Legislative Assembly of Alberta

The 29th Legislature
Second Session

Standing Committee
on
Families and Communities

Mental Health Amendment Act, 2007, Review

Monday, June 13, 2016
8:31 a.m.

Transcript No. 29-2-9

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Standing Committee on Families and Communities

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Transcript produced by *Alberta Hansard*

Standing Committee on Families and Communities

Participants

8:31 a.m. Monday, June 13, 2016

[Ms Goehring in the chair]

The Chair: Good morning, everyone. I'd like to call this meeting to order, and I'd ask that you please take your seats. I'd like to welcome all the members, staff, and guests in attendance for this morning's meeting of the Standing Committee on Families and Communities. My name is Nicole Goehring. I'm the MLA for Edmonton-Castle Downs and the chair of this committee.

Before we start this morning, I just wanted to acknowledge the devastating tragedy that occurred in Orlando, Florida, regarding the mass shootings at the LGBTQ nightclub. I want to mention that Albertans join with people everywhere in offering our thoughts and prayers to the victims, their families, partners, and loved ones, who are suffering at this moment.

This morning I'd ask that all members and those joining the committee at the table introduce themselves for the record, and then I will call on the members teleconferencing to introduce themselves. Please indicate in your introduction if you are substituting for a committee member today. I will start on my right with our deputy chair.

Mr. M. Smith: Hello. My name is Mark Smith, and I'm the MLA for Drayton Valley-Devon.

Mr. Orr: I'm Ron Orr, MLA for Lacombe-Ponoka.

D/Commr. Ryan: I'm Deputy Commissioner Marianne Ryan. I'm the commanding officer for the RCMP in Alberta, and I'm a presenter here this morning.

Chief Knecht: My name is Rod Knecht. I'm the chief of police with the Edmonton Police Service, and I'm presenting this morning.

Mr. Roberts: Good morning. My name is Brian Roberts. I'm the chief administrative officer for the Police Service and I'm assisting Chief Knecht this morning.

Mr. Shepherd: David Shepherd, MLA, Edmonton-Centre.

Ms Woollard: Denise Woollard, MLA, Edmonton-Mill Creek. I'm standing in for Karen McPherson, I believe.

Ms McKitrick: Annie McKitrick, MLA for Sherwood Park.

Mr. Horne: Trevor Horne, MLA for Spruce Grove-St. Albert.

Mr. Hinkley: Good morning. My name is Bruce Hinkley. I'm the MLA for Wetaskiwin-Camrose.

Mr. Koenig: Trafton Koenig. I'm counsel with the Parliamentary Counsel office.

Ms Robert: Good morning. Nancy Robert, research officer with the Legislative Assembly Office.

Dr. Massolin: Good morning. Philip Massolin, manager of research and committee services, from the Assembly.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: Go ahead, Thomas.

Mr. Dang: Thomas Dang, Edmonton-South West.

The Chair: Those on the phone. Ms Jansen, I'd ask you to introduce yourself.

Ms Jansen: Sandra Jansen, Calgary-North West.

The Chair: Ms Luff.

Ms Luff: Robyn Luff, Calgary-East.

The Chair: Dr. Swann.

Dr. Swann: David Swann, Calgary-Mountain View. Good morning.

The Chair: Good morning.
Mrs. Pitt.

Mrs. Pitt: Angela Pitt, MLA for Airdrie. Good morning.

The Chair: Thank you.
A few . . .

Mr. Yao: Hey, you forgot Tany Yao.

The Chair: Oh. Sorry, Tany; I didn't know that you had called in. Go ahead, please.

Mr. Yao: Tany Yao, MLA for Fort McMurray-Wood Buffalo. Thank you.

The Chair: Thank you.

Is there anyone else on the phone lines that I'm not aware of that has called in this morning?

Hearing none, just a few housekeeping items to address before we turn to the business at hand. The microphone consoles are being operated by the *Hansard* staff, so there's no need for members to touch them. Please keep your cell phones, iPhones, and BlackBerrys off the table as they 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.

Up next is the approval of the agenda. Would a member move a motion to approve? Thank you. Mr. Orr moved that the agenda for the June 13, 2016, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of this . . .

Mr. M. Smith: Excuse me, Madam Chair. Is there going to be a time for us to put in other motions or to change the agenda if we need to?

The Chair: I don't believe so.

Mr. M. Smith: I'd like to add one thing to the agenda if I could.

The Chair: Perhaps it could fall under other business.

Mr. M. Smith: Oh, yeah. Other business.

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

We have the minutes from our last meeting. Are there any errors or omissions to note? Seeing none, would a member move the adoption of the minutes, please? Moved by Mr. Horne that the minutes of the April 13, 2016, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of this motion? Any opposed? On the phones? Hearing no one opposed, this motion is carried.

The committee is hearing oral presentations today respecting its review of the Mental Health Amendment Act, 2007. I'd like to welcome our first guests: Chief Knecht and Mr. Roberts from the Edmonton Police Service and Deputy Commissioner Ryan from the RCMP in Alberta.

Before we hear from our guests, a quick overview of the format for today's meeting. Each group will have 10 minutes to speak. Following all presentations on a panel, I will open the floor to questions from the committee members. Members, I will follow our usual practice of alternating between opposition and government members, and I'd suggest that members keep their questions to one plus one supplementary in each round. Members can be added back onto the speaking list if they wish. Members on the phone lines joining us this morning, please e-mail or send a Lync message to our committee clerk if you wish to be added to the speaking list.

We'll begin with our first presentation by the Edmonton Police Service's Chief Knecht. The floor is yours.

Edmonton Police Service and RCMP

Chief Knecht: Good morning, Madam Chair. Thank you very much for the opportunity to speak before the committee this morning. With only 10 minutes – I've got actually nine slides – I'm going to go through the slides rather quickly here and try to hit the more salient points and then invite my colleague Deputy Commissioner Ryan to speak as well.

We'll just go through some of the issues we see as very common sense. These have been fed to us by front-line service deliverers, our front-line people who are dealing with the mentally ill on a daily basis. We can say as the Edmonton Police Service that probably 30 per cent of all the calls we deal with have a mental health component to them. Often they involve the homeless and the addicted. All vulnerable groups are involved in this particular situation. I'll just talk about some legislative changes that we think can be made as well as some areas of practice that can be made by the police service as well as mental health experts and the health care system in general.

Slide 2. Something very, very simple in the act is just a definition of harm. Nowhere in the act is there a definition of harm, so this is left to be very subjective. The police, for example, interpret harm in one way, and a health care professional, a doctor or a nurse, for example, may interpret it a different way. We look at harm, I guess, in a more global setting. It's harm to the community as well as to the individual. The health care professional may look at it as harm to that specific individual: is that individual going to harm themselves?

I think that if we added a common definition of harm that everybody was working towards, that would help us, even when we're arresting the individual, with where we should take them, something very, very simple but something that would really help everybody, particularly the health care professionals, the doctor that's providing care to that individual in an emergency setting, if they're taking into account the harm on the community. This person may not be looked upon as actually harming themselves, but they may harm somebody in the community. That's where I think we have a little bit of a rub in the entire system between health care professionals and police, for example.

I'll go to the next slide if I could, please. Again, we find this to be a very, very simple fix. We've had an increase of 25 per cent of folks that we're taking to units for mental health assessments over the past year – that's a very significant jump – yet we've had a reduction in designated sites. We had five designated sites that we could take people to in the city of Edmonton. With the closure of Alberta hospital we're now down to four, yet a 25 per cent increase.

8:40

The fix is very simple. Actually, health care professionals have come forward with this solution, and we totally agree with it, which is that we just need to take that individual before a physician for an assessment as opposed to a designated site. The act says: designated site. With only four sites, that really restricts us, yet we have places all around the city where we could take these people and get a very quick assessment. As well, we wouldn't be plugging up those four designated sites, and we wouldn't have to drive people across the city, depending on where the site is to where we arrest that particular individual. So we see this as a very, very easy fix that would reduce the burden on the system and allow more proficiency, both for health care workers and the police.

Next slide, please. The legal opinion of convey. Now, this is, again, lawyers' opinions, and it's different in practice. The strict definition is that when the police arrest somebody under the Mental Health Act, we're just supposed to convey them to a designated site. So convey means exactly that. We have to stay with them for 90 minutes, and then we release them. Often there's nobody to release them to. If we were just to go by the act the way it is right now, we'd be leaving these people in facilities all over the city, and there would be harm to the public and to the individual. So in emergency departments and other places we need commissionaires or somebody that can take carriage of that individual after the police drop them off.

We're in a situation, again, where these are taking up a huge amount of police resources, to the tune of, I think, 34,000 hours that we invest in this sort of activity. Our police officers are often at emergency wards on a Friday or Saturday night. We'll have three or four cars with two police officers in each car, so that's eight individuals, eight individual police officers tied up for often a minimum – a minimum – of three hours, and sometimes we're having to shift people. We're holding them in custody for up to eight to 10 hours, waiting for them to see a health care professional. Actually, one police officer or two police officers will go off duty and hand that individual off to somebody else.

This is a huge burden on the Police Service. Really, we should be out there focusing on the predators, those people who are preying on the vulnerable, as opposed to, essentially, babysitting these people. It's not a good use of police resources, and of course we're not out there doing the job that we're supposed to be doing just because of something – again, a very simple solution. A police officer gets paid – on double time you're looking at a hundred dollars an hour. We have people that would be coming in on straight time, commissionaires or peace officers, at $25 an hour. That's simply an economic argument for that particular issue.

Next slide, please. Many of the heavy users of services for mental health complaints exist in the downtown core and are homeless and have little or no support systems. They are also typically addicted to substances and are not connected to medical supports. This increases the likelihood of noncompliance with treatment plan referrals, which ultimately results in police involvement due to recurring crises. Doctors need to consider the likelihood of the deterioration of the patient when discharged.

This goes right into slide 6. There's a nice segue into slide 6. We're releasing people into homelessness again. So these people are being treated, their street wounds or their medication is being dealt with after that six- or eight- or 10-hour wait, and they're immediately released into the community. Very often police officers are arresting these people again an hour later, two hours later, three hours later. So we're on this cycle of despair, and we're actually taking them right back to the Royal Alex, for example, for them to be reassessed and sometimes on the same shift or back-to-back shifts. So it's a poor use, obviously, of health care resources. It's a poor use of police resources. We think that there's got to be a consideration of what we're releasing these people into after they're treated.

What we should be linking into is more wraparound services. We should be linking into the shelters, we should be linking into family caregivers, other folks that can help these people to ensure that they are medicating properly, are taking their meds, are getting properly treated, are connecting with family members or medical professionals or with people involved in homelessness so that they can get them a bed to sleep in that night because this is, again, a huge drain on resources. Our most expensive resources, quite frankly, are the criminal justice system and the health care system. There is a better way to build a mousetrap, and I'll get to that toward the end of my presentation.

The next slide. This has been a real challenge for us here, the sharing of information. This has gone on for years, quite frankly – I'm sorry. Did I miss a slide here?

Mr. Roberts: Yes. Slide 6.

Chief Knecht: Sorry about that. Actually, no, I didn't. That was slide 5 and slide 6, where we're releasing those people into homelessness or despair.

Slide 7. We're not sharing information properly. We have challenges between the health care system and police sharing information. This has been a long-standing problem, and largely, if you look at the legislation, it's not so much the legislation. The legislation actually allows us to share information. It could possibly be cleaned up a little bit and be in, I guess, common language that everybody understands. Again, it's an interpretation issue.

The bigger problem is around: people are so afraid of liability that they will not release information. So you have perhaps an overcautious health care worker, or somebody in the health care system has said that you can't share this information with the police when, in fact, you can share it with the police, but there's a process to share the information with the police. We're actually putting people's lives in danger over the lack of our ability to share information effectively between agencies and organizations.

This is not just exclusive to police and the health care system. The entire system is really challenged with this fear of sharing information, and we're putting people at risk. It's to the advantage of the police to know that this person has maybe had an episode or needs medication or any one of a number of things, and conversely it's good for that health care professional to know that this person has acted out in a violent situation prior to them being brought to a health care facility.

There's got to be more of a client focus, the sharing of information for the betterment of the individual. Sometimes we get into a situation – I mean, I would violate the law to make sure somebody was safe. I think there's sort of the moral, ethical side of the thing, and the law is too prescriptive. I think we've got to be very, very careful, and that's a great way to make the system more effective.

I'll go to slide 8 now. Historically emergency department staff have used police to supplement their security staff to watch for form 10 apprehensions – we've already talked about that – and the inconsistencies with the CTAS scoring across hospitals. Here again, when we're taking people to these emergency wards, there's actually a Canadian triage and acuity scale – I'm not sure if everybody is familiar with that – and it's the interpretation of that scale. It's not consistent across the city at emergency wards or health care facilities, it's not consistent across the province, and it's not consistent across Canada. I think the key is that it's a Canadian triage and acuity scale.

We see in some provinces where, when the police bring in an individual that is in mental distress or needs an evaluation, they're assessed at a level 2, and a level 2 is very – again, I can read it off for you: "Conditions that are a potential threat to life, limb or function, requiring rapid medical intervention or delegated acts." For example, types of level 2 conditions would be altered mental states, which is what we're dealing with – that's why the police are bringing them in – head injury, severe trauma, neonates, MI, overdose, and CVA. Often what we're dealing with is the altered mental states issue and in some cases overdoses or the abuse or use of a prescription medication.

Unfortunately, when we bring somebody in at a level 4, that's qualified as less urgent. I'll describe the definition of a level 4, which is:

> Conditions that are related to patient age, distress, or potential for deterioration or complications would benefit from intervention or reassurance within 1-2 hours.

I don't think we're looking for reassurance when we bring somebody in on a form 10.

> Examples of types of conditions which would be Level 4 are headache, corneal foreign body and chronic back pain.

That's not why we're bringing these people in. We're actually arresting them. We're depriving them of their rights, and we're bringing them to get a mental health assessment because we the police don't have that ability. We're not mental health assessors. We can say that somebody is acting out erratically or that they're violent, or we get a complaint of causing a disturbance or whatever else. We see that what we're bringing these people in for is a level 2, and we go back to a level 2 as emergent, and that requires an assessment within an hour.

I'll go to slide 9 here now. Supplementing community supports with additional personnel will allow increased diversion and stabilization within the community and will decrease mental health presentations at hospital emergency departments. What we're talking about is what we would like to see. One way we can reduce the lineups, the waiting periods at emergency wards in hospitals is that we could have somebody that would come out and do a field assessment. So we arrest somebody in the field. If we could have somebody come out and actually do an assessment in the field, that person never has to see an emergency ward at all. We the police or somebody else, the ambulance driver or whoever, could actually take this person to a shelter or someplace else because they're getting an on-site assessment. What we're looking for is somebody that can be mobile – it doesn't necessarily have to be a doctor; they could be a designated individual – that can do a health care assessment, a mental health assessment in the field.

8:50

Again, you wouldn't see those three, four, five police cars, eight police officers, and a lot of those ambulances tied up in emergency wards waiting to get a mental health assessment from a physician. This could be done in the field, very simple, straightforward, and that would just require somebody to be mobile. The police give them a call. They show up on the scene, do that assessment, and we can take them, again really reducing the burden on the health care system, really reducing the burden on those emergency wards throughout the city.

Finally, something I have been pushing for, well, since probably six months after I became the chief of police is a wellness centre, wraparound services where we can take these people. Again, we don't have to take them to an emergency ward. We can take them to a place where they'll get their street wounds taken care of. They can get their warrants cleared up so they don't have to be arrested and put in jail. That's the last thing we want to do. We want to get them to where these vulnerable people can get the health care they need.

Again, I'll stress that most of these people that have mental health

issues are also homeless and they're addicted. They're self-medicating to deal with their issues. We feel that if there was a wellness centre set up, one or two throughout the province, where police, health care workers, social workers, ambulance drivers, et cetera, could take these people and get them briefly assessed, we could get them assessed and get them to a place where they can sleep overnight, get their street wounds taken care of, get their medication or nonmedication.

The whole medication issue is that some of these people just aren't capable of ensuring that they take, you know, three pills a day: morning, noon, and night. Most of us take that for granted. These folks may not have that ability. Their pills can get stolen, they may overmedicate, or they may sell it because they need the money, any one of a number of things. This is extremely common. This goes on a block from this setting right now. One or two blocks from here this goes on on an hourly if not a minute-by-minute basis.

If we could get these folks to a place where they can get immediate care, again, it will take the burden off the health care system. Now, does this require an upfront investment? It absolutely does, but it's actually an upfront investment that would save millions and millions of dollars in health care, in the criminal justice system as well, and in social services. It has a massive benefit. We've actually done a lot of work on this. We have presentation papers, et cetera. We've done the math. Actually, the heavy users of services project has also been used, where we can prove that we've taken somebody that society would consider a throwaway, somebody that was homeless . . .

The Chair: I apologize for the interruption, Chief.

Chief Knecht: I'm out of time?

The Chair: Yes.

Just in awareness of time, I'm going to quickly move on to our next presenter, RCMP Deputy Commissioner Ryan, and then we'll have all of our questions for the end.

Please go ahead.

D/Commr. Ryan: Good morning, and thank you for the opportunity to present to this committee this morning. My comments will likely correspond very closely to the comments and presentation of Chief Knecht, so I expect my comments and remarks to be very brief.

Before I get into what I believe the committee is seeking input on with respect to changes in the two distinct areas, just a couple of comments. Law enforcement is an integral part of Alberta's addiction and mental health system, and the issues surrounding mental health are of great significance to our police services. Our officers are often placed in the position of dealing with persons in crisis. In this area we are so often the true first responders, but with the current gaps in the health and social service systems the police are also required to act as a service of last resort for individuals unable or unwilling to access more appropriate services. This results in undue demands on police resources and poor outcomes for clients.

Based on information obtained through Statistics Canada, it is our finding that 1 in every 5 police contacts involves someone with a mental health or substance abuse disorder. The RCMP is Alberta's provincial police service, so the reality of dealing with mental health issues in RCMP jurisdictions, many in rural areas, is significantly different in communities outside of major urban centres. Partnership with key stakeholders is essential as we move forward, and addressing mental health in Alberta requires a multidisciplinary approach to ensure individuals and communities achieve and maintain good mental health. The RCMP is a strong supporter of this collaborative approach, and the sharing of information will be an important part of this process. This will require careful consideration.

With respect to the areas of concern and changes, with respect to the criteria for involuntary admission of persons with mental disorders to health care facilities, we also believe that the change from "danger" to "harm" better articulates what we are trying to prevent from an involuntary admission. Protection of the patient and the community from harm is paramount.

The criteria that mandate a doctor to determine whether or not a person will experience a serious deterioration to their physical or mental health must be secondary to the criteria on harm. The safety of the subject and the members of the general public must be paramount in the assessment and decision-making process. It is felt that changes to the criteria as they now are that would make it more difficult to admit a patient involuntarily for examination and treatment would be detrimental as this may result in the increased likelihood of those persons becoming involved in a violent interaction with police.

