Title: Monday, July 16, 2007 Community Services Committee
Date: 07/07/16
Time: 2:04 p.m.
[Mr. Marz in the chair]

The Chair: Well, good afternoon, everyone. My name is Richard Marz. I'm the acting chair of the Standing Committee on Community Services.

We will start today by asking all the members of the committee as well as the members of the Legislative Assembly Office to introduce themselves, and we'll start with Dr. Pannu.

[The following committee members introduced themselves: Rev. Abbott, Mr. Backs, Mr. Johnston, Mr. Lukaszuk, Mrs. Mather, Dr. Pannu, and Mr. Shariff]

[The following departmental support staff introduced themselves: Ms Bennett, Mr. Chamberlain, and Ms Miller]

Ms Dean: Shannon Dean, Parliamentary Counsel.

Ms Rempel: Jody Rempel, committee clerk.

Dr. Massolin: Philip Massolin, committee research co-ordinator.

Ms Sorensen: Rhonda Sorensen, manager of communication services.

Mrs. Kamuchik: Louise Kamuchik, Clerk Assistant, director of House services.

The Chair: I'd like to welcome everyone. Just a reminder that there's no need for anyone to operate the mikes yourself because the staff are doing it automatically.

The meeting materials have been available online for printing and viewing since Thursday, July 12. I'd just note that members are welcome to bring their laptops, and I see that some have. That way you can access the documents online during the meetings.

Could we have a motion for the approval of the agenda?

Rev. Abbott: So moved.

The Chair: Moved by Reverend Abbott that the agenda for the July 16, 2007, meeting of the Standing Committee on Community Services be adopted as circulated. Those in favour? That's carried.

On the July 4 minutes has everyone had a chance to have a look at them? A motion to approve those minutes? Mr. Lukaszuk. Those in favour? Opposed? That's carried.

Based on our discussions last meeting, July 4, it was decided to have officials from the Department of Health and Wellness provide some technical briefings on Bill 31 and Bill 41 today. We have with us Ms Paddy Meade, deputy minister; Mr. Martin Chamberlain, corporate counsel; Ms Karel Bennett, director of health professions, health workforce division; and Ms Fern Miller, senior manager, population health strategies branch, public health division. I'd like to thank you all for joining us today. I believe we're going to be hearing about Bill 31 first, and we'll follow that presentation with questions before we go on to Bill 41. So please proceed with your presentation.

Ms Meade: Thank you very much to the committee. I am here representing, of course, the minister. You wanted a technical briefing, so I'm actually going to turn most of this over to Martin Chamberlain, our legal counsel, to give you a walk-through of Bill 31, the Mental Health Amendment Act, 2007. Then we'll take questions, Chair. Thank you.

Mr. Chamberlain: Mr. Chair, committee members, thanks for inviting us to come. We've provided you with a binder of materials on Bill 31. I just want to walk you quickly through it to let you know what's in there, and then I think the simplest is that we'll go through some of the highlights of the bill.

Essentially, you've got a one-page backgrounder that is just a little bit of history on the Mental Health Act. As you can see, it's been around since 1964. The last significant amendments were done in 1990, so there hasn't really been anything done since then. It's the legislation that sets out basic provisions for formal patients in Alberta, for involuntary admission into facilities, and primarily that's what the legislation deals with. Significant changes back in 1990 were the introduction of the Mental Health Patient Advocate and a few updates to the legislation. So I've provided you with a little bit of background on what the legislation does in parts.

The second tab is an overview of the Bill 31 amendments and what's proposed, a highlight of what we're actually trying to accomplish with this bill. I'll come back to that in a minute.

Under tab 3 we've provided you with a very brief comparison chart that indicates which other provinces have similar CTO legislation and the test that's used in those other provinces for involuntary commitment of patients.

Tab 4 is just a copy of the bill, which you should already have, but I wanted to make sure that everybody had it in case anybody hadn't brought their bill with them. What we haven't put in there is the explanatory notes simply because I find it difficult to read through with the explanatory notes, so this is just the text of the bill without the explanatory notes in it. Behind that, if anybody needs to reference it, is a copy of the current Mental Health Act.

2:10

Mr. Chair, what I'd like to do is just highlight the three objectives of the bill. In the overview I've provided, we do go through a section-by-section outline. Unless there are any questions about specific sections, I don't propose to go through it section by section simply because the bill does three main things, and most of the amendments are just consequential to those three main things. For example, we're broadening the criteria for involuntary admission, and I'll read that to you in a minute. The criteria actually appears in half a dozen places through the act, so we've amended it in various sections, which is why you get a number of different sections in the amendment act. As I say, I don't propose to go through each of those. They're pretty self explanatory when you review them.

Of the three things the first is expanding the criteria for involuntary admission. The second one is making provision for CTOs. That's the main purpose of this legislation, to actually build a mechanism for community treatment orders into our legislation. That's something that a number of provinces have moved towards. We don't have anything like it in Alberta at present. The third one actually follows from a recommendation in the recent Galloway fatality inquiry, which was a recommendation that there be some follow-up with physicians once a patient is discharged from care. So we put some provisions in to deal with that.

Now, the current involuntary admission criteria is set out under the first heading there, and the key piece of language is subsection (b): "in a condition presenting or likely to present a danger to the person or others." That's the language that's been in the act since 1964. The issue that's arisen with that particular language is that it's been interpreted by the courts as requiring some immediate harm, some immediate danger, which means that for somebody who's

starting to deteriorate, unless they've actually become an immediate harm, that there's sort of an immediate risk that they're going to cause harm to themselves or others, there's no ability under our current legislation to admit them. That's the interpretation the courts have provided.

Most of the other provinces have moved towards broader language, and the different language from the other provinces is set out in tab 3. What we're proposing is very similar to that other language. It's basically adding the criteria of substantial mental or physical deterioration or serious physical impairment. That's set out, actually, in section 7 of the bill and in various other places: "likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment." The theory – and, again, this is consistent with what the other provinces have moved towards – is that once you've got an individual who's starting to deteriorate, starting to spiral, getting off their medications, who may not yet be an immediate harm, it gives us the ability to step in, have them assessed, and if they are likely to cause themselves harm or physically deteriorate further, physicians can admit them. The admission process isn't changing other than that the criteria is changing.

Now, that has a couple of implications. First, obviously it means that we can intervene a little bit earlier, but it also means that patients who have been admitted could in theory be kept in a little bit longer. Under our current legislation once a patient no longer meets that immediate harm criteria, then physicians have no choice but to release them. They may have gone back on their medications and meet the criteria, but they may not be stable. We may have a history, that we know that within a week or two they're going to go off their medications. It's very difficult for the physicians to keep them in under our current criteria. Under this criteria if a physician believes they're likely to deteriorate – so they're not stable enough that they're likely to stay on their medication – this would enable physicians to retain them as an involuntary patient until they were satisfied that there would no longer be a risk of that deterioration. That, in a nutshell, is the gist of that change.

The second provision is to provide for community treatment orders. The provisions for that are set out in Bill 31. I expect that you're all familiar with the type of circumstances when we deal with patients. These are what colloquially are referred to as revolving-door patients. They come in, they get treated, they get stabilized, and they leave a facility. Within a period of time they're off their medication, they're deteriorating again, and they end up back in.

