in my own area where people that may fit into this category have not been hospitalized. I suppose that would be kind of a hurdle in the way. I'm not sure if it would be, you know, the best thing to hospitalize them first just so that a CTO can be issued. It seems to me that that would not be wise if that were the eventual outcome of this.

The Chair: Mr. Backs.

Mr. Backs: Thank you, Mr. Chairman. I agree with the comments of Mr. Lukaszuk, actually. I've had in my constituency of Edmonton-Manning a fair number of homeless and do at any point in time. It's one of the peripheral sort of preferred areas in the province, I think, for homeless to go, and it's also the site of Alberta Hospital. We do have a great deal of those homeless, when I participated in the homeless count, that are obviously in need of treatment. To try and get them into treatment is the challenge of professionals. That is the silent population, I believe, that is often spoken of. Many are hospitalized quite often, but it's for violence and other things that they run into from being in their state. I think that the comments of the Member for Edmonton-Castle Downs are well taken.

Mr. Lukaszuk: I think we have a motion on the floor that we may have to vote on. Did Dr. Pannu? If there is no motion on the floor, I would like to put a motion that prior hospitalization not be a factor in issuing a CTO.

The Chair: Did you have a motion? I don't believe you had a motion on the floor, Dr. Pannu.

Dr. Pannu: No. I think the motion became redundant because of the explanation that was provided.

Mr. Lukaszuk: Then I will ask that my motion stand.

The Chair: Shannon Dean, did you have any comments you wanted to make, or Dr. Massolin?

Ms Dean: Sorry; I don't want to interrupt the flow of discussion here. I just wanted to point out that it is my understanding that prior hospitalization is a standard that's fairly consistent from jurisdiction to jurisdiction. I don't know if the committee members would like to hear from the department as to whether there was any consideration of removing hospitalization as a condition for the issuance of a CTO.

The Chair: Would that be within the principle of the bill? Dr. Massolin, you had a comment you wanted to make on this?

Dr. Massolin: No. I was just going to make the same comment, that the department may want to speak on this issue.

The Chair: So we have a motion on the floor.

Mr. Chamberlain.

Mr. Chamberlain: Thank you, Mr. Chair. Obviously, we're looking for some input from the department. There are two issues at play here, and they are related. Dr. Massolin has referred to one of them, which is the requirement that you be a formal patient before you can issue a CTO and then the trigger that you have prior hospitalization history. The bill was drafted based on the model that Ms Dean is referring to. There are prior hospitalization criteria across the country. They differ. Ours is not inconsistent with those. There have been a lot of concerns about both issues: whether or not a patient actually needs to be a formal patient before a CTO is issued, and what the right test for prior hospitalization or repetitive behaviour is.

The rationale behind CTOs is that you're trying to deal with a patient who's in what we call the revolving door. They've been in and out of episodes. They've been in and out of hospitals, on and off drugs, and they need something more than just a prescription or some advice or some counselling to keep them on the straight and narrow, hence the CTO.

The minister is currently considering a couple of amendments in response to the chair's request to provide input on the House amendments that the minister is proposing. He's looking at some right now, and I'm hoping that he'll be in a position to respond to the committee soon. I won't promise before the next meeting, but I'm certainly trying to get information up to him so he can make some decision before the next meeting. He'll be considering both of those issues. What's currently before him as a proposal is removing the formal patient requirement, maintaining the prior hospitalization but also adding an additional trigger, which is a history of repetitive behaviour and episodes. Hospitalization would be one of the triggers, but there would be an additional trigger, which is the repetitive behaviour.

Mr. Lukaszuk: In that case, we can vote on my motion, and then the minister can simply supplement additional triggers. We can remove the prior hospitalization as a trigger, and then the minister can simply have carte blanche to add to it. Would that work?

Mr. Chamberlain: That's a process question. The minister is considering a similar amendment. Obviously, if this committee recommends amendments, he may not need to bring House amendments forward. It's that simple. That's one of the ones he is considering and I suspect will adopt, but I can't speak for him until he's actually made that decision and given me some instructions on it.

Mr. Shariff: I would suggest that maybe we could proceed with this aspect that's before us with an understanding that when we come back next time, the department will have found a way of including people who have not been hospitalized as also being eligible by certain criteria for a CTO. Is that possible?

Mr. Chamberlain: I will have to defer to the minister, but I believe it would be possible for us to come back with whatever the minister is proposing to do. Whether or not it ends up being consistent with that, I can't make that commitment at this time. It certainly would give the committee some additional information on what the ministry is proposing, which would help them in this deliberation, I believe.

Mr. Shariff: Well, the minister is within his right to decide what he wants to change, but as a committee here we can make recommendations. I think the issue that Thomas is raising is very valid. There are people in the province who have not been hospitalized but may be in need of a CTO. If the bill would allow a section that certain criteria have to be met for those people who have not been hospitalized in order for a CTO to be issued, then I think that makes it easy for us to move forward to the next stage. Nobody is objecting to what is currently before us. The concern is that there is a segment that is being left out.