With respect to the community treatment orders, police agencies are not currently informed about persons in the community who are subject to a community treatment order. We only become involved in the event when the person does not follow the treatment plan and that results in an apprehension order. It is our observation that presently there seems to be minimal impact on policing operations from the community treatment orders as they are now set out. I would add that I agree with Chief Knecht's comments that this is where the information sharing is really key for us. We're very mindful of the balance that has to be found between an individual's right to privacy but also safety in the community.

Lastly, with respect to the Mental Health Patient Advocate it is also our view that investigations by the Mental Health Patient Advocate have had little impact on policing operations. We believe there are sufficient processes for the investigation of complaints against police, and allegations relating to police apprehension should be directed to the public complaint process for the police agency involved.

Those are my comments. Thank you.

The Chair: Thank you very much.

I now have a list started of members wanting to speak. We'll begin with questions. Dr. Swann, go ahead.

Dr. Swann: Thank you very much, both of you, for a terrific overview of some of the issues that we certainly heard about in the mental health review in the latter part of 2015.

With respect to the mobile assessments, Chief Knecht, that is an eminently sensible issue that is more related to some of the ongoing PAC teams, I think you call them, or is it the ASIRT team that goes out with a social worker or a health worker to assess a situation of mental crisis?

Chief Knecht: Yes. Thank you, Doctor. You're correct. It's PAC teams, police and community teams. I can't remember the exact definition, but what they are is a police officer and a mental health professional who work together and travel throughout the community and deal with those police calls that have a mental health component to them. Now, one of the things we could look at is an increase of those teams or a redirection of those teams because the mandate of those teams has deteriorated over time. We'd like to get them back on mandate, specifically where they could do assessments out in the community and help those front-line police officers or those ambulance drivers as well.

Dr. Swann: That is certainly something that we reinforced in the mental health review, and I certainly see the tremendous cost saving as well as in suffering.

The second area that you mentioned was the wellness centre. Surely we could be using PCNs and family health centres in that respect to pop in except that they only operate during working hours, generally. Is that the problem, that the wellness centre could co-exist with the primary care network or the family health centres?

9:00

Chief Knecht: Absolutely. We would see that as a 24/7, 365 service that needs to be delivered. It goes to Deputy Commissioner Ryan's comments around us being sort of the front line, the pointy end of the stick because we are, you know, 24/7, 365. When you have a health care facility that's 8 to 4, Monday through Friday, we know that those folks that are in crisis: it's often at night, it's often late at night, and it's usually Friday night and Saturday night.

Dr. Swann: Thank you.

Could I squeeze in one quick other one?

The Chair: No. Dr. Swann, I'll ask that you go back into the rotation.

Dr. Swann: Okay.

The Chair: Mr. Horne, go ahead.

Mr. Horne: Yes. You both kind of touched on this, both in your submission and in your presentation, but I was hoping to get a little bit more information on the impact CTOs have had on police operations and if you've noticed any reduction since their introduction or any real change.

D/Commr. Ryan: I'll speak first. No, actually, we haven't. Again, as I alluded to and, I believe, Chief Knecht did, there is a bit of a disconnect in the relaying of that information. I totally understand, you know, that it's finding that balance between respecting an individual's privacy versus the community harm. I think we have work to do.

I don't have the answer, but I do feel that the pendulum needs to move a little closer to somehow providing information to the police so that when we arrive at a scene with, you know, someone that has been subject of one of these orders, we're certainly sensitive to it and we're alive to it because it does significantly affect our approach to some of these incidents. As I noted, many times we're called as a last resort, and sometimes it's at a point of extreme violence. However, if we had more awareness somehow, through some filter, again, which respects the privacy, that this individual was subject of one of these orders, I think it would be very helpful. It would be helpful for the client, and it would also be helpful for the police.

Mr. Horne: Of course. Thank you.

Chief Knecht: Can I add to that?

The Chair: Absolutely.

Chief Knecht: I think, you know, quite often we do get the information, but it's a timeliness issue. As Deputy Commissioner Ryan has stated, we're in an emergent situation, a live, real-time situation. Folks will go back and say that they're going to have to talk to their supervisors and they're going to have to talk to their legal team and so on and so forth. I mean, it's the bureaucracy, and it's the interpretation of the law. People are just very fearful of liability. I've actually heard supervisors talk to health care professionals and say: "We can't release that, you know. You're going to get sued. You're going to lose your job." So people are saying, "Well, I'm going to make a choice here." It's a bit of a Sophie's choice, quite frankly, because we've got somebody that is in a violent situation. We have to respond immediately.

I think that the system has to provide very clear direction on what can be legally shared, and that's where the challenge is, because it's just this delay and this fear and this liability. There's got to be very clear direction.

Mr. Horne: Okay. Thank you.

The Chair: Thank you very much.

Mr. Orr.

Mr. Orr: Thank you. I heard both of you speak very clearly about the issues of lack of communication, interdepartmental, interagency, all of that sort of thing, and I totally support you on that point. I really think that our society has swung the pendulum way too far on that one. In my mind, it's sort of like cutting off the synapses within your own brain cells. If your own brain cells don't communicate with each other, you're only working with a small portion of your brain. On the social level, if we don't communicate with each other, we're only working with small parts of ourselves.

I know of at least one case where a client was released to family. The medical establishment absolutely refused to share any information, and within hours the client was dead. We are actually harming people by refusing to communicate. I would like to ask your opinion and also your assessment of risks of the inclusion of family members in that. You've included that here in your submission, Chief. Oftentimes it's family members who get left to pick up the pieces which get dumped on these people. They have no idea what's going on. They're completely incapacitated to actually help. In our society we realize more and more that it's the social supports, the supports around a person, that make a huge difference, yet we're not including them in the process. I just would appreciate your further comments on that.

D/Commr. Ryan: I agree a hundred per cent on the information sharing as well as the family piece. In my mind – I'm a visual person – right now I see police interaction with people with mental health issues in terms of a spectrum. The police are quite often involved at the front end of the spectrum, and they're involved at the end of the spectrum. Somewhere in the middle are the health and social services. I believe a perfect model would be more of a hub type of a system with the client in the middle, where the police are one of the spokes, and the family would also be one of those spokes so that you'd have the central co-ordination. The families could somehow relay, you know, concerns that they're worried about their son or daughter or their mother or father, and somehow, if the police come into contact with that subject, we are aware of the previous history. We are aware, certainly, with respect to the behaviour, but secondly, the family is alive to the situation. Is there a way that we can work with the family before it gets to that far end of the spectrum?

Chief Knecht: I, too, would echo those comments. I mean, family is key. I can give you examples that I'm personally aware of here in Edmonton, where we have people that are homeless, addicted, mentally ill. They're on the streets. Their family doesn't know where they are. They've lost track of them. An example that comes to mind is a Fort St. John individual. The family is up in Fort St. John. That individual is continuously accessing police, medical services, emergency ward, shelters, et cetera, et cetera, and the

family doesn't know where they are. The family believes that individual is dead. Our ability to reconnect with family – and the family knows the history. They know, quite often, how that person got to where they are, and if the family can be reintegrated into the system, I mean, what a tremendous asset.

I think a lot of these people just aren't capable of giving permission. You know, we're so hung up on, "Well, you've got to give permission," but they're not capable of giving permission. I mean, it's ridiculous. It's actually ridiculous when we get into a situation with somebody that can't give permission, yet we have a system that says: you've got to give permission for us to share this information with family, with police, with health care workers. It's all about getting these people to a better, safe place and helping them. I think the system is letting them down, quite frankly.

The Chair: Thank you.

Ms McKitrick.

Ms McKitrick: Thank you. Chief and Deputy Commissioner Ryan, I really felt during your presentations the caring that your officers have for these vulnerable people, so I wanted to thank you.

I wanted to ask you questions about the training of the officers or the members regarding mental health symptoms and the behaviors around mental health and especially about how to best de-escalate or support these individuals. Another aspect of the training: I also was wondering what kind of training or what kind of support your officers have in terms of dealing with the cross-cultural population.

D/Commr. Ryan: I will speak briefly. Our training starts right at our academy in Regina. As I mentioned, because this is a big piece of our police interactions, it's very important that our folks are trained on those indicators or indicia that signal: something's not right here. That training starts – we have, you know, courses designed to help, again, our folks in the field, the front-line responders, be very alert to that. We have online, regular, mandatory training that we do.

9:10

You touched on a point, and that's about the support of our members. That is really, really key. It's a big concern for us. That's where we don't – you know, we have to have that training. We call it critical incident debriefing. But, to me, that's when things are at their worst. We've had our members attend a scene, and we're alive to the fact that there are some mental health issues. However, the individual is armed and discharges a firearm through their own head, and our members see that. Not only do you have the obvious harm to the client, to the client's family; now I have officers who may or may not be able to return to work, so there's a significant loss there. We immediately do a wraparound type of treatment. I use the analogy of the blanket that the First Nations people use. We deploy that immediately, but that's a significant piece because, again, there's a loss there, that our officers may not return from.

Lastly, your piece about the cross-cultural: again, very similar. Training starts with our folks right at our training academy. Here in Alberta we have regular outreach programs where we're reaching out to the various ethnic and aboriginal groups. I have committees, that I chair, which call on leaders of those various communities as well as a strong committee with aboriginal leaders. It gives me an opportunity to hear how our officers are doing in those communities but also, you know, share what we're doing well and best practices and hear any concerns that the community leaders have.

Chief Knecht: From an external perspective we recognize, you know, that 30 per cent of our calls for service are dealing with folks with mental health issues, so we've trained over a thousand of our front-line people specifically to recognize those issues of mental health. That training has been through the University of Alberta, so we've had an external group train our people.

Cross-cultural training: we've trained, I think, all our front-line people now, given them cross-cultural training specific to the aboriginal population. By providing that training to our people, we've seen a reduction in violence, in our folks interacting in a violent situation with external clients; we've seen a reduction in arrests; and we've seen a drop in complaints against the police as well: all positives as a result of investing in that training for front-line employees.

Internally, we have an employee and family assistance support section, that helps our folks that are dealing with issues similar to what Deputy Commissioner Ryan spoke of. We have between eight and 10 members dedicated to that within the Edmonton Police Service. We have robust supports within the service. We have psychologists. We have psychiatrists. We have an early warning system, so people are flagged if they're continuously dealing – we have folks that are in high-risk situations, obviously, undercover operators, those kinds of folks, that get an assessment. We have a program that we borrowed from the military. It's called the road to mental readiness, R2MR. We train all our people in that program as well to recognize when they're having an issue or when their partner or colleague is having an issue that may require augmented support.

The Chair: Thank you very much.

I'm just very aware of time. We are running out of time, so I'd like to thank our guests for their presentations this morning and for answering the committee's questions.

I still have three members left in the rotation. We will start with Mr. Shepherd. I would ask that Mr. Shepherd, then Dr. Swann, and then Mr. Horne simply read their questions into the record, which will allow an opportunity for our guests to provide a response in writing. We would ask that it be done by, at the latest, Monday, June 20. If there's any additional information that you would like to add for any other questions that were brought up this morning, that will also provide an opportunity for you to submit some supplemental answers.

Please, Mr. Shepherd, go ahead and read your question.

Mr. Shepherd: Thank you, Chair, for the opportunity. Just a couple things I wanted to ask about. One, you noted in your presentation, Chief, the value of the PAC teams. Certainly, I've had a chance to meet with them and talk with them about their work. I think it is fantastic. You said that two more PAC teams would be extremely helpful in addressing the issues. I was just wondering: what would be required in order for that to happen? What are the resources? What kind of co-operation would you need to allow that to go forward?

The other question I had is sort of along those lines. You said that in terms of diversion, if you were able to take people to somewhere other than the emergency department, if you could take them directly to a physician: could you give us some clarity on what that would entail? Is that just any doctor? Is that a medicentre? Or are we talking about specific expertise with a mental health focus?

Thank you.

The Chair: Thank you.

Dr. Swann, please go ahead and ask your question.

Dr. Swann: Well, thank you. With respect to transfer of supervision from the police service to a custodian, a security person, perhaps, in the emergency room, I think that's a difficult one but something that we could look into. If you haven't made a

formal request to that effect, I would ask that you do that. Make a formal request to Alberta Health Services about the legality of transferring care from the police to a custodian in the emergency room.

The Chair: Thank you, Dr. Swann.

Mr. Horne, please go ahead and read your question.

Mr. Horne: I represent a constituency with both very rural and decidedly urban areas, so I was hoping to get some insight into the effectiveness of CTOs, a comparison of smaller or rural communities as well as large urban centres and if you feel that this is an issue.

The Chair: Thank you very much.

Again I would like to thank our guests for their presentations this morning. I would request that all answers be forwarded through the committee clerk, ideally before next Monday, June 20. I'd like to note for our guests' information that the transcript of today's meeting will be available via the Assembly website by the end of this week. Thank you very much.

Chief Knecht: Thank you.

9:20

The Chair: I'd like to invite everyone to take their seats as we'll reconvene. Thank you.

The committee is hearing oral presentations today respecting its review of the Mental Health Amendment Act, 2007. I'd like to welcome our guests on the next panel.

We'll do a quick round of introductions of members and those joining the committee at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and the chair of this committee. We'll continue to my right.

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

Mr. Orr: Ron Orr, MLA for Lacombe-Ponoka.

Ms York: Erika York. I'm from the Schizophrenia Society of Alberta.

Mrs. Daviduck: Louise Daviduck, Schizophrenia Society of Alberta.

Dr. Dhaliwal: Arsh Kaur Dhaliwal from the Canadian Mental Health Association: Forward Action in Mental Health.

Ms Hughes: Kathy Hughes, Canadian Mental Health Association, Calgary, and Forward Action in Mental Health.

Mr. Reiniger: Jordan Reiniger from Boyle Street Community Services.

Ms Bergwall: Sandy Bergwall from Boyle Street Community Services.

Mr. Shepherd: David Shepherd, MLA, Edmonton-Centre.

Ms Woollard: Denise Woollard, Edmonton-Mill Creek, standing in for Karen McPherson.

Ms McKitrick: Annie McKitrick, MLA, Sherwood Park.

Mr. Horne: Trevor Horne, MLA for Spruce Grove-St. Albert.

Mr. Hinkley: Good morning. I'm Bruce Hinkley, MLA, Wetaskiwin-Camrose.

Mr. Koenig: Trafton Koenig. I'm counsel with the Parliamentary Counsel's office.

Ms Robert: Good morning. I'm Nancy Robert, research officer with the Legislative Assembly Office.

Dr. Massolin: Good morning. Philip Massolin, manager of research and committee services for the Assembly.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: On the phones.

Ms Jansen: Sandra Jansen, Calgary-North West.

Ms Luff: Robyn Luff, Calgary-East.

Dr. Swann: Good morning and welcome. David Swann, Calgary-Mountain View.

Mr. Gill: Good morning. Prab Gill, MLA, Calgary-Greenway.

Mrs. Pitt: Angela Pitt, MLA, Airdrie.

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

The Chair: Thank you.

Before we hear from our guests, a quick overview of the format for today's meeting. Each group will have 10 minutes to speak, and following all presentations of the panel, I will open the floor to questions from committee members. Since we have a number of presenters from each organization attending, please identify yourself before you begin speaking for the record and for the benefit of those listening online.

We'll begin with our first presentation by Boyle Street Community Services. The floor is yours.

Community Support and Health Services Organizations

Mr. Reiniger: Thank you. We'd like to thank the chair and the committee for giving us this opportunity to speak to you on behalf of Boyle Street Community Services and the community that we serve. Boyle Street supports over 12,000 individuals each year; 80 per cent of those are of aboriginal descent. We serve a broad spectrum of clients, from children and families and youth to adults and seniors. All that we serve are adversely impacted by poverty, including homelessness. Many in our community struggle with severe mental health and substance misuse challenges.

When looking at mental health services in general, we wish to emphasize two important principles that we utilize in our work that we think ought to form a lens through which any decision on mental health and substance misuse interventions is viewed.

The first is harm reduction. Harm reduction is defined by Alberta Health Services as "those policies, programs and practices that aim primarily to reduce the adverse health, social or economic consequences of the use of legal and illegal psychoactive substances without necessarily reducing consumption." At Boyle Street we believe the philosophy is much more robust than that. At its core it's about a lack of judgment and meeting people where they're at. It's about not prescribing our own opinions, treatments, and ways of doing things on people and utilizing one-size-fits-all approaches. It's about doing whatever it takes to meet the clients where they're at and thinking outside the box to provide the most effective and culturally appropriate and client-centred treatment possible.

We find that our clients often disengage from mental health

supports because they don't want to go on a particular drug regime or treatment that's being prescribed. If we take a harm reduction approach, we would be able to explore other possible paths towards healing by meeting the client where they're at. We have lots of examples of how that's been effective in the past.

Secondly, if we're going to be effective in walking alongside people on their journey toward healing, we have to take a trauma-informed approach. The vast majority of the marginalized population that we serve has experienced significant trauma in their life and indeed continues to experience incidents of trauma as a result of their health condition. The trauma is often both a cause and condition of their health challenges. Working in a trauma-informed way is about establishing a relationship of trust by being present, consistent, and familiar. It's about making services available in places where individuals are comfortable and feel welcome and at any time when they feel ready to access them. It's about creating conditions where emotional and personal safety exist or providing services in the community where those conditions already exist.

With respect to the 2007 amendments we agree with a broader definition for involuntary admission. However, we found that the definition is not consistently applied. We have often had the experience where we call police or Alberta Health Services because of a client at our downtown community centre. They're clearly likely to cause harm to themselves or others or suffer serious mental or physical deterioration or serious physical impairment if not provided appropriate treatment. However, they're often not admitted for treatment. We are unable to allow them to stay in our building because of the risk of harm to others, so they fall through the cracks and have nowhere to go but the street, which impacts negatively on them and their health and the broader community. We hear far too often that people are just not sick enough. We have to wait to the point of complete crisis before somebody can be admitted for treatment. Many of these experiences, that we face in the community centre, should not be happening, and these individuals should be admitted for treatment.

That brings me to two points. First, what is sick enough? From our experience many of the clients we see are sick enough, based on the definition provided in the 2007 amendments. Greater clarity around how the change in criteria for involuntary admission in 2007 should be impacting practice would be helpful throughout the system but also for community-based organizations like ours so we can be more effective advocates.

Second, the notion that someone is not sick enough to receive mental health assistance is a difficult one. We need far greater emphasis on prevention and greater support in the community to assist people so they don't get to crisis. Unfortunately, we're moving in the wrong direction on this front. Mental health services at Boyle Street have actually been on the decline due to a lack of resources for mental health services system-wide and strategic decisions by AHS to change how services are delivered in the community.

If we want to make a true impact on health outcomes, we have to focus on prevention in the community. Therefore, we wish to encourage the committee to look at community-based organizations such as Boyle Street and all of my colleagues sitting here as key partners in the delivery of mental health services. What we know from experience is that clients achieve significantly improved health outcomes when a spectrum of support is provided to them, including community-based support.

An example of this is a pilot project that we're working on, in conjunction with Alberta Health Services and our partner E4C, called the youth community support program. It's a step-down program out of institutionalization for youth. We as community-based outreach workers engage in joint case planning and joint case management with the clinical team at Alberta Health Services. We leverage the strength of each team to truly wrap around the youth and their families to meet their complex and multifaceted needs. We believe that similar joint case planning and management could occur with individuals being discharged from involuntary admission or engaged in community treatment orders.