The idea is to create a community treatment order to give another tool. It's not a panacea. It's not a fix-all. It's just another tool that physicians could use in appropriate circumstances to provide an order requiring a person to stay on their medications or to see their counsellor or to visit their physician regularly or whatever it is that the physician and psychiatrist feel is necessary in order to keep them stable so that they don't have to be readmitted to a facility. That's kind of the essence of the tool.

Specifically, what we're talking about is two physicians, one of whom must be a psychiatrist, assessing that they meet the criteria for a formal patient, that they meet our revolving-door criteria, so

(a) one or more of the following apply:
  (i) during the immediately preceding 2-year period the person has been detained as a formal patient for at least 60 days;
  (ii) during the immediately preceding 2-year period the person has been detained as a formal patient on 3 or more separate occasions; [or]
  (iii) the person has previously been subject to a community treatment order.

Then the physicians, as long as one is a psychiatrist, who have examined them within 72 hours can give them a certificate, again, if they meet certain criteria, which are the same criteria as the involuntary admission, so they are likely to cause harm to a person or themselves or to deteriorate physically or mentally, and – this is a key one – the treatment or care the person requires actually exists in the community.

We recognize that there's no point issuing a community treatment order to somebody and requiring that they see a psychiatrist if there's no psychiatrist in their town – the resources actually have to be available before the community treatment order is going to make any sense – and the physician issuing the certificate has to be satisfied that the person is able to comply with them. Again, same rationale: you've got to have somebody who's actually going to be able to comply with the order.

Then either the person has consented to the order or their substitute decision-maker has consented to the order if they don't have capacity to do so. If the person and substitute decision-maker won't consent, if in the opinion of the issuing physicians the person has while living in the community exhibited a history of not obtaining or continuing with treatment that's necessary to prevent the likelihood of harm to others, a community treatment order is reasonable in the circumstances. In other words, a person could be released on a community treatment order even if they don't consent to one if the physician feels that it's in their best interest and that if they don't issue the order, they're likely to cause harm to others. It's a slightly different test than the criteria. It's a little narrower. That, in a nutshell, is the CTO.

Now, a lot of the amendments around the legislation actually changed the review panel procedures and other things to reflect that there is a CTO, changed the Mental Health Patient Advocate's powers to reflect that she may be dealing with a CTO. Most of the changes are consequential changes to actually effect that new tool into the legislation.

Now, the third piece: the mandatory follow-up with physicians. As I indicated, that's a response to a specific recommendation that Judge Ayotte made in the Galloway/Ostopovich inquiry report. We've added a provision which requires that on release of a patient or on issuance of a community treatment order the issuing physician notify the family doctor if known, recognizing that they may not have a family doctor or that they may not be able to determine who it is.

Now, Mr. Chair, those are the key pieces. I'm happy to look at any specific sections or answer any questions if you like.

The Chair: Okay. I have a number of people indicating that they have some questions. Mr. Lukaszuk, followed by Mr. Shariff.

2:20

Mr. Lukaszuk: Thank you very much. Thank you for that overview. This is a very important piece of legislation as it will directly affect Albertans' liberties in a manner that can't be more profound than compelling someone to an institution and/or treatment. Having said this, I know that it is a fact that this is a problematic issue within our health system and our justice system and for many law enforcement agencies, so we must strike a balance here.

When I'm looking at the proposed section of the act and I compare that of Saskatchewan and Alberta, what I'm wondering is: are we not overcodifying the terms under which a person may be subjected to a community treatment order? It is very specific, and it gives very specific circumstances. On one hand, one could argue that that's the right thing to do because one should not be issuing those orders liberally. But, on the other hand, we know that our

health care workers are confronted with various situations where they use and we trust their best judgment. I know that they would not in any way abuse this ability to exercise this right, yet it may not be reflected in one of the subsections.

British Columbia and Saskatchewan seem to have a very overarching definition: if it is in the best interest of the patient and his care and to prevent his deterioration and if it is in the best interest of society, then you're allowed to do so. We tend to be very specific. I know that the courts will do that for us as time goes on, so I'm wondering if we're not overcodifying it at this point and hence perhaps defeating the very purpose, why we're doing this in the first place, and tying our physicians' hands.

The second one is: because you're so specific on who can sign them and when and how, how will this act be, if passed, enforceable in the remote areas of Alberta, where there are no psychiatrists available and where there is limited medical staffing? How do you foresee that being enforced?

Ms Meade: Again, thank you for your question. First of all, the numbers in the provinces that have already implemented CTO legislation remain quite small. We don't think that ours are going to be any less or any more. This tends to be a known, identifiable population, so your concern about overcodifying and perhaps being even more restrictive – actually, I think it's interpretation.

The other issue is that a lot of psychiatry consultations are also done through telehealth, video conferencing, and that will be considered by the courts and looked at in the implementation. It's true that we have shortages of all health care providers but in particular psychiatry. That's why we went to one, not two, and we think we can deal with that electronically.

As for your other concerns, Martin, do you want to add here?

Mr. Chamberlain: Yeah. Let me supplement that one too. We recognize that there may be issues with getting psychiatrists in remote areas. In fact, one of the provisions in the amendment does allow a health authority to designate a physician who they feel is competent to act where there isn't a psychiatrist reasonably available, but that physician can only make decisions on issuing a renewal of orders on consultation with a psychiatrist, which would be the telehealth link that the deputy was discussing.

On the specific criteria we have looked at other provinces. I do have Saskatchewan here, but I'm not going to try and file through it. All of the provinces have certain criteria. They differ slightly from province to province. I'm not going to pretend that we've got it perfect. The reality is that you hit the nail on the head when you said that we have to balance rights. We're providing a tool for psychiatrists and physicians to use to help patients, but that tool has to balance the effect that you are affecting their liberties. So we've put in some criteria to try and effect that balance. At the end of the day it may well be the courts that decide whether or not we've got it right, but certainly we'd welcome input from this committee on whether or not we've got the balance correct.

Mr. Shariff: I have two questions. The first one I think you've partially dealt with, and that's to do with the Charter of Rights and Freedoms. Have you had a thorough assessment of whether this would stand in the courts with regard to personal rights?

The second aspect of my question has to do with experience with regard to children needing care. I know and I've read a number of articles whereby children have been subjected to phenobarbitals or other such drugs to control them without any control on the side of the prescribing physician. My concern stems from this: the psychiatrist will be giving a community treatment order in the best interest of the patient – and that I support – but, you know, there may be somebody who is overusing it or abusing that authority given to that person or that psychiatrist. What safety measures are we building in this? If the psychiatrist consistently continues to give treatment orders, is there going to be a peer review at a certain point, when so many treatment orders have been issued, or is there going to be any other safety measure to make sure that nobody's rights have been abused?

Mr. Chamberlain: Thank you, Mr. Shariff. In answer to your first question, of course we are consulting with a justice constitutional group as we proceed. They've been looking at drafts and will continue to do so. I'm not prepared to disclose what legal opinions we have got, obviously, but we have been working with them and will continue to do so as we develop regulations under the bill.