Dr. Pannu: Mr. Chairman, the cross-jurisdictional review of this provision clearly indicates that what is proposed in Bill 31 is very much similar to what other jurisdictions have adopted, including the most recent case of Newfoundland. There's a great deal of similarity there. I have a fear that we may be blowing the whole issue of mental illness related to homelessness, that the homeless are the ones that really need our help now, not in terms of finding shelter but being put in hospitals or being put under CTOs. I find that kind of approach quite unacceptable to start with. I think the provision here is fine.

The revolving door argument was the one that was used with a great deal of passion and knowledge by Dr. White when he appeared before us last week to argue for supporting this bill. Now we seem to have lost sight of the revolving door argument as the key justification for Bill 31 and have expanded the argument to include the invisible population or silent population, lots of whom are suffering from mental illness and should perhaps be subject to CTOs.

I find that argument objectionable. I take objection to that argument very seriously. I think people who are poor, people who are homeless must not automatically be seen as mentally ill. One of the reasons that being a formal patient is used here as a criterion for a CTO issuance is that there you have prior sound medical evidence, as sound as evidence can be in the case of psychiatric assessment, before us, in our hands before we take someone's liberty away or issue a CTO.

3:20

What's being proposed in the motion, at least to my understanding, is that we want to broaden the criteria to the point where sound medical evidence being available to us prior to the issuance of a CTO in the form of the state of the formal patient or hospitalization is no longer enough. We want to expand that criterion, which to me would be a step in the wrong direction. Very seriously, I think the step would be dangerous, in my view, to the whole issue of people who may be on the street today and tomorrow may be in a house but are suspected of being there because they're mentally ill and, therefore, in need of our help in the form of a CTO. So I'd be very, very seriously opposed to this motion.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. I'm starting to regret that we didn't listen to Dr. Pannu to begin with and not vote the other way around. [interjection] Well, before you start applauding, Dr. Pannu, hear me out because you may feel just the opposite at the end of my comments.

It sort of reminds me of the T model of a Ford: you can have any colour you want as long as it's black. What I'm listening to, Dr. Pannu, is: you can have CTOs whenever you want as long as this and this and this and this and this doesn't happen, and frankly what we really end up with at the end is that there are no CTOs whatsoever. You vote, on one hand, to support them, but then you will find any possible reason to make sure that they don't come to fruition to begin with. That is the stereotypical case of having a cake and actually eating it too.

I did not indicate that every homeless person out there on the street is in need of mental health assistance, but I think you would know better than anybody else around this table that there are many homeless people out there who are in obvious need of mental health assistance, who for many reasons have never received any medical attention relevant to their mental illness. Because of the fact that they have mental illness, they don't check themselves into hospital. They do end up in our emergency wards very often – and I know you do know that – for physical injuries, and they get patched up and released two hours later. They are not in a position to avail themselves of housing and clothing and food and all the necessities of life. Those individuals under your criteria will never benefit from a CTO and will never have been given a chance to partly or fully recover and lead productive lives.

To generalize that I'm saying that every homeless person is mentally ill is a perversion of what I said. What I'm saying is that there are many out there who should benefit, for whom this bill is specifically designed, who under your circumstances will never avail themselves of the proper mental health care that they not only need but deserve.

Now, the fact is that we can sit here till tomorrow morning and come up with restrictions. The fact is, then, that we might as well vote against Bill 31 to begin with because no one, really, ever will be able to benefit from this bill. We all realize – and that's including Dr. Pannu – that the intent of the bill is positive. This bill has been put on the floor of the Legislature to help people out, not to frivolously incarcerate people or deprive them of their liberties. If we want to go through obstacles, then we might as well go back to motion 1 and say that we're against CTOs and cut the discussion because that's what we will end up with at the end anyhow.

Dr. Massolin: Sorry. I don't want to disrupt the flow of the discussion here. I just wanted to point out that this silent patient population comment was made by Dr. White himself in his written submission. He was the one who kind of suggested broadening to an outpatient situation.

Mr. Lougheed: Well, for individuals who would benefit from a CTO, although in their current state of mind they may not recognize that, as we discussed two or three meetings ago, I certainly am concerned that we don't put in so many restrictions that we are not able to act in their best interests. There are all sorts of circumstances, whether it be some kind of a drug-induced psychosis or a closed brain injury. I don't understand those circumstances well enough except that I know they exist. Those persons are deserving of being considered and helped through this legislation and the implementation of a CTO. Their families on their behalf would want to see that they would not be excluded by some criteria. We may be putting too many restrictions around the benefits available.

Dr. Pannu: Mr. Chairman, I am talking about the provisions of the bill that is before us. I have reservations about CTOs. I made them very clear from the very beginning; there is no doubt about this. But the committee having made its decision to proceed with CTOs, then we go to the actual detailed conditions under which a CTO will be issued: to whom it will be issued, to whom it will apply.

