Title: Thursday, October 18, 2007 Community Services Committee
Date: 07/10/18
Time: 1:01 p.m.
[Mr. Marz in the chair]

The Chair: Good afternoon, everyone. I'd like to call the meeting to order. My name is Richard Marz, chair of the Standing Committee on Community Services.

We'll go around the table and introduce each other. We'll start at my right with our deputy chair.

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

Mr. Johnston: Good afternoon. Art Johnston, Calgary-Hays.

Mr. Shariff: Shiraz Shariff, Calgary-McCall.

Rev. Abbott: Tony Abbott, Drayton Valley-Calmar.

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

Ms Dean: Shannon Dean, Senior Parliamentary Counsel.

Mrs. Dacyshyn: Corinne Dacyshyn, committee clerk.

The Chair: Welcome. Has everyone had a chance to look at the agenda? If so, could I have a motion approving the agenda? Mr. Flaherty moves approval of the agenda. Those in favour? That's carried.

Is Mr. Hancock here?

Mrs. Dacyshyn: No, he's not.

Mr. Johnston: I just wanted to make a note that it does say 1:15 for Mr. Hancock today.

The Chair: Okay. We will review the proposed amendments, or did you want to move to the standing committee discussion on the follow-up items from last meeting? Did you want to do that now? I'll ask Shannon Dean, Parliamentary Counsel, to take us through those items that were left over from the last meeting.

Ms Dean: Thank you, Mr. Chairman. Last week there was an item of discussion that was tabled pending some wording to be prepared by myself for the committee members' review this week. You will recall that the issue surrounded authorizing other types of health professionals, such as psychologists, to be involved in the issuance of community treatment orders under certain circumstances.

Just to refresh members' memories, the current wording of Bill 31 includes a two-physician requirement; one must be a psychiatrist. There is an exception where no psychiatrist is available which provides that two physicians are authorized to issue a CTO provided that one of the physicians has been designated by a regional health authority and the designated physician consults with a psychiatrist prior to the issuance of the CTO.

At the October 11 meeting this committee supported the option of other health professionals being involved in the issuance of the CTOs. There appeared to be general agreement that the requisite qualifications should be addressed through regulation. My question for the committee is: is it your intent for this to have application only where a psychiatrist is not available, which would entail an amendment to section 9.7 of the bill, or does the committee wish this proposal to have broad application, whereby section 9.1 would be amended to remove the reference to one psychiatrist and one physician and replace it with more generic wording that would simply refer to two health professionals who meet the qualifications specified in the regulations?

The Chair: Any questions from anyone on that?

Rev. Abbott: I'm wondering if the department has any recommendations or suggestions on this. Personally, I would rather see us go with the latter wording, but I would be very open to hearing what Fern or Martin has to say about it, if I'm allowed to ask that, Mr. Chairman.

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

Mr. Chamberlain: Mr. Chair, I've just had an opportunity to review it, and Ms Miller just arrived, so she hasn't had a chance to look at it yet. What we discussed last meeting I think in response to Mr. Shariff's question was a suggestion that we go to dealing with "qualified health professionals" as the term in the act or some term like that and then putting the specifics in the regulations.

My personal view is that I would favour the second option because that creates more flexibility for the department. We can maintain the status quo for the time being in regulation until we've determined what other health professionals might be appropriate and done the necessary consultations with the colleges to determine that.

The Chair: Any other comments?

Mr. Shariff: I would support the second motion.

Mr. Flaherty: Mr. Chair, if I may. Does that imply that when we use the words "health professionals," the person designated would have suitable training to do this? I'm just not sure. When you use the words "health professional," it would be my understanding in approving this that they would have the proper professional background to be doing this job.

The reason I mention this: I had discussed a little bit of this deliberation that we had regarding psychologists during the week, and it was suggested to me that when called upon, these people would have to have the right backgrounds and right training to do this job. I'm just seeking the information regarding this to see that the people that we are talking about would have the background to do the work that we're asking them to do.

Thank you, Mr. Chair.

The Chair: It's my understanding that those health professionals would have to meet qualifications that would be outlined in the regulations. That could be included in a motion if someone wants to make a motion in that regard.

Mr. Flaherty: I will.

Mr. Shariff: It's already there.

The Chair: Okay. I'll just try to say what you would like to move, Mr. Flaherty: that the committee recommend that

> section 9.1 of Bill 31 be amended to remove the reference to one psychiatrist and one physician and replace it with a wording that would allow for a CTO to be issued by two health professionals who meet the qualifications outlined in the regulations.

Any discussion on that motion?

Dr. Pannu: Mr. Chairman, there are two proposed motions before us, but I guess we're dealing with the second one now.

The Chair: I understood that Mr. Flaherty moved that. Is that correct?

Mr. Flaherty: Yes, that's correct.

1:10

Dr. Pannu: All right. I heard the department representative's preference for this motion premised on the need for flexibility. Yes, in health matters flexibility is important, but at the same time, mind you, there ought to be in place fairly strict rules on what qualifications are appropriate for the purpose. You know, psychiatrists are at the moment at least recognized as people appropriately qualified to make judgments on mental illness. Psychologists have made an argument that they be included among those who are. I have a concern that while all psychiatrists with that label would be qualified to make those judgments, not all psychologists would be.

That raises the issue of permitting, by way of supporting this motion, some psychologists who are not qualified, in fact, to make these very important judgments. We have to do both for the health of individuals, and we need as watertight a judgment as possibly can be made. Also, the question of freedom of people: CTOs will affect that too. Given these two considerations, I think the consideration of flexibility should be balanced against these other possibilities that might be increased if we relax the conditions with respect to who can make these judgments. This broad and generic version that is contained in motion 2 I think carries some risks that I am concerned about.

The Chair: On this point, Reverend Abbott.

Rev. Abbott: Thank you. Yes, I'd like to speak in favour of the motion because I do believe that as we heard from the Psychologists' Association when they came during the public hearings, they feel that they are qualified to make these judgment calls. My understanding of a psychiatrist is that all psychiatrists are psychologists, but not all psychologists are psychiatrists. In other words, one has the additional credentials of a medical doctor, so basically it's a psychiatrist who can issue prescriptions. That's the difference between a psychiatrist and a psychologist. I would say that a psychologist would be qualified, and therefore I think it is imperative that we do change the wording to include them and to be more flexible. If it pleases the committee, we could perhaps add the words "health professionals who meet the mental health qualifications specified in the regulations" just to be very specific that we're talking about mental health here.

The Chair: Were you proposing an amendment at this time?

Rev. Abbott: Well, I'm just throwing it out as a point of debate.

Mr. Shariff: I think that Dr. Pannu makes a very interesting and a very important point. I believe that last time when we met, we did raise that issue, that not every psychologist may be qualified to issue a CTO. That's why I think the direction was sent to the department that they work in consultation with the professional bodies to determine what category of psychologist could be designated by the professional body to have the qualifications necessary to issue a CTO. Similarly, the same would be applying, I believe, to the physicians. That might be a generic application by the College of Physicians and Surgeons, but I believe that that was the direction that we sent, that it must be people who do have the necessary qualifications, and not every psychologist is able to issue it.

The Chair: Mrs. Mather.

Mrs. Mather: Yes. Thank you. I feel very strongly about this motion. I think that it needs to be supported. This bill is the beginning of the recognition of a problem that we have in our province. It's a really good step, but in order for it to work, we need the experts to implement the services. Without the services and supports this bill will be meaningless. Now, psychologists – and we're talking here clinical psychologists, okay? – are trained.

I think that what we need to do here is open up the idea of treatment as being more than medication. All right? If we're just going to talk about issuing drugs, we're missing the target. I think that in looking at this, therefore, we need to broaden the spectrum here of people who are trained within mental health, properly trained and have the skills – that could be psychiatric nurses, clinical psychologists, and so on – so that treatment, again, is not just prescriptions and medication but that treatment involves other resources, and we are making them available.

I strongly support this, and I think that the motion is clear. It says, "qualifications outlined in the regulations." That would be done in this case with psychologists, with the College of Psychologists, and I think it would be pretty black and white, pretty clear.

Dr. Pannu: Mr. Chairman, I've heard, with a good deal of attention to my colleagues, comments on motion 2. We are trying to facilitate, particularly in small communities, the availability of help for people who suffer with mental illness when they need it and as soon as they can get it. We're trying to do this. There's no dispute over this. I think we are all focused on this. These are our intentions. They are good intentions.

My only concern is that by passing this motion, we might set in motion turf wars between psychiatrists and psychologists, which I think would be counterproductive. If that happened inadvertently, if we didn't anticipate this, if we didn't talk about it at least, how to address this if it happens, I think that will be counterproductive to the intentions that we have. If somehow in the development of the regulations some sort of formal advice is sought from psychiatrists as well as clinical psychologists and taken into account in the development of regulations, that will be helpful. That will help, I think, defuse the possibility. We all know that professional groups do have their turfs, and they want to protect them. We want to make sure that we don't set in motion unintentionally some strife, you know, between these groups because we want them to work together rather than work against each other. That's my concern.

The comment was made by you that all psychiatrists are psychologists, but I think psychologists wouldn't agree with that. All psychiatrists have first a medical degree, not a degree in psychology. Psychologists would dispute that all psychiatrists are in fact psychologists and vice versa. We know that all psychologists are not necessarily psychiatrists. They can't be unless they are first an MD. There's a problem in terms of initial qualifications that have turned them into psychiatrists or psychologists. Psychiatrists are trained very differently from psychologists, under very different conditions. So that's my concern here.

This motion may be too broad to not give some direction in the development of regulations to pay attention to this possibility of strife developing between the two. That's all I want to say. I want to be on record so that we have considered as a committee the possibility.

The Chair: Any others?

Mr. Lougheed: Dr. Pannu makes a good point, and it's unfortunate that with whatever best intentions there are for persons with disabilities, in this case mental health issues, other things get in their road. I would support this motion in that we want to broaden and make as immediate as possible whatever help can be marshalled to support the families and the persons with these challenges that come before whatever the professional is. I support this recommendation, this motion that was made.

Mr. Backs: Just briefly. I do support this motion. I do think that it does address what we spoke about last time and the importance of having the broadest community supports and availability in this important area. I do support this motion.

The Chair: Anyone else? Are you ready for the question?

Mr. Shariff: Mr. Chair, in order to allay the fears or concerns that Dr. Pannu has, I'm sure the department is aware of the concerns you're raising and that they will do their very best to try and get the appropriate regulations in place that'll ensure that proper service be provided to mental health patients.

Dr. Pannu: I raised the issue precisely to put ourselves on record so that the department pays far more attention to it.

Thank you.

The Chair: Okay. Those in favour of the motion? Opposed? None. It's carried unanimously.

The committee received a letter from the Minister of Health and Wellness and has attached some proposed amendments that we have in our package. We've also invited him here, and he's graciously accepted to give us a 15-minute overview of these proposed amendments, and we've set aside about half an hour for questions. So I'd invite the minister and his staff to join us at the table.

Mr. Shariff: Are we finished with 31?

The Chair: No. The minister was scheduled to come at 1:15.

Mr. Shariff: Okay. We'll go back to Bill 31 after this?

The Chair: Yeah, we'll come back to that. So we'll deal with this issue now.

Welcome, Mr. Hancock. I invite you to give us an overview of the proposed amendments. You do have them in your package. They should be under tab 4 in your binders.

1:20

Mr. Hancock: Well, thank you very much. I appreciate a number of things, and I just want to go on record as saying that this has been, in my view, a very positive process, where we've been able to take a bill which we believe has some essential elements to improve the mental health structure in the province and then have people who are concerned about the bill have an opportunity to be heard and to be heard in public. So I'd like to thank the committee for the work and the, I believe, very sensitive way in which a very important but sometimes delicate topic has been dealt with in terms of the hearings and for the positive way forward that I think this bill is tracking.

In putting out the bill, I engaged a group of people as a steering committee for me to provide advice and direction with respect to the go forward. They are doing that. As part of that work, of course, they were hearing some of the same things that you heard in terms of areas where the bill could be improved, and we agree with them. The recommendations that we've provided you with respect to amendments are provided to you at the request of your chair and in an attempt to make sure that we have, where possible, alignment so that as we go forward, we see if there are areas of similarity or, perhaps more importantly, areas where there might be a difference, where you may want to explore what our view is on the difference if there is one.

