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The 29th Legislature
First Session

Standing Committee on Families and Communities

Mental Health Amendment Act, 2007, Review

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Legislative Assembly of Alberta
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First Session

Standing Committee on Families and Communities

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Standing Committee on Families and Communities

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Fern Miller, Director, Addiction and Mental Health

Ministry of Justice and Solicitor General
Sunny Menon, Barrister and Solicitor, Health Law

Office of the Mental Health Patient Advocate
Carol Robertson Baker, Mental Health Patient Advocate

1:01 p.m. Monday, October 5, 2015

[Ms Sweet in the chair]

The Chair: Good afternoon, everybody. We're all here, I think, so I'll call the meeting to order. Welcome to members, staff, and guests in attendance for this meeting of the Standing Committee on Families and Communities. My name is Heather Sweet, and I am the MLA for Edmonton-Manning and chair of this committee.

I'd ask that members and those joining the committee at the table introduce themselves for the record, and then we will call on the members on the phone lines to introduce themselves.

Mr. Smith: Mark Smith, Drayton Valley-Devon.

Mr. Yao: Tany Yao, Fort McMurray-Wood Buffalo.

Mr. Westhead: Cam Westhead, Banff-Cochrane.

Mr. Shepherd: David Shepherd, Edmonton-Centre.

Ms Payne: Brandy Payne, MLA for Calgary-Acadia.

Mr. Hinkley: Bruce Hinkley, Wetaskiwin-Camrose.

Ms Luff: Robyn Luff, Calgary-East.

Ms Babcock: Erin Babcock, Stony Plain.

Mrs. Littlewood: Jessica Littlewood, Fort Saskatchewan-Vegreville.

Ms Robertson Baker: Carol Robertson Baker, Mental Health Patient Advocate.

Ms Berg: Shannon Berg from the health services division.

Ms Miller: Fern Miller, addiction and mental health branch, Alberta Health.

Mr. Menon: Sunny Menon, legal counsel for Health.

Mr. Orr: Ron Orr, Lacombe-Ponoka.

Ms Sorensen: Rhonda Sorensen, manager of corporate communications and broadcast services for the Legislative Assembly.

Ms Robert: Nancy Robert, research officer.

Ms Dean: Shannon Dean, Senior Parliamentary Counsel and director of House services.

Mr. Koenig: Trafton Koenig, legal counsel with the Parliamentary Counsel office.

Dr. Massolin: Good afternoon. Philip Massolin, manager of research services.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: To the phones.

Mrs. Pitt: Angela Pitt, Airdrie.

The Chair: Ms Jansen? No? Okay.

Mr. Rodney: Hi there. Dave Rodney, MLA for Calgary-Lougheed. I wonder if it's worth noting that Thursday is indeed National Depression Screening Day.

The Chair: Good to know.

Is Dr. Swann on the line yet? No? Okay.

We'll just go ahead, then, with a few housekeeping items to address before we get to the business at hand. The microphone consoles are operated by the *Hansard* staff, so there's no need to touch them. Please keep cellphones, iPhones, BlackBerrys off the table as these may interfere with the audiofeed. Audio of committee proceedings is streamed live on the Internet and recorded by *Hansard*. Audio access and meeting transcripts are obtained via the Legislative Assembly website.

If we could just move on to the approval of the agenda. Could I please have a member move a motion to approve? There are no additions?

Mr. Shepherd: I move to approve.

The Chair: Thank you, Mr. Shepherd. So moved that the agenda for the October 5, 2015, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of the motion? Those opposed? Thank you.

Next are the minutes from our last meeting. Are there any errors or omissions to note? No? If not, would a member move adoption of the minutes, please?

Mr. Westhead: So moved.

The Chair: Mr. Westhead. So moved by Mr. Westhead that the minutes of the July 16, 2015, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of the motion? Any opposed? Carried. Thank you.

All right. We're moving on to our guests. We have a number of presenters joining us today from the Ministry of Health and from the office of the Mental Health Patient Advocate. There is a little change; I guess I should have brought that up when we moved the agenda. The Ministry of Health is actually going to go first, and then we will have the office of the Mental Health Patient Advocate go second.

I understand that the ministry officials joining us today represent a number of branches within the department as well as the Ministry of Justice and Solicitor General, and they will be combining their time. You have 20 to 25 minutes for your presentation. If you could please identify yourself when speaking for the record for the benefit of the committee, the members on the phone lines, and those listening to the audio of our proceedings.

Ms Jansen, you're on the line now? Would you like to introduce yourself?

Ms Jansen: Yes, I am. Thank you very much. Sandra Jansen, the MLA for Calgary-North West.

The Chair: Thank you.

Go ahead, please.

Ms Berg: Thank you, and thank you very much for inviting us and welcoming us to your meeting this afternoon. I'm Shannon Berg, and I'm the executive director for the addiction and mental health branch of the health services division. I'm here on behalf of Ruby Brown, who's the assistant deputy minister for the health services division of Alberta Health.

The Chair: Dr. Swann, you're on the line?

Dr. Swann: Yes. Thank you. David Swann, Calgary-Mountain View.

The Chair: Thank you.

Go ahead.

Ms Berg: With me today I have Fern Miller, who's the director of addiction and mental health. I also have Sunny Menon, who's a Justice counsel, with me today. Also involved in the presentation was Tracey Bailey, who's general counsel for Alberta Health. Also with me today is Carol Robertson Baker, who will be providing you with a briefing. She's the Alberta Mental Health Patient Advocate.

Just very quickly before we go into the details of the presentation – and Dr. Swann will know this well – for the rest of you I wanted to just make the distinction between our mental health review that's going on and what we're here for today. In June 2015, as you all know, Premier Notley announced the review of the addiction and mental health system in Alberta, and that's being co-chaired by Dr. Swann and Danielle Larivee, with Tyler White there as the third committee member. The review may receive feedback about the Mental Health Act, but this is about the review of the Mental Health Amendment Act, 2007.

The other thing I wanted to just say is that the public servants on our team are very, very willing and would love to be at your disposal as you go through this process. We're here today just to give you an introduction, but we want to make ourselves available. Please feel free to call on us at any point for anything that you need. Please let our team know what additional information would be helpful to you as you carry on with the review.

Now I'll turn it over to Sunny.

Mr. Menon: As Shannon mentioned, my name is Sunny Menon. I work for Alberta Justice and Solicitor General, but I'm counsel for Alberta Health and work on the health law team.

Our aims for today: what we plan to cover today in our background briefing covers three main topics. First, what is mental health law? Is it only legislation such as Alberta's Mental Health Act? Does it encompass other things? Second, key elements of Alberta's Mental Health Act so that you have an introduction to this key piece of Alberta legislation and its aims and functions. Third, the subject of your review, amendments made by the Mental Health Amendment Act, 2007, both the summary of the changes that were made as well as the policy rationale behind such changes.

Before describing the different types of mental health law, I thought it important to set out for you very briefly the three main types of law in Canada, Quebec excepted. The first type of law is the common law. This is law created by judges when there is an absence of legislation or where judges are asked to interpret legislation.

Legislation is the second type of law. It is the body of law created by the federal or provincial or territorial governments. Alberta's Mental Health Act is an example of such legislation.

Third, the Constitution. All legislation enacted by governments must be constitutional. Our Constitution Act, 1867, generally speaking, sets out the authority of the federal government to make certain types of legislation, for example criminal law, while it also provides authority for provincial governments to enact other types of legislation, for example most health law.

1:10

The Charter of Rights and Freedoms sets out certain rights and freedoms that are protected at the constitutional level such as the right to life, liberty, and security of the person or freedom of religion. These rights are not absolute. They can be limited but only as demonstrably justifiable in a free and democratic society. Legislation passed by governments may be challenged in the courts as unconstitutional. This is part of the checks and balances created by government to protect the democratic system that exists in Canada.

Mental health legislation can typically be grouped in three different ways. One, across Canada mental health acts similar to Alberta's have been enacted. Two, legislation dealing with criminal matters such as the Criminal Code codifies most criminal offences and procedures in Canada. From a mental health law perspective, it sets out certain processes with respect to individuals with mental disorders in certain circumstances. Finally, legislation has been enacted provincially setting out legal requirements with respect to obtaining consent for health care treatment from individuals or their substitute decision-makers. One example is Alberta's Adult Guardianship and Trusteeship Act, or, as we call it, AGTA.