I am simply supporting now a provision in the proposed act that I think is most reasonable given that it is very similar to what other jurisdictions have done, unless we somehow argue that the problem of mental illness is exceptionally high, exceptionally serious in

Alberta alone. There is Ontario, there is Newfoundland, there is Saskatchewan, and there are others who obviously are dealing with the same issue, and they're moving cautiously to expand the provisions of CTOs beyond what's proposed here. I think the case will be to argue on the basis of the fact that Alberta has all of a sudden come up with a very exceptionally serious problem related to mental illness and, therefore, the dangers that it entails and poses to our security and the security of those who are ill from it.

The last comment I want to make is that, you know, homelessness has to be understood as a social issue, first and foremost, not as a medical issue, not as a mental issue. Homelessness does result in mental disorders, physical disorders, and all kinds of other maladies that flow from it, but primarily homeless people should not be seen as potentially in need of our help in terms of the issuance of CTOs. They need assistance but not by being labelled as mental patients. That's the danger there.

I'm not suggesting that Mr. Lukaszuk is saying every homeless person. I'm suggesting that he is saying that they are mentally ill. We have to not conflate these two issues: the issue of mental illness and the issue of homelessness. They are separate issues. One is a medical issue; the other is a social one. One can lead to the other and vice versa, but let's not conflate the two. I just want to make that clear.

3:30

The Chair: Okay. Any other questions? I don't have any other on the list.

We have a motion on the floor that

the requirement for a 60-day prior hospitalization be deleted.

Is that correct?

An Hon. Member: That's correct.

The Chair: Those in favour of the motion? Those opposed? Could I have the opposed again? I believe that's carried. Is that correct?

Mr. Shariff: Yes. You're right.

The Chair: Okay.

Dr. Massolin, carry on.

Dr. Massolin: Thank you, Mr. Chair. The next issue is a related issue, and it has to do with the prerequisite of having a prior CTO as being a condition for admission under a new CTO. Obviously, when you implement a new act, this consideration would not be active, but down the road it might be an issue. The other thing that I should point out is the fact that the other jurisdictions that have community treatment order legislation, including Saskatchewan, Ontario, and Newfoundland, all have that condition – has been the subject of a prior CTO – in their legislation.

The other issue to consider here is that one of the submitters indicated that there should be a time limit placed on this prior CTO. In other words, the patient who's possibly the subject of a CTO should have that prior CTO situation considered only within a two-year period. If it's more than two years, then that condition would not enter into the equation.

Mr. Shariff: I just have a question. I don't know if we have the expertise around the table, but can somebody explain to me from a medical perspective: what does the two-year time limit have to do with this?

The Chair: Mr. Chamberlain, do you have any comments on that?

Mr. Chamberlain: Mr. Chair, I'm not sure there's any magic to a two-year period. One of the things we are considering is whether it should be a three-year period. It's just a question of not going back forever and having somebody's ancient history being used to consider their current situation. There isn't a lot of magic to the time frame; it's just having some end point.

Mr. Shariff: I'm just thinking this: if a person is in need of treatment, then the past is irrelevant, whether it happened two years ago or five years ago. If the two professionals involved feel that this person is in need of treatment because he or she is not accessing services voluntarily, I'm just wondering whether the two-year time limit is relevant at all.

Mr. Chamberlain: Clearly, a physician, in examining a patient, would be considering for treatment purposes a history. If a patient has a history of mental illness and admissions to hospital, that's something they're going to be factoring in when they're looking at treatment. What we're talking about now is just a trigger for using the somewhat extraordinary remedy of a CTO and having some time frames around it so that it's the recent history of the patient that's being considered when they're making that decision.

Dr. Massolin: I just wanted to add to that that, first of all, it was the Canadian Mental Health Association that was the submitter who actually made this comment and this recommendation. Just to reinforce what has already been said, there may be a perceived stigma attached to having a CTO on your medical records. The idea is that the two-year provision might alleviate that concern.

The Chair: Are there any other comments on that? Does the committee wish to make any recommendations on that, or leave it as it is? I don't see any ideas coming forth, so I'm assuming that there's no desire on behalf of the committee to make comment on that.

Mr. Shariff: So the current is the status quo, that there is no time limit being considered?

The Chair: No time limit.

Mr. Shariff: Yeah. Okay.

The Chair: Would we wish to put a time limit in?

Mr. Shariff: No.

The Chair: Okay. No motions coming forward? I guess that we'll carry on to the next issue. Before we do that, we're going to take a five minute break.

[The committee adjourned from 3:35 p.m. to 3:43 p.m.]

The Chair: If we could take our seats, we'll reconvene.

Are you ready to proceed, Dr. Massolin? Okay. We'll continue then with 2.2.1.c.

Dr. Massolin: Yes. Thank you very much, Mr. Chair. I guess the next issue that we should turn our attention to is the issue of patient consent. The left-hand column, the first column there, sort of isolates an issue. The issue follows that there's an override provision in this bill with respect to a competent patient's or substitute decision-maker's consent, an override of a competent patient's

consent as to whether or not to undergo treatment. It appears – and I stand to be corrected on this – that Alberta is the only jurisdiction among those in Canada that have CTO legislation that has this override provision.