I think the amendments are relatively straightforward or well explained at least, so rather than going through each of them individually, I'll leave that to questions from you as to what the background behind them is or which ones you have an interest in. Really, my purpose, I suppose, in being here is to answer any of your questions and to provide sort of an explanation of the policy basis behind some of the directions if you have a question related to it. I don't believe it's fair for me to leave that in the hands of the department because the policy issues, of course, are taken at my level rather than at the department's level. I'm more than happy to answer any questions you might have on those items, of course with the assistance of staff.

Of course, Bill 41 as well had the same invitation with respect to amendments. I do not have proposed amendments at this time relative to Bill 41. With respect to the policy behind it I would just say that it's very clear in my mind that there is a duty of assurance on government to ensure that there are appropriate standards for quality in infection prevention and control and quality standards across the health system. That is not only with respect to, of course, the health facilities, the RHA-run facilities and other health facilities in the province, but also with respect to the professions. In the process of this year we actually surveyed all of the health authorities and all of the professions relative to their procedures for infection prevention and control.

What we found was that there was a wide variety among the professions and hence the need for some ability to be able to work with the professions and say, first of all, that it's very important; secondly, that there needs to be alignment because there's a much, much greater degree as we go forward into the 21st century with our health system: health care professionals working together, health care professionals working in institutional settings. The issue of who's responsible or when people are responsible is a very important question. So we need to be working as government in our role of assurance with the professions and across the professions to make sure that there's alignment and an understanding of the importance of the area.

Now, I'd be very clear to say that no health minister, no government would use the amendments relative to the governance of health professions unilaterally without having first gone through a process. This would be a last-resort piece, not a first-resort piece. But it's very important as a resource to be able to say to professions: we need you at the table, we need to be discussing these issues across professions, and we need to do it on a timely basis.

This is a very important amendment from a policy perspective, from a governance perspective, very important to be able to assure Albertans of the safety and quality of the system as a whole. So I would ask that you support that on a policy basis.

I would also say that I have met with the regulatory authorities and professions, and I've indicated to them that if their concern is the issue of whether they would be consulted, I think that goes without saying, but I'm happy to hear from them if they have some suggestions relative to wording that would give them that assurance in the statute. To my knowledge I haven't received any such assurances yet, so I'm not proposing any amendments at this time,

but there may be something going forward. If there's an acceptable amendment in that model, I'm certainly willing to look at it.

I'd only end by saying that this is not out of line with what happens in other jurisdictions. B.C. and Ontario, for example, notwithstanding that they have self-governing professions, retain the ability of government to have a role in that as it needs to have.

So with respect to those two bills I'd just end where I started, by saying thank you. I think the work that the committee has done has helped significantly in terms of hearing the public on issues of importance, particularly in Bill 31, a very sensitive issue, and I look forward to any questions you might have and to your report eventually.

The Chair: Thank you very much, Mr. Hancock.

We do have one question so far. Reverend Abbott.

Rev. Abbott: Thank you very much. Thank you, Minister, for being here today, and thanks for your amendments that you've brought forward. I support all of them.

My questions. You mentioned your stakeholder group that helped you to arrive at these. I'm wondering also if you included some of the comments and suggestions from the public review or if these are simply the department's amendments. Did you consider what some of the different groups that were in during our public hearings had to say? I see that some of the amendments certainly reflect some of their suggestions, so I'm wondering if those were included here.

I'm also curious as to kind of the go-forward plan – and this is more for the chairman, I guess, than the minister – as to how we treat these. Are you looking for an actual decision of these today, or are you looking for us to dovetail these into the amendments that we have? I'm not exactly sure how that process works.

Then I have one other question, and it's with regard to Bill 41. I guess we are considering the two concurrently this afternoon. Is that correct?

The Chair: That's correct.

Rev. Abbott: Okay. In that case, with Bill 41 you mentioned that there were no amendments, Minister. We did have one group that was actually in favour of Bill 41, and they asked if they could be included in it. I wonder if you've considered that group at all as well.

Mr. Hancock: Which group was this?

Rev. Abbott: I thought you were going to ask that. I'd have to go back and check in my notes. I think it was the marriage counsellors or something.

The Chair: We will be considering the amendments after Mr. Hancock is done here today.

Rev. Abbott: Oh, so this is just a presentation of the amendments.

The Chair: It's a presentation and questions, so we'll be considering them after his time here is concluded.

Rev. Abbott: Okay. Just a question, then, on how you derived them, if you used any of the public hearing stuff or just your own stakeholder group.

Mr. Hancock: As I mentioned, we had a steering committee, which I put together, which has representatives from the mental health alliance and others in the mental health community stakeholder group as well as the department, who has been helping us with the development both of the legislation and then coming forward from that, the broader questions about implementation because, of course, legislation is just one piece. The community treatment order is a tool to work for a very small group within the mental health community but an important tool, but it's only valuable if it's worked in a community context and if assertive community treatment and those sorts of issues are addressed.

These amendments came forward in the context of that steering committee, but obviously we had a number of groups that were contacting us right from the time it became apparent we were bringing forward this legislation. Many of those same groups made the same presentation to the committee. But once we had our review of it, yes, I did ask the department to review the hearing before the committee and make sure that there was alignment with respect to what we had received independently and what the committee had heard.

1:30

Rev. Abbott: Excellent. Thank you.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. Mr. Hancock, not as much a question but rather a solicitation of a comment from you. I know, judging by your comments now, that you have been following and tracking the progression of this committee and what has and hasn't been said. A couple of meetings ago, two meetings ago, I believe, we had the pleasure of hearing a presentation from the Alberta College of Physicians and Surgeons. The president of the college made some remarks on which I challenged him. He in return challenged me and advised me that it was my interpretation of his remarks and not exactly what he was saying, but I took the time to reread the *Hansard* just to conclude the same.

His remarks appeared rather damning not only of you as the minister but overall of the ministry of health and, by extension, government. These are not remarks coming from a citizen with a political agenda. He represents the entire medical profession in this province. Basically, his comments can be fairly paraphrased to him saying that the minister, frankly, and the ministry are not concerned about the quality of care provided to Albertans, that the ministry is more concerned about the political ramifications and the politics of providing care than the actual quality of care, and that he and his office are the only checkstop in this province that actually monitors the quality of care provided to Albertans. As an elected member of this Assembly and as an individual who partially through you also sees himself as a filter that monitors the quality of care provided to Albertans I found those remarks to be, if not offensive, definitely challenging.

The nature of this committee is that whatever is said here ends up in *Hansard,* and it is in *Hansard* in perpetuity, and I think I would want to hear your comments relative to that. This is not to solicit a contentious relationship between your office and his, but when remarks like these are made, I think it's in the best interest of the public and their confidence in our health care system that we comment on them.

Mr. Hancock: I don't care, Mr. Chairman, to comment on the remarks of anyone who's made comments before the committee. That's their viewpoint and their opinion.

I would say this. My relationship personally and our relationship as a department with both the College of Physicians and Surgeons

and the Alberta Medical Association I think is in very good shape. We consult with them. We listen to them. We debate with them. We have some agreement on issues and some disagreement on other issues, and that's true with respect to the other health professions in the province. In short, I as minister and the department do our role with respect to the whole issue of assurance, which is our function.

We've had a focus this year, and I think quite appropriately so, on quality assurance and on infection prevention and control. That started immediately after my appointment as minister. It may surprise you that it didn't start at the end of March. It started in January when I met with board chairs and others in the system, including the registrar of the college and presidents of the associations where there were two, and talked about a number of issues relative to governance of the system and including in that the whole focus on infection prevention, control, and quality, and meetings across the province with RHAs focusing on their role in quality. I think I've made it clear in a number of the things that we've done this year and in the positions we've taken that we were bringing forward legislation relative to the professions and intending to bring forward legislation with respect to the RHAs to make it clear that government has a role in assurance and that we intend to fully play that role.

I would say that it's not just a profession's responsibility, although I'm very pleased that the professions know and understand that they have a duty with respect to quality. That's very important. Some professions are actually being very proactive in that area in terms of practice review and other issues. Our role is to make sure that all professionals both separately and together maintain that high standard and that it's also applicable to the regional health authorities and the associated organizations that work with them in terms of delivery and then, most importantly, how professionals align with the regional health authorities and their associated partners in delivery so that there's clarity with respect to who has responsibility in what circumstances. I think that's a very important role for government to be playing, and we're playing that role.

Mr. Lukaszuk: Thank you.

Mr. Lougheed: Just a question about the proposed amendments for Bill 31 with respect to the previous CTO not being considered unless it's been within the preceding three years. Can you from the department's and your perspective just elaborate on that? Why did you pick three? I've had some discussions and have heard some things, and I have not yet made up my mind on what's appropriate here. Can you just elaborate on that? Why not one? Why not four? Why not two?

Mr. Hancock: I'm going to ask Martin to supplement if I don't go far enough on this. Essentially, we need to achieve a balance between the rights of the individual and the importance of treatment and the importance of the ability to help families who have adult children with mental health issues deal with those issues on a timely basis. If you have people who are managing appropriately and taking care of themselves and are not in need of someone else making that decision for them, which essentially a community treatment order becomes, then that is the preferred mode. So if assertive community treatment is working, if the supports are there, if someone is managing, and that's exhibited in the fact that they haven't needed hospitalization or a CTO within three years – granted that's probably an arbitrary time frame, but it's an exhibition of an appropriate level of time that would say if people are managing. Then before you took that into account, you'd have to do a further assessment.

Mr. Chamberlain: Yeah. Thank you, Minister. Essentially, Mr. Lougheed, the original bill, as you know, had a two-year hospitalization requirement, and the suggestion that you've raised is that the department is proposing to extend that to three and also to add some additional repetitive behaviour requirements. That came out of some comments back from the steering committee that the minister referred to and also from a review of the information that was provided to this committee that suggested that we needed to be a bit more flexible on who could be eligible for a CTO, that the original two-year period and the three-year period are really just a look at what other provinces across the country have done. There are varying time periods. As the minister indicated, it is somewhat arbitrary. Three years is just making it a little bit more flexible, which is one of the concerns we've heard, than the two years. That's simply all it is.

The Chair: Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. Mr. Hancock, thank you for joining us in our deliberations. I'm looking forward to your amendments. It says: recommendations of the minister. I take it that these are amendments that will go forward regardless of what this committee's decisions are. Am I right?

Mr. Hancock: I think it would be fairer, in my mind, to say that we will want to see what the committee recommends, and if there's a distinct difference, we would take that into account in determining. This is what we've seen as being necessary, but I think that the committee's deliberations are important.

Dr. Pannu: Thank you for that. I just wanted a clarification on it.

Some of the amendments that are proposed here I think reflect what this committee heard from a variety of people who appeared before us, and they reflect the collective wisdom of the committee on some of those issues. So you have probably tried to incorporate some of the deliberations of the committee in these; for example, the automatic mandatory review provision. That, I think, wasn't there; it's now incorporated. It's there in the amendments, and that, I think, improves the bill immensely. I appreciate that very much, that it has not only the committee's support but your support as well.

1:40

I have one concern, and I may be the only member who has that concern, knowing what we know about what's on the record and the *Hansard.* It is the expansion of the eligibility criteria for CTOs, the very first amendment, amendment 1. No other province or territory, to my knowledge, has that kind of expanded provision for CTO issuance. It says, "Expand eligibility for CTOs to persons who are not currently formal patients." The committee did vote on this, and I certainly disagreed with their decision. Nevertheless, it's a concern that needs to be addressed in view of the fact that no other provincial jurisdiction has really expanded those criteria to this point. We are at this moment the very last provincial jurisdiction introducing CTOs. We need to learn from experience. I suppose that's a normal expectation, that we bring in a piece of legislation, we try it out, and see how it works. In view of the fact that other provinces don't have the criteria that you have proposed be included in the issuance of CTOs, I'm concerned about this, and I wonder why you think this province should move forward with amendment 1.