A brief history of Alberta's Mental Health Act and its predecessors may provide some helpful context for your current work. In 1905 Alberta was established as a province. In 1907 the Insanity Act was passed. It provided for patients to be sent to an asylum in Manitoba or some other province as Alberta did not have any asylums. In 1919 Alberta passed the Mental Defectives Act, and a mentally defective person was defined as "any person afflicted with mental deficiency from birth, or from an early age, so pronounced that he is incapable of managing himself or his [own] affairs." In 1928 Alberta passed the Sexual Sterilization Act, and that act allowed a board of doctors to direct the sterilization of a patient who was to be discharged.

In 1964 Alberta passed the Mental Health Act. The legislation allowed for complaints by patients and the establishment of mental health review panels. In 1988, after tabling something called the Drewry report, which was a report that provided 199 recommendations to the mental health system, and also after the recent introduction of the Charter, the Mental Health Act was amended. The new act established a Mental Health Patient Advocate. That brings us to 1990, which is the act that most closely resembles what we currently have today.

This very abridged historical look kind of illustrates how mental health legislation has evolved over the years from something very paternalistic, aimed at protecting the public, to our current framework, which tries to balance public protection with protecting individual rights.

Before reviewing the main changes made in the Mental Health Amendment Act, 2007, we thought it important to introduce you to the key aspects of Alberta's Mental Health Act. There are four main issues the act addresses: first, involuntary admission of individuals to mental health facilities; second, when treatment can be provided to individuals, with or without their consent; third, community treatment orders, mechanisms to increase the likelihood that individuals with mental disorders can live in the community rather than be detained in a facility but still comply with treatment; fourth, the rights and safeguards provided to offset the infringements on an individual's liberty which the act imposes.

The first one, involuntary admission. If in the opinion of a physician certain criteria are met, a certificate may be issued and a whole host of actions may be taken as a result which could not normally be taken. That person may be apprehended by a peace officer and conveyed to a mental health facility, where he or she may be cared for, observed, examined, assessed, treated, detained, and controlled. If a second physician is also of the opinion that the admission criteria are met, he or she may issue a second certificate. Once this occurs, the individual is referred to in the act as a formal, or involuntary, patient. These certificates are in effect for one month, though they can be challenged or renewed.

What are the criteria? The criteria that must be met for certificates to be issued are as follows: the individual has to be "suffering from mental disorder," an individual has to be "likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment," and the individual

must be "unsuitable for admission to a facility other than as a formal patient."

The second issue that the Mental Health Act addresses is treatment authorization, but before we consider the treatment provisions in the Mental Health Act, it is important to understand what the law normally requires before health care providers administer treatment to individuals. Where legislation has not been enacted, the common law says that you always need the consent of an individual or an appropriate substitute decision-maker before treatment can be administered. The only exception to that general rule is where treatment is required as a result of an emergency; however, the courts have restricted this to very narrow exceptions. Another exception to this general rule is where government has said that treatment will be administered in the absence of consent. Some key Alberta examples are public health legislation, our child welfare legislation, and Alberta's Mental Health Act.

To be legally valid, there are three elements that must be present. A consent must be provided by a competent individual or an appropriate substitute decision-maker. Second, the consent must be given voluntarily; in other words, if a consent is provided as a result of undue influence or coercion, it will not be legally valid. Third, the consent must be the result of the person being properly informed. He or she must be given the information that a reasonable person in the patient's shoes would want to have, and he or she must be provided with an opportunity to ask questions and have those questions answered.

Under the Mental Health Act a health care provider would normally start by seeking consent for treatment from the individual if he or she is competent. Competence under the act means that the individual has decision-making capacity. Consent is provided by a competent individual before treatment is provided.

The act also sets out a substitute decision-making scheme in the event that the individual is not competent. If consent is provided by a substitute decision-maker, treatment may be administered. A physician must prepare a certificate of incompetence if they believe their formal patient is not competent to make treatment decisions. Patients can challenge a certificate of incompetence. If a patient challenges a certificate of incompetence, it may be reviewed by administrative tribunals established under the act called review panels.

When a competent patient does not consent to treatment which the attending physician feels is in the best interests of the patient, the physician can apply to the review panel for a treatment order. The review panel may issue a treatment order only if the review panel is satisfied that the proposed treatment is in the best interests of the patient. Treatment can then be provided to the competent individual without consent.

1:20

As I mentioned earlier, legislation enacted by government may be challenged as unconstitutional. This includes challenges under our Charter. For example, a treatment order forcing competent individuals to undergo treatment they do not consent to may be challenged as infringing on an individual's right to security of the person. Normally a competent adult can refuse any treatment, even treatment that would save his or her life. For example, if a physician advises a patient that he or she needs a blood transfusion or he or she will die, then that person may refuse consent based on religious beliefs or simply because the person doesn't wish to undergo the treatment. This is constitutionally protected. Such infringement of rights can only be imposed by a government where it's viewed as demonstrably justified in a free and democratic society. Courts have protected such a right to refuse treatment in most cases. Courts have weighed in on such issues generally and in the mental health law context.

We talked about involuntary admission and then treatment authorization. The third issue addressed in the Mental Health Act is community treatment orders, or CTOs. A CTO is a treatment option that allows individuals with serious and persistent mental disorders to be treated in the community and is usually undertaken with the consent of the individual. CTOs include a personalized care plan outlining the mental health treatment needed by the individual, including medication and appointments with care providers. Services may be provided at home or within the community such as at mental health clinics, in a physician's office, or on an outpatient basis. A CTO is intended to be less restrictive than formal detainment and is intended to break the cycle of admission, discharge, and readmission.

Generally CTOs are intended primarily for individuals who have cycled through admission, discharge, deterioration, and readmission, often repeatedly throughout the course of their illness. CTOs are intended as a tool to help individuals maintain compliance with treatment while in the community. The Mental Health Act sets out very specific criteria that must be met in order for a CTO to be issued. If an individual fails to comply with a CTO, there are tools available in the legislation to bring that individual back into a facility for examination.

The fourth and last issue that is addressed in the Mental Health Act is rights and safeguards. Given that certain provisions within the Mental Health Act can have the effect of infringing on individual rights, the legislation also creates a number of checks and balances to protect individuals. The act provides a number of notification provisions. For instance, when a person becomes a formal patient, specific individuals must be notified of the certification and the reasons for the certification. For example, the formal patient, the patient's guardian, if any, and, unless the patient objects, the patient's nearest relative have to be notified.

Patients are also afforded a number of rights in the act. Patients can send and receive communications without such communications being opened, examined, delayed, or withheld. Patients can meet with visitors at approved times. Patients can meet with their lawyer at any time. Formal patients have the right to apply to mental health review panels to request that admission certificates or renewal certificates be cancelled. Also, formal patients may challenge a physician's opinion that the patient is not mentally competent to make treatment decisions. Individuals subject to a CTO can request that a CTO be cancelled. If an individual is unsuccessful before the review panel, the patient may appeal to the Court of Queen's Bench.

Lastly, the Mental Health Patient Advocate, who is here with us today, is authorized to investigate complaints from or relating to patients, both those detained under one certificate or formal patients or persons subject to a CTO. She also has the power to initiate an investigation without a complaint.

With that, I'll turn it over to my colleague Fern Miller, who's going to be addressing amendments introduced in the Mental Health Amendment Act, 2007.

The Chair: Sorry to interrupt. We have five minutes left.

Ms Miller: Thank you, Sunny. The main amendments, the first one being the change in eligibility for certification as a formal patient. Prior to the Mental Health Amendment Act, 2007, the wording was: "in a condition presenting or likely to present a danger to the person or others." This likelihood of danger was constrained by the courts, which interpreted that danger as a serious risk of physical harm with

some immediacy. There had actually been a suicide attempt. Perhaps there had been violence toward someone.

This amended wording is intended to permit family members and health professionals to intervene earlier. It also allows for patients to remain subject to certificates as long as they are likely to suffer mental or physical deterioration or impairment if discharged. This change actually aligned Alberta's legislation with that of a number of other Canadian jurisdictions: B.C., Saskatchewan, Ontario, New Brunswick, just to name a few.

