Legislative Assembly of Alberta

The 29th Legislature
Second Session

Standing Committee
on
Families and Communities

Mental Health Amendment Act, 2007, Review

Monday, June 20, 2016
9 a.m.

Transcript No. 29-2-10

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Second Session

Standing Committee on Families and Communities

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Standing Committee on Families and Communities

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Ministry of Health
Fern Miller, Director, Addiction and Mental Health, Health Services
Kathy Ness, Assistant Deputy Minister, Health Services

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

9 a.m. Monday, June 20, 2016

[Ms Goehring in the chair]

The Chair: Good morning. I'd like to call the meeting to order. Welcome to members, staff, and guests in attendance for this meeting of the Standing Committee on Families and Communities. My name is Nicole Goehring. I'm the MLA for Edmonton-Castle Downs and chair of this committee.

I'd ask that members and those joining the committee at the table introduce themselves for the record, and then I will call on those joining us via teleconference. I will start on my right.

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

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

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

Ms Bailey: Tracey Bailey, general counsel, health law, Alberta Justice and Solicitor General, guest.

Mr. Menon: Sunny Menon, legal counsel, Alberta Justice and Solicitor General, for Alberta Health.

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

Ms Woollard: Denise Woollard, MLA, Edmonton-Mill Creek.

Ms McKitrick: Annie McKitrick, MLA, Sherwood Park.

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

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

Mr. Koenig: Trafton Koenig, Parliamentary Counsel with the Legislative Assembly.

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.

Ms Ness: Kathy Ness, assistant deputy minister, Alberta Health.

The Chair: Thank you.

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

Mr. Rodney: Dave Rodney, MLA for Calgary-Lougheed. Good morning, everyone.

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

Ms Jansen: Sandra Jansen, Calgary-North West. Good morning.

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

Mr. van Dijken: Glenn van Dijken, Barrhead-Morinville-Westlock.

Mrs. Pitt: Angela Pitt, MLA for Airdrie.

The Chair: Thank you.

I'd like to note for the record the following substitutions. Ms Woollard is here for Ms McPherson, and Mr. van Dijken is here for Mr. Orr.

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 all cellphones, 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.

Next is the approval of the agenda. Would a member move a motion to approve? Moved by Ms McKitrick that the agenda for the June 20, 2016, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of the motion? Any opposed? Hearing none, the motion is carried.

We have the minutes from our last meeting. Are there any errors or omissions to note? Hearing none, would a member move the adoption of the minutes, please.

Mr. Yao: I so move.

The Chair: Thank you.

Mr. Yao moved that the minutes of the June 13, 2016, meeting of the Standing Committee on Families and Communities be adopted as circulated. All in favour of the motion? On the phones? Dr. Swann?

Dr. Swann: Sorry. I was muted there.

The Chair: Mr. Rodney? Is there anyone opposed? The motion is carried.

The following motion was made by Mr. Orr at our meeting last Monday, and following discussion, debate was adjourned. I'll have our committee clerk read the motion for the record.

Mrs. Sawchuk: Thank you, Chair. Moved by Mr. Orr 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.

The Chair: Thank you.

Before I open the floor to members for discussion, I want to remind the committee that it currently has the review of the Mental Health Amendment Act, 2007, to be completed by July 15 of this year. Following this review, the committee will be commencing its review of Bill 203, Fair Trading (Motor Vehicle Repair Pricing Protection for Consumers) Amendment Act, 2016, referred to it by the Assembly after first reading. As referenced by Dr. Massolin at our last meeting, Standing Order 52.07(3) directs that a matter referred to a committee by the Assembly "shall take priority over any other inquiry." My understanding is that Mr. Smith would like to speak to this.

Mr. Smith: Thank you very much, Madam Chair. We would like to put forward an amendment to the motion, which would read as

follows. I move that the motion be amended by adding the following. This study shall be undertaken following the completion of the review of the Mental Health Amendment Act, 2007, and the review of Bill 203, Fair Trading (Motor Vehicle Repair Pricing Protection for Consumers) Amendment Act, 2016, pursuant to Standing Order 52.07(3).

The Chair: Thank you, Mr. Smith.

I will now open the floor for discussion about the amendment.

Mr. Smith: I guess we would suggest that we understand that there is business that this committee has to attend to, that we need to do the review of the Mental Health Amendment Act and that we have to do a review of Bill 203, but after that business has been completed, it would be in the interests of Albertans that we then pursue this motion.

The Chair: Thank you, Mr. Smith.

Is there anyone wanting to speak to this amendment?

I will call the question on the amendment. I guess with the people on the phone I'll call each member, and they can indicate how they would like to vote. At this point we're going to reread the amendment so that we're clear on what we're voting on because those members on the phone do not have the amendment in front of them. Mr. Smith moved that

> the motion be amended by adding the following: "This study shall be undertaken following the completion of the review of the Mental Health Amendment Act, 2007, and the review of Bill 203, Fair Trading (Motor Vehicle Repair Pricing Protection for Consumers) Amendment Act, 2016, pursuant to Standing Order 52.07(3)."

We'll go around the room and have everyone in the room indicate whether they are voting yes for this amendment or no, starting on my right.

Mr. Yao: Yes.

Mr. Horne: No.

Ms Woollard: No.

Ms McKitrick: No.

Mr. Hinkley: No.

Mr. Shepherd: No.

The Chair: We will move to members on the phone.

Ms Luff: No.

The Chair: Mr. Rodney?

Dr. Swann: Yes.

Ms Jansen: No.

Mr. Smith: Yes.

Mr. van Dijken: Yes, in favour.

Mrs. Pitt: Yes.

The Chair: At this time we have five in favour of the amendment, and seven opposed to the amendment. The amendment is defeated.

I will now open the floor to discuss the motion that is before this committee.

9:10

Ms Woollard: Just as kind of an overview I was going to say that we are well aware that synthetic opiates have emerged as a deadly threat to drug users right across Canada and the United States, but our government is taking the safety of Albertans very seriously, and it's really important to acknowledge that we are doing a number of things as we move along to address this issue.

We've massively expanded access to naloxone to save lives for people in crisis. We've increased access to opioid dependency treatment to help people stabilize their lives. We have a number of new detox beds and counselling programs in place across Alberta to help people move past this affliction. We're really working to educate the public and raise awareness that these highly toxic chemicals are frequently disguised as other street drugs and that people are often under the impression that they are getting one thing when, in fact, they are getting an opioid. So it's important to look at all the things that are presently going on, that are in place, to deal with this problem, this difficulty.

The Chair: Thank you.

Anyone else wishing to contribute to the conversation?

Dr. Swann: As part of the mental health review we've certainly touched on the addiction issues and heard from experts as well as patients who raised some important issues around especially the opiates, particularly fentanyl because of its currency. It became quite evident, I think, that even today B.C. is struggling with controlling its problem, and we still have two deaths every three days in Alberta relating to opiates. It's such a complex issue, relating to everything from, you know, early childhood development and issues relating to family dynamics, parenting, addictions in the home, trauma in childhood.

I just believe that any more light that we can shed on the opiate and addictions issue is to the good. Addictions have always been kind of the third cousin in the mental health system: neglected, stigmatized. We are far from the number of physicians who can deal with the addictions. According to Dr. Hakique Virani in Edmonton I think physicians are dealing with about one-quarter of the addicts because of the long wait-lists, so we're critically short of physicians who want to deal with the substitute therapy like Suboxone or methadone. Often institutional care is not very helpful for these opiate problems, but intensive psychotherapy and other modes are now being tried.

I just think it's a critically important issue that we're not getting a handle on. B.C. itself has declared a state of emergency because they're losing something like two people a day or at least one person a day and more than that. I think there's much social and medical misunderstanding and stigma around this that needs to be brought to the fore and just understood better and addressed in a more comprehensive fashion.

So I think it would be an excellent opportunity to review and go into greater depth on something that's a growing and emerging issue in our society and that we really haven't got a good handle on yet. Yes, there have been some improvements, especially under this government, in our approach to it, but we're a long way from having a comprehensive approach and an adequately resourced approach in schools, in communities, in workplaces. There's so much that still needs to be done.

I think it's an important issue for us to at least plan to do at some point. It may get bumped again by another legislative review, but I

think we should have it on the radar and have it on the list of things that should be done in a timely way if we can.

The Chair: Thank you, Dr. Swann.

Is there anyone else wishing to contribute to the discussion on the motion?

I will call the question on the motion. Again, I will ask every member to identify whether they are in support of the motion or against the motion, and we'll start with the members present, starting to my right.

Mr. Yao, are you in favour of the motion, the original motion?

Mr. Yao: Ron Orr's?

The Chair: Yes.

Mr. Yao: Yes.

Mr. Horne: No.

Ms Woollard: No.

Ms McKitrick: No.

Mr. Hinkley: No.

Mr. Shepherd: No.

The Chair: On the phones?

Ms Luff: No.

Dr. Swann: Yes.

Ms Jansen: No.

Mr. Smith: Yes.

Mr. van Dijken: In favour.

Mrs. Pitt: Yes.

The Chair: For this motion I have five in favour and seven opposed. This motion is defeated.

The next part on the agenda is the review of the Mental Health Amendment Act, 2007. As we are set to start our deliberations related to the committee's review of the Mental Health Amendment Act, 2007, I would like to thank the staff from Health and from Justice and Solicitor General for joining us today should we require their expertise and for their briefings previously provided to the committee.

Our goal today is to identify those issues the committee wishes to address in its report. If the committee decides to make a recommendation with respect to an issue, it will be put forward as a motion for discussion and, ultimately, for a vote by the committee. Our LAO committee staff are here to assist us in this respect, including any questions the committee may have with respect to process as well as with the drafting of any motions.

9:20

Our first item of business under item 5 on our agenda is the summary of issues identified through our consultation process. An issues document was provided following our meeting last Monday, and it addresses all issues identified during our consultation process and through the written submissions received as well as the oral presentations that we heard. This document organizes and summarizes the issues identified by the stakeholders, individuals, and organizations who provided input to the committee as well as any suggestions or recommendations put forward by these parties. As I noted at the close of our meeting last Monday, the committee is not required to address all issues identified in the document, nor are we precluded from identifying issues of our own.

I'd now ask Ms Robert to provide an overview of the summary of issues and proposals document.

Ms Robert: Thank you, Madam Chair. Okay. All of you will have received Summary of Issues and Proposals: Review of the Mental Health Amendment Act, 2007. The way that we have organized it is that any issues and proposals that were raised that proposed legislative changes to the act are organized under section 4.0 of the document, and they're itemized and categorized between involuntary admission and community treatment orders. A number of other proposals were made by stakeholders and members of the public for changes that would not require legislative amendments but would be done more at a management or operational level like extra support in the community, that type of stuff. Those are set out in appendix A to the document because they're not proposals for legislative change. Appendix B contains proposals for legislative changes that were made that are outside the scope of the review that this committee has undertaken. That's the way the document has been organized.

I'll just tell you before we get going here that you might have noticed that some submissions and some presentations spoke about the 2000 amendments as prospective amendments, and they're of course not prospective amendments. They came into force, and we're reviewing how they've been operating. Hopefully, that didn't cause any confusion for anybody.

Section 4.0 of the document is where the proposals for legislative change that are within the scope of this review are located. They're in five different categories: the change criteria for involuntary admission, the effect of that, and proposals to change it even more; issues on release from involuntary admission, which mostly relate to notification, medical information sharing, treatment supports in the community; the next section relates to community treatment orders, and there were quite a few proposals made with respect to community treatment orders with respect to consent, the administration of CTOs, issues with respect to when a person is apprehended and detained if they have not complied with their CTO, and a number of other general issues; there were also proposals raised with respect to "Who can issue a CTO?" and "Who can issue a certificate for involuntary admission?" and "Should that be expanded to include other health professionals?" and "Should that be within the purview of the courts?" and that type of thing; then a number of general matters were raised with respect to things like "Should there be judicial review with respect to CTOs and involuntary admission?" and that type of thing.

That's basically how the document is set out. I'd be happy to try to answer any questions anybody might have.

The Chair: Thank you, Ms Robert.

Are there any questions for Ms Robert before we start the process of identifying issues for deliberation?

Seeing none and hearing none, as a starting point I'd ask members to identify the specific issue or issues they would like to bring forward during the committee's deliberations. Of course, this doesn't preclude members from adding to the list throughout the course of the meeting.

Would a member like to start off our list? Mr. Shepherd.

Mr. Shepherd: Yeah. I'd like to have the opportunity to discuss notification on discharge.

The Chair: Thank you.

Dr. Swann: I'd like to discuss the alternate practitioners who may be eligible to issue orders.

The Chair: Thank you.

Mr. Smith: I'd like to look at 1(a), the change in criteria from "danger" to "harm."

Mr. Horne: If I can, I would like to look at the prioritization of harm in assessment criteria.

Ms McKitrick: I'm really interested in discussing the definition of health professionals and broadening those professionals that can fulfill some of the requirements.

The Chair: Mr. Hinkley.

Mr. Hinkley: Yes. I'd like to bring up the topic of information sharing.

The Chair: Thank you.
Anyone on the phone? Ms Luff?

Ms Luff: I think I'm okay. Mr. Smith already mentioned the definition of harm.

The Chair: Thank you.
Ms Jansen.

Ms Jansen: I don't think you need to call us out individually. When I have something to say, I'll add it in. Thank you.

The Chair: Thank you.
Is anyone else on the phone wanting to contribute to the list?
Hearing none, we'll start the conversation with notification upon discharge. I will start a speaking rotation list. Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. I appreciated the presentation we had from Boyle Street Community Services. They as well as some others, I think, who made submissions noted some concerns with the fact that they're out there in the community, working with these individuals, keeping very close. In many cases the treatment workers and the outreach workers that work with many of these organizations have a better relationship with these individuals than even their family and have a better idea of sort of what their issues are and, in fact, end up delivering a lot of the care and services that these individuals require.

That being the case, they noted that they aren't able currently to receive that information regarding notification, so when these individuals are released from care, whether that's under a CTO or not, they're not provided with the information that would allow them to know that this was taking place so they could step in and begin to provide some of the services and care these individuals need.

Under the Mental Health Act as it was amended, at present it requires that a facility give notice of discharge of a patient from a facility to the patient's doctor, but AHS, Boyle Street Community Services, and the Edmonton Police Service have suggested that the act could be amended to allow the possibility of sharing that information with other health professionals. That could allow for improved treatment and help ensure that these individuals are provided with the care and support they need to remain stable in the community.

I would like to make a motion on this if possible, basically moving that our committee, the Standing Committee on Families and Communities, recommend that the Mental Health Amendment Act, 2007, be amended to ensure that health care professionals notify not only the patient's family physician but also the other appropriate medical practitioner and health facilities as well as family members.

Again, I believe that if we're able to recommend this sort of amendment, this is going to ensure that patients, when released, will be able to receive the best care possible by providing the information about their condition and their needs to the people who are closest to them and providing the most direct care.

The Chair: Thank you, Mr. Shepherd.
Anyone else wishing to contribute to this discussion?
Is there anyone from research that would like to add to this?

9:30

Ms Robert: Thank you, Madam Chair. I think that covers a lot of the notification issues. If that's what the committee is interested in talking about, yes, that does cover a lot of the notification issues that were raised.