As it stands now, we have no way of knowing whether a client accessing support at Boyle Street is under a CTO, has been admitted or discharged from involuntary admission, or even if they're working with anyone else on their mental health or substance misuse challenges. Due to their mental health and transience many often don't know if they have a CTO or what it says or what they have to do. They don't remember if they were involuntarily admitted or if they're on any medication or if they have any upcoming appointments. As a strategic partner, community-based organizations like Boyle Street could play a key role in supporting people, but we cannot effectively do our job if we're working in the dark and don't know what's happening with our clients.

We need to do better on information sharing so we can work together with clinicians to create better health outcomes with our clients. We're proposing two possible options for overcoming this information-sharing gap but acknowledge that there may be other ways of getting to the same solution. The first option would be to provide mental health workers at community-based organizations with limited access to Netcare and eClinician. After obtaining proper consent, they could type in the name and date of birth of a client to see if that person is currently working with any other worker in Alberta Health Services. If so, our worker could connect with the AHS worker and provide consent from our client to engage in a discussion. They could then begin working together to better support the client.

The second option is to embed a system navigator within community-based organizations. That person would have access to Netcare and eClinician and could facilitate the relationship between our workers and AHS clinicians. It's worth noting that we previously had two full-time Alberta Health Services workers at Boyle Street and effectively had this in place, but those individuals were removed because of strategic change.

9:30

Finally, community-based organizations themselves could be effective system navigators for our clients, and if we had the ability to refer directly to some key Alberta Health programs such as treatment facilities like Henwood or psychiatrists, that would be very helpful. At present the only way to access such treatment is through AHS clinicians on an appointment-based system, which rarely works for a transient community suffering from severe mental health challenges.

In conclusion, in 10 minutes we can really only scratch the surface. We're open to any questions that you may have. However, we wish to implore you to examine any changes to the Mental Health Act through the two key lenses of being trauma informed and harm-reduction oriented. We as a community-based organization also want to work with you as key partners in the delivery of mental health services for our community to achieve better outcomes.

That's all I have for today. Thank you.

The Chair: Thank you very much.

Our next presentation is by Forward Action in Mental Health. Please go ahead.

Ms Hughes: Good morning. My name is Kathy Hughes. Thank you for giving Forward Action in Mental Health a chance to present today.

We are a peer advocate group made up of concerned individuals with lived experiences of emotional health concerns. Before I discuss my own lived experience as a mental health patient, I want to acknowledge all of the work that this committee has done thus far. I can't believe that I have been given this extraordinary opportunity to speak to the very amendment that, had it been written more definitively, would have protected me as a patient admitted involuntarily to the hospital six years ago. The Mental Health Amendment Act, 2007, is a very powerful piece of legislation, and revisions to this act will impact the civil liberties of persons in severe emotional crisis. We feel that further changes need to be made to ensure that the rights of at-risk and our most vulnerable are protected.

A few years ago I was taking antidepressants to help me cope with the grief and depression caused by the loss of three close family members while struggling to put a parent with acute dementia into long-term care, ironically, without her consent. When I was prescribed an antidepressant called Paxil, it caused a severe manic episode. I was not a danger to anyone. However, I wasn't rational, reasonable, or cognitive of how critically ill I actually was. After a family physician signed a form 1 certificate, the police were called, and I was taken to the hospital under a form 10. I was taken against my will even though I was not harming anyone, just myself if I wasn't treated.

I will never forget being put in the back of a police car and feeling sick with fear when I realized I couldn't open the door without a handle. In that moment I no longer felt safe and felt more like a criminal than a critically ill patient. I will also never forget being escorted into the hospital by the police, and even though it has been six years, I still remember the feel of their grip on my arms. I wish I could forget being put into a locked room with a peace officer guarding the door and being forced to sleep in my clothes until I was taken to the psychiatric ward.

It was the most traumatizing and demoralizing thing I have ever been through. It took over three years before I could drive by a police car without having to pull over to control my shaking and crying. If I had only one wish to change what happened and make the experience more humane, I would replace the police escort with a PAC team, a mental health clinician and police officer that are trained to help persons suffering a mental health crisis.

After I was admitted to the hospital, I was treated for one month. When I was in the process of being discharged, I was asked to help co-ordinate my own release. My family physician was not known. I didn't have a full-time physician due to shortages at the time. Needless to say, I didn't co-ordinate my release very well. The obstacles I had to overcome to get the follow-up care I needed were almost insurmountable. A family physician that was willing to take charge of my ongoing care did not have the expertise to properly adjust the medications I was on. I also needed a psychiatrist that had the experience to both monitor and adjust my medications.

Unfortunately, not long after I was released from the hospital, I started to become ill and fell into a severe depressive state that can follow extreme mania. I spent a number of weeks trying to navigate my way through a complex and disjointed health care system, looking for the ongoing care that I needed. I finally found an empathetic psychiatrist willing to take charge of my care, but she was not able to treat the debilitating fatigue that gripped me like a vice. She finally had me readmitted to the hospital for another month of treatment.

I have been described as being very strong, determined, courageous, and even fearless, something that is a prerequisite of having taught junior high and high school students. I had to be strong. I had to be determined and courageous, trying to find the follow-up patient care that I needed, being told, "No; there's a long waiting list; we can't help you; try another physician or psychiatrist," week after week and becoming critically ill in the process. This is why I am truly fearless and standing in front of you today.

My lived experience has also made me very determined and very passionate. The recognition and appreciation by the MLA for my city's Calgary-North West, Ms Sandra Jansen, of the importance of having folks with some lived experiences involved in this process have helped fuel my determination, passion and give me the courage to ask for help again. I am asking for this committee's help to make sure that the amendments to the Mental Health Amendment Act, 2007, are written in a way that protect at-risk and critically ill mental health patients.

I am asking the committee's help to ensure there is co-ordination of proper follow-up and ongoing care for persons admitted involuntarily, like I was. The consistency of their care must be guaranteed, and if a family physician is not known, then one must be provided. A nurse, social worker, or designated navigator, as Dr. Swann has recommended, must take charge of co-ordinating, communicating, and facilitating their ongoing care. Community extension teams currently in existence that have psychiatrists on staff and provide interim care must be expanded in order to help patients access the quality of care they need. In-patient psychiatrists also have to take on more responsibility and keep treating patients to ensure their continued care until an outpatient psychiatrist is found.

Empathy is defined as the experience of understanding another person's condition from their perspective. By sharing my experiences with you today, I hope that you have gained a better understanding and compassion for persons admitted involuntarily, like I was, and that when they are released from the hospital, they be given the care that they truly need.

My friend and famed group member, Arsh, will now be continuing with our presentation.

Dr. Dhaliwal: Good morning, everyone. My name is Dr. Arsh Kaur Dhaliwal, and I'd like to speak to you today on the impact of the Mental Health Act and the power that it holds. I speak not only of the power it holds within the clinical setting but, truly, the power it holds to restrain and simply take away an Albertan's rights and freedom.

An emphasis needs to be made within this act that a proper, comprehensive risk assessment be made on patients. Early intervention and recognizing the signs of decompensating all can lead to using the Mental Health Act less, and that should be a goal because the weight this act has on the lives of patients should not be taken lightly and needs to be used as a last resort. Citizens of Alberta should never have their liberties taken away because of a lack of community service options.

9:40

As many of you know and have perhaps seen, the stigma within those suffering from mental illness is a significant problem in this field. I speak not only of the stigma from the perceptions of society at large but also the self-stigma and that within the health care system. Stigma has led to several acts of discrimination, and this not only affects patient care and recovery but also seeking care in the future. Legislation like the Mental Health Act should protect citizens. He who controls the past now controls the future, and we ask that you look at the present state of mental health care when making amendments.

In conclusion, the amendments proposed in Alberta's Mental Health Act do not provide improvements for those suffering emotional crises. A focus on the importance of proper risk

assessment, transitional care, community extension teams, and protecting those against adversity like stigma and discrimination can lead to the betterment of the lives of all Albertans.

We thank you kindly for your time and work and for allowing us to have a voice here today.

The Chair: Thank you so much.

Our final group on this panel is the Calgary branch of the Schizophrenia Society of Alberta. Please go ahead with your presentation.

Ms York: Thank you. Good morning, and thank you for allowing us this opportunity to share from our clients' perspective. I'm Erika York, and this is Louise Daviduck. We're representing the Schizophrenia Society of Alberta. I'm the family support co-ordinator from the Calgary branch, and I am here today expressing the perspective and experiences of family members and caregivers of a loved one with schizophrenia or related psychotic illness who attend our educational sessions or are in support programs.

Twenty per cent of the Canadian population experiences a mental health disorder; that's 1 in 5 individuals. Then 1 in 100, or 1 per cent, will experience schizophrenia. That means approximately 34,000 Albertans live with schizophrenia and a related psychotic illness today. That doesn't include the countless family members, caregivers, neighbours, colleagues, and friends who are all impacted by this disease of the brain.

The Mental Health Commission of Canada estimated in 2013 that family caregivers save the health care system $3.9 billion in health care costs, not including the emotional and financial support that they provide daily to their loved ones. Yet family caregivers are often excluded from health care decisions and are rarely relied upon as a source of information for the psychiatric evaluation process.

Generally an involuntary admission to hospital is a very traumatic crisis for any family, creating disruption and dysfunction in the family unit. When their loved one is discharged, family members are rarely given information on their loved one or their care, where to access further supports or to receive education on mental illness. Many family caregivers have shared with me that they feel like the enemy of the system because of these communication barriers. Family members struggling with their loved one's illness provide unpaid labour and extreme financial benefit to the mental health care system, yet they receive little to no recognition or support in return.

As a result of the Mental Health Amendment Act, 2007, the criteria for involuntary treatment, or detaining and treating a person without consent, were revised and expanded to include the notion of harm rather than danger and the notion of deterioration. This amendment in theory was a great change for family members wanting to court order an involuntary admission of their loved one to acute-care facilities who didn't necessarily present this danger but whose condition was seriously worsening. The act expanded the criteria to allow more individuals suffering mental health disorders to be assessed and treated.

On the other hand, once the loved one with schizophrenia is detained in hospital, the criteria or assessment process here becomes way more strict. It is at this point that two physicians within a 24-hour period must agree that the person is suffering a mental disorder, is likely to cause harm to themselves or others or to suffer serious mental or physical deterioration or physical impairment. So what are the assessment tools here? What is the assessment for harm, for deterioration? How long is an assessment? These are some of the questions that family caregivers have.

A crack in the system that many of my family member clients have mentioned in this involuntary treatment process is the fact that many individuals with severe mental illness, one, believe that they are not ill and, two, are able to mask their symptoms for brief periods of time as the social desirability effect takes place. If a doctor were to ask you, "Are you hearing voices?" most people know what the right answer is.

Family members and caregivers have mentioned that the assessment from a physician or psychiatrist is brief, less than 30 minutes, and does not assess for anosognosia, the symptom of lack of insight into your own condition. Anosognosia is a severe symptom and is the leading cause of noncompliance to medication treatment, mental deterioration, and the revolving-door phenomenon; in other words, the repeated detainment or admission of a person on multiple occasions due to their lack of compliance with treatment and mental health deterioration in the community. Fifty per cent of individuals with schizophrenia and bipolar disorder experience this symptom, so it is not a rare circumstance to have individuals not believe they are ill and, thus, not accept treatment and, of course, not want to be in hospital. In fact, this means that approximately 37,000 Albertans experience this symptom alone. Creating more sophisticated assessment tools to account for this lack of insight may reduce the revolving-door phenomenon, again, the repeated detainment or admission of the same individual.

Following this line of thought, the criteria for likelihood of suffering serious mental or physical deterioration are vague. One of the family member clients quoted the emergency physician who would not admit her loved one as saying that, quote, she is not bad enough yet to get in. This directly supports the notion that physicians are not determining for future deterioration; however, they know that this person is likely to further decline in the community. Another example provided by a family caregiver was an emergency physician saying that the patient has to hit rock bottom before they are admitted. Again, this physician demonstrated knowledge that deterioration to rock bottom was likely to occur but would not admit the individual based on this criteria.

A goal for future amendments would be to expand the definition of mental or physical deterioration and reflect this in the involuntary admission assessment process for psychiatric medical professionals. Looking at previous hospitalizations and medical records may demonstrate to the emergency physicians assessing the individual that a deterioration has occurred, based on the frequency and nature of these detainments/admissions. As well, discussing with family members and caregivers who initiated the mental health warrants in the first place may indicate the why behind the detainments.

Community treatment orders, CTOs, were introduced in Alberta following the Mental Health Amendment Act, 2007, in order to provide support for persons who have a mental illness as an alternative to involuntary admission to a health-care facility. The introduction of the CTO was a very promising new alternative as it seemed to hold promise of limiting the revolving-door phenomenon.

The Mental Health Act, section 9.1(1), states that two physicians may issue a CTO with respect to a person if within the immediately preceding three-year period the person has on two or more occasions been in a formal facility, a hospital, or has exhibited a pattern of recurring mental or physical deterioration. Family members and caregivers have shared with me two problems with these criteria. One, the vague notion of deterioration is a significant part of issuing a CTO. However, as I just mentioned, many physicians do not seem to appropriately assess for this decline. Two, family members have noticed that it requires upwards of seven to 10 mental health warrants, involuntary admissions, before

that emergency psychiatrist will consider issuing a CTO rather than the two or more as stated in the Mental Health Act.

When an individual is voluntarily or involuntarily admitted to an acute-care facility or hospital on multiple occasions, they often will be brought to different hospitals with different physicians, different psychiatrists on staff. Very rarely do admissions to hospitals receive the same medical staff that they would have had on a past admission. Therefore, the continuity of care is just not present.

Although the medical staff assessing this individual may change, their medical records do not. Psychiatrists and physicians assessing individuals detained in acute-care facilities could simply look at previous hospitalizations and admission records to assess if the individual has been detained or admitted to a psychiatric facility on multiple occasions within the previous three years. Lack of communication between emergency physicians and lack of communication from physicians to family members promote the continued deterioration of certain individuals and the continued perpetuation of the revolving door. The accessibility and availability criteria for CTOs should be reviewed and expanded to allow physicians to be more comfortable with issuing these.

9:50

All medical professionals will agree that early detection, early prevention, and early intervention are the best medicines to prevent and treat different physical and mental disabilities. If doctors waited until the heart attack was bad enough to issue treatment, we would lose thousands more lives each year. Involuntary treatment and CTOs can be and are meant to be the tools for early intervention for people with severe mental illness, yet we only see these mandated after many repeated hospitalizations and after significant deterioration has already occurred.

The goals of family members and caregivers affected by the mental health legislation are to advocate for more sophisticated assessment tools for both involuntary admission and CTO criteria and for better communication between health professionals and family members to aid and reduce the amount of relapse and rehospitalization that occurs.

Thank you.

The Chair: Thank you to everyone who presented on the panel this morning and a special thank you to you, Ms Hughes, for sharing your personal story. I'm very grateful for the strength and courage that you showed this morning.

I have started a list of members for questions, so I will open the floor. I have Mr. Shepherd.

Mr. Shepherd: Thank you very much, and thank you to all of you for your presentations this morning. I just wanted to follow up with the folks from Boyle Street Community Services. In your submission that you sent us, you mentioned – and we heard this also from Ms York – that clients can present very well in the hospital, that they can know what to say or not to say to avoid admission even though they may be very ill. We've also heard that other individuals brought in are often quickly discharged. Is it your feeling, then, or your consideration – and Ms York, please feel free to add to this as well – that perhaps the bar for involuntary admission may be too high?

Ms Bergwall: I believe that it is too high. I think that a lot of the clientele, or community members, that end up at the hospital do present well. They know what to say. Therefore, through that process they're released and come back. They are not well, and we can't keep them in the community centre because they are at risk of getting hurt or hurting someone else. They're just unable to be there.

The Chair: I would just like to remind panel members to please introduce yourselves for the record, just for those listening.

Thank you.

Mr. Shepherd: Ms York, did you have any comment?

Ms York: I would agree. I believe that the bar is a little bit too high. I know that it does have to do with resources as well. We always hear: there are not enough beds, not enough beds. So I know that that can be an issue as well.

Thank you.

Mr. Shepherd: Okay. Along those lines, then, that being the case, what changes do you think could be made to help address that? Is it a matter of clarifying some of the terms? Is it improving the assessment process? What do you think could be done to help address this?

Ms Bergwall: I think that it would really help if there were more Alberta Health Services workers out in the community that actually could do some assessments or at least community engage, understand where people are at, can see when they are cycling out of control and that there is some record of their health that could be attached that Alberta Health Services could be entering into e-Clinician on individuals so that when someone is presenting in the community, it can slide into the hospital system and they can see the deterioration. I think that's one way of looking at people in the community and for Alberta Health Services to have some kind of record.

Ms York: I would just like to add to that. I mean, I don't know the assessment process right now, but as I mentioned, I think it needs to be just a little bit more sophisticated, allowing those emergency physicians and emergency psychiatrists to be more comfortable with assessing an individual. What I've heard from my family member clients is that it's just as if they don't have the time of day. They just hit a wall, and it's not a proper assessment, from what I've heard.

The Chair: Thank you.

Ms Hughes: Yes, I definitely would agree with that. I have a copy of a form 1 certificate. There's so little information that it's hard to believe that this document is going to take away somebody's civil liberties.

The Chair: Thank you.

Ms Jansen, go ahead.

Ms Jansen: Thank you so much, and thank you to all the presenters. I think there is some very valuable information here. I want to give a special thank you to Kathy Hughes because I think telling an intensely personal story like that takes a tremendous amount of courage. Kathy, when I met with you in my office, your ability to articulate what you went through just blew me away. I want to thank you for that and ask you, Kathy, if you could expand a little bit, perhaps, on what your suggestions might be going into the future about the kinds of resources we need so that what happened to you doesn't happen to other people.

Ms Hughes: Well, I've given the suggestions in a broad way: community extension teams, designated navigators to co-ordinate the care, in-patient psychiatrists taking on more responsibility. Our

new south health centre actually does that. The psychiatrist will take care of the patient's medications until they find a psychiatrist on an outpatient basis. Transitional care is big. Community extension teams: there is one in Calgary. They have about 15 on staff, and the social worker at the hospital has to refer you to this community extension team, where they can provide interim service, not just medical but also housing, education, and anything that the patients need at that point.

I'm just going to ask my group if I've missed anything or if they want to address.

The Chair: If you could please come to the mike and introduce yourself.

Ms Wren: I'm Noreen Wren. I'm the group facilitator of Forward Action in Mental Health. I think, just to reiterate in terms of Kathy, the main thing she is really asking for is that follow-up after discharge. There just wasn't anyone to help her navigate, and she was the person that was critically ill. We need to do better on that piece. For her there wasn't a family doctor known. There just needs to be a connection. She ended up becoming very critically ill and back into the hospital.

The Chair: Thank you.

Ms Jansen: Thank you.

The Chair: Ms Jansen, did you have a follow-up question?

Ms Jansen: No. That was it. That was terrific. Thank you again, Kathy and your group from Canadian Mental Health. You did fantastic today.

Ms Hughes: Thank you.