Formal patients are known to have mental illnesses. They have been treated. They have received treatment in the hospital. They are released; they come out; they don't get the treatment; they get sent back under a CTO. I think the revolving door issue was a primary

consideration for introducing the legislation on CTOs. Now, it seems to me that amendment 1 expands the criteria to include people who have not been formal patients. I wonder if you'd like to comment on that. I continue to be concerned about that one because no other province really has found it necessary to go that route.

The Chair: Mr. Hancock.

Mr. Hancock: Thank you, Mr. Chair. I think one of the benefits of going last or close to last is that you get to learn from the experiences in the other jurisdictions. I think that one of the areas where we could improve upon, in my view, in the legislation – I recognize that this again is a sensitive area and has to be used sensitively. Where you have people who are in and out and who have not actually been formally committed to a facility but have had the benefit of a number of intercessions, if you will, we felt that it was prudent to make this tool available.

We recognize that this is a very small group of people. We have situations where families are dealing with an adult child, and they don't have the tool that they need to get treatment on a timely basis. If we require that the individual involved deteriorate to a point of crashing, so to speak, and then need the intensive therapies and lengths of stay to bring them back to a point where they can again be in the community and have a quality of life and productivity in the community as a requirement before you have the tool necessary to intercede, you're using up a portion of a person's life and opportunity, first and foremost, but you're also using resources in the system.

One of the things I've heard over and over again from families is that they lack the tool to intercede on a timely basis. It's clear to me that that's as important early in the process as it is after they've had a number of hospitalizations or after they've gone through the process a number of times.

The important piece to this is not that a person has been hospitalized already before they have access to the treatment order. The important piece is that in any event the person involved has appropriate appeal mechanisms or opportunities to be heard if they believe that it's not an appropriate tool. We can protect the individual on that side while making sure that the resources are available to the families so that they can have the necessary intercession without having to go through the pain and suffering of the full relapse and failure of an individual's health to the point where they need to be hospitalized probably for a period of time before restabilization and reintroduction to the community.

The Chair: Go ahead on this point.

Dr. Pannu: I see your point. I think this is premised on a sort of notion of pre-emption and prevention so that people don't end up in the hospital before they really receive services for medical treatment. My concern is how to identify people other than what we hear from family members, who, obviously, for all kinds of good reasons, you know, are concerned about the well-being of their members who maybe they see as mentally ill but who may not be mentally ill. They say it's a question of diagnosis which requires specialist knowledge. Would expression of family concern be enough consideration to subject someone to a CTO? How would the determination be made that a person really should receive a CTO, although he or she has a history of other committal to mental treatment or hospitalization? That's my concern. How do we do that?

Mr. Hancock: Mr. Chair, through you to Dr. Pannu. Clearly the use of this tool, the CTO, would be done under the direction of qualified health care professionals, not the basis of a family's dissertation. Of course, the family is of primary importance in this, and the individual involved is of primary importance, but we're talking about two health care professionals making an appropriate diagnosis. One would assume – and I think it's appropriate to assume in this circumstance – that they would have a stricter test application if they were to utilize a tool of this nature prior to hospitalization. It would be easier for them to make a decision if there was a history of hospitalization than it would for someone who hadn't, but obviously we have to rely on the health care professionals making the appropriate determination here.

As I say, if you've got the appropriate mechanism for people to appeal that process or to have a review of that process, I think you provide the protection for the individual, which is necessary, while making sure that health care professionals can use their professional advice to provide the appropriate tools to ensure that individuals can have a quality of life in the community.

Dr. Pannu: Two medical professionals' assessment would be the basis on which the CTO will be issued to people who are not formal patients, right? Is that the minimum requirement?

Mr. Chamberlain: Dr. Pannu, it's the same test currently in the act, and there's no proposed change in the amendments as to what would be required for an admission certificate. Currently it's two physicians, one who has to be a psychiatrist.

The Chair: On this point, Mr. Hancock, would you agree that oftentimes not being a formal patient, the first intercession is with the law enforcement authorities rather than medical professionals that could help people in these situations? This clause may well prevent that sort of an experience in that particular instance.

Mr. Hancock: Yes, Mr. Chair. That wouldn't be the defining criteria in terms of admission, but often, unfortunately, we find persons with mental health issues coming into contact with the law. That's how they're introduced perhaps, not first to the treatment process, but that's how they're brought into the treatment system as being in need of help. All too often it's a legal process rather than a health process which intercedes.

With this sort of a tool there may some other outcomes, more preferable outcomes, for those individuals, and one can see appropriate alignment with the justice system for more diversion of persons with mental health issues. As you are probably aware, we have started diversion processes in the past. But you're right: people with mental health issues often come into contact with the law as their first point of contact. However, it's still up to two health care professionals to determine whether a CTO is an appropriate tool.

1:50

The Chair: Mr. Lukaszuk on this point.

Mr. Lukaszuk: Thank you, Mr. Chair. You brought up an important point. I know that in the last meeting we had a bit of a debate because I brought up the topic of homelessness and transiency, and I know that Dr. Pannu was challenging me on this. This is not in any way to imply that all homeless people are suffering from mental illness. As a matter of fact, the opposite is the case. But the fact of the matter is that when dealing with issues of intervention with individuals in dire need of shelter, particularly in Edmonton in the wintertime, often it becomes abundantly obvious that some – and I stress some – of the individuals may be suffering from mental

illness, which then incapacitates them from making proper decisions relevant to seeking help, shelter, and monetary support from government. These individuals have no previous engagement with hospitals because by virtue of their situation they don't go and seek medical help, and this may be a good tool to intervene and assist them with the plight that they may be in.

Mr. Hancock: Mr. Chair, I don't want to hold myself out as a medical professional who could make those sorts of determinations. I think we have to rely on those who are appropriately qualified to determine whether a period of hospitalization is necessary to bring stability before a person is ready to be reintegrated into the community or whether a tool such as this can be helpful. Often that will depend on the resources that are available: family resources, community assertive treatment resources, those sorts of issues. I think it is an issue that would have to be determined at an appropriate time by the appropriate professionals. This is intended to make sure that there's one more tool available in that basket and, where appropriate, to continue to ensure that individuals can have a quality of life in the community with the support that they need. I think it has to be a case-by-case analysis.

The Chair: Reverend Abbott.

Rev. Abbott: Thanks, Mr. Chairman. I think, also on this point, just to maybe help clarify a little bit, that – and this is for Dr. Pannu – we're not talking about issuing CTOs on a person's first contact with a mental health issue. You know, we're talking about people who do have a history of mental health issues, and we're talking about people that other treatments, et cetera, have been tried and perhaps even been successful, but for whatever reason the treatments have not continued. I think we're talking here about, as the minister said, a very small group of people who have maybe had successes in the past and maybe just need a little bit of help to stay with those successes. I know that there's probably a lot of Albertans that have had maybe one or two – I don't want to say "run-ins" but certainly meetings with mental health situations, and they're perfectly fine, and we're not going to slap a CTO on everybody that has one of those. I think the committee needs to know that these are for very special circumstances, and they're very unique.

With regard to the comments about the nearest relatives, quite often they are the ones who see the mental and physical deterioration. Obviously, a health professional who may only see that person at a time of crisis or once every several years would not see that mental or physical deterioration. They could verify it through their own examinations and through talking to some of the relatives, et cetera, but I think it's important to include the nearest relatives because they do, as I said, interact with these people on a more frequent and regular basis.

I actually think the way that this amendment is worded is excellent, and the way it broadens the criteria is very good because otherwise we would never issue a CTO. I shouldn't say never, but it would take years. It would take years before we could ever issue our first one, whereas we know that there are people in Alberta right now that could benefit from this sooner rather than later.

The Chair: Did you have any comments on that, Mr. Hancock?

Mr. Hancock: No. I think that was a good statement.

The Chair: Mrs. Mather.

Mrs. Mather: Thank you. I agree with Reverend Abbott. I strongly support this amendment. I think, to address part of your concern, Dr. Pannu, about family members making a referral and therefore somebody being issued with a CTO, there are far more resources out there than that.

I'm hoping that we start looking at the whole picture here. We should be involving school personnel. I would imagine that a classroom teacher would notice something, a school principal, social workers, our child care workers, and sometimes the police too. But the point is that the earlier the intervention, I believe, the better the possibility of preventing criminal activity down the road and a lifetime record. I think that if we can provide swift and efficient and competent help with the proper input needed for a positive recovery, a lot of these individuals we're talking about will have the hope of becoming contributing members of society even if it's on a volunteer basis or a part-time job. They're going to have a sense that they are important and will hopefully be able to overcome some of the social and certainly the legal concerns.

Dr. Pannu: Two questions. One is a very simple one. There are repeated references made to the fact that there is a very small number of people who will be subjected to CTOs or who will qualify to get CTOs. What is that number? Any idea? I've heard this reference to "very small," yet it begs the question of what kind of number we're talking about.

Mr. Hancock: Mr. Chair, I don't know that I can actually responsibly answer that question. All I can do is say that I rely on the advice that I've been given by people like Dr. P.J. White, who I know has appeared before the committee and is also on our steering committee, and others who are active in this area to say. The number of 300 has been utilized in some discussions, but I don't have any way to verify that number or know exactly where it comes from.

Suffice to say, though, that this is not a tool that's going to be used in a broad circumstance. This is a tool which would be available to families primarily with adult children who are capable of living in the community under appropriate treatment regimes but who from time to time for whatever reason stop pursuing that treatment regime, resulting in a deterioration of their health condition, and if caught early, a lot of aggravation and harm can be stopped both to the family as well as to the individual, more importantly, and resources can be appropriately utilized supporting them in the community instead of being used up with a deteriorating condition.

I'm comfortable with the advice that I receive from the health care professionals, including, as I say, people like Dr. P.J. White, who tell me that this is not a wide population of people. We do know that there are these certain situations. We know that anecdotally from the families that come to us, and we know it from the fatality review report that we received last year. We know that there are those circumstances that exist, but I can't quantify it for you any better than that.

Dr. Pannu: Two more questions of the minister, but I'm willing to wait.

The Chair: I have no one else on the list right now. Go ahead.

Dr. Pannu: Okay. The second question is about amendment 3. I'm just trying to understand the application of eligibility criteria for hospitalization. In column 3, on the extreme right hand side column, it says, "Permits eligibility for persons who meet the criteria while in a hospital." Is this for some illness other than mental illness? That's the first part. The second part is: "other custodial institution, other than a designated facility (e.g. correctional institute)." I

wonder if you would elaborate on that. What exactly is involved? Who are the people that you have in mind?

Mr. Hancock: Thank you, Mr. Chair, through to Dr. Pannu. This is really the same discussion as we had under the first amendment, and that is that in some circumstances people come into contact with the law primarily as a result of their mental health conditions. So in that case it may be appropriate to have a better outcome for them rather than just continuing through the justice process. In other circumstances, yes, indeed, a person may be in a hospital or in a correctional facility when the mental health condition becomes one for which this might be appropriate. So we're saying that the hospitalization criteria is one criteria, but there are other circumstances where a person could be appropriately treated and released into the community with a community treatment order, and that should be taken into account.

2:00

Dr. Pannu: Thank you. My last question, Mr. Chairman, to the minister is about implementation. You very rightly underlined the importance of not just having a piece of legislation but making sure that it's implemented and that there are resources available to properly implement it. I had a visit from a representative of the Edmonton chapter, I guess, of the Canadian Mental Health Association in my office on Monday or Tuesday – I'm trying to recall – and although the CMHA, the Canadian Mental Health Association, is supportive of the bill, they did express concern about the absence of or lack of facilities available in communities to achieve the results that we want to achieve. I want to seek some thoughts from you on whether or not before the bill is proclaimed or as it is proclaimed, you are in the process of also taking steps to make sure there are support facilities, from housing to caseworkers, you know, for people who are on CTOs who need some guidance and some monitoring, that these arrangements would be available for the implementation of this piece of legislation that we are discussing.

Mr. Hancock: Mr. Chair, as I say, we have been working with an early consultation with the Canadian Mental Health Association and others associated with the alliance on mental health even before the bill came forward and through the process through the steering committee, with representation on it, and very clearly have been making a commitment that, yes, this is one of the tools, but it needs to be supported in the community. There needs to be assertive community treatment. There need to be resources available, and I would acknowledge that those resources go beyond just these sorts of community treatments. Obviously, housing is an issue.