The Chair: Thank you.
Any of our guests?

Ms Bailey: Madam Chair, has the committee heard anything about the details of the Health Information Act and when health care providers are allowed to disclose without a patient's consent? Has the committee heard any presentations on how disclosure of personal health information is already allowed under our Health Information Act, which would apply to situations where a patient is discharged from hospital as a formal patient?

The Chair: Ms Robert.

Ms Robert: Thank you, Madam Chair. The Information and Privacy Commissioner, I believe, made a presentation to this committee and talked about the Health Information Act, and I'll paraphrase what they said. Under the Health Information Act a custodian – for example, AHS, a physician, nurse, or pharmacist – has the authority to disclose health information without consent in certain situations, which enables custodians to exercise their professional judgment to share a patient's health information with another health services provider or person who is providing continuing treatment and care. They went on to say that section 32(1) of the Mental Health Act, which is the notification section, is an example of a specific disclosure authority and it aligns with the Health Information Act as that act recognizes that disclosure may be authorized under another enactment.

Then AHS sort of clarified the issue as well, suggesting that the act does not say that you cannot share this type of medical information with other health professionals, just that it must be shared with the family doctor.

I don't know if that helps.

The Chair: Thank you.

Ms Bailey: Thank you. The reason for my question is not to take away from your wish to make that recommendation but just to ensure that you had all of the information. I thought that perhaps

you didn't know that was already possible under our current legislation.

The Chair: Thank you.

I would just like to ask guests, when they're speaking, to identify their name so that people listening online are aware of who's speaking.

Ms Bailey: Apologies, and this is Tracey Bailey. Thank you.

The Chair: Thank you, Tracey.

Mr. Yao: From my personal experience, while the Member for Edmonton-Centre's intentions are good, I don't know if it's drafted in such a generic manner that it would eliminate all patient confidentiality. This is something we haven't reviewed in its entirety in previous committees. Is that correct?

The Chair: I'm not aware.

Mr. Yao: Exactly. So it's something that we should – I do like it, and as someone who has worked in the health profession, it is desired, but there is a fine line that we have to tread there. I'm just afraid that statement might be a bit too open.

The Chair: Thank you.

Is there anyone on the phone wanting to contribute to discussion on the motion?

Ms Luff: We are aware that the ability to share information is already present in the act, but the fact is that the information isn't getting shared. So enabling it to be more clear, so that people are aware that they can share that information, I think is a good step in the right direction.

The Chair: Thank you.

Dr. Swann: I was going to add my support for that in the sense that what we heard in the mental health review is that too often people on the health side are reluctant to share information for the reasons given or for other reasons, really, a lack of thinking about it, a lack of taking the time to forward it, a lack of contact information, perhaps, and not doing the necessary research to find out who might be and who is going to be involved with that person afterwards. So I think any affirmative action on this to clarify that the expectation is that this will be shared with caregivers in the community and family would send a much stronger message to the health community, who err on the side of withholding information.

I mean, the major complaints we heard were that the information was hard to get at by those who were caring for the individual and was often late in arriving and wasn't helpful when it arrived much later than it was necessary. So to put the expectation on the primary health system to get the information out to those caring in the community is an important shift in the whole health system.

Thank you.

The Chair: Thank you.

Mr. Shepherd.

Mr. Shepherd: Thank you. I appreciate the concerns that Mr. Yao brought forward. I mean, certainly we want to be circumspect about how much information is shared about individuals. I think it's important to note, though, as has been clarified today, that this is information that's already available, so we're not mandating that additional information be made available that currently is not legally able to be made available. It's simply noting that in these circumstances, when an individual is discharged, currently the act only requires us to inform the person's family physician if known.

Unfortunately, in many of these situations, especially for individuals who may not have a permanent address or may not have a fixed address or may be in other situations, that doctor may not be available, may not be aware. They may not have a family physician. Then these individuals are being discharged, and no one is aware, so no support services, nothing is made available. This motion is simply suggesting that the act should explicitly state that when an individual is released, they would inform not only the physician, if available, but whoever else might be serving as primary support or caregiver for the individual.

So I don't think it's an issue of exposing extra information or invading privacy further. It's a matter, instead, of trying to provide the best support we can for individuals to help them transition back into the community.

The Chair: Thank you.

Any other members wanting to discuss the motion?

Mr. Yao: Thank you, Mr. Shepherd, for that response, that answer. Yes, I agree with you. I understand. I've been in the situation where we weren't privy to information and we should have had that information. So the pendulum has swung in favour of confidentiality, and when we draft this document, the pendulum is going to swing the other way, towards ensuring that the right people have the right information. But depending on how it's used, it could go beyond those borders. The only way we're going to find out is to actually go through it and see where we're at, so I'm comfortable with your amendment. We just have to be cautious. We have to be cautious, to all the health care workers out there and other people, about respecting confidentiality. The pendulum could swing the other way, and it could be wide open.

Thank you.

The Chair: Thank you.

Any other members? Ms McKitrick.

Ms McKitrick: Thank you. I'm always reminded of the fact that for many in Alberta, be it in rural and so on, access to a family doctor can be quite a challenge, so broadening the definition of who can have the information to ensure that someone will be following the patient, I believe, is very, very, very important. I understand the concerns around, you know, who can have access to the information and how it can be misused, but I also know that the wide range of health care professionals or mental health professionals are bound by some very strict criteria around confidentiality and use of information. So I think that everyone would respect the information if it was shared more broadly than with a family doctor.

The Chair: Thank you.

Mr. van Dijken.

Mr. van Dijken: Yes. Thank you, Chair. My concern is that when we discharge patients, they are discharged understanding that they are autonomous individuals and that they are to be treated with the rights and privileges of all with regard to their personal information. My concern is that this is way too broad of a spectrum and is infringing on their rights. I don't know if there's been a thorough study done to get a better understanding of that. As the motion is put forward, I do not feel comfortable with supporting this in the fact that I believe we are not protecting the individual's rights adequately with regard to their personal information.

Thank you.

9:40

The Chair: Thank you.
Any other discussion?

Ms Robertson Baker: From a patient's perspective, some patients have told us that they're concerned about the release of information about the discharge planning to family members as some of them believe it could be used for nefarious purposes. I would just like to say that if a nearest relative or family members are included in this and they're providing that primary support, the legislation be phrased in such a way that there are assurances that the caregiver is providing primary support.

The Chair: Thank you.
Any other discussion?

Mr. Yao: Can we send this to expert counsel or Parliamentary Counsel to review? This is pretty broad and generic.

The Chair: Well, we have counsel present that could contribute to the conversation. Do you have anything else that you'd like to add?

Mr. Koenig: Yeah. I'm happy to provide some general commentary. I know we have some counsel from Justice here, and they might be able to provide some more specific commentary. It is always important to ensure that when information is being disclosed, issues of consent are considered. You know, I would just offer the committee a word of caution to carefully consider the ramifications when information is disclosed.

Because I'm not an expert in this area of the law, I'm wondering if maybe one of the counsel from Justice might like to add a few comments.

Ms Bailey: Well, a few things to consider. One is grouping health care professionals and family members within the same motion. As Ms Robertson Baker pointed out, I think there are different considerations at times between health care professionals providing care to a person upon discharge and family members who may or may not be providing care and support for family or friends that are discharged from hospital. So I think the considerations are different.

Now, not that your call will be the same call that has been made previously, but if you look at how these issues are considered under the Health Information Act of this province, health care professionals may provide, without a patient's consent, information to caregivers, information to people responsible for providing continuing treatment and care, and there are no qualifications on that. It provides them with the discretion to do that. So they exercise some professional judgment as opposed to the motion that's on the floor, as I understand it, which would be to add to the section of the Mental Health Act, which requires information to be disclosed. It takes that judgment call out of the hands of a discharging health care professional as to whether it's a good idea in this particular individual's case or not to disclose that information.

In the case of family members under the Health Information Act it also allows for disclosure, without an individual's consent, to family, but it qualifies it. It basically talks about allowing disclosure "to family members of the individual or to another person with whom the individual is believed to have a close personal relationship" if it's general and not contrary to the express wishes of the patient. As Ms Robertson Baker has pointed out, not all family situations are equal, not all reflect the same kind of scenario. Some families may be providing support; others may not be. Let's leave it at that.

I would say that some of the factors are: is it discretionary or mandatory? Are you saying health care professionals have the ability to do this if they think it's helpful, or must they do it regardless of the circumstances? Then do you want to keep health care professionals and family members in the same category, or do you want to apply different considerations to them? It is a balancing of rights in wanting to assist the individual to ensure treatment and support are in place for them in the community but not to violate their rights.

The last thing I'll say is that in terms of dealing with mental illness – and I'm sure you've talked a lot about this – there is that issue of stigma. Do you want to treat patients being discharged as a result of mental illness differently than other patients being discharged from hospital, and if so, how differently do you want to treat them?

The Chair: Thank you very much.
Are there any other members wanting to contribute to the discussion? Mr. Shepherd.

Mr. Shepherd: Well, thank you, Chair. Those are some good points. I appreciate the advice from Ms Bailey as well as from counsel here to help shed some additional light, and I appreciate the discussion that's been brought up by other members as well. Certainly, I think we want to be quite clear with this, that we're not in fact stating that this is an absolute requirement. I would be open, I think, to amending the motion that I've put forward to clarify on that point.

Also, I think another good point that was raised was that we should be clarifying that these are individuals who are in fact providing primary care or support, so not in general just any family member for any reason but simply only in the case where that family member is in fact providing primary care or support.

Just taking a look here at the motion as I had proposed it, that professionals notify not only the patient's family physician, I would say: not only the patient's family physician but may also notify other appropriate medical practitioners and health facility as well as family members, provided they are . . .

The Chair: Mr. Shepherd, I would just like to note that you can't amend your own motion.

Mr. Shepherd: Oh, I apologize. Okay.

The Chair: I would request that another member . . .

Mr. Shepherd: Sure. I would put those suggestions forward, then, if there's another member that would be willing to take those up on my behalf.

The Chair: You can propose it, and then if someone else wants to move it.

Mr. Shepherd: Okay. I would propose, then, adding the word "may," so "but may also notify other appropriate," and then adding to the end "provided they are providing primary care or support."

The Chair: Is there someone wanting to move the amended motion?

Mr. Hinkley: I would move as Mr. Shepherd outlined it.

The Chair: Thank you.
I'll read out the amended motion. Moved by Mr. Hinkley that the Standing Committee on Families and Communities recommend that the Mental Health Amendment Act, 2007, be amended to ensure that health care providers notify not only the family physician but may, which has been amended, also notify other

appropriate medical practitioners and health facilities as well as family members, amended, providing primary care or support.

Is there any discussion on the amendment?

Dr. Swann: I would replace the word "may" with "should": should notify other primary care providers and family members providing care. I think there needs to be an expectation of providing the resources that people need to care for this individual.

The Chair: Dr. Swann, are you proposing a subamendment?

Dr. Swann: I'm proposing that
> we change the word "may" to "should."

The Chair: Thank you.

Is there discussion on the subamendment?

Mr. Shepherd: I would appreciate hearing again, then, from Ms Bailey and the others, who sort of raised concerns, I guess, about being too prescriptive with this motion, if using the word "should" might fall into that as well.

Ms Bailey: If Dr. Swann's intention is to have it as a mandatory disclosure, then my suggestion would be to use the word "shall," which is already in the Mental Health Act, as opposed to "should" because "shall" is a must: you must do this. If Dr. Swann is suggesting that "should" means that you should do it because it's appropriate to do it but he's also implying that there should be some professional judgment exercised in that, then you might want to consider some wording along the lines of "should, when appropriate" or something to that effect. Those would be a couple of things to consider.

9:50

Dr. Swann: Thank you. That's helpful. I find that "may" is no different from what's happening today, where the default position is that they don't share information, so I'd certainly like to include the possibility of "shall."

The Chair: Thank you.

Is there any other discussion on the subamendment? On the phones?

Mr. Shepherd: To add the words "when appropriate," would that be an additional subamendment, then?

Mr. Koenig: You can't amend any further.

Mr. Shepherd: Right. Okay. So if we add "should," then it's going to simply be "should . . . and."

Dr. Massolin: Yeah.

Mr. Shepherd: Okay. Just wanted to clarify on that point.

Dr. Massolin: May I?

The Chair: Absolutely. Go ahead.

Dr. Massolin: Yes. Thank you. I think you've reached your limit of amendments here, just to put a little levity in this conversation. Yes, perhaps another subamendment might come forward . . .

Mr. Shepherd: After.

Dr. Massolin: Possibly. If that's the way the committee would decide, that's a possibility. At this point you have "should" before you.

The Chair: Any other discussion on the subamendment for the wording "should"? On the phones?

Dr. Swann: I would defer to our counsel there, who suggested "shall, when appropriate." That's a stronger and a more clear directive than the "should."

The Chair: At this point, Dr. Swann, we're only discussing the "should" subamendment.

I will call the vote regarding the wording for "should." All in favour say aye. On the phones? Any opposed? Motion carried.

Now with the subamendment I will read the motion. Moved by Mr. Hinkley that the Standing Committee on Families and Communities recommend that the Mental Health Amendment Act, 2007, be amended to ensure that health care professionals notify not only the patient's family physician but should also notify the appropriate medical practitioner and health facility as well as family members providing primary care or support.

Any discussion on the motion?

Mr. Shepherd: I did appreciate, again, the advice from Ms Bailey, and I appreciate the addition of the word "should." I appreciate Dr. Swann's concern there that "may" was a bit too soft given the confusion that's already existed with the application of some of these amendments. However, I also did appreciate Ms Bailey's suggestion that perhaps the addition of the words "when appropriate" might also help clarify the situation. Again, of course, this is my own motion, so I'm not able to move that subamendment, as I understand, but perhaps there's another member that would wish to do so.

The Chair: Mr. Horne, to move that?

Mr. Horne: Yeah. To move
> the inclusion of "when appropriate."

The Chair: Is there any discussion on the proposed subamendment to include "when appropriate" after "should"?

Seeing none, hearing none, I will call the question. Those in favour of the subamendment say aye. Any opposed? Motion carried.

Now back to the amended motion.

Dr. Massolin: The amendment as amended.

The Chair: The amendment as amended. Sorry. Any discussion?

Dr. Swann: Sorry; could you repeat what we're voting on?

The Chair: Yes. Moved by Mr. Hinkley that
> the Standing Committee on Families and Communities recommend that the Mental Health Amendment Act, 2007, be amended to ensure that health care professionals notify not only the patient's family physician but should, when appropriate, also notify the other appropriate medical practitioner and health facility as well as family members providing primary care or support.

Any discussion? Ms Bailey, go ahead.

Ms Bailey: Thank you. Just something quick to consider. I'm sorry to be technical, but I would suggest you may want to amend the motion to amend the Mental Health Act as opposed to the Mental Health Amendment Act, 2007, so to amend our current legislation.

The Chair: Is it to remove the word "Amendment"?

Dr. Massolin: Instead of the Mental Health Amendment Act, 2007, just the Mental Health Act.

The Chair: Can someone move that motion? Mr. Yao.

Any discussion?