The Chair: Thank you.

Next on the list I have Ms Luff.

Ms Luff: Can everybody hear me?

The Chair: Yes.

Ms Luff: Okay. Good. I wanted to thank everyone as well for presenting and just also say a big thank you to Ms Hughes for . . .

The Chair: Robyn, we can't hear you anymore.

Ms Luff: Okay. Sorry. Do I have to talk louder?

The Chair: Yes, please.

Ms Luff: Okay. I just wanted to say thank you to everyone and a special thank you to Ms Hughes from Forward Action in Mental Health for sharing your story because it takes a huge amount of courage. I think it's so important that we hear the voices of the people who are directly affected by this legislation.

In that vein, I was just curious if you or anyone from your group had any comment on – we've heard a lot about more sharing of information, sharing of information between police and AHS and doctors, to be able to help folks more. I'm just wondering if you had any concerns around that in terms of privacy or patient liberties.

Ms Hughes: I'd have to think about that one for a moment, so can I defer to one of my group members?

Ms Luff: You absolutely can.

Ms Hughes: All right. David, would you like to address that?

Mr. Grauwiler: My name is Dave Grauwiler. I'm the executive director of the Canadian Mental Health Association in Alberta. You know, the balance between privacy and the sharing of information really is a critical issue, I think. Particularly when we're talking about transitions in support, through the Institute of Health Economics there was a report done on mental health transitions, and it talked specifically about the difficulties people face when they are moving from the community to the hospital and when they are moving from the hospital back into the community, the challenges that exist right at those transition points. It really is about ensuring that there is the right balance between respecting the privacy and the civil liberties of the individual as well as ensuring that the right information is shared at the right time with the right people.

10:00

The Chair: Thank you.

Ms Luff, do you have a supplemental question?

Ms Luff: No. I mean, I guess I'm just wondering if there is any feeling that the current balance is correct or if it could be tweaked one way or the other. We have been hearing from a lot of, you know, community organizations and the police service that more sharing of information would be helpful, and I just want to – I don't know – be sure that we're striking the right balance there.

Sorry. Could you repeat the name of that report that you just mentioned?

Mr. Grauwiler: It was done I think a year and a half or two years ago by the Institute of Health Economics. It was done here as a part of a symposium in Edmonton on transitions in mental health. It should be searchable. I'm sorry; I don't have all of the information right here.

I think that currently there are not the mechanisms in place to share that information, particularly between community-based organizations and the health care system. They could be improved.

The Chair: Thank you.

Mr. M. Smith: First of all, I'd like to thank everyone for coming here today. We've brought up so many important issues here as we've gone through the morning so far, everything from communication to how we treat them, get them into the system and then keep them in the system to the point where they can get the help they need and then how we release them. All of those are so important, and we're going to have to be very wise in how we draft legislation and regulation.

I want to throw something out that maybe you can't answer today, but I would love to have you do some sort of a written submission to this committee. We just spent last week, from my point of view, only six hours debating a motion on physician-assisted death. Here we have three organizations that are dealing with a clientele that I think are very vulnerable. We're trying as a society, I think, to figure out, now that we have, quote, a civil liberty to access physician-assisted death, how the regulations that we're dealing with for community treatment orders or just in general as you're dealing with a vulnerable clientele – how is physician-assisted death going to impact your clientele and their access to appropriate mental health care and quality health care when that physician-assisted death option, which is patient-driven, is now accessible to probably many of the people that you're dealing with on a daily basis? If you've got any comments on that. I think that it's a really critical issue. Go ahead.

Mr. Reiniger: This is Jordan from Boyle Street. I'll just say that that's a very big question, and we can get back to you on that.

Mr. M. Smith: I would love that. I think it would help this committee, and I think it would help, you know, the government as they're looking at the regulations. You deal most directly with the people that I think are probably the most vulnerable.

Mr. Reiniger: Yeah.

The Chair: Thank you.

Mr. Grauwiler: We have been working on this matter for a number of months now in trying to again find the right balance and approach. Currently our national office is drafting a statement paper, and when that is ready, we will submit it.

The Chair: Thank you.

Mr. M. Smith: I'd be very interested to hear the Schizophrenia Society or Dr. Dhaliwal speak to this issue.

Ms York: We can get back to you with a written submission if that works.

Mr. M. Smith: That would really be helpful, I think.

Ms York: Thank you.

Dr. Dhaliwal: I will say that part of the stigma and part of the approach when it comes to mental health is assessing capacity of a patient and seeing if they have the self-determination to make a decision. That is something that we as a group will probably be putting forth. Really, being able to advocate for yourself is something that I think is passed on when someone has a mental illness and something that can't be put lightly.

The Chair: Thank you.
Dr. Swann.

Dr. Swann: Well, thank you very much. All of you: a terrific presentation and not unlike presentations I heard in 2015 with the mental health review. You've reinforced the critical breakdowns in communications; the cost to the system; the lack of capacity, I would say, in the emergency rooms to assess risk; the challenges in the community, where family physicians are not necessarily comfortable with assessing mental health risk; and the loss of continuity of care in a system that is very fragmented, where in many cases nobody takes charge and helps co-ordinate or navigate this very complex system.

I just wanted to thank you all for highlighting those issues again and say that part of what you've said has been well heard by the review committee. It's been forwarded to the ministry. The ministry has set up an implementation committee to change some of these issues, from training and skill development through the requirement to educate our staff about sharing information and ensuring continuity of care between four ministries – Health, Human Services, police, and Education – the first time that we've seen this kind of top-level co-ordination of planning and funding. We will be keeping some of these points and suggestions you've made very much to the fore and ensuring that we see change over the next year along with all of you, I hope, who will be watching for the decisions and the improvements in the system that have to be made.

Thank you very much.

Ms Hughes: I just want to emphasize that the release of an involuntary patient is so, so critical. As I said, they just can't be thrown to the wolves, so to speak. Whether it's a social worker at the hospital or a nurse, someone has to co-ordinate their release and find a physician if they don't and get them, you know, to the interim services, like the community extension teams, Honestly, I came this close to dying. Had this psychiatrist not taken on my care, it could have been very fatal for me.

Thank you.

The Chair: Thank you.
Dr. Swann, do you have any supplemental?

Dr. Swann: No. Thank you.

The Chair: Ms McKitrick.

Ms McKitrick: Yes. Thank you. I heard from some of your presentation that physicians were a bit of a challenge because of the limited access to physicians who are trained in dealing with mental health patients. I note that in the Mental Health Act it states, "in the opinion of the 2 physicians." I'm wondering, now that there's a broader number of medical practitioners that are trained in mental health – I'm thinking of psychiatric nurses, nurse practitioners, qualified social workers, psychologists – if you had some comments to make around limiting the people who can assess this issue to just physicians.

Dr. Dhaliwal: I do agree. There has been a lot of talk about first responders. There are a lot of first responders sitting here as well who see a patient first when dealing with mental illness or emotional wellness issues. But I think a big portion of that is people needing care, finally recognizing that they need care, and not getting that care. That, a lot of the time, has to do with waiting lists. Yes, there are more staff being trained. However, the number of psychiatrists in this province is still at a lack, not being addressed, really. So I do think that there needs to be more psychiatrists who are here in this province.

10:10

Ms McKitrick: So what you're saying is that in the act "in the opinion of the 2 physicians" should stay, that you agree that it should be a physician?

Dr. Dhaliwal: I think there was an idea of maybe only having one physician; two for sure.

Ms McKitrick: Okay.

The Chair: Thank you.

Ms McKitrick: I guess I was just asking that question because medical practice has changed quite a lot over the years, and the scope of a lot of medical practitioners has changed, and I was wondering if in the act when it says "2 physicians," that is limiting or if you had opinions that there would be other qualified medical practitioners who could be written in the act.

Ms Bergwall: I think that it almost is the comfort of the physician. A lot of times what I'm hearing from clientele is that they may go to their doctor, but the doctor is feeling that because of what they're presenting with, there needs to be an assessment from a psychiatrist. The comfort level of the physician that they're actually seeing is to be determined as well.

Ms McKitrick: More the training.

Ms Bergwall: That's right.

Ms McKitrick: More the training of the physician is then the issue around their ability to work with a patient who comes in.

Ms Bergwall: Correct.

Ms McKitrick: Okay. Thank you.

The Chair: Thank you.

Ms Hughes: Can we have David come up just to talk about the form 1 a little bit? Thank you.

Mr. Grauwiler: I think there are two things. You're talking about broadening those who can do the assessment, and I think that if you're looking at that, we also need to look at the forms that are being used, clearly, right? The forms are very simple. They don't seem to give enough information for anybody, really, to begin that process of assessment. Also, you know, if you're looking at broadening who makes those assessments, you're also needing to again address how we share that information, how information is shared and to whom and with whom, et cetera. The community-based organizations that often are the front line of those experiences need the ability and the insight to be able to help people begin that process. Whether it's through a formal system or taking them to the emergency room, they need the ability to make those judgments as well.

The Chair: Thank you.
Next on my list I have Mr. Orr.

Mr. Orr: Thank you, and thanks to all of you not just for showing up here but also for the daily, weekly, ongoing work you do. Important. In the interests of really trying to get to some points that I think I heard some of you sort of skirting around or touching: have we created a system wherein we either expect too much or depend too much or have even given too much authority to medical doctors? I think it's specifically in three areas: the absolute authority to either confine and take away rights or deny service by doctors; number two, the ability of doctors to administer unwanted and behaviour-altering, mind-changing drugs, which is a big issue often raised; and thirdly, the issue of what I'm going to call unaccountability or the fact that there is no review process, there's no court, there's no commission or anyone who reviews the decision of doctors, so they are absolute, they are complete, and they are unchallengeable. I'd just appreciate your comments on that question. Have we given too much or do we expect too much from doctors?

Ms Hughes: I think we absolutely do, and I think many, many, many physicians would say the same, that they almost feel like they're being dumped on. I know my family physician didn't take charge of my care, but he has taken charge of three mental health patients' care because they've gone to the hospital and they have no one to be released to other than him. It is a huge burden. But, off the top of the head, I don't really know how we can change that – if anyone would like to further speak to that.

Mr. Reiniger: I think one of the challenges is the limited number of physicians available, so it creates a bottleneck. I think then there's time pressure on them to do things quickly. You know, we referenced sort of the harm reduction approach. When you're dealing with severely mentally ill people, it takes time. The easy solution is just to prescribe drugs. We do whatever we can to try and make people healthy. It could be acupuncture, it could be medical marijuana, it could be all sorts of different things that we can do. I think that, you know, a big challenge is that doctors don't have the time to engage in that type of activity.

That's why we're really encouraging this committee to seriously look at community-based organizations as allies and as partners in people's treatment because we know the individuals and we can spend that time with people and work closely with doctors to make sure that their care is appropriate.

The Chair: Hi. Could you please introduce yourself? Are you with someone from the panel?

Mr. Morris: Not the current panel, ma'am.

The Chair: I'm sorry; this isn't open to the public. At this point we're scheduling from the panels that are present. I apologize.

Mr. Morris: That's fine.

The Chair: Thank you.
Mr. Orr, do you have a follow-up?

Mr. Orr: No. Just that, you know, any further thoughts – I guess, partly I'm a little bit concerned about the absolute legal power that we have created for doctors or at least the legal implications that we've created. I don't need any more time on it, but if you have any further submissions and you want to include that, I'd be interested in hearing what you have to say about that.

Dr. Dhaliwal: I just wanted to say that the Mental Health Act exists for a reason; that is, to be used as a last resort when someone is completely decompensated and completely unable to make medical decisions for themselves. There is a purpose for it. However, I think a lot of us here recognize that it shouldn't be one of the first or thought of near the beginning. Having prevention, having harm reduction practices, and ensuring that people are getting the care when they need it are vital and would reduce that burden of someone having to make that decision to take someone's rights away.

Ms Hughes: I do understand the power because I know that when my physician signed form 1, you know, he was absolutely shaking, and he didn't want to do it. They do have a lot of power. Whether adding another doctor on the certificate would take pressure off, I don't know.
Any thoughts, people?

Ms York: One thing that my family members have mentioned is the accountability. They do have absolute power but zero accountability, and it's almost as if the physicians don't want that accountability. Like Kathy mentioned, it's like they're being dumped on, exactly, and they're trying to avoid that as much as possible. The same thing with the lack of time: it makes it that much more difficult.
Thank you.

The Chair: Thank you.
The next I have up for asking questions is Ms Woollard.

Ms Woollard: Thank you. Thank you very much for your presentations and the work you're doing. I'm very aware of the challenges that are being experienced right now. I was going to ask a few questions of the Schizophrenia Society of Alberta and Erika. Now, your submission noted the challenges of assessing individuals with schizophrenia in a short time frame, and that's always difficult. Because people are often able to hide their symptoms for a time if they don't want a diagnosis, what would you recommend as a solution for that difficulty, getting an accurate assessment but, you

know, not having unlimited time to spare, in a short time frame? Do you have any thoughts on that?

Ms York: I think that's a kind of multifaceted answer. One part of the solution, I feel, would be to involve the family members or the caregivers that are involved, especially if they were the ones that form 8ed their loved one, too. They, obviously, did that for a reason, so getting any background information that you can can help that assessment process, especially if the patient is hiding their symptoms. The physician may ask that family or the caregivers involved how that generally passes, what it looks like, and how long the masking can go on for.

Ms Woollard: Okay. That's not usually a formal part of the assessment, getting the history from the family or caregivers?

Ms York: No.

Ms Woollard: That sounds like a gap.

You mentioned in your submission that the community treatment orders should be made more widely available. Can you expand on that? Do you think there should be a lower threshold for qualifying for CTOs?

10:20

Ms York: I think so. It's theory versus practice. In theory I think that two or more admissions is a great kind of qualifying criteria, but what we see in practice is that it's upwards of seven to 10 involuntary admissions. I think that if we can kind of bring those two together more, even three or four admissions would be better for the CTO, especially with what some family members have shared with me. Like I mentioned, it's almost as if the physicians are scared to issue one. They don't want that accountability. So I don't know if there are any kinds of tools that could make it easier for the doctors or more comfortable for them to issue it.

Ms Woollard: Great.

The Chair: Next I have Mr. Shepherd.

Mr. Shepherd: Thank you. Somewhat, I guess, along some – yeah. There's been much discussion about families being involved in this process, then, being both primary caregivers and the people who often, I guess, are responsible for care after release. I'm just wondering: I'm guessing that in these situations there may often be tension between the individuals and their families. The individuals may be resistant in some cases to having their families involved in their care. What thoughts do you have on how we can best navigate that, where family may be the ones who are very concerned about them but due to other issues the relationship may be where that individual does not want their family to be involved in their care? How do we negotiate that tension?

Ms Bergwall: I really believe that there are a lot of outreach support caseworkers that are available in the community, that do actually mediate between family and the person that has mental health and that if we were to work closer together with Alberta Health Services and were able to pull both resources, medical and community, it would be a really great partnership. I see it within the youth community support program, working for youth that have mental health. That community and Alberta Health Services work fantastically together, but there needs to be people present to share that information. If there is nobody there at the table, then it's hard to co-ordinate that effort.

Mr. Shepherd: Thank you.

Ms Hughes: You know, that's so true. I so agree because after I was released, it wasn't even a matter that I wasn't complying and not taking my medication; it's just that my husband didn't know what to do. My friends didn't know what to do. They hid my illness because they were embarrassed, and that made it even worse. So if there were outreach people available to come in and look at the options and give you the options, that would have definitely made things a lot better.

Dr. Dhaliwal: One of the newer mental health acts is out of Victoria, Australia, and they have emphasized family within their act and speaking of the support and the communication between them. Yes, there may be tensions, but I think that having a grounded support system there is very important to having long-term benefit for the patient. Again, as was mentioned here, it is important, having that bridge, and there are services available in our community for that.

Ms York: I'd just like to add that usually a family that's not supportive is not very involved. When the family is present, it's often because they are very involved and they are being supportive or as supportive as they can be for the loved one. Oftentimes, from what I've seen with patients with schizophrenia, they don't believe they're ill, so they are going to resent the family that believes they are ill. Whether there's tension there or no tension there, I think it's a matter of if that person needs to be treated or not, again, that capacity assessment. Involving the family members in that capacity assessment, obviously not taking their word as gospel completely, can give you a little bit more background information.

Mr. Reiniger: I would just say that, you know, the population that we deal with is very marginalized. Often there isn't a lot of family supporting that individual, and that's when you have to look at: what are the other supports that are available to that person? Whether it's a worker at a community-based organization or maybe another doctor that's been supporting them, it's not always family. To have the flexibility to allow those other individuals to be able to participate in that, I think, is also very important.

The Chair: Thank you.

Mr. Shepherd, a second supplemental?

Mr. Shepherd: No. I don't have anything else.

That was very helpful. Thank you.

The Chair: Ms Woollard.

Ms Woollard: Do I have time for one more? Good. Thank you. Again to the Schizophrenia Society people: I appreciate your patience here, but I noticed – it was spoken about – the need for more sophisticated assessment tools. I'm back on assessment here, but I'm curious. On targeted training for physicians to prevent the revolving-door phenomenon – and we've been hearing about that, and that's a real issue – can you expand on what some of the new or different tools might be and the training that might be effective in getting a more accurate assessment, possibly?

Ms York: I currently don't know what the assessment process is, so it's hard to really touch on that. I think that more time . . .

Ms Woollard: More time.

Ms York: Yeah.

. . . more time for the assessment process or repeated occasions over a period of time can help with that masking. If there are family or community workers, caregivers, involving them could be another

tool. Again, it's hard to say. More training for the staff that are doing those assessments and then more criteria that they can follow rather than kind of a really convoluted map. Those are some of my ideas, but it's hard to say when I'm unaware of the assessment process.

Mrs. Daviduck: We have three housing programs, and we see it all the time there, where a client is getting ill over quite a long period of time. We call and call and call, and then they come to assess, and it's a very short time period and very quick. They're there for a few minutes, and then they say, "Well, the client is going to be okay; we'll have to wait," but we, the people that are working with that client daily, eight hours a day, are saying: "You know, this client is really declining. There are serious issues here." They're not taking that information into account. We see that all the time.

Ms Woollard: Okay. So that might be definitely part of the process in stopping the revolving door.

Mrs. Daviduck: Yeah.

Ms Woollard: All right. Thank you.

Mr. Reiniger: I just want to echo that because I think that's something that we see a lot in our work. The people on the ground, our team, know people. We work with them every day. We see them every day, and we notice the deterioration in their mental health. That's often not taken into consideration when, you know, somebody from outside comes in to assess.

Ms Woollard: Okay. You're seeing the subtle signs.

Mr. Reiniger: Yeah. Sometimes not-so-subtle signs.

Ms Woollard: Thank you.

The Chair: Thank you.

I'd like to thank all the guests for their presentation this morning and for answering the committee's questions. If a question is outstanding or if you wish to provide any additional information, please forward it through the committee clerk by, at the very latest, June 20, ideally before that date. I'd like to note for our guests' information that the transcript of today's meeting will be available via the Assembly website by the end of this week. Thank you.

Members, we will now take a short, 10-minute break to set up for our next presentation.