The question that committee members may want to consider here is whether there is an issue with respect to a Charter challenge. You may want to consider asking representatives of the department whether or not a Charter issue was contemplated.

The Chair: Could you just outline for us briefly, to refresh our memories, what a competent patient means as opposed to an incompetent patient?

Dr. Massolin: Maybe, you know, others can add to my sense of this, but to put it in layman's terms, a person that's able to make a willful and a mentally able decision as opposed to a person affected by a mental disorder that would not have that same capacity. Now, I know that there is a legal definition, which I am afraid I cannot indicate here right now. Maybe I can call on one of my legal colleagues here to elaborate further.

The Chair: I guess the point I'm trying to make is that if you're a competent patient, you may consent to a CTO. Why would you need a community treatment order when you can just consent to treatment or seek treatment as opposed to consenting to an order for treatment?

Dr. Massolin: I'll defer to Katrin on this.

Ms Roth von Szepesbéla: If I may be of assistance. The issue doesn't arise if a competent person consents to the CTO. That is provided for. However, if a competent person does not consent to a CTO, two physicians can override that refusal to receive treatment, including drug treatment, and that is the issue here. Does that help?

The Chair: Not entirely.

Ms Roth von Szepesbéla: All right. Let me try again. The proposed section 9.1(1)(e) provides for several things. On the one hand, a competent patient may consent to a CTO, so we're okay on that. If a patient is incompetent, which means not capable of making decisions that are in the best interest of the patient himself or herself, then another person, either an agent or a guardian or even a public guardian that was appointed to act on behalf of that incompetent patient, may consent to a CTO.

The Chair: Katrin, just the first statement: a competent patient may consent to a CTO. A competent patient could seek treatment, then, without going through a community treatment order or an order. If he's competent, why would he consent to a CTO instead of just consenting to go and seek treatment without an order to get treatment. It's between seeking treatment and getting an order to get treatment. I don't know if I'm making myself clear.

Ms Roth von Szepesbéla: Mr. Chairman, again if I may. I can't comment on how much or how little sense it makes or on whether a competent person would in fact agree to a CTO. It is provided for. Perhaps the department may wish to comment on that. What I would like to point out is that the issue here that we're trying to highlight in preparing this document for the committee is that in the event that a competent person does not consent to receiving treatment in the form of a CTO or under a CTO, that person's refusal to consent to a CTO can be overridden if two physicians decide that a CTO, against the wishes of the competent patient, is in the best interest of the patient.

The Chair: Okay.

Mr. Lougheed: I'm as confused as you are, Chair. Could the department illuminate us?

The Chair: On the wording, you mean?

Mr. Lougheed: Why is it there?

Mrs. Mather: It sounds like the assumption is that if they give consent, they're competent.

Mr. Lougheed: Can the department comment on it?

The Chair: Mr. Chamberlain, do you have any comments on this?

Mr. Chamberlain: Yeah. Perhaps I could assist and provide some input that may explain the purpose of the sections generally.

The concept of competence is in fact defined in the act, and we're not proposing to change that. It's in section 26. It talks about a person being competent if they're "able to understand the subject-matter relating to the decisions and able to appreciate the consequences of making the decisions," which is a fairly standard competency test. So when you're dealing with CTOs, you're quite correct: a person who has competence to make treatment decisions could choose to make treatment decisions and could choose to go on a course of medication or to see a counsellor on a regular basis or whatever.

The basis behind the CTOs, as Dr. Pannu indicated earlier, is that you're trying to address the revolving patient, the patient who may at a certain point in time deteriorate, may become a risk to public safety, may become a risk to themselves. If you've got a patient that's got that kind of history, the potential advantage of a CTO would be that he could agree to consent to a treatment regime that would see him or her seeing a physician on a regular basis or a counsellor or taking a certain type of antidepressant medication or whatever the treatment was on a regular basis. Then the legislation provides for tools to bring that patient in for reassessment if they fall off the treatment regime.

3:50

In other words, they are consenting to an order which sets out the treatment regime, and if they're competent, they're doing it at a time when they're competent, recognizing that because of their history if their medication gets out of whack or if they go off their medication, it may become necessary to reassess them, to admit them as a formal patient. The CTO just gives them an additional tool to help monitor that and create some additional remedies for a physician or a psychiatrist to bring a patient in to reassess them on a more flexible and easier basis.

I don't know if that helps.

The Chair: Well, as I would understand it, if a patient is at a level of competency to consent to a CTO, given some of the concerns that people have about having a CTO on their record or on their health record, why would they ever do that and not just consent to seek treatment instead of through a CTO?

Mr. Chamberlain: I think the answer is that CTOs are issued when a patient meets the criteria for admission as a formal patient, so

you're talking about somebody who is at the point where they meet those criteria. The CTO is an alternative to detaining them in a hospital as a formal patient. It's allowing them to leave the facility, leave it on a treatment regime or a counselling regime or whatever the appropriate treatment is for the individual as an alternative to remaining as a formal patient.

The aspect of the consent would be that you literally have two physicians, one who's a psychiatrist under our current act, who would say: this person meets the criteria for admission, but we think they're a good candidate for going out as long as they stay on a certain treatment regime, as long as they report to their physician every month, or whatever the requirements are for that particular patient.