The community treatment orders were introduced mainly because some individuals are caught in this revolving door of admission, stabilization, discharge, deterioration, and readmission repeatedly, often throughout their illness. The Schizophrenia Society of Alberta in particular had been advocating for CTOs, and Alberta was studying the experience of other Canadian jurisdictions, primarily Saskatchewan and Ontario, when we had a fatality in Alberta. Martin Ostopovich shot and killed RCMP Corporal James Galloway in 2004.

During the fatality inquiry a number of mental health professionals gave evidence on the inadequacies of our current act and the possibility of improvements if CTOs were introduced. In the fatality report the judge recommended that the province in consultation with mental health professionals draft and incorporate into the act provisions permitting the making of community treatment orders. These CTOs are intended to encourage compliance with treatment in the community and provide a tool for health professionals.

Another change was introduced in the Mental Health Amendment Act, 2007. Section 32 states:

> When a patient is discharged from a facility, the board shall, where reasonably possible, give notice of the discharge . . .
>
> (c) to the patient's family doctor, if known, along with the discharge summary, including any recommendations for treatment.

This was another recommendation in the fatality report, which had recommended that this change be introduced. The change is intended to, again, facilitate that compliance with treatment in the community so that the family physician can assist the individual.

The last two changes spoke to expanded roles: one, the Mental Health Patient Advocate, expanding the role to people detained under one certificate, having responsibility for that group as well as individuals subject to CTOs; the final sort of expansion of responsibilities was with respect to the mental health review panels, that now individuals subject to CTOs could come to that body to have appeals.

I just want to take a moment here to distinguish between the mental health review panels in the act and something called the Alberta Review Board, which some of you may have heard of. This is an independent tribunal established under the Criminal Code of Canada, and it makes and reviews dispositions with respect to accused persons for whom a verdict of not criminally responsible or unfit to stand trial because of mental disorder is rendered. These boards also hold hearings, but they're responsible for determining whether people should be subject to detention orders or conditional discharge or be granted absolute discharge, and it's under the Criminal Code as opposed to the Mental Health Act.

Some of the outcomes of the Mental Health Amendment Act, 2007, just kind of generally. Feedback to our ministry from providers, community organizations, and families has been positive. Community treatment orders in particular have been positively received. We're doing an evaluation. Some of our findings: a positive effect on the number of individuals admitted to facilities pre- and postissuance of a CTO and on lengths of stay when they are admitted. We're also getting qualitative data that speak to improved mental health, medication compliance, engagement with the treatment team, living situations, and relationships with significant others.

1:30

Ms Berg: That concludes the technical part of our discussion. I'd just like to reiterate that we're most happy to make ourselves available. It's a lot of information in a short period of time, so if you have questions or you want further information or more detailed information, then we are happy to make ourselves available.

Thank you.

The Chair: Well, thank you for the presentation.

I'll open up the floor for questions. I'd just like to remind the members to please limit your questions to one plus a supplemental so that all members have an opportunity to ask their questions. I would just like to go to the phones and see if anybody would like to be added to the speakers list before we start so that we don't interrupt each other.

Mr. Rodney: No need to be on the list at this point in time. Thank you.

The Chair: Okay. Ms Jansen? Mrs. Pitt?

Ms Jansen: No. I'm fine. Thank you.

Mrs. Pitt: I'm okay for now. Thank you.

The Chair: Dr. Swann?

Dr. Swann: Fine for now. Thanks.

The Chair: Thank you.

I'd just like to open up the questions to those present.

Ms Payne: Sorry. I'm not sure if this is necessarily fully germane to the presentation, but it was one thing that had stood out for me when I was looking at the crossjurisdictional comparison that our research team kindly provided for us, and since we'd commented a little bit about community treatment orders, I thought this might be a good opportunity to ask. One of the things that I noted in the crossjurisdictional comparison was that Alberta, I guess, is unique in that people are allowed to be subjected to a community treatment order without necessarily having spent time in involuntary admission at a mental health facility. I was just curious if someone could maybe comment about why that might be or what some of the benefits of that might be.

Ms Miller: We didn't put it in the overhead, but there are very specific criteria as to when a CTO can be issued. Individuals do have to have a history with the mental health system. Typically the first time you're encountering mental health professionals, CTOs are not being issued. I did get a copy of the crossjurisdictional review, and, you know, I'm not quite sure as to the interpretation. You do have to have so many admissions and discharges within a certain specified period of time. Typically those admissions are mental health facilities. There are provisions if you were held in other custodial institutions, for instance corrections, where a CTO could be issued.

Carol, do you know, from some of your experience with the patients who you're actually dealing with, kind of the perspective you would have on that piece?

Ms Robertson Baker: We haven't had any individuals contact our office from a custodial institution who indicated that they've been placed under a CTO.

Ms Berg: The final, more general answer to that question, maybe more what you're after, is that overall the evidence is pretty clear across the entire health system that the more we can actually work towards having treatment take place within a person's own community and the less we can involve admission, whether it's voluntary or involuntary, to facilities, that's what patients in our system like better and want more. There's a growing body of evidence that says that we have better health outcomes.

Ms Payne: Thank you.
No supplemental.

Mr. Hinkley: You mention the community treatment centres in rural areas. I'm curious about the treatment options in places outside of Edmonton and Calgary. Are there a lot of cases where there is a lack of sufficient community treatment options?

Ms Miller: Alberta has a network of over 90 community mental health clinics, so community-based services across Alberta. Initially, when we were introducing community treatment orders, because there is a requirement in the legislation which states that the treatment or care a person requires must exist in the community, that it must be available to the person and will be provided to the person, there was some speculation: might CTOs be more of an urban offering? But in the five years since they've been introduced, we have seen them in many, many communities. I think it's somewhere around 50 communities where we have seen CTOs issued. I can certainly look up the exact numbers. We are seeing that they are a rural option as well.

I think what we find in the rural areas is that there's often more innovation in how their services are provided because the reality is often that the volume of clients that we have to the staffing – sometimes it's just staff that are in the clinics for a couple of days a week or half days. Alberta Health Services needs to therefore work more with your community agencies like the Canadian Mental Health Association and other local social service agencies to provide those sorts of services, certainly partnerships with the primary care networks and with family physicians and outpatient services. But they are not being limited to just being urban offerings.

Mr. Hinkley: Okay. Well, a supplemental to that, then: are there cases that result in involuntary detainment at in-patient facilities in rural areas?

Ms Miller: People who are involuntarily detained need to be in mental health facilities as they are defined in the mental health regulation. Some of these are stand-alone facilities like the Centennial centre or Alberta Hospital Edmonton, but many of them are local hospitals: the Royal Alex hospital, the Grey Nuns hospital. We do not have designated facilities in all communities, again because of the volume of patients you would be seeing and the expertise of staff that you need. The act requires that someone involuntarily detained be in a mental health facility. For some patients that might mean leaving their home community, if there isn't a designated mental health facility there, to seek that treatment, and how you are being detained is, as Sunny had explained, under admission certificates and renewal certificates, not under community treatment orders. Did I answer the question?

Mr. Hinkley: Yes, but it now brought up other questions, and I only get one supplemental.

The Chair: Well, Mr. Orr is on the list, and maybe there's more time.

Mr. Hinkley: Okay. Yeah. Thank you.

Mr. Orr: Since, in my mind, this is really all about balancing the importance of protecting the patient from abuses of authority and protection of the public from danger, I guess my real question would be: where have the community treatment orders and some of these other things that have been put in place fallen down? Have there been issues where the public has not been protected? How do we balance the outcomes that have actually been brought to play since some of these amendments have been put into place?

Ms Miller: Certainly, I think that we rely a lot on the professional judgment of the health professionals, the psychiatrists and the physicians, who are issuing the CTOs and, you know, ensuring that we want to be successful in issuing them if there are risks. I do not want to criminalize mental illness, but if there are concerns about safety, typically those individuals would be held in mental health facilities under admission certificates, and we would not be looking to community treatment orders as the option.

Ms Berg: None of us have the answer to your question, obviously, today, so we can for sure go back and find out if there have been incidents where people have been on CTOs.

1:40

Mr. Orr: Okay. Fine. I'm okay with that. I don't need to follow that up.