[The committee adjourned from 10:29 a.m. to 10:39 a.m.]

The Chair: I would like to ask people to please take their seats as we would like to return to the committee meeting. The committee is hearing oral presentations today respecting its review of the Mental Health Amendment Act, 2007. I'd like to welcome Dr. Tailfeathers, who is joining us via teleconference.

We'll do a quick round of introduction of members and those joining the committee at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and committee chair, and continuing to my right.

Mr. Orr: Hi. My name is Ron Orr. I'm the MLA for Lacombe-Ponoka.

Mr. Dang: Thomas Dang, Edmonton-South West.

Mr. Shepherd: David Shepherd, Edmonton-Centre.

Ms Woollard: Denise Woollard, Edmonton-Mill Creek.

Ms McKitrick: Annie McKitrick, MLA for Sherwood Park.

Mr. Horne: Trevor Horne, MLA for Spruce Grove-St. Albert.

Mr. Hinkley: Good morning. I'm Bruce Hinkley, MLA for Wetaskiwin-Camrose.

Mr. Koenig: Good morning. I'm Trafton Koenig, counsel with the Parliamentary Counsel office.

Ms Robert: Good morning. Nancy Robert, research officer with the Legislative Assembly Office.

Dr. Massolin: Good morning. Philip Massolin, manager of research and committee services with the Assembly.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: Thank you.

And on the phone lines.

Ms Jansen: Sandra Jansen, Calgary-North West MLA.

Ms Luff: Robyn Luff, MLA for Calgary-East.

Dr. Swann: Good morning and welcome. David Swann, Calgary-Mountain View.

Mr. Gill: Good morning. Prab Gill, Calgary-Greenway.

Mrs. Pitt: Angela Pitt, MLA for Airdrie.

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

The Chair: Thank you.

Before we hear from our guest, a quick overview of the format for today's meeting. Dr. Tailfeathers, you will have 15 minutes or so to speak, and following your presentation I will open the floor for questions from committee members.

Dr. Tailfeathers, please go ahead with your presentation.

Dr. Esther Tailfeathers

Dr. Tailfeathers: Hi. Thank you very much for asking me to present to this committee, which has been doing a lot of work, I can see. I'm very honoured to be asked.

A little bit about what I do. I work in two aboriginal communities. I work in Fort Chipewyan, which is a remote northern community north of Fort McMurray, and I work on the Blood reserve in Stand Off, which is at the very southern end of the province. Those communities are very different.

The community in Fort Chipewyan has been affected by youth suicides over the last two years. On my last trip up there I flew out with two suicidal teenagers who had a pact to commit suicide on that day. So I flew out with them and escorted them to the hospital. There have been suicide attempts or suicidal ideation among the young people in Fort Chip. Over the last two years there have been two successful suicides, so that's a huge problem in the north.

In the south, as you may have heard, the Blood Tribe was quite affected by the fentanyl or the Oxy 80 crisis between the summer of 2014 and the summer of 2015, so we've had to deal with this crisis. We had close to 20 deaths secondary to overdoses and multiple overdoses that had come into the Cardston emergency room, where I work.

We instituted a number of measures. One was that the community got together and began working on community education and solutions to our fentanyl crisis. We introduced the Narcan kits,

which were not yet – I can't say legislated, but they weren't allowed on federal Indian reserves, just because they hadn't been used yet. We were the first reserve in Canada to start the Narcan kits, with the help of Lethbridge HIV connections. With Alberta Health and Health Canada we introduced the Narcan kits to the reserve, and as of March 2015 we saw the last of our 20 deaths in the community.

We also started Suboxone clinics. Dr. Christenson and myself trained for the Suboxone and then started doing the opioid replacement. What we're aiming at is trying to put families back together and trying to give added stability in their lives so that they're able to carry on at least keeping the children in home. We had a lot of family breakdown, even greater poverty because of the amount of money that was going into buying fentanyl.

So we've taken some measures, and I think that we've had some success in terms of what we've done with the fentanyl crisis on our reserves. But as far as the mental health amendments go, there are some recommendations that I would like to make. One is that I think there needs to be a greater amount of energy put into suicide prevention and awareness in aboriginal communities across the province. The second is that we are overrun with addictions in aboriginal communities, including rural and urban communities.

10:45

One of the problems that I think we face is in terms of enforced treatment of patients. I think that as a physician my hands are tied when a patient comes into the emergency room or into the clinic and I know that they are a danger to themselves in terms of them overdosing. I have seen many patients who have come in that I've admitted to hospital to detox or help them through their withdrawal, but then they leave, against medical advice or medical orders, and return to the use of fentanyl or the use of dangerous narcotics. I've seen a few of them end up dying after they've been discharged from hospital. If we could somehow add to the amendments in terms of enforced treatment that physicians along with family members are able to have patients, because they are a danger to themselves, go into enforced treatment, I think that would be really helpful.

I'm not sure if there's anything else I need to cover. I think that those are the issues that we're facing in aboriginal communities.

The Chair: Thank you so much, Dr. Tailfeathers.

At this point I would like to open the floor for members to ask questions. Is there anyone wishing to speak? Mr. Hinkley.

Mr. Hinkley: Thank you. Dr. Tailfeathers, I appreciate your input with regard to the social issues of suicide and fentanyl. I have three questions for you if we have time, more to the community treatment orders and the involuntary confinement or admissions with regard to effectiveness impact and maybe some recommendations from yourself.

The first one: could you speak to the effectiveness of community treatment orders from an indigenous perspective, and have you seen any improvement over other forms of treatment?

Dr. Tailfeathers: I mean, we haven't tried it before. I worked in the United States on the Blackfeet reservation, where they do have enforced treatment orders and people are sent for treatment against their will. Initially, you know, I don't think that they're open to it, but once they are in treatment, at least they're safe, and if the treatment is effective, then they come back and at least have a chance at life.

I think that the trauma that people experience because they've lost a family member to overdose is especially difficult for children and youth. The last two parents that died as a result of a fentanyl overdose were a couple, and their four children woke to find them at the kitchen table overdosed in the morning. Those four children are orphaned, and the amount of trauma that will carry on through their lives is – I mean, we don't know what to expect, but if their parents were alive, I'm sure that it would have made a difference to those children's lives as well. If we can head it off where the trauma is happening, at least we're doing something.

Mr. Hinkley: Okay. So do you see the effectiveness of those community treatment orders and the involuntary admissions as not having worked at this point, then?

Dr. Tailfeathers: I think they work to a point, but like I said, there are a number of places where, you know, patients are able to just leave. I know that in the treatment world it all depends on self-admission and that, but I think that the strength of the community treatment orders is not strong enough. I think higher measures are needed in order to help the community.

Mr. Hinkley: Okay. When you talk about higher measures, from the indigenous perspective are there any concerns, then, about civil liberties or personal rights being infringed upon in any way?

Dr. Tailfeathers: I know it's going to be an issue. I mean, it is basically an infringement as we see it. When you do admit somebody that's suicidal, with depression, and you admit them on a community treatment order, basically their mental illness is the reason for us committing them. I think that addictions should follow along the same lines.

The Chair: Thank you.

I have Mr. Orr up next.

Mr. Orr: Thank you. Nice to meet you, even if it's over the phone. I think you sit in a very unique position to help us to understand some things. I guess my question would relate to the use and even effectiveness of traditional healing circles, the importance of the aboriginal community and social healing sorts of engagements. How does that compare with your understanding of the current medical treatment model that's in the act? Your comments on that, please.

Dr. Tailfeathers: Thank you very much for that question. It's a very good question. In my experience in working with addictions and people with depression and anxiety and mental health disorders, I think the use of traditional healing circles is very helpful. I find that in trying to put people's lives back together now, people that are on Suboxone or trying to get off fentanyl, sweat lodges, returning to traditional advisers and healers, the elders, as well as taking up therapy through beadwork, traditional crafts, learning language, all of those things, are very important in terms of people healing and putting their lives back together again.

I'm not sure how you could include that in legislation, but it needs to be respected as a very effective way of treatment and part of treatment for aboriginal people. I think the core part of that is the identity of aboriginal people and those young people that are displaced from that identity, who are the ones that we're seeing in jails, that we're seeing on the streets and lost, you know, in drug addictions. If they had some connection to their identity and had the ability or the capacity within the institutions around them to connect with that, I think that would be very effective in terms of helping with the mental illness or mental health crisis that we're facing right now.

Mr. Orr: Maybe just a follow-up to that. I hear your comment that you're not sure how you put that into legislation. I guess, maybe to phrase it a little differently: are there elements of the current

legislation that you feel hinder or prevent those healing circles and other elements of community support treatments?

Dr. Tailfeathers: I'm not sure. I'm really sorry, but I took a look at the recommendations, and I don't remember all of it right now. I think that it's really important to open the doors for people to understand that that is possible. I'm not sure how you can legislate it, but you probably could add a section recommending that the access to traditional healing be equal, you know, to other types of treatment. I really don't know how you would legislate it.

The Chair: Thank you very much.

The next speaker I have on the list is Dr. Swann.

Dr. Swann: Thank you very much. Dr. Tailfeathers, you've raised a very interesting question that I haven't heard raised before even in the mental health review, and that is on forcing someone into treatment, not just for mental illness as it's considered but addictions. It is possible under the act if two physicians sign a form 10 or sign on for a community treatment order that requires the person to follow a certain regimen or has follow-up from people in the health system to ensure that they take their medication, Suboxone for example. I think that's an important area that we could at least pursue. The legislation appears to be open ended in the sense that it says that anyone who is at risk to themselves or others could be subject to a form 10 or a community treatment order. Maybe it needs to be tested.

10:55

Dr. Tailfeathers: I know it would be really contentious, but I know that it works in the United States on the Blackfeet reservation. That's what they do, and it helps save lives. I know that.

Dr. Swann: In follow-up, it sounds like, from my reading of the legislation, I guess, if two doctors determine that the person is at risk to themselves or others, they could initiate something, a preventive action, on the basis of that and either commit someone to an institution for a period of time or commit them to a community treatment order. If it hasn't been tested in your community, maybe it's time we tried it.

Dr. Tailfeathers: Well, yeah. The only thing is that I know we're talking about it at the legislative level, but we probably need to talk about it at a resource level because I know our treatment centres are overwhelmed across the province. You know, something that needs to be discussed is the capacity of the treatment centres across the province but also the education of treatment centres and their training. Most of the treatment centres are still at the level of alcohol and possibly prescription drugs. Most of our treatment centres are not ready for opioid abuse like fentanyl, so that needs to be addressed for future treatment initiatives.

Dr. Swann: Thank you.

The Chair: Dr. Swann, did you have a supplemental question?

Dr. Swann: No. Thank you.

The Chair: Next on my list I have Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. Thank you, Dr. Tailfeathers. It's very appreciated that you are able to join us today and provide some unique perspective on this. Along the lines of what you were just saying – you were talking about the need for increased resources for treatment, I guess, both in the communities we're speaking of and through treatment centres – can you give us a sense of that? You're working on two different reserves in the province at sort of opposite ends. What is currently available there in terms of community resources for mental health? Is that solely being provided by yourself, or are there other things that are available in the community?

Dr. Tailfeathers: Both communities are served by Health Canada. In Fort Chipewyan, which is a community of about 1,200 people, they have very limited mental health facilities, and those are provided by Health Canada. They have something called the wellness centre, and they have about four community-based wellness workers. They're something like counsellors, but they're not social workers or psychologists. They have one social worker who flies in and does mental health counselling four days every other week, which isn't enough.

There is no permanent youth counsellor or mental health counsellor. In those northern communities, especially where suicide has become an epidemic or where it's at least something that's very prevalent in the community, I think that we need to address youth mental health workers in the northern communities. They do belong to Wood Buffalo, and they do belong to the Wood Buffalo PCN, but we're not seeing any mental health resources coming into Fort Chip from the Wood Buffalo PCN although the patient panel is included in Wood Buffalo.

Mr. Yao, I'm wondering if you could maybe look into that for the people of Fort Chipewyan.

Also, in Stand Off, around the Blood reserve, the federal government or Health Canada does provide the same services but to a larger population. They have a larger team of mental health workers there. We have had a lot of co-operation and work with Alberta Health in the south zone, and they now have opened up the Suboxone clinic, which is a third clinic. It's in the Cardston hospital, and the doctors that will be in that Suboxone clinic are actually going to be provided via telehealth from Edmonton, Dr. Hakique Virani and his associates.

The support in itself has been really good in terms of Alberta Health helping out and Health Canada trying to do what it can. Certainly, where it's lacking is in treatment facilities and the training of those people that are working in treatment centres and the capacity that they have to address fentanyl and opioid issues.

Mr. Shepherd: Thank you, Doctor. That's helpful. It sounds like one of the main things you're talking about here that's unique, I guess, to the indigenous experience in dealing with this, particularly in these more remote communities, is that tension between the support from Alberta Health Services and co-ordination with the services from Health Canada and trying to find a way to bridge that.

Now, one of the things we've heard from many of the others that have spoken to us today is concerns about sharing of information and particularly co-ordination between different groups that are serving these clients. Is that also an issue that you're dealing with there, then, where perhaps co-ordinating information between Health Canada, between Alberta Health Services, and then, I guess, likely with some of the community organizations, which may serve some of this populace when they're in more urban settings – and then they may also be moving sort of between there and the reserves.

Dr. Tailfeathers: Yeah. I think that is a huge issue. I think that's probably why we're not using our resources to their maximum benefit, that we're duplicating, and I'm not just speaking for the two communities that I work for but a number of the other people that I've spoken with and have had the chance to discuss this issue with. I think a lot of it is providing a mechanism for Health Canada or

Alberta Health and for the tribal leadership to sit down and talk about resource sharing and also function, or the delivery of services sometimes is duplicated and doesn't need to be. I think that a greater amount of co-operation between those three entities would result in less duplication and better or more effective delivery of those services that are needed in terms of mental health to aboriginal people.

Mr. Shepherd: Thank you, Doctor.

The Chair: Mr. Horne.

Mr. Horne: Yeah. Thank you. I have been very interested in your presentation today, both as the Member for Spruce Grove-St. Albert – and I represent the Alexander First Nation – but I'm also a member of the Métis Nation. Certainly, mental health and especially the area of addictions is something I come across when I'm talking to the Métis, especially the northern Métis, constantly, so I've definitely been very intrigued by your discussion today.

As part of St. Albert one of the important organizations in my area is the Poundmaker's Lodge. Unfortunately, they're outside of my constituency, but I've met with them a few times. They're certainly a vital part of our community, focusing primarily on alcohol treatment. When I was talking to them, they highlighted that they found that it's not enough for them to just focus on alcohol. They often have to go into other areas of mental health as well as part of that treatment. For the benefit of the rest of the committee, the Poundmaker's Lodge focuses on traditional healing, using a lot of sweat lodges and such, that you were talking about earlier. I was wondering if you had any insight on how communities, whether it's band councils, municipalities, or really any level of government or community organizations, can support that type of healing and treatment in communities.

Dr. Tailfeathers: Thank you for that question, Mr. Horne. I don't know if it's the era that we're in, but I'm finding that there is a lot more openness to accepting traditional healing or traditional methods as part of an overall treatment process for aboriginal people. I think it's quite essential that we start to include that and recognize it as an important part of healing of aboriginal people.

11:05

Most of us understand that the trauma that was inflicted because of residential schools has resulted in the overwhelming numbers in mental health that we see these days in terms of depression, anxiety, and addictions as well as suicide. It's all related to adverse events in childhood that most of the people have experienced, so I think not replacing but recognizing and respecting that traditional healing is actually a very essential part of how we're going to put things back together here is important. You know, I'm really quite happy that the overall Canadian view of what's necessary – and respecting that traditional healing is not something to be just shrugged off and thought of as rhetoric but is something that actually is really going to be effective in helping our mental health issues is really important. I don't know how you legislate that, but I'm really happy to recognize that overall our society is starting to change in terms of how it respects traditional healing.

Mr. Horne: Yeah. Thank you for your comments there. I definitely agree that there's been a shift in Canadian society, I think, in no small part but perhaps preceding a bit the Truth and Reconciliation Commission and starting the dialogue on healing the entire Canadian fabric. A lot of this, certainly, impacts especially indigenous communities, but as part of society it really impacts all of us when we start to heal and address these issues, so thank you for your insight.

The Chair: Do you have any additional questions?

Mr. Horne: I don't have an additional question.

The Chair: Thank you.
Next I have Mr. Shepherd.

Mr. Shepherd: Thank you. Just continuing, I guess, off a bit of our discussion earlier, Doctor, you've mentioned a couple things, like, for example, that you're up in Fort Chipewyan, and then you had to fly out with a couple of young people. I guess issues of access may be present here as well. I know that certainly we've heard from the RCMP and some others who are working in some of the rural areas that there are challenges in terms of even when you're able to access a community treatment order or a form 10 or some of these other things involved, that there are difficulties accessing appropriate facilities under the act to which to convey the individuals. Is that a challenge that you've run into in your situation as well?

Dr. Tailfeathers: Certainly, that's a huge challenge. In Fort Chipewyan there is no medical facility other than the nurses' station, and it's not a 24-hour facility. It's normally manned by nurses during, you know, the normal eight-hour day and paramedics, which help during an eight-hour day and then are there for the evening, and if somebody is suicidal and is on suicidal watch, there is no facility to keep those people except in the RCMP cell unless they can be flown out. With the bed crisis always in the north it's really difficult especially to get children out of Fort Chipewyan into Edmonton to Stollery clinic.

On my last tour up to Fort Chip – the medevacs can only accommodate one person, and because of the fires in Fort McMurray the backup was at least 12 hours, so it was recommended that we take them out on a commercial flight, which really isn't that safe, but because I accompanied them, I took two young teens on a commercial flight and conveyed them to the children's facility in Edmonton. As a physician I don't think that too many physicians do that, but because of the geography and the poor resources or services that the people of Fort Chipewyan have, they're forced to use whatever means they can to keep their children safe.

Mr. Shepherd: Okay. So is that something, then, where you end up co-ordinating, I guess, quite a bit, then, with the RCMP, having to make use of their services and place people in their care where there are these crisis situations?

Dr. Tailfeathers: Yes, and I think it's really inappropriate, especially for a 15- or 16-year-old, to have to spend the night in cells, which is even more traumatic for them, and the situation just isn't conducive to healing. It's actually more damaging, I think, but there is no other solution in an area where there isn't any other facility to accommodate those children and, you know, the only and most immediate way is to fly them out of the community, and that's not always possible. The difficulties of the people of the north have a lot to do with their remoteness from tertiary facilities as well as their in-community resources, which are lacking.

The Chair: Thank you.

Ms McKitrick: First of all, I really wanted to thank you for the work that you're doing with communities, both in northern and in southern Alberta. I'm sure that the work that you're doing is having some really profound effects in people's lives there.

I really had two questions. I know that a lot of indigenous communities have their own police systems, or they have band police. I was wondering how you're working with them in terms of the work that you're doing with patients who are at risk of harming themselves or others in the community and if you knew, those police officers that are part of band policing, what kind of training they may have had so that they are better able to help you.