Hearing none, I'll call the question. All those in favour of the subamendment

to remove "Amendment . . . 2007."

Sorry. Dr. Massolin.

Dr. Massolin: Thank you. Just to be clear on what the committee is voting on. I think, as was indicated, the act that's being amended here is not the Mental Health Amendment Act, 2007, but rather the Mental Health Act, so that is the subamendment, just striking out "Mental Health Amendment Act, 2007," and replacing it with "Mental Health Act."

Thank you.

The Chair: Thank you. All those in favour? Any opposed? Carried.

Back to the amendment by Mr. Hinkley. I will read it out. Did members want me to read it out, or would you like to vote on it?

Mr. Yao: Read it out.

The Chair: Moved by Mr. Hinkley that the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to ensure that health care professionals notify not only the patient's family physician but should, when appropriate, also notify the other appropriate medical practitioner and health facility as well as family members providing primary care or support.

Go ahead.

Dr. Massolin: Yeah. I'm very sorry for this, but, Madam Chair, maybe the committee clerk can just highlight those words that are the subject of this amendment by Mr. Hinkley. That's the proposed amendment in the context of the original motion, but what are the words exactly that the committee is voting on at this point?

Thank you.

Mrs. Sawchuk: The addition of the words

providing primary care or support

at the very end of the motion.

Dr. Massolin: The family.

Mrs. Sawchuk: "Family members" is already in here.

Dr. Massolin: Yeah, but that's the context, right?

Mrs. Sawchuk: Okay.

As well as family members providing primary care or support.

The Chair: Any discussion? [An electronic device sounded] Someone is beeping on the phone. It sounds like they're getting text messages or notifications. If you could please remove your phone from the area where you're speaking, that would be greatly appreciated.

Is there any discussion on the amendment proposed by Mr. Hinkley?

Seeing none and hearing none, I will call the question. All those in favour of the amendment, say aye. Any opposed? The amendment carried.

Now back to the amended motion. Any discussion?

10:00

Mr. van Dijken: Can we please get the motion read out?

The Chair: I will read the motion as amended. Moved by Mr. Shepherd that

the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to ensure that health care professionals notify not only the patient's family physician but should, when appropriate, also notify the other appropriate medical practitioner and health facility as well as family members providing primary care or support.

All those in favour say aye. Any opposed? Motion carried.

Our next issue up for consideration is from Dr. Swann. Could you please read out the issue that you would like to discuss?

Dr. Swann: One of the issues was – could you remind me? I have a couple of issues that I wanted to raise. Which one were you referring to?

The Chair: Alternative practitioners to issue orders.

Dr. Swann: Oh, yes. I'm assuming here that there has been no specific dedication to or past involvement of psychologists or nurse practitioners to this point in Alberta, but I don't know what discussions have already been held with those professionals about whether they would be open to having a role in these treatment orders or involuntary admission orders. Could someone bring me up to speed on that?

The Chair: Ms Robert.

Ms Robert: Thank you, Madam Chair. Yes, the committee received a submission from the Nurse Practitioner Association of Alberta asking that nurse practitioners be given the same authority as physicians to issue and renew admission certificates and CTOs. The college and association of psychologists also proposed that registered psychologists should be able to issue CTOs and certificates of involuntary admission and be eligible for appointment to the Alberta Review Board. Those are the professional organizations that asked to have that ability. Oh, sorry. We're on page 16 of the issues and proposals document. It's issue 4(a).

Thank you.

The Chair: Thank you.

Guests, would you like to comment?

Ms Miller: To this point there has not been discussion of what the other professions – the way the act was worded, when we're looking at the Mental Health Amendment Act, is that in sections 9.7(1) and (2) it gives that permission to consider other health professionals. However, the community treatment order regulation then restricts that designation only to physicians.

As I recall the discussion at that time with the colleges of the professionals who were suggesting that they ought to be able to issue, what was put back to them was that we needed a way to ensure that they could determine the qualifications of their providers to ensure that they had the knowledge and skills to be issuing the CTOs. For instance, with psychologists, I think, those that would do mental health therapy certainly would be deemed to have the skills, but there are different kinds of psychologists, that are trained. There was some question: would perhaps a classification like an educational psychologist have the skills? To this point, though, there have not been discussions with those professions.

Certainly, depending on what the committee rules, it could be work that we look into. I think that we've seen in recent years the

utilization of nurse practitioners, and the role has really grown since 2010, when we initially introduced the community treatment orders.

The Chair: Thank you.
Anyone else from the guests wishing to contribute?
Seeing none, I'd like to open the floor to members for discussion.

Mr. Yao: This question is to Parliamentary Counsel. Expanding the people who can authorize CTOs and whatnot: is this an attempt to empower people who are in communities where they don't have full resources and whatnot; say, for example, Fort Chipewyan, where they don't have a lot of the resources or professionals to provide this support? Is that fair to say?

Ms Miller: Yes, that was how it came about. When debate was going on on the Mental Health Amendment Act, 2007, this was sort of an amendment to an amendment, kind of like what we've seen today. It was certainly, I believe, rural MLAs who were raising the issue of the availability of psychiatrists, in particular in rural areas, and that is what brought about this particular section of the act, 9.7, where we're using the term "designated physician or health professional." It was an availability issue.

The Chair: Thank you.
Ms Woollard.

Ms Woollard: Thank you. I appreciate the caveat on making sure that people have expertise in the area before they're involved in issuing CTOs or whatever, but it is important to look at 9.7(1) and to consider that there is also a recommendation in the report here that even physicians should be knowledgeable in the diagnosis of severe mental illness before being involved in issuing a CTO. It doesn't matter if it's a psychologist, you know, where that's not their main area of practice, but for a nurse practitioner or a doctor, for instance, who's a dermatologist or some other speciality that is not involved with mental illness, that could be a problem. I just wanted to mention that.

The Chair: Thank you.
Any other member wanting to contribute to the discussion?

Dr. Swann: I wonder if it might be appropriate to set this aside and ask that the department explore, whether it's with the faculty of psychology or the faculty of nursing, whether there would be an interest in developing in certain streams within psychology and within nursing the capacity to designate individuals who could, in collaboration with a physician or in some cases independently, with other practitioners take on that role. It sounds like some more groundwork needs to be done before this is changed.

The Chair: Go ahead.

Dr. Massolin: Thank you, Madam Chair. I just was wondering, maybe to get some clarity from Dr. Swann, if the proposal here is maybe for a recommendation in the report of the committee that this should happen. Or are you asking for something different?
Thank you.

10:10

Dr. Swann: Yeah. I'm suggesting a recommendation from this committee. Some areas are not well served in the province with respect to mental health, and there needs to be some alternative arrangements with people, appropriately trained, outside the medical profession who can provide this service.

The Chair: Go ahead.

Ms Robert: Thank you, Madam Chair. I just wanted to point out one subsection of the act for the information of the committee. Section 9.7(1) of the Mental Health Act provides that

> subject to the regulations, where no psychiatrist is available to issue, renew, amend or cancel a community treatment order . . . a board or a regional health authority may designate a physician or health professional for the purpose of issuing, renewing, amending or cancelling a community treatment order.

So it's not clear if health professional includes psychologists and nurse practitioners. I'm not sure, but that provision does exist in the act right now.
Thank you.

Ms Miller: Yes, the provision is in the act. Section 5 in the community treatment order regulation – you know, the lead-in is "subject to the regulations" – then limits designated physician or professional only to physician currently. So there is wording in the regulation which narrows it to only being a designated physician. The act is broader in its description, but it is the reg that then narrows it only to being a designated physician.

The Chair: Thank you.

Dr. Swann: Could I ask you a question, then? Could that preclude the health authority in a particular area from designating a nurse practitioner or a psychologist? Does the regulation preclude that?

Ms Bailey: I'm checking quickly, but on the face of the act, if it does currently, that would be an easy amendment to the regulation. I will check quickly.
While I'm checking, I'll just point out that the section that you're discussing, section 9.7 of the act, does only refer to community treatment orders or apprehension orders. If I look at the suggested amendment, it's also speaking about issuing a certificate with respect to formal patients. So if you wanted to include certificates issued to keep someone at a designated facility, that would require an amendment to the act, I believe.

The Chair: Thank you.

Mr. Yao: Sorry. I agree with Dr. Swann. It should definitely be expanded, but we do need clarity on the definitions of psychologists and whatnot.

The Chair: Thank you.

Ms McKitrick: I'm really glad that we're having this conversation because it's very challenging in the rural areas to have access in a timely manner to physicians, who may or may not be qualified to define if somebody requires mental health services or not. We are looking at the health system much more broadly these days, and the scope of nurse practitioners and other medical practitioners has changed an awful lot in the last 10 years or so. People are qualified in a very different way than they used to be when the act was thought up, probably. I'm really interested in seeing what options there may be in the regulations to include other qualified medical practitioners or mental health specialists in being able to properly assess the patient and be part of the decision around the CTO. I think this is going to be really, really important to our rural communities, to any community outside of Calgary or Edmonton.

The Chair: Thank you.
Go ahead.

Ms Bailey: Yes. Just to confirm, as was previously suggested, the regulation does restrict the act in this case, so at the moment the only designated health care professional that may be designated is a physician. But that would be, as I say, an easy amendment to the regulation if that was desired.

The Chair: Thank you.

Dr. Swann, are you wanting to move a motion in this respect?

Dr. Swann: Yes, I will if you could help me, Ms Bailey, in crafting it. The purpose of this amendment would be to expand the regulation to include other trained health professionals, including psychologists or nurse practitioners.

Ms Bailey: Just a question, Dr. Swann. Are you suggesting that this be proposed today, or do you think it would also be advisable to come back to this issue once the department has explored with the colleges further about the qualifications of certain health care professionals and about what, if anything, would need to be put into place?

Dr. Swann: Yeah. I'm just conscious of the fact that we have one month to report. Do you think you could get back to us on this before the next meeting?

The Chair: Go ahead.

Mr. Koenig: All right. I'm wondering if this is maybe an issue between, just for clarity's sake, moving a motion to have other health care professionals added into this group or urging that that be considered, you know, when the regulations are changed, that a consideration be undertaken to add in those professionals, so not necessarily that the decision has to be made now but that the committee urge that consideration to happen.

The Chair: Thank you. So are you suggesting that we revisit it at the next meeting?

Mr. Koenig: I am just putting out the clarification that it's possible, if the committee wishes, to make specific recommendations to broaden health care professionals, to add in other types of practitioners. It's also possible, if the committee wishes, to make a recommendation that this be examined so that if these regulations are amended in the future, consideration be made to adding in other professionals like nurse practitioners or whatnot.

The Chair: Thank you.

Are you open to having that included as a recommendation as part of the report?

Mr. Koenig: That's up to the committee to decide, so I will leave that to you.

The Chair: Dr. Swann.

Dr. Swann: Well, yes. I think it's timely now. One doesn't know how many years or decades it might take to get back to reviewing this act. I think we should try and make some decisions quickly if we can. This is only going to enhance, as I see it, the access to appropriate mental health care.

The Chair: Dr. Swann, are you ready at this point to make a motion?

Dr. Swann: Yes. I made what I thought was at least the skeleton of the motion. Can you read it back as it was?

The Chair: No. We don't have anything in writing. That's the thing; we're asking you to move the wording that you would like to see.

Dr. Swann: That the regulations be amended to include psychologists and nurse practitioners, appropriately trained, in addition to physicians.

The Chair: Dr. Swann, are you okay with the wording "that the regulations be amended to include other health practitioners"?

Dr. Swann: "Including psychologists and nurse practitioners where appropriately trained." Or "appropriately credentialed" maybe.

The Chair: "That the committee recommend that the regulations be amended to include other health practitioners, including psychologists and nurse practitioners."

10:20

Dr. Swann: "When appropriately trained."

The Chair: "When appropriately trained." Okay.

So this is what we have. Moved by Dr. Swann that the Standing Committee on Families and Communities recommend that the regulations to the Mental Health Act be amended to include other health practitioners, including psychologists and nurse practitioners, when appropriately trained. Is that correct, Dr. Swann?

Dr. Swann: Thank you.

The Chair: Any discussion on the motion?

Ms Woollard: It's just a matter of wording, but in the original act it does designate "health professional," indicating that the person has a professional status as a health care provider, not health practitioner but health professional, and then nurse practitioner is one of the categories. Does that make sense? Well, you can decide.

The Chair: So you're wanting to amend the wording "health practitioner" to "health professional"?

Ms Woollard: In accordance with the original Mental Health Act it is "health professional." It says: "physician or health professional."

The Chair: Thank you.

Any discussion on the amendment proposed by Ms Woollard to change the wording "health practitioner" to "health professional"?

Dr. Swann: I fully support it.

The Chair: I will call the question. All those in support of the amendment, say aye. Any opposed? Carried.

Any discussion on the motion as amended?

Mr. Yao: I think we have to amend Dr. Swann's motion somehow regarding the terminology around education.

The Chair: It says: "when appropriately trained."

Mr. Yao: When appropriately trained. A physician can turn around and say that unless you're a physician, you're not appropriately trained. All health professionals have some mental health training and education. If we consider that what we're trying to do is address areas that don't have access to these readily available resources, maybe we need to define that in here, to the situation. Or do we

open it wide open for every psychologist to be able to put in a community treatment order?

The Chair: Is there any feedback from our guests?

Ms Ness: I think that as our legal counsel has suggested, we'll have to take this back to the regulatory bodies. I don't know how they designate "appropriately trained" for this particular area.

Ms Bailey: I think they may want us to use the wording along the lines of those health care professionals that have been authorized under the Health Professions Act or something along those lines.

Mr. Yao: But, then, that does nothing. It goes back to the original "physicians" again because they're the only ones authorized to provide this.

Ms Bailey: No, not necessarily. If a college tells us that some or all of its members are actually appropriately trained, educated, et cetera, or that with additional training they could be able to provide this kind of service, that can happen within the workings of the college. We have actually dealt with that. For example, you talked about the opioid crisis this morning briefly, dealing on that front with health care professionals providing take-home naloxone kits who couldn't do so before we did certain legislative things. There were discussions that occurred with the relevant health professional colleges about: do your members have the appropriate training or could you provide them with the appropriate training to allow them to undertake this kind of service?

The Chair: Thank you.

Mr. Yao: Could we allow Dr. Swann's motion to be reviewed by Parliamentary Counsel and come back next week with some recommendations? I have a hard time passing any of these things without some good review and whatnot. These generically written comments can get misinterpreted out in the field and abused, for lack of a better term, or continue to restrict people when we want the intent of being able to address all citizens of Alberta, regardless of where they're at, with the appropriate care and attention.

The Chair: Go ahead.

Mr. Koenig: I'm not entirely certain what is being asked. If the committee wishes, I'm happy to provide additional information, or in consultation with research services, on this point. What I would suggest, though, for the benefit of the committee, is that motions to include recommendations in the report don't need to set out the legal language unless you wish. They don't need to set out the exact legal language you wish to have added into the act. It can specify topic areas, issues, things that are being raised as areas that the committee recommends be changed or amended or where additional focus be added on.

To clarify for the committee, there's not a requirement here that you're proposing, you know, exact language to be added into the regulation. It can be, in a general sense, a recommendation that that regulation be re-examined, that there be a consideration as to whether nurse practitioners or psychologists be added into that regulation. I mean, it can be more general in nature.