The Chair: Thank you.
Ms Babcock.

Ms Babcock: Thank you. Within my riding of Stony Plain there are both the Enoch Cree Nation and the Paul First Nation bands, and I'd like to know if the reviewers have noted any impacts on the First Nations' mentally ill persons distinct from those subject to the Mental Health Act, generally speaking.

Ms Miller: Yeah. I don't have any stats on, you know, the number of CTOs issued. I just have numbers of Albertans. Certainly, individuals, whether on-reserve or off-reserve, would be eligible. Because of the requirement that the services be available in the community, it might have an impact on the success of issuing them to people on-reserve because, of course, then we get into sort of federal jurisdiction versus provincial, but the act certainly does not preclude CTOs being issued to First Nations. Albertans, certainly youth or children, could come under them as well as adults and seniors. It really is intended for all Albertans, but often the determining factor is those local services and whether they can arrange those so that that person can be successful on that CTO.

Ms Babcock: Thank you. No supplemental.

The Chair: I just want to go to the phones one more time to make sure. There's an opportunity if you'd like to ask a question. No? Okay.

Mr. Rodney: I think I'll have questions later, I'm sure, or suggestions, but I'll also hold off as per the agenda. Thank you.

The Chair: Thank you.
Mr. Hinkley, did you want to ask one more question before we move on?

Mr. Hinkley: No. That's okay.

The Chair: No? Okay.

Well, thank you for that, so we will move on if there are no more questions. No? Okay.

Next we will hear from Ms Robertson Baker, the Mental Health Patient Advocate. You also have 20 minutes for your presentation, and then we'll open the floor again for questions. Please, go ahead.

Ms Robertson Baker: Okay. Thank you very much. My name is Carol Robertson Baker, and as Ms Sweet mentioned, I am the Mental Health Patient Advocate, office of the Alberta health advocates under Alberta Health.

I want to share a client's story that is very typical of some of the individuals that we serve. I think it's important for you to have a better understanding of their experience and perhaps their introduction to the mental health system. So imagine you haven't been feeling very well for some time. Perhaps you haven't been sleeping. Maybe you've lost your appetite. Perhaps you've been feeling very anxious and have snapped at people for no reason. Also, perhaps you've thought about harming yourself. You decide to tell your parents about how you're feeling. They become very, very upset. They're elderly, and they're insistent that you need to get the help to ensure that you're safe and that you get the treatment you require and that you need this help right now. You reluctantly agree to go with them to emergency.

You walk into emergency. It's very, very busy. People are sitting in rows, waiting to be seen. There are also people on stretchers in the hallway. You're told to sit down and that you'll be called. You wait and you wait and you wait. You're eventually seen by a doctor, who asks you a lot of questions. It's a very, very confusing time for you. The doctor tells you that she's going to get another physician to examine you. She asks you to stay in the room until the next physician comes. You agree to that. After a significant period of time, you're still waiting to see the second doctor. You decide you want to leave and just go home and go to bed. You start exiting the room, only to be stopped by security. Security tells you that you can't leave because you're being detained under the Mental Health Act. Your confusion and anxiety escalate. You've never heard of the Mental Health Act. You didn't break any laws. How can they possibly detain you? What are your rights? You're a Canadian. Aren't there rights that you should have? You simply came here for help voluntarily. You tell security that you're going to leave. Your door is locked.

A second physician eventually comes in and examines you. He, too, asks many, many questions, and he tells you that he's going to issue a second certificate and that you're going to be detained under the Mental Health Act for one month. This is an example of some of the experiences our clients have. For many this is their introduction to the mental health system.

I'm going to look a little bit at the role of the Mental Health Patient Advocate. Fern and Sunny have already covered quite a bit. I'm going to talk about the amendments and what our clients have told us, and I'm going to speak about eight recommendations I have regarding the act. I want to stress that I'm not a lawyer and that everything is based on what we've heard since the amendments came into place.

As mentioned, we serve individuals under one or two admission or renewal certificates – these are the individuals who are detained in hospital against their will and also individuals who are subject to a community treatment order – and those acting on their behalf. So anyone can contact us. We hear largely from the patients themselves, but we also hear from clinicians, including doctors, nurses, social workers; we hear from landlords; we hear from group home operators and service agencies. So it's very, very diverse.

Our core functions are complaints investigation, advocacy, the provision of rights information – these rights are enshrined under the act – as well as education. When you look at the legislation and our regulation, only complaints and rights fall under our legislative role.

Each year we submit an annual report that's tabled in the Legislature.

I just want to tell you a little bit about the client files that we've opened since the amendments to the legislation came into effect, up until March 31, 2015. We opened approximately 4,000 client files, and about 5.6 per cent, or 224, of them fell under our expanded jurisdiction. Of the individuals who are subject to a single form 1 admission certificate, we opened 149 client files. Issues that they presented to us included detainment and their rights, consent to treatment, and quality of care such as patient-centred care. We opened 75 client files for persons subject to a CTO. Their primary issues were requesting information on their enshrined rights and how to exercise their rights as well as quality of care such as courtesy of some of the individuals who have been assisting them in the community as well as patient-centred care.

Fern has already covered the key amendments, so I'll move on to the next slide.

I have eight recommendations in this briefing, and I've looked at the different themes that are present in these recommendations. The themes are as follows. Maintain what is working well. There are some very, very good things that are happening with the legislation, and Fern has already talked about the success of community treatment orders.

Align the enshrined rights of persons subject to a CTO with individuals who are formal patients. When you look at the legislation, there are numerous checks and balances for formal patients detained in hospital, and some of these checks and balances are not afforded to individuals subject to a CTO.

Clarify areas of the amendments that have caused confusion.

Amend the Mental Health Act to reflect its application in practice, especially in the rural communities, where there are some challenges.

Increase transparency and align the Mental Health Act with other pieces of legislation, including the Canadian Charter of Rights and Freedoms.

1:50

When you look at the changes in the second criteria, families have told us that they're very, very pleased with the help that their loved ones are receiving within the health system. Many families, however, believe that their loved ones need hospitalization, and they're upset if the person is not admitted under the three criteria. From our clients' perspective, generally they don't complain about "harm." They just complain about being detained in hospital against their will. They have a better understanding of how they met the criteria with the use of "harm" rather than "danger" – it's what it used to be – and they certainly are more accepting of "harm." They found that "danger" increased the stigma often associated with living with a mental illness. Now that the second criteria is looking at "harm," they believe that for individuals living with a mental illness, there's a better understanding of mental illness and better acceptance.

When we look at the implementation of community treatment orders, family members are very, very pleased that the CTOs have helped their loved ones remain on the medication and especially that they're receiving the supports that they need to successfully reside in the community. Persons subject to a community treatment order prefer to be in the community under a CTO than involuntarily detained in hospital. Some feel, however, that being under a CTO is similar to probation and is very punitive, especially if they're under a CTO for a prolonged period of time. They want to better

understand their enshrined rights, and some of them are concerned about dual status, where if they go to hospital voluntarily for, perhaps, a medical concern, they end up under formal status as well as a community treatment order, and they're not always told that they're under a CTO when they're discharged from hospital.

Under the current legislation there is no provision to suspend a CTO if the person ends up hospitalized. Some individuals have this dual status for several weeks, which is contrary to the spirit of the community treatment order. As such, the Mental Health Act should be amended to state whether or not a CTO can be suspended in specified circumstances and the maximum length of time of the suspension.

Looking at consent and competence for persons subject to a community treatment order, this area has caused some confusion, and it has also resulted in a great deal of ethical discussion surrounding it. A client reported that they felt coerced to sign a CTO in order to have their certificates cancelled and to be discharged from hospital. Often the CTO is issued while they're still in hospital. They report that they were told that if they don't consent, the doctor will deem them incompetent and get consent from a substitute decision-maker or they'll issue the CTO without any consent. They ask about revoking the CTO once discharged, what happens if they don't comply with the conditions on the CTO, and if forced treatment can occur in the safety and security of their own home.

Some health care providers have told us that competency to consent to a CTO is unclear. Unlike formal patients, there is no regulated form to complete that deems the person incompetent to consent to a CTO. The person subject to a CTO has no enshrined right to apply to the review panel for a review of the physician's opinion regarding competency, and the Mental Health Act allows physicians to issue a CTO without consent under certain circumstances.