You will recognize and understand that not all of these areas are within my purview, and even those in my purview are subject to the resources being available. My commitment to the groups that I've consulted with and my public commitment has been that I understand and support the concept that there need to be resources available to deal with these situations, that that's part and parcel of this process, that the legislated piece is one of the pieces. The resources are another important piece, and I will be working as hard as I can to ensure that we have the resources available to do it. I'm obviously going to have to live within constraints of budget and work with others in government with respect to the housing issue, which we're very clearly moving to address, and recognizing that housing, particularly for persons with mental health conditions, in the community is an important part of that housing piece. So, yes, it's a very clear priority.

Can I make a hard and fast commitment that one won't go without a number of dollars or certain pieces? I can't make that as a hard and fast commitment. All I can commit to you is that this is a very important part of my agenda as health minister and a very important tool for the community, and I'll do everything I can to make sure that it's implemented in an appropriate way. That's the commitment I've made to the Canadian Mental Health Association and other stakeholder groups.

The Chair: Any others have any questions?

Mr. Backs: Thank you, Mr. Hancock, for coming there today. It's very much of a good experience having you here and having you before this committee and having this committee experience, all in all.

The representative – I think it probably was the same one – from the Canadian Mental Health Association also saw me this week and was very supportive of this legislation and did make the comment that there is a need for more community supports. To be more specific, what might be some areas that your ministry in your purview could provide greater supports to in order to bring about the better operation of this provision and to ensure that it does help those families to the best possibilities in this new development, specifically looking at adult children and keeping them as productive members of society?

Mr. Hancock: Well, I think I've used the term assertive community treatment a number of times. I think it's accepted that that's the best practice currently relative to supporting independent adults in the community. I would think that there needs to be more work, more resources relative to that particular field. Obviously, we do that through our health authorities. The regional health authorities are responsible for provision of mental health services in the community, so I'll have to be working with them to make sure that they understand the priority that we're putting on this. Of course, they will be expecting resources to deal with it. I will be working to see if I can accommodate that. In any event, in my view, we're going to have to devote more resources to assertive community treatment programs as one example.

I had a visit as well from representatives in my constituency office who encouraged me to support this bill. I think it's clear that a lot of stakeholder groups who are involved in this area have come to the view that this is an important tool. Almost unanimously they would say to us – and I've heard it – that we need the resources to back it up with respect to the community support. There are never enough resources for all the things that need to be done. All I can really say is that I know that, I understand that, and I've heard that. I'm committed to doing that within the capabilities that I'm given subject to, you know, budget pressures and allocations. There's a budgeting process that has to happen.

In any event, I'll work through the regional health authorities to make sure that they understand the value of this tool and the priority that needs to be put on the mental health resources in the community. It's an important area which has not received the priority, in my view, that it needs to have received in the past. One of my missions this year has been to make sure that mental health and particularly children's mental health – I'm straying a little bit, I know, but I think it's important to say that this is an area that needs attention. We've been giving it attention. The Mental Health Board has their policy framework in place. There was a children's mental health framework a year ago in September. There was an aboriginal policy document relative to mental health. I'm hoping that we're moving this agenda ahead, and that includes resourcing the treatment piece in the community that's necessary.

Mr. Backs: Just another question, Mr. Chair.

The Chair: We're getting close to being right on schedule, but if it's brief.

Mr. Backs: Okay. For the operation in the area, in particular, of CTOs would you be looking in the department to assign particular case managers for each CTO as soon as, you know, the CTO is issued?

Mr. Hancock: Mr. Chair, the process of assertive community treatment and, as I understand it, part of the process during issuing of a CTO is to make sure that there's a case manager. That wouldn't be in the department per se, not directly in the department. Presumably, that would be at the service end, so it would be within the RHA and within that purview. But, yes, there would be a need to have case management specific to each CTO issued.

Mr. Backs: Just one more question. We are still dealing with Bill 41 concurrently, right?

The Chair: Bills 41 and 31.

Mr. Backs: So I could ask a question on Bill 41?

The Chair: Yes.

Mr. Backs: On Bill 41, Mr. Minister, all of the representatives of colleges were very supportive of some parts of Bill 41, especially ensuring the quality of infection prevention and control, but they're all very concerned about sections 135.1 to 135.4, almost completely all of them. They are saying that it gives too much subjectivity to the department, to the minister, and there are really no built-in appeal mechanisms that they feel are there by having this open now just to the Legislature. What is the rationale for creating such sweeping powers for the minister to appoint an administrator to take over the running of a college and to take away those checks and balances that would be in place if that was only open to the Legislature?

2:10

Mr. Hancock: Mr. Chair, the purpose of the administrative power is more in the area of the operation of smaller colleges who don't have the ability to carry out the duties and functions fully of a college. The concept of the Health Professions Act was to have all health professions under a common framework, a statute, but it is not possible to bring some professions in because they're not large enough or don't have the capacity to provide all the functions. So one of the rationales for that section, if I'm on the right track here, is to make sure that we can appoint an administrator in those areas.

I suppose it could be used in other circumstances in a broader context if there was a rationale, but it's not intended as a section that would allow government to come in and take over a college. We have self-governing professions. We respect the concept of self-governance of professions. It's a necessary thing because you need to have both the governance structure and the disciplinary processes, et cetera, done by people who understand the issues and the complexities of it. We need to have, as I say, the ultimate role of assurance. So it's not a position to move in and take over a profession; it's really about making it possible for all professions to operate as professions with the roles and functions that are necessary.

Mr. Backs: Thank you.

The Chair: I'd like to thank Mr. Hancock for his time – I know we scheduled a specific time – on behalf of the committee. We are going to take a five-minute break now while you make your departure. Thanks again for coming out today.

Mr. Hancock: Thank you.

[The committee adjourned from 2:13 p.m. to 2:19 p.m.]

The Chair: If we could take our seats, we'll get started here. I think the committee will consider reviewing and debating the amendments that were discussed with the minister just previously while it's fresh in our minds. I suggest that we can go through them one line at a time, section by section, and get approval, or if there are some contentious ones that you want to have discussed separately, we can do that and then approve the rest as a single motion. Do you want to go one at a time, or do you want to approve them all as a block?

An Hon. Member: That sounds good.

Mr. Lougheed: I think one at a time.

The Chair: Okay. To expedite things, line 1.

Mr. Backs: I'll move it.

The Chair: Mr. Backs moves that we approve that amendment. Any discussion? I have to remind everybody that there are no abstentions from voting. You have to vote one way or another.

Dr. Pannu: No abstentions is the chair's ruling?

The Chair: No. That's in the Standing Orders, or you can leave the room if you want to abstain.

Dr. Pannu: So Standing Orders require this?

The Chair: Yeah.

Dr. Pannu: Okay.

The Chair: I can get legal counsel to provide the appropriate section.

Those in favour of the motion to approve 1? Those opposed?

Mr. Flaherty: Can you just read it?

Mr. Shariff: This is 2.1, right?

Mr. Flaherty: Which one are you on, Mr. Chair?

The Chair: We're going through the minister's documents, the amendments approved, the three-column document.

Rev. Abbott: To Bill 31?

The Chair: It was attached with the minister's letter.

Rev. Abbott: Yes. So we're talking about the amendments to Bill 31. There are 11 of them in the three-column document.

The Chair: Right.

Mrs. Dacyshyn: And we're going one by one.

Mr. Shariff: But we are already dealing with some amendments of our own.

The Chair: We'll be dealing with those later. Right now we're dealing with the ones the minister proposed while it's fresh in our minds because we just discussed them.

Ms Dean: If I may, Mr. Chairman, just for clarity to Mr. Shariff's comment. If there's some deviation from what's been approved by the committee at its last meeting with respect to any of these recommendations, I'll just pipe in and mention the nuances.

The Chair: Okay. We are dealing with recommendation 1.

> Expand eligibility for CTOs to persons who are not currently formal patients.
>
> Also expand criteria to require that the issuing physicians, after separate examinations, also be of the opinion that the person is suffering from a mental disorder.
>
> Consequential amendment to section 104 of Health Information Act to remove the restriction to formal patients, and allow nearest relatives (as defined under the Mental Health Act) to access information for persons subject to CTO.

I'm not going to read them all after this one because I'm sure all members are capable of doing that. All those in favour of Mr. Back's motion to approve this?

Mr. Shariff: Have we dealt with this subject in the previous approvals?

The Chair: Shannon Dean.

Ms Dean: Thank you, Mr. Chairman. The committee passed a motion last week that was a little narrower. It actually just dealt with removal of the 60-day hospitalization criteria. The committee didn't actually approve expanding eligibility with respect to formal patients. However, there was a lot of discussion and a lot of consensus on this point, but there was no motion actually passed. Based on my understanding of the committee's intent, this reflects the discussion, but there was no formal motion passed on this point.

Mr. Shariff: Oh. Okay.

The Chair: Any other questions? Okay. I didn't see everybody's hand go up in either situation. I'm going to take the vote again. Those in favour of this? Those opposed? That's carried.

Okay. Moving to line 2. Any questions on that particular one? Any additions, Shannon?

2:25

Ms Dean: If I may, Mr. Chairman, just point out that, again, as I just mentioned through you to Mr. Shariff, your motion from last week dealt with the removal of the 60-day prior hospitalization criteria. This is consistent in the sense that that is what the minister is proposing here as well, but there are some additional criteria that are part of this recommendation.

I would like to offer a comment with respect to the third alternative eligibility criteria with respect to recurrent or repetitive behaviour. This is, I think, a new type of criteria. I don't think it's found in other jurisdictions. I point that out in case you wanted to direct any questions to the department.

Mr. Shariff: Thomas had some extensive contribution to this issue of people not necessarily requiring to be hospitalized or be on a prior CTO. We did have some motion, right?

Mr. Lukaszuk: Mr. Chair, I am not certain whether an actual motion was put before the committee and passed, but there definitely was, as Mr. Shariff indicates, a very extensive discussion to which I have now recently alluded to Minister Hancock. I was under the impression that the committee at least by and large was congruent in the fact that no prior hospitalization or prior CTOs would be required in order to engage the system. So maybe this warrants just refreshing our memories because this number 2 seems to be ultra vires to what was the intent of the discussion and anticipated outcome.

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

Mr. Chamberlain: Yeah. There was a motion on this. Mr. Lukaszuk is correct, and Ms Dean can correct me if I'm wrong.

Ms Dean and I struggled with exactly what it meant in the context of the discussions the committee was having. The concern, as I understood it, Mr. Lukaszuk, was that there may be cases where a patient hasn't got that history of prior hospitalization. In those cases that patient shouldn't be deprived of the opportunity to take the benefits of a CTO where there is still a repetitive behaviour type of instance.

What the minister's proposal is is not to remove the hospitalization requirement, to make it a little more flexible – hence the change from two years to three years and the reduction in days – but to add an additional criteria, which is the repetitive behaviour. So you could have a CTO issued because of prior hospitalization – revolving door – or because of repetitive behaviour. It's not an "and." You don't need the prior hospitalization, but it's one of the criteria that would qualify a patient for a CTO.

Mr. Lukaszuk: I appreciate it. Those comments are valid, but they still exclude this cohort, however large or small it may be, of potential beneficiaries from a CTO who have neither had repetitive behaviour, nor were they previously hospitalized. I would imagine those may be some of the most severe cases that could benefit most from a CTO.

It almost sounds like you're questioning the ability of professionals to make a determination. If we are not convinced that there is medical expertise out there that can make a determination, and now we're putting in those buffers, I have a question with CTOs, then, to begin with. You know, are we going down the right path to begin with?

I am not certain whether previous behaviour patterns or hospitalizations should be – they should have some bearing, perhaps, on the physician's decision, but I don't think they should be detrimental to his or her ability to determine whether this patient at this moment in time would be well served by a CTO. But if you put this section in place, now it doesn't become just an added piece of information that the physician will take into consideration, but it will actually become a determining factor, where the physician may conclude that this is the best course and yet not be able to implement it because there is no history of repetitive behaviour and/or hospitalization.