What I would also just point out – and I think this has been identified already by the experts here today – is that what we're talking about specifically here, the regulation, relates to community treatment orders in particular. What we're talking about is community treatment orders, so that other aspect, involuntary admissions – please correct me if I'm wrong here – we're not dealing with. It's only with the regulation dealing with who is empowered to deal with that CTO aspect.

The Chair: Thank you.

Any other discussion regarding the amended motion?

Seeing none, I will call the question.

Mr. Shepherd: Sorry. Could we just have the motion read one more time?

The Chair: There's been a request to read the motion, so I'm going to read it. Moved by Dr. Swann that

> the Standing Committee on Families and Communities recommend that the regulations to the Mental Health Act be amended to include other health professionals, including psychologists and nurse practitioners, when appropriately trained.

All in favour of this amended motion please say aye. Any opposed? Carried.

Our next issue up for consideration is from Mr. Smith. If you could read out the issue, please.

Mr. Smith: Thank you very much, Madam Chair. We're going to be dealing with issue 1(a), the change in criteria from "danger" to "harm." It's on page 5.

The Chair: Thank you. Go ahead.

Mr. Smith: Okay. Thank you very much. We know that this is a good motion, the motion that I would read. The recommendation that they're giving is that the Mental Health Act should be amended to define the term "harm," and I think that's a good recommendation. But there is a concern that I have, and I'll eventually get to a motion that I would like to read. Well, maybe I'll read the motion right now. It would be moved by myself that the Standing Committee on Families and Communities accept the recommendation that the Mental Health Act be amended to define harm and that the definition include that a request for physician-assisted death by anyone not facing reasonably foreseeable death be added.

10:30

We know that Bill C-14, present legislation, sets that physician-assisted death is appropriate only when foreseeable death is imminent, and I believe we need to ensure that all Alberta legislation and regulation is consistent with federal legislation. Those suffering from mental health: we know that they're a vulnerable group to physician-assisted death, that they suffer from a treatable illness, and that they deserve treatment. We need to ensure that their right to life is balanced by the Supreme Court ruling regarding physician-assisted death.

The motion I'm presenting to the committee today would ensure that anyone asking for physician-assisted death that is not facing foreseeable death gets treatment regardless of whether they believe they can be helped or not. We have a duty to ensure that people who want to end their lives receive the best possible psychosocial help that they can receive even if it means that they have to be involuntarily admitted so that they can receive the health care they both need and deserve. The point of this motion is to ensure that anybody who is requesting physician-assisted death but is not facing reasonably foreseeable death would fall under the criteria of the Mental Health Act and that they would fall under the definition of harm.

The Chair: Thank you.

Sorry, Mr. Smith. We lost you after "amended to," so if you could please read the motion again.

Mr. Smith: Okay. Moved by myself that the Standing Committee on Families and Communities accept the recommendation that the Mental Health Act be amended to define harm and that the definition include that a request for a physician-assisted death by anyone not facing reasonably foreseeable death be added to the definition of harm.

Mr. Koenig: I'm wondering, Mr. Smith, if you might just explain the intent of this motion just to make sure that we all understand.

Mr. Smith: Sure. I'd be happy to do that. We know people that suffer from mental illness are a vulnerable group when it comes to physician-assisted death. We know that we've had witnesses appear before us that say that there are often situations where people that suffer from mental health will not believe that they actually have a condition or that they actually have issues. There are times when an involuntary admission is important, especially when the patient is capable of harming themselves but they don't believe that they have a problem. What I'm suggesting here is that this group of people is very vulnerable when it comes to physician-assisted death. This motion is asking that should a physician or two be faced with a request for physician-assisted death by someone that is not facing reasonably foreseeable death, this would be considered as a part of a request for them to harm themselves or to have somebody else harm them, and therefore they would be a candidate for involuntary admission.

The Chair: Go ahead.

Mr. Koenig: All right. I will maybe just make a few comments on harm and how it's used in the legislation. Then I may, if the committee so wishes, have some of our experts here today, if they wish, comment as well just so that everyone can have an idea of that concept of harm and what it does in the legislation. Currently, in section 2, one of the requirements for a person to be subject to an involuntary admission is that the person is "likely to cause harm to [themselves] or others or to suffer substantial mental or physical deterioration or serious physical impairment." The concept of harm is being used in a way that, you know, if a person is going to cause harm to themselves or to others, that is a requirement for them to be admitted without their consent to a health facility. I'm not sure if maybe some of the experts here today might wish to add in a bit more information.

Ms Bailey: It sounds like a few issues are kind of intertwined within that motion. One is the move from danger to harm in the amendment that was made and whether or not there needs to be a definition at all in the legislation. One of the rationales, as I understand it – and my colleagues here will correct me if they have a different understanding – is that when those amendments were made, the word "danger," that had been in the previous act, had been defined by the courts, and it had been interpreted very narrowly. Part of the reason, as I understand it, for that quite narrow interpretation of the word "danger" was because when you certify somebody and keep them against their will in hospital to assess, treat, et cetera, it is a significant violation of their normal rights and freedoms that they enjoy in this country. It had a narrow interpretation, and one of the things it was defined to mean was that the danger had to be imminent or within a short period of time foreseeable in the future.

The Legislative Assembly of Alberta thought that was too narrow of a definition. They were worried that it did not allow health care providers to certify people when it was appropriate, and that was the reason for the change from danger to harm. One thing to consider is on the general point of: do you want to actually provide a definition in the legislation? If you provide a definition, there are some potential kind of adverse, perhaps unintended consequences. Right now that new term "harm" allows health care providers to assess a patient and to decide: is this a serious enough case or not that we are going to restrict their liberties and keep them in hospital, et cetera? That's general discussion, and if you have more specific comments about that, I think we could provide some further commentary ourselves.

On the suggestion that this be used to protect vulnerable people with mental illness from a physician-assisted death, my suggestion – and it may be an inappropriate one – is that that is probably better addressed in the Alberta law and now the federal law around physician-assisted dying directly. There is, as you know, now federal legislation that – and we can discuss whether it's constitutional or not in a different forum – whether or not it's constitutionally valid, actually restricts physician-assisted dying to be provided only to those whose death is reasonably foreseeable. That does impact the situation here in Alberta already. The broader kind of base for physician-assisted death here that was provided by the Alberta government has been restricted by that new federal legislation already. I'm not sure if that would help Mr. Smith with his concerns around that particular issue or not.

The Chair: Thank you.

Mr. Smith, is it possible for you to please e-mail the wording to the committee clerk? We don't quite have it.

Mr. Smith: Yeah, I can do that.

The Chair: Thank you.

Do you have anything to add after hearing the comments?

10:40

Mr. Smith: I guess that my comments would simply be: we know that we have federal legislation, but we also know that we have provincial legislation. While the federal legislation will indeed deal directly with physician-assisted death, we are looking here at the Mental Health Act. I believe that there is a very valid reason for being concerned when it comes to the expansion by individuals when trying to deal with the federal legislation and that we need to, with the Mental Health Act, ensure that people receive treatment rather than physician-assisted death. I would suggest that there's still a very important thing that needs to be accomplished by passing this motion. I'll send it to you in just a second here.

The Chair: Thank you.

I have a list started for discussion. Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. I appreciate the opportunity to speak to this motion. We're here today considering some very significant and, I think, important issues, you know, regarding personal human rights and sort of when those can be abrogated and the effects that can have on individuals. We are not here today to discuss the issue of medical assistance in dying. That's not in any way to dismiss the import of that issue. That certainly is a very important one, I think, to all Albertans. We want to ensure that people have access to the rights that are mandated by the Supreme Court, and we want to ensure that that is done in a way that protects all Albertans. Certainly, protecting vulnerable Albertans is a priority, I think, of myself and all of my colleagues here at the Assembly and of the government.

They've brought forward regulations. They've been signed into place. They protect the rights of physicians and health care professionals as well as Albertans here in the province. They provide that patients have to be aware of all their medical options. It requires that two doctors meet the criteria set out by the Supreme Court and that any questions about mental state must be referred to a psychiatrist or a psychologist. In addition, two people must witness the patient's request that are not relatives or heirs, the physician, or anyone that's affiliated with the health facility where they're receiving treatment. The patient must be advised at each step that they can change their mind, including just before the procedure.

I think there are robust pieces that are in place, but even that is aside from the discussion we are having here today. Today we are here to discuss the issues pertaining to the amendments to the Mental Health Act. I believe those are weighty and significant enough that they should remain our focus. This particular motion goes well beyond that, and I don't think it's what we're here to do today.

The Chair: Thank you.
Please.

Mrs. Sawchuk: Thank you, Chair. The motion by Mr. Smith is that the Standing Committee on Families and Communities accept the recommendation that the Mental Health Act be amended to define harm and that a request for physician-assisted death by anyone not facing reasonably foreseeable death be added to the definition of harm.

The Chair: Thank you.
Any other discussion on the motion?

Mr. Smith: I would just like to respond to Mr. Shepherd's comments if that's possible.

The Chair: Go ahead.

Mr. Smith: We know that in the regulations, Mr. Shepherd, that were just passed, one portion of them says:

> (2.1) Before a regulated member provides a patient with medical assistance in dying, the regulated member must
>
> (a) be of the opinion that the patient
>
> iv. has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the patient in the circumstances of their condition and that cannot be relieved under the conditions that the patient considers acceptable.

We can have a situation here where a person is suffering from a mental health condition. They do not believe that the treatment that is being suggested by the doctor can relieve their symptoms in a way that they consider to be acceptable; therefore, they would have the ability to pursue physician-assisted death based on the regulations that we have in this province. My suggestion is that when we have a person that's suffering from a mental health condition, they receive treatment for their mental health condition even if it means that they need to be placed into care involuntarily. That is treating the illness.

The regulation that we have is consistent with the federal regulation. The regulation that we have presently as passed by the government and the Legislature would allow a patient to say, "Well, that doesn't meet what is acceptable to me; therefore, pursue that," even in their very vulnerable mental condition. So I believe that this is reinforcing and allowing us to ensure that Albertans are going to be treated for their health rather than have their life taken.

The Chair: Thank you.
Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. I appreciate Mr. Smith's additional comments to clarify. All that aside, we're not here today to debate the regulations regarding medical assistance in dying. It's simply not part of this review. It's not part of what we're looking at here today. While I respect Mr. Smith's concerns and clear feelings on the matter, I feel that our committee's time is best spent on the work that we're actually here for today, and that, looking at the information we've heard from stakeholders, none of whom raised this issue – and we've heard the expert advice from the representative of Justice and others here today – this is well beyond the scope of our committee. I recommend we simply vote this motion down and move on.

Thank you.

The Chair: Thank you, Mr. Shepherd.
Mr. Rodney.

Mr. Rodney: Thank you very much. Again, I heard Mr. Shepherd mention the time of the committee. As you folks well know, I spoke on assisted dying every opportunity we had, so you know my view on the topic, specifically related to protecting the vulnerable. The fact of the matter is that any time we have an opportunity to protect the vulnerable, I firmly believe that we should do exactly that. So rather than me taking the amount of time I took in the Legislature to spell out my feelings and that of my constituents, I would simply say: Mr. Smith, thank you very much for bringing forward this motion, and I will definitely be voting for it.

Thank you.

The Chair: Thank you.
Any other discussion regarding this motion?

Mr. van Dijken: I guess, you know, Mr. Shepherd feels we're debating the assisted dying regulations, but actually all the motion is intended to do is to help in the development of a proper definition of harm and to include this part in that development. All it is is putting forward a request that allows those that will be coming up with the definition to also recognize that this is another area that probably needs to be considered seeing that we have very recent legislation federally and regulation provincially put in place. I don't think the intent of the motion is to debate assisted dying. I think the intent of the motion is to help those that are in the development of this definition take into consideration very recent activities and very recent developments in our country. Thank you for that.

Ms Jansen: I just want to concur with Mr. Shepherd. This is not the time and place to have this discussion, for one. For another thing, just to be on the record, I think that the intent of this motion and the idea of providing an opportunity to lock someone up who expresses an interest in assisted suicide is heinous, and I certainly would be no part of voting for any motion that contains wording of that nature.

The Chair: Thank you, Ms Jansen.
Any others wishing to contribute to the discussion?
Hearing none, I'm going to call the question. All in favour of the motion, say aye.

An Hon. Member: Sorry. Read the motion.

The Chair: Sorry. There's been a request to read out the motion.

Mrs. Sawchuk: That

> the Standing Committee on Families and Communities accept the recommendation that the Mental Health Act be amended to define harm and that the definition include a request for physician-assisted death by anyone not facing reasonably foreseeable death.

10:50

The Chair: Thank you.

All in favour of the motion, say aye. All opposed? Motion defeated.

Ms Luff, I had you wanting . . .

Mr. van Dijken: Chair, excuse me. Could we have a recorded vote on that, please?

The Chair: Sure. I'll be going one by one. We'll start with members in the room. You'll have to indicate whether you are in favour of this motion or opposed. I will start to my right.

Mr. Yao: Support.

Mr. Horne: Against.

Ms Woollard: Against.

Ms McKitrick: Against.

Mr. Hinkley: Opposed.

Mr. Shepherd: Emphatically against.

The Chair: I will go to the phones.

Ms Luff: Opposed.

Mr. Rodney: In favour. Thank you.

Dr. Swann: Opposed.

Ms Jansen: Opposed.

Mr. Smith: In favour.

Mr. van Dijken: In favour.

Mrs. Pitt: In favour.

Drever: Definitely opposed.

The Chair: Thank you.

We have five members in favour and nine opposed. This motion is defeated.

At this point we're going to be calling a 10-minute break. I would ask that you return in 10 minutes to resume committee.

[The committee adjourned from 10:52 a.m. to 11:04 a.m.]

The Chair: I'd like to call the meeting back to order.

I have Ms Luff wanting to speak to changes in criteria for involuntary admission. Go ahead, Ms Luff.

Ms Luff: Hello?

The Chair: Hi. Go ahead.

Ms Luff: Sorry. I was muted. I was just talking to nobody.

The Chair: That's okay. Go ahead.

Ms Luff: Yeah. I'd just like to speak to the proposal to amend the Mental Health Act to define the term "harm." This is one of the things that I sort of noticed early on in that there had been fairly a lot of support for changing the criteria . . .

The Chair: Ms Luff, sorry to interrupt. Could you please speak up? We're having a difficult time hearing you.

Ms Luff: For sure. Can you hear me now?

The Chair: Yes. It's a lot better. Thank you.

Ms Luff: Okay. I just wanted to touch on the proposal on page 5, the suggestion that has been made that "the Mental Health Act should be amended to define the term 'harm'." This is something I sort of noticed fairly early on in this conversation, that people were generally favourable of the change of the criteria from "danger" to "harm"; however, you know, some people had noticed some issues around the fact that the word is still not defined.

Psychiatrists have noticed that it hasn't changed the amount of involuntary admissions or the type of involuntary admissions because, again, the term just hasn't been defined. The Edmonton Police Service was particularly concerned because they felt that police perceive harm differently than physicians do. What that does is that it uses up a lot of police time bringing folks to hospital when the majority of them end up being let go. Approximately 70 per cent of folks who are apprehended and brought to hospital end up being discharged by the physician. So having some definition around the term "harm" I think would be very helpful.