As such, the Mental Health Act should be amended so that it's necessary to apply to the review panel to make an order for the issuance of a CTO for a competent person if consent has not been obtained. The provision to allow mentally competent people subject to a CTO to refuse consent to treatment should be maintained along with the recourse of issuing a form 23 CTO apprehension order if required. There should be a regulated form stating that there has been a determination that the person is not mentally competent to consent to the CTO. Finally, there should be a further review of the Mental Health Act after a specified period of time that would allow for the review of the consent process.

Another thing that clients have reported to us regarding consent is that their personal directive was not enacted and that, instead, consent for treatment was obtained under the Mental Health Act. They tell us that their clear instructions under their directive differs from the treatment decisions by the substitute decision-maker under the Mental Health Act. As such, the act should be amended to address the conflict between the provisions of the Personal Directives Act's clear instructions and the Mental Health Act's best interests as set out in the criteria.

Another area of the amendments looks at the authority of peace officers and detainment upon arrival at a facility. Clients wonder about police entering the safety and security of their own homes. They wonder, once again, what occurs if they don't comply with the CTO. They wonder if the CTO is in effect should they decide to leave Alberta because they don't want to be under the CTO anymore. They report that they were apprehended under form 23 for noncompliance and taken to hospital. It's unclear if they can be detained until examination occurs by two physicians.

Rural health care service providers expressed concern that individuals are being conveyed to a nondesignated facility that is close by rather than one of the 20 designated facilities across the province. The designated facility could be some distance from where they live. Nondesignated facilities do not have the expertise and safeguards in place that designated facilities have. As such, the Mental Health Act should be amended to consistently deal with the authority of peace officers to use physical restraint and enter the premises in specified circumstances. It should also set out when conveyance to a nondesignated facility may occur and the steps that must be taken at the nondesignated facility. It should clarify whether or not the individual can be detained upon arrival at the facility pending examination. If they are able to be detained, the act should be amended to align with section 10 of the Canadian Charter of Rights and Freedoms, whereby the individual is to be "informed promptly of the reasons" for the detention and their right "to retain and instruct counsel without delay."

Another area is the expansion of the mandate of the review panel. Many clients have told us that they appreciate the notice that's required of the hearing, but some wonder if they can waive the review panel's notice period to expedite the hearing. They're very concerned about being under a CTO, and some of them want it cancelled as soon as possible. They also wonder if they have the right to receive written and electronic transcripts of the review panel hearings. Some wonder how the review panel arrives at their decision and the percentage of successful appeals. They tell us that sometimes they'll base their decision as to whether or not to file an application for a hearing – that it all depends on how many hearings are actually successful, where the CTO is cancelled.

As such, it's recommended that provisions allowing a person to request that the review panel cancel a CTO should be maintained and that any extensions to the notice of hearing period should be carefully scrutinized. The Mental Health Act should enshrine the right of persons subject to the act to waive the period of the notice of hearing so that they can get prompt access. Finally, health care service providers, applicants, and their counsel should have the right to access nonidentifying review panel decisions that would show how the panel interprets and applies the Mental Health Act and provide guidance for future applications and decisions.

Another area of the amendments looks at disclosure of information to a family doctor. Many health care service providers in hospital have told us that they don't provide notice of discharge for voluntary patients as the Mental Health Act is unclear. As such, the act should be amended to clarify that the provisions that require disclosure of information apply to voluntary patients as well as formal patients.

The last area I'm going to address is the expansion of the Mental Health Patient Advocate's duties and responsibilities. Single-certificate patients have told us that they feel that they have no rights while being detained. Some individuals contact our office, and they've expressed appreciation that we're there to listen to them, and they've also told us that they appreciate the care and compassion that our staff have provided.

2:00

One area that the recommendation looks at is expanding our jurisdiction to include all individuals who fall under the Mental Health Act because right now it is limited to certain individuals. It also looks at strengthening the Mental Health Patient Advocate's authority by protecting our investigations and reports, expanding our investigations into complaints, into own-motion, or issues where we have not received a complaint. It also looks at recognizing the role of the Mental Health Patient Advocate in the advocacy and education that we do provide and that are currently not under our legislative mandate. It also looks at reinforcing the independence of the Mental Health Patient Advocate.

A second part is looking at the individuals who now fall under our jurisdiction who are subject to a single admission certificate. Once again looking at the Canadian Charter of Rights and Freedoms, section 10, these individuals should have the enshrined right "to be informed promptly of the reasons" for their detention and that they have the right "to retain and instruct counsel without delay and to be informed of that right."

In conclusion, the mental health amendments have generally had a very positive impact on the clients we serve. Clients appear to better understand and accept how they met the second criteria. They certainly prefer to be under CTOs than to be detained in hospital, and they're very appreciative of the supports they're receiving in the community. Families are grateful for the help that their loved ones are getting while under CTOs. For those clients who believe they no longer need a CTO, they do have the enshrined right to appear before the review panel and request cancellation of the CTO.

Disclosure of information to the family doctor helps support the continuity of care and the person's success in the community, and individuals who contact the Mental Health Patient Advocate appreciate having someone who is independent of the health authority and at arm's length from government, and they also are appreciative of the compassionate staff who assist them.

Thank you once again for inviting me to speak with you today. I also would like to extend an offer to assist you if you require additional information or briefings.

The Chair: Thank you.

Are there any questions from the committee?

Mr. Yao: Regarding your recommendation 5, for peace officers and nondesignated facilities, I just want to understand. If you're not going to be recommending anything that would impair the ability of any peace officers or these nondesignated facilities to deal with these issues, recognizing that some of these areas are in rural areas where travel is difficult and whatnot – we also have to recognize that most physicians and other health providers do have some level of training with these mental health issues and recognize that these people probably demonstrated a need for these restrictions on their ability to be free.

Ms Robertson Baker: I agree with you. The current practice in the rural areas is often that common sense says: just take them a few blocks down the street to the local hospital. When you look at the Mental Health Act, it talks about taking them to one of the 20 designated facilities. Designated facilities are set up in such a way that they have trained staff, the expertise, and all the safeguards that may be needed to ensure the security and safety of all.

What I'm suggesting is that the Mental Health Act perhaps be amended to reflect times where it may be necessary to take an individual to a nondesignated facility, and as such those nondesignated facilities need to set up their practice and the safeguards to ensure that these patients are treated with dignity and respect and that there's a thorough examination and that there are trained personnel to help them and ensure that everyone is safe and secure.

Mr. Yao: No further questions.

The Chair: Okay. Just going to the phones real quick, would anybody like to ask a question? Dr. Swann.

Dr. Swann: Thank you. That was a helpful exposé on both the reform recommendations and some of your roles as the Mental Health Patient Advocate. With respect to reporting to physicians, is that the only profession that is permitted to receive reports?

Ms Robertson Baker: Are you referring to the discharge summary and recommendations?

Dr. Swann: Yes.

Ms Robertson Baker: Yes. It's to the physician if known. Some individuals do not have a community physician, and my understanding is that the staff in the hospital really try to set them up with a community physician so that there is that continuity of care.

Dr. Swann: I'm just curious as to whether there is flexibility under the act to allow other caregivers, like social workers and mental health counsellors, who are directly involved in the care of the person to receive the discharge summary as well.

Ms Robertson Baker: Currently under the Mental Health Act it talks about the physician, but I think it would be a very wise consideration to expand it to other clinicians, especially those that are spending significant time with their client or their patient.

Dr. Swann: So that would require another amendment.

Ms Robertson Baker: Yes.

Ms Miller: Right. The requirement for the discharge summary to be provided to physicians stems from a recommendation in the fatality report and was something introduced through the Mental Health Amendment Act, 2007, and therefore falls under the purview of your review. You know, it really is a change introduced in the Mental Health Amendment Act, 2007.

Provided that the sharing falls within the provisions of the Health Information Act, which speaks to the sharing of personal health information, it's certainly something that can be considered. I think what we're seeing sometimes with family physicians practising in primary care networks – we do see that there are expanded teams of health professionals that are providing the services, so through that physician, I think, there often is a larger treatment team, with other professions engaged.

Dr. Swann: Thank you.