Dr. Tailfeathers: My experiences are of the two very different communities at the RCMP and Fort Chipewyan. You know, they're very helpful when they can be. Of course, that community, because it's a remote community, has very different problems, but they are very concerned about the suicide, and they are willing to help. I'm not sure how much training they've had, but they're very helpful. But like I said, it's not the proper place for a young teen or child, to be held in an RCMP jail cell. I don't think it's the officers themselves. I think it's the lack of facilities in the north.

In the south on the Blood reserve are the band-managed police officers, the Blood Tribe police. We have been really quite lucky because when the fentanyl crisis started, we started what was called a core team. We included the police in the meetings that we had. It's a very co-operative atmosphere between the social workers, the mental health workers, the doctors, and the police in terms of trying to co-ordinate our efforts to put a stop to the fentanyl overdoses on our reserve. I think that the problem with the band police is that they're overwhelmed with the number of calls that they have, and they do not have, you know, the capacity to continue to answer to all of the overdoses.

One of the things that I would ask for the Blood Tribe police is that they be able to carry Narcan kits in the police cars so that they can, when they arrive on scene to an overdose, immediately administer the Narcan. As of yet they can't do that, so they're held to doing CPR, which they're very well trained with now. You know, they are trying to be helpful, but as far as I can see, they're overrun in their capacity to address the issues in the community because it's just overwhelming, what addictions can do, especially the fentanyl problem, what it can do to a community.

Ms McKitrick: Thank you very much.

The Chair: The next I have on my list is Ms Woollard.

Ms Woollard: Hi. Thank you. Thank you, Dr. Tailfeathers, for your information. So many challenges in different places. I worked up in Fort Chipewyan a few years ago as an educational psychologist. One of the things I remember is that in the Athabasca Delta community school there was a school counselling department, helping hands I believe it was called. It seemed like they were doing some pretty good kind of screening work with children and noticing students that were having some beginning signs of mental illness or emotional difficulty. I just wondered: are they still working? Is that an area that has been expanded upon? It certainly looked like it would be worth while moving in that direction more.

11:15

Dr. Tailfeathers: Yeah. I think that they've done a very good job in the schools in Fort Chipewyan. I'm not sure if it's still called helping hands, but they have, I think, two or three counsellors that are very aware of the suicidal ideation of the teens there. They alert families, or families alert them. In fact, in this last situation it was a school counsellor that brought both girls to the nursing station. So they are doing a really good job there. I'm not sure how fatigued they are, you know, because they are the ones that see the teens and the children on a daily basis and are able to see those changes or screen for them. I think it's a really good idea to keep them involved and to support them in the resources that they need to continue that.

Ms Woollard: Well, that's good to hear. I've heard from other young people that they find the school counsellors to be very valuable in giving them a level of support and being easier to access than physicians. So it's a part of the process, part of the helping workers.

Dr. Tailfeathers: Well, for sure, they're very valuable. A couple of them that I know are almost like second mothers to a lot of the children there, and they are very good at reaching out to the mental health workers to help support these children. So they're doing a good job. I'm not sure how long they can do that without burnout or without support.

Ms Woollard: Exactly. One last question if I can just squeeze it in. If people can't be flown out – I know that happens; I got socked in one time – is there no provision to be able to keep people in the health unit for just an overnight stay until they can get flown out?

Dr. Tailfeathers: We had to do that with those two teens that we flew out. We took shifts watching them overnight. Like I said, it's a nursing station; it's not a hospital facility. Basically, what we have to do is figure out who is available to do suicide watch through the night. It's quite a task, especially for the nurses and paramedics in that community who are doing their regular job, which is overwhelming, to be spending the night on suicide watch. I mean, it has to be done, but it's not part of what the facility should be doing. You know, it doesn't have that capacity.

Ms Woollard: Well, thank you very much. Everyone appreciates your good work.

Dr. Tailfeathers: Thank you.

The Chair: Next on the list I have Mr. Hinkley.

Mr. Hinkley: Dr. Tailfeathers, thank you for the insight on the recommendations you've made so far about incorporating traditional healing practices and co-ordinating existing resources as well as resource sharing and the need for access to programs and facilities. I would like to know if you have any further recommendations with regard to involuntary admissions and CTOs pertaining to staff training, the process and procedures of how those are implemented, and maybe even on follow-up support that might be more effective in treating and supporting indigenous Albertans living with mental health issues.

Dr. Tailfeathers: Thank you, Mr. Hinkley. That is a really good question. Basically, what we're looking at is that if we legislate or make rules to help people in mental health crisis, we also need the safety net or the backing of being able to send them to a facility which is appropriate for them or into treatment which is appropriate. I think Alberta is vastly lacking in terms of staff training and treatment centres for prescription drug abuse and for street drugs such as fentanyl and some of the new drugs that we're seeing. Alcohol still is a problem, but I think we need to focus on the overall training of people in the mental health field as well as in the treatment field for prescription drug abuse and drugs such as fentanyl because those treatment centres and those people in the helping fields are lacking knowledge and education on what to do with those individuals with that type of addiction.

Mr. Hinkley: Okay. Thank you.

This might be just a side question, but in either of the communities that you work in, is there a detox centre?

Dr. Tailfeathers: No. I think that falls under provincial jurisdiction, so Health Canada is not willing to build detox centres on-reserve. That was one of our biggest problems in the initial crisis with fentanyl. We were overwhelming the provincial detox centres. Fort Macleod I think has 11 places, and I think Lethbridge and Medicine Hat also were overwhelmed with us sending our detox patients to them. You know, we aren't able to detox those individuals on-reserve because the federal government does not cover detox facilities.

Mr. Hinkley: Okay. Thank you.

The Chair: Thank you.

At this point I don't have any other members on my speaking list. I'm just wondering: before I close this portion of the meeting, is there anyone else wanting to ask any questions of Dr. Tailfeathers?

Seeing no questions and hearing none on the phones, at this point I would like to thank you, Dr. Tailfeathers, for your presentation this morning and for answering our committee's questions. If a question is outstanding or if you wish to provide additional information, please forward it through the committee clerk at the latest by next Monday, June 20, ideally before that date. I'd like to note that the transcript of today's meeting will be available via the Assembly website by the end of this week.

Thank you again.

Dr. Tailfeathers: Thank you very much.

The Chair: At this point I'd like to let the committee know that we'll be taking a short five-minute break to allow the next group to set up at the table. Thank you.

[The committee adjourned from 11:22 a.m. to 11:30 a.m.]

The Chair: Welcome, everyone. I'd like to call the meeting back to order. If you could please take your seats. Thank you.

The committee is hearing oral presentations today respecting the review of the Mental Health Amendment Act, 2007. I'd like to welcome our guests on our last panel.

We'll do a quick round of introductions of members and those joining the committee at the table. I'm Nicole Goehring, MLA for Edmonton-Castle Downs and the chair of this committee. Continuing to my right.

Mr. Orr: Hi. I'm Ron Orr, MLA for Lacombe-Ponoka.

Mr. S. Smith: Hello. My name is Sean Smith. I'm going to be here to answer any questions arising out of Mr. Morris's presentation. Like Mr. Morris, I am a lawyer who does a lot of work in front of mental health review panels for Legal Aid.

Mr. Morris: Hi. My name is Jason Morris, and I'm a lawyer who acts before mental health review panels for Legal Aid.

Mr. Shand: Tom Shand. I'm here as executive director of the Alberta Alliance on Mental Illness and Mental Health, which is a coalition of 14 community- and professional-type mental health organizations.

Dr. Bland: I'm Roger Bland. I'm a psychiatrist, and I'm appearing on behalf of the Alberta alliance. I'm a professor at the University of Alberta and formerly an assistant deputy minister for mental health in this province and medical director for the Mental Health Board.

Ms Armstrong: I'm Susan Armstrong. I'm the manager of the provincial team with provincial addiction and mental health that has been implementing CTOs across the province.

Dr. Watson: Good morning and thank you very much for the opportunity to come and talk with you folks about the Mental Health Act amendments and the community treatment orders. My name is Doug Watson. I'm a psychiatrist as well. I have a practice in Calgary and in Canmore. The reason I'm here this morning is because I've been working part-time with the Alberta Health Services team that has been working on the amendments and the CTO file over the last eight or nine years.

Thank you for inviting me.

Mr. Dang: Thank you. I'm Thomas Dang, MLA for Edmonton-South West.

Mr. Shepherd: David Shepherd, Edmonton-Centre.

Ms Woollard: Denise Woollard, Edmonton-Mill Creek.

Ms McKitrick: Hello. I'm Annie McKitrick, MLA for Sherwood Park.

Mr. Horne: Trevor Horne, MLA for Spruce Grove-St. Albert.

Mr. Hinkley: Good morning. My name is Bruce Hinkley. I'm the MLA for Wetaskiwin-Camrose.

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

Ms Robert: Good morning. I'm Nancy Robert, research officer with the Legislative Assembly Office.

Dr. Massolin: Good morning. Philip Massolin, manager of research and committee services with the Assembly.

Mrs. Sawchuk: Karen Sawchuk, committee clerk.

The Chair: Thank you.

On the phone lines.

Ms Jansen: Sandra Jansen, MLA for Calgary-North West.

Ms Luff: Robyn Luff, MLA for Calgary-East.

Dr. Swann: Good morning, all, and welcome. David Swann, Calgary-Mountain View. I look forward to hearing you.

Mrs. Pitt: Angela Pitt, MLA for Airdrie.

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

The Chair: Thank you.

Before we hear from our guests, a quick overview of the format for today's meeting. Each group will have 10 minutes to speak. Following all the presentations on the panel, I will then open the floor to questions from committee members. Since we have a number of presenters from the organizations on this panel, please identify yourself every time you begin speaking for the record and for the benefit of those listening online.

We'll begin with our first presentation, by Alberta Health Services. The floor is yours.

Health Program Services

Ms Armstrong: Thanks very much. We really do truly appreciate this opportunity to come and present to you. You may find that our presentation is a little bit different than some of what you've heard so far today, where we've heard a lot about the larger system issues, which we certainly acknowledge, and also from the individual with the lived experience. That certainly is the context in which all of this is occurring. Our presentation is going to focus a little more directly on the amendments since that's been our role over the last, as Dr. Watson says, seven or eight years, to be implementing those with service providers, physicians, and working with various stakeholders across the province.

Part of it is, you know, that the Mental Health Act gives you the what we've been working on and the how do you do this and who does what and putting processes in place, providing education, developing resources, flow charts, that sort of thing to try to figure out how we do all of this, especially with the CTO component, which is new for Alberta. That's been our role.

Over time we've gained a significant amount of experience around the act and its application and, you know, some of the challenges and things. We've collected data along the way about utilization and numbers of how many individuals have been on community treatment orders. We've also done some evaluation activities along the way that we have used to guide the implementation and do some course corrections, if you will, as we learn from the people who are actually working with the clients and doing things on the street.

You'll see throughout in our written submission that we've identified some top priorities for what we think should be potentially amended and made recommendations. We know that we don't have the only viewpoint and that these are complex issues, so we've made recommendations understanding that there would need to be further discussion around what would work to go forward.

We also have included some areas where there are other portions of the Mental Health Act that it might be prudent to actually make changes in, other sections that are not part of the Mental Health Amendment Act. If, for example, you make a change in the area of the community treatment order legislation, you wouldn't want to have a different kind of process happening for certification processes, where you then would have conflicts and confusion that would arise. Some of those things are included. We'll talk about one in particular this morning, but some of those are included in the act as well so that we, like I say, end up kind of with parity in the act because it adds to more confusion when you have one way of doing things for community treatment orders and another way to do it for formal clients.

I'll hand it over to Dr. Watson for a moment.

Dr. Watson: Thank you. I'm going to talk about the individual amendments and provide you with our belief that as a group and individually they should be maintained as part of the Mental Health Act, that they have been useful additions to the act since 2009 and 2010, and then Susan is going to talk about some of the tweaks, some of the changes we think would be yet helpful in terms of helping to manage the patients, some of which you've heard about this morning already.

The first change in the 2009 amendments, actually, was a change in the criteria under which a patient can be formally admitted to hospital. That's the first bit on your first slide. The first change was that the word "danger" was changed to "harm," and we support continuing with the word "harm" in that criteria, the reason being that "harm" is the term used all across the country, so bringing Alberta into some sort of uniformity with the other mental health acts across the country is a good idea. Secondly, the term "harm" is generally accepted as a little bit of a broader indication of risk than is the term "danger," so no longer does it have to be a concern about physical danger; it can be a concern about harm in a broader sense. I've heard consideration of words like "emotional harm" or other kinds of harm. Abuse is a form of harm, even if it didn't involve physical abuse. So we believe that the term "harm" should be maintained.

Probably a major change in that first criteria was the addition of the deterioration clause, which was "suffer substantial mental or physical deterioration or serious physical impairment." This has opened up a really large number of patients who might not have been able to be treated involuntarily prior to these amendments, and the ability to consider the possibility and the likelihood and the probability of deterioration if they're not treated has really been a very positive part of the amendments of 2009.

The second major change in the amendments of 2009 was that prior to that amendment act there was no formal requirement that hospitals notify physicians when patients were discharged. This is now part of the Mental Health Act, of course, and seems to be working reasonably well. There were some initial concerns around confidentiality issues, around how you define a physician in some of the clinics that had, for example, nurse practitioners, not physicians, in the clinics, but I think over time we've managed to nullify most of those concerns about this particular amendment. It does seem to be working well, and we believe that it should be continued as in the amendment act.

Probably the newest and most exciting change in the amendment act in 2010 was the advent of community treatment orders. As you know, this allows physicians and treating individuals this exceptional tool of being able, when appropriate, to manage patients in the community as if they were certified and in a hospital. That is, they're required to participate in an active treatment plan and accept care.

11:40

This slide – I apologize; it's kind of a busy slide. But what I'm really interested in is one thing on that top graph, and that's the blue line. The blue line represents the number of active community treatment orders in Alberta over the period of time from the left side, where it started at zero, to March 31, 2016, when there are 936 patients who are living in the community in Alberta who might otherwise be in a mental hospital bed or recently discharged from a mental hospital bed or in the process of deterioration and needing the bed again. The proof of the pudding is in the eating, and that blue line, in our view, indicates that community treatment orders are indeed being accepted because they're useful tools. They're being accepted by the people who are implementing this community treatment order legislation; that is, the service providers, including psychiatrists and physicians and other individuals looking after these people in the communities.

The table at the bottom is a little bit confusing, but what it says is that though there are 936 active community treatment order patients right now, at any one time, in any one fiscal year there are perhaps more than that. So pay it what heed and concern you want to.

Let's have a look at the next slide. Apart from the uptake and the indications that treating physicians and other service providers are enthusiastic about community treatment orders and the way the legislation is written in Alberta, this slide indicates that actually they do some of the other things that they were set up to do. The numbers indicate that for an individual patient in the year prior to and in the year after the CTO was written, there was a considerable change in the number of hospitalizations and the number of

hospitalized individuals, and when those patients who were on CTOs were readmitted to hospital, their average length of stay the second time around was substantially lower.

Some people would complain about this before-and-after kind of data, so we've actually looked at before and after going out to three years. I will tell you that before and after going out to three years, the numbers, if you want to jot them in, are not that different, in the sense of the three-year data for the individuals hospitalized in the three years before and the three years after the CTO is a reduction of 36 per cent. The number of hospitalizations in the three years before the CTO versus the three years after the CTO goes down 53 per cent, and the average length of stay goes down four days. The utilization data for one year seem to be positive and hardy going out to three years at least. I don't claim that the CTO alone is responsible for these changes, but the CTO probably is a good part of it.

I've managed to mix myself up here in terms of my sheets. I'll just read off of there. One of the things that Alberta Health Services has been really good about right from the beginning has been the collection of data around the community treatment orders. For example, we have been collecting information from service providers and did a service provider survey in 2014 to say: you know, what do you think of the CTO stuff? The service provider questionnaires were sent out to 300 service providers: mental health therapists, nurses, psychiatrists, assertive outreach community workers, and social workers. The results were that over 90 per cent of the service providers felt that CTOs were either somewhat positive or very positive in terms of the mental health of the clients, the client's quality of life, and helping clients stay well in their home communities. Medication compliance, access to services, and client support systems were all noted to be improved. So there's a buy-in from the service providers right across the province.

Carol Robertson Baker, the provincial Mental Health Patient Advocate, is with us today. Her support for CTOs was quoted in the October 5, 2015, *Hansard* as well, in which she said:

> When we look at the implementation of community treatment orders, family members are very, very pleased that 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.

These are the comments we get from families as well as what we hear at review panels when family members join the patients to attend the review panels.

I'm going to stop and have Susan talk a bit about some of the tweaks that we think should happen yet.

Ms Armstrong: I'm going to go fairly quickly because I know we're running out of time here, so we'll just show you – this is a very busy map, but it gives you an idea of where in Alberta individuals have been supported on a community treatment order over the years since it's been implemented. There have been individuals supported in 170 communities across the province. The map also, then, helps to show some of the challenges that you heard about this morning from the RCMP and the police around the apprehension and conveyance and the distances travelled and things like that. We heard more of the local perspective, but for the RCMP in the rural and remote areas there certainly are challenges with geography and that sort of thing.

As Dr. Watson pointed out, overall we're recommending that the amendments be continued, but there is some room for tweaking. [A timer sounded] May I continue for a couple of minutes?

The Chair: We've already extended it two minutes.

Ms Armstrong: All right.

The Chair: I apologize for the interruption.

I would now like to move on to our next presenter, Mr. Jason Morris. Go ahead, please.

Mr. Morris: Thank you, Madam Chair and members of the committee. I'm very happy to be here today. I'd like to thank MLA Drever for having asked that I be included in the hearings today. As I mentioned, I'm a lawyer practising in Sherwood Park, Alberta, as duty counsel before mental health review panels, and I've been asked to speak about that process.

For context, when a formal patient objects to admission or renewal certificates, when they object to a certificate of incompetence, or when a hospital wants to impose a specific treatment on an unwilling but otherwise competent patient, those matters are dealt with in a hearing held by the mental health review panel. The review panel has the authority to either maintain or quash those certificates. Legal Aid tries to provide duty counsel for all such hearings where requested, and my experience with the Mental Health Act arises from acting in that capacity for much of the last four or five years. As I mentioned, my colleague Sean Smith is here. He also acts in that capacity and will be helping to answer questions later.

Rather than rehash my written submissions, which I understand the committee has had the opportunity to review – Susan from AHS said that there was a what and a how. I'd like to talk a little bit about the why, particularly why this committee should view this question of the amendments to the Mental Health Act through a lens of dealing with a justice problem as opposed to through a lens of dealing primarily with a health problem.

If the government proposes to put you in jail for the rest of your life for a crime, you can be assured of a few things. You can be sure that the matter will be considered by a judge, you can be sure that you will receive procedural fairness, you can be sure that your constitutional rights will be protected, you can be sure that no one will have the power to medicate you into compliance with your incarceration, and you can be sure that these things will happen regardless of your capacity to ask for them. If the government proposes to put you in hospital for the rest of your life due to an illness, you can be sure of none of those things.