Mr. Chamberlain: You're correct, Mr. Lukaszuk, that the change would not allow a CTO to be issued for a first-time patient who appears in the system. There is no question: that's what this change would require. But the CTOs as designed in the legislation and, as far as I'm aware, consistent across the country are for the revolving-door type of patient; they're not for the first time. In part that's a

balancing of rights issue. So the minister's design and proposal preserves the revolving-door concept but makes it more flexible to a person who has been exposed to the medical system, has been subject to prescriptions and other things but not necessarily as a formal patient in a hospital.

The Chair: Weslyn Mather on this point and then Reverend Abbott and then Dr. Pannu.

Mrs. Mather: I really do appreciate the intent that was just mentioned. I think it's important to realize that if an assessment is made that there's a need for this kind of treatment, it almost always is going to have to be based on some history. You know, it can't be just that at this moment in time this person is acting irrationally. There would have to be a history of a lack of insight and poor decision-making. I think that goes hand in hand with the need to balance the rights of the individual, I guess, to treatment and the importance of helping the family of that individual.

The Chair: Reverend Abbott.

Rev. Abbott: Yeah. I'm going to say that I agree with what Mrs. Mather just said. I think that we have to think of a community treatment order as more of a second or third tool in the belt, that there are going to be other mental health professionals involved early on and maybe other treatment histories, et cetera. If those prove to not be successful or to not hold for a period of time, then we look at a community treatment order. To me it's not a first line of treatment.

I think the way that this is worded is excellent. I like the idea of the third alternative eligibility because it does use the words "pattern of recurrent or repetitive behaviour suggesting [they] may be likely to cause harm." They don't actually have to have that run-in with the law, but they have to be eligible for that run-in with the law, I guess is the way to say it. So I think this is worded well.

The Chair: Mr. Lukaszuk on this point.

Mr. Lukaszuk: This argument that we're limiting rights and hence prior behaviour and recorded prior behaviour or hospitalization is required is really not congruent with the rest of the legal system. You know, issuing a CTO is not analogous to sentencing someone to a sentence. If you were to draw an analogy within the legal scope, it is analogous to being charged. That person still has the full reach of the law to appeal that CTO and present evidence to the contrary and absolve themselves of the CTO.

CTOs, I imagine, will not be used frivolously. They will be used in the most drastic of cases, where physicians feel compelled to use the CTO. Those physicians will make rational decisions at that time, and very often past behaviour will not be documented, particularly now in this province, where we have an influx of some hundred thousand people and many transient individuals whose past history we don't know. There are roughly 300,000 people every year in this province whom we would not know about being hospitalized within the last three years, who would never be able to benefit from this CTO, yet at that moment in time there may be a compelling situation where the physicians would unequivocally conclude that a CTO is the right way to go.

Dr. Pannu: Mr. Chairman, I asked the minister about the size of this population who will benefit from CTOs, and although he was frank with us in acknowledging that he has no way of being definite about it, he talked of 300 people. These are people who, according to existing knowledge and experience here and elsewhere, are the ones who are likely to benefit from the issuance of a CTO. That's the population we're talking about. That's where CTOs should be used. So any suggestion that this proposed change frustrates the effectiveness of the proposed legislation, I think, is not persuasive to me. We are dealing with a specific population that, based on the expert advice to us and recommendations to the minister, is a small population, and they are the ones who have to meet these criteria in order to get into that group. I don't think this piece of legislation errs in the direction that Mr. Lukaszuk is saying. If it does at all, in my view it relaxes the conditions under which CTOs can be issued.

2:35

We discussed this, and the people who came before us raised the issue of: how many years into the past should one go in terms of the history of mental illness of a patient? Five years? Ten years? Three years? How much? The original piece of legislation talked about two years, and that made sense to me. The minister has extended it, I guess, in light of the discussion that this committee had. He's making it three years now, going back three years rather than stopping at two. In place of 60 days he is changing it to 30 days, so already I think there is, in my view, an undesirable relaxation here. But, certainly, to go as far as Mr. Lukaszuk is suggesting I think would simply negate the purposes of the bill altogether.

Mr. Shariff: The discussion has moved a little further on, but I just looked at the *Hansard* copy that we have, and I just want to remind ourselves of what transpired last week on the motion that Thomas Lukaszuk had brought forward. He had suggested that prior hospitalization not be a factor in issuing a CTO. Then there was discussion, and Mr. Chamberlain went into some of the departmental considerations and concluded with a statement that hospitalization would be one of the triggers, but there would be an additional trigger, which is the repetitive behaviour.

Then I spoke after that. I suggested that we could proceed with this aspect that was before the committee at that time and that when we come back next time, which is now, the department will have found a way of including people who have not been hospitalized as also being eligible for certain criteria for a CTO. Then by the time all the discussion happened and we came to a vote, the vote ended up being that the requirement for a 60-day prior hospitalization be deleted. That's where Shannon is indicating that that was what we had approved, but I think the discussion that happened in between was indicating very strongly the committee's desire that prior hospitalization not be the only means of issuing a CTO.

Mr. Lukaszuk wants to add something.

The Chair: I have Mr. Lougheed first.

Mr. Lougheed: Let's conclude the discussion around this because I'd like to talk about the three years as opposed to two years.

Mr. Lukaszuk: Well, in anticipation of the department's response – the department was asked to find a possibility where prior hospitalization would not be required but have a trigger – there really is a trigger in number 2 because it says, "Only formal patients who have previous hospitalizations or have been on a prior CTO are eligible for CTOs." Let's look at this section and how you would be implementing it. Even if the department says, "Well, you don't have to be a formal patient," in that case you would have had to have a previous CTO because that's the only other trigger. But how are you going to get your first CTO unless you were previously hospitalized? So you need a prior CTO to trigger clause 2. Otherwise, you're

going back to clause 1, and prior hospitalization is the only trigger.

Now, this new bill, once passed, would only apply to those who either have been prior hospitalized or have had a CTO prior to the passage of this bill because they can never have a CTO unless they were hospitalized. This is a closed loop, and clause 2 of this amendment is a red herring because you can never apply clause 2 unless somebody had a previous CTO or is hospitalized.

The Chair: No. That's being amended. Column 1 is the current provision, being amended in the second column.

Dr. Pannu: So it's clear, Mr. Chairman, that that's not the case. The proposed amendment changes the original.

The Chair: Exactly. We're not dealing with the first column. We're dealing with the amendment, which is the second column, which is changing only the formal thing.

Mrs. Mather: You were right about the original.

Mr. Lukaszuk: About the original, yeah.

I still have, Mr. Chair, concerns about this pattern of behaviour. What defines a pattern of behaviour? How will it be documented, and how will this apply to individuals in need of this intervention with no prior history? Who is documenting this prior behaviour? If there is family? In many cases there isn't. Where do we get this pattern of behaviour from?

My hope was that this bill would address a larger issue and an issue that we dealt with recently and some of the issues that our Solicitor General and Justice department deals with, where individuals could have benefited and some serious incidents could have been prevented if mental health intervention was put in place. But over here we require this lengthy pattern of behaviour which, obviously, has to be a documented pattern of behaviour. So we need this person to be arrested a number of times, and that should be documented or have the benefit of family to document it because otherwise they will not fall into this criteria.

The Chair: Since I have no one else on the list on this point besides myself, I'll take the liberty to express some views I have on this. I support this because I'm also concerned with the rights of individuals. This is the only medical treatment that is actually forced upon individuals, and some of that treatment, as we've seen through the course of the public consultations, can be drug therapies that can have very positive effects or sometimes not so positive effects, as was related to us personally. It could also end up resulting in some shock therapies, where the person can't refuse them once the CTO is issued. They can't refuse the treatment once the CTO is issued. I think that to err on the side of a little caution, to make sure there is a history, is not a bad thing. I think it's a good thing.

Dr. Pannu on that point.

Dr. Pannu: I think some clarification from the department on the repetitive behaviour might be useful. What would be the evidentiary basis on which repetitive behaviour would come, then, and the proper criteria? Has the department given some thought to it?

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

Mr. Chamberlain: Yes, at the highest level. Because we're relying on two qualified health professionals, two physicians, one a psychiatrist, as the bill is currently drafted to make that determination, they would have to make the determination that there was suitable repetitive behaviour to justify a patient requiring a CTO to stabilize themselves or whatever. That might be reviewing their medical records. It might be consulting with previous physicians. It might be discussions with the family. It may be previous interaction with law enforcement or previous hospitalization, voluntarily or other than as a formal patient. All of that could be taken into account by the physicians. If they had no history, it would obviously be very difficult to determine whether or not a CTO would make sense for that patient; hence, the revolving-door criteria and trying to keep it as broad as possible but relying on the health professionals to make the final determination.

The Chair: Mr. Lougheed and then Mr. Backs. Were you prepared to talk now?

Mr. Lougheed: We're moving off that part?

The Chair: Well, Mr. Backs, were you on this point?

Mr. Lougheed: Maybe go to Dan first.

The Chair: Go ahead, Mr. Backs.

2:45

Mr. Backs: A question to the department, Mr. Chair, please. This particular amendment: would that meet the recommendations of Justice Ayotte in the Ostopovich situation and his fatality inquiry recommendations there?

Mr. Chamberlain: I'm going from memory, Mr. Backs. The inquiry report recommended consideration of CTOs and referred to, I believe it was, Saskatchewan's and one of the other province's requirements. The bill itself addresses that recommendation in that it proposes CTOs. Justice Ayotte was not specific on the details of what would be in that CTO, so we've relied on what other provinces have done, and we've relied on some of the submissions we've heard through the ministers during committee and, quite frankly, through the submissions that were made to this committee to address the concerns as best we could.

Mr. Backs: Thank you.

Mr. Shariff: Having reviewed the *Hansard* from last week and looking at what is being proposed, it basically reflects the discussion that we had last week which the department was supposed to come back with. Therefore, I would support the recommendation before us.

The Chair: Okay.

Mr. Lougheed, you had a comment on this?

Mr. Lougheed: I was waiting until some of the other discussion was finished.

The Chair: It's on this amendment, so it's appropriate that we have discussion after the motion.

Mr. Lougheed: What was all the stuff before, then?

The Chair: That was discussion.

Are you done, Mr. Lougheed?

Mr. Lougheed: I haven't started yet. Upon some reflection – and

I did ask the minister about the time, you know, the three years, and why three as opposed to other – and feedback from the community, some people are somewhat concerned with having too long a period over which a previous CTO having been issued can still be considered. There's some concern about stigmatization and that sort of thing.

I'm wondering if we might consider splitting up the previous three years, the hospitalization, but being the subject of a previous CTO, which could have been issued who knows how much previous, to the two-year window that I would propose we revert to. That would help to address some of that concern that's been expressed. You'd have the first two bullets split and have three years for the hospitalization consideration but only two years for the: during which period they would have been the subject – you know, in that period to have a previous CTO.

The Chair: So you would be suggesting that that last bullet would say: has been the subject of a previous CTO within the last two years?

Mr. Lougheed: Yeah. Just say, "that during the previous three years," then you have the first bullet; "that during the previous two years," then you have the second bullet.

The Chair: In the previous two years has been the issuance of a CTO.

Mr. Lougheed: Yeah. Has been the subject of a previous CTO.

The Chair: Within the last two years.

Mr. Lougheed: No. The stem would say: that during the previous two years. Then the second bullet.

The Chair: Oh. Okay. Changing three to two.

Mr. Lougheed: Only for the second bullet.

The Chair: Well, what I said was basically the same thing, wasn't it?

Mr. Lougheed: Convoluted, but that was it.

The Chair: I think it was probably far briefer. Are you proposing an amendment, preferably worded properly?

Mr. Lougheed: I propose that we accept this amendment with the following change, that would read thus:

> that during the previous three years the individual has been a patient in a designated facility on two or more occasions or for at least 30 days in total or during the previous two years has been the subject of a previous CTO.

The Chair: The chair won't argue.

The Reverend Abbott, then Mr. Shariff.

Rev. Abbott: Thank you, Mr. Chairman. I would speak against that change just because we had talked a little bit, I think I remember, several meetings ago about a CTO and a person's medical records. You know, your medical records are basically for life. They are kept in confidence with the medical profession.