Just a quick follow-up. I think you mentioned it, but your report is a public report – you report to the Legislature – and it's accessible by the public. Is that correct?

Ms Robertson Baker: Yes. My annual report is tabled by the Minister of Health, and it is a public document.

Dr. Swann: So you are directly reporting to the Minister of Health, not to the Legislature.

Ms Robertson Baker: Correct. Yes.

Dr. Swann: Yeah. How do you feel about that? Would you prefer to have some independence from the Minister of Health and report to the Legislature?

2:10

Ms Robertson Baker: It is something that our office has considered over a number of years. A few years ago we did forward a request for that, and I would appreciate any further consideration of that.

The Chair: Thank you.

Mrs. Littlewood.

Mrs. Littlewood: Thank you. In Fort Saskatchewan we have a correctional facility, so criminality can at times be top of mind for

those living in the community. Being that the terminology of "harm" versus "dangerous" is being discussed here, I'm wondering: other jurisdictions with similar mental health legislation have found that the only justifiable criteria for detainment is the risk of suicide, finding no significant link between mental illness and criminality. Does the review show any indication of a connection between mental illness and violent crime?

Ms Robertson Baker: That would be beyond my scope, to respond to that question. Fern or Shannon?

Ms Berg: It's probably something that none of us are prepared to answer right now, but I'm making notes, so we can get back to you on that.

Mrs. Littlewood: Maybe a supplemental.

Ms Payne: Shifting focus a little bit, I was wondering if you could comment on the circumstances in which an involuntary admission is most often applied.

Ms Robertson Baker: It would simply be based on our experiences with our clients. The vast majority of them have told us that they might be issued a single form 1 admission certificate in the community, perhaps at their doctor's office, or maybe the crisis team has come to their home and a certificate was issued. Similar to that story I told you at the beginning, a number of individuals will go to emergency for help, and they end up being detained. But there are also individuals who are already in hospital as a voluntary patient, and perhaps they tell their doctor that they no longer want to stay there, so the doctor will then issue a certificate. When two certificates are issued, then they're detained there under the Mental Health Act.

Ms Miller: The important thing to remember is that all three of those criteria must be present for someone to become a formal patient: they are "suffering from mental disorder"; they meet the harm criteria; and the third one is "unsuitable for admission to a facility other than as a formal patient." In plain language that means that they're not agreeing to voluntary admission. All three must be present. If one ceases to be there, those admission certificates or renewal certificates should be cancelled.

Ms Payne: Thank you.

The Chair: Mr. Shepherd.

Mr. Shepherd: Thank you. In your remarks there are a couple times when you noted the need for the MHA to be amended to align it with the Canadian Charter of Rights and Freedoms, specifically section 10. Is that something where it's just a need to bring it into alignment to reflect current practice, or is this something where in your role as the advocate you've heard that the procedures have not been followed and you feel that we need to therefore strengthen the act to ensure that they are?

Ms Robertson Baker: Some hospitals, depending on the unit and the understanding of the Mental Health Act, will inform them of being detained under a single admissions certificate. But it's not required under the Mental Health Act; it's not an enshrined right. To respect all patients and to be aligned with the Charter, I feel that this amendment needs to happen so that it is a basic, enshrined right.

Mr. Shepherd: The concern, then, is that there's currently inconsistency in how that's applied.

Ms Robertson Baker: Absolutely.

Mr. Shepherd: So if we put that into the act, then we can ensure that we have consistent treatment.

Ms Robertson Baker: Yes.

Mr. Shepherd: Excellent. Thank you.

The Chair: Mr. Smith.

Mr. Smith: Thank you. I want to go back to the discharge issue that was brought up here. I guess, having been a teacher for many, many years, I'm just wondering if that information would also be able to go down to teachers. If I have a student that's attempted suicide twice in the last three months and is now out – I mean, it's a concern for many teachers.

Ms Miller: Again, it's the sharing that's permitted under the Health Information Act, which is paramount. Certainly, I think you could get deeper legal advice on that, but the Health Information Act, you know, does set the rules as to who can get information, when, under what circumstances.

Mr. Smith: Would that be something that this committee would be looking at with regard to the Health Information Act?

Ms Berg: It might be important to ensure that whatever amendments are considered here align or work with the HIA. You could get a briefing on the HIA.

Mr. Smith: I realize that the struggle is: how wide is the circle? When you're talking about kids that are in the school system for six, seven, eight hours a day, you know . . .

Ms Berg: Well, the struggle is even in terms of: how widely do you need to enshrine something in the Mental Health Act versus what's already there? Health care professionals can share information for continuity of care already through the HIA, so how widely do you need to move things into the Mental Health Act? That's one issue related to the recommendation and what Dr. Swann was talking about.

Then the second point is: how much wider should you need to or be able to share it? It may actually end up being part of the care plan. You know, if you have someone that's discharged into their community setting on a CTO, then potentially that might be part of the care plan, to ensure that teachers are aware and know how to support that individual.

Mr. Smith: Okay. Thank you.

The Chair: Thank you.

Ms Luff: I guess this is maybe more of a legal question, but it seems that patients do prefer the term "harm" instead of "danger." I have heard from a few people who have come into my constituency office that they still felt like perhaps they were held and they didn't quite understand the reasoning. So while maintaining that second criteria as being "harm" as opposed to "danger," could there perhaps be greater restrictions on or definitions of the term so that we ensure more clarity and more protection for people under the Charter of Rights? Is there any way to – I don't know – define it a little more closely?

Mr. Menon: It sounds like a drafting question. Certainly, it could be looked at, and it's within your scope to do so.

Ms Luff: Is that something that you think might be helpful, to have a more clear definition of that term?

Ms Robertson Baker: It certainly could be looked at. From my perspective, though, because it's patient centred, it's the doctor's responsibility to explain to the patient exactly how they met the criteria, and that includes documenting it on the certificate as well as informing the patient verbally.

Ms Luff: Thank you.

Mr. Westhead: Obviously, having access to leading-edge mental health care is crucial to Albertans, and giving the Mental Health Patient Advocate the necessary resources is an important part of ensuring that we do deliver the best possible care. I think it was mentioned at the beginning of your presentation that you act on formal complaints, but you also do have the power to initiate complaints of your own accord. Is that correct?

Ms Robertson Baker: Yes, to initiate an investigation without a complaint. We've been in place for over 25 years now, and we've never used that provision of the act. I'm very interested in initiating an own-motion investigation, but I'm unable to do so right now because of lack of resources.

2:20

Mr. Westhead: Okay. In recommendation 8 you say that the authority of the MHPA should be strengthened to include, as sub (iii) there says, "own motion investigations." I just want to clarify that you have the ability but you don't have the resources. Is that correct?

Ms Robertson Baker: Yes. Right now, when you look at the act, the own-motion investigation is very limiting. It's looking at admission procedures and notification of being a formal patient. I would like consideration to be given to expanding that own motion. Sometimes we see systemic issues, and we're unable to investigate them because it's not in our legislation.

Mr. Westhead: Okay. Just further to that, too, you know, it was mentioned earlier that you report to the Minister of Health. I'm just wondering. Besides the own-motion investigations, that you've just told us about, are there any other limitations that we could address, potentially within the current mandate that you have in your role, in order to make the most effective use of your role as it stands currently?

Ms Robertson Baker: One key area is that for voluntary patients and individuals under conveyance certificates such as a warrant for apprehension or a peace officer's form 10, those individuals do not fall under our current jurisdiction. I would like to have everyone who falls under the Mental Health Act, whether they be voluntary or those individuals under the conveyance certificates, all of them, fall under my jurisdiction because the likelihood is very strong that they will end up as a formal patient, so we may as well assist them right through their experience while under the act.

There are areas of the act that apply to everyone, for example communications. They can't be hampered with written communication. Also, all patients in designated facilities have the right to access a lawyer, and the lawyer can visit them at any time within reason. So there are certain provisions that apply to everyone.

Mr. Westhead: Thank you.

The Chair: Thank you.

Just going to the phones one last time for questions. Nobody? Okay.

I'd just like to thank the advocate and the ministry officials for their presentations today.

We'll take a five-minute break to allow our guests to return to their offices if required or to move to the gallery if they wish to remain for the balance of the meeting.

Thank you so much.

