LEGISLATIVE ASSEMBLY OF ALBERTA

Tuesday, October 31, 1972

[Mr. Speaker resumed the Chair at 8:00 p.m.]

INTRODUCTION OF BILLS

MR. HYNDMAN:

Mr. Speaker, I would like to ask the leave of the House to revert to Introduction of Bills on the Order Paper.

MR. SPEAKER:

Does the hon. Government House Leader have leave of the House to revert?

HON. MEMBERS:

Agreed.

Bill No. 123 The Alberta Lord's Day Amendment Act, 1972

MR. LEITCH:

Mr. Speaker, I beg leave to introduce a bill, being The Alberta Lord's Day Amendment Act, 1972. The purpose of this bill is (in answer to a question earlier in the session) to amend The Lord's Day Act to remove any doubts about the Attorney General's authority to issue permits for Sunday bingos.

[Leave being granted, Bill No. 123, The Alberta Lord's Day Amendment Act, was introduced and read a first time.]

Bill No. 121 The Improvement Districts Amendment Act, 1972

Bill No. 117 The Municipal Government Amendment Act, 1972

MR. PURDY:

Mr. Speaker, I beg leave to introduce two bills, one, The Municipal Government Amendment Act and two, The Improvement District Amendment Act. Both these bills mainly introduce legislation to give people in mobile homes the right to appeal their mobile home assessment.

[Leave being granted, Bills Nos. 117 and 121 were introduced and read a first time.]

MR. RUSSELL:

Mr. Speaker, I move, seconded by the hon. Dr. Backus, that Bill No. 121, The Improvement Districts Amendment Act, 1972 and Bill No. 117, The Municipal Government Amendment Act, 1972be placed on the Order Paper under Government Bills and Orders.

[The motion was carried without debate.]

GOVERNMENT MOTIONS

MR. HYNDMAN:

Mr. Speaker, I move that you do now leave the Chair and the Assembly resolve itself into Committee of the Whole for consideration of Resolutions 3 and 4 on the Order Paper. In respect of each of these resolutions, Mr. Speaker, the Lieutenant Governor has been advised as to their contents and recommends them for the consideration of the assembly.

[The motion was carried without dissent.]

[Mr. Speaker left the Chair.]

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COMMITTEE OF THE WHOLE

[Mr. Diachuk in the Chair.]

MR. CHAIRMAN:

Resolution No. 3, on Page 7 of the Order Paper:

Resolved that it is expedient to introduce a bill for an act, being the AGT-Edmonton Telephones Act. Is it agreed?

HON. MEMBERS:

Agreed.

MR. CHAIRMAN:

The second resolution is on Page 8 of the Order paper:

Resolved that it is expedient to introduce a bill for an act, being the Legislative Assembly Amendment Act, 1972 (No. 2).

Is it agreed?

HON. MEMBERS:

Agreed.

MR. HYNDMAN:

Mr. Chairman, I move that both resolutions be reported.

HON. MEMBERS:

Agreed.

MR. HYNDMAN:

Mr. Chairman, I move that the committee rise and report the resolutions and ask leave to sit again.

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[Mr. Speaker resumed the chair.]

MR. DIACHUK:

Mr. Speaker, the Assembly has had under consideration the following resolutions:

Resolved that it is expedient to introduce a bill for an act, being the AGT-Edmonton Telephones Act.

Resolved that it is expedient to introduce a bill for an act, being the Legislative Assembly Amendment Act, 1972.

MR. SPEAKER:

Having heard the report and the request for leave to sit again, do you all agree?

HON. MEMBERS:

Agreed.

MR. HYNDMAN:

I move that the resolutions be now read a second time.

MR. SPEAKER:

Having heard the motions by the hon. Government House Leader, do you agree that the resolutions be read a second time?

HON. MEMBERS:

Agreed.

INTRODUCTION OF BILLS

Bill No. 120: The AGT-Edmonton Telephones Act

MR. WERRY:

I beg leave to introduce a bill, being the AGT Edmonton Telephones Act. Under the provisions of this bill, Mr. Speaker, the City of Edmonton is authorized to acquire the local exchange assets that are located within the corporate boundaries of the City of Edmonton as of December 31, 1972 from AGT. It also sets out the method to be used in evaluating the equipment and the terms of payment thereunder. If the parties cannot agree to the purchase price, there is provision where a tribunal may be selected by the Executive Council and the terms of reference are also incorporated in the bill, Mr. Speaker.

The concluding point in the bill is that AGT is in no way authorized or empowered to enter into any arrangement with the city of Edmonton to share any portion of the long distance toll revenue that originates or terminates within the City of Edmonton telephone system.

This bill, Mr. Speaker, concludes the long-standing dispute that the City and Alberta Government Telephones have had since 1968 as to boundaries, and also the question of toll revenue. As most members are aware, there was a mediation committee struck and set last August, which was a technical committee, and they reported their findings in December of last year. Upon the receipt of that Technical Mediation Committee report, both sides to the dispute appointed negotiating teams from the city and from the government and they commenced to negotiate the various points that were outstanding concluding in July of this year. On July 24th, the City of Edmonton passed a Resolution in Council and the government now introduces the bill, which will incorporate all of the points that have been oustanding for some time.

[Leave being granted, Bill No. 120 was introduced and read a first time.]

The Legislative Assembly Amendment Act 1972, No.2

DR. HORNER:

Mr. Speaker, I beg leave to introduce a bill being The Legislative Assembly Amendment Act, 1972 (No. 2). The purpose of this bill, Mr. Speaker, is to put into legislation the recommendations of the O'Byrne Report.