With respect to your second question about potential abuse the current Mental Health Act does have review provisions. There are mental health review panels around the province that deal with reviews from patients. There is also the Mental Health Patient Advocate who deals with complaints from patients. The amendments do expand to include CTOs, so CTOs are subject to review. If a physician or a psychiatrist is abusing the CTO, the patient or their representative can appeal to the review panel and address it. With respect to what I heard, essentially, as potential professional misconduct, then we have the health professions legislation and complaints procedures under the college legislation that would deal with that, I believe.

Ms Meade: Just to add on to that, the issue of youth or any prescribing that is being questionable, as we now have our pharmaceutical information coming online with the electronic health record, as this moves out, we will finally be in a position, more so than most provinces, to actually do far better scrutiny and manage best practice and clinical practice. We're working with both the College of Physicians and Surgeons and the College of Pharmacists to ensure that we'll be able to flag some of those, where there's ongoing questionable clinical practice well beyond a CTO.

Mr. Shariff: Mr. Chairman, I'm not satisfied on both the answers, so let me just go back to the point. On the first one the reason we wanted you to be here is to get an assurance that your purpose is meeting the requirements of Albertans. So my question once again is: do you – and you don't need to disclose the details of it – in your professional opinion have confidence that this can stand a challenge on the basis of the Charter of Rights and Freedoms? Question 1.

Two, going back to that issue about vulnerable people who are not able to speak for themselves, I know that our society is trying to do the best that it can for such vulnerable people, but they don't have the ability to challenge the system or fight for their rights. Therefore, I'm not seeing a safety net in this bill that will say: "Okay. If the person has received more than five, 10 treatment orders, then there will be an automatic review process so that there's a peer review," or whatever the format is, "to determine and make sure that that person's rights have been protected."

Mr. Chamberlain: I know that the deputy wants to add on the second one, but on the second one you're right. There is no automatic review, but there is a review available whenever the patient wants to bring it. That's the way the amendment is set up. With respect to the first question I can't provide legal advice to this committee. Parliamentary Counsel may be able to provide advice to

the committee. We obviously are working with our constitutional law branch to make sure that we put in the appropriate safeguards. The only one who can ultimately determine whether or not we've got the balance right is the Supreme Court of Canada. We're obviously making every effort to make sure that we do balance rights of patients versus public interest, public safety, but at the end of the day it's going to be up to the courts to determine whether or not we've got it right.

Ms Meade: Just on that, I think, also, that the examples in other provinces have shown us what you do have to include. So while there's never a foolproof against a Charter challenge, we feel that this is well-protected, developed legislation, no guarantees but well protected.

2:30

On the issue of rights we also have the Mental Health Patient Advocate, and we see in the implementation of this that that role will expand so that there is another voice for those that can't speak. The balance of the patient right with the public right is what this legislation is about, and we will certainly see that in the implementation and the practice, but I would envision that that role becomes even more important to be that other voice.

The Chair: I have Mr. Lukaszuk on this point as well.

Mr. Lukaszuk: Thank you. Mr. Shariff raises, in my opinion, a very valid concern. One of the most terrible things about mental health illness is the fact that you don't know that you are suffering from mental health illness. When you're suffering from mental health illness, you don't realize your own symptoms, and unfortunately in many cases when suffering from mental health illness, you may not be in a position to be aware of what your rights and privileges are or what methods there are by which you may appeal a certain decision. Those decisions also have to be made on your behalf by someone. In many cases, particularly in those quote, unquote revolving door patients that you're referring to, I imagine many of them don't have the support network around them that would point them to an office, an advocate that would then advocate on their behalf.

My question to the department is: what would your response be to an amendment brought to this bill that would be in essence requiring an automatic review of a case file following a specific number of CTOs, be it three, five, 10? I guess one could argue in favour of it by saying that it would not only review the process and the usage of CTOs, but also it would allow other external professionals to review the modality of medical care that is being afforded to the patient.

Mr. Chamberlain: The short answer, Mr. Lukaszuk, is that we'd obviously welcome any recommendations from the committee on an automatic review. That's one of the things we have heard from some of the feedback we've received on the bill. There is an automatic review of admission certificates. They review automatically every six months. That wasn't built into the CTOs. They're reviewable any time a patient wants to bring it and can only be rejected if there has been no change in circumstances or if they're brought frivolously. Certainly, the six-month current provision could easily be extended to apply to CTO renewals as well.

The Chair: Reverend Abbott.

Rev. Abbott: Thank you very much, Mr. Chairman, and thanks for the explanation, Martin. It's very good. My question is going to stem a little bit around the regulations. I'm looking specifically at 9.1(2)(f) on page 5. It talks about "in accordance with the regulations." Subsection (g) also talks about "provided for in the regulations." Some of these concerns that some of the members are bringing up may be answered in the regulations with regard to what would be disclosed to the patients, you know, before the CTOs or as the CTOs are being issued, what the reporting responsibilities are, et cetera, et cetera. So I guess I'm wondering if the regulations are currently being worked on or when we can expect to see those or what kind of a timeline we have in light of the fact that this bill will be coming back before the House, likely in the fall?

Mr. Chamberlain: The answer on the regulation is a very, very preliminary step, and certainly from my perspective, if the committee has any recommendations on what should be in the regulations, we're happy to consider them.

Ms Meade: Just to add on, the minister has directed that I am chairing with the CEO of the Mental Health Board a task group looking at implementation of the CTOs, everything from what are the community programs that we're going to need, what's the communication and rollout and the role of the patient advocate. So some of those things will also be reflected back in the regulations, and some may just be on process. How do you actually monitor the person that, you know, feels good because the medication kicks in and starts to noncomply?

Rev. Abbott: Thank you.

Mr. Flaherty: My question, Mr. Chair, through you to the appropriate person, is to ask about the evaluation of the bill once it's in place. I'm a rookie at this, and I don't know exactly how that works. But I can recall that with the Department of Education, before they fired me I was . . . [interjections] Be quiet. We had a set system where we went in after I think it was three years and looked to ascertain if the opportunity fund was working correctly and helping special education children across Alberta. Sometimes when you go and implement bills – and this is certainly a new innovation in the sense of delivering mental health. I was wondering: is there anything that you use in the department to look at how things are going and what the reaction is and a chance to look at alternative ways of delivering the service after a period of time? I'd be interested in your comments.

Ms Meade: I'll take that question. Thank you very much. Evaluation of any kind of mental health program is very important and, unfortunately, hasn't always been there in our history. That's part of the task force that the minister has us working on with the Mental Health Board because the outcomes will be very important. Do we have the right community programs? How is the casework? What are the numbers? We have not mandated within the legislation an automatic review, but that will be part of the implementation. We probably want to look at how the numbers are at first and how they settle down, also the response from the justice side, and do we need more education with providers. So there is as part of the implementation group a full area of evaluation being considered.

Mr. Flaherty: A supplemental: is there in research given any guidelines regarding an appropriate time to look at review?

Ms Meade: Not in the area of mental health. I think that again we'll want to go at least two years when you bring in new legislation to a program and ensure that you have the follow-up. Who are the

caseworkers? What's the education? I won't be specific to mental health, but in the health field you usually go two to three years, and you're monitoring and making adjustments along the way.