Those protections exist in the criminal justice system because of the abuses that are possible in their absence. The mental health system is equally a potential source of abuse. The imposition of psychiatric treatment without consent by governmental bodies has in recent history been used to jail political dissenters and whistle-blowers, prevent the escape of slaves, contribute to genocide, and reduce the practical and financial burdens in caring for orphans and abandoned children. In the last 100 years those things have happened in such distant jurisdictions as the People's Republic of China, Germany, the United States of America, Quebec, and Alberta.

The same powers which must be granted for the protection of the public and the seriously mentally ill are therefore also fraught with risk of violations of human rights, not only the human rights of the mentally ill who legitimately enter the system but also the human rights of every person who might enter the system who does not belong there, including the mentally ill who enter the system but do not belong there.

11:50

Now, the committee might take some comfort in the fact that the Mental Health Act is administered and adjudicated by bodies including members of the medical profession, who as a profession care only for the well-being of their patients. With all due respect to the medical profession, from the perspective of building a system

that protects the rights of the vulnerable, that should be a source of deep discomfort. It would be like saying that criminal judges and Crown prosecutors ought to be selected from among the ranks of police officers because of their subject-matter experience. What we would expect from such a system is that it would be strongly biased in favour of what police are concerned about: the protection of innocents. What we have in the Mental Health Act is a system strongly biased in favour of what doctors are concerned about: the promotion of health. Neither is perfectly aligned with justice, and injustices result.

As an example, last week I acted at a mental health review panel hearing for a patient who was diagnosed with a schizoaffective disorder. The doctor presenting the case told the panel that he wanted the panel to maintain her in hospital and declare her incompetent to make her own treatment decisions despite the fact that the hospital could not demonstrate that her illness led to any risk mentioned in the act and despite the fact that she was willing to stay in the hospital voluntarily. She did not meet two of the three criteria, but the doctor wanted the panel to maintain her certificates anyway. Why? Well, the patient valued being in hospital but refused treatment, and in the absence of formal patient status it would have been impossible for the hospital to legally impose treatment against her will.

Now, in the hearing the doctor readily admitted all of these points, but consider that in order for those certificates to have been appealed, they had to have been issued, which means that that same doctor signed his name to the bottom of a document that said that his opinion on two points was the opposite of what he actually believed. For this doctor, then, the Mental Health Act was not to be strictly interpreted in order to protect people's liberties. It was to be misinterpreted to the point of being ignored in order to promote a person's health, and signing his name to a lie was just one step in that process. That is an extreme but not atypical example of the way that the Mental Health Act is viewed by the people who are responsible for administering it.

What about the review panels, half of whose members are doctors? Surely they didn't allow the doctor's request. Thankfully, no. They denied it. But that very same day a review panel held up an incompetence certificate for a man on the basis that he disagreed with receiving electroconvulsive therapy, more familiarly known as electroshock therapy. Now, if preferring not to receive electroconvulsive therapy is in and of itself proof of incapacity to make treatment decisions generally, I'm not sure there is a competent person in this room.

I argued strenuously before that panel that it was not a question of whether my client needed electroshock therapy but a question of whether the hospital had proven that he was incompetent to make treatment decisions. Three of the four panelists disagreed. I note, perhaps self-servingly, that three of the four panelists were not lawyers. In both, the people who administer the act and the people who adjudicate it, there is a very strong bias toward concern about the patient's health over the patient's liberty.

Consider also the onus put on the patient. The certificates are not questioned unless the patient has the wherewithal to file an appeal because there is seldom anyone else with the knowledge or the motivation. How difficult is it for a doctor to do or say something that dissuades a patient from appealing their certificates? One of the written submissions to this committee was by a patient who says that they were told that if they appeal their certificates and lose, the hospital will gain additional authority over them. They requested that this committee repeal the sections of the act that have that effect. I would second that request if those sections of the act existed. That patient was lied to.

So this is the system we have. We have a test for admission but no legal process at that point. The legal process is at the point of discharge and has to decide whether the admission criteria are still met. But doctors don't admit people to hospital in order to get them barely well enough to regain their civil liberties. Doctors admit people to hospital to get them as well as they can be, and every week people are held in hospital illegally because they are not yet as well as they could be. Every week people are being declared incompetent who aren't because they refuse treatment they need even though there is a way in the Mental Health Act to legitimately ensure treatment will be received without depriving them of the right to decide whether or not they will accept Advil for a headache.

So what you have before you is a question of justice, not merely a question of health. That is the lens through which you should view the requests of all the various stakeholders.

Now, briefly, I'd like to amend my written submissions in one way. The vast majority of the issues that I raised in my written submissions – and there were 14 – are systemic issues of statutory interpretation, constitutional law, and procedural fairness. They're issues about which mental health review panels and this committee ought to have received considerable instruction from the courts over the last several years. They're issues that could already have been resolved, but there is no instruction and there is no resolution because the Mental Health Act does not allow for judicial review. Allowing for judicial review is the single most effective thing that the Assembly could do to enhance the fairness of the Mental Health Act and to protect the liberty interests of everyone who comes into contact with that system.

The absence of judicial review is because of the wording of section 43 of the act, which deals with appeals, and it was amended in the 2007 amendments. Because that section of the act was amended, I would ask the committee to seriously consider recommending adding a subsection which states that nothing in that section should have the effect of limiting the availability of judicial review of a decision of a mental health review panel on an issue of law or jurisdiction. That amendment would make it clear that our judges have the power to instruct mental health review panels on how to properly interpret the act in a way that is compliant with the Charter and how to achieve procedural fairness. It would graft the Mental Health Act back onto our justice system and make it a part of the whole.

That amendment, had it been made in 2007, would have had the potential to reduce my list of 14 concerns to a list of four. That amendment, had it been made in 2007, would likely have made it unnecessary for me to go to court last Friday and file an appeal and seek an injunction against treating one of my clients with ECT, electroshock therapy, a treatment which, were it not for that injunction, he would be receiving as I speak.

To reiterate my proposed amendments, which are set out specifically in my written submissions, I believe that the admission and readmission criteria should be amended by making explicit the requirement of a causal relationship between the mental disorder and the risk, that it should be made explicit that there is a requirement that involuntary hospitalization will mitigate that risk, a requirement that hospitalization be proportional to that mitigation, and that all the pertinent risk, necessity, and proportionality factors are considered. Also, I recommend that the requirement of either consent or danger in order to obtain a CTO should be removed entirely and, again, to repeat, that judicial review should be made explicitly available.

Thank you.

The Chair: Thank you.

I would now like to invite our final group on this panel, the Alberta Alliance on Mental Illness and Mental Health, to please go ahead with your presentation.

Mr. Shand: Thank you very much, Madam Chair, and thank you for this opportunity. My name is Tom Shand. I'll be addressing the group first, followed by my most distinguished friend and colleague Dr. Roger Bland to add some more from his wealth of experience.

As you may or probably don't know, the Alberta Alliance is a coalition of 14 provincial organizations that either are community-type organizations like the Schizophrenia Society, CMHA, and others, or they are professional organizations like the psychiatrists, social workers, psych nurses, psychologists, and others.

We have a couple of particularly strong parts of our mandate, both of which are important here today, one of which is, certainly, to have a voice and to advocate on behalf of those living with mental illness. Our members, certainly, work with those clientele, mental illness and addiction, on a regular basis, and we appreciate the chance to share that voice here today. Dr. Bland is one of our associate members. We also have several other associate members here in the gallery: Lerena Greig, who's from an organization called Parents Empowering Parents; Orrin Lyseng, who's well known in the mental health community and was the executive director of this organization prior to myself; and Dr. Austin Mardon, who's one of the better known provincial and national advocates, living with mental illness himself. They are in the gallery and will be available to address any questions you may have of them.

12:00

The other thing I wanted to make very clear is that the alliance, when we speak here, is speaking, really, on behalf of those 14 organizations on things that we have agreement on. Mental health is not simple. It's a very complex thing. As you've heard from the presentation just before me, there are a lot of complex issues. Some of you probably don't recall, but there weren't community treatment orders in Alberta prior to this amendment. Some of the organizations which I'm representing here today actually were not in favour of, at least in this province, going ahead with community treatment orders.

We came to an agreement amongst us that there was far more value in looking at them and proceeding with them than risk there of taking away, potentially, people's liberties, that there were safeguards in the system to protect that. Most of all, as was mentioned earlier, for the families of many patients who were living with mental illness and weren't getting treatment and who weren't in situations where they could be committed to treatment, this assisted them. Those families were grateful, but so were those individuals. I think you'll find, certainly, in the hearings that you've had so far, in the submissions that you've had, the number of people that have benefited. Right now there are 900 and some-odd people around the province.

I'll submit to you, though, that our expectations were greater. If I run out of time, I want to make it very clear that we're supportive of community treatment orders. We think there has been a good job done in implementing them, good acceptance across the province, but it could be much better. Our expectation when we came into supporting this initially – a previous government's Minister of Health, Dave Hancock, had us come together and said: "We really want you to do this. We know that historically there have been some issues with community treatment orders or their equivalents in other provinces, but we believe this is really important for getting people access to treatment."

If my presentation leaves you with anything today, it's that access to treatment is the most important thing. I don't think anybody at this table or around this table or certainly those people behind me would disagree with that. If people can get access to treatment, they're far more likely to get better. Access to treatment, to go further on Dr. Watson's point, shouldn't come from just endangerment. In essence, it shouldn't come just from fear. It shouldn't come from fear that somebody is going to do something atrocious. It should come from a recognition. Mental illness is very widespread. Most of you have probably dealt with mental illness and addiction with your friends and family. People quote 1 in 5; it's probably far more common than that. People need treatment, and we're happy that the community treatment orders have enabled some of that treatment to take place in the community.

What is disappointing to us and what hasn't been followed through on entirely – and I'm not going to blame Alberta Health Services because I know Alberta Health Services agrees with this entirely – is that that scope of supports in the communities hasn't been supplied to others to anywhere near the degree that it could be or should be to not only protect but encourage the support and treatment of people living with mental illness. What is essentially happening right now is that if it is agreed that a person is going to have a community treatment order, there will be certain criteria for that. Those treatments or supports in the community, not just medical treatments but other types of supports, housing and others, will be dealt with for those individuals. We're relatively comfortable that that, in fact, is being done.

But what hasn't been done in those very communities is to extend those services or those supports to the literally thousands of people that are in need of them. The services have been focused on those people in need of community treatment orders or who have been assigned community treatment orders to their benefit, for the most part overwhelmingly to their benefit, but not extended as they could be. So I'm asking you as you're wearing, I guess, your MLA hats: when you go back, when the Legislature reconvenes – and you're going to have issues, you're going to have subjects, and you're going to have things to consider, all with, obviously, at this time and at any time, budgetary considerations – keep in mind that this is not being supported.

Community treatment orders are being supported, but the supports that they provide within the community, from not-for-profit organizations, from Alberta Health Services itself, are certainly nowhere near the level that they should be to support people. There should be thousands of people getting those supports as opposed to the significant supports that are supplied by community treatment orders. The Institute of Health Economics could reinforce hugely the value of that economically and certainly the value to the person in your family.

I wanted to provide one specific example if I could, and this deals not only with treatment but getting access to treatment. Dr. Bland in one of his roles was involved in putting together a research symposium, which we used to attend. In fact, many of the people in the gallery behind me were there as well. This particular instance brought together people with lived experience with mental illness, people with addiction, people with mental health issues, Alberta Health Services, Alberta Health, and others.

We had a lady drive back in the car with us who said: "I want to give you a story. It's a true story. It's very personal to me, but this is why we need community treatment orders." It's dealing specifically with the criteria aspect of getting treatment. Although you may not be at risk to yourself or others, your health is going to deteriorate. Any of you, most of you probably, who have children or even grandchildren, I think, will take this to heart. She said that her daughter told her: "Mom, I've told my psychiatrist that I have a plan to take my life. I've made out a specific plan for suicide, but I don't want you to be alarmed because you're going to be made aware of this." Her mom said, "Well, you

know, how is that?" She said, "I can't get treatment if I don't have a plan to endanger myself or others."

If there's a real difference in what this legislation brought about, it's that that girl no longer had to do that. That mother no longer had to listen to a child, an adult child by that time, I think, perhaps in her early 20s, say: Mom, I've declared a plan to take my life because that's the only way I get treatment. There's a woman who has the courage to step forward and say, "I need treatment," to recognize that she needs treatment, let alone the many thousands of others who, for stigma or other reasons, can't do that. At that time she couldn't get treatment. We need that treatment through community treatment orders, through the continuation of the amendments made to the Mental Health Act. Also, I ask for your support when AHS and Alberta Health come to you and say: we need to expand services for those kinds of community treatments.

With that, I'll pass it on to Dr. Bland, and I'm sorry I've dug into your time, sir.

Dr. Bland: Can you tell me how much time is left?

The Chair: Two minutes and 45 seconds.

Dr. Bland: Okay. First, let me address the changes to the formal patient or involuntary admission criteria, which you've had some information on. Under the previous legislation it had been interpreted by courts under section 2(b) to mean imminent and present physical danger only. You've heard about the changes to this, but the previous situation led to situations where persons who were clearly mentally ill, deteriorating, and refusing treatment continued to deteriorate and die on occasion without intervention. Unsurprisingly, their distressed families saw this as a system failure, which I think it was. I'm very much in support of the changed criteria although I recognize that there is more scope for interpretation with the change from "danger" to "harm" and the inclusion of mental or physical deterioration and physical impairment to broaden the criteria.

I'll move rapidly to community treatment orders in the remaining minute and just give you an example. A young man in his mid-20s in central Alberta with a caring and involved family had become mentally ill and developed ideas that he had to live close to nature. Various attempts had been made to treat him, but each time he would discontinue treatment and follow-up. Eventually he went to live in the bush and would only eat roadkill, often very old and infested roadkill which had taken on a new life of its own with worms and insects and other things. His physical state deteriorated, with weight loss, malnutrition, and infections.

He eventually got placed on a community treatment order, and I saw him at a review. His appearance had improved. He was consistently taking medication. He was living in a group home, had developed a social life and restored a relationship with his family. He wanted to discontinue the community treatment order, but his family made representation to continue with the community treatment order as this was the best they had seen him functioning in several years.

12:10

I'm fully in support of community treatment orders, but I do think that there's a cumbersome bureaucracy associated with them. There is the consent issue, which you have heard. You also heard, I think, about the possibility of extending them to a year instead of six months. You also just heard about the lack of resources limiting the numbers. When the legislation was introduced, there was a commitment made to vastly increase the resources, and I don't believe that this has taken place to the extent that was envisaged.

I think that's my time.

The Chair: That is your time.

Thank you very much to all presenters.

I would now like to open the floor for our members to ask questions. I have Mr. Orr.

Mr. Orr: Thank you very much. I appreciate all of your comments. I guess I'll direct my comments to the legal team, but others of you can reply to it as well. As we've already heard, it's one thing to create legislation, but it's another issue if we don't back it up with the resources to make it happen. If we're to try and institute some sort of a process for judicial review, not so much for the patients but for the medical team that cares for them, how do we do that? Do you see that as being an issue of the courts, which would be a huge challenge, or some other kind of a judicial panel? What kind of costs are we looking at?

Mr. S. Smith: This is less of a challenge financially than you might imagine. What we're talking about here is simply expanding the kind of review that a judge can do. There is already a mechanism for judicial review of a panel's decision. That's currently what's called a de novo hearing, which means the judge makes a decision of their own which replaces the ruling of the panel. What isn't available is a mechanism for appealing the legal technicalities of the way that decision is being made. The result is that if a decision is being made the wrong way, that wrong method of decision-making applies over and over and over again, producing not less but more expense and burden on the system overall. The precision we would get from having a clear judicial ruling about the validity of a panel's interpretation of the legislation would not cost the system money; it would save the system money.

Mr. Morris: If I could elaborate just briefly on that, the system of judicial review exists by default. It's an inherent capability of the Court of Queen's Bench. You would not be so much building something as you would be removing a blockade from something that already exists. Judicial review is available unless the Legislature specifically precludes it. It seems, in my interpretation, the Legislature has perhaps inadvertently done that in the way that this legislation is drafted.

As for cost, we need more judges, but that's the federal government's problem.

Mr. Orr: May I go another route, or do you want me to go back on the rotation?

The Chair: Absolutely. You're allowed a first question and a supplemental.

Mr. Orr: Okay. A slight change of subject. Again for the legal team, one of the things that's come up numerous times here is the exclusion of family in this whole process. Is it within the realm of possibility to think about creating some mechanism whereby we could create some sort of family intervenor status?

Mr. Morris: The way the current system operates is that the hearings are private, but the decision as to who can attend them is in the control of the chairperson of the hearings. It is not uncommon for members of the families to attend at mental health panel review hearings.

Mr. Orr: But they have no right to speak, right?

Mr. Morris: I won't agree with that.

Mr. Orr: Okay.

Mr. Morris: The right to speak is determined by the chairperson, and my experience is that the chairperson has never refused a family member the opportunity to speak. It's not inconceivable that that could happen. What interferes with the ability of family to attend at hearings like this is the fact that they won't necessarily receive notice that the hearing is happening. They won't necessarily receive notice unless the patient requests that that happen. The patient is left in control of who they want aware of their legal and medical issues when they are in hospital. Oftentimes they specifically exclude family members and say, "I don't want these people to know," or if they are asked, "Is there anyone we should inform?" they say, "No."

I don't know that the hospitals have the information that they need right now. I don't know that there would be a constitutional way to compel the patients to provide it, but certainly where a patient is willing to have family members attend at a mental health review panel hearing, there's nothing preventing that from happening in the current system.

Mr. Orr: Thank you.

Thank you, Madam Chair.

The Chair: Thank you.

I have Dr. Swann.

Dr. Swann: Thank you very much. Very stimulating presentations from all sides. It's news to me that the judicial review is so difficult, but I guess the reality is that a patient or his family would have to have financial resources and the will to take it to another level. That's a challenge, for sure. I appreciate Mr. Morris's concerns about the human rights issues and judicial rights here and the ability to actually implement them.

I'd like now to hear from Dr. Bland on his experience with the review panel and the extent to which there is a sensitivity to the whole issue around legal rights and the opportunity for many of these patients, many of whom would appear, to me, on the face of it, at least, to have neither the mental capacity nor the finances to consider anything like a call for a judicial review.

Dr. Bland: Thank you, Dr. Swann. I sat for 26 years on mental health review panels, and Dr. Watson, on my right, has sat for a number of years, too, as the psychiatrist member.

Mr. Morris rightly pointed out, I think, that patients do have a right to be represented, and Legal Aid is willing to represent them, those who want to be represented. Most do but certainly not all. The families, as has been pointed out, may appear. It should be remembered that the review panel's purpose and objective is to implement the legislation as written. The review panel is not there to act in the best interest, as it perceives it, of the patient, nor is the lawyer representing the patient necessarily there to act in what he or she perceives to be the best interests of the patient. They may represent the patient's wishes, but that may not be in their best interests since they may be delusional wishes or others distorted by mental disorder. It's not an easy situation.

The number of appeals that go to court – and I don't know whether that's judicial review or hearings de novo or what – is very small. There was a time in Alberta when Alberta was having about seven appeals per year and Ontario was having seven per day, a slight difference. I don't know whether I can really answer your question about appeals to court, Dr. Swann, if that's what you were meaning.