I've been looking at this as an additional tool that may or may not fit a specific circumstance or a specific patient. The competency piece is that he could be consenting to it at a time when he understands what the consequences of that are, recognizing that it has repercussions for him, which is that the physician may require him to come back into the facility if he fails to maintain the treatment regime that's being suggested in the community treatment order.

The Chair: Okay.

Thomas, did you have a question?

Mr. Lukaszuk: Yeah. I would like to hear from our legal counsel because I'm wondering what the ramifications are. If you determine me to be a competent patient, which means that I can competently make decisions and I understand the consequences of my decisions, and then, given that, I choose not to avail myself of mental health care treatment, fully understanding the negative consequences of it to myself – I made that competent decision not to – how can you then bring forward a treatment order which, in essence, requires passing the test that I am not in a position to make competent decisions about my personal care and you're overriding that? Now, obviously, if I am competent and I chose not to, that is something that I would be appealing. What you're really saying in this piece of legislation is that you find me competent as long as I agree with your decisions, and then you agree with my competence. But the moment I disagree with your decisions, you find me to be incompetent. Isn't that really what that section is saying?

Legal counsel, could you address that?

Ms Dean: I'm looking at page 4 of the bill right now. Where consent is not provided, CTOs can be issued where the issuing physicians are of the opinion that likelihood of harm may occur to others. So there are third parties involved, and that's when the consent override would occur according to my reading of the bill. You are correct in the sense that the patient could meet the competency test. However, the override would be triggered where there's a likelihood of harm to others. That's the wording in that subclause.

The Chair: Did you have any further comments?

Mr. Lukaszuk: I'm wondering: in this case, then, doesn't that refute the validity of the initial competency test? Did the patient make a competent and hence rational decision in choosing to do harm to others by not availing himself of medical help? The answer to that would be: obviously not. No competent, rational person would expose society to harm by choosing not to avail himself of help. Obviously, that person isn't competent to begin with, so you have this bit of a catch-22. You know, if you go with the override, what you're really doing is passively consenting to the fact that your initial competency test was not valid. If your competency test was valid, that person should have arrived at the rational decision.

Ms Dean: Well, I'm just going back to section 26, which is what Mr. Chamberlain referred to. Again, mentally competent for the purposes of the Mental Health Act means that the person is able to understand the subject matter relating to the decisions associated with treatment. They may be able to understand it, but they still may pose a harm to others. I think that's the scenario that that consent override is dealing with.

The Chair: You wish to supplement, Katrin?

Ms Roth von Szepesbéla: If I may. It sounds to me that the gentleman in the back may equate competence with a lack of ill will. I think it's possible to have a competent person who knows and appreciates that treatment would alter and perhaps restrict the individual freedom in the sense that they may subject themselves to treatment, report frequently to physicians, and perhaps take medication yet full well knowing that still refuse to take that treatment, thereby posing a danger to others.

Mr. Lukaszuk: I appreciate what you're saying, but my dilemma is that the purpose of CTOs is not to deal with ill will. There are a lot of ill-willed people out there whose conduct jeopardizes the public at large, but we would not issue CTOs against them. You know, a person driving at 190 kilometres an hour through Jasper Avenue is definitely ill willed, but we would not issue a CTO against that person in most cases.

Ms Roth von Szepesbéla: Mr. Chair, if I may. That would be a healthy person. There's a difference with a mentally healthy person. This act deals with mental disorders.

Ms Dean: If I just may add, Mr. Chair, that a question for this committee to consider is whether the consent override is an appropriate part of this bill.

Mr. Shariff: You know, I'm agreeing with Thomas's arguments, but I can also think of one example that I can share about a constituent of mine who has a mental health disorder. So long as he takes his medication every day, he comes across as a very competent person. The day he doesn't or the week he doesn't take his medication, you can see the difference. I don't even know whether that argument holds any logic, but I see that the point you're making is: how do you deal with competent people, or how can a competent person meet the criteria of a CTO?

4:00

If the example that I've given you can lead to some better service down the road, then that would be the kind of person who in the right frame of mind with the right medication taken that day may consent but two days later in the process of the treatment may not be able to make rational decisions and, therefore, will say: "Okay. Confine me, treat me. I'm giving myself up for 60 days, and I would like to see a good outcome at the end of it for my long run."

Mr. Backs: Focusing on consent override in Bill 31. I suppose this question is best put to the department. In column 3 on page 7 it states that "the consent override in Bill 31 appears to be unique in comparison to other Canadian jurisdictions." This bill is moving beyond other Canadian jurisdictions in this area. What is the rationale behind that?

Mr. Chamberlain: Mr. Backs, the rationale is simply to provide an additional tool for a patient who is potentially a harm to others. That section which allows a CTO to be issued without either consent or a substitute decision-maker's consent applies only when the patient is potentially a harm to others.