Mr. Flaherty: Thank you, Mr. Chair.

Mrs. Mather: This is such an important piece of legislation. There are so many factors to consider. Now hearing about the task force's mandate to consider regulations, when would we know what's being considered in terms of regulations?

Ms Meade: They're not really working on the regulations as much as feeding into the department on the regulations. They're doing beyond regulations, which is community programs, training of providers, whether that's on the justice side, and the numbers and the evaluation and outcomes. Theirs is more on the operational side. When I call it a task group, it's a committee of the RHAs, – I'm co-chair – the Mental Health Board, two independent psychiatrists, and a mental health worker formerly from Canadian Mental Health.

Mrs. Mather: That's good. It sounds really comprehensive, but I'm still concerned about when we will know what the regulations are. Who can answer that?

Ms Meade: I think we're going to have to go by the direction of this committee, our minister, and government. But our idea is that the legislation will go through. The regulations will then be developed with the input from all of that.

The Chair: Dr. Pannu.

Dr. Pannu: Thank you, Mr. Chairman. We are engaged in a very serious discussion, I think food for discussion. I want to thank the staff of the department for providing the information and answering our questions. I think it bears reiterating that it's an important bill, a very serious bill. It deals with the most vulnerable among us, people who depend on our good judgment, our ability to help and support, as well as making sure that they're protected from harm themselves and that others are protected from harm where that may be a possibility. So a serious discussion. I think it's a good beginning.

I again want to thank the research staff for providing in table form, you know, the comparisons across provinces, provisions of similar legislation that's already in place. One of my questions has to do with the involuntary admission criteria. I understand that the involuntary admission criteria as provided for in this Bill 31, an amendment act, are quite different from those that are provided in the Ontario legislation dealing with similar situations. Would you like to outline the similarities and differences with respect to the involuntary nature of the criteria that are present in this proposed piece of legislation and that which exists in Ontario?

2:40

Mr. Chamberlain: Thank you. In the chart that we provided under tab 3 there is a breakdown. What it indicates for Ontario – and each of the provinces has slightly different criteria. We've carved out the piece that's relevant to this: given the person's history of mental disorder and current mental or physical condition "is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment." That's compared to our draft language, which is "likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment." So in my mind there are some minor language changes, but essentially the gist of it is the same. They are likely, which is the key sort of test. They are likely to cause it. That gives the physician some discretion to figure out whether or not they are likely. It's reasonable they might cause harm or suffer deterioration, physical or mental. So in our minds the tests are similar.

Dr. Pannu: Somewhere in the briefing provided for here I noticed that in Ontario if the person suffering from a mental disorder is either unwilling or unable to give consent for admission, then the guardian or some responsible cohort of the person must give consent. We have no such provision. Or do we?

Mr. Chamberlain: With respect to involuntary admission or with respect to CTOs? I'm sorry. I don't have the material the research officer has prepared.

Dr. Pannu: I believe it's in relation to CTOs.

Mr. Chamberlain: In relation to CTOs we do in fact have provision for consent or consent by a substitute decision-maker where the patient doesn't have capacity. I'd have to flip through to find it, but there's a test for the physicians to determine whether or not they have capacity, and then a substitute decision-maker can make the decision for them. Then we went further than Ontario and made provision for without consent in the event that they are likely to cause harm to others.

Dr. Pannu: Mr. Chairman, may I expand the question to include the involuntary admission issue, not just the CTO issue?

Mr. Chamberlain: I can't off the top of my head tell you what Ontario's provision says with respect to involuntary admission. The test is similar. Whether there's an additional consent provision, I didn't think there was, but I honestly can't comment on that.

Dr. Pannu: I was quickly going through the material this afternoon before coming here, and I think I noticed somewhere that there was a difference on that issue between our legislation and the Ontario legislation, that's been in operation for some time now.

Mr. Chamberlain: Yeah, and I apologize, Dr. Pannu. I don't have those materials.

Dr. Pannu: Okay. All right. We'll look into it later.

The Chair: Are there others? Seeing none, I think that at this point we can move forward to the presentation on Bill 41.

Ms Meade: Mr. Chair, Bill 41 is the Health Professions Statutes Amendment Act, 2007. Martin will give a high-level overview, tell you what's in the binder, and we'd be most willing to take questions.

Mr. Chamberlain: Thank you, Mr. Chair. Again I've provided a small binder of materials. This one has in it a backgrounder which explains what the Health Professions Act currently does. It goes through in some detail the mechanism for dealing with health professions. Essentially our Health Professions Act was designed to get rid of the myriad of professional legislation we had for health professionals, so ultimately the Medical Professions Act, the Nursing Act, the Health Disciplines Act. All of those statutes and many more, quite frankly, roll into the Health Professions Act, the scheme being to create an omnibus legislation that would deal with gover-

nance of health professions, set out their standards, allow the setting of their code of ethics, maintain a structure for discipline committees and registration: set out that whole mechanism. The first tab of the binder I provided is background that just essentially goes through those pieces, talks about the regulations, what's in them, and how organizations for health professions come under the statute.

In a nutshell, just to explain that bit because it confuses me and many others, the Health Professions Act has been proclaimed into force, but it has a list of schedules for the 28 health professions. Each profession – for example, the doctors – would come under the Health Professions Act when their schedule is proclaimed into force, and that happens once they have developed regulations, which then go through cabinet. Cabinet can't do anything with them except approve them or not approve them, so cabinet essentially has a veto the first time through on the regulations. Once the regulations are in effect and the schedule has been proclaimed, then the profession comes under the Health Professions Act. At present, I believe – Karel, correct me if I'm wrong – roughly 20 of the professions have come under the Health Professions Act and another eight are still working on regulations and other processes to bring them under. Tab 1 provides some background on that.

Tab 2 I'm actually not going to go through in detail. This is a little different than the Mental Health Amendment Act because the structure of the act and the changes are different. There are essentially a couple of types of changes in here. Most of these I'll call housekeeping. Some may view them as a little more significant than housekeeping. They are changing names for department changes. They are updating names of colleges where they've changed their names. The chiropractors, for example, changed their name. There's a number of changes like that. There were some provisions in there for employers who aren't allowed to hire somebody to perform restricted health services if they're not properly authorized, but there were no offence provisions, so we've included offence provisions. There's a number of sections like that that have been added or clarified at the request either of the department or of health professions.

A number of health professions have had problems with some of the sections in the act. They feel that there's some ambiguity. Some of them I agree with; some of them I don't, quite frankly. But they've had problems administering certain sections. One of them – and I can't remember the name offhand – was the application section. You were required to put your fees in with your application for registration as a health profession. That was being interpreted by some colleges as meaning both your application fee and your registration fee, which can be fairly substantive. So we've clarified that on the application you just have to put your application fee in, and when you get registered, you can't be registered until you pay that fee. There's a bunch of clarifications like that, and then there are some substantial changes that I would like to come back to.

Another tab in here is Bill 41, which you should have as well. Again, this doesn't have the explanatory notes in it. Tab 4 is the Health Professions Act. Tab 5 is the Medical Profession Act because we're also making some amendments to that.