I'd like to propose a motion to that effect. Basically, the motion would be: that the Standing Committee on Families and Communities recommend that the Mental Health Amendment Act, 2007, be amended to provide a definition of the term "harm" given that the term is currently interpreted differently by various stakeholders.

The Chair: Thank you.

Dr. Massolin, do you or your staff have any comments that you would like to make?

Ms Robert: Thank you, Madam Chair. Actually, Ms Luff covered all of the rationale that I found in the submissions, so unless anyone has any questions, no, I don't have anything to add.

Thank you.

The Chair: Thank you.

Do any of our guests have anything that they'd like to contribute?

Ms Bailey: Just a few things to keep in mind. One, when a term such as "harm" is used in a statute and it's not defined, the way that we interpret it is just by using the plain meaning of the word. You go to a dictionary, and you look up "harm."

The thought that police use it differently than a psychiatrist, for example, in a mental health facility may make some good sense. If you're a police officer and you're assessing whether you need to take someone to hospital, your threshold is likely going to be lower, you know. You see that you've got some concerns about their mental state – might they cause harm to themselves or others? – and you're wanting to take them in to be assessed. A psychiatrist's assessment in a mental health facility will be a very different one based on their professional judgment and not only whether or not they meet the criteria but whether or not it's going to be beneficial to them to be admitted as a formal patient.

That's just food for thought in that it may actually be a positive thing that the thresholds are different for police and for assessing health care professionals at a mental health facility.

The Chair: Thank you.

Are there any members wanting to discuss the motion? Ms Woollard.

Ms Woollard: Just a quick question. Are we in fact making a motion for the recommendation for the Mental Health Amendment Act or the Mental Health Act?

The Chair: It would be the Mental Health Act.

Ms Woollard: Thank you.

The Chair: Anyone on the phones? Go ahead, Dr. Swann.

Dr. Swann: Thanks. I appreciate that this is a difficult discussion and that a lot of judgment is involved where one is trying to assess harm to self or others. I'm not sure further definition is going to help us much because in each case an individual with their individual background – I'm talking about a professional: a policeman, a social worker, a psychologist, a physician – is using their own personal experience and background and training to decide whether this person could or would harm themselves or others. It's always going to be a judgment call.

11:10

I don't know how you'd define it any better than simply to ask people with their best assessment to decide whether this person would be better in protective circumstances in a health care setting or, in fact, involuntarily admitted to a hospital under observation for 30 days or, indeed, following up on the community treatment orders that have been imposed. I don't think it's possible. I think I would be a bit concerned if we got too specific about defining harm or defining what danger is. It limits people's sense of judgment.

I appreciate that police are having difficulty with this because in some instances they have a revolving door of perhaps seriously ill people who are not able to get into hospital, and physicians are also constrained by the lack of beds. In fact, many would have admitted those patients, but because of the lack of beds they have to find others. And then they don't believe that there is imminent death, in other words imminent suicide. Then they have to make judgments around where else people can go, and that necessarily means assessing the relative harm and the relative resources that are available. So it does speak to a severe lack of resources.

The Chair: Dr. Swann, I hesitate to interrupt, but you're cutting in and out.

Dr. Swann: Oh. Well, all that to say that I hesitate to try to define harm or danger for individuals because if one person decides that the person is at risk of harming themselves or others or in danger of harming themselves or others – I don't mind what term is used – they have to act on that. I don't know that we can define it any more clearly than that. We're asking people to use their best judgment of whether a person should be restricted in their freedom or not. Everybody has to use their own judgment in that.

The Chair: Thank you.

Mr. Yao: I agree with Ms Bailey with Justice. The definition of harm is out there already, and it's pretty clear. The previous amendment that Mr. Smith put forward was that people who have asked for a physician to help them with death and they aren't in a situation where death is imminent or they're suffering from such a situation, we've discouraged that from defining harm, and I think we have to continue with that thought forward if you truly believe that – how do I say this? Yeah, I agree with Ms Bailey that we shouldn't define harm because it already is defined, and it's a pretty straightforward definition.

When people are trying to hurt themselves or hurt others, that is harm, and they're in a certain mental state that has to be addressed in the field. When they are before a physician or a panel deciding on their fate or on their diagnosis, they tend to be in a different mindset. It's a more calm situation as opposed to out in the field where they're dealing with extreme duress. To answer Ms Luff's question: yes, police and EMS and other people might have a more generic view of what harm is, but it's well warranted and validated out in the field, so I think the definition of harm is adequate as it stands.

The Chair: Thank you.

Are there any other members wanting to contribute to the discussion? Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. I think it's important to note here that, you know, these individuals who are out doing this work in the field, these folks who are out there on the front lines and trying to navigate this system, have specifically asked us for this definition. The EPS, when they came in, Chief Knecht came in and said that

> 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.

The concern is that I recognize that we want to be careful about being too prescriptive in a definition because that takes it in the other direction, and then it makes it much more difficult, I guess, to take steps that are necessary in some cases.

But in this case I think we've heard from more than one presenter that simply having the word "harm" there is not adequately addressing the problem and not allowing for things to be adequately addressed, noting that, you know, 70 per cent of apprehensions are discharged by the attending physician. If 70 per cent of the people that the police are bringing in or other people are bringing in for care under a concern of harm are then being defined by medical staff as not being in danger of harm, there is a broad, a very vast difference in opinion on what harm actually constitutes. So I think it's worth while for us to recommend that we look at ways that we can further clarify the term to try to reduce that discrepancy.

Thank you.

The Chair: Thank you.

Ms Jansen.

Ms Jansen: Yeah. I think in this conversation we've heard members say that the definition of harm is adequate. Well, first of all, I'm not sure who said that, but I certainly would suspect that you don't come from a place where you can actually make that pronouncement with any kind of academic certainty. On the other side, we're hearing anecdotal evidence that police are a bit hamstrung, being faced with a number of definitions of harm. So rather than run around with our butts on fire, why don't we get some people in to further have this discussion. Why do we have to make a decision on a motion today? Why can't we continue this

conversation and get to a place where we're actually helping the people who need to use this definition properly?

Ms Luff: It wasn't only the police and it wasn't only a psychiatrist that suggested that we needed to look at defining harm and that there's some clarity that needs to be made here. The motion is simply asking that we take steps; you know, it's saying that we should define the term. We're not defining the term, I think, by making this motion and putting it in the report as a recommendation. What would happen is that we would get people who are able to make that decision more fully than we would be able to here. I feel like we've heard from a significant number of professionals who have stated that a definition of the term would be useful. Given that we have to have this report done relatively quickly, I think that this motion to actually define the term and just for us to recommend that we seek to define the term is something that I think is valid.

The Chair: Thank you.

Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. This being the first time, I guess, that I've personally as a legislator participated in a legislative review, I was wondering if we could perhaps ask counsel just to clarify a little bit. What precisely is our role here? It's my understanding that we are simply making recommendations and then those who would be drafting the legislation or looking at making changes based on our recommendations would have the opportunity to pursue some of the more expert advice, then, along the lines of how they would move forward with a definition of harm, that sort of thing. We're not mandating or prescribing anything in particular, but we're simply making a general recommendation that then could have further examination in detail. Would that be correct?

The Chair: Go ahead.

Dr. Massolin: Thank you, Madam Chair. I'll just talk about the reporting process first because I think that maybe will help clarify what the product of the committee's work today will be, and that's basically the next step, which is the draft report, which ultimately will be approved and tabled in the Assembly. That report will contain the recommendations that the committee has made, including those that have been voted in favour of in this meeting today. So that report, those recommendations, are tabled, then they're brought to government, and government will consider them and then make their changes or not, depending on what they decide.

I don't know if Mr. Koenig has anything to add to that.

11:20

Mr. Koenig: I'm happy to make some general comments. Once that report process happens, it's in the purview of the government to decide which of those recommendations, you know – how they're going to move forward with those and the process for doing so. That may include conducting their own examination into some of those recommendations and looking at how those recommendations might be implemented, maybe deciding not to move forward with some of those recommendations. The recommendations themselves aren't binding; they're not obligatory to be implemented. But they do provide the government direction based on what this committee has seen and heard and how they would recommend the government proceed.

The Chair: Thank you.

Any other members wanting to contribute to the discussion on the motion?

Mr. van Dijken: I would just ask Member Jansen if she is satisfied with the [inaudible] regarding her concerns [inaudible] . . .

The Chair: You're cutting out.

Mr. van Dijken: Sorry about that. I would ask Member Jansen if she's comfortable with moving forward on the motion considering that process in place that's been described, if that's amenable to the member or if we need to adjourn debate to get more information.

Ms Jansen: Thank you to the member. This is my level of discomfort: any recommendations that come forward in this report have our names on them, and I don't believe that I'm comfortable making a recommendation to look into something when I don't know enough about the issue. Maybe a number of members there have gone and had conversations with the police and have gone and had conversations with mental health experts; I was not privy to those conversations. So I would be more comfortable having someone come in and talk to us about the definition of harm and where it has its drawbacks before I'm ready to make any recommendation that goes forward in a report that is reviewed by anyone.

Mr. van Dijken: I make a motion to

> adjourn debate at this point in time and to obtain more information.

The Chair: I'll call the question on adjourning the debate. All those in favour, say yes. All those opposed, say no.

There's a lot of background noise coming from over the phones. If you could please mute your phone after you've responded, that'd be very helpful.

My understanding is that the motion is carried. We're adjourning debate on this issue.

Ms Luff: I was opposed. I don't know if you heard me.

Drever: I was also opposed.

The Chair: Perhaps we should have every member identify. I will start to my right.

Mr. Yao: Agreed.

Mr. Horne: Opposed.

Ms Woollard: Opposed.

Ms McKitrick: Opposed.

Mr. Hinkley: I agree.

Mr. Shepherd: Opposed.

The Chair: Members on the phone.

Ms Luff: Opposed.

Mr. Rodney: I'm in favour of suspending, so in favour.

Dr. Swann: Opposed.

Ms Jansen: Agreed.

Mr. van Dijken: In favour.

Mrs. Pitt: I'm in favour.

Drever: Opposed.

The Chair: The motion is lost as we had seven opposed and six in favour.

Mr. van Dijken: Chair, is that considered a recorded vote?

The Chair: Yes.

Mr. van Dijken: Thank you.

The Chair: So debate continues. Any other members wanting to discuss the motion?

Hearing none, perhaps, Madam Clerk, you could read the motion into the record.

Mrs. Sawchuk: Moved by Ms Luff that

> the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to provide a definition of the term "harm," given that the term is currently interpreted differently by various stakeholders.

The Chair: I will call the question. All those in favour of the motion, say aye. Any opposed? Motion carried.

Our next issue up for consideration, it's my understanding, is the priority of harm criteria. Mr. Horne, if you could read that out, please.

Mr. Horne: Okay. Following from our oral presentations last week and from the written submissions there were a couple of concerns raised about how harm is prioritized with regard to involuntary admission. In particular, the RCMP suggested that

> a physician's assessment of the likelihood that an individual's physical or mental condition will deteriorate "must be secondary to the criteria on 'harm'."

Following that line, I would like to propose that the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to prioritize harm to the individual or others over the deterioration of an individual's physical or mental condition in the criteria for involuntary admission.

The Chair: Thank you.

Ms Robert.

Ms Robert: Thank you, Madam Chair. Yes. That proposal was made on page 6 of the document, item (c). As Mr. Horne stated, the RCMP proposed that

> a physician's assessment of the likelihood that an individual's physical or mental condition will deteriorate "must be secondary to the criteria on 'harm'."

The organization Forward Action in Mental Health also made a similar proposal, that

> the partial criterion "likely to cause harm to themselves or others" should be considered to have the highest priority of all the criteria for involuntary admission.

In the RCMP's proposal part of the rationale was that the safety of both the individual and the public must be paramount in the assessment and decision-making process.

Thank you.

The Chair: Our guests, are you wanting to contribute?

Ms Bailey: I don't see any legal reason why you would need to prioritize between these. In the definition there are "ors" between the categories. A psychiatrist making an assessment or a physician making an assessment can rely on any of those criteria within subsection 2(b). They don't need them all in place. So if their assessment is based on "likely to cause harm to the person or others," that's their assessment. I guess I'm missing the rationale for prioritizing. I don't see any reason that you would need to do so.

Mr. Rodney: Madam Chair, just a quick point. I have to attend an indigenous relations event right now. I wish everyone good luck with the rest of the debate, and I'm sorry that I must sign off now as I am part of the procession.

Thank you.

The Chair: Thank you, Mr. Rodney.

Mr. Shepherd: Thank you, Ms Bailey. I appreciate your contribution there. In taking a look at this, then, is there a way to implement something like this? If so, how would that be done, given what you've just said, that it lists a number of criteria with simply stating "or," "or," "or"? How would one go about prioritizing one of those conditions over the other?

11:30

Ms Bailey: I guess I'm missing why the RCMP thought in their submission that it was important to prioritize. A physician or a psychiatrist doing the assessment now does not need to rely on any of the other criteria in subsection (b). For example, they don't necessarily need to believe that there will be a "substantial mental or physical deterioration or serious physical impairment." They can simply focus on: is this individual likely to cause harm to themselves or others? If they meet that piece along with the criteria in (a) and (c), then they have the ability to certify that person as a formal patient, and then they exercise their professional discretion as to whether they will or not. I'm sorry; I think I'm just missing the rationale behind the RCMP's submission as to why they thought that that would be important. I just see it as unnecessary. A physician could currently place the emphasis on that section. They don't need the rest of the section to apply at all.

The Chair: Thank you.

Mr. Yao: My question is for counsel. I heard earlier – I think Ms Luff mentioned it – that 70 per cent of the people that the RCMP and other professionals bring in are released by the psychiatrists and other mental health professionals. Could this be a reflection of that? In the field when these members or other professionals take people in, there is a legitimate reason. There usually is. They are measured more than anybody, so they have to be quite sure. When these patients are before a psychiatrist and whatnot, the volatility tends to settle down. They are in a more controlled situation. They're calmer; they're more relaxed. They give a physician the impression that they're fine, and they leave only to go back to the same situation they were in. Is that possibly why they've asked for this?

Ms Bailey: It's a possibility, and I guess maybe that was why one of the members was suggesting that you hear further evidence or that the department look into further evidence. It could be for a number of reasons. It could be related to that; it could be related to the definition of mental disorder. So it's simply not enough that a person have a mental illness.

If you look at the definition of mental disorder in the act, it's "a substantial disorder of thought, mood," et cetera, that is significant and that "grossly impairs," not just impairs a little bit, one of four things that are listed:

(i) judgment,
(ii) behaviour,
(iii) capacity to recognize reality, or

(iv) ability to meet ordinary demands of life.

That's the first thing.

Again, an assessing psychiatrist or physician could look at this person and say: okay, they have a mental illness, but it doesn't meet the definition of mental disorder in the legislation. They might well think that they're likely to cause harm to themselves or others or the rest of the criteria in (b). They might also think: well, they're not going to voluntarily check into hospital, but I still have to exercise discretion about whether this is an appropriate thing to do. So the decision not to admit that 70 per cent: I think it's hard for anyone, it sounds like, based on what you've heard in the submissions, to say why that is the case. It may be for one of any of those reasons.