Going back to my earlier comments, this would apply where you've got patients who could be admitted as formal patients; they meet that criteria. So there's an alternative. Instead of detaining somebody in a facility as a formal patient, where it's appropriate to release them on a CTO, even though they're not consenting to the CTO, but where the physician, psychiatrist believe it's appropriate and they will be able to comply with the terms, it's an alternative to detaining them. But it is being done against their consent; hence, the limit on that, which is that it's a harm to others.

We're looking at a public safety perspective. We're not proposing to do it if it's just a harm to self, where, as Mr. Lukaszuk indicated, a patient can make decisions about how they want to treat themselves. If they are going to have incidents or cycle down a little bit but aren't going to be a harm to others, then if they're competent to make that decision, they can do so.

It is going further than any of the other provinces, but it was an attempt to create additional alternatives, additional tools for formal patients but recognizing that there have to be some limits on it for Charter purposes.

Mr. Backs: Yeah. It's very sensible, but is there any sense why the other provinces have avoided that in their recent legislation?

Mr. Chamberlain: I can't answer that.

Mr. Backs: Okay.

Dr. Pannu: It seems to me, Mr. Chairman, that the override provision is something that we shouldn't approve, shouldn't support, so I will move in a moment that it be deleted.

I think the issue is of competence. A competent patient being compelled to take psychiatric treatment would seem to be, really, an unreasonable restraint on the liberty and security of that person. I think that's certainly an issue. That's why I guess other provinces have decided to refrain from going this route. So I would move that we delete the override provision in the proposed act.

The Chair: Any discussion on that motion?

Mr. Lougheed: I appreciated the comments made by Mr. Chamberlain on behalf of the department and the definition of competent that's in the act already. I think in my mind it has clarified that this is okay.

The nature of the mental illness a person has – he may choose to be placed under a CTO at some point in time when he would be considered competent in his best interests because he recognizes that sometime a little while from now he may want to have the benefits of a CTO. I think that's an important opportunity for individuals during those times when they would be considered competent to make that decision on their own behalf without having, sometime down the road, somebody else making it on their behalf when they are no longer competent. I think this, as explained by the department, seems to make sense to me.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. My concern with this section is that, first of all, this act is not intended to deal with competent persons to begin with. That's the very nature of the act. My concern is that if we find, according to a well-defined criteria or medical opinion, that a person is competent to make a decision – and as the department and legal counsel have indicated, a competent person is aware of his actions and consequences of his actions, irrelevant of whether those consequences or good or bad or whether those actions are positive or negative. If that person who is found to be competent to make those decisions chooses to take negative actions which will lead to negative consequences, that doesn't make that person mentally ill. It makes that person ill-willed. They're choosing to do wrong, and they're willing to accept the negative consequences of it. That doesn't mean they meet the criteria of CTO.

I understand the cyclical nature of mental illness, but the problem with this act is that we are assessing this person at this moment in time. So at this moment in time, irrelevant of whether they were better off when they took medications yesterday or not or will tomorrow or not, at this moment in time are they competent? If the answer is, "Yes, they are," even though they choose to take negative actions, we can't compel them to treatment because they made a competent decision. It begs the question of whether our decision whether they were competent was right to begin with.

The whole issue of assessing competence and then overriding competency if a person does something that we simply disagree with is something that I have a difficult time even comprehending in the context of this act.

The Chair: Any other comments?

Dr. Pannu moved that

the override provisions of Bill 31 be deleted.

Dr. Pannu: In the case of competent patients, yes.

The Chair: Yeah. On the competency, which would be 2.2.1.c in the three-column document, that that be deleted. Seeing no other discussion on the issue, those in favour of the motion? Those opposed? The motion is carried.

Okay. Dr. Massolin, if you want to continue with 2.2.1.d.

Dr. Massolin: Yes. Well, the good news is that if we take out that consent override, we don't have to deal with 2.2.1.d because that is no longer there.

The Chair: We're on to which one, then?

Dr. Massolin: Then we're on to 2.2.1.e, Disclosure of Health or Personal Information, the first issue on page 8. Here we have an issue that was raised by one of the submitters from the Information and Privacy Commissioner in terms of ensuring that the collection of personal or health information disclosed pertaining to a CTO is authorized by the applicable privacy legislation. You can see the section of the bill that currently prescribes the content. The committee members may want to consider seeking assurances from the ministry on this issue.

4:10

Dr. Pannu: Mr. Chairman, in terms of action required, what would be the action? Simply seeking assurance, or should it be in the legislation?

Dr. Massolin: Just that Bill 31 is in compliance with that privacy legislation.

Mr. Shariff: By law it has to be.

Dr. Pannu: That section 2.2.1.e comply with the privacy legislation of the province: that would be the motion that I would make.

Mr. Shariff: Does it even require a motion? Isn't that the law in the province?

The Chair: Shannon, do you have a comment on whether it's required or not?

Ms Dean: I don't think there's any motion required unless there are specific amendments that the committee is looking for. I don't know if the committee has enough information to make that decision at this point. I just want to point out that that comment, I believe, came from the Information and Privacy Commissioner, and based on brief discussions with department officials, I understand that there are provisions in the Health Information Act that cover this off. I would call upon Mr. Chamberlain to provide more comment on this.