All of the changes have been summarized in that section-by-section overview that I've provided. The first one I would like to highlight for you is section 1.1, which deals with public health threats. We are proposing to add a section into the legislation which would apply notwithstanding any provisions in the act or bylaws or regulations of a college.

In discipline matters, for example, most of the colleges have in their bylaws confidentiality provisions so that what's in the discipline committee isn't going to be public knowledge, or isn't disclosed. They have different confidentiality provisions, and that sometimes can be a concern from a public health perspective. If something has come to a college's attention which is an infection control issue, a public health issue, we want to make sure that the members of the profession and the college have an obligation to bring it forward to the chief medical officer or the medical officers of health in the region. The concept behind this section is to make sure that if we have a public health issue that's come to the attention of a college, there is a positive obligation to report it to the medical officers of health so that we can address it.

2:50

The other changes I would like to bring to your attention relate to part 8.1, which is summarized on page 7 of my materials but starts at section 135.1 of the bill. We are making some changes to the legislation, and you may well hear some criticism of these sections. We have a health profession system which has all 28 health professions ultimately coming under the legislation. What we've learned over the years is that we need the professions to integrate. We need the professions to work together. We need to have accountability at the highest levels for how the system functions.

Unlike a lot of other professionals, who practise independently, most of our health professions actually practise in the public system. They're funded by the public system. They work with regions. They work with patients. They get money from government. What we have learned is that when issues happen, complaints come up here. The minister ends up having to address issues that deal with the professions or the integration of professions or the scope of practice of the professions. Under our current legislation there is no mechanism for government or for the minister to actually deal with those.

Dr. Pannu: Any particular section that you're addressing?

Mr. Chamberlain: They start in part 8.1 in the bill, which is on page 12 of the bill, section 135.1. It's referenced on page 7 of 8 of my overview. I'm kind of leading up to what the sections do because they do a number of pieces here.

Essentially, what we've done to try to make sure that the minister and the government have the ability to address issues as they come up and to deal with a couple of other issues that we've identified – and it's in section 135.1 – is provide that the minister can issue directives to a college or colleges to change their bylaws, change their regulations, do something with their standard of conduct, with their code of ethics if it's in the public interest to do so or if he determines that it's necessary for health and safety and quality assurance. So we've put a frame on it. But if there is a quality issue or significant public interest, it allows the minister to go in and say: your standards of practice need to reflect a common infection prevention control regime; doctors, nurses, physiotherapists, dentists all have to use the same basic practices, and you've all got slightly different clinical guidelines. So we want to make sure that they're constant and that we can, if necessary, direct the colleges to do that.

Now, if they don't do that, then he can ask cabinet – and cabinet has regulation-making power – to actually do that in place of the college. That's in section 135.4. So if he were to request a change to their standards of practice to require a common standard for infection control across the health system and one of the colleges refused, cabinet could in theory step in, pass a regulation to change the standard of conduct.

The other provisions are termed support and variation provisions. They're 135.2 and 135.3. The support provision may well be broader. It may be broader than this, but the intent is that we need to deal with a number of colleges that, notwithstanding that we have an omnibus bill, really don't fit. It's not really one size fits all.

Just to give you the concept, we have over 28,000 registered nurses in the province. We currently have midwives under the Health Disciplines Act because they haven't yet moved under the Health Professions Act. I can't remember the number, but I think it's 21, 20, 23. Anyway, it's not more than 30 midwives in the province. When they look at the Health Professions Act and the registration committees and the discipline committees and the education committees and the structure that they have to have in order to bring themselves under the legislation, quite frankly it's daunting. They simply don't have the critical mass to do it.

The concept behind the support and variation provisions was to build in a mechanism where the ministry can provide an administrator to support the college until they're big enough or until they're ready to do so with whatever powers need to be given to the administrator to do that. That's, in fact, similar to what we're doing for the midwives now under the Health Disciplines Act, where the registrar is an employee of the department, and we're providing a great deal of assistance and support. But the end goal, the legislative directive originally on this was that we wanted to move all of the professions under the Health Professions Act. There certainly is some merit in having everybody with as common a set of rules as you can.

We have also authorized cabinet to vary, on the recommendation of the minister, provisions of the act or the regulations that apply to colleges with respect to a specific college. So you could reduce the number of members on a committee. You could provide for less public members. You could require that you don't need an education committee or whatever change was necessary in order to allow them to come under the act and to function properly. We provided a variation power, which is actually similar to and mirrored on a provision in the Regional Health Authorities Act, that allows the government, when it's setting up a provincial health board like the Mental Health Board or the Health Quality Council, to modify the act to the extent necessary to make provision for a smaller board or a slightly different functioning board. All the rules of the Regional Health Authorities Act that don't necessarily make any sense for a smaller provincial board can be varied or don't need to apply.

I think, Mr. Chair, that summarizes the key sections. Again, I'm happy to answer any questions on either the specific sections or on the substantive stuff that we've discussed.

The Chair: Okay. Thank you for that presentation.

Rev. Abbott: Thanks again, Martin. Good explanation. I'm just wondering why this bill has not yet received second reading. Bill 31 came here after second reading, which means that we agree in principle with the bill. Bill 41 came after first reading, which means that it's still fairly wide open. I guess I'm curious if the department is still kind of out there in public consultation or maybe not public but certainly with your stakeholders. Are you doing a similar kind of consultation that we talked about in Bill 31 and is this still an evolving piece of legislation, or have you, you know, narrowed it down, that these are the necessary amendments that need to be brought forward?

Ms Meade: It was timing. It was basically timing. No real agenda. The minister has met recently with the executives and chairs of the colleges and gone through this. We're having ongoing discussions specific to 135.1. The other piece of work we're doing is in preparation for the minister's review of infection control provincially, a review of some of the incidents that have occurred in the last while. There's, I think, total alignment, in my mind, with where that will go, and this is required. So the only issue of second and first was timing.

Rev. Abbott: Just a quick follow-up. With regard to 135.1 it seems like that's probably one of the bigger sticking points. I'm just wondering: is this something that the colleges and the various stakeholders welcome, or are they kind of bucking this? You know, where did this come from, and why do we have this?

Ms Meade: Well, you have it because there seemed to be an interpretation around what had paramountcy. In my mind, I had viewed the Public Health Act as having paramountcy. Self-regulating colleges were in a conflict between their own legislation, so this is required to ensure that we all understand when there is a public health issue. We've seen this in different places in Canada. It's required. I think there was some trepidation around how you balance a self-regulating profession with this. It's not our intent to take over the professions whatsoever. I feel that as we've clarified and met with stakeholders – there are still some more to go – they'll be concerned about how this will roll out, but that will be understood, that this is not about us taking over self-regulating professions. This is about how you deal with a public health issue.

Rev. Abbott: Excellent. Thank you.

The Chair: Mr. Lukaszuk.

Mr. Lukaszuk: Thank you, Mr. Chairman. I think it would be fair to say that not only in the medical profession but overall in Alberta self-governing professional bodies have provided and generated a high standard of service to Albertans and have been competent in addressing most issues. Having said this – and this may be my personal observation – with relevance to potential expansion of scopes of practices within individual professions or perhaps in the area of recognition of outside of jurisdiction trained professionals, some form of inertia has set in in many professions, not only medical professions. I'm wondering if this type of legislation amendment would allow for, perhaps, more acceptance or more fluidity in the transference of scopes of practices between member professions and more readily open professions toward foreign-trained or outside of jurisdiction, perhaps even from other provinces, trained professionals.