Mr. Yao: Are there any measures in place right now to gauge all this at Alberta Health?

Ms Bailey: I think that's probably a more appropriate question, and the department might be able to gather some information or may already have it.

Ms Miller: There are no definitions, and this is the instance where we rely on the professional judgment and training of the health professionals to make these decisions.

The Chair: Thank you.

Mr. Shepherd: I was wondering if perhaps counsel might be able to provide further insight regarding the submission from the RCMP. Was there anything that could help clarify, I guess, the question that's before us, why they're asking specifically for this prioritization.

The Chair: Go ahead.

Ms Robert: Thank you, Madam Chair. I have the transcript in front of me from when the RCMP was speaking to the committee last week, and I can read to you what she said about that.

> 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.

That's all that she said.

Thank you.

The Chair: Thank you.

Any other members?

Ms Robertson Baker: My understanding is that Alberta Health Services is doing some training with the police on having a better understanding of what harm means to address this issue. The other thing, from a patient's or client's perspective, is that if they end up being conveyed to hospital and not admitted, some of them are appreciative of just going to hospital because then in emergency, depending on where they'll go, they're set up with supports when they return to the community, which they might not have had if they hadn't gone to hospital. By all means, if we can prevent conveyance to hospital, that would be ideal.

The Chair: Thank you.

Any other members wanting to contribute to the discussion? Mr. Shepherd.

Mr. Shepherd: Thank you, Chair.

Ms Bailey, if I may ask you one more question, and I guess this is open to counsel as well if they feel they can answer. If this were to be recommended and then implemented, would that be a question, then – right now it says: this criteria or this criteria or this criteria or this criteria. If we're recommending prioritizing particular criteria, would it then be written in a manner such as, you know: must consider, first, harm to themselves or others, and then this or this or this or this or this? Is that the manner in which something like this would be implemented?

Ms Bailey: That sounds conceivable, a very possible way that it would go forward in terms of amending the legislation. I still am not quite sure what effect it would have for the physician doing the assessment. Would it mean, for example, that if I have two patients in front of me, both of whom meet the criteria, both of whom I think could benefit from admission, but I have one bed for something – is it a resource allocation question? That is not really supposed to be part of the assessment right now. The assessment is supposed to be focused on: is it appropriate to admit this person or not? I guess I'm wondering: as you think through this, what do you want the effect to be? That's where it could lead. It could lead to resource allocation as opposed to a strict assessment. Does the person meet the criteria or not? Would they benefit from admission or not? Would they better benefit from receiving supports in the community or discharge, et cetera?

The Chair: Any other members wanting to contribute to the discussion on the motion?

Seeing none, hearing none, I will read the motion. Moved by Mr. Horne that

> the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to prioritize harm to themselves or others over the deterioration of an individual's physical or mental condition in the criteria for involuntary admission.

I will call the question. All in favour of the motion, say aye. All opposed, say no. You guys have to vote. You can't abstain. Thank you. The motion is defeated.

Our next issue up for consideration is from Ms McKitrick regarding, I believe, the definition of a health professional. If you could read the issue, please.

11:40

Ms McKitrick: Sure. Moved that the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to broaden the definition of health care professionals able to administer care after the patient is discharged to include nurse practitioners and other professional health care practitioners.

We kind of talked about the subject a little bit earlier, but I'm always reminded that, really, the persons who are going to be working with mental health patients after they're discharged from facilities are not psychiatrists. They're often paraprofessionals or psychiatric nurses or people at the Boyle community centre or the Hope Mission here. I'm sorry; I don't have the names of organizations outside of Edmonton. Those people may be trained as social workers, or they may have had specific training to work with mental health patients. We've had a number of interesting presentations on this committee about the challenges, that those organizations are more likely to help support and especially, I think,

help mental health patients to the path around wellness, not physicians or psychiatrists.

We talked already a little bit about the need for information sharing and that it was important. So I think it's really important to ensure that we recognize, when we're talking about mental health – I've done a little bit of research, and what I understand is that a psychiatrist or doctor may see a mental health patient less than once a month or even less than that, and the persons who are the most able to assess and provide information on their patient, the workers who deal with them on a day-to-day basis, very often are mental health support workers or they're the workers in a rooming house and so on. So I think it's really important to me and to many of us that those persons are able to not only get information but also be able to administer care and work with the physicians or doctors in terms of the best possible way of helping that patient.

The Chair: Thank you.

Mr. van Dijken: Madam Chair, can we, when we start on a subject, identify where it is in the recommendations in the document so that we can be clear. It will save us from trying to locate what the member, or the MLA, is speaking towards. I think I'm working with 2(b) here, but I'm not sure if that's what's being addressed.

The Chair: Thank you very much. I believe that this was not part of the actual recommendations. It was brought forward by MLA McKitrick. It's not listed as one of the identified issues.

Ms Robert.

Ms Robert: Thank you, Madam Chair. I don't really have anything to add. I don't know if Justice has anything they'd like to add with respect to this.

The Chair: Thank you.

Go ahead. Any one of our guests is able to respond.

Ms Miller: Again, because this isn't sort of a specific change that I can determine you're suggesting to the Mental Health Act, I can just say from a service provider perspective, at least from Alberta Health Services but certainly organizations such as you touched on that are community-based NGOs, that multidisciplinary practice is the norm, not the exception, so when we are talking about service provision, it typically is in a team kind of environment. Yes, I would say that it is true that the time with the psychiatrist may be less than their weekly therapy sessions, which could be, you know, social workers, OTs.

Certainly, a big portion of the provision when we're talking severe and persistent mental illness are those community support workers who might be assisting with prompting to take medications, you know, budgeting, maintaining housing. So the very nature of mental health service delivery through community mental health clinics, through community-based organizations is multidisciplinary. I think that earlier there was a motion accepted that sharing of information upon discharge, including treatment recommendations, ought to go to more than just the family physician, if one can be identified, because it really is important that the team is aware and working together.

Ms Bailey: Just to build on Ms Miller's comments in case this is helpful, as she suggests, in the hospital setting that's the norm; in the community setting it's the norm. One thing that may be of assistance is that when a community treatment order is issued for individuals in the community, one of the things it must identify is the person responsible for supervising that community treatment order. I think the intention and hope is that if you are a health care professional/provider or even a community support provider providing supports, if you have concerns or things that you think need to be conveyed, you're actually expected to convey those to that psychiatrist, that physician responsible for supervising the CTO. I'm not sure if that helps, but in case it does.

The Chair: Thank you.

Ms McKitrick.

Ms McKitrick: Yeah. That's helpful. I guess the concern is that very often that psychiatrist is not very available, and it may be that the person who should be supervising is another health care professional. I think that's the issue that to many is becoming apparent when we're talking about mental health. I guess the intent around this motion is – and we talked about it a little bit, again, in the committee when we talked about an earlier motion, when we brought in the definition and tried to include nurse practitioners and psychologists – just to ensure that we don't limit the ability of someone to get better because we're not ensuring that we're including all of the persons who are more likely to deal with that individual in their care plan or in the decision-making. As someone who's worked a lot in social services, it's all sometimes not – even though the team approach and so on is what we hope for and what our approach is, it always depends on the person who is entitled legally to deal with this. I guess the concern was that we may not be involving the person who should be involved more appropriately in the care of the patient and the decision-making.

The Chair: Thank you.

Ms Bailey: Madam Chair, may I just give one additional piece of information?

The Chair: Absolutely. Go ahead.

Ms Bailey: In the community treatment order regulation currently it requires a physician to be responsible for supervising it. It doesn't need to be a psychiatrist, but it must be a physician. Just so you know, if you wanted to make some recommendation or suggestion to expand that beyond physician, again, the restriction right now is in the regulation as opposed to the act.

Ms McKitrick: Just so I'm clear, it would have to be in the regulation that we expand the definition to include others?

Ms Bailey: Yes. Well, the act says that you need someone responsible for supervising "in accordance with the regulations," and currently section 3 of the community treatment order regulation is what specifies that it must be supervised only by a physician. If you wanted it expanded beyond physicians, it would be this section of the regulation that would need to be amended.

Mr. Koenig: Just as a point of clarification for the committee, it's my understanding that a motion has already been carried relating to expanding the definition of health care professional as it's set out in the regulation, so that would deal with health care professionals in terms of community treatment orders, not necessarily, like, discharge support. I would just maybe suggest that if there was a specific focus on that discharge support, that was a bit separate from the process of issuing or renewing the CTOs. That might require something slightly different.

11:50

The Chair: The motion is specific to a patient discharge.

Madam Clerk, if you could read the motion.

Mrs. Sawchuk: Okay. That

> the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to broaden the definition of health care professionals able to administer care after the patient is discharged to include nurse practitioners and other professional health care practitioners.

The Chair: Go ahead.

Dr. Massolin: Thank you, Madam Chair. I'm not certain – and perhaps we can get guidance from our experts at the end of the table here – but perhaps what is necessary here is an amendment that would stipulate that the regulation, this community treatment order regulation, is the instrument to be amended. Perhaps that would help.

Thank you.

Ms Bailey: I think I misunderstood MLA McKitrick's suggestion. I think you're speaking to what can be done by whom after a patient is discharged. I'm not aware of any sections in the act that currently set any requirements about that if we're talking about discharge of a formal patient from hospital. Is what you're suggesting a requirement that certain supports be in place, or is it a sharing of information concern, kind of related to the earlier discussion we had?

Ms McKitrick: It's both sharing of information and ensuring that patients who live outside of the main urban centres are not limited in the care that they can receive because the health care practitioners in that setting are not doctors or psychiatrists but may be a nurse practitioner in a remote reserve or may be a nurse practitioner in a small community, or they may be a social worker with mental health training. Knowing that access to a physician or a doctor may only be done, at the most, remotely – I've been really struck by the limitation of access to the limited supply of psychiatrists and doctors in parts of our communities.

Ms Bailey: Thank you. I think, if I've understood you, currently this legislation doesn't deal with access to services generally in the community. It's quite restricted to the kind of powers, duties with respect to other formal patients, patients under a community treatment order. So that would be beyond the narrower scope of the work of the committee, but it could fall into the category of other issues raised.

The Chair: Go ahead.

Dr. Massolin: Thank you, Madam Chair. Perhaps Ms McKitrick is suggesting sort of a policy change, that the committee urge the government to include such supports for patients being discharged under involuntary admission or something to that effect.

Ms McKitrick: I guess my concern was that if somebody is discharged, wherever they are, whatever health care practitioner that is qualified in their community can access the information and has a right to provide information back to the psychiatrist or whomever and that that is not something that is prevented from happening. I'm really thinking of the workers at the Boyle Street centre, for example, who probably have the closest rapport with people who have mental health problems, and I just want to make sure that the information that they provide is taken into account.

The Chair: Thank you.

Mr. Koenig: Would it potentially be helpful for the committee if the clerk could read out the motion that was carried earlier this morning in regard to disclosure of information on discharge?

Mrs. Sawchuk: Is that the disclosure motion by . . .

Ms Robert: It was Mr. Shepherd's motion about notification.

Mrs. Sawchuk: Oh, yeah. Moved by Mr. Shepherd that

> the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to ensure that health care professionals notify not only the patient's family physician but should, when appropriate, also notify the other appropriate medical practitioner and health facility as well as family members providing primary care or supports.

The Chair: Thank you.

Mr. Yao: To clarify Ms McKitrick's concerns, I wonder if Alberta Health could provide some information on the follow-up that patients do receive. Some are released outright; others are placed into care or have continued social supports. Is that correct? Is it a wide spectrum of situations that aren't currently addressed in the current process?

Ms Miller: Yes. There are a variety of outcomes when someone is discharged. They may be connected with a community mental health clinic. There's a network of over 90 of those across Alberta, that have multidisciplinary teams. They may continue to have one-on-one sessions with a psychiatrist who is providing their care.

I think what you're talking about – probably the broad parameters for this are in section 49(1) of the act, which talks about the powers of the minister and speaks to having available to Albertans services that may prevent further decline and mental disorder and distress. They're also for promoting and restoring health, and it makes mention of services like community residential services, clinical services in the community. It's really how Alberta Health Services provides mental health across the zones that we have in the province.

Much of the act deals realistically with involuntary patients and what the powers are to certify someone and the rights available to them, and then it speaks to people on community treatment orders. There's kind of this section 49(1), which is this broad catch-all speaking about a lot of other mental health services that are going on for what we would consider voluntary patients, either in the facility – they're not certified as formal patients – or that support and follow-up that they have in the community.

As part of that network of service delivery, you know, sort of supplementing what Alberta Health Services provides – you're right – there are a variety of agencies like Boyle Street Community Services. I would hazard to say that some of the inner-city shelters provide services. The Canadian Mental Health Association is a provider. The act doesn't set a lot of rules around those services, but they are part of this broad network of what is going on in Alberta to meet the needs of those with mental illness.

The Chair: Thank you.

Mr. Yao: So on the follow-up: this motion might be redundant because the supports are already there for the people that need it, and there is follow-up, and no one is just left falling through the cracks?

12:00

Ms Miller: Of course, there is always room for improvement. We also know that we're in a situation right now with fiscal resources being tight. Certainly, I think efforts are made upon discharge. Is it a perfect system? No. But there are efforts to do that referral to community-based services, and those are kind of the pieces that are captured in this section 49(1) of the act.

Mr. Yao: So it is in place. There are supports there, so this might be a redundant motion, possibly?

Ms Miller: You know, I'm not a lawyer, so I can't weigh in on that. But we do talk about having a system that includes facility-based services, a system that includes services in the community, and as part of that, the importance of those community-based organizations and NGOs, the importance of the support they get from family and friends. There is both formal and informal support. Yes, services exist. Do they meet every need of every patient or client? We all know that they don't. There is certainly room for improvement, but services are definitely out there in the community.

The Chair: Thank you.

Mr. Koenig: It may be helpful for the committee to keep in mind or consider that the review is to the Mental Health Amendment Act, 2007. In terms of that, section 49(1), the powers of the minister to create programs, was not included in the amendment act. I believe there were some other subsections dealing with other powers of the minister that were included in that amendment act, and I'm not certain if the representatives from Alberta Justice would maybe like to touch upon those powers that were included in the 2007 amendment act. It may be helpful to just keep that in mind in terms of scope and how this may fall within the mandate of the committee.

The Chair: Thank you.

Ms Bailey: The only section in the Mental Health Amendment Act, 2007, that dealt with the minister's powers was an addition to section 49, and it was the addition of subsections (2) and (3). Those subsections spoke to the minister being able to designate individuals as health professionals for the purposes of this act in circumstances where there were no psychiatrists or physicians available. That related to the issuance, et cetera, of community treatment orders or the issuance of an apprehension order for someone under a community treatment order. Those were the sections that were added at the time.

The Chair: Thank you.

Ms McKitrick: It appears that a lot of the intent of this motion was in a previous motion around information and that we've now clarified there is the possibility of more medical and social practitioners that can be involved in the provision of services after discharge. It's really what happens after discharge and who has access to the information and who also provides information that is crucial to the health of these patients.

The Chair: Thank you.
Mr. Shepherd.

Mr. Shepherd: Yeah. I appreciate what Ms McKitrick just had to say there and the clarification we received from the expertise present. I thank everyone for their contributions.

I'm wondering if we might want to just consider, then, maybe amending this motion. The main concern that I'm seeing here appears to be regarding discharge supports and ensuring that there are appropriate supports available in the community when individuals are released. So I would like to maybe move an amendment that would recommend that the Mental Health Act be supported by having available on discharge services provided by all appropriate health professionals to support individuals in remaining in the community.

The Chair: Is it possible to have that e-mailed to us?

Mr. Shepherd: Absolutely. Sure. Just give me one moment. I was sort of freelancing there a little bit. I'll arrange my thoughts here a little bit more clearly.

The Chair: Thank you.

Mr. Yao: I'm not interested in making legislation for the sake of legislation. Based on what counsel has said, it sounds like the supports are already there. There is a system in place. The intent of Member McKitrick was excellent, but I think the issue might already be addressed and we could possibly scratch this.

The Chair: Well, we have an amendment on the floor at this point, so we need to deal with the amendment first, and then we can look at a motion.
Thank you.

Mr. Yao: Sorry.

The Chair: That's okay.
Are members okay if we call the question? [interjection] Sorry. We're just going to read it out once we get it.
Is there anyone on the phones wanting to contribute to the discussion? No one?

Ms Woollard: I think that the amendment is good in intent. I do wonder if really both the original motion and the amended motion are somewhat avoiding the issue of resources and access to resources in all the various areas of Alberta being, you know, kind of the crux of the problem of after discharge care.

The Chair: Thank you.

Mrs. Sawchuk: The amendment by Mr. Shepherd is that
> the Mental Health Act be supported by ensuring the availability upon discharge of services provided by all appropriate health professionals to help individuals remain in the community.

The Chair: Any discussion on the amendment?

Mr. van Dijken: I guess the amendment adds to the vagueness of the whole intent of what's trying to be accomplished here. I do believe that we are getting into a position where we're really stretching ourselves beyond what the act is meant to encompass, and I would suggest that this will not necessarily lead to any good direction for development of a report with regard to improving the act itself. A lot of this appears to me to be more with regard to the application of the act in the field, and I don't think the act is meant to be that prescriptive.

One thing that really needs to be noted here is that every individual also has rights for their information to be protected, so we're moving into an area, I believe, that is possibly going to skirt the rights of those individuals by making information available to others that is not necessary.

The Chair: Thank you.

Anyone else wanting to contribute to the discussion of the amendment?

Hearing none, I'll call the question. All those in favour of the amendment, say aye. All those opposed, say no. Motion carried.

Now to the motion as amended.

12:10

Mrs. Sawchuk: Do you want me to read it in?

The Chair: Yes, please.

Mrs. Sawchuk: That the Standing Committee on Families and Communities recommend that the Mental Health Act be supported by ensuring the availability upon discharge of services provided by all appropriate health professionals to help individuals remain in the community.

The Chair: Any discussion on the amended motion?

Mr. Yao: Again, I believe we're just trying to write legislation for the sake of legislation. I believe this is already implied in this, so that will reflect my vote on this. I do think it is implied in the Health Professions Act even, that they don't outright release people without supports in place.

I don't know if Alberta Health can confirm or deny that, that each case is on an individual basis. Do we need to legislate this to tell you to do your job?

Ms Miller: You know, certainly, the discharge plan and the intent for someone in the community who is no longer being served is that they will be supported by a multidisciplinary team. It's kind of the essence of having a mental health system.

The Chair: Thank you.

Anyone else?

Ms Bailey: This is not an opinionated comment on the motion that's on the floor. It might be that while the intent is to say, "Government, you must make resources and funds available to support people properly in the community," I would just suggest keeping in mind that if it is ensuring that those supports are in place, you may have situations where you have a formal patient who doesn't have supports in place to go to but may well wish to get out of the hospital at the end of the treatment period that's been deemed necessary for that individual. Again, it's just a bit of a balancing act. That's just with a focus on the word "ensure" at the moment.

The Chair: Thank you.

Anyone else wanting to contribute to the discussion on the amended motion?

Mr. van Dijken: Yeah. Again, I would refer back. I believe that this motion is getting way too prescriptive and too deep into the weeds. I think that although the intent is good, there's way too much broadness in the scope of this. Even the definition of "in the community": what does that mean? Does that mean within the community of a certain region, of the whole province? There's a lot of ambiguity within this motion, that does not give clear direction to those that will be putting together a report on the committee's recommendations for the amendments in this act. So I would be opposed to this motion.

The Chair: Thank you.

Any other members wanting to discuss the amended motion?

Mrs. Pitt: While I agree that the intent of this motion is admirable, extremely – I think we all recognize the need for that – I think that Justice or Health has said that this is already something that should exist in our health system as a complete health care system. I think this is a little bit redundant, and I wouldn't support this motion.

The Chair: Thank you.

Any other members wishing to contribute to the discussion?

Ms Robertson Baker: Just one comment about what we've seen from some of the patients, our clients. Some of them are discharged very quickly. Perhaps they're under a single admission certificate, 24-hour hold, and a second certificate isn't issued, so they can leave the hospital after expiry of that 24-hour hold or sooner if the doctor cancels it. The other thing that could happen is that they could go in front of the review panel, and the review panel cancels the certificate. When they no longer have the formal status, then they're considered voluntary and are free to go. So sometimes the good intent of having appropriate discharge planning in place doesn't happen because of how quickly a person can get discharged.

The Chair: Thank you.

Any other members wishing to discuss the amended motion? I would ask the clerk to read the motion as amended.

Mrs. Sawchuk: Moved by Ms McKitrick that

> the Standing Committee on Families and Communities recommend that the Mental Health Act be supported by ensuring the availability upon discharge of services provided by all appropriate health professionals to help individuals remain in the community.

The Chair: Thank you.

I will call the question. All in favour of the amended motion, say aye. All opposed, say no. Motion carried.

Mr. van Dijken: Chair, could we get a recorded vote on that, please?

The Chair: Okay. Yeah. This time we can absolutely do it. In future votes I would ask that members request a recorded vote prior to voting.

I will start with the members present in the room, to my right.

Mr. Yao: Against.

Mr. Horne: For.

Ms Woollard: For.

Ms McKitrick: For.

Mr. Hinkley: For.

Mr. Shepherd: For.

The Chair: On the phones.

Ms Luff: For.

Dr. Swann: Against.

Ms Jansen: Against.

Mr. van Dijken: Opposed.

Mrs. Pitt: Opposed.

Drever: For.

The Chair: This motion is carried. We have seven for the amended motion and five against.

Our next issue up for consideration is information sharing. Mr. Hinkley, if you could identify where the issue is in the document, please. Thank you.

Mr. Hinkley: Yes. I would like to propose two motions. This is with regard to information sharing on page 8, item 2(a). We're looking at information sharing as an impact on patients. We read many times in the written submissions and we heard oral presentations about the issue of information sharing, particularly from the Edmonton Police Service.

Now, we have the concerns about legal and ethical implications of information sharing and respecting patient confidentiality. However, in the presentation from Chief Knecht he often brought up that many of the health care workers are reluctant to share information with police because of perceived liability issues. Many of the workers were concerned that they would be sued or lose their job if they released the medical information. So I'm looking for some clarity on this.

Before I make those proposals, I just want to read Chief Knecht's statement about shared information and the conflict, the problem that the police have.

> 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 the 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.

12:20

So there seems to be some unclarity. Although the legislation says that this can be done, the workers who have that information maybe do not feel they have the responsibility of allowing that. They are concerned about confidentiality. They are concerned about their liability.

I would like to propose that the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to clarify when and how the sharing of patient information regarding a patient's discharge is allowed with health professionals other than the family physician.

The Chair: Thank you.

Ms Robert.

Ms Robert: Thank you, Madam Chair. Just to clarify for the committee, I know Mr. Hinkley was talking about this issue being raised on page 8 of the document, issues on release from involuntary admission, information sharing. I'll just also point the committee to page 15 of the document, item (d), which talks about information sharing with respect to CTOs. As I understood the information that came from the EPS, they were talking about the restrictions on sharing information regarding the issuance of CTOs as opposed to release from involuntary admission and talking about the fact that

> current restrictions on sharing information regarding the issuance of CTOs with law enforcement limit the "effectiveness of joint efforts [between the police and health professionals] to screen and mitigate risks and to ensure that the police appropriately support health professionals when necessary."

Then the RCMP added that

> "the pendulum needs to move a little closer" to providing information to the police so that when they arrive at a scene with someone that has been subject of one of these orders, we're sensitive because it does significantly affect our approach to some of these incidents. If the police had more awareness while still respecting a person's privacy, this information would be very helpful to the client and to the police.
>
> EPS indicated that many health-care workers are reluctant to share information with police because of perceived liability issues ([that is,] many workers are concerned that they will be sued or lose their job if they release medical information).

Now, I just wanted to make sure the committee is clear that the RCMP's and EPS's issue with this was with respect to being given information, having information shared with them about CTOs as opposed to the discharge of a person from involuntary admission.

Thank you.

The Chair: Thank you.

Any of our guests wanting to contribute?

Ms Robertson Baker: From our clients' perspective, once again, and for some individuals who have contacted our office that don't fall under our jurisdiction, there are concerns about police information checks and information that the police have and may release when they look at information checks. There is the stigma associated with it. People have told us that there isn't necessarily a need to know. They're very concerned about the police automatically getting a list of individuals who are under a community treatment order because of their past experience. My understanding of what the police wish is that they'd be informed of whoever is under a CTO regardless of whether or not they're involved in their system.

The Chair: Thank you.

Ms Bailey: As a more general comment, if the thought is that the legal provisions are already there to share this information appropriately and it's a matter that we would like to replicate some of that in the Mental Health Act, my advice would be: don't replicate unless you need to or you're doing something a little differently. The legislation is complicated. Most of our rules about the handling of health information are currently contained in the Health Information Act. It is already a lot to get up to speed for health care professionals, police officers, and others.

When you duplicate, you have, I guess, a few risks associated with that. One is just administrative. If you want to make changes to the rules, so to speak, you're amending not just one act but multiple acts, depending on where those different rules simultaneously exist. Just for the sake of duplication, I'm not sure that any clarity is going to be added for people by duplicating sections that already are in another piece of legislation primarily focused on how to appropriately handle people's personal health information.

Following on Carol's comments about the police wanting this information, if it's just the issuance of a CTO, that could be very misleading information. "Is a person under a CTO without a consent because they may well pose a danger to others if not appropriately following their treatment?" is very different than "a

physician had a concern that their health would deteriorate unless they're under an issuance of a CTO." So I'm not sure, depending on what information is shared with the police, that it's necessarily going to be helpful to protect the public or to appropriately interact with individuals in the community.

The Chair: Thank you.

Are there any members wishing to discuss the motion?

Mr. Yao: A question to Justice and to the advocate: do these patients who have been released under community treatment orders also have an expectation that they're going to be treated in areas that are sensitive to their needs? Does it impair police when they have to deal with them in the worst situation and aren't aware of their situation? What is the advocate's stance on that aspect of it?

Ms Robertson Baker: When a person is subject to a CTO, there are conditions that they need to comply with, and if it's felt that they're not complying with those conditions, then there are provisions where someone needs to sit down and talk about the noncompliance. The concern that we have is that the police shouldn't automatically get information about people who are subject to a community treatment order. If there's a need to know, then other legislation would allow for it but not for them to automatically get this list.

Mr. Yao: How would our law enforcement get this information if there was a situation? Is there any way that they could access your office and run a name through you if there's a situation or something like that, where they can access information? Currently the police do have limited information they can get on everybody. They usually just literally have someone in the office surfing the Internet looking for that sort of thing. But are there some more defined ways that they could identify these people when they do need supports; I mean, when they're under a community treatment order? Maybe you can redefine that for me because I'm starting to get a little bit of a vague understanding of that. That could be anyone from someone who truly wants to harm themselves to someone with pedophilia. Can you clarify this for me?

Ms Robertson Baker: To give you an example of someone who might be under a community treatment order, it could be somebody who is living with schizophrenia and who has met the criteria to be issued the CTO. They've been in hospital, go back into the community, go off their medication, fall ill again, go back into hospital, get stabilized on the medication. So it's to ensure that the individual has the supports to remain in the community successfully. To automatically provide the police with a list of individuals who are subject to a community treatment order, from my perspective, increases the stigma associated with living with a mental illness.

As far as the police needing to know when they encounter someone in the community, to find out whether or not they have a CTO, they definitely cannot contact our office because we wouldn't have that information. I couldn't really respond on how they could determine if the person is subject to a CTO.

12:30

Mr. Yao: To follow up again, so they arrest someone who is acting incoherently. They bring him into the cells. They don't know anything about this patient's condition. Do they get crucified, then, for subduing someone with a mental illness?

Because the stigma thing – I have to be honest with you. I'm very sensitive to that issue. In my previous life, working with lots of medical patients, they wouldn't tell us if a patient had HIV or AIDS, yet we'd be transporting them in long-term transport from, say, Fort McMurray to Edmonton or St. Paul or someplace. Obviously, we used proper PPE and whatnot, but that nurse didn't feel confident to give us the information because she wasn't sure whether she could give us that, yet we were exposed to those very same things. It was a concern about the stigma of having HIV or AIDS. But as a medical professional on the other end who's transporting that patient who's exposed to that, I had a concern about that.

So there are two sides to these aspects, and I just want to make sure that we're not so concerned about the stigma as worried about the actual treatment of the patient or the individual and not worried about their feelings so much as truly treating their situation. Do we impair police with this because of a stigma?

Ms Bailey: I think you raise a very important issue, but it's an issue where someone such as the police or a health care provider might be put at risk in dealing with an interaction. Is there information that they may be appropriately provided with to know that they can then handle a situation in a better way? One of the issues that I see with just giving police a list of individuals under a CTO is that it doesn't tell them anything about that individual and why they're under a CTO – many people under CTOs will pose no risk of harm to anyone but perhaps themselves – so then do you set up an encounter between police and this individual that is inappropriate from the beginning of the encounter, I guess? Where there's a risk and people are aware of that risk, there are already legislative sections that allow for the sharing of that information.

Mr. Yao: So there's a process in place for them to identify if there is an issue, or do they go into this blind? Like, I'm vague on this. The police have asked for some way to access the information. Recognizing all the various idiosyncrasies of each situation, is there any way that we can address their concerns?

Ms Bailey: Did you get a better idea of the purpose of accessing the information? I think that's been in part commented on: for what purpose? The purpose does matter as to why you would want to enable them to have additional access if needed.

The Chair: Thank you.

Perhaps, Ms Robert, you could contribute your understanding. Is there something specific that the police identified?

Ms Robert: Thank you, Madam Chair. Only that they feel like they go into situations blind sometimes and that it would be helpful for them if they were alive to and aware of the fact that the person that they're about to arrest, who's, like – I think they kind of talked about: "You know, we go to arrest someone. Something bad is potentially going on, so the situation is not great. The more information we have to be able to deal properly and appropriately, the better."

Thank you.

The Chair: Thank you.

Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. I appreciate the discussion that we're having here. I think that this is an important discussion as well. Certainly, as Ms Robert noted, it is something that was brought forward by the stakeholders from the police. However, the motion that we're considering right now does not in fact address that. It's simply addressing the sharing of patient information on discharge with health professionals other than the family physician. I can appreciate the concerns being discussed about police interaction and providing that information to those individuals, but

as it's not part of the motion right now, that's perhaps something we could address in a separate motion.

Thank you.

The Chair: We're going to have the clerk read the motion again.

Mrs. Sawchuk: Moved by Mr. Hinkley that

> the Standing Committee on Families and Communities recommend that the Mental Health Act be amended to clarify when and how the sharing of patient information regarding a patient's discharge is allowed with health professionals other than the family physician.

The Chair: Any further discussion on the motion?

Hearing none, I'll call the question. All those in favour of the motion, please say aye. Any opposed, say no. Members on the phone, you can't abstain, and I only heard one member vote. All those in favour of the motion on the phone lines, please say aye. Thank you. All those on the phone lines opposed, please say no. Thank you. Motion carried.

That's all I have identified on – oh, sorry. Mr. Hinkley has a second discussion.

Mr. Hinkley: Sorry to keep everybody here longer, but I do have one more motion. I move that the Standing Committee on Families and Communities' report reflect the need to increase measures to educate and raise awareness among health care and community workers about the legality of information sharing in order to facilitate communication and improve care.

The Chair: Thank you.

Ms Robert.

Ms Robert: Thank you, Madam Chair. I wonder if I could just ask Mr. Hinkley: are you referring to an information sharing proposal in the issues and proposals document, and if so, would you mind just identifying which one, please?

Thank you.

The Chair: Thank you.

Mr. Hinkley: Yeah. Good question. It's not so much a specific proposal. We're recommending in this motion that the health care and the community workers be informed of their right to share that information and that they will not be fired or held liable in any way.

The Chair: Thank you.

Go ahead.

Ms Robert: Thank you, Madam Chair. Just to be really clear, are you talking about the issue we were sort of talking about before, about health professionals feeling comfortable that they can share information with respect to CTOs with police officers?

Thank you.

Mr. Hinkley: Yes, both the CTOs and discharge, as in the previous motion.

Ms Robert: Okay. Thank you. In that case the piece with respect to CTOs is on page 15, and it's proposal (d), with respect to information sharing. That proposal has nothing to do with involuntary admission. The proposal with respect to involuntary admission is not in this document, so I can't really speak to it. The one with respect to CTOs, I think, we've already spoken to, with respect to health professionals feeling that they might be liable, might lose their jobs or be sued if they share information with respect to CTOs with the police.

Thank you.

The Chair: Thank you.

Any of our guests wishing to contribute?

Ms Bailey: Well, it sounds like an excellent suggestion. Is it an amendment to the act that is being recommended? To me, it's a recommendation around education and training, not that that means it's not worth while to record, of course.

The Chair: Thank you.

Mr. Shepherd: From what I heard of the motion there, it doesn't sound to me like – and Mr. Hinkley can correct me if I'm wrong – he's recommending a specific amendment to the act so much as just simply that the report reflect that this is feedback we've heard from stakeholders, that it's a concern, and that steps should be taken to perhaps increase education to ensure that people understand the operation of what's already available through the act.

The Chair: Thank you.

Any other members wanting to contribute to the discussion on the motion proposed?

Hearing none, I'll call the question. I'll have the committee clerk maybe read it out one more time.

Mrs. Sawchuk: Moved by Mr. Hinkley that

> the Standing Committee on Families and Communities' report reflect the need to increase measures to be taken to educate and raise awareness among health care and community workers about the legality of information sharing in order to facilitate communication and improve care.

The Chair: Thank you.

All in favour of the motion, say aye. Any opposed, say no. Motion carried.

At this point I don't have any other members identifying issues that they would like to discuss. I would like to give the opportunity for any additional members to come forward if there are any issues that they would like to discuss.

12:40

Dr. Swann: As was suggested by one of the human rights lawyers at the last meeting, I'd like to make an amendment to enable individuals under a treatment order to appeal for judicial review. As indicated, there's very little outside of the mental health review panel. There's no opportunity to review the process that was followed and whether it followed proper legal and human rights principles, so as a last resort an individual who wanted to be released from a treatment order could appeal to the courts and have judicial review. I think that's an appropriate amendment to the Mental Health Act.

The Chair: Thank you, Dr. Swann.

Ms Robert, please.

Ms Robert: Thank you, Madam Chair. The issue that Dr. Swann is referring to, I believe, is located on page 16 of the document, item 5(a), the process for judicial review. He's, I think, referring to the written submission and oral presentation of Mr. Jason Morris, who is duty counsel for the mental health review panel in northern Alberta, I think. The proposal from Mr. Morris is:

> Section 43 of the Mental Health Act should be amended by 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.

Now, I can tell you what Mr. Morris said. I can't tell you if what Mr. Morris said is accurate or not accurate because I'm not a lawyer. But I can tell you what he said if you would like me to.

The Chair: Thank you. Go ahead.

Ms Robert: According to duty counsel for the mental health review panel

> there is already a mechanism for judicial review of a panel's decision [in section 43 of the act.] . . . [Such a review is] 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.

If available,

> judicial review would allow us on a case-by-case basis to ask that question [of the process used in] individual hearings, and the answers would educate our mental health review panels on what the law is and how it ought to be interpreted.

According to Mr. Morris in Ontario

> the availability of judicial review is not an issue in [their legislation] . . . because the way that their appeal provisions are drafted, they don't . . . impliedly prohibit it.

The proposed amendment

> would make it clear that . . . 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 [would] achieve procedural fairness [in the act].

Thank you.

The Chair: Thank you.

Are any of our guests wanting to contribute?

Ms Bailey: I think that Mr. Morris has raised some important concerns. It is my opinion, at least, that the act does not need to be amended.

The first comment I'll make is that section 43 of the Mental Health Act does not provide for judicial review; it provides for an appeal. Now, this is a bit technical, but there is a legal distinction between a right of appeal and seeking judicial review by a court. Government often sets up in pieces of legislation what it considers appropriate appeal mechanisms of a decision and what powers exist on an appeal, et cetera. The ability to have a court undertake judicial review of a decision of an administrative tribunal occurs under different legislation in Alberta – we've got legislation; we've also got something called the *Rules of Court* – so it is available to legal counsel to apply for judicial review of a decision in this instance. That's just a bit of a distinction.

I don't think it would be necessary to add to section 43 to make it clear that judicial review is available. There's a large body of administrative law that speaks to when it's appropriate to have something judicially reviewed and when it's not. It's also possible, actually, to pursue both at times in the same instance.

In terms of some guidance for review panels in terms of how to make decisions, it is true that we do not have a lot of reported case law in Alberta. That's for a couple of reasons. One is that when mental health review panels here make decisions, those decisions are not published. Now, in some Canadian jurisdictions they are, so those decisions are publicly available, and anyone could read them and see: what process has the review panel undertaken? However, when decisions are appealed to the court, unless there is a special order, which would not occur often, those decisions are publicly available.

As an example, we have a case that we reviewed last week. It's a 2015 decision from the Court of Queen's Bench of Alberta in which the justice of that court was in fact reviewing a decision by a review panel, and it wasn't restricted to looking at the decision itself and whether it was the right decision or the wrong decision. Justice Eidsvik in this case actually spoke to the process and the things that were considered and spoke to what was appropriate, what wasn't appropriate. While guidance is limited just because there are not a lot of Court of Queen's Bench cases in Alberta, there is guidance available if people seek it out.

I guess I'd make one last comment, and that's on constitutional issues. It is also possible to challenge the constitutionality of a section of the Mental Health Act. Again, there's Alberta law and process about how one does that.

In short, I would say that all of those things are currently available under the law of Alberta.

The Chair: Thank you.

Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. Well, I think Ms Bailey pretty much answered the question I sort of had. It sounds like a process is in place. The means are there. It was my understanding that the right of appeal must occur first, and then a decision is made before judicial review would be initiated. Is that correct?

Ms Bailey: Normally you exhaust your appeal process before you apply for judicial review. If I understood the concerns of Mr. Morris correctly, I think he was concerned about: well, what if judicial review was more appropriate? On the other hand, an appeal under the act is going to happen a lot more quickly, which would be, I imagine, an important thing for an individual who's appealing, for example, a declaration that they're incompetent or that they're being held in hospital against their will under certificates.

A judicial review process is a much more time-consuming process. That doesn't mean that it's not important to pursue at times, but to substitute that for an appeal probably isn't in many cases going to serve the individuals that counsel is actually trying to the best of their ability to represent.

Mr. Shepherd: If I understand you correctly, there is nothing currently in the legislation which is an impediment to anyone being able to access judicial review.

Ms Bailey: Not that we're aware of. Now, we're happy to take a more in-depth look at that if that would be of assistance to this committee, but that would be our general summary of the law at the moment.

Mr. Shepherd: Thank you.

Ms Robertson Baker: Another avenue or recourse available to the patient, that we have referred individuals to, is our understanding that if the patient doesn't apply to the Court of Queen's Bench within that 14-day window of opportunity for a review of the review panel's decision, then they can certainly lodge a complaint with the Ombudsman, who may be able to do an administrative review. That's something else to consider.

The Chair: Thank you.

Go ahead.

Mrs. Sawchuk: Madam Chair, the motion by Dr. Swann is that the Mental Health Act be amended to enable an individual under a community treatment order to apply for judicial review.

The Chair: Thank you.

Mr. Shepherd.

Mr. Shepherd: Thank you, Chair. While I appreciate Dr. Swann's interest in what was raised by Mr. Morris, from what we've heard from Ms Bailey, I don't see that this is necessary. There does not appear to be any impediment. There does not appear to be anything blocking an individual from accessing judicial review, and the other elements that are involved in the process pretty much fall outside the realm of this act. I don't think this is something that we need to be concerned with addressing here.

Thank you.

The Chair: Thank you.

Any other members wishing to contribute to the discussion on the motion?

Dr. Swann: Could I ask legal counsel if there are time constraints on this appeal and if there are significant costs associated for the client or the patient?

Ms Bailey: In terms of timing for the appeal that's currently available under section 43 of the act, there are deadlines, so to speak, to meet in terms of filing for appeal. I think Ms Robertson Baker spoke to some of that. Some of them apply to the giving of notice. For example, in section 40 of the act, on receipt of an application for certain appeals a review panel – oh. Sorry. Notice of hearing. Am I looking at the review panel section?

12:50

An Hon. Member: Section 43.

Ms Bailey: Thank you. I'm looking at the wrong section.

One of the sections talks about: "Within 14 days after the receipt of an order or a written decision of a review panel . . . the applicant or formal patient may appeal the order or decision to the Court of Queen's Bench." So there is that time reference that, as I say, Ms Robertson Baker already referred to. There are also notice provisions, I believe, in addition to that. There's another section that talks about who notice shall be served on. You have "not less than 15 days before the application is returnable" to make sure that that happens.

There are some fairly short timelines, but I would say that at least it was an attempt to appropriately balance enough time for people to prepare for the appeal versus dealing with it in an expedited way given that the person's rights, et cetera, are being impinged upon.

In terms of: is it expensive, et cetera? I mean, we can thank people like Mr. Morris, who serve as duty counsel for individuals that have to appear in front of review panels, et cetera, and there is a certain amount of government support for funding of legal aid. It's definitely an important practical issue for access to the justice system in terms of if you can retain appropriate legal counsel, whether it's to appear in front a review panel, to appeal a decision. I'm not personally up to speed as to, you know, how much particular support is provided for those types of applications. That's certainly something we could look into.

The Chair: Thank you.

Dr. Swann: That's very helpful. Thank you.

The Chair: Are there any other members wanting to contribute to the discussion on the motion?

Hearing none, I'll call the question. All in favour of the motion, please say aye.

An Hon. Member: Sorry. Can you read that again, please?

The Chair: Sorry. There's been a request to read the motion.

Mrs. Sawchuk: Motion by Dr. Swann that

> the Mental Health Act be amended to enable an individual under a community treatment order to apply for judicial review.

The Chair: Thank you.

Mrs. Pitt: Can I ask for a recorded vote?

The Chair: Absolutely. There's been a request for a recorded vote, so I will go around the table and then to the phones, requesting that members identify if they are in favour of the motion or opposed, starting to my right.

Mr. Yao: Aye.

Mr. Horne: Opposed.

Ms Woollard: Opposed.

Ms McKitrick: Opposed.

Mr. Hinkley: Opposed.

Mr. Shepherd: No.

The Chair: I will now go to the phones.

Dr. Swann: Support. Thank you.

Ms Jansen: Opposed.

Mr. Smith: Support.

Mrs. Pitt: In favour.

Drever: Opposed.

Ms Luff: Hey. Sorry. Did you miss me?

The Chair: Ms Luff?

Ms Luff: Yes. Sorry. I was muted. Against.

The Chair: Thank you.

This motion is defeated as we have four in support of the motion and eight opposed to this motion.

Mr. van Dijken: Chair, did you get my in favour?

The Chair: No, we didn't. That would make it eight to five, so this motion is defeated.

Are there any other issues that a member would like to bring forward for discussion? Any on the phones?

Hearing none, I will move to the next item on the agenda, the directions for the draft report. I believe we've completed our work with respect to the issues identified and have passed motions where required for inclusion in our report. During this process we have also provided the background information necessary for LAO committee staff to begin drafting a report for the committee's consideration at its next meeting.

Dr. Massolin, could you speak to the usual process that follows?

Dr. Massolin: Yes. Thank you, Madam Chair. The usual process is that we as research services are tasked with the preparation of the

committee's draft report. It's your report. We draft it. The drafting of that report will be based on the resolutions arrived at by the committee today, surrounded by some contextual information; in other words, how the committee came to those resolutions. We'll also provide some background information on the committee process, what the committee did in terms of hearing from stakeholders and other interested parties during the course of its review. We will draft that report and then prepare it for posting so that at the next committee meeting, which I believe is on June 30, the committee can go about the process of approving the report, which will ultimately be tabled in the Assembly, as mentioned.

Thank you.

The Chair: Thank you.

Mr. Koenig, do you have anything that you would like to add at this point?

Mr. Koenig: No.

The Chair: Thank you.

Would a member move that

> the Standing Committee on Families and Communities direct committee staff from the Legislative Assembly Office to draft a report respecting the committee's review of the Mental Health Amendment Act, 2007, which incorporates the recommendations and motions approved at the June 20, 2016, meeting for the committee's consideration at its June 30, 2016, meeting.

Moved by Mr. Yao. Thank you.

Any discussion?

Seeing none, hearing none, we'll call the question. All in favour of this, please say aye. Any opposed? Carried.

Are there any other issues for discussion before we conclude our meeting? No one on the phones?

As noted, we will reconvene on Thursday, June 30, from 9 to 10:30 a.m.

I'll call for a motion to adjourn. Moved by Mr. Shepherd that the meeting be adjourned. All in favour of the motion, say aye. Any opposed? Thank you. The motion is carried. This meeting is adjourned.

[The committee adjourned at 12:59 p.m.]

Published under the Authority of the Speaker
of the Legislative Assembly of Alberta