Unfortunately, there are cases where a person can live in society, live in the community, live as a fully functioning member of society for a long number of years. It might be 10 years. It might be eight years. Then all of a sudden for whatever reason, perhaps, something will trigger a going off of that course of treatment and going back into a state of deterioration. I think it would be unfortunate to have to start the process all over again for the family to prove that this person would be eligible for a CTO.

I actually like it the way it is. I don't think two years or three years is long enough. I think it needs to be just the way it's worded right here, again, respecting that the medical community do keep health records for life but that they're kept very confidential.

Mr. Shariff: I'd like to ask Mr. Lougheed if he has any studies to suggest any advantage in changing from three to two years or otherwise.

Mr. Lougheed: No studies that I could put my hand on, only that these are expressions of concern from persons active in the mental health community either as patients living with some mental illness or professionals not having been subject to this legislation or anything but, rather, observing on behalf of persons with mental illness.

Mr. Shariff: Just a supplementary, then, to Dr. Massolin. As part of our studies and the contribution made by various individuals before this committee, what was the consensus about a two- or three-year timeline?

Dr. Massolin: Well, it varies slightly in terms of the other jurisdictions. Two years tends to be the preferred time frame, but there is an example of three years as well.

The Chair: Any others on the amendment?

Dr. Pannu: Mr. Chairman, the amendment deals with the second bullet. I wish it had dealt in the same way with the first bullet as well; in other words, cutting the three years to two years, again, in the first bullet. Certainly in the second bullet I think the amendment is most appropriate. Otherwise, it's indefinite, you know. One could have a CTO, and then this could hang over that person's head for the rest of her or his life. It's simply not fair. It's simply not appropriate. The amendment, I think, goes at least halfway in addressing some of the concerns that I expressed earlier, so I would be in support of the amendment.

The Chair: Dr. Massolin.

Dr. Massolin: Thank you, Mr. Chair. I just wanted to supplement my earlier response in terms of what I said on the time frame. That had to do with prior detention as an in-patient for those two- and three-year periods. The other jurisdictions, however, don't put a restriction in terms of a time limit on being the prior subject of a CTO. There's no time limit there.

The Chair: Any other discussion on the amendment? We're dealing with Mr. Lougheed's amendment. Those in favour of the amendment? Those opposed? That amendment is lost.

Now we're back to the motion as it is drafted.

2:55

Rev. Abbott: I move the amendment as drafted.

The Chair: I think it was Mr. Shariff who already moved that.

Mr. Shariff: You can second it.

The Chair: We don't require a seconder.

Dr. Pannu: Mr. Chairman, let me tell you another amendment that I'm concerned about related to the first bullet. I am proposing that in the reference to three years, "that during the previous 3 years," three years be changed to two years.

The Chair: Okay. Everybody understand the amendment? Any discussion on it? Seeing none, all those in favour of the amendment changing three years to two years? Those opposed? That amendment is lost.

So we're back to the motion as proposed by Mr. Shariff, which is as it's drafted. Ready for the question? Those in favour of the motion? Those opposed? That motion is carried.

Moving right along to number 3, "Expand the criteria to apply to any person," as you can read on that line. Is there anyone wishing to move that particular amendment at this time?

Rev. Abbott: I move amendment 3 as written.

The Chair: Okay. Any discussion on the motion?

Mr. Shariff: Can somebody just explain in a nutshell what exactly it means?

The Chair: Mr. Chamberlain, would you like to take a shot at that?

Mr. Chamberlain: Thank you, Mr. Chair. The current bill, basically, requires hospitalization as a formal patient. That doesn't necessarily recognize a patient who may have admitted themselves voluntarily or who may have been subject to a criminal court order and in as a forensic patient. We just want to make sure that any type of hospitalization/custodial care is considered for the prior hospitalization requirement.

Dr. Pannu: Clarification on the clarification of the explanation given to number 3 on the right-hand side bottom there on that page. Someone who is in a correctional institution, someone who is in jail, someone who is imprisoned, but authorities come to the conclusion that the person is in the wrong place. He needs out of there and needs a CTO for some mental health treatment. The imprisonment judgment made by the courts: would that come in the way of the implementation of this recommendation?

Mr. Chamberlain: Yeah. Dr. Pannu, the section in column 2 of the provision talks about satisfactory evidence available, that the person would have met the admission/hospitalization criteria. So a physician making the determination of whether or not a person has met CTO requirements would have to be satisfied that the person was in a facility and would have at that time met the hospitalization criteria. If they don't have that evidence available to them, then they wouldn't be able to utilize that time as one of the hospitalization time periods.

Dr. Pannu: Not currently in custodial care.

Mr. Chamberlain: No. This is an historical piece. This amendment really factors into and assists the second amendment, that was just voted on. It in some ways goes hand in hand.

Mrs. Mather: I just would really appreciate some clarification on the last, the third column there, where it says, "Permits eligibility for persons who meet the criteria while in a hospital or other custodial institution, other than a designated facility (e.g. correctional institute)." Can you explain that to me?

Mr. Chamberlain: Yeah. Ms Miller is with me. She'll kick me and correct me if I get this wrong. We have certain facilities designated for formal patients under the Mental Health Act for formal patients to be detained in. There may well be patients who were at another facility, not necessarily formally detained, or in transit to a facility that are formally detained or by criminal court order. We're trying to catch any of those facilities so that if a patient has been in another facility that's not necessarily designated as a formal Mental Health Act formal patient facility, that time can be recognized, again, if there's satisfactory evidence that the person would have met the admission criteria.

Mrs. Mather: Thank you.

The Chair: Okay. Anyone else?

Mr. Lukaszuk: Just a question. Up until recently the provision of mental health care was under the Mental Health Board, and there was very little, if any, transfer of patient data from the actual medical care system, being the Capital health authority in this case, and the Mental Health Board. Up until this three-year time elapses, is it possible that someone would have been in Alberta Hospital, yet that information would not be now available within the system of Capital health? Is that possible?

The reason I'm asking is because I've heard actually from psychiatrists where very often they would have an in-patient at the Royal Alexandra hospital and not be at all aware of the history the patient may have. The patient may have been a resident of Alberta Hospital on many occasions, but they wouldn't have that information because these are two separate operating bodies. At least they were up until not so long ago.

Mr. Chamberlain: Yeah. The transfer from the Mental Health Board to the regions of the operational services was done in 2003, so the short story is that there's now a four-year history. Those other records would still be available. They may not be on the same system, but they would be accessible if physicians required them. I honestly don't know how easy that would be to access. The transfer happened in 2003, so you're now talking about four years of history that would be in the regional health authority systems.

Mr. Lukaszuk: Okay.

The Chair: Any other discussion?

Are you ready for the vote? Those in favour of the motion as proposed by Reverend Abbott? Those opposed? That's carried.

Okay. We haven't even got to Bill 41 yet, and we've got eight more sections to get through on this plus something else on Bill 31 that we haven't finished. Are we looking for some other meeting dates between now and the 1st of November? We have to consider that possibility. We've got about 25 minutes left in this meeting.

Rev. Abbott: There are currently no amendments proposed for 41?

The Chair: By the minister.

Rev. Abbott: So we're going to deal with our own? Is that what you're mentioning?

The Chair: Well, at this particular time, yes. There's been nothing proposed.

Rev. Abbott: Okay. So we're going to try to get through these today.

The Chair: We have to try to get through these, but I do want to get through one other thing that we were talking about before the minister came in. Maybe we could do that now, or do we want to continue with this? Okay. We'll continue with this.

> Number 4, add regulation-making power respecting examinations. Where appropriate, regulations will permit patients to be remotely examined, e.g. telehealth.

This avoids conveyance of patients for examination where a psychiatrist is not available in the patient's community, e.g. remote communities. With the increase in possibility of getting SuperNet to every community, perhaps that type of thing would be more common in the future.

Mr. Backs: I'll move that, Mr. Chair.

The Chair: Mr. Backs moves. Any discussion? Those in favour? It's carried.

The Chair: Number 5, expand authority to allow the supervising psychiatrist/ physician to issue an apprehension order. Mr. Shariff, are you moving that?

Mr. Shariff: I have a question on it. Maybe somebody can move it, and then we can have a discussion.

Rev. Abbott: So moved.

The Chair: Reverend Abbott moves.

3:05

Mr. Shariff: My question was with regard to psychologists having the authority, if they will fit in here. It's not identified. Now that we've included them in being able to issue a CTO, is there any room for that to occur here?

The Chair: Perhaps the wording could be changed to the exact same wording as we approved earlier on: appropriate health professional. Would that cover it? Shannon, do you have a comment on that?

Ms Dean: Mr. Chairman, I think the committee might be interested in whether Mr. Chamberlain has any comments on that.

Mr. Chamberlain: Thank you, Ms Dean. Mr. Chair, one of the issues that was raised in the briefing note that the committee was looking at earlier was in fact this question, whether health professionals other than just physicians and psychiatrists may be able to do renewals and other matters with respect to CTOs. This amendment spoke to the current language, which is a physician or a psychiatrist who may be directed as a supervisor, or a person overseeing the CTO. The purpose of the amendment is that the psychiatrist who originally issues the CTO may not have any ongoing dealing with the patient once they're out in the community and reporting to their physician or their psychologist, whoever in the community they're dealing with. So this was intended to enable the community physician to actually issue the apprehension order because they're more likely to understand and know whether a person has gone off the requirements of the CTO.

I haven't discussed this with the minister, but it is consistent with the other change that the committee discussed, to move towards a qualified health professional, whatever the appropriate language is, and then moving that power into regulations so that the qualifications would be set in regulations. I can't imagine that the minister would have any objections to that because we've been able to maintain the same status quo through the regulations unless and until we determined that it was appropriate to expand them.

Mr. Shariff: In that case, I'm wondering whether we should even vote on this or wait for you to come back next week with the same format that we had previously, that a psychiatrist could issue an apprehension order, but if it is a physician or a psychologist, then at least those two professionals would have to be consulted before an apprehension order is issued, just as we have it with the CTO.

Mr. Chamberlain: My response, Mr. Shariff, would be that we could certainly do that, although I think that's a relatively straightforward amendment that the committee could vote on today rather than having to come back.

Mr. Shariff: Okay. Can we then find the appropriate wording, Shannon, to reflect what I just said?

Ms Dean: Sure. Can I just point out a procedural matter? What I envision happening – that's why we're trying to get through this document – is that the committee will direct myself and Mr. Chamberlain to work on the text of these amendments for formal approval by the committee next week. So what I would suggest procedurally is that an amendment be moved to that recommendation to allow for other qualified health professionals to be caught by this change. Then we could address that formally in the amendment next week.

Mr. Shariff: In that case, Mr. Chairman, I move that item 5 read as follows.

> Expand authority to allow the supervising psychiatrist or, in their absence, an approved health professional to issue an apprehension order . . .

I don't know what else to say there, Shannon, after that.

Ms Dean: Through the chair:

> . . . consistent with the committee's earlier recommendation that other health professionals besides physicians be allowed to be involved in the issuance and other related matters regarding CTOs.

Mr. Shariff: That's exactly what I had in my mind.

The Chair: Okay. This would be an new motion, not an amendment.

Ms Dean: No. It's an amendment to Reverend Abbott's motion.

Rev. Abbott: Mr. Chairman, I accept that amendment as a friendly amendment.

The Chair: Thank you.

Any discussion on the amendment? Those in favour of the amendment as moved by Mr. Shariff? Those opposed? That's carried.

Any more discussion on the motion as amended?

Hon. Members: Question.

The Chair: Those in favour? Opposed? Carried.

Okay. Number 6:

> Add provision that requires an automatic/mandatory review by the review panel after the first renewal and every second renewal thereafter until a CTO expires or is cancelled, except where the person has made an application within the preceding month.

Were you moving that?

Mrs. Mather: I'll move that.

The Chair: Mrs. Mather moves that.

Shannon, you wanted to comment on this?