3:00

Ms Meade: I'm going to go first and open it up to Martin or others. This legislation enables scope of practice, and it enables whoever comes in and meets the criteria to practise here regardless of where you were trained. We have many foreign-trained who have successfully fit under this.

The real issue is not the legislation. The real issue is inertia right from the beginning of training to how professions have lack of knowledge, so really that's another major piece of work by the department, the colleges, the universities, and the RHAs. I think we're starting to see that. Primary care networks are probably a classic example of where we're starting to see better teamwork. Some of the training modules we're going to bring on stream hopefully will start to break down some of that training. I think the legislation enables, but it's going to take practice and many other incentives to move it. I don't see it as a hindrance, though.

The Chair: Any other questions?

I'd like to thank all the department officials very much for their very enlightening presentations on Bill 31 and Bill 41. With that, we will move forward to the next item on the agenda which is the draft communications plan.

At this time we'll have Ms Rhonda Sorensen and staff from the

communications branch from the office of the Clerk. They prepared a draft communications plan based on the directions outlined by the committee at our July 4 meeting. Rhonda, I'll turn it over to you now to give us a brief outline of that plan. We have copies of these in our binders.

Ms Sorensen: Thank you, Mr. Chair. Yes, you should all have a copy. Essentially, what we did was we went away from the July 4 meeting and based on the conversation that was held at that meeting came up with some specific strategies to help meet the direction by the committee to solicit written submissions as well as the strong intent that there was to hold public hearings. It doesn't deviate very far from what we had presented as kind of an outline of what we were thinking at the previous meeting, but it just gives a little bit more detail.

The first thing that I'll touch on is the development of key public messages. These messages would be carried forth throughout all public information, whether it's a news release, advertisement, website, just to create some consistency in the messages we're putting out.

The first message we're proposing is that it's very important to create an open dialogue with Albertans in this process. The second message is that the scope of review for Bill 31 is a little bit more limited – we want to make that clear when we're dealing with the public – and that Bill 41 has a little bit broader of a scope, but there are still some limitations in that as well. The third message would be different for each bill that's referred to the committee. Happily, the outline that we've provided does keep in line with what Alberta Health has just put forward. So they're essentially just trying to really simplify the content of the bill so that the public understands what it is that's being reviewed. You have the plan in front of you which outlines the specific messages.

The second strategy that we're proposing is the media relations component, and I believe you all were handed a copy of the draft news release this afternoon. It wouldn't have been in your package prior, but you should have it now.

The Chair: That's the one that was with the news release and the letter to the stakeholders?

Ms Sorensen: Yes.

The Chair: That was just handed out at the table today.

Ms Sorensen: Take a minute to review that. Essentially, what we'd be proposing is that we release that this week. It contains a little bit of information to the news community about what it is that we're reviewing as well as a deadline for public submissions. With any news release you can't be guaranteed that it's going to actually filter through to the publications. So you put it out there, and you hope that as many news organizations as possible pick up on it, but of course supplementing that will be an ad campaign which does guarantee us that the message that we want to put out there is put out there.

The third is a public website. It is a part of your package. It looks like this for any of you who are searching. Essentially, we're looking for any direction that you have on what you would like to see on the website. So far what we've put in there are the terms of reference of the committee, the transcripts, meeting information, any news releases that are going out, contacts for the committee as well as information about the bills. If there's specific information that you want to see on the website, please feel free to forward that on to us.

The website would go up first, and as soon as that goes up, then the news release and the advertising campaign will go out simultaneously so that everybody's on track and there's plenty of time for the public to meet the, I believe, August 24 deadline.

The final component to the communications plan is a province-wide ad campaign. There's also a sample of the proposed ad in your package. This ad would go out to weekly newspapers associated with the Alberta Weekly Newspapers Association, and that should cover all of your constituencies. Weekly newspapers do have the benefit of a longer shelf life. They're well read within the community, and they're usually on people's coffee tables for about a week. So you have a pretty good chance of the community seeing the ad. We would also put it in the major dailies, probably this weekend if everything is copacetic with the committee.

So that essentially, in a nutshell, is what we're proposing. If the committee is in agreement, like I say, we will get moving on this right away in order to give the public enough time to meet the deadline for submissions.

The Chair: Any questions about the communications plan? If not, we require a motion to approve the plan as distributed.

Dr. Pannu: Mr. Chairman, the cost issue is something that you might want to touch on, especially with the advertising, I suppose.

Ms Sorensen: Absolutely. Yeah, advertising is actually the only direct cost you're going to have. The Weekly Newspapers Association is $33,000. Just to give you a little bit of perspective on that, because it might seem a little high, you are going to be reaching 713,000 people, a little bit more than that, so you're hitting a lot of Albertans. In comparison to the coverage that you're getting, it is a really cost effective way to reach all Albertans. The dailies, of course, have a very high circulation within the cities and are also well read. You're hitting 97 weekly publications, and there are nine dailies. So you're getting a good saturation throughout Alberta.

The other thing I also wanted to touch on was that we had talked about the intent to hold public hearings. I don't want you to think I've forgotten about that. What we're recommending, though, is that the specifics on that will be dealt with at a later date, and when those specifics are determined, that's when we'll put forth a strategy. For example, if you were going to hold public hearings in a number of different communities, we would target those communities as opposed to saturating the province.

The Chair: Reverend Abbott, you had a question?

Rev. Abbott: I just had a question with regard to the news release. I should have mentioned this earlier. I guess it's the third paragraph. You say, "The Standing Committee on Community Services is one of four Policy Field Committees." I wonder if we should include the words "all-party." The reason being is because if people think it's a government committee, they may not be as inclined to participate. [interjection] Well, you never know. Sometimes they think you have a preset agenda or whatever. So I'm just wondering if you considered using the words "all-party."

Ms Sorensen: Yeah. Actually, we usually do use the words "all-party." There's also been a little bit of discussion about terming it multiparty just because perhaps all parties may not be a part. So if the committee is in agreement with that, we can certainly put forward the multiparty stipulation in the news release.

Rev. Abbott: Yeah. Just something like that. I don't know. I would leave it up to the committee, but it's just a thought.

The Chair: Would that be in agreement to the committee? It's more definitive.

Any other questions? Are we ready to make a motion that we approve the communications plan as revised with that change of multiparty? Moved by Dr. Pannu. Those in favour?

Mr. Shariff: Just some clarification. From a Legislative Assembly perspective there is a clear understanding of what all-party would mean, what the recognized parties of the Assembly are.

3:10

The Chair: What was that?

Mr. Shariff: In the Legislative Assembly when we talk about a party, there is a clear definition of, you know, what is a recognized party, so this multiparty myth would be throwing a completely different curve on the interpretation.

Rev. Abbott: Yeah. If I may, on that point I think the word "all-party," you know, is just a term. It doesn't necessarily mean all of the parties are represented. It just means more than one, so I think Shiraz is right in that all-party is a very common media term. In fact, it's the term that the Premier used when he talked about setting up the all-party committees, and all, I think, is in quotations. So we could probably call it an all-party even though it's not.