[The committee adjourned from 2:23 p.m. to 2:31 p.m.]

The Chair: Okay. We're all back in the room. We'll call the meeting back. Thank you.

Moving on to our next piece of the agenda, which is research services, I'd like to turn it over to the committee research services team to address the three documents listed on our agenda today.

Dr. Massolin, please go ahead.

Dr. Massolin: Thank you, Madam Chair. As you can see on the agenda, there are three items: the case law summary, the crossjurisdictional comparison, which has already been mentioned, and then we'll finish off with the stakeholders list.

I'll turn it over to Trafton Koenig in just a moment, but before I start, I just wanted, Madam Chair, with your indulgence, to briefly introduce Mr. Koenig to the committee. I think he was here last time, but I didn't have a chance to introduce him. Trafton is legal counsel here with the Parliamentary Counsel office. He holds a degree in law from the University of Ottawa, and he's here to talk about the crossjurisdictional report and the case law summary and is helping research services out.

I'll turn it over to Mr. Koenig.

Mr. Koenig: All right. Thank you. I'm going to dive right into this, and I'll just provide you with a brief overview of the crossjurisdictional report. Essentially, this report is a comparison of the changes introduced by the Mental Health Amendment Act, 2007, with equivalent legislation in other Canadian jurisdictions. The point is to provide context for the changes made to the Mental Health Act in Alberta and to highlight similarities and differences between other legislative regimes in Canada. Pursuant to the direction of the committee this report is looking primarily at two things. First is the criteria for involuntary admission of persons with mental disorders, and that's encapsulated in section 2(b) of the Mental Health Act. The second is the community treatment order regime, which is set out in section 9.1 of the Mental Health Act.

Why is this important? Well, Alberta legislation shares similarities and also differences with other provinces. To lead you very quickly through this report and highlight some of these similarities and differences, on page 4 the report sets out the criteria for involuntary admission. That's essentially when a person can be hospitalized without their consent. An important change that's already been mentioned earlier is the change in focus, the concept of "harm" in place of "danger." Discussed briefly on page 6 is that the majority of Canadian provinces have made this change to their mental health legislation. "Harm" is the standard in all provinces other than Quebec presently.

Included in the section on involuntary admission there's also some general information about the process for an involuntary admission. Those are things outside of, let's say, the criteria for involuntary admission and may relate to things, for example, like the duration of an involuntary admission. Now, some of those items aren't squarely within the changes that were introduced by the Mental Health Amendment Act, 2007, but they do provide important context for how the system functions, and there's a relationship with those changes that were made by the amendment

act. Those are provided as context, and those instances should be highlighted as providing information and background as opposed to items that are strictly subject to the review.

Now, on page 10 of this report we provide a table of equivalent sections of provincial mental health acts for involuntary admission. That's just a quick resource to have a look at how the different provinces deal with the criteria for involuntary admission.

Moving on briefly to the criteria for community treatment order, the important thing to remember about this is that the CTO regime was introduced in its entirety in the Mental Health Amendment Act. It was a new regime that was introduced completely to the Mental Health Act, where involuntary admission criteria were changed, and some of the procedures and processes were changed. CTOs were brand new to the Mental Health Act.

Page 12 of the report discusses some of the similar legislation in other provinces. Just to touch on some of those highlights, Saskatchewan, Ontario, Nova Scotia, and Newfoundland and Labrador use the community treatment order model. Other provinces such as British Columbia and Quebec have a form of community treatment, but it's not a community treatment order model. It works as an outpatient committal. They use a process that is not the same as in Alberta, but it is interesting to note how those work. Then on page 22 there is a table as well that provides equivalent sections of the provincial mental health acts for community treatment.

If I might just take this opportunity to come back to a question raised by Ms Payne a little earlier on – and forgive me if I misunderstood – a question related to a community treatment order and the criteria for when that applies. It may be a unique feature of Alberta legislation. Typically what's required for a person to be subject to a community treatment order is some previous involvement in the mental health system. For example, in Saskatchewan a person must in the preceding two years have been detained in an in-patient facility for at least 60 days, or they have to have been detained in an in-patient facility on three or more occasions, or they had to have been subject to a community treatment order previously.

What's different in Alberta is that in section 9.1 there's a provision that allows a person to sort of meet this threshold of previous interaction with the mental health system if that person has been "lawfully detained in a custodial institution." Essentially, what that means is that they've been detained in prison. That may mean that they've been found not criminally responsible under the criminal justice system and have been detained in the mental health system. This was raised in the report not as a comment on whether that was, you know, a positive or negative aspect but that that is something that does not appear in other jurisdictions. It's just something to be highlighted for this committee to consider.

Now, moving on, a compendium of statutory provisions has also been provided alongside this crossjurisdictional report, and that was provided as a reference to give more detailed excerpts of the relevant legislation across Canada. What that is essentially is longer pieces of the statutes in other provinces, should you wish to sort of see a bit more of that legislation. For your information, the sections dealing strictly with the criteria for involuntary admission and also the criteria for community treatment have been bolded, so you can hopefully find those fairly quickly. Then some of the other information there is just dealing with some of the other aspects of those legislations. If you'd like to look at those, they should be available.

Now, I've gone through that fairly quickly. The committee may have questions about the crossjurisdictional report.

The Chair: Are there any questions about the crossjurisdictional report? Not in the room. On the phones, are there any questions that you'd like to ask?

Dr. Swann: Not at this time.

Mr. Rodney: No. I just want to say thanks for doing that. I've always found these extremely useful when we're determining the effectiveness for ahead-of-the-game, behind-the-game, or any changes that might need to be made. Again, I'll save further comments for future sections of the meeting and perhaps on the subcommittee.

The Chair: Thank you.

All right. We'll move on to case law.

2:40

Mr. Koenig: All right. That is me again. Just to give a bit of background for those of you who have never read a case law summary, it's essentially going to be a survey of court decisions from Alberta and other Canadian jurisdictions with respect to the criteria for involuntary admission and community treatment orders.

Since Alberta legislation is similar to other jurisdictions, comments from courts in other provinces can be important and useful in reviewing the Mental Health Act. The case law summary is also, hopefully, useful to you because there hasn't been a great deal of commentary from the courts in Alberta with respect to the changes introduced by the Mental Health Amendment Act, 2007. So some of these cases from other provinces can be useful because they provide some commentary on how courts typically apply these provisions and challenges that have been made to these provisions in other jurisdictions. The purpose of the case law summary is to highlight relevant decisions in Alberta and other provinces.

To date the courts in Ontario have provided the most significant commentary regarding both involuntary admissions and community treatment orders in terms of both the number of decisions and the importance of the decisions that have come forward. The one that I would highlight for the committee today is Thompson versus Ontario, which is from 2013. That was a challenge of both involuntary admission and community treatment orders in Ontario. The primary argument was that the provincial mental health legislation was a violation of the applicant's Charter of Rights and Freedoms. They argued in that case that those provisions reinforced stereotypes of persons with mental disorder, that they forced treatment, and that those provisions were overbroad. They brought forward a lot of concerns that may also have application in Alberta. What's interesting about that case and what I think is likely relevant to you as you review this legislation is that the Alberta provisions in our legislation are similar to Ontario's, particularly with respect to community treatment orders. We both share the same model. It's also important because the court in that case ultimately dismissed the application and found that the Ontario legislation was, in fact, constitutional and not a violation of the applicant's Charter rights.

In terms of other elements that you may wish to review as part of the case law summary, on page 9 the report highlights many of the foundational issues raised by people in contact with the mental health system, issues such as detention without consent, coercive psychiatry, and limits of state intervention in individual treatment. Other cases in this case law summary also touch on the issues of consent and division of power. Those are to provide context. Again, like some of the items mentioned in the crossjurisdictional report, these cases are mentioned for context but may not be entirely within the purview of this review so are provided just as background materials.

To sort of give you a concrete example, on page 5 of the case law summary there's a discussion of consent to psychiatric treatment. Now, consent to treatment was not necessarily amended directly by the Mental Health Act; that is something that was pre-existing. What was amended was to introduce references to community treatment orders and consent because the community treatment model was brand new. So it's just important to remember which aspects are included in that amendment act and which are not but are useful to understand the processes.

I will leave it there for the case law summary.