Ms Dean: Mr. Chairman, I just wanted to point out to the committee that there was a motion approved last week on this point. It varies somewhat from what the minister is proposing here; however, I do think that it's consistent in terms of intent. For your information, last week the motion that you approved about an automatic review, the time frame involved was 12 months, whereas the proposal here is before the expiry. It's six months and then every 12 months thereafter. So what I would suggest is that the committee can vote on this. I think that that's consistent with the intent from last week.

The Chair: Any discussion?

Mr. Shariff: Just to be clear. If a CTO is ordered, before it is renewed for the first time there would be a review. If that is reviewed, then after two CTOs would be the next review. So we're looking at six months and 18 months, potentially.

Mr. Chamberlain: Mr. Chair, I want to be clear on what the minister's amendment is proposing because it's a little different than what Mr. Shariff just explained. There would be a review on the first renewal, which is the six months Ms Dean was referring to, and then on every second one, which is a 12-month, essentially. But the reality is that it's not before the renewal. The renewal has to happen because it's then the renewal certificate that is reviewed. Otherwise, you get into timing issues. You go through the first CTO, which is a six-month. It's renewed. That would trigger a mandatory review of the renewal. You actually have a certificate for the review panel to review and consider. Otherwise, the physicians may have decided not to reissue the certificate, so it wouldn't be that decision that triggered the review. It would be actually the renewal.

Dr. Pannu: And the review could result in the cancellation of the renewal?

Mr. Chamberlain: Yes. Correct.

Dr. Pannu: Okay.

The Chair: Those in favour? Opposed? It's carried.

Okay. Number 7:

> Amend the review panel hearing and appeal provisions so that the supervising physician/psychiatrist, if different from the issuing psychiatrist, receives the notices and attends the hearings/court applications.

Were there any changes on that, Shannon, that we need to know about before a motion is made?

Rev. Abbott: Well, I think just the obvious changes, and maybe we should have said that those would be concurrent. Whenever we talk about psychiatrist or physician, we mean mental health professional. But I like the spirit of this as saying that it can't be the same person doing their own review. So we need to stick with that.

Mr. Shariff: Well, if I'm hearing Tony correctly, then would you move that amendment therein consistent with the previous terminology?

Rev. Abbott: Yes. So moved, consistent with the previous terminology.

The Chair: Okay. Tony is moving this with the same wording as the previous.

Dr. Pannu: What exactly is the change in wording, then?

Rev. Abbott: All we're really saying, Raj, is again: the supervising mental health professional. So it just is a little bit broader net, but it's still saying that it has to be different from the issuing mental health professional.

Dr. Pannu: Okay. Right.

The Chair: Any discussion? Mr. Chamberlain, you had a comment?

Mr. Chamberlain: Yeah. I just want to clarify that to make sure that there's no misunderstanding. It might not necessarily be a different person. The purpose of this is to enable the supervising psychiatrist or physician to attend the panel if that person is more appropriate because the issuing psychiatrist or physician may not know enough to attend on the review because it may be the supervising psychiatrist who has in fact issued the renewal. This is making sure that the person who is best able to address the review is in front of the review panel.

The Chair: The person most familiar with the patient's history.

Mr. Chamberlain: Exactly. The current history, yes.

Mr. Shariff: But Tony's point about the panel being independent of the person issuing the certificate?

Mr. Chamberlain: The review panel is independent, yeah. The review panel is structured quite differently and is already in the act dealing with reviews of formal patients.

Dr. Pannu: It's in the Mental Health Act?

Mr. Chamberlain: The Mental Health Act already requires and provides for mental health review panels, of which we have, I believe, three across the province that hear reviews from formal patients. The current bill has those panels charged with dealing with CTO issues. So it would be those panels who would be addressing the CTO reviews. This amendment is just addressing who on behalf of, sort of supporting the CTO would be appearing in front of the panel and explaining what the purpose and the reason for the renewal was and the terms of the CTO.

3:15

The Chair: Are you ready for the question?

Hon. Members: Question.

The Chair: Those in favour? Opposed? That's carried.

Okay. Number 8, technical amendments.

Rev. Abbott: Mr. Chairman, in light of the last four being technical amendments, could we just deal with those as a block?

The Chair: If that's agreeable with the committee.

Rev. Abbott: They're essentially housekeeping.

The Chair: Any comments, Mr. Chamberlain or Shannon, on these that we should know about?

Mr. Chamberlain: Not from me, Mr. Chair. They are, in fact, technical amendments or things we've picked up over the last few months in drafting, where there were changes that were missed or words that were incorrect, typographical errors, that type of thing. In our estimation they are simply housekeeping matters.

Rev. Abbott: Then I move acceptance of amendments 8 through 11.

The Chair: Amendments 8, 9, 10, and 11. Any discussion on any of them? Those in favour? That's carried. Thank you very much.

Do we want to finish that item we were discussing before Mr. Hancock came in? There's one more issue we wished to discuss after that motion, and it's: does the committee wish to amend Bill 31 to allow for alternate types of health professionals to be involved in anything beyond the issuance of a CTO; for example, renewing and/or amending the order?

Rev. Abbott: Again, I would say that I think our answer to that has to be yes, especially in light of some of the amendments that we just passed. I think we're trying to show that we prefer a psychiatrist. Obviously, that's first. If not, then a physician or another qualified mental health professional would be able to stand in. So I believe that this additional issue would be consistent with the spirit of all of the amendments we've made to date.

The Chair: Is that a motion, Reverend Abbott?

Rev. Abbott: So moved. If the wording is clear enough for the committee, then I'm fine with it.

The Chair: Do you have some wording, Corinne or Shannon?

Ms Dean: If I may offer this to the committee. Perhaps if Reverend Abbott's motion is worded something to the effect that

> the committee wishes to recommend amendments to Bill 31 that would allow for alternative types of health professionals to be involved in the issuance of the CTO in addition to renewals and amendments and other consequential amendments, with those amendments to come back for formal consideration next week.

Rev. Abbott: Shannon, perhaps as another safeguard we could say approved types of alternative health professionals. Like, I'm just thinking that perhaps in regulation we need to be specific.

Ms Dean: Sure. Qualified health professionals as designated in regulations.

Rev. Abbott: Yes, something like that.

The Chair: Okay. Any other discussion on the motion?

Mr. Shariff: I'd like to ask Mr. Chamberlain if the department has given any consideration to this expansion that we have approved and passed on so many of these motions, its impact on overall mental health care delivery, because now we are expanding to psychologists. If they are involved in a lot of these issuances, I presume they would also be a part of the panel and maybe part of the treatment plan. What kind of an impact will it have on the overall health care delivery system?

Mr. Chamberlain: Thank you, Mr. Shariff. The short answer is: no; we haven't given specific consideration to what the impacts of this might be nor which health professionals might be best suited to be qualified. That's something that we'll obviously have to review and consult with the colleges on and make some determinations. That's why I'm quite comfortable with having the matter referred to regulation so that initially we can maintain the status quo while we have those consultations and discussions and then determine which professionals are appropriate for issuing CTOs, for amending CTOs, for renewing CTOs. That is consistent, though, with the Health Professions Act concept of expanding scopes of practice where appropriate.

So I don't have any objections or concerns about the proposed amendments as long as the power is sufficient in the regulations to give us the flexibility for professions to designate classes within professions, to designate specific individuals as appropriate, and allow us the flexibility to come up with appropriate tools to address the very concerns you're raising about resources.

Mr. Shariff: Okay. Question.

The Chair: Okay. Those in favour of the motion? Opposed? That's carried.

I remind all members that they have to vote.

We're going to move back to where we left off last week on the Bill 31 amendments that the committee was going through, and we are at 2.2.2, apprehension for noncompliance. Does everybody have those documents? It was Bill 31 amendments that the committee was going through.

Go ahead, Dr. Massolin.

Dr. Massolin: Thanks very much, Mr. Chair. Yes, the document that the chair is referring to is this focus issues document. We dealt with it last time, and we didn't quite finish it. It's basically going through, as the name of the document indicates, focus issues that were identified by the committee but also by the submitters during the public consultation period. We left off, as the chair indicated, on page 8, 2.2.2, apprehension for noncompliance.

Now, you can read section 9.6(1) and what it entails there. The real issue here is whether or not the committee should consider whether there should be an interim step applied when a patient is not compliant. The situation is as follows. You have a patient who is not compliant, but the suggestion is – and this recommendation is made on the part of some submitters – that before you take the step of obtaining a physician-ordered measure, you provide support to bring that patient into compliance with a CTO without issuing that order. So you'd add that interim step to the process, and this is a process that has been considered and implemented in the legislation in Newfoundland and Labrador.

I'll turn the floor over.

The Chair: That wouldn't be a mandatory interim step. It would be at the discretion of the health professional. Is that correct?

Dr. Massolin: I don't think so, necessarily, although I can't speak with absolute certainty.

The Chair: It would be an automatic step?

Dr. Massolin: Oh, yes.

The Chair: Okay.

Dr. Pannu: Mr. Chairman, I would say that it's a very, very appropriate safeguard to protect the rights of individuals who may be subjected to CTOs. As you very rightly reminded the committee some time ago, this is, after all, a coercive action. It does force people to undergo a certain kind of treatment. It is important to therefore put in some safeguards, and this provision in the Newfoundland act I think provides the kind of safeguard that we need to apply here. So I'm willing to move, if you so wish, with the language here on page 8 in the very last, right-hand side column, that in the act we require that

> reasonable efforts be made to inform the patient of his or her failure to comply, explain that such failure to comply may lead to an involuntary psychiatric assessment, and provide assistance to the patient to comply with the CTO.

The Chair: Okay. You all heard the motion?

Mr. Shariff: I would just suggest to hon. Dr. Pannu that the amendment that he's proposing also indicates that authorization be given to the other approved health care professionals – it's currently authorizing a psychiatrist to issue – so that it's consistent in the bill.

Dr. Pannu: That would be fine now that we've gone and taken that step. I mean, it has to be consistent with that, but the substance of the amendment stays, yeah.

3:25

Mr. Shariff: Is the record reflecting Dr. Pannu appropriately?

The Chair: What was that?

Mr. Shariff: I had just made a suggestion to Dr. Pannu that as part of his motion he expand it a little further to include other approved mental health care professionals and that, you know, the bill would be then consistent throughout.

The Chair: Okay. Any other discussion?

Those in favour of the motion as proposed by Dr. Pannu? Those opposed? That's carried.

Our time is beyond getting into another area. We are going to need another date, possibly next week.

Mr. Shariff: I thought we had a date set.

The Chair: The 25th, but we've got Bill 41 to go through unless you want to expand the time on the 25th. We've got 1:30 to 4:30 on the 25th.

Mr. Shariff: Bill 41 doesn't have any amendments, so really there won't be – we'll deal with our proposals.

The Chair: We're not through Bill 31 yet.

Dr. Pannu: I wonder if we can ask Mr. Chamberlain if he is aware as to whether the department is likely to bring forward any amendments to 41.

Mr. Chamberlain: Dr. Pannu, I can only echo what the minister indicated. He's not proposing any amendments to Bill 41, but he is still consulting with stakeholders.

The Chair: We're running short of time, and we have to report by the 1st of November.

Mr. Lougheed: Could we meet earlier on Thursday? Instead of 1:30 could we meet at 10 or something like that?

The Chair: Ten or 9 on Thursday. We're scheduled to meet on Thursday at 1:30 as it is, so could people make it earlier?

Rev. Abbott: Sure. That's fine. What time, Mr. Chair?

Mr. Shariff: I'm part of Members' Services, and I think that's next week as well.

Mr. Flaherty: Why don't you buy us supper, Mr. Chair, and we'll just stay? I'm batching next week.

The Chair: There are other commitments that people have that have to leave here momentarily. Is it agreeable to start the meeting next Thursday at 10 a.m.?

Some Hon. Members: Agreed.

Mr. Flaherty: I might have to join you late, Mr. Chair, but I'll join you if that's all right. I might be a little late.

Mr. Shariff: Mr. Chairman, I'll just advise you that in the event that the Members' Services Committee meets at that time, I will not be present.

The Chair: Okay. Is there anybody that can't make it on the 25th?

Mrs. Dacyshyn: Basically, just to clarify, we're talking about 10 o'clock right to 4:30?

The Chair: Ten o'clock till when?