The Chair: Shannon, do you have any comment on that?

Dr. Pannu: I think that's a commonly used term. I think we should stick to that.

The Chair: All-party? Okay. So those in favour of the motion as revised? Opposed? Carried.

Review of Research Materials, number 6 on the agenda. The committee received some briefing materials relating to bills 31 and 41, including press clippings and a cross-jurisdictional analysis. Also, at the July 4 meeting the committee directed staff to compile a stakeholders list for these two bills. These lists are included in the materials that you have in your handouts or your binders, and I believe, Philip, you've got some comments to add about this stakeholders group at this time.

Dr. Massolin: Yes, I do. Thank you, Mr. Chair. I just wanted to make a comment on the three research products that we prepared for this committee. First of all, we provided you with a package of press highlights. I think it's pretty self-explanatory what's in there. Second of all, we provided you a stakeholder list for both bills, and I'll come back to that later because that will lead into the decision item that the committee will have to deal with afterwards. Third of all, research provided the committee two cross-jurisdictional analyses.

Now, on that one I was hoping that I could ask the committee to provide some feedback on what they read and some feedback as to the contents of those analyses as well as to the presentation. Did you find it useful? What would you suggest to add or subtract from them? So perhaps if committee members could do that now or through the chair, I would be very grateful.

To get back to the stakeholder list, I just wanted to go through some of the methodology that was undertaken in order to arrive at those lists. I want to first, however, point out to you that in the handout package that was given to you at the beginning of the meeting, you were given at the back of it a couple of additional pages and a correction page and an addendum page as well, so these go with the stakeholder list that you received through the website.

Dr. Pannu: Where are those pages?

Dr. Massolin: In the handout package that was provided to you at the very beginning of the meeting. At the very end, the last two pages, there is an addendum for Bill 41 and a correction page for Bill 31.

Now, with respect to the stakeholder list, just how we arrived at these lists. First of all, of course, we did some research, including reading the bills. We read through the press clippings, and we looked selectively through other lists such as the *Canadian Almanac & Directory*. Then we sort of went through the process of paring back the preliminary list based on, you know, additional research in terms of finding mandates of the organizations involved with stakeholders and so on and in consultation with Parliamentary Counsel. The final product, as you can see, is a list that's divided into two groupings. The first group is a core list of stakeholders for both bills, section 1, and the second list is the supplementary stakeholders as well. Obviously, there's a difference there as the names imply. Beneath each of those two basic categories we have subcategories just for navigation purposes to understand what types of groups we suggest that you can potentially consult with.

That's sort of a brief overview of the thought process here. I was wondering if there are any questions for me at this point.

Mr. Backs: I see that the Health Sciences Association was moved from 1.7, Other, in the addendum to 1.3, Associations, but it's also in 1.3, under Unions, on the main list. Is there a difference there?

Dr. Massolin: We just wanted to put it under the list of core stakeholders as opposed to secondary. That was the reason.

Mr. Backs: Oh. If you're consulting unions, I think that you should perhaps have AUPE in there, especially for Bill 31, because they have Alberta Hospital and other mental health facilities as their membership.

Dr. Massolin: AUPE. Okay.

Mr. Backs: And there are some others, like the operating engineers have a lot of nurses in long-term care and such, and they may have some concern.

Dr. Massolin: Right. Okay. I'm not sure how we want to handle that. The suggestion was to put AUPE in with the Bill 31 stakeholder list.

Mr. Backs: Yes.

The Chair: Under unions?

Mr. Backs: Page 3, 1.3 in the main book, I guess. Do we need a motion for that, Mr. Chair?

Mr. Shariff: The present list doesn't have a motion.

The Chair: We're going to have a motion for the stakeholders groups as presented or as revised, so we can take a vote as to whether the group will accept it. One on one: is everybody in favour of adding AUPE?

Mr. Shariff: Well, I have no difficulty. Not only that, but if members come up with any other bodies that can make a positive contribution or provide any feedback that'll help us, certainly we can add and revise that list as we proceed.

Rev. Abbott: Likewise, I would say that if we are approached directly, you know, by an association that feels left off the list, we need to have provision to allow them to be on.

Ms Dean: I just want to remind everyone that, of course, we're going to be advertising for public submissions. If you are approached any time after Friday, I would say – I mean, the news release will be going out shortly – you can certainly refer these people to the website and the information there.

Mr. Flaherty: Well, I was just going to ask the question on the criteria for selecting who is on this list. Maybe I'm missing something here in the sense of understanding, so please help me. What about the Alberta Teachers' Association? It seems to me that that's a large body that utilizes or works around mental health and so forth, and I'm just wondering if that could be included. Okay? I just thought to ask.

The Chair: Is that the wish of the committee, to add the ATA? Okay. Those opposed? Okay. We'll add that, and then we'll have a motion to cover it at the end.

I have a question, Philip, on the difference between the supplementary stakeholders list and the core stakeholders list. Could you just briefly explain that and why the police association would be on a supplementary list rather than the core list. I don't know if it makes much difference, but the police association as an organization deals with this on a pretty regular basis. I would think they would be a fairly core stakeholder.

3:20

Dr. Massolin: Yes, and we struggled with this one. There's no doubt with respect to the law enforcement in general. The idea was to give the committee an opportunity to look at sort of a pared-back list, a core list, but also to consider a wider list as well. That's the reason for two categories and the option to accept the larger list as a whole and to, as we're doing now, make additions. Is that satisfactory?

The Chair: Okay. Is there a motion to approve the list as revised with the ATA and the AUPE on there? Mr. Shariff moved that

> we accept the stakeholder list for Bill 31 as circulated and revised.

Any other questions?

Dr. Pannu: Yes, Mr. Chairman. I just wanted to go on record as expressing my understanding of this list. This list is something that we are now approving, but certainly if there are some omissions that come to our knowledge later on, we'll be happy to address them and add other relevant groups.

The Chair: I think that would have to come through the committee.

Dr. Pannu: Indeed. But the committee remains open to this possibility? That's the question.

The Chair: Yes. We've got to start someplace because we've got to get on with the advertising.

Those in favour of the motion? Opposed? That's carried.

Now the stakeholders list for Bill 41. Did you have anything to add on that, Philip?

Dr. Massolin: No.

The Chair: Okay. Are there any comments or questions with regard to Bill 41?

Ms Dean: Sorry, Mr. Chairman. I just wanted to point out to the committee members – perhaps Philip mentioned this earlier – that there was an addendum to the stakeholder list that was circulated this morning at the beginning of the meeting.

Thank you.

The Chair: That was with the revised, with the addendum. So a motion to

> approve the stakeholders list for Bill 41 with the addendum.

Moved by Reverend Abbott. Those in favour? Opposed? That's carried as well.

We've already dealt with the news release. I think Philip dealt with that.

We also have a letter that was submitted with the handout. That's been circulated. Does anyone have any comments regarding that letter that would be used as a template?

Mrs. Mather: Well, the only comment I have is that the first paragraph says multiparty committee. I think we need to be consistent and go to all-party.

The Chair: Good point.