Dr. Swann: I guess I'm trying to get at the interesting question that Mr. Morris raises of trying to find the balance between the focus on human rights, free choice, and the assessment of health, often not by the patient themselves because they are unable to do so. Maybe it would be best to put the question like this: how well are we achieving the balance today, do you think, for those whose rights we've taken away and incarcerated or put on a community treatment order? How well have we to date balanced, do you think, the interests of the law and human rights versus the health of the person and the community?

12:20

Dr. Bland: In my opinion, I would suggest: reasonably. But it's always in a state of flux, and there are always situations where you think that perhaps it's been unduly legalistic or you think that the patient's treatment is not being looked after adequately. As you say, it's a question of balance. I think the review panels try to maintain balance, and there is the understanding that in a case of doubt the benefit goes to the patient, no question about it. I've been at review panels where, for example, the doctor has said that they are not sure whether the patient meets the criteria, and that's been case over because the benefit goes to the patient. Whether that's in their best interest necessarily is another question. One can be accused of being paternalistic if one talks about interpreting somebody else's best interests. I don't think there's any absolute answer to this.

One can become unduly legalistic. Some U.S. states, for example, have a judicial hearing whenever a patient is certified. This judicial hearing, when somebody investigated this, had an average duration of I think 32 seconds, which is hardly real protection through the legal system.

If one goes to various European countries, the certification process has to be initiated by a physician but is then reviewed and has to be formalized by what is called competent local authority, which usually means the mayor. I have been in Amsterdam with the mayor at the daily occurrence where the certificates completed by physicians are brought in for the mayor's approval. The mayor cannot delegate this except when he is out of town or out of country. The competent civil authority is the one with the authority there. Whether that adds anything to the process I don't know. It's different jurisdictions attempting to find a different sort of balance.

Mr. Morris: If I could add to that answer.

The Chair: Yes. Go ahead.

Mr. Morris: I actually agree with everything that Dr. Bland has just said. Dr. Swann, my answer to your question would be that we don't know whether we're achieving the right balance, and the reason we don't know is because these things are not regularly being reviewed by judges. If we were to make judicial review available, judicial review would allow us on a case-by-case basis to ask that question about individual hearings, and the answers would educate our mental health review panels on what the law is and how it ought to be interpreted. My recommendation that judicial review be allowed is specifically to get an answer to that question.

Dr. Swann: Thank you very much.

The Chair: Mr. Smith, go ahead.

Mr. S. Smith: Thank you, Madam Chairman. Just one thing I would add about Dr. Bland's comments. He says that Legal Aid is willing to represent the patient. That is certainly true at the panel level, but there are substantial barriers to obtaining Legal Aid representation for a patient who wants to go any further than that. I could elaborate if any member of this group wants me to, but I'll just say that that's a large and systemic issue.

The Chair: Thank you.

Alberta Health Services, do you have anything that you'd like to contribute to this?

Dr. Watson: I don't think so. Thank you.

The Chair: Thank you.

The next member I have on the list is Mr. Dang.

Mr. Dang: Thank you, Madam Chair. Thank you to everyone here today that's joining us. I do have a question about the MHA, that talks about how when reasonably possible we need to give notice of discharge of a patient from a designated facility to the patient's doctor. I know you spoke a bit about that and how that's evolved over the last few years to become more efficient and whatnot. Given that some patients don't actually have family physicians, is this creating a support gap for those patients? What are some other strategies that other jurisdictions have implemented around this? Do you know any of those?

Dr. Watson: Well, you've nailed the problem. One of the problems is that in Alberta, unfortunately, many people do not have family physicians. If they're in the mental health system, they're even less likely to have a family physician because they're not viewed, in general, as really attractive patients to have in your caseload. When patients who do not have a family physician are discharged from hospital, what do you do with this notification to the family physician? It is often discussed with the patient. "Who do you want the notification to go to?" You often get the reply, "Well, nobody," so you don't have consent to send it to anyone.

Many of these patients are not attached to a particular physician, but in the era of PCNs they're attached to a PCN, so it is possible to send the notification of the discharge to the PCN rather than to the individual family physician, and that has helped. In situations in which patients are discharged, for example, to nursing stations, where nurse practitioners replace physicians for much of the time, then the same notification can be sent to the nurse practitioner in the clinic that the patient attends in their own community.

Ms Armstrong: If I may, I'll just add to that a little bit because I know this has come up in some of the submissions around the discharges and that sort of thing as well. The act specifies that it needs to go to a physician. It doesn't say that it can't go to others. Under the Health Information Act information can be shared: if you have a client in common, if it's on that need-to-know basis. So it certainly could be shared. There's no obstacle to that, to sharing it with a nurse practitioner or a psychologist or a social worker in the community if they're involved in that client's care. It's just that the Mental Health Act says that you must make reasonable efforts to get it to the physician.

As Dr. Watson says, with those clinics, if they're in a walk-in clinic or something like that, if that information is shared, it certainly can go to that kind of setting as well. It's been more of a matter of education around that, of trying to bridge that gap, looking at the intention, which was the continuity of care, trying to keep that intention in mind.

Mr. Dang: Do you know of anything from other jurisdictions that's being used in sort of the same file?

Ms Armstrong: I don't know whether other jurisdictions have the same kind of expectation that that's to be shared. Sorry.

The Chair: Anyone else wanting to contribute to that? No?

At this point I don't have any other members on the speaking rotation. Is there anyone else wanting to ask questions of the current panel members?

Dr. Swann: I'll just follow up with one question if I may.

The Chair: Absolutely. Go ahead.

Dr. Swann: Can we draw on any other Canadian experience in relation to the judicial review question? I understand that Ontario has recently made changes to their Mental Health Act. I don't remember that being one of the issues, but perhaps one of the panelists can comment on other jurisdictions that have embraced a readier access to judicial review.

Mr. Morris: I can comment on that, Dr. Swann. For some background for the panel members, there was a case in Ontario of a gentleman who was nonverbal. He had very poor sign-language skills, he had some intellectual disability, and he had been diagnosed as a pedophile. He had been committed to hospital in Ontario under their legislation and remained in a high-security facility in Ontario, a high-security psychiatric institution, for a period, if memory serves, of roughly 18 years despite the fact that no one in any of the hospitals thought that he needed high-security treatment.

Eventually a lawyer took his case to the courts in Ontario and asked if it was constitutional that their version of the mental health review panel, which is called the Consent and Capacity Board if I'm not mistaken, didn't have the ability to order that that individual be transferred into a lower security facility or that he be given certain privileges. The decision was made by the Ontario Court of Appeal eventually that the mental health legislation in that province was, in fact, unconstitutional and needed to be amended. That was the motivation for the changes that were made in Ontario recently, because there was a stay of the act, and if they didn't change the legislation, it was going to be impossible to hold people for longer than six months. All of the things that the Ontario Court of Appeal found unconstitutional about the Ontario legislation exist in our legislation. All of them.

12:30

With regard to Dr. Swann's question about judicial review, the availability of judicial review is not an issue in the current legislation in Ontario because the way that their appeal provisions are drafted, they don't kind of impliedly prohibit it. It's a bit of a legal nicety. Judicial review is available if there's nothing equivalently effective. By creating an appeal de novo – which means that when you go to court, we're not talking about what was discussed before. We're having a brand new hearing from scratch, with new evidence. Because you have the ability to get a hearing de novo at Queen's Bench, that is an adequate remedy for anything that went wrong.

Because you have this option of going in and saying, "Just start again from scratch; prove that this person needs to be in hospital," and then the judge says either yes or no, then when we ask the judge, "Can we have judicial review?" the judge says: "Well, is there an adequate alternate remedy? What does your person want?" "Well, they want out of hospital." "Okay. Well, they can use the appeal." We've lost that access to the judicial review process, which has the additional benefit of instructing the mental health review panels and, by extension, the doctors on how to interpret the Mental Health Act.

That's not as much the case in Ontario for two reasons. First, it's drafted differently. Second, with all due respect to the efforts by the mental health review panels in Alberta, Ontario treats its mental health review system as the quasi-judicial body that it actually is, with the serious implications for people's liberties that it actually has. That body in Ontario has a full-time staff of between 10 and 15 people, including one full-time lawyer, who is paid by the department of justice, and a large number of panel members; its

own facilities; policies. Its decisions are published as decisions of a court would be, so they're available to be looked up as precedent. It is essentially run as if it was subject to judicial review. Frankly, if our panels were subject to judicial review, I can assure the committee that those are the sorts of directions that the Queen's Bench is going to start saying where the panels need to move.

By comparison, our panels are chaired by one lawyer in each of, I understand it to be, three regions. They have a list of panel members, which is currently lacking in family physicians for reasons that are not clear to me, and it is administered entirely by the chairman's secretary at his law firm. That's the entire administration in each region. Now, the exception to that is the hospitals that do a lot of hearings who have found this so unacceptable of a practice that they have hired their own staff to administer the hearings. So there's a wonderful woman, Miss Thomas, at Alberta Hospital Edmonton, who makes our lives much, much easier as duty counsel by taking care of the scheduling.

But think of this. This is a quasi-judicial hearing that involves a person's liberties at stake. The parties at this hearing are the patient and the hospital – officially, under the legislation, the hospital is the body that appears, represented by the doctor – and it is the hospital that decides what week the hearing will happen in. It's the hospital who decides, if there's not enough room in the schedule, who is getting bumped. The scheduling is being decided by the people who are employed by and who pay for the doctors. So it's as if the police owned the court.

So I just cannot overstate how far away the mental health review panel system is from what it ought to be when one considers that it is one of only two ways in Alberta that a person can be held indefinitely by the government against their will without ever having appeared in front of a judge.

The Chair: Thank you.

Dr. Swann, did you have a supplemental?

Dr. Swann: Could I just follow up?

The Chair: Yes. Go ahead.

Dr. Swann: Well, as a nonlegal person – and most of us around the table are nonlegal – could you summarize, very briefly, what single change you are calling for in the Mental Health Amendment Act, 2007?

Mr. Morris: Well, in my written submissions I was calling for 14. I categorized five, originally, as being pertinent to the 2007 amendments. I would now say that the judicial review recommendation is also pertinent because the appeal section was amended in the 2007 amendments. If I had to pick only one thing to change, I would pick judicial review. If we add in judicial review, 10 of the 14 issues that I raised in my written submissions could have been dealt with by a judge of the Court of Queen's Bench. So if I had to pick one, I would pick that one.

The Chair: Thank you.

Go ahead, Mr. Smith.

Mr. S. Smith: I'm aware that Mr. Morris has already picked the most overarching one. If you'd allow me to pick one as well, I would say that the causal connection test that Mr. Morris spoke of is also very, very important. Right now a person can be held in a hospital because there is a risk of deterioration even though the hospital may not prevent that deterioration in any way. In fact, they can be held in a hospital because their health may deteriorate as a result of social factors such as homelessness, which are connected but only peripherally connected to the illness itself.

To give you a hypothetical – no, this isn't a hypothetical example. This is something which I encounter on at least a monthly basis. Imagine yourself as an elderly person who, unfortunately, has a bout of depression and is treated by a psychiatrist. The psychiatrist gets your depression under control, but unfortunately for you in the course of that psychiatric treatment it's discovered that you have early stage Alzheimer's. Right now you're still able to function in society, right now you're still able to take care of yourself, but Alzheimer's is a disease which has a particular prognosis. That prognosis goes in one direction whether or not you receive treatment from the hospital.

I would ask all members of this panel to look at the three criteria in the legislation and ask: what is going to happen to that patient if you apply the three criteria in the legislation right now? I'll tell you that the answer is not that they gain their freedom for whatever small length of time is still available to them. There has to be a causal connection between the deprivation of liberty and some genuine benefit with respect to the deterioration, and there has to be some causal connection between the mental illness and the risk of deterioration. In my hypothetical example the depression wasn't causing the risk of deterioration and the hospitalization wasn't helping to prevent the deterioration.

Thank you.

The Chair: Thank you.

The next member I have on my list is Ms McKitrick.

Ms McKitrick: No, thank you. No more questions.

The Chair: Thank you.

Are there any other members wanting to ask a question of the panel?

Seeing none and hearing none, I would like to thank our guests for their presentations today and for answering all of our committee's questions. If a question is outstanding or if you wish to provide any additional information to your answers, please forward them to the committee clerk by, at the very latest, June 20, ideally before that date. I'd like to note for our guests' information that the transcript of today's meeting will be available via the Assembly website by the end of the week. Thank you so much.

I'd just like to note that we will provide a few minutes of transition time while our guests leave the room so that we can take on the next portion of our meeting.

Thank you.

[The committee adjourned from 12:39 a.m. to 12:42 a.m.]

The Chair: I would like to call the meeting back to order. If you could please take your seats.

Under section 5, Other Business, I wanted to address the objective of our meeting for next week, and that is to start our deliberation process. We will be reviewing an issue document that research services will complete within the next few days summarizing the issues brought forward through our consultation process, both the written submissions received and the oral presentations we heard today. It's important to note that the committee is not restricted in its discussions solely to the issues arising from the submissions received pertaining to the review of the Mental Health Amendment Act, 2007. The committee may decide to address issues related to the amendment act beyond those that have been identified through our consultation with stakeholders and the public.

Representatives from Alberta Health, including the Mental Health Patient Advocate, and from Justice and Solicitor General, health law, will be attending next Monday's meeting should we require their expertise. Members may recall that these ministers were invited at the beginning of the process to assist the committee where requested.

Dr. Massolin, do you have anything to add?

Dr. Massolin: Thank you, Madam Chair. I think that you've said it well. I would just like to underscore or sort of highlight what we're preparing for the committee for next Monday's meeting, and that is, as you said, the issues document, which is basically a summary of the written and now oral feedback that this committee has heard. It will be posted in the next few days, and it will include the issues that have come up, mostly to do with involuntary admission as well as CTOs, community treatment orders, and provide a little bit of background – who said it, and why they said it – and will also include, where appropriate, proposals or potential recommendations to the committee.

Now, the other thing I'd like to add to that is to emphasize what you said, that this document is simply a reflection of what the committee has heard to this point. It does not preclude the committee from coming up with other issues of their own devising related to the Mental Health Amendment Act, 2007. So it's not an exclusive document, of course. The other thing, too, is that the committee is under no obligation, of course, to deal with every last sort of proposal or issue that's indicated there. It's up to the committee to make that decision.

That's all I have to say. Thank you.

The Chair: Thank you so much.

Are there any other issues for discussion before we conclude our meeting?

Mr. Orr: This is other business?

The Chair: Yes.

Mr. Orr: Okay. Thank you for the opportunity. I guess I'm on. Yes. One of the things that we've discussed a lot here is the included complication of addictions and the impact that it has on mental health and possibly the review, so I'd just like to submit a motion. I have written copies for everybody so that they can read them.

The Chair: I would ask that you wait until I have the actual copy.

Mr. Orr: Absolutely. Fine.

The Chair: Thank you.

Mr. Orr: It deals with the issues of addiction and drug abuse. The reality is that Alberta is on track this year to have over 275 fentanyl-related deaths. That number gets higher if you consider some of the other opioid deaths that are occurring in the province: heroin, morphine, meth, some of those other things. I think it's important that we address that, so I would like to move that

> the Standing Committee on Families and Communities undertake a study of the opioid crisis in the province of Alberta for the health, safety, and well-being of Albertans. The scope of the review shall include but not necessarily be limited to the availability and timeliness of access to treatment beds and treatment solutions for those addicted to opioids; secondly, public awareness and public reporting campaigns to prevent further opioid addictions and to give real-time information on which communities are hardest hit by the opioid crisis; and thirdly, adequate preparation and funding to create safer communities, including proper addictions training in correctional facilities and proper funding for law enforcement programs.

Thank you.

The Chair: Thank you, Mr. Orr.

I would now like to open the floor to discussion. Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. Well, certainly, yes, we heard some excellent testimony today and some excellent perspective from a number of people with a great deal of experience in the field, and, yes, it did in fact touch on synthetic opiates, opiate and other addictions in general.

I think it's important that we take the safety of Albertans very seriously. I believe our government has done that. Certainly, we've seen some good things that have come forward: expanding access to naloxone, increasing treatment access for opioid dependency, opening new detox beds and counselling, and, of course, continuing to educate the public and raise awareness about these highly toxic chemicals, that unfortunately are even often found mixed in common street drugs. We certainly acknowledge this, and I appreciate the member's concern for this and his follow-up on the things we've heard today.

However, this being a fairly significant issue and one that, I think, requires a fair bit of discussion, I think it would be best that we take some time to consider this and bring this back at a time when we would be able to have more fruitful debate. That being the case, I'd like to move that we adjourn debate on this for today until a future meeting.

The Chair: Perhaps just before we do that, we could hear from Dr. Massolin.

Dr. Massolin: Thank you, Madam Chair. Just to talk about the nature of the motion: while, you know, obviously an important subject area I look at the words "undertake a study" as, I think, the key, operative words there. The reality is that this committee currently is undertaking a study, and it is actually doing a statutory review of the Mental Health Amendment Act, 2007. It's been charged by the Assembly according to Government Motion 10, that was passed on June 25, 2015, to undertake this study and report back to the Assembly within one year according to section 54 of the act. So I would submit to you that the committee needs to conclude that review before it undertakes anything else.

I would also refer committee members to Standing Order 52.07(3):

> An order of the Assembly that a Legislative Policy Committee undertake an inquiry shall take priority over any other inquiry, but a Legislative Policy Committee shall not inquire into any [other] matters which are being examined by a special committee.

In other words, you've got an order of the Assembly before you, and you need to complete that review; that is, of the Mental Health Amendment Act.

The other point to be made, and this is the final one: after this review is concluded by mid-June – the Assembly has also referred Bill 203. I would assume that if the committee would like to undertake a review of this motion or look into it and perhaps vote on it, that would have to happen before those two other things take place.

Thank you.

The Chair: Thank you.

At this point, Mr. Shepherd.

12:50

Mr. Shepherd: Yes. Thank you, Dr. Massolin, for that insight. But, again, as I said, we are running close to the clock. I think, again,

this is something that would require some significant debate and consideration, so I would move that we adjourn and table this particular motion to a future meeting.

The Chair: The recommendation that I have received is that this matter be deferred until both reviews that are under this committee at this time occur and that this matter be brought forward at that time.

Mr. Orr: If that's our legal counsel's advice, I think that's something I'm prepared to live with. I do think that it does definitely fall within the scope of this committee since it is mandated both for Health and Justice and Solicitor General issues. So I think it fits within the committee. It is a crisis that Alberta is facing, but if it's a matter of procedure and process, then I'm fine with that.

The Chair: Okay. Thank you.

With that, are there any other matters that anyone from this committee would like to bring forward to discuss under other business?

Seeing and hearing none, the motion has been deferred.

We will move on to item 6 of our agenda, the date of the next meeting. Our next meeting is next Monday, June 20, from 9 a.m. to 1 p.m.

Item 7 of the agenda is our adjournment. I'd like to call for a motion to adjourn.

Mr. Dang: So moved.

The Chair: Mr. Dang moves that the meeting be adjourned. All in favour of the motion? Any opposed? Hearing none, the motion is carried.

Thank you very much.

[The committee adjourned at 12:52 p.m.]

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