The Chair: Mr. Chamberlain.

Mr. Chamberlain: Thank you, Mr. Chair. The Privacy Commissioner did request or suggest looking at a few sections, which we have done. As the bill is currently drafted, we don't have any concerns with respect to health information issues. The Health Information Act does apply. We believe it covers the issues that the commissioner had asked about. I don't believe he said that there were problems; he just said that these things need to be looked at.

If the minister goes ahead with one of the proposed changes with respect to a formal patient requirement for a CTO to be issued, then as a corollary amendment to that there will be a minor amendment required to the HIA. The HIA does have provisions in it that deal with the nearest-relative provisions in the Mental Health Act and provide that the nearest relatives under the Mental Health Act for formal patients have powers of patients under the Health Information Act. If we make a change to the formal patient requirement, we'll need to make a minor amendment to that section to make it consistent. The department didn't have any particular concerns with the health information issues raised by the commissioner. We believe they're appropriately dealt with.

The Chair: But the question remains: is a motion required of this committee to do something, or does the law already require it?

Dr. Pannu: I'm willing to withdraw that motion, Mr. Chairman.

The Chair: So no action is necessary by the committee on this? Is that agreed? Okay. Carry on.

Dr. Massolin: Thank you. The next consideration is 2.2.1.f, and it has to do with renewal of CTOs. I just would direct the committee's attention to the first bullet point in the first column, and that is the recommendation on the part of one submitter to add a six-month autoapplication to have a review panel to review the CTO. So after a six-month period you'd have this autoreview provision.

I'd just like to point out that section 9.3 of the bill already provides for an unlimited six-month renewal of the CTO prior to the expiration, right? But there may be a question here whether if not a six-month autoreview process, you could just have an autoreview process, the thought process being in this that the patient has the option to request a review but may not avail him or herself of that option. Should there be an autoreview process in place here? What are the disadvantages and advantages of that?

Mr. Shariff: At a previous meeting I had raised this issue for consideration, that if three CTOs have been issued, then there be a mandatory process for a review. This is to protect the patients and their rights and their interests. I don't see that having come through, but the idea was that, look, if there are three consecutive CTOs, then let's take that decision to another body of professionals within the same field to just oversee it to make sure that the patient's rights and treatment requirements are being met, rather than just prolonging the CTO because we don't have services available in a region of Alberta.

Dr. Pannu: A clarification, Mr. Chairman. You made reference to three CTOs having been issued. In other words, it would take a year and a half.

Mr. Shariff: Well, I had suggested at some stage very early on that because an unlimited number of extensions can be granted currently, a person could be under a CTO for 10 years. I'm saying: let's set a standard that after a certain period of time, if the person continues to be under a CTO, then there be a professional body that's mandated by legislation to review this to make sure that it meets the interests and the treatment requirements of the patient. [interjection] Automatic, yeah.

Dr. Pannu: Mr. Chairman, could our legal staff and research staff review the similar provision in some other piece of legislation across the country? How is this notion of either unlimited renewals or mandatory requirement to review reflected in other acts in other provinces?

Ms Dean: If I may just begin the discussion, then I'll pass the discussion to my colleagues. I'm not sure if this is going to your point, Dr. Pannu, but the issue of the automatic review of a CTO I think was discussed at the previous meeting in the sense that it's a measure that protects patients' rights.

One of the things that came out of the public hearings was that Newfoundland seemed to have perhaps more protection on that front. One thing the committee may want to be aware of is that in Newfoundland they do have this automatic review of a CTO, I believe after the second renewal, but I will call on my colleagues here just to highlight the details for you.

The Chair: Katrin.

Ms Roth von Szepesbéla: Thank you, Mr. Chair. The issue of the renewal of the CTO also speaks to the issue of CTO reviews, which is point 2.3 in this document. I've tried to summarize the Newfoundland legislation.

Newfoundland also has CTOs which are of six months' duration. However, after a second renewal, which would mean after 12 months, there is a provision that triggers a mandatory review by a review panel. Under the Mental Health Act as it currently exists, there is already a review panel established, and there's also a form of mandatory review established, not for CTOs but for cancellations of admission certificates and renewals thereof, which is section 39 of the Mental Health Act. So if the committee decides that it would be beneficial to have a mandatory review, that is a section that that could be added to.

I also wanted to clarify that the six-month CTOs do expire after

six months, subject to the renewal. As you pointed out, sir, it is correct: there is an unlimited number of renewals permitted. However, the patient also has a right to apply for review of the CTO. So there is a mechanism for the patient to seek a review of the CTO by a review panel to begin with and any renewal thereof. However, a mandatory review would cover cases where perhaps the patient or an agent on behalf of the patient has not made an application for a review of a CTO.

Mr. Shariff: But that would require competence of the patient, to ask for a review.

Ms Roth von Szepesbéla: Well, in the event of an incompetent patient, it would be the representative of the patient who has the right to apply for a review.