Rev. Abbott: Yeah. Mr. Chairman, I would agree with that. Also, there seems to be a little bit of confusion about standing committee versus policy field committee, and it would be nice if we could use consistent language for that as well. I don't really care which one we choose.

Mr. Shariff: A standing committee is one that's appointed by the Legislative Assembly.

The Chair: The official name for this is Standing Committee on Community Services.

Rev. Abbott: Well, then, perhaps we could or should drop the usage of policy field committee because everybody's – well, not everybody. I've had comments even from my own assistant wondering if it's two different committees or one and the same. Again, because we have the same name as our cabinet policy committee, you know, it's even more confusion. So if we could just stick with one reference, that would be great.

The Chair: Yeah. A good point. I've been referring to this only as the printed material says: the Standing Committee on Community Services.

Rev. Abbott: Okay. Perfect.

The Chair: Are there any other changes to the letter, or is there a motion forthcoming?

Mrs. Mather: I'll make a motion.

The Chair: Mrs. Mather moves that

> the letter as presented with the revised multi- to all-party committee be adopted.

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

Item 7, public hearing locations and dates. If we could get our calendars out, we have some proposed times. Until the committee has received input on both bills 31 and 41 through its submissions, it may be difficult to determine all the specifics of the public hearings and the dates, but I think we can set aside some times. The

deputy chair and myself have gone through some proposed times. The next meeting is already set for September 10 for the committee, and I believe everyone has that down. The next dates after that are the evenings of October 1 and 2.

Dr. Pannu: After September 10 the next meetings will be October . . .

The Chair: The 1st and 2nd in the evenings for public consultations.

Mr. Shariff: Mr. Chair, can you go through all the dates so that we just get them consistently? From here on what are the next dates that have been set?

The Chair: The next date is September 10. That's our next meeting. The actual deadline for submissions is August 24, but we're not having any meeting on that particular date. The next meeting is September 10. The next ones after that are Monday and Tuesday, October 1 and 2, and possibly presentations through the day as well.

Mr. Shariff: So the 1st and 2nd are set aside for public submissions.

The Chair: So keep the 1st and 2nd, the whole day and evenings, set aside for that.

Dr. Pannu: Oh. Whole day and evenings. Okay. That makes sense. One day for each bill, or is this to be determined?

The Chair: Well, we're thinking possibly one day in Calgary and one day in Edmonton.

Dr. Pannu: Oh, I see.

An Hon. Member: Per bill?

The Chair: No, for both.

Mrs. Mather: The time period is short after that before we have to have the report done.

The Chair: We've got to have the report submitted by November, so we need to look at a day possibly the following week, the second week in October, to see what the staff has compiled and give some direction to the staff as to what's going to be in the report. We didn't have any proposals after that because we ran out of time. We had to start this meeting.

Ms Dean: Mr. Chairman, just in terms of having enough opportunity for the staff to do a compilation with respect to the public hearings, you may want to allow at least a week for that to occur. If you're looking at scheduling another date tentatively at this point, I would suggest at least a week to 10 days.

The Chair: So the week of the 15th, somewhere in there?

Ms Dean: Or the latter part of the previous week.

The Chair: The 12th or 11th. Is the 11th of October okay with everyone for a meeting?

Mr. Shariff: What day is that?

Dr. Pannu: That would be Thursday.

The Chair: Ten o'clock in the morning? What does the committee prefer? Afternoon or morning?

Some Hon. Members: Afternoon.

The Chair: Okay, from 2 to 4. And then after that would we be looking at probably the week of the 22nd or the 29th? Would we need one day? We may need more than two hours.

Ms Dean: Again, we're in a new process here, so I am just offering suggestions because I don't know what kind of public input you'll be looking at. What I would suggest is that you'd probably need about a week or 10 days after the meeting on the 11th for staff to prepare the proposed reports and for you to have time to review them and then to come back and meet as a group. So either late in the week of the 22nd or early in the week of the 29th is what I would suggest and perhaps, again, a two- to three-hour window.

3:30

The Chair: The 25th in the afternoon, 2 to 4? Would that be enough time?

Dr. Pannu: Wednesday afternoon. Do we meet at 2 o'clock, Mr. Chairman?

The Chair: That would be Thursday. Would we need another meeting, then, the following week? We maybe should set it aside.

Mr. Shariff: Well, let's book it. If we don't need it, we can cancel it.

The Chair: Yeah. We should set aside a time. How about the 31st? Is that enough time in between?

Mr. Flaherty: The 25th and the 31st?

Mr. Shariff: We are booking it tentatively just in case we need it.

Mr. Lougheed: It's not a good day unless it's 2 in the morning on the 25th.

The Chair: Government Services is already booked, and we don't want to interfere with them.

Dr. Pannu: So what's the proposed date? The 31st?

The Chair: The 31st, 2 to 4 again.

Rev. Abbott: We have to be in Medicine Hat the next day, if that affects anything.

The Chair: The next day of what?

Rev. Abbott: November 1.

The Chair: Lots of time. It's only six hours.

Rev. Abbott: Perhaps we could meet in the morning on that day.

The Chair: These are tentative dates. We don't need a motion for this. It's setting these dates aside in case we need them.

Mr. Lukaszuk: Mr. Chairman, would it be too much to ask that the staff e-mail those dates to our respective offices so that our offices can make arrangements?

Thank you.

The Chair: Consider it done.

Okay. It was suggested that we kind of stick to Tuesdays, Wednesdays, or Thursdays for the public hearings. I know that October 1 is a Monday, but it's not a long weekend or anything like that. Because of the time, I think that was about as late as we could go, and there were no other available times left in September. That's how we arrived at that.

Is there any other business?

Dr. Pannu: Mr. Chairman, I need clarification on the September 10 meeting. Is that also in the afternoon?

The Chair: It's 9:30 to 11:30.

Dr. Pannu: Okay.

The Chair: Any other business?

Rev. Abbott: Well, just a question. Perhaps we could change it to 2 to 4, the reason being that Shiraz just mentioned that he has to come in the night before.

The Chair: As do others.

Mr. Shariff: I suggest that if it's a two-hour meeting to try and do it in the afternoon. If it's more than two hours, then I don't mind.

The Chair: Well, there are other members that also have to come in possibly for other things, but whatever the committee wants. Would you prefer the afternoon?

Mr. Johnston: I would, yeah.

Dr. Pannu: Especially if it's convenient for out-of-town members, I think that's when we should hold it.

The Chair: Does the chair get any preference?

Rev. Abbott: No. It's the members. The members voted for it. You can try to overrule us.

Dr. Pannu: From 2 to 4?

The Chair: Okay, 2 to 4 on September 10. Is that agreeable to everybody?

Hon. Members: Agreed.

The Chair: Four could be a little bit open ended on all those dates.

Mr. Flaherty: You're sending these dates out to the offices?

The Chair: Yes.

Mr. Flaherty: Thank you.

The Chair: But October 1 and 2, I want to clarify, will be all day, from 9 o'clock in the morning until probably 9 or 10 at night.

Okay. We've covered the date of the next meeting. Is there any other business?

Now a motion to adjourn is in order. Mr. Backs. Those in favour? It's carried.

[The committee adjourned at 3:36 p.m.]