[Leave being granted, Bill No. 118 was introduced and read a first time.]

PRESENTING REPORTS BY STANDING AND SELECT COMMITTEES

Select Committee on Industrial Investment and Opportunities

MR. HYNDMAN:

Mr. Speaker, before proceeding with the committee study continuation of the Mental Health Act, I would like to ask leave of the House to revert for a moment to presenting reports by standing and select committees. The purpose of asking for reversion to that order at this time would be to allow the hon. Member for Edmonton Strathcona, Mr. Koziak, to table the interim report of the Foreign Investment Committee with regard to The Public Land Amendment Act, 1972 (No. 2), which instruction was given to his committee at the earlier sittings of this Assembly. I would ask for leave at this time.

HON. MEMBERS:

Agreed.

MR. KOZIAK:

Mr. Speaker, I beg leave to table the interim report of the Select Committee as pointed out by the hon. House Leader. The report deals primarily with the examination of Bill No. 107 with which this committee was charged by this House on the 1st of June, 1972.

GOVERNMENT BILLS AND ORDERS
(Committee of the Whole)

MR. HYNDMAN:

Mr. Speaker, I move that you do now leave the Chair and the assembly resolve itself into Committee of the Whole for study of certain bills on the order paper.

[The motion was carried, Mr. Speaker left the Chair]

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COMMITTEE OF THE WHOLE

[Mr. Diachuk in the Chair.]

Bill No. 83: The Mental Health Act, 1972

Section 5.1

MR. CHAIRMAN:

We will return to Page 10 of the amendment, Section 5.1, which we had agreed to return to at yesterday's sitting.

MR. R. SPEAKER:

This is a section that I had asked yesterday to hold. I think the concern that we have on this side of the House and certainly other members have too, with regard to the therapist and as we expressed all the arguments that we had in discussion in debate yesterday, I think the question I would like to give to the minister at this time, so that we have a clear understanding of his view, is the following. What we would like to know, is the minister, and in turn the government, satisfied that the present definition of the therapist gives adequate protection to the rights of the individual, and particularly in light of the 24 hour committal power that the therapist is given under this act. And I think that's the crux of the whole argument. Can they adequately assure us that there is adequate protection there?

MR. CRAWFORD:

Thank you, Mr. Chairman. Yes, we think that the beginning has to be made at some point, and that some workable arrangement has to be worked out.

The hon. member's particular reference to the 24 hour committal, I submit, is not accurate and I know that he knows what I mean when I say that. It is in no sense a committal to be examined under these provisions and that a commitment can only take place after the examination by a therapist and a physician or by two physicians. And the suggestion is that the conveying for the examination is an essential part of the procedure.

The hon. member, of course, is relating it to the fact that this bill introduces therapists and is, I suppose, asking us if it would be desirable during that first 24 hour period where an examination is intended to take place -- and it is not longer than 24 and could indeed, where the proper facilities exist, be somewhat less than that no doubt -- if some person other than the therapist had the power that's given. And I think the answer to that is that it is not likely that a physician has any greater power of sensing when an emotional disturbance or mental disorder is present or is pending than a therapist properly qualified.

Yesterday we did go through the references to the various occupational skills of psychologists and others that may be called into play at that important moment in the diagnosis of the patient to make that albeit difficult but nevertheless necessary judgment that an examination should take place. I think that many people who are very familiar with the field would say that the nature of a physicians practise, although he has the enormous prestige of a

medical degree and his membership in the College of Physicians and Surgeons, does not necessarily acquaint him with some of the subtle indicies of mental illness as much as the work of the psychologist or social worker, and it is a belief in that that is part of the decision to put it forward on this basis.

MR. R. SPEAKER:

I appreciate the first answer of the hon. minister when he said, yes, we believe this definition in the act and the terms are adequate to give protection to the rights of all the individuals in Alberta, and we will take that as his position at this particular point.

I do take exception though to the statement that I had "made an inaccurate statement", because in Section 12 of Page 19, it says very clearly that the certificate is sufficient authority to detain the person named therein for a period of 24 hours. Detaining the We may argue over what the difference is between those two words 'commital' and 'detain', but it does say that in an institution, whether government or non-government, that person can be detained or held against his own judgment. I think that is the key point that we are concerned about.

MR. CHAIRMAN:

Very well. Mr. Henderson.

MR. HENDERSON:

Mr. Chairman, I sympathize with what the hon. minister is trying to do but it gets a little difficult to follow the argument that the physician is maybe not well equipped to judge whether a person needs some sort of mental treatment or not as opposed to a therapist, when we really don't know what the qualifications of the therapist are. And this is really what we are groping for in the first place, because the hon. minister has not been able to really -- and I appreciate the difficulty -- come up with a better or very clear picture on what the qualifications of the therapist will be. So the capability of a therapist to judge the need for some sort of mental treatment or assistance, as opposed to a physician, is rather hard to accept when you don't know what you are comparing the physician to. And that happens to be the accepted criteria at this point in time. This legislature has delegated to medical practitioners in the province of Alberta certain rights, for a limited period of time of certain protections to restrict the freedom of individuals in the interests of facilitating their treatment for a mental health problem.

We are being asked now to extend this prerogative to an as yet undefined group of people with undefined qualifications who would also have the right on their own sole judgment to detain a person for 24 hours against his will. And while I fully appreciate, and I think we all do, