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The 31st Legislature
First Session

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Day 103

The Honourable Nathan M. Cooper, Speaker

Legislative Assembly of Alberta
The 31st Legislature
First Session

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Legislative Assembly of Alberta

7:30 p.m. Tuesday, April 29, 2025

[Mr. van Dijken in the chair]

The Acting Speaker: Please be seated.

Government Bills and Orders
Second Reading
Bill 53
Compassionate Intervention Act

The Acting Speaker: The hon. Minister for Mental Health and Addiction.

Mr. Williams: Well, thank you, Mr. Speaker. I'm very pleased today to be able to move second reading of Bill 53, Compassionate Intervention Act, here in the province of Alberta, which will be the first of its kind not just in Alberta, in Canada but from what I can tell across the world with the wraparound services we have and a full, integrated recovery model associated with it.

Mr. Speaker, the reason for compassionate intervention is plain and clear. Albertans see every single day in their families, in their communities, on the streets, whether it be Peace River in my constituency or we talk about downtown Edmonton and Jasper Avenue or Stephen Avenue in Calgary and most every community in between. When it comes to the tragedy and the public addiction crisis, it is on full display in the province of Alberta.

We have a serious heart and also a mandate to address this crisis, to address it in health care reform that brings care and compassion back to those who are suffering because every single Albertan deserves an opportunity at recovery because recovery is not only possible, Mr. Speaker, it is probable. It's more probable than not.

We need to facilitate and play the role as government to be a convener, a policy builder, and bring together not-for-profits, our health care authorities and of course the wider society, law enforcement, and all sorts of other parts of civil society in order to get care to those who suffer.

Mr. Speaker, the tragedy of addiction is on full display. This deadly disease is merciless, and it permeates all aspects of our communities. Over 50,000 Canadians' lives have been lost by drug overdose over the last decade, so much of that tragically related to the escalation of the opioid crisis, which I want to speak more about later on. In its current incarnation it's fentanyl, but there will be other incarnations with very clever chemists and very cynical drug cartels that continue to push more and more powerful versions of opioids. As Albertans and Canadians become tolerant to the use of these incredible opioids, the potency will continue to escalate and this threat will continue. It will continue until we intervene in a way to give care and compassion back to those who are suffering.

These individuals, these 50,000 we see and 2,000-odd a year in the province of Alberta, are not simply statistics. They're family members and community members, and we care deeply about building a model that cares for them. Mr. Speaker, I spoke to a First Nation community that told me that they've gone to 400 funerals over the last three years. Every one of those funerals; a loved community member. As members of this House know on both sides of the Chamber, First Nation communities are tight knit. They have a deep sense of care for each other, and they have had just a tragic history of trauma unfolding, and it continues intergenerationally over and over again. Trauma lives in addiction, and it lives in the mourning over and over again of preventable deaths where we could find care and reach out to them. Instead, we see lives lost. That toll continues over and over again to the tune of hundreds in a small community of a First Nation with funeral after funeral, multiple a week.

Mr. Speaker, I look at one of the shelters here in Edmonton operated by an Indigenous community. They told me that 30 out of 31 days in December 2024 they had one man they revived from opioid overdoses, 30 out of 31 days in the month of December. This rips out the heart of a family member, of a community, of the shelter provider that has to revive them every single time, as it does each and every one of us in this Chamber.

The statistic that I go to most often as I talk about this is the anonymous number of one woman in Alberta who overdosed 186 times last year. That is 186 times that we have recorded with the provincial health care number. That means that there is an emergency response vehicle dispatched or they were in an emergency room in response to that overdose. As we all well know, most Naloxone that is deployed: we do not collect the provincial health care number for those individuals. It is highly likely that this woman has overdosed more than 186 times in a calendar year.

Mr. Speaker, what we are doing as a society has not worked to care for those who are vulnerable, and that is why we have stepped in as a government and built the Alberta recovery model. The Alberta recovery model is in contrast to a model that I'm going to call the Vancouver harm production model. The intention was well intended initially. The intention was to say that, at the end of the war on drugs as we came out of the '80s and we saw that these drugs, at the time heroin and crack cocaine, are too dense, too powerful, and too valuable for us to have a serious attempt at reducing the supply of drugs from foreign and domestic markets into those who are consuming it, especially in North America, especially the United States, if we're not going to be able to prohibit that consumption through the supply, then maybe we could reduce the harm of those who use. That is a noble and good intention.

That means clean needles, so that those who were using, especially in the '90s when it was intravenous injection, to make sure there weren't communicable diseases. HIV, AIDS were obviously very widespread at the time. Much has been done to curtail that, of course.

But that didn't stop there. Needle cleanups and needle exchanges continued with this philosophy of harm reduction, saying that we just have to reduce the harm and we're not about stopping the use of drugs. That is part of the function of the fallen world we live in. It will continue. We have to reduce the harm where we see it. Again, a noble intent, but again it happened in the early 2000s in Canada where it articulated into Insite or a so-called safe injection site. That idea has exploded in British Columbia and parts of Canada though not the rest of the world. Canada holds more than 50 per cent of the world's drug consumption sites; Canada alone. The world has seen this on offer from San Francisco to Tokyo and every jurisdiction in between, and they have turned it down, obviously seeing that it has not produced the acclaimed results that it said that it would achieve around reducing overdose deaths.

Of course, I want to continue digging into the data there and the results we've had in Alberta, and more news to come on that. But it didn't stop just with the so-called safe injection sites or drug consumption sites. It continued, Mr. Speaker, in this policy that had unsafe supply. That's government-funded heroin offered en masse, paid for by the government, a share between the government of Canada and local provinces. Ontario and British Columbia participated in this. Canada spent, at the federal level, close to $100 million on free, high-power, pharmaceutical-grade opioids distributed en masse to continue facilitating addiction, and it has had a predictable result. It has not reduced overdoses. It has not

reduced those who are suffering from addiction. Instead, it has just incurred more and more inclination to it.

The culture was one of despair, Mr. Speaker, instead of hope, and this is the heart of why the Alberta recovery model, I think, strikes such an important chord with family members of those who suffer from addiction, because the idea that someone will just continue to be in addiction no matter the circumstance, we just have to mitigate their slow and inevitable decline into succumbing to that addiction, eventually, given enough time without intervention, a death, and that death is one of those 400 at the funeral in the First Nation community I spoke to. That death is maybe the 31st day of December for that one individual at the shelter in Edmonton, or maybe it's the 187th overdose for that woman in Alberta, who is still alive, happily, in dear need of intervention. Without it, we will see another life lost, and that is a tragedy, a true, heartfelt tragedy.

That, Mr. Speaker, is why are we introducing this legislation, not for the average individual who suffers from addiction. Many individuals suffer from serious addiction, but that is not who we have crafted this legislation for. This legislation is for a narrow group of individuals, a narrow group of individuals who are likely, within a reasonable amount of time, to cause harm to themselves or others due to their substance use or addiction. Each one of those words in that sentence as a test, both legally and socially, narrows the scope of who we're talking about.

Of course, I want to see every Albertan have intervention, but this dramatic recourse for those who are causing harm to themselves, potentially death with cerebral hypoxia, brain damage – cerebral hypoxia is what happens when you overdose from an opioid. It's a starvation of your brain from oxygen because the lungs stop breathing, you stop respiring; therefore you can no longer pump fresh oxygen into your brain. It's equivalent to effectively drowning or suffocating in daylight with hundreds or maybe hundreds of thousands of your citizens around you.

7:40

Maybe you're at Jasper Avenue or Stephen, and those citizens don't know how to address. Though they have a heart wanting to see compassion, they do not know how to address the crisis in front of them, and they tragically step over someone's loved one in an attempt to get to work or see their family member, wanting to have some way to intervene, but not knowing because they're not equipped for this crisis unfolding in front of them daily. It sadly dehumanizes each and every one of us as we look past that individual and no longer see the dignity of somebody, made in imago Dei, but instead see an obstacle.

That, Mr. Speaker, is where we have an obligation here in this Chamber, in this Legislature to be able to provide a pathway, one where we have the resources of a health care system with a health care centred response. This is not the criminal justice response. I'm not the new sheriff in town, despite the moustache. I leave that up to my colleague, the minister of public safety. I instead remain a minister of health, with a focus on health care, healing individuals who suffer from addiction and not harming them. That is why we must bring forward compassionate intervention, and I'm proud to be reading the second reading now. In this argument, Mr. Speaker, we have done a thoughtful analysis to make sure that we continue to build out the Alberta recovery model in a continuum of care, to make sure that the compassionate intervention program works within a full continuum of health care for recovery for those suffering from addiction.

If someone is a danger to themselves or others, it can start with a family member, perhaps a parent or a police officer or a peace officer, perhaps a registered health professional or guardian can make an application. That application will be reviewed by a statutory director. If that seems like it has met prima facie analysis that it meets the criteria that I described earlier, then it would continue on to a desk application of a commissioner. This commissioner has a legal background, and they would look to see if they legally meet this criteria. At that point the commissioner could potentially order an apprehension and also a detention order for an individual. This, at this point, would now engage with local law enforcement, peace officers, Indigenous police force to make sure that we work closely most of the time, Mr. Speaker, with PACT teams that we have funded across the province, that we engage in a thoughtful way with a health professional and law enforcement to bring somebody in to see if they do meet that criteria.

Upon that person coming into custody, that's where a 72-hour clock begins, and that person is informed of their rights because we want to make sure that this is something that is above board, that is seen to be civilly reviewable by the civil courts, the Court of King's Bench, the entire process. That individual has access to defence and resources if they would like, and that 72-hour clock begins. Now, they must have a commission hearing within the 72 hours. During that period we have information gathered by the statutory director, family members, and testimony is gathered, and unless there's a conveyance issue, for example, or some other unforeseen circumstance where there could be a delay, there will be that commission hearing within 72 hours.

The commission is going to be made up of three members, Mr. Speaker, Made up of one member of the public: this will be an Indigenous member as a matter of policy. If somebody identifies as Indigenous – I am very glad to see I have already spoken to a number of Indigenous partners and they are very keen to have their elders and their community members' lived experience be a part of the compassion intervention program. The second member of that commission is going to be a health care professional, an MD or psychiatrist for example, that has a certification and specialization in addiction care. That last member is going to be the chair of the commission. The third member is going to be somebody with a legal background, a lawyer. Obviously, these reasons need to be written and defended because it's appealable through Court of King's Bench and ultimately court of appeal, et cetera.

At this point, Mr. Speaker, if the individual does not meet the standard, they would obviously be put in touch with supports and resources and community, but they would end their trajectory within the compassionate intervention program. But if the person meets the criteria, if this is perhaps an individual who has overdosed dozens of times, that is acting erratically because they're having a schizophrenic break due to perhaps methamphetamine use along with the fentanyl and this polysubstance use that we see is tragically so common, at that point compassionate intervention commission could order a treatment order.

This care plan could take one of two forms, a secure-treatment care plan or one in community for three- or six-month-length processes. The reason, Mr. Speaker, we've done that is because it's so important to focus on the data. This is an evidence-based program with evidence-based best practices, medication, and policies to bring people out of addiction and into recovery, and that recovery needs time.

I spoke to Dr. De Leon, who is probably one of the original creators of the therapeutic community, out of New York City at Phoenix House. Community is method, which animates so much of the ROSC model or, in our terms, the Alberta recovery model. This is our instantiation of it. He said so clearly, along with the data that he presented, that the longer someone has recovery supports and is living in a therapeutic community, living in true recovery – recovery is not simply abstinence but a positive, life-affirming

purpose in their life again, being a family member, a community member, a mother, and a brother again – then the more likely it's going to be long term. The longer you can get that person to treatment, the better the odds are that you have long-term recovery and low rates of recidivism, which is why, Mr. Speaker, we have three- and six-month terms that, obviously, if they're going to be renewed, need to be renewed in front of that commission hearing so that they can continue to have an appealable response.

Mr. Speaker, the process of compassionate intervention is essential. It's essential because we need to show that we are a caring, compassionate society, and the process needs to allow a health care response. We see a public health care crisis like none we have seen. I say that absolutely seriously, in the most literal sense. The lives lost and, short of lives lost, lives destroyed immediately and directly due to addiction in this province is staggering. I say this knowing that we have a very big hill to climb here. But the work we have done, adding 10,000 spaces since 2019, adding 700 spaces through our recovery communities with one-year, long-term, high-quality, best in standard, in industry recovery beds, with five of these with Indigenous partners, on-reserve for four of them: this is essential.

The virtual opioid dependency program is part of that continuum, is one of those first steps, with Sublocade and Suboxone being a part of what it looks like to see long-term recovery initiated. The technology available through some of these drugs, with opioid agonist therapy partnered with therapeutic living communities, partnered with programming for community therapy, group therapy, and individualized therapy, working with a program is incredible. The outcomes continue to show better and better rates the more we pair the best evidence around opioid agonist therapy, long-term treatment, and, of course, supports.

Mr. Speaker, I have much, much more to say around compassionate intervention, but I will come more to a conclusion, talking about the best evidence. Recently in the Canadian journal of addiction medicine there was a publication that showed there is no evidence to show that this will not work. There's no evidence to show that compulsory treatment and mandatory treatment orders don't work. We see it in all parts of the legal system already across Canada and North America dealing with the opioid addiction crisis. We see it in drug treatment courts. We see it in conditions of bail.

Mr. Speaker, the best data around this is actually when you look at industry. If you look at best practices in the airlines industry or safety-sensitive industries like medical professionals, physicians, for example, they have a compulsory condition of treatment. You will lose your licence to practise if you do not continue to remain sober, clean, and in recovery. You will lose your ability to fly a plane as a commercial airliner and your ability to provide for your family and deal with the tragic shame that is often associated with recidivism. There are consequences to actions in these industries, and those consequences are essential to a working system in recovery.

We are not building a system where we say that this is not important what happens as a consequence. That is the Vancouver harm production model, that says: consequences are irrelevant; we'll facilitate indefinitely; this will magically go away as we provide high-powered opioids for those who suffer. No, Mr. Speaker. There must be consequences in charity and care for those who suffer. There's nothing charitable, there's nothing caring, there's nothing compassionate or Canadian about leaving your loved ones to die in the street to speedball, methamphetamine, and fentanyl, to be living intermittently homeless in a community like Peace River or Edmonton or Calgary in minus 40 weather. It's an abandoning of our responsibility, our moral obligation that we hold as elected members of this Chamber to vote on legislation that truly cares for the compassionate approach to those who suffer.

Mr. Speaker, the alternative to the Alberta recovery model, the alternative to compassionate intervention is unthinkable. It's 187 overdoses and that young woman dying. It's a 31st overdose for a New Year's tragedy and that individual dying. It's another 401st funeral in that First Nation community.

7:50

This not only will work, Mr. Speaker; it will work because we have built it into a health care model that cares for those who suffer. I can't imagine the idea of doing nothing if I were responsible for the care of so many people suffering from addiction. I ask all members to join me in debating this legislation. The concerns I will address I know will be legitimate, but I will be there to respond.

Thank you, Mr. Speaker.

The Acting Speaker: I will recognize the Member for Calgary-Currie.

Member Eremenko: Thank you, Mr. Speaker. I'm pleased to finally have the opportunity to stand in these Chambers and speak to the UCP's Bill 53, the Compassionate Intervention Act. Since becoming the elected representative for the good people of Calgary-Currie and since being appointed to the file of Mental Health and Addiction, I've been privy to stories of courage and grit and persistence. I've also been privy to stories of loss and pain and struggle, and often those are all for the same person because frequently all of those things – grief and suffering, determination and hope – are what pave the path for a person who lives with addiction. It's not an easy path. It's a path I wish we could prevent people from having to take in the first place, which is why I was hoping to hear from the minister about why they decided to cut $20 million from Budget 2025 in prevention and early intervention.

For now we'll focus on Bill 53. There are so many elements to this bill. It's dizzying, Mr. Speaker, and there is no time, really, that could be permitted in these Chambers to fully unpack what Bill 53 suggests we offer to Albertans, but I'm going to focus on three of my top concerns here tonight.

One, compassionate intervention is an unworkable system. It's an incredibly resource-intensive endeavour, putting pressure on two systems, law enforcement and health care, that are already bursting at the seams.

My second concern, Mr. Speaker, is that there are so many other ways we can intervene in a person's life to prevent them from harm as a result of their drug use. The government has not done the work to facilitate those options.

Three, this is an approach that will not achieve what families and communities desperately need it to. It doesn't address the reasons why a person might be using drugs in the first place and thus creates a revolving door that does nothing to staunch the flow of drug use or new drug users.

My next notes here summarize what the UCP's legislation is meant to do, but I think the minister covered much of that content. I won't spend too much time on the incredibly intensive and, frankly, bureaucratic system that is meant to apprehend a person, detain, transport them, have them stand before a commission, have regular six-week reviews. There is an appeal process, and there is also a discharge process with the facility. Indeed, a person can be referred to three months in a locked compassionate intervention facility and be sentenced to six months in a community-based facility. They can have one or the other, they can have both, and both of those periods can be renewed up to any number of times that the commission deems necessary.

When the commission approves of a discharge, Mr. Speaker, the person's treatment team must make some recommendations related to that person's discharge, but there is no legislated requirement to actually provide a safe place for that person to land after discharge. There's no legal requirement to ensure that person is discharged to a home, to safety, or to social services and health care. They may very likely be discharged right back into the environment that fed their drug use in the first place. There is no requirement for government in the legislation to bring that person back home, which could be hundreds of miles away.

While they're in a facility, Mr. Speaker, they are not permitted to leave. They do not have the right. That's in the secure and the community-based facility. They are not permitted to leave. They do not have the right to refuse treatment. That includes observation, monitoring, or assessment, and they do not have the right to refuse medication.

For people who are reading Bill 53, don't be fooled. They do say in the legislation that a client may have the right to refuse treatment. If you read further on, it actually identifies that some of the most fundamental services that are provided in that facility cannot be refused, regardless of capacity or competency.

I know how it sounds on paper, Mr. Speaker, and I know how the minister and the Premier have presented it. Forced treatment has been talked about in very grandiose terms that are heavy on rhetoric but, sadly, low on fact. What little independent, objective research there is on the subject can be very hard to apply because the policies differ so much between jurisdictions, as does the measure of impact. For example, a number of pieces of research evaluate the rate of recidivism of a person within the criminal justice system. Bill 53 says nothing about the criminal justice system. This has nothing to do with the number of times that a person may or may not be charged or sentenced for a criminal act. We need to make sure that when we're talking about evaluation and measurements of success, we're actually making apples-to-apples comparisons.

In academic research by Jain in 2018 and Werb in 2016 the existing evidence, quote, does not support the assumption that either short-term civil commitment or longer term compulsory treatment can improve outcomes for substance use. A 2023 article in the *Canadian Journal of Addiction* reviewed 42 studies measuring the effectiveness of involuntary treatment relative to drug use outcomes with 354,000 participants. Most studies measured substance use changes, criminal recidivism, and retention treatment. Only seven out of 42 – this is international, Mr. Speaker – reported improved outcomes in the involuntary group, with most for retention and treatment, well, probably because they had no choice but to be there. Only one out of 42 showed a reduction in substance use. Six out of seven were in the context of prison or probation.

When the minister says that there is no evidence that this works or doesn't work when one out of 42 out of a study that initially started with hundreds of studies around relevancy to what we're trying to do here in Alberta – I would say that that's not great odds, but here we are putting half a billion dollars into a system where there is one out of 42 relevant studies that actually show that there could be some benefit to the program.

Interestingly, though, I want to note that Dr. Rob Tanguay is one of the authors of that report. He's now really at the helm of much of this work around compassionate intervention, and I'd like to, you know, maybe hear more from some of the leadership on this Compassionate Intervention Act to see just how much they've chosen to ignore when it comes to the application and implementation of this legislation.

Let's not talk about this incredibly complicated and very personal issue in platitudes and euphemism. Rather, let's look at a very possible anecdotal story to actually unpack the promises that this legislation makes but, sadly, cannot keep. Let's pretend there's an individual up in High Level, Alberta, whose polysubstance drug use of opioids and benzodiazepines has gotten out of control. A family member, let's say a grandparent, submits an application online. The application will be reviewed, and assuming it's approved, law enforcement will have permission to apprehend, detain, and transport that person possibly, you know, 800 kilometres down the road to Edmonton, to the nearest compassionate intervention facility.

The person has no charges laid against him. No judge has approved his apprehension. He is not even assessed for the first time – he doesn't stand before a medical doctor until he has been apprehended by police and driven what might be hundreds of miles from home, where he will be subject to an assessment without his consent. From the point of apprehension, Mr. Speaker, a clock starts ticking down. Law enforcement has 72 hours to get the person to a designated facility and assessed. That means a police or peace officer must observe, control, and take care of the individual being detained and transported.

Here's my top concern, that I listed at the start of my speaking. Those 72 hours demand monitoring, observance, and transportation by a police officer. That means potentially days when a police officer isn't otherwise available for 911 calls, highway collisions, break and enters, and it's happening while a person is going through what is often a violent and very dangerous, sometimes fatal, withdrawal period. Oddly, Bill 53 makes no mention of the requirement for medical detox or for consideration of mental illness comorbidities. This is putting everybody, the individual and the person trying to care for them, at risk.

If our friend from High Level needs medical intervention, the police officer has to bring them to a hospital. Our health care system is on the brink, and we are now about to flood hospitals with patients who don't want to be there. They are a flight risk. They are a potential danger to themselves or others – that's apparently why they got picked up in the first place – and they might require round-the-clock supervision.

8:00

Guess who that job now falls to. It falls to law enforcement. They cannot legally just leave a person in the emergency department once they are in their care and custody. More demands on law enforcement, emergency departments, and acute care, and all of that has happened before an official assessment is even completed; 72 hours before that person actually stands before a medical professional to make an informed diagnosis and an assessment to determine their treatment fate, that could amount to nine months or more, Mr. Speaker.

I want desperately – desperately – to give families a solution for their loved one's addiction. I do, truly, more than anything. As a parent in one of our round-tables recounted, she wished there was a magical solution, but a magic solution simply doesn't exist. I understand why the UCP's bill sounds promising, but it's not the solution they make it out to be. Simply executing on these first days of the apprehension order is taxing our systems with demands that it cannot bear, and in that process we are putting our loved ones' lives at risk.

In some of my discussions with stakeholders they assumed Bill 53 is a way to divert people from prison, like, that it's a natural extension of the drug treatment court. It's not. Drug treatment court is a judicial body, a program which a person found guilty of drug-related charges can access that will mandate in-patient or outpatient treatment to address their problematic drug use as a means of

avoiding a jail sentence. The program can be very successful for some participants, but this is my second issue with Bill 53, Mr. Speaker.

Bill 53 is presented like all the other options have failed and the UCP's hands are tied, but it's a despair and a desperation of their own making. Whittle away at funding, lowball operating budget needs, undermine decision-making, concentrate power and control in the minister's office, make a program so inaccessible it might as well not exist, and you have created the conditions of last resort.

What other options did the government investigate before going down this path? Did they consider mirroring a bill in Ontario that legislated the provision of mental health and addiction care for Ontario residents under the age of 26 within 30 days of presenting with a desire for treatment? Did they investigate what the government of B.C. has pursued, not to create a whole new bureaucratic system to the tune of half a billion dollars guided by an entirely new legislative framework but, rather, to enhance what they already have in the Mental Health Act so it is more appropriately and robustly applied to people with severe substance use disorder, a disease that is universally recognized as a psychiatric disorder and is in the DSM-5?

Did they actually investigate the full-spectrum approach of Portugal, whose groundbreaking system is fundamentally based on the principles of harm reduction and decriminalization, whose chief designer of the program, as a witness to the Standing Committee on Health meeting of the Opioid Epidemic and Toxic Drug Crisis in Canada, said:

> We find that motivation and . . . providing people the minimum levels of dignity and allowing them to make their [own] choices is much more effective than forcing someone to do whatever he doesn't want to do . . . If we have someone who is homeless and living on the streets, with no dignity, no access to hygiene or to health care, if we provide those conditions, then we can work on motivation to change the lifestyle.

Bill 53 replaces PCHAD, the Protection of Children Abusing Drugs Act. This certainly was a program in need of significant review. Did government ever fulfill the recommendations made by the OCYA in its 2018 report evaluating PCHAD? Has it sought to address the 30 to 60 per cent of street youth who have met criteria for a substance use disorder and mental health problem?

There are countless examples of ways that we coerce, incentivize, even require treatment, Mr. Speaker, that existed long before Bill 53 was ever introduced. Just look at the Mental Health Act. There are people out there in our communities with deep, indescribable trauma and mental illness. Many of them need support even if that support must be provided against their will. This is a sad but inescapable reality.

Where are the psychiatrists, Mr. Speaker? Where are the psychiatric acute-care beds? Where are the secure continuing care beds for Albertans who are so out of touch with the world around them that they take illegal drugs due to the absence of adequate health care? The concurrence of mental health and drug addiction is well known. I've heard the minister recognize it time and time again. Why is there nothing in Bill 53 that speaks to the concurrence of these two significant issues? More often than not that illegal drug use is masking an undiagnosed, poorly treated mental health issue, and unless we address some of those root causes, we will only create a revolving door with Bill 53.

The therapeutic care in these facilities under the Alberta recovery model is not there. That is clearly evidenced in the recovery communities thus far, with a high propensity to hire and employ recovery coaches with very minimal training, and very little standards are on the level of care that is in fact provided there. These are not creating the environments or the conditions for healing that people desperately need, especially having gone through the retraumatizing event of apprehension and detention and monitoring and the administration of medications against their will.

I woe the day, Mr. Speaker, that Albertans grow as frustrated with compassionate intervention as they are with the Mental Health Act. Consecutive Conservative governments have refused to fund the programs to positively sustain those initiatives, programs like low-cost psychological services, permanent supportive housing, adequate income supports, and prevention.

There are other forms of mandated or coerced treatment: community treatment orders, professional associations, child and family services, bail conditions. Are these working to their fullest extent? Did the government even bother to evaluate enhancements in these areas before suggesting that the only option left to families and communities was forced treatment? How dare they suggest that this is the only thing available that remains. How incredibly unfair to the families who have to make this impossible choice. It is the option of last resort because they have refused to fund the other options.

One thing that was abundantly clear in my conversations with addiction specialists, even those who are open minded about the prospect of forced treatment, is that you cannot cohouse voluntary and involuntary clients. This brings me to my third point, that forced treatment simply doesn't work, and its unintended consequences can be fatal.

Recovery communities are just that, Mr. Speaker: communities. Participants are living communally, eating together, sharing double occupancy to a room, working out together, going to therapy together. Where the readiness for change is high and participation is voluntary, it can be a positive, collaborative, and supportive environment. When some people have volunteered to be there but others in their midst did not, the entire therapeutic community can be derailed. It can become dangerous, and it can set people back. Recovery communities are not equipped for this challenge. They do not prioritize therapeutic care. They do not prioritize trauma-informed care. They do not provide for the security, accountability, and cleanliness that participants need to heal. Commingling voluntary with involuntary clients will only make this situation worse.

Let's talk about the men and women who will be counted on to implement forced treatment in this province. We've already discussed the resource intensity of the apprehension and assessment process, the significant demands it will place on law enforcement and health care. When I spoke with a mental health professional working in urgent care about this bill, their reply was simply, "My patients will stop coming," meaning that people with addiction issues will not access the health care, including the critical mental health care, they need out of fear of being forced into treatment. That will have the opposite effect of what the UCP wants Albertans to believe will happen with Bill 53.

Another addiction specialist told me that there has to be consideration for the vicarious trauma of workers who have to fulfill these orders. As a health care provider it's deeply upsetting to commit a person, and it is done with the greatest of caution. They said, quote, that people just won't submit the application because it risks what might be the only positive trusting connection a person might have with a system of support. They ended further with: this will make health care worse; people will hide their substance use; overdoses will get worse; people won't trust the hospital. Those are not the hallmarks of a recovery-oriented system of care. That cannot be deemed a success of the Alberta recovery model.

8:10

Speaking of the Alberta recovery model, for nearly two years I have sat and stood in these Chambers and heard the minister celebrate the UCP's accomplishments on mental health and addiction. The UCP government has chosen to allocate more than $400 million in capital and operating costs to implement forced treatment. This makes no consideration for accommodating the increased demands on law enforcement and health care. All this despite being way, way behind on their commitments to provide voluntary treatment.

The Acting Speaker: Thank you.

The Member for Edmonton-City Centre.

Mr. Shepherd: Thank you, Mr. Speaker. I appreciate the opportunity to rise and speak at second reading of Bill 53. Now, there is no question that there is a problem. I've been hearing about it for years from people living in the communities I represent, from the people who own and operate businesses here, from people who come to visit our downtown from across the city, across the province – hey – from around the world in the face of encountering people here in our community on the streets openly using substances, people passed out in doorways, on back steps of businesses in our public spaces, people dying as they succumb to an overdose, requiring emergency intervention.

Mr. Speaker, a few months back I had a breakfast date at a restaurant downtown called De Dutch, right on Jasper Avenue. As I sat at the table waiting for my date to arrive, a gentleman, looking a little rough, walked up and looked in the front window. I assumed he was just, you know, taking a look inside, watching people eat, maybe feeling a bit hungry himself, but that gentleman facing into the window proceeded to reach into his pocket, pull out a crack pipe, light up, take a number of puffs, extinguish it, and then go on his way in full view of everyone having breakfast in that restaurant that morning. That is a reality of what we're facing in downtown Edmonton.

Understandably, I hear from people that they feel uncomfortable, they feel afraid, they feel unsafe. I hear from people that they are afraid to take public transit, that they are afraid to come downtown, that their employees don't want to come to work, that their customers are steering away. A message I got from a professional working downtown who owns and operates a business here:

> What is happening downtown is tragic and untenable. Our staff are still very uncomfortable in lrt stations and the disorder remains unsettling. My partners and I have just invested millions of dollars to stay downtown for the long term. We've taken the risk but it makes me nervous. I'm hoping we can find a balanced set of effective solutions asap.

Mr. Speaker, let me be clear. Those are real experiences. Those are real problems, and they need to be addressed. Every Albertan deserves to be able to feel safe and welcome in their communities. For that to happen, we need to address this problem. On that myself, the minister, this government: we agree.

Now, Mr. Speaker, this didn't happen overnight. Indeed, I and many others from our communities here in the heart of Edmonton have been speaking about this for years. We've been calling on this government to take real action to provide supports and solutions, and the government dragged their feet. For their first three years they formed committees and task forces, they generated reports and recommendations, but they didn't lift a finger. We did not see significant action from this government until just before the 2023 election.

Six years ago they promised they would invest in unprecedented access to treatment and recovery. They promised to fund and open hundreds of beds to meet the need, 11 recovery communities located across the province. Six years later where are we? The minister stands here tonight and talks about creating 10,000 spaces, but the fact is people who want to access treatment voluntarily are waiting three months – waits of three months – to get in. The minister talked about despair and wanted to give hope, not despair. Mr. Speaker, when people come in, desperately ready to access help, and they are told, "Come back in three months" when they don't have a roof over their head, that is despair. That is the record of this government. They've only managed to build three of their promised recovery communities with no indication of when the rest are going to come online.

Meanwhile during that period we saw record numbers of Albertans dying from drug poisonings, many here on the streets of my community. The government talked while people died, and safety on our streets continued to decline. Those are not the actions of a government that actually believed we were in a crisis. Those are not the actions of a government that actually cared. Those are not the actions of a government that actually wanted to find a solution, but we owe a solution to those people that are struggling, to the people that live in my community, to those business owners who are trying to rebuild our downtown.

The government says that they have a solution, but the fact is that they can't even provide voluntary access on demand, yet they're saying that the only path to rebuilding safety in our communities, to getting those in desperate need help is to create a massive new system in bureaucracy to force people into treatment. Now, again, I agree. There's a problem here, one that we have to address, but this legislation, unfortunately, Bill 53, is not going to get us there. I owe it to the people in my community to ensure we are implementing real solutions that will actually make an impact on our communities today. Bill 53 will not.

There are significant questions about this government's capacity to actually build and operate their proposed system and deliver on this significant promise. Let's talk about some of them. Now, first of all, what the minister is proposing is to stand up a whole new quasi-judicial system with the effective powers of a public inquiry, a compassionate intervention commission that will hold the power of essentially taking away an individual's free will for months at a time, that would be required to make those decisions, create complex care plans within 72 hours of apprehension or assessment.

Now, what we have currently is that our court system is already struggling with significant delays due to this government's failure to appoint enough judges or fund the support staff that we need to actually keep our courthouses running. Just last fall Justice Mark Tyndale in Calgary raised the alarm when two Calgary trial courts had to be merged into one due to a lack of resources under this government. Said the judge: the government has continually refused to live up to, in terms of judicial resources, what is their legal obligation under an MOU, memorandum of understanding. He added: scarce resources have also put pressure on court clerks and the prosecution service to deal with the overwhelming number of cases coming in. I find it difficult to believe, Mr. Speaker, that a government that has failed to support the timely operations of our existing court system has the capability to build, staff, and operate the complex quasi-judicial system that's going to be required to implement forced treatment, let alone do it responsibly and compassionately and without harm. That's the first question.

Secondly, there are significant questions about the impacts the system will have on law enforcement, as noted by my colleague from Calgary-Currie. Now, I've had the chance, Mr. Speaker, to talk with front-line officers, many who are working on the front lines here in my community, some folks from other parts of the province. I've gone out with them on patrol. I've had the chance to

hear from and speak with municipal leaders across the province who fund police and community peace officers, and what I am hearing across the board is that our front-line officers are spending more and more time dealing with things like drug poisonings, people in mental health crisis during substance use, individuals who are using substances.

What I've heard from those officers, Mr. Speaker, is that they're desperate to have a place they can bring those people to get help. They are desperate for this. They are begging for this. Again, they have been asking for this for years. This has been the request of the Edmonton Police Service, of individuals here, to this government, and they've seen no action. After six years under this government they still don't have it. Even when people are ready and willing to get help, to go to treatment, to seek recovery, they can't. So these officers are left cycling people through the system, and with Bill 53 there's no indication that is going to change. The facilities that are needed to operate this system at any appreciable level of significant scale will not be open until 2029, so that's not going to make a lick of difference for the officers, for my residents, for the businesses in my communities today.

8:20

The bill creates significant new responsibilities for law enforcement. Let's be clear. This isn't a simple process where officers can simply just pick someone up and deliver them to a facility and be done. There is going to be a significant process in place by which the officer will need to make an application to commit the individual to treatment. Then they'll be tasked with finding, apprehending, and conveying those individuals to a facility. From what I can see, those officers may then have to remain with those individuals until they're taken into care, much like paramedics are caught waiting in ER waiting rooms for patients to be taken into hospital care, something this government said they solved, but when I talk to paramedics, the problem is back because, again, this is not a government that looks for actual solutions. They look for cosmetic fixes, and that is not what we need right now. We need real solutions.

What I hear from people in communities across Alberta, from those municipal leaders, those front-line officers is that our provincial government currently isn't even able to provide enough Alberta sheriffs to handle routine prisoner transfers – that's one of their core duties – and other police are having to take that work on. In fact, I was told that directly by sheriffs themselves. So I do question: is this government going to have the capacity to ensure that law enforcement is able, has the manpower to be able to apprehend, detain, and oversee hundreds of people waiting to be assessed for forced treatment?

Then there's the question of whether forced treatment will actually work to help people recover, to find actual stability. Now, the minister says that there's no evidence that this won't work. As my colleague the Member for Calgary-Currie has noted, there's no evidence that this program will. We can look at the evidence from other jurisdictions . . . [interjection] I thank the minister for his interest, but I'd like to finish my remarks. He will have more opportunities to speak further on. There's the question, Mr. Speaker, of how – even if these people go through the program, there's no guarantee it's going to work.

And then when they come out, how are they going to be supported in the community? How are we going to support those individuals when they're released from treatment? One of the biggest problems we face in our communities right now is the revolving door for individuals who are struggling with substance use who lack housing. Police, social workers, others: they bring them to this government's first solution that they claim they put in, the navigation centre. Now, let's be clear. The navigation centre has value. It is an excellent entranceway into the system. It provides people with ID, signs them up for income support and other needed financial assistance, connects them with services.

The problem is that it doesn't help when there's nothing else after it because the resources aren't there to help them. Police bring individuals to the navigation centre, and they're put on a housing list, they're offered access to a shelter where they don't feel welcome or safe, and they're put on a three-month waiting list if they want to access detox treatment and recovery. Then they're back on the street, back into the doorways, onto the back steps, into the streets of our communities, a danger to them, an insult to their dignity, and a continued issue for our community because our residents, our business owners then are left to start that cycle again, to call for help, have the same workers, the same officers come out and face the same lack of any place where they can take them to get actual help. Bill 53 does nothing to address that need, that utter lack of resources, of treatment space, of housing, of wraparound supports for people who are seeking help voluntarily.

So it's clear, Mr. Speaker. We agree with the government that there is a problem. We disagree – I imagine, if we were to ask the minister or others, that it is this government that has chosen to exacerbate this problem that they have chosen to ignore, that they have chosen to underfund, that they have failed to step up with the resources and the supports that were needed to help people, and we disagree that Bill 53 is going to do anything to move that needle. This government is moving to what is essentially the nuclear option, unprecedented levels of spending on new infrastructure, new bureaucracy, new systems when this government has refused to do the most basic work.

Ultimately, Mr. Speaker, what it comes down to then is that this government is going to fail to solve the problem, to provide that safety for the residents in my communities, for the businesses that are asking for help here in my constituency and across this province. This government has had years. How long have they been talking about introducing this legislation and they still haven't answered these questions? Well, perhaps I'll have that opportunity during further debate.

Thank you, Mr. Speaker.

The Acting Speaker: The chief government whip.

Mr. Getson: Yeah, Mr. Speaker. I really appreciate the debate taking place here that's given everyone pause for concern on a number of items, but at this point I would move to adjourn debate.

[Motion to adjourn debate carried]

Government Bills and Orders
Committee of the Whole

[Mr. Rowswell in the chair]

The Acting Chair: Okay. I would like to call the committee to order.

Bill 37
Mental Health Services Protection Amendment Act, 2025

The Acting Chair: Are there any comments, questions, or amendments to be offered with this bill? I have the Member for Edmonton-Rutherford. Go ahead.

Member Calahoo Stonehouse: Thank you, Mr. Chair. I rise to address comments I made with respect to recovery when debating Bill 37 in second reading. During the debate I made reference to

how difficult recovery is. I want to be clear: recovery is an exceptional thing, but it is very hard work. My comments were attempting to draw attention to the fact that recovery is a lot of work not just on the individual undergoing recovery but also for their loved ones and their community. It is the medicine wheel. It is a spiritual journey, a physical journey, an emotional journey, and an intellectual journey. It is about healing childhood trauma.

The night before I made those comments my cousin Dennis, who had been in recovery for two decades, relapsed and died of fentanyl poisoning. I'd also spent part of that morning with my cousin Darren, who had spent hours trying to revive him with mouth to mouth. My cousins are loved. They are my family. Recovery is very much rooted in our recovery and healing as a family. I wish my cousin were still alive, but that is not the fact. He died, and in my grief I may have said things rooted in my pain that some may have interpreted as being anti recovery. While speaking, my language was unclear. I support recovery and hope all Albertans are able to live lives of dignity and safety. I have grave concerns about the model that is being proposed by this government. There must be Indigenous-led recovery, harm reduction models if we are truly going to be compassionate.

Hay-hay. Thank you.

The Acting Chair: Are there any others? The Minister of Mental Health and Addiction. Go ahead.

Mr. Williams: Thank you. I just want to say that in the circumstances of the debate of the Legislature, passions run high. If I ever cross a line, I would never want to politicize anyone's personal story. I appreciate so much the Member for Edmonton-Rutherford for her commitment to her loved ones and say that we have to have some prepolitical common ground, and caring for our loved ones is definitely that. In the most sincere, humble way, thank you for that statement, and I would always be happy to chat with you and support in any way we can, of course. Whatever political differences we have, legislative differences, there needs to be common ground on these things. It was wonderful to hear you say that from a place of deep love, and I appreciate how deeply challenging it can be. I don't pretend to know it. Thank you for that.

8:30

The Acting Chair: Are there any others that wish to – Member for Calgary-Currie, go ahead.

Member Eremenko: Thank you. I'm not totally sure on the process on how to do this, so I'm going to need some guidance from my colleagues here. I have an amendment to make for Bill 37, please.

The Acting Chair: Yeah. We'll just get you to bring down the original copy here, and then once we get it, we'll get you to read it as we distribute.

Okay. Carry on.

Member Eremenko: Thank you. Would you like me to read it into the record, into *Hansard*?

The Acting Chair: Yeah. Go ahead.

Member Eremenko: This is a notice of amendment for Bill 37, Mental Health Services Protection Amendment Act, 2025. The Member for Calgary-Currie to move that Bill 37, Mental Health Services Protection Amendment Act, 2025, be amended by striking out section 12.

Mr. Chair, thank you for the opportunity to speak to this amendment and certainly to Bill 37 a little more broadly, though I know some of my colleagues will be able to do so this evening as well. Really, the amendment as proposed is to remove a section of the amendment act that pertains to the rights of the minister to exempt a specific individual at a given facility from being subject to the licensing and standards of care of that particular facility.

The legislation – sorry; you'll just have to bear with me here – speaks to the conditions in which a ministerial exemption can be granted. Those include areas of public interest and also being able to grant an exemption to a particular person for research and medical purposes. It's that particular area that is of grave concern for me, Mr. Chair. Individuals are accessing mental health and addiction facilities. Of course, we've just had a very robust initial conversation around the compassionate intervention facilities that are going to be provided through Bill 53 at great significant cost to the taxpayer at a stage of life for the individuals and the participants of that program who are experiencing maximum vulnerability and risk to their personal safety, to their emotional well-being, and to their future prospects for recovery.

When we're talking about individuals who are so vulnerable, to suggest that the minister can waive the minimum standards of care for that individual in that facility for any reason, let alone those listed in the legislation, is incredibly concerning. At no point should anyone not be reliant and confident that the rules that apply to the facility and to all of their colleagues don't also apply to them, especially for reasons as complex and as well documented as ethical decisions relating to research and health care.

I'm not going to take a whole lot of time on the floor this evening. I think some of my colleagues who are physicians, scientists, who have had to apply for ethics approvals to pursue research grants, particularly in the health care related fields, will be far better suited than I to speak to the incredible diligence and the utmost transparency and fidelity to the standards and licensing requirements to be able to fulfill those research requirements. To suggest that anybody – the minister, the director of the facility, the health care team, a family member, a guardian – has the ability to waive the protections that those standards and regulations and licensing requirements actually provide to protect the person in care is acceptable is just completely inappropriate, in my mind.

The Mental Health Services Protection Amendment Act takes out standards and regulations from the legislation, brings it into the regs that already are going to concentrate great decision-making power and control in the hands of the ministers, where those kinds of decisions will not be brought to the floor here for debate. It certainly tracks with other pieces of legislation where there is a real concentration of power and control in the hands of ministers to make decisions without, you know, a fulsome review and consideration by members on both sides of these Chambers. That in and of itself is a concern. When it comes to this particular amendment, the minister nor anybody else within the department or the ministry should have the right to waive a person's fundamental rights to protection and privacy at this facility or, frankly, any other, especially when it comes to a somehow justified rationale of research purposes.

With that, I will sit and allow for my colleagues to further the debate.

The Acting Chair: Are there any others that wish to speak to the amendment?

Member for Calgary-Acadia, go ahead.

Member Batten: Thank you so much, Mr. Chair. It is with gratitude that I rise to speak in favour of the amendment to Bill 37 that was just introduced by my colleague from Calgary-Currie. I

just want to quickly revisit that the last time we debated this bill inside the House was actually back in February of this session. So in aid to refresh all of our memories on what the prior debate was, I specifically just want to reference something that the Minister of Mental Health and Addiction had shared.

> Albertans who are seeking mental health and addiction treatment services need to know that when they seek support from the province, they'll be taken care of with services that fit their needs and meet the absolute highest standards.

That sounds amazing to me. Let's meet Albertans where they are and not where we think they should be. Let's provide the necessary resources and not just standard-issue, nonindividualized support.

Now, the thoughtful, articulate, and very needed amendment that has been brought forward this evening from the Member for Calgary-Currie is absolutely what is needed to support Albertans. Mr. Chair, the Member for Calgary-Currie was exactly right. All Albertans deserve to receive the highest quality of care. Regardless of what an elected official might have to say, someone who is not a health care professional or, goodness, even a prior health care professional should not be making that call. Regardless of whether there's interest in scientific or research purposes or for public interest, we do not put Albertans behind that train. A person's life is valuable. A person's autonomy is valuable. Albertans are valuable, and they deserve the best care. Period.

Now, I've always been in awe of health care professionals who seek out mental health as their specialty. Personally, I have always been drawn to high-acuity practice, where, basically, you figure out what's wrong and you fix it. But the work done in mental health and addictions is never that simple, and you certainly don't fix it. Mental health, Mr. Chair, is not something you fix. It is not something that is bad or good. It is something that ebbs and flows with all of us. We have good days; we have bad days. Yes, some days we need support, and some days we don't. It is part of the human journey. Everyone inside this Chamber, I would say, has had good days, has had bad days, knows people who potentially need a little bit more support with their mental health from time to time or possibly their entire lives. Who are any of us inside this Chamber to say that they don't deserve high-quality care? That's not our call.

I want to highlight the incredible empathy and emotional maturity that is necessary to work in the area of mental health. It's incredibly difficult work, and it is so incredibly valued.

8:40

Now, reflecting on the minister's comment from debate, where the ministry will provide "services that fit their needs," I want to share a lesson that I learned through my nursing practice. That is that what a person needs, Mr. Chair, isn't always apparent, and many times it's not what we might personally think they need. Hearing that the minister is committed to providing a spectrum of services – how else are you going to fulfill that commitment to provide the services that "fit their needs"? – brings hope to Albertans. It brings hope to Albertans who share that concern that, you know, the government, this government, has only been putting out reactive bills. They aren't about upstream resourcing. They aren't about preventing the problem. They're about, well, apparently, deciding who deserves care and who doesn't. That's not the job of the government. I'm hopeful that the commitment that we heard from the minister continues to resonate.

Now, I want to share a story about I think it was probably the first time I ever managed a patient who was in active withdrawal. We'll call this patient Jim. I was a nursing student at the time. He was withdrawing from alcohol, and I was following the CIWA protocol for the first time. Now, the CIWA protocol is the clinical institute withdrawal assessment. There are specific ones for different drugs. This one, of course, specifically was for alcohol.

Now, you might remember that before I was an MLA, before I was a nurse, I was a research scientist, so very accustomed to strict analytical protocols. If this happens, you do this. You control for everything inside the environment that you can so that you're only looking at the thing that you need to change or possibly change. I was accustomed to having these standard operating protocols, strict, quantitative data, but that's not CIWA, Mr. Chair. CIWA is a highly subjective assessment, which makes sense because, of course, not everyone who is undergoing withdrawal shows the same symptoms or has the same, well, needs. Health care professionals are educated and trained specifically to be able to do this assessment. Not just anyone can do it, including elected officials. That's not our call. That's not our job.

Now, the assessment forces the medical professional to watch for very concerning realities that happen with alcohol withdrawal because, Mr. Chair, withdrawing from alcohol can be deadly if not treated. Deadly. Now, remember that at the time I was a nursing student. I remember just being super excited because this patient assignment was something that I thought I knew what I was getting into. Intellectually, I understood the long-term effect of alcohol abuse. I understood that something called Wernicke encephalopathy could be a thing. I could be walking in and having to deal with this. For the Chamber that is long-term brain damage from alcohol abuse. It means that someone who has a long history of alcohol abuse isn't themselves any longer. Their brain literally does not work the way it did before. Now, this can kind of come and go a little bit, depending on where you are in the withdrawal process.

Thinking I was all ready for this, that I knew what I was walking into, well, I really wasn't. Real life doesn't look like that. Intellectually, I understood what the prior nurse had reported to me. I understood what I had learned in class, what I'd been told to expect, but instead, Mr. Chair, I was confronted with Jim, a man in four-point restraints, babbling gibberish, and talking to I'm not sure what. It was terrifying. It honestly was. It wasn't what I expected. It wasn't something I could have been prepared for in any other way.

And it taught me a lot because, let me tell you, at the beginning of my nursing journey, I was judgy. Oh, goodness. Like, when you haven't truly learned how to put yourself in someone else's shoes and to let them choose the path that they want to go, not whatever you think – ah. What I wanted for a patient, even if I desperately believed that's what they needed: that wasn't my job, and that's not our job inside this House.

Now, Jim's story didn't end that day. I continued to provide care for him for a number of days after that, and I got to see different sides of Jim. Now, initially, remember that I walked into that space, and he was not in a good space. And, yes, I went through the protocol, and the protocol was kind of neat, Mr. Chair, because it was the first time where something was happening that I actually got to fix. What I mean by that is that part of the treatment for alcohol withdrawal, part of the CIWA protocol is that we provide things like benzodiazepine to prevent seizures. We restrain them so that they don't hurt themselves or others. Now, Jim went from that all the way to walking around the unit chatting with friends or, well, I guess making friends. It was a huge transformation. So you really cannot judge someone until you walk in their shoes. That might be one of the largest gifts that nursing has ever given me. I'm hopeful that just like I did, the ministry will mature and put aside their personal beliefs and meet Albertans where they are and never discount an Albertan.

We've absolutely heard nothing from this government about prevention and that is very concerning. Instead of talking about, "How can we support folks before they get into these situations?" and "How do we address the upstream concerns that people have?" we're talking about, "You know what? I don't think you deserve the highest quality care today. I've decided that you don't get what everyone else gets." Who are we to say that?

Now, this whole bill, the amendment, is all reactionary. Albertans are in crisis. There is no question, and there is need for urgent support. But by deciding, by somehow taking on the role of judge and jury and apparently medical professional, we aren't serving Albertans. I'm not sure who we're serving, and that's a problem. So I strongly support this amendment, and I strongly hope that everyone in this Chamber considers what you're hearing in this Chamber this evening. Think about the Alberta that you would like. Think about how you would like your child, your husband, your wife, your partner, should they need support – do they not deserve the highest quality care we can provide regardless of what an elected official says? I think so.

Thank you.

The Acting Chair: Is there anyone else that would like to speak? The Member for Edmonton-South on amendment A1.

Member Hoyle: Thank you, Mr. Chair. I'm pleased to rise to speak in favour of the amendment to Bill 37, Mental Health Services Protection Amendment Act, 2025, put forward by my fabulous colleague the Member for Calgary-Currie.

I want to begin by speaking to those who may be struggling with addiction, who have loved ones struggling with addiction. Addiction is not a sign of weakness or a character flaw or a moral failure. It's a common condition that affects millions of people of all ages, all backgrounds and socioeconomic groups. A person is not less than because they're dealing with addiction. They are deserving of our empathy and compassion.

On this side of the aisle we want Albertans who need health care support, including mental health and addictions care, to have equal access to high-quality care, and this amendment ensures that.

8:50

It's clear that the UCP is truly out of touch with what Albertans care about and need. Their priorities couldn't be further from what Albertans really care about. Albertans should be able to trust that the government is acting in their best interest, especially during an incredibly vulnerable time of dealing with mental health crises and battling addiction.

I cannot agree more with what the Member for Calgary-Currie has emphasized, that the protections and licensing requirements are essential to ensuring the safety of all Albertans. Bringing in clarity through this amendment is absolutely vital to maintain confidence in how we are delivering care to Albertans.

On this side of the aisle we understand what Albertans are dealing with. I want to note that the ongoing opioid crisis is something that this government should be absolutely addressing. For those dealing with homelessness and struggling with long-term addiction, the supply has become increasingly dangerous. Substances like fentanyl and heroin are now being contaminated with an even more dangerous mix of drugs including veterinary-grade benzos, diabetic medications, blood thinners, acetaminophen, and even animal dewormers, which could increase the risk of accidental overdose.

To make matters worse, we truly don't know the full picture of the crisis because of fluctuating statistics which can be traced to a backlog of medical examiner reports. Sometimes they're released 3 to 6 months late, skewing the data anywhere from 10 to 30 per cent. An annual report from the Alberta Ministry of Justice said that the medical examiner only completed 3 per cent of cases every 60 days, significantly below its 2023-24 goal of 20 per cent.

The UCP government has continuously revised their past statistics, undermining confidence in their numbers. In June 2022 the government of Alberta released a statement saying that there were 113 opioid-related deaths in April of that year. As of February 2025 that number is at 121.

I bring this up, Mr. Chair, because what we're seeing is an overall callousness towards the needs of Albertans struggling with mental health and addiction. These are real people, real people who deserve access to quality care that we would want for any of our loved ones in a similar position.

Albertans can't even trust the UCP to get their numbers straight and provide an accurate idea of what's happening, but what we do know is that Alberta has become less safe under the UCP with a 32 per cent increase in gun violence in Edmonton compared to 2019 and a 14 per cent increase in knife violence since 2020. Nearly 25 per cent of Albertans have been victims of crime over the last four years under the watch of this UCP government.

We want an Alberta where businesses can thrive without fear, where people struggling with mental health and addiction can get the help and compassion they need and when they need it, and it's clear that the UCP is set on undermining core services in this province while they continue their self-serving agenda. The Premier's focus on this agenda won't fix our public services like health care, protect the CPP, or find ways to combat the rising cost of living, and it certainly won't support those struggling with addiction.

As it stands, Bill 37 would make changes to licensing for mental health and addiction services while giving the minister the power to exempt certain people and providers from the framework. It also grants the minister power to exempt specific service providers including private providers and contractors from all requirements in the act.

This is why this amendment is so important. Without it Bill 37 could be interpreted as giving the minister the power to exempt a service provider from the act's licensing and inspection requirements.

Health care professionals should be the only people who decide what kind of care an individual will receive. The minister currently has the power to grant exemptions based on medical reasons, scientific research when there's a clear benefit, or public interest, but we absolutely oppose allowing a minister to exempt individuals from care standards. This isn't something an elected official should have the power to make decisions about.

At the end of the day we know the UCP has a damning track record of not consulting with front-line service providers who have been calling for evidence-based approaches and wraparound services to truly save lives. The record-breaking deaths in Alberta under the UCP's watch shows that their approach is not saving Albertans' lives. In 2023 Alberta recorded its highest ever number of deaths due to drug poisoning. Nearly 2,000 Albertans lost their lives. This is absolutely unacceptable. These losses are not just statistics. They're our loved ones, our friends, our neighbours who desperately want the help but sadly will never make it to treatment. These are real people, with real lives, with friends and families. They deserve better, and better is possible.

Instead of changing course, the government seems rooted in rhetoric over evidence and playing politics over taking concerted action. Despite experts being clear about potential solutions that can save lives, the UCP refused to collaborate with mental health experts when designing their recovery-only model. The opioid crisis is a bigger pandemic than COVID, and we need to act like it.

The folks that are entering treatment are beloved family members, colleagues, and friends.

While the minister has suggested that this bill will help operators be more flexible and adaptive to treatment needs, the biggest concern I have with this bill is its levels of red tape it will be adding and the fact that we just can't trust this UCP government. Bill 37 proposes creating three service types for bed-based addiction treatment services: withdrawal management, intensive treatment, and nonintensive recovery. Operators who might have multiple service types could face challenges as they will need to get licensed under new classifications. Essentially what this bill is doing is introducing even more red tape, with the potential for less oversight, but putting forward superficial solutions once again. Hence, this amendment is so important.

Despite wait times not being made public by the minister, we have heard that wait times for men at the Red Deer Recovery Community are between four to six months and wait times for women are nine to 12 months. I'm curious. Why is the government making it harder for Albertans to see what they're doing? Why are we moving standards into regulations when Albertans deserve more, not less, transparency?

In the wake of the allegations that the UCP was involved in inflating contracts to their friends to run private surgical centres and covered it up, there's a huge question mark over whether this government is acting in the best interests of Albertans. The UCP are implicated in the biggest corruption scandal in Alberta's history. They've shown Albertans that they're completely incapable of running a public health care system. Mr. Chair, we have grave concerns about the ties between Mental Health and Addiction contracts and the corrupt care scandal. How does this create trust amongst Albertans that the UCP's recovery model has their best interests and not their friends' financial interests at heart?

The Premier's former chief of staff is often called the architect of Alberta's recovery model and is cited in the statement of claim by the fired AHS CEO. Before that he was also the chief of staff of the first Minister of Mental Health and Addiction. If this is true, these allegations suggest that ministers, including the minister introducing this bill and the Premier herself, may have known about internal AHS investigation on these bloated contracts. So more than ever Albertans need an independent public inquiry now.

Mr. Williams: Point of order.

Member Hoyle: How can Albertans trust this government to provide appropriate addictions care?

The Acting Chair: Excuse me. A point of order has been called.

Member Hoyle: No, thank you.

The Acting Chair: No. A point of order has been called.

Member Hoyle: Oh, okay. Yeah. Sure.

Point of Order
Relevance

Mr. Williams: I appreciate the member thought I was intervening. In fact, I'm rising on 23(b)(i). It's an important piece of legislation. I believe that. I've introduced it. Members in this Chamber have said how important it is. That is the subject of the amendment, that we want to make sure that it remains whole and intact and that it fulfills its purpose of a high standard. What the member is speaking to is not at all related to this legislation in the least. Who her chief of staff was when, et cetera, AHS contracts that have nothing to do with my ministry: I'm happy to address those as the time comes. Question period is most appropriate I would suggest. This time in Committee of the Whole should be reserved for this legislation, and I think your constituents and mine and Albertans want to see us debate this legislation because it is important.

9:00

The Acting Chair: Go ahead.

Mr. Shepherd: Thank you, Mr. Chair. What I would say is that I don't believe this is a point of order. The member was certainly speaking to the topic at hand, which is changes in the Mental Health Act, and it does certainly touch on addictions and substance use. I think, generally, we afford members some fairly wide latitude in their debate and certainly, as has been discussed here, it is difficult for a member to stand and say that somebody's debate is not relevant until they have seen where that, in fact, concludes. So I think if we afford the member the opportunity to continue with her debate, she will indeed bring this around to a place that may be satisfactory to the minister.

Thank you, Mr. Chair.

The Acting Chair: I am prepared to rule. Yeah. I think if we can just make sure it stays or gets to your point, I guess, relative to the amendment, that would be great.

Thank you very much. Continue.

Debate Continued

Member Hoyle: Albertans deserve competent, ethical government. There are 11 recovery communities, two secure compassionate intervention facilities that will cost over $500 million. That's a lot of taxpayer money that could be at risk of even more corrupt care scandals. How can Albertans trust that their money will be used to support people who need and want compassionate care and treatment and not used to benefit the UCP's friends?

This government is dead set on doing things their way even if their way isn't rooted in fact or based on recommendations of addiction specialists, and this can potentially compromise Albertans' health. The amendment proposed is about protecting vulnerable Albertans, something the UCP should be able to get behind if their goal is to provide quality access to treatment.

Across Canada various policies have been put in place to tackle the opioid crisis, but the UCP's responses primarily lean towards investigating in recovery options, particularly residential addiction treatment beds, without striking a well-rounded balance that includes ample support. There is research that shows other measures can reduce costs, improve health outcomes, and reduce public drug use and extra pressure on calls to emergency services. These are costs to our health care system, to our law enforcement agencies, that we can easily avoid. These measures also provide an opportunity for people who have been excluded from mainstream services to begin to rebuild trust and relationships with health care professionals. They act as a pathway to housing, mental health supports, primary care, and addiction treatment. Has any of this been taken into consideration by the minister?

We need this amendment in place for Bill 37 so Albertans can feel confident in our mental health and addiction health care system. We have all known people who were not ready or able to accept help yet, and these Albertans have the right to health care that meets them where they're at in their journey and gives people a path towards recovery. The hostility of this UCP government to hard facts and evidence of providing access to care has led to the

preventable deaths of many Albertans. How can those that will be affected by Bill 37 trust that these measures will actually help them?

The UCP's focus is failing because far too many people do not live long enough to get there. Truth be told, Mr. Chair, a key component missing from the government's response to addiction treatment is the fact that there doesn't seem to be any consideration for where people should go after their time in treatment. Without a robust, actionable plan to address housing shortages and affordability, the prospect for a person's long-term, sustained recovery is poor. Sadly, this government has yet to demonstrate any commitment to tackling housing in general, let alone for this vulnerable population.

These are things our New Democrat caucus is thinking about. How can we do all we can to take care of Albertans, to let them know that during an ongoing affordability crisis, a health care crisis, with government-wide scandals, economic threats of tariffs, their worries are heard and being responded to?

Mr. Chair, Albertans can't trust the UCP's reckless policies. They can't trust them to remove themselves and commit to investigations free from political interference. They can't trust the UCP to protect our public health care, and they certainly can't trust the UCP to stand up for Alberta. They can't trust them to care enough about people who are struggling at some of the lowest points in their lives. Bill 37 is a clear indication that the UCP doesn't care enough about Albertans.

Without this amendment, Albertans are at risk for not getting the care they so desperately need. If the members opposite support the amendment put forward, there could be a real way forward to protect vulnerable Albertans.

The UCP simply cannot be trusted when it comes to new contracts and their friends. Why should Albertans trust them to create a massive recovery system from scratch in our province? How can we trust that recovery care procurement is not embroiled in the same corrupt care situation? Until a thorough public inquiry is conducted, these are the trust issues and the basis that Albertans will feel with this model. Getting to the bottom of this scandal requires a public inquiry.

Mr. Chair, I cannot support Bill 37 as it stands, and I firmly believe we need this amendment in place. I encourage the members opposite to vote in favour of it. Without it, Albertans cannot have confidence in our addiction and mental health systems if standards of care can be arbitrarily just pushed aside and decided by a minister instead of health experts. Quite frankly, better is possible.

Thank you.

The Acting Chair: Thank you very much.

Are there others? We have the Member for Calgary-Varsity. Go ahead.

Dr. Metz: Thank you very much. I feel that it is very important to me to speak to this bill, particularly to the amendment that has been submitted. The Mental Health Services Protection Act, which is the act that Bill 37 is amending, is the act that is meant to provide a foundation for safe, quality addiction and mental health care. And it provides authority to establishing licensing programs for addiction and mental health service providers. It also very specifically establishes a licensing requirement for residential addiction treatment service providers and outlines the core requirements that must be met.

Now, Bill 37 is an amendment to this act, and the amendment that the Member for Calgary-Currie has submitted to Bill 37 is to strike out the ministerial exemption which was included in this Bill 37. It's one they are trying to amend. The ministerial exemption may – in relation to an individual who is being provided a service, or a service provider, or any other person may be exempted from meeting all of these quality requirements and all of the licensing provisions that are built into this Mental Health Services Protection Act.

So the issue here is that we're giving tremendous power to the minister to not abide by the regulations that are built into this act. And the problem with that is that the minister can do this based on the medical condition that the person has or the treatment that the person is going to receive or exempt them for scientific or research purposes. Do we want to exempt people from getting the minimum quality care so that they can participate in a scientific or a research study? That goes against the principles of research when you are undertaking research on or about a person that is vulnerable.

9:10

There are very clear requirements, ethical requirements, for all research. Research needs to take into account the status of the individual, and if an individual is incarcerated, for example, or, under this act, receiving treatment that they did not consent to, the ethical considerations are extremely high. The vulnerable person does not have autonomy to make their own decisions, so how can they possibly consent to be part of a study? It seems unreasonable to me, and therefore I cannot support the part of Bill 37 that would waive the minimum care requirements laid out in the Mental Health Services Protection Act because a person might be involved in a research study. At least that's the way the act reads.

These are vulnerable people. They cannot give truly informed consent. They do not have autonomy as to whether they wish to participate in this work. There is no one to protect them from harm other than those that are providing the care, and now we're going to remove the standards that give them the minimum amount of care and treatment that they're supposed to receive. There is great potential here for exploitation of these individuals.

The other thing that is very challenging in this Bill 37, and why I believe that this amendment is necessary, is that we should not be giving the minister the power to exempt patients, people, from getting care under this act that meets the minimal standards based on their condition. There's nothing in this act that actually shows how these individuals are going to be truly assessed for what their condition is. People with addictions often have concurrent brain injury, either because of the addiction itself or, prior to that, they had a brain injury that contributed to why they have problems with addiction.

This is a very high percentage of people that are suffering from addiction, and understanding and identifying the underlying brain injury is very challenging. Some of the symptoms would include poor balance, unclear thinking, poor memory. Those are common symptoms. How are we going to know without very expert assessment whether these are things that need to be dealt with as part of the person's treatment plan or if we can just wipe out and not bother to abide by the minimum standards?

We also know that people with addictions very commonly – and it's 50 to 60 per cent of people with addictions – will have other concurrent mental health conditions. Are we going to, with this, allow the conditions of their addiction treatment to be less than other people would receive because, perhaps, they have a mental health condition that makes them less worthy of this? What really is going on here with why we're going to be allowing this amendment? I would like to understand why it's even there. There doesn't appear to be any rationale for taking away the minimum standards of other people being treated for their addictions.

Alberta's New Democrats want all Albertans who need health care supports, including the mental health and addictions care, to have equal access to high-quality care. That doesn't mean equal

access to any level of care and you get worse care because the minister decided you would be exempted. We know that access to care is one of the greatest challenges facing our health care system right now. Poor access is leading to very long wait-lists. It's causing people's conditions to deteriorate such that they have less chance of actually benefiting from care, and now we're looking at reducing the standards that are written into the Mental Health Services Protection Act at the will of the minister to some people so that they would have lesser care than others.

One of the reasons built in here to give the minister this power is that it says, "the public interest." That's very interesting to know. What does that mean? Does that mean that it's in the public interest to offer lesser care to this person so that more people perhaps will get a different standard of care? Maybe that is the reason that we are seeing shifting of certain surgeries to private surgical facilities away from people that have more challenging conditions and need hospital care because then a greater number of procedures can be done and those that have greater needs will just have to wait longer. Is this similar to that, that we're going to waive the basic standards?

Who is going to make the decisions around who has these conditions? Where is there going to be an assessment? These are challenging, expensive, time-consuming assessments when we're looking for evidence of brain injury and we're trying to uncover concurrent mental health conditions. These take time. How are we going to manage these people in the meantime? Are they going to start with a low level of care while this assessment goes on, or will they ever get it? We know that there are years-long wait-lists, sometimes two years to get in to see a psychiatrist, for example, for certain things. People that have brain injuries can't even get care unless they're referred within a very short period of time from when their injury occurs because we just don't have the capacity to provide that care. So how are we going to do that?

We wholeheartedly oppose allowing the minister to exempt individuals from care standards for scientific or research purposes or for the public interest, which is the reason that this amendment to Bill 37, which is to cross out this section, has been proposed. We do not believe that this should be in the power of elected officials to make these decisions. We do not believe that we should have a standard and then say, "except for some people," such that we probably will have a pretty low standard to begin with given that the wait times to get in are very long. Now we want to waive any of those standards, or is this to waive these standards for particular institutions? Because we've been talking about waiving a standard for an individual, but this amendment proposed in Bill 37, which we are hoping to remove from Bill 37, also allows the minister to exempt any provider from meeting those standards.

9:20

Now, when we look at this in the light of things that have been going on with corrupt care, where we see that some of the private surgical centres get paid double what it costs in the public system, where there are big differences between the amount of pay going to different centres, now we're looking at, perhaps, different standards that have to be met by different providers of the mental health services for people with addictions. Is one recovery centre going to have one standard and another recovery centre now going to not have to meet any of those standards because the minister decides that this is the way that it should be?

I'm very concerned that Albertans will not get the care that they need. I already have a huge concern with the model itself being truly an experiment at a provincial level. There are study designs that can be done where a model can be compared between different centres. This is done in, for example, looking at obstetric care in one place versus another place rather than to the level of the individual, but we are subjecting the whole province to this experiment in recovery, and we're not even going to keep a minimum standard that will allow us to evaluate the outcome, because if you change the standard as to how you're going to evaluate the outcome of your intervention, you don't really know what you did for many different people.

For many ways, it makes the whole expensive experiment unassessable, because we don't even know what has been tested, what the standard of care was in different situations. It is setting the system up to fail to show benefit because we're not even going to provide a standard of care. Now, then that opens the argument that, well, we didn't actually do that here, so let's keep trying it, because, you know, maybe it'll work this time. Just like privatization: maybe it'll work this time despite evidence after evidence after evidence that it costs more and your care decreases and that more people lose access to the care that they need.

This whole experiment is not going to create confidence in our mental health and addictions care systems. If standards can easily be pushed aside for any broad reasons, we're not even going to know how to evaluate the whole program, aside from the fact that we really don't have information on what kind of outcomes we're going to be getting, we don't have information on what the standards actually will be, we don't know when things start, we don't know who's going into this system. So far we're looking at a very small number of individuals even receiving care in recovery centres, let alone being forced into care. Therefore, I must say that this is ridiculous that we would allow the ability for the minister to first write standards and then decide, for a variety of reasons that are very broad and essentially mean whenever they want, to push those standards aside.

I will rest my case on this issue. I believe I have colleagues that have other points to raise around this amendment.

The Acting Chair: Thank you very much.

Are there others that would like to speak? The Minister of Mental Health and Addiction, go ahead.

Mr. Williams: Thank you. I'll take a short opportunity to help clarify with members opposite what are legitimate concerns and questions and I think perhaps a misunderstanding, beginning with the most recent speech from the Member for Calgary-Varsity, who I think seemed to imply that individuals subject to this act are there involuntarily. Just to clarify, this is not Bill 53; this is not compassion intervention. That was previously. What we're talking about here with MHSPAA is regulating narcotic transition services, drug consumption services, bed-based addiction treatment services, including treatment beds, stabilization detox beds, and of course psychedelic drug treatment services.

So it's not a question of capacity for the vast majority of these individuals, and I think that was maybe a misunderstanding. This is not a question of people not able to make decisions legally on their own. Of course, they can, and they should. If they want to participate in research, for example, they should. As the member very clearly articulated, there are high standards for that medical research that happens in academic settings, the ethical review that happens with approvals. Obviously, this doesn't connect with any of that. Those ethical standards continue for research. They always must by requirement of the institutions that those academics are a part of. This is not about academic and ethical standards for research.

What this does allow, for example, is if psilocybin, a psychedelic, were to be researched for PTSD in a novel use, which is restricted right now by this act, we can have the flexibility so that if it's in the public interest for us to do this kind of research for medical

purposes, then we can say that it will not apply in those circumstances with that particular research project, individuals who are consenting, individuals who are knowledgeable about this, who understand the risk, that have gone through the ethics board approval at the academic setting. Otherwise, this act would limit that because of the law.

What we're talking about is not a worse or lesser standard but, instead, a flexible and better health care for people because there can be outside of the research setting all sorts of unique circumstances for an individual's medical circumstance that might say that the legislation drafted for 4.4 million Albertans is uniquely put in this one spot for an individual, talking about that person's individual health care needs, whether you're talking about NTS, you're talking about drug consumption services.

There could of course be unique case-by-case – not class-by-class but case-by-case – exemptions. This kind of exemption for a ministerial ability is not uncommon in federal and other provincial jurisdictions. We see it in immigration legislation. We see it as a request from courts to make sure that the legislation is flexible and can meet the needs in a very broad set of circumstances. I can promise you it's not my interest as a minister to introduce these very high standards to then in some sort of conspiratorial way undermine all of them in some broad way.

I do want to provide flexibility in unique case-by-case circumstances, and if any member opposite were in my seat – it's a nonpolitical and important piece of the legislation that allows it to continue to sustain the high standards so that it's better able to stand up to court tests. This avoids more litigation. It instead allows unique circumstances to continue to exist within the province. It is really not the circumstance that we're looking at. It is going to always be written, it will have conditions associated with it, and it will be evaluated case by case and always be published on a public-facing website.

It's not as though the Minister of Mental Health and Addiction has got a friend, and I think he really should provide without the same standards. It's not as though I have an enemy, and that individual shouldn't get as good of health care. That is not possible under this system. That is not its purpose, of course, and the public scrutiny that will be there will continue to allow it. I appreciate the concerns, and I can understand where the concern is coming from. The truth is that it is not based in some legitimate instantiation of this act, especially around section 12.

I appreciate that debate will continue. I'm happy to address it. This is a legitimate section that is found in other pieces of legislation, especially broad ones that apply to wide classes of people where unique circumstances and case-by-case analyses need to be considered, both for the dignity of those individuals and to maintain the legitimacy and quality of the broader regime at the same time.

9:30

I'm happy to continue the debate, but I can say right now that this government will not be accepting because it would weaken the legislation. It would weaken it in the eyes of the courts. It would weaken it in its flexibility and ability to deal with, say, public interest, medical research, unique circumstances case by case, which would paralyze us in ability to address the concerns. This is very strict legislation. It's meant to license on purpose. Without the ability for us to be nimble in an important way as a province, no matter who is in this ministerial seat, I think it would weaken the ability for us to provide that care.

Thank you, Mr. Chair.

The Acting Chair: Is there anyone who would like to speak to amendment A1? The Member for Edmonton-Beverly-Clareview. Go ahead.

Ms Wright: Thanks, Mr. Chair. It's an honour to be here this evening to speak to this amendment to Bill 37. I certainly do thank the minister for his recent clarification, but nonetheless there are still many concerns that I hold having to do with section 12, as I know many of my colleagues have already very admirably discussed, particularly my colleague from Calgary-Varsity as well as other folks who we know have had quite a bit to do with research in the past.

Certainly, this is an amendment that in my view would really assure all of us in this area that we're dealing with today to ensure that health care really does stay at the heart of all of this. The minister's comments – nonetheless, I do wonder why these sorts of decisions would need to land on a minister's desk rather than simply go through all of the normal research protocols. But aside from all of that, this amendment also means that the delivery of health care, as I said, stays firmly in the centre and, not only that, will be in the purview of the health care professionals. Those folks, whether they're on the research side or whether they are on the acute-care side or wherever they may be, are the ones working, of course, with that patient to ensure the very best care possible.

Also, further, by the striking of section 12, which is what this amendment really talks about – I suppose, you know, I'm kind of hemming and hawing now. I will certainly cop to a fair amount of confusion at the moment because "confusion" would be the right word, I think, here. Again, I'm not entirely certain why these sorts of decisions to kind of brush care decisions aside, even in the case that there's a research study going on – the minister talked about psilocybin and that sort of thing. But, you know, again, confused. I'm not certain. Like, would standards of care not be included in that particular research as well? I would think that they would be, so I'm still not certain why we would need to do that, hence my support for this.

Certainly, you know, that health care plan is there for a reason. Whether you're involved in the health care system because of a physical issue or a mental health issue, it is indeed all health care. That health care plan, as we've mentioned, is developed in terms of what that person wants as their outcome, what their health care provider or providers are looking for in terms of the outcome, which I believe really needs to be at the centre.

I truly don't understand – and again I use the word "confused" – why these sorts of decisions, whether it's because of a scientific purpose or research or public interest, would need to land on the minister's desk. Why indeed would, you know, folks not go through the proper research protocols and then do the research, always ensuring, of course, that the care of that person who is in the midst of that research study is paramount?

Like, I think about friends of mine who are in fact in the midst of research studies, and they are required to visit their family doctor as well as a specialist on a very regular basis to ensure that, you know, they're not getting left behind, to ensure that their other care is not being left behind, to ensure that indeed their standards of care are excellent and are not being pushed to the side. Perhaps there's an issue in terms of what people mean by standards of care. Again, I don't understand why standards of care would end up in the minister's office.

Leaving all that aside, there are certainly many, many issues that are part and parcel of all of this. Certainly, for me much of this does indeed – and I think we need to bring this back again because when people are in receipt of health care, the people giving that health care are, of course, health care professionals. As we know, health

care professionals these days: there's a massive recruitment and retention crisis out there. If we're pushing aside care standards, I would wonder if some of those health care professionals would even want to continue to practise.

You know, the bill itself – and the amendment, of course, is seeking to mitigate a few things in the bill. What this government is asking us to accomplish here, what this government is hoping that we will support here is rather consequential. These things that we are being asked to change as a result of this legislation will have huge impacts on patients throughout the province, but it won't only just have huge impacts in terms of the patients themselves. It will have absolutely huge impacts on top of those people who are offering care to all of those patients. We know that right now we are in the midst of a mental health crisis.

I think about what it's like in schools these days for kids who are having, you know, perhaps a bit of a challenging time just in that day-to-day world. For them to be able to simply access health care in school is very, very difficult these days, to say nothing of that if they and their parents decide that they're trying to access that through their family care provider, there's oftentimes an even longer wait. Part of the reason for that wait is that we just simply don't have the professionals here to offer the standard of care – speaking of standard of care – that we would want those folks to have. Particularly when we are speaking of mental health issues, many of these folks are some of the most vulnerable folks that we know, and it could be that in that moment they are vulnerable and they need our help, they need our assistance, they need our support, but they also need whoever that health care professional is to be okay as well.

In the course of some of the research I've done, our mental health care crisis these days really is indeed in an alarming state. We're looking at the suicide rate in Alberta reaching 14.3 deaths per 100,000 people. That's an astonishing, huge number. It's really frightening to me certainly as a person who taught for 24 years to know that, you know, at least one of those kids in a couple of those classes I taught was facing a crisis that certainly I and perhaps the system as well were ill equipped to deal with.

We know that we, as I mentioned before, don't have enough mental health professionals. We only have 10.6 psychiatrists per 100,000 people. Regardless of the situation, research or public interest or not, you know, if we are indeed pushing aside and making exemptions for things, like, I really do wonder who it is that's going to be giving that care depending upon what that care may be, the reason for that care may be.

Of course, what we also know is that there are so many pressures that are being brought to bear, and all of those things are part and parcel with the mental health care crisis that we're dealing with. Rents have shot up. Complex mental health needs have doubled. There's an economic burden, too, on Alberta's health care system. The costs – and my colleagues have talked about this as well – in terms of access to care, particularly when you're talking about that "in the public interest," there's no definition of what "in the public interest" may be. So I do think it's right to question what that "in the public interest" might be because, quite frankly, it really does lend one to wonder what that definition would be. Are we going to see, you know, the definition written out, codified somewhere in regulations? Why would it not be here if that were the case?

Particularly, that mental health care crisis is really kind of resting itself on our young folk here in Alberta. Depression and anxiety symptoms have doubled, and certainly part of that might have come from COVID, but, you know, the other part of it is simply from the act of living from day to day.

Nonetheless, getting back to some of my main points here, for me, Bill 37 and as well this amendment which we are, of course, talking about right now: it's really about those health care providers and some of the things which we know a few of them are going through as well.

9:40

Having just come from participating in the Day of Mourning and listening to those 203 names yesterday, it wasn't just about occupational illness, injury, disease; it was also about trauma. It was about people who had lost their lives because of trauma. Certainly, regardless of the health care coverage that might be offered in any particular moment for any particular reason, when you're offering that health care coverage for someone who's in the midst of a mental health crisis, you yourself as you shepherd that person through that crisis could indeed be experiencing trauma. Your own trauma then kind of goes on to add to more trauma, because you are the one who's supposed to know how to handle all of this. But the reality is that sometimes you simply cannot.

In fact, in the recent contract that nurses talked about, you know, one of the things that they were able to do was to take back that idea of presumptive coverage, which I think is really, really important. Again, we're talking about the safety of our patients, but we're also talking about the safety of the people who care for them. Sometimes I think that we're leaving out those folks in the middle. We also have people who are caring for all of us in this health care system that we know are not just suffering one incident of trauma, but in fact they're suffering a series of trauma. They're suffering from anxiety. They're suffering from clinical depression. Part of my worry, too, is: how are we going to be able to retain those folks in our mental health profession if they themselves are having injury as a result of doing a job that many of these folks love? We know that we have a recruitment and retention crisis.

[Mr. van Dijken in the chair]

To add to all of that, of course, one of the things that's happening right now is that idea of regulated versus unregulated professions. Within our mental health I'll call it an industry now, one of my concerns is that we are soon going to be entering into an area where, you know – and speaking of care standards – particularly even if it is something that the minister themselves might be exempting, if you're exempting that notion of a care standard, I worry if you are also exempting that notion of someone who has clinical expertise, who comes with some sort of certification, who has skill, who has a team around them to ensure that whatever that research study may be or whatever that scientific thing may might be that may be in the public interest, the level of care that person is receiving while they are in the midst of that study, quite frankly, isn't substandard.

Albertans aren't asking for anything other than a good, appropriate level of care, and that good, appropriate level of care needs to be provided by health care providers who themselves are doing okay. That's just one of the things I'm concerned about.

In terms of the unregulated professionals – and this is to get to one of my points about this – I do in fact worry that we know that those folks who are recovery counsellors, addictions counsellors right now have been waiting for a very long time to become a regulated profession. I think now they're waiting for another year and a half, and we really haven't heard if this is moving or not. I know that the folks, ACTA, who are going to be that regulatory body right now aren't taking in any other folks to join them in their profession and to receive that sort of level of certification because, quite frankly, they're not sure if that's going to go forward or not.

When you look at the ethics that are involved, when you look at the standards that are involved, when you look at the education that's involved, the level of skill, the level of experience, the depth and breadth of patient work that's involved and then you contrast

that with some of the offerings that are there for folks who may want to be recovery counsellors – and certainly, you know, people get to be peer support workers; people get to be recovery counsellors. But I come back to that central point. Regardless of whatever that patient might be involved in, I think we as legislators owe a real duty of care to those folks who are going through those sorts of things, whether it's in the public interest – again I don't really know what that means – or if it's because of a research study that's coming out of university. We owe it to them to make sure, again, that the people who are working with them have a certain standard, a certain level of expertise. Quite frankly, in those situations I would hope that the standard level of expertise is a wee bit higher, maybe, than you might find in some other conditions. If indeed it's because they're doing some research that some other levels of care need to be, you know, exempted, then I would hope that they'd be able to pick up on things when they might be going a wee bit awry. You know?

Again – and I know I'm speaking like I'm confused, Chair, and that honestly is because I am. I am confused as to why it would be okay to exempt any sort of standard level of care to any patient regardless of the circumstance.

Quite frankly, you know, it won't surprise folks that I have some friends who are in the health care profession, who work as EMS professionals, who work as LPNs, and who work with people who work with them, and they carry a great burden on behalf of all of us. They want to make sure that we are okay. That goes right from that RN who's perhaps supervising a few folks to the LPN who comes in to the home-care person who's then helping out that person on their path to recovery. It really is a team effort, but all throughout that team they deserve to know that we are behind them and supporting them. Part of that support means that we're not sacrificing them in the process.

Coming back again to that issue of nonregulated professionals and knowing kind of where we're headed, we might be finding that there are more nonregulated professionals out there. I do worry that if there is a nonregulated professional out there or someone who has maybe a week and a half of training, as I noted on a few websites there – you know, you're interested in being a recovery counsellor. I'm sure you're doing it for all the right reasons. You want to help out folks because perhaps you, yourself, have had some experiences. But we also need to make sure – again, there are some ethical components here.

If people are going to be recovery coaches, recovery counsellors, then we need to make sure that they are able to deal with the trauma that they're going to be hearing as they take someone through their own journey. Quite frankly, a week-and-a-half-long course online, sometimes in person, is not exactly the way that we need to be going with this. Again, whether or not it's an experiment that's coming from a university or there's a research study going on, we owe a duty of care to the people who are caring for us as well as to the people who are being cared for.

I've talked a little bit about that issue of deskilling, you know, and it's not that different from the microcredentials that we sometimes find in the trades. These sorts of things are, you know – they should be an add-on to one's education, not kind of an "instead of." If you're going to be a plumber or a pipefitter, you really do need to have that blue or that red seal. But, in addition, we, of course, would hope that you'd be able to go out and perhaps get another credential to add to what you already know. That's fine. If I'm taking that further to the idea of, like, a recovery coach: totally fine. If you've already had a great deal of experience, perhaps in mental health and addictions counselling and care, it would make sense, perhaps, to take that certification that you already have and then to kind of buttress it with a few extra added things because those extra added things are going to help inform your practice. That is fine.

But that is not what we're talking about here. We're talking about, instead of years of experience, years of education, years of developing that skill, sending someone into a mental health – perhaps a sober living house, whatever it might be, perhaps working with someone who is in the throes of something really challenging, whether it's a disorder, whether it's a disease, whether it's kind of a momentary challenge, whatever it is. We're expecting them, with just a week and a half of online training, to give the very best level of care for our family members. Quite frankly, I'm not certain that that's a really fair thing to be doing for these folks.

9:50

The fact that we have this amendment in front of us here and the fact that we have so many questions – certainly again, appreciating the minister's comments – you know, I would love to have, I guess, a more concise definition of what "in the public interest" might indeed be. I'm very curious about that particular one. Again, also just kind of curious about why it's necessary that these decisions end up on a minister's desk rather than with the health care professionals who are paid to take care of this.

The Deputy Chair: Thank you, Member. Are there any other members wishing to provide comment?

Seeing none, I will call the question on amendment A1 as proposed by the Member for Calgary-Currie.

[The voice vote indicated that the motion on amendment A1 lost]

[Several members rose calling for a division. The division bell was rung at 9:51 p.m.]

[Fifteen minutes having elapsed, the committee divided]

[Mr. van Dijken in the chair]

For the motion:

Batten	Ganley	Shepherd
Boparai	Hoffman	Sigurdson, L.
Calahoo Stonehouse	Hoyle	Sweet
Deol	Kayande	Wright, P.
Eremenko	Metz	

Against the motion:

Amery	Johnson	Rowswell
Armstrong-Homeniuk	Jones	Schow
Boitchenko	LaGrange	Schulz
Bouchard	Long	Sigurdson, R.J.
Cyr	Lovely	Singh
de Jonge	Lunty	Stephan
Dreeshen	McDougall	Turton
Dyck	McIver	Wiebe
Ellis	Nally	Williams
Fir	Neudorf	Wilson
Getson	Nicolaides	Wright, J.
Glubish	Nixon	Yao
Horner	Petrovic	Yaseen
Jean		

Totals: For – 14 Against – 40

[Motion on amendment A1 lost]

Mr. Williams: Mr. Chair, I ask that we adjourn debate and report progress.

[Motion carried]

Bill 44
Agricultural Operation Practices Amendment Act, 2025

The Deputy Chair: Are there any members wishing to make comment? I recognize the Minister of Agriculture and Irrigation.

Mr. Sigurdson: Well, thank you. Of course, I'm pleased to speak to my Bill 44. If passed, changes to the Agricultural Operation Practices Act will provide clarity for the emerging biogas industry and spur job-creating investment in rural Alberta. This is a win-win for rural Alberta.

10:10

Now agriculture producers and agriprocessors will have another option to help manage their organic materials and reduce the amount of these materials sent to waste disposal facilities. This is good news for them. It's also good news for our environment. Farmers, ranchers, and agriprocessors produce about 3.4 million tonnes of organic waste annually. These biogas plants use that organic feedstock, including livestock manure and that organic waste from agriprocessors, to create biogas that can be used to generate heat and electricity or be refined into renewable natural gas. Material remaining after the process is called digestate, which can be used as a soil amendment to grow crops and improve soil health. Anaerobic digesters also divert organic waste from landfills and become additional revenue sources for producers or save producers money if they use it as a supplement or replace synthetic fertilizer.

Additions to the act would define organic material to include not only material generated at a farm or ranch but also organic material from greenhouses or agriprocessing facilities, allowing them to be composted and stored in manure facilities or at farms. This would divert a lot of waste that is currently going to landfills. This change will elevate the existing rules regarding the storage of biodigester feedstock, land application of digestate from a memorandum of understanding into legislation to provide the agricultural sector, the investment sector, regulatory clarity, and the certainty.

Now, Mr. Chair, I think we can all agree that this bill will help grow our agricultural sector and bring investment into rural areas. However, it was noted that the province has been able to manage biodigesters through a memorandum of understanding between my ministry, the Ministry of Environment and Protected Areas, and the Natural Resources Conservation Board. The question is, why can't we continue to use this MOU? Well, the MOU approach to managing biodigesters was always meant to only be a temporary fix, and it was established over a decade ago so it was time to update it. What we're doing right now is an efficient approach that does provide the clarity and certainty for agricultural producers, investors, residents, and municipalities. Everyone needs to know the rules in advance. Our proposed changes would set into legislation what's currently contained in the MOU, thus providing that certainty and clarity.

The second criticism I have heard from the members opposite was that biodigesters should only be built in certain areas, for example, industrial areas. Now, I think they're missing the point a bit here, Mr. Chair. The point is that we are intending that this is and will become a common on-farm manure management process. Storage of manure, then moving, loading, trucking, burning diesel through those trucks to move it elsewhere, definitely is not sustainable and is less environmental.

Now, I've also heard that those who read the bill were maybe not content that we're just providing 20 days notice of an application to build a confined feeding operation or manure storage facility to affected landowners and the public. Mr. Chair, previously a select group of landowners and residents called the affected parties in the MOU only had 10 working days after they were notified that they could provide a submission. The public had 20 working days from when the application was complete. In practice, the day from both the affected parties and the public to submit essentially was the same, but we have clarified this now to allow straight across 20 days in the proposed amendment.

In conclusion, Mr. Chair, this bill aims to grow the agricultural industry, one of the biggest, and I would argue, one of the most important sectors in Alberta's economy. It aims to boost the livestock sector. It aims to help diversify Alberta's economy. Of course, Alberta, being large in the livestock industry, we are presupposed to be very successful for gaining a lot of this investment that we'll see in years to come, as we do have an abundant feedstock for this biogas industry.

We know that Alberta, of course, is the best place in North America to do business. We have amongst the lowest tax regimes in North America. We have cut red tape to make our economy the fastest and freest in the continent, and our agriculture, of course, is one of the strongest in the world. Through Bill 44 we have an opportunity to make it even stronger. Let's seize this opportunity for the good of Albertans, for the good of our farmers and ranchers, who work tirelessly every day to feed families at home here and, of course, abroad.

With that opening statement, Mr. Chair, I would also like to move an amendment. Unfortunately, there was a small error in wording in section 1. I'd like to move an amendment, which I'll pass on to the chair now. Of course, this is a very, very simple wording change just in section 1 by amending and striking out "this section" and substituting "this Act." I hope all members of the Assembly will support this simple amendment on just a needed wording change.

Thank you.

The Deputy Chair: Thank you, members. We have before us amendment A1. We'll be waiting till all members have it available to them.

Are there any comments, questions on amendment A1?

Hon. Members: Question.

[Motion on amendment A1 carried]

The Deputy Chair: Any other members wishing to comment on the main bill? The Member for Edmonton-Manning has risen.

Ms Sweet: Thank you, Mr. Chair. It's a pleasure to rise and speak to Bill 44, Agricultural Operation Practices Amendment Act, 2025. I appreciate the comments from the minister opposite in regard to some of the questions that I had brought up in second reading of the bill.

One of the pieces that does continue to be a bit of a concern when we're hearing from individuals is the proximity. As much as I appreciate the minister saying that, you know, if we're going to start hauling biomass from one point to another point to be able to be processed, it seems to be less energy efficient – I appreciate that, but we do see it happening in the province already. We do see that there are jurisdictions that are using a more centralized approach so that more feedlots and more producers are able to bring their biomass and have it processed instead of having to create a whole bunch of different processors.

If communities and if individuals are wanting to build them directly beside their feedlot, I don't think that there's an issue there as long as the surrounding communities are not being impacted. I think that's the bigger piece and the concern that's come up, that some of the projects that are being discussed and being proposed in the province are quite close to residential properties. I haven't really heard from the government what the solution is or what the government is proposing to help address those communities that may be potentially downstream or downwind from these facilities.

Part of the legislation and part of the requirement is and should be that when these projects are being explored, an environmental assessment is being done and we're able to determine whether or not there will be an environmental impact. We do know for a fact that certain communities that are looking at these projects do have concerns about the environmental impact, which is why one of the projects specifically is being reviewed at this point to see if the tailings pond that is going to be built will have the appropriate protections to ensure that there is no leakage, that there is an appropriate cover, and that any of the smell or potential contaminations are not mixed in to the local municipality.

10:20

In saying that, I do have an amendment that I would like to propose, and I have the requisite copies as well as the original that I will provide. I also would like to be able to discuss it for a few minutes.

Thank you.

The Deputy Chair: The amendment will be known as amendment A2.

The member can proceed with comments. Read it into the record, please.

Ms Sweet: Thank you, Mr. Chair. The Member for Edmonton-Manning to move that Bill 44, Agriculture Operation Practices Amendment Act, 2025, be amended in section 17 in the proposed section 44.1 as follows: (a) in subsection (1) by striking out "The Minister may" and substituting "Subject to subsection (1.1), the Minister may", (b) by adding the following after subsection (1):

> (1.1) Before establishing or amending a code, standard or guideline that relates to the environment, the Minister must consult with the Minister determined under section 16 of the Government Organization Act as the Minister responsible for the Environmental Protection and Enhancement Act.

Mr. Speaker, basically, what this amendment is doing is ensuring that under this piece of legislation before the minister can develop any regulation or guidelines, the consultation with the minister of environment is done to ensure that those regulations will align with the environmental protection measures that the communities are asking for, so basically to ensure that as this legislation moves forward and as this legislation comes into force, we recognize that any environmental pieces around potential downwind smell, anything around tailing pond coverage and potential leaking, and all of those environmental factors that communities are talking about have been addressed and do meet the standard underneath the act that the environment minister is required to review and that all of those standards are met within the regulation. Basically, it is enabling and ensuring that the minister is working with his counterparts in cabinet to ensure that those environmental protections are being done.

It's quite a simple amendment. It basically protects communities. It ensures that we know that we are preventing any future environmental impacts, and it protects local municipalities, local residences, and any potential contamination of waterways, including drinking water, as well as, basically, quality of life for many of the communities that these biodigesters are going to be connected to.

Thank you, Mr. Chair.

The Deputy Chair: Any other members wishing to comment on amendment A2? The Minister of Agriculture and Irrigation has risen.

Mr. Sigurdson: Thank you, Chair. I just wanted to respond to the member opposite. I appreciate the amendment that she's put forward. Of course, as a government we want to make sure, as we're moving forward, that the environment is protected and that we do have a process that also considers the impact of those in the surrounding areas, including those individuals that may live in affected areas. I just want to clarify that, of course, I appreciate this amendment, but I won't be supporting it, and I'll explain why.

When we look at the co-ordination that happens within our entire cabinet review process and the close relationship, of course, agriculture has with environment already – we work very closely with our Minister of Environment and Protected Areas. But with the process itself and the way the Ag Operation Practices Act relates with the environment, I think it's important to understand why this is redundant and unnecessary. Environment and Protected Areas already retains responsibility for permitting anaerobic digester and agriprocessing facilities under the EPEA, or the Environmental Protection Enhancement Act. Through their permitting process they set conditions related to an anaerobic digester feedstock and the digestate as well as waste generated by the processing facility. Additionally, organic material generated off-farm is regulated under Environment and Protected Areas' Environment Protection and Enhancement Act as well, and the associated waste control regulation, or the WCR, is considered as well.

The on-farm management of digestate will fall, of course, under the NRCB, the body that answers to the Minister of EPA but is separate and independent and deals with the entire approval process of any of the on-farm management biodigester facilities that we intend on having here in the province. Of course, environmental consideration is present throughout this entire piece of legislation, and that's why I won't be supporting this amendment.

Thank you, Chair.

The Deputy Chair: Any others wishing to provide comment?

Seeing none, I will call the question on amendment A2 as proposed by the Member for Edmonton-Manning.

[Motion on amendment A2 lost]

The Deputy Chair: Are there any others wishing to provide comment? The Deputy Government House Leader.

Mr. Williams: Well, thank you. Mr. Chair, I thank you very much for the time, and I move that the committee rise and report progress on bills 37 and 44.

[Motion carried]

[Mr. van Dijken in the chair]

The Acting Speaker: The Member for Bonnyville-Cold Lake-St. Paul.

Mr. Cyr: Thank you, Mr. Speaker. The Committee of the Whole has had under consideration certain bills. The committee reports progress on the following bills: Bill 37 and Bill 44. I wish to table copies of all amendments considered by the Committee of the Whole on this date for the official record of the Assembly.

The Acting Speaker: Thank you.

Does the Assembly concur in the report? All those in favour, please say aye.

Hon. Members: Aye.

The Acting Speaker: Any opposed, please say no. That is carried and so ordered.

Mr. Williams: It's been a tremendous evening with lots of lively debate. However, I think it must end so that we might see how the Oilers did and what the sound was in the government lobby just before rising and reporting. Mr. Speaker, I move that the Assembly be adjourned until tomorrow, Wednesday, at 1:30 in the afternoon, April 30.

[Motion carried; the Assembly adjourned at 10:28 p.m.]

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