The Chair: Any questions about the case law summary? Anybody on the phones?

Mr. Smith: If I wanted to talk to you later, how would I get a hold of you?

Mr. Koenig: I can provide my contact information. I'm part of the Parliamentary Counsel office, and I am available on PeopleFind through the Leg. Assembly directory. I also have a card, and I'm happy to provide my information.

The Chair: Okay. We'll move on, then, to the draft stakeholders list.

Ms Robert: Thank you, Madam Chair. At the request of the committee research services has prepared a draft list of prospective stakeholders for the review of the Mental Health Amendment Act, 2007. It, as I'm sure you know, was posted to the internal committee website a little over a week ago. You'll notice that it says that it's revised. It was originally posted to the committee's website in July, and since that time some names have been added to the list, and that's why it was reposted at the end of September. Of course, it is just a draft list that research services has prepared. Members are, of course, able and welcome to add organizations to the list if they so choose.

I'll just turn your attention to page 2 of the list, which is the table of contents, just to give you a brief overview of what types of groups are included in the list. There are eight different groupings: professional associations, so things like the Psychologists' Association of Alberta; interest groups – an example would be the Canadian Mental Health Association, the Alberta division – regulatory colleges, so all the different colleges, the Alberta College of Social Workers, psychiatric nurses, all the different colleges. Also, there are policy research institutes, the Civil Liberties Research Centre and Health Research Ethics Board; legal organizations and law enforcement, so police organizations, the bar associations, the heath law sections of the bar associations in Alberta. There's a section for patient advocate groups and tribunals, so the mental health patient review panels and the Mental Health Patient Advocate. There's a section on academic organizations and scholars, so there are a couple of different professors of psychiatry, one in Alberta, one in Ontario, and then the longest list is service providers. I won't go through them all, but examples would be Alberta Health Services and different counselling and community service organizations.

The only other thing I want to do is just draw your attention to the fact that you're going to see little notations, like asterisks or crosses, after some organizations. That means they either presented to the committee or made a submission to the committee that reviewed this amendment act when it was still a bill in 2007. So we just wanted to draw the attention of the committee to that aspect.

That's basically it unless anybody has any questions.

The Chair: If everybody has had a chance to look at the stakeholders list, are there any additions that have been missed that we should add to the record today?

Ms Babcock: I think that there seems to be a hole for the rural indigenous population, so I suggest native friendship centres for addition to the stakeholders list.

The Chair: I think we can accept that addition.

Mr. Smith.

Mr. Smith: Yeah. I guess the questions I had were about the process and the timeline. If we wanted to add groups and individuals onto this list, how do we go about doing that, and what would the timeline be?

The Chair: The stakeholders list was sent out for additions, and I guess, from what I'm hearing, there might be a need for more additions. If we were to do that, we would have to table a motion to approve that today for the next meeting, or can we do – go ahead, Ms Dean.

Ms Dean: Madam Chair, I think that addition, if it's in agreement with the rest of the committee, is fairly straightforward, and that addition can be made very easily. You don't need to hold up the process with respect to reaching out and sending letters to the stakeholders.

The Chair: Okay. For that one addition of native friendship centres, but if members wanted to add another addition, could we . . .

Ms Dean: Well, it's up to the committee how they want to handle that.

Mr. Smith: I didn't have anybody in particular that I was thinking of. I was just thinking that if you're going to make that suggestion, we can add to it. Then how do we do that, and what's the process?

The Chair: Historically – and please correct me if I'm wrong. Because the stakeholders list was sent out in July – I believe we sent it out – the request for additions would've been part of that with the intention that today we would finalize the list.

Mr. Smith: So today would be the final? Okay.

Ms Dean: Madam Chair, I mean, this is an initial round of consultation. So let's say that you get some results back in December, and you're thinking: oh, I think we need to go back and touch base with this group that wasn't included in our list. It's certainly open to the committee to do that at that point in time.

The Chair: Okay. I'll just put a motion on the floor that

> we add native friendship centres to the current stakeholder list.

If I could have someone to move the motion. Ms Babcock. All in favour? Opposed? So we'll add that to the current stakeholders list.

Any other comments or additions before we move on to the actual motion of ratifying the list? No? Okay. If I could have a motion moved that we would adopt the revised stakeholders list as it is with the addition of the native friendship centres.

2:50

Mr. Orr: So moved.

The Chair: Mr. Orr has moved that

> the Standing Committee on Families and Communities adopt the revised stakeholders list and that the chair invite written submissions from these stakeholders with a submission deadline of November 16, 2015.

Mr. Orr, thank you. The motion has been moved.

Again, going back, if we have the written submissions that come back and we decide there needs to be additions, we can revisit the

matter in the future. Thank you. So correspondence will be sent out within the next week.

Oh, sorry. Any discussion on the motion? My apologies. Just moving through. All in favour of the motion? Any opposed? The motion is carried. Thank you.

Okay. Correspondence will be sent out within the next week or so inviting stakeholders to provide their written submissions. Thank you again for the information.

We'll move on now to the draft timeline. There was a draft timeline that would have been sent out to all of you. Members should have a copy of the draft timeline document prepared by the committee support staff. It's a general timeline only, intended to provide an idea of the work ahead of us and the various steps that need to be taken through the review process.

I'll just quickly go through the draft timeline. The initial timeline was dated for July 16, 2015, which would be our orientation meeting, which did occur. Today's date of October 5, 2015: the committee was to meet to do the background and research briefings and discuss the stakeholders' and public submissions. At the end of September to early October, which is now, correspondence to the stakeholders will be invited by a written submission, so that will go out next week.

It's estimated that in November we will do main estimates for the 2015-2016 budget cycle. In mid-November, so November 16 as the motion has just been approved, we will receive the deadline for the written submissions.

In December we will set a meeting date for the committee to review the written submissions and the summary document provided by our research staff and discuss planning for any oral presentations if we choose to do so.

January, early February: the committee will meet to review any oral presentations, and then we will be back into main estimates for the 2016-2017 budget in February to mid-March. At the end of March and April the committee will meet to review the issue summary document, begin deliberations and identifying issues for inclusion in a draft final report, and provide direction to the committee research services for the report drafting.

In May we will have a draft report. In June the committee will meet to review the final draft report, and then in July 2016 the report will be tabled in the Legislature.

Any discussion on the draft timeline? On the phones, any concerns, questions?

Mr. Rodney: No.

The Chair: Okay. If I could have a member move a motion that the Standing Committee on Families and Communities adopt the draft timeline for 2015-2016 respecting the committee's review of the Mental Health Amendment Act, 2007, as distributed.

Ms Payne: So moved.

The Chair: Ms Payne, thank you. All in favour of the motion? Any opposed? Okay. Motion carried.

Moving on to the consideration of establishing a committee working group. There was some discussion at our July 16 meeting respecting the concept of a committee working group, and it was agreed that we would discuss this issue at our next meeting. I don't believe there's a purpose to be served by a committee working group at this time and would suggest that the committee could revisit this matter at a future date if wished. Are there any comments or questions in regard to that?

Mr. Rodney: Just a quick question, and it might be obvious. Is it anticipated that the group as a whole would be able to take care of the work at hand rather than assigning this? Or what would be the purpose of not having a working group in this case?

The Chair: At this time it's suggested that we don't have one just because we don't have any issues that are directly in front of the committee that would require a working group. If in the future, say, we decide we'd like to have a breakout working group for a review of the draft report, we could look at that as a possibility, but at this time it was recommended that we table it until the future.

Mr. Rodney: Yeah. I think tabling it is a fine idea. I'm happy to meet any time, anywhere if it makes sense. If it makes sense as a full committee, great, and if there's need – again, I stress: if there's need – for a subcommittee to do extra work, I'm fine with that, too. Tabling it is just fine with me.

Thanks.

The Chair: Thank you.

Any other discussions? No? Okay. We'll just table this for further discussion as required.

Any other business that we need to discuss today? If not, okay.

We will set a next date as per the polling of the e-mail for future dates as set out.

If there's no other discussion or comments, if I could have a member move to adjourn the meeting. Mr. Shepherd.

Mr. Shepherd: So moved.

The Chair: All in favour of the motion? Any opposed? Carried.

Thank you so much.

[The committee adjourned at 2:57 p.m.]

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