Mr. Lougheed: Till 2 at the most. I'll be excusing myself about 2 or 2:30.

The Chair: That'll be fine as long as a quorum is maintained.

Mr. Shariff: Currently we have three hours of meeting time. Do we really need more than three hours?

The Chair: We're just upping the time to 10 o'clock.

Ms Dean: Mr. Chairman, if there's any ability to keep a quorum for a few more minutes, there are only a few more issues in the focus issues document on Bill 31. If we can finish those focus issues, then I think we might be okay with respect to where we are next week.

The Chair: You're prepared to do that?

Okay. Item 2.3, Bill 31 proposes to amend section 38 of the Mental Health Act.

Dr. Massolin: If I can just sort of chime in here.

The Chair: Please do.

Dr. Massolin: Okay. Thank you. The key consideration here is really brought forward by some of the submitters, and that is to inform patients of their rights to review. We've already talked about the auto review situation and have handled that, but the other consideration is to inform patients of their rights to review so that there is, you know, full disclosure, full information there. Then they can avail themselves or not of that right. That's sort of what the committee should consider right now, in our view.

Rev. Abbott: Mr. Chairman, do you need a motion on that?

The Chair: I sure do.

Rev. Abbott: So moved.

The Chair: Okay. Thank you. Mr. Abbott moves that. Any discussion? Did you have something, Dr. Pannu?

Dr. Pannu: Well, Mr. Chairman, this seems to me to be a fairly straightforward issue. It's a question of informing patients of their right to appeal CTOs. I think this should be included in the legislation: the obligation to inform the patient of the right to appeal. Patients are, of course, not able, necessarily, to know all of this or remember all of this, so I think it's good to have it included in the legislation. I'll so move.

The Chair: I believe I have a mover already, Dr. Pannu. Reverend Abbott moved that.

Mr. Chamberlain: I apologize, Mr. Chair. I'm flipping through trying to address this, and perhaps Dr. Massolin can help me. I believe section 14.1.1 already provides for a copy of the notice of information to be provided to the patient.

Dr. Massolin: Okay. I guess the only concern was that there be sort of more proactive information in addition to that. It was just brought up by the submitters for the information of the committee here. Perhaps the question is whether or not there is another way to strengthen that aspect of the legislation.

Mr. Chamberlain: Yeah. Section (1.1) in section 14 already indicates that there has to be a written statement of the right to review, and then that statement has to be provided to the patient. So that provision is, to my estimation, already in there, Mr. Chair.

Dr. Pannu: That assumes complete literacy on the part of patients. Is that correct, Mr. Chamberlain? We are dealing with people who are not necessarily totally literate. It is good that that provision is there, but I think we need to perhaps go an extra distance if we can.

Mr. Chamberlain: The practice, obviously, is that the physicians and psychiatrists do sit down with the patients and review these things with them, and the Mental Health Patient Advocate also has a role. The proposed section in Bill 31 currently says:

> (a) shall prepare a written statement of
>
> (i) the reason, in simple language, for the issuance, amendment or renewal of the community treatment order.

Then that has to be provided to the person and also to any substitute decision-maker. Certainly, if the committee thinks that some clarification is required, I don't believe the ministry has any objection, but I would submit that it really isn't necessary in this instance.

Mr. Shariff: I just have a question. Currently as it stands in the act, does every person who is the subject of a CTO have a substitute decision-maker? Do they have to have somebody else who is substituting for them as a decision-maker?

Mr. Chamberlain: No. The substitute decision-maker provisions would only apply where the person doesn't have the competence to make a decision on their own.

Mr. Shariff: If they had competence to make a decision, they would not be part of the CTO to start with.

Mr. Chamberlain: That's correct, although I want to be careful with that answer. Obviously, the physicians and psychiatrists, when they're making these determinations, may well be consulting with the family and others to determine whether or not the appropriate supports were available. They wouldn't necessarily be involved in the process, but the decision on whether or not to consent to a CTO would be the patient's if the patient had the competence to make that decision.

3:35

Mr. Shariff: Then, Mr. Chair, what I would suggest is maybe an amendment to that motion that Tony made that should necessitate, should force that this information be shared with the substitute decision-maker and, in the absence of a substitute decision-maker, the next of kin that is most involved with this individual.

Rev. Abbott: I think that's included already, but that's fine.

Mr. Chamberlain: The provision is already in the section to provide it to the substitute decision-maker, yes.

Mr. Shariff: What I'm saying is when there isn't a substitute decision-maker.

Mr. Chamberlain: When there isn't a substitute decision-maker – again, I want to be careful because we're getting into areas where if the person is competent and able to consent on their own, it may well be that the family is not involved or aware of what's going on because you have confidentiality concerns. If they don't need to be involved in the support part of the community treatment order, if there's some kind of separation of family, you may not want to mandatorily give notice to those people who may not have any right under the Health Information Act to that information.

Mr. Shariff: Well, then, I'll just put for the record that the concern, that I heard from Dr. Pannu as well, is for patients who are unable to really make a decision on their own or understand the written document that we provided to them, who may not necessarily fully understand its implication. If they don't have a substitute decision-maker, they may truly be deprived of the right to have a fair assessment of what is being done unto them. But I'm willing to live with the outcome for now.

The Chair: So you're not introducing an amendment?

Mr. Shariff: No.

The Chair: Okay. Are you ready to vote on the motion? Those in favour? Opposed? That's carried.

Section 2.4, CTO implementation issues.

Dr. Massolin: Just before we get there, there's actually a previous

issue. It starts at the bottom of page 9 and continues on page 10. It has to do with a similar issue we've already dealt with but one that's relevant here, and that is that the committee consider that this proposed amendment be consistent with section 104 of the Health Information Act.

Also, the other key consideration that I think committee members may wish to consider is that because the CTOs have already been extended to outpatients, at least under the proposed amendment – sorry; did you want to jump in, Shannon?

Ms Dean: Mr. Chairman, if I may supplement. This is an important issue that was flagged in the submissions, but I believe this is addressed in the minister's recommended amendment on page 1. Perhaps Mr. Chamberlain can confirm that.

Mr. Chamberlain: Yes. That's correct. This was an issue that was raised by the commissioner. We did address it with this committee. I believe I got a question on it last time. There is a change required because of the move away from a formal patient requirement, and I believe this is the same amendment that you've already approved as part of approving the minister's proposed amendments.

The Chair: So this isn't necessary, then?

Mr. Chamberlain: I don't believe so, Mr. Chairman.

Dr. Massolin: Thank you very much.

The Chair: Okay. Then can we just move on?

Dr. Massolin: Yes, very much so. Under 2.4, the CTO implementation issues, as you can see there, the AMHPA, Alberta Mental Health Patient Advocate, wants to be considered as part of . . .

Ms Dean: If I may, Mr. Chairman. I believe the patient advocate was looking for a broader mandate with respect to its role. Again, I don't think that this is, strictly speaking, within the scope of this bill because powers and duties of the patient advocate are spelled out in regulation, so any changes to those powers and duties should be dealt with through an amendment to that regulation. We just wanted to point this out to the committee at this time.

The Chair: So there's no motion required.

Dr. Massolin: The final consideration has to do with a potential review of Bill 31 and the time frame of that review, you know, three years, five years, whatever the committee may consider.

Mr. Shariff: Don't we have an automatic sunset clause normally on every bill?

Dr. Pannu: We don't. That's the thing. In the other committee this morning I think that for the first review we determined that two years is a good time.

The Chair: And five years after that.

Dr. Pannu: That's right. So the first review should be two years from the date of . . .

The Chair: Coming into force.

Dr. Pannu: Right. And then every five years.

Rev. Abbott: My question is: is that enough time for it to be used? It'll take two to three years to get this thing figured out and to start to implement it.

Dr. Pannu: Well, we are talking about from the date the bill is proclaimed, so the first two years will be crucial, I think.

Mr. Chamberlain: Mr. Chair, if I might. From the ministry's perspective we would be concerned about such a short time frame because it will take some time to implement this, to educate health professionals, to determine how widely it's being used. Quite frankly, with a two-year review we probably won't have enough information to know whether or not it's being effective.

Dr. Pannu: Would three or four be good?

Mr. Chamberlain: Part of the answer to that is that we're going to have to wait and see how it rolls out, how aggressively it's being used by professionals, and what issues we arrive at. If there are some court challenges, obviously they will take some time to work through the courts. So a minimum of five would be my preference. That doesn't preclude the ministry from looking at it and reviewing issues as they come up, obviously.

The Chair: Mr. Shariff.

Mr. Shariff: Yeah. Mr. Chairman, normally, you know, in the event that something is not working out or the feedback is negative, there is an opportunity for the minister to bring forward an amendment during session. So I'd like to move that we establish a timeline of five years for review.

Ms Dean: Just a point of clarification. There are different types of reviews, as you know, Mr. Shariff, that can take place. Are you proposing that this review be undertaken by a committee of the Assembly?

Mr. Shariff: That's an interesting question. Is that something that occurs in other bills?

Ms Dean: Yes. For example, the Conflicts of Interest Act has that type of provision. The Health Information Act I believe does too.

The Chair: It could be a departmental review.

Mr. Shariff: No. I move: by the committee.

Rev. Abbott: Mr. Chairman, I just think this is a little bit different than the Conflicts of Interest Act or the lobbyist registry or anything else. This one is more one of our bills that we put into the hands of our medical professionals. I think once we turn this one back to the department, it's really something that they need to look at through their eyes of expertise. I don't know that it needs to come back. I believe it's very, very important for the committee to look at it now, as we have, to get public opinion, to get feedback and input. But to bring this one back to the committee – it would be a tremendous education process to bring everybody back to where we are right now. I think a review is important, but I think it could be well done by the department.

Dr. Pannu: I respectfully disagree on that issue. I think this committee is a new process. I think we have found that it's a productive and a rewarding process. It's educational not only for us

as lawmakers; it's also very educational for people who appear before it. The mental health issue is something on which we'd all agree that we all need to promote more information, more education, and exchange of experience.

This committee would be the right forum, Mr. Chairman, for the review. I would with some hesitation accept the five-year period, but the review should appropriately be done by the Legislature, that is through this committee, not by the department alone.

Mr. Lougheed: I would expect the department had better be reviewing everything all the time anyway. That's the expectation. I'd propose and support a committee of the Legislature doing the review.

3:45

The Chair: And a standing committee can summons any professionals that they so wish to advise them as well. Any other discussion on the motion?

Those in favour? Those opposed? That's carried.

Okay. That concludes our issues on Bill 31.

Mr. Shariff: So then the 1 to 4 for the next meeting should be sufficient for Bill 41.

The Chair: The 1:30 to 4:30.

Mr. Lougheed: It doesn't help. Some of us will not be here.

The Chair: How many won't be here for all or part of the meeting on the 25th?

Mr. Lougheed: Well, just for a tiny part.

The Chair: Then we'll still have six. I won't be here.

Dr. Pannu: The 25th is a Friday, right?

Mrs. Dacyshyn: No, it's Thursday. It's scheduled for Thursday, October 25, from 1:30 to 4:30 right now.

Mr. Shariff: In the event, Mr. Chairman, that you feel we need more time, maybe we can move it a little earlier, to 1 o'clock or 12:30.

The Chair: Since I'm unable to be here, I could move it as early as . . .

Mrs. Mather: Did you say 1:30 to 4:30?

Mrs. Dacyshyn: Yes, that's the time that's currently posted.

Mr. Lougheed: You're prepared, then, for some of us not to be here past 2 o'clock.

The Chair: Would you like to move it up earlier? Would that be helpful?

Mr. Lougheed: We talked about going to 10 o'clock. Why not start at noon or something?

Mrs. Dacyshyn: How about 12:30?

The Chair: Twelve-thirty is the earliest we can go, and we'll provide lunch.

Mr. Lougheed: Lunch at 12. The meeting at 12:30.

Mrs. Dacyshyn: So to confirm: lunch at 12, the meeting starts at 12:30.

Mrs. Mather: And we're going to end at 3:30.

The Chair: We'll end as soon as we can.

A motion to adjourn? Dr. Pannu moves that we adjourn. Those in favour? It's carried.

[The committee adjourned at 3:47 p.m.]