Mr. Shariff: Well, then, Mr. Chairman, maybe this is an appropriate moment to make a motion that

> we do include here a mandatory review after two CTOs have been issued.

The Chair: Okay. Any discussion on that motion?

Mr. Backs: Just a clarification: that would be on the third.

Mr. Shariff: After two CTOs expire, yeah, a 12-month period. That

> before a third one is issued, there be a process whereby an independent panel reviews whether the patient should be granted a third CTO or not.

The Chair: Any other discussion? Those in favour of that motion? Opposed? That's carried unanimously.

We're not going to get everything done on the agenda today by the looks of the clock. Are there some things that absolutely have to be accomplished today?

Outstanding Research. Did we want to maybe move to that right now? Dr. Massolin, do you want to bring us up to date on that?

4:20

Dr. Massolin: Thank you, Mr. Chair. I will, yes. There was just another research task that was brought up at the last meeting. It had to do with the issue of standard psychiatric treatments that are available compared with alternative treatment therapies. The research question that was brought up was basically to ask for a comparison of the effectiveness of both of those treatments in terms of treating patients with mental health disorders. I recommended at that point that perhaps it would be a good idea to consider asking that question of somebody with particular expertise in the field. One option might be to approach the ministry for some guidance on this. A possibility, as well, is maybe a third-party alternative in terms of asking somebody who's an expert.

Ms Dean: Mr. Chairman, if I may just throw another option into the mix here. Based on the discussions today, the committee may not require that information. I'm not sure where you're going with that request, but again we're here to take your direction.

The Chair: Questions from the committee? Is there any optional research anyone would like to see?

Dr. Pannu: I think that at the last meeting the committee was of the view that we could benefit from having that review done and available to us. What has changed today that in your judgment changes that? I think it's a very useful thing to consider, you know, as additional information.

Ms Dean: Certainly, if the committee members want this as additional information, I'm not suggesting that you not proceed with that request.

One thing I would just like to draw to your attention again is that Bill 31 deals with some specific things, and prescribed treatment isn't, technically speaking, part of that bill. I think this research may be useful background information, but what the committee could do with that in terms of amendments to the bill would be very limited.

Dr. Pannu: I think you're right on that.

Would it not be consistent with the principles of the bill to bring that in as an amendment to some section of it? I'm seeking your advice on it.

Ms Dean: The precise forms of treatment that psychiatrists or other physicians prescribe, that's not addressed anywhere in the bill. That's dealt with through the profession in terms of how they handle medical situations. However, if this committee wanted to make some recommendations with respect to other considerations that the ministry may want to pay attention to, that's fine, but what I'm saying is that you're constrained with respect to that topic in terms of what you can do with the bill.

Mr. Shariff: You know, I'm just compelled to make this remark. I'm not so sure that we politicians are competent to make that decision.

The Chair: My question, Shannon, is that making recommendations to the type of therapies, whether they're alternate therapies or traditional therapies, I believe would be outside the scope of our mandate as a committee and beyond the principle of the bill.

Ms Dean: I would agree, Mr. Chairman.

The Chair: We probably don't require, then, anyone from the department coming in and making those presentations. Is that agreed?

Hon. Members: Agreed.

The Chair: Okay. What else do we need for the next meeting? Is there any direction to staff that anyone needs to have? That's for October 18.

Dr. Pannu: There was one other thing in the review, I think. It was apprehension for noncompliance. What section of the bill deals with that? I saw it somewhere here.

Dr. Massolin: Yes. That's the very next item that I assume we'll be picking up on next time.

Dr. Pannu: Oh. Okay. That's on the agenda.

The Chair: What was that, Dr. Pannu?

Mr. Flaherty: He's satisfied. Don't push him.

Dr. Massolin: It was just a question as to where we'd pick up next

time round. So we'll come on to, I assume, if we're dealing with this document next time around, apprehension for noncompliance. That's the next issue.

The Chair: Yes. That's probably a good place to start since that's the place we ended.

Just a reminder that the next meeting is October 18 between 1 and 3:30 p.m. We also have October 25, 1:30 to 4:30 p.m., and October 31, 1:30 to 4:30 p.m. Apparently, it can be a dress-up meeting if you want because it's Halloween.

Mr. Shariff: So why is the 18th only until 3:30, just based on today's proceedings?

The Chair: I can't remember, but that was what they agreed to.

Mr. Shariff: I'm just wondering. You know, we drive up this far, long distance.

The Chair: I'm prepared. Is everybody agreed to make it 4:30?

Mr. Shariff: Let's keep it 3:30, then.

The Chair: There was probably a reason by some of the members.

Mr. Shariff: Okay.

The Chair: So that's 1:30 to 3:30 on October 18, and the other two meetings are 1:30 to 4:30.

Mr. Flaherty: You've sent out a notice on those, Mr. Chair, have you not?

Mrs. Dacyshyn: Yes.

Mr. Flaherty: Good. No problem.

The Chair: Motion to adjourn?

Mr. Backs: So moved.

The Chair: Dan Backs moves that we adjourn. Those in favour? That's carried.

[The committee adjourned at 4:28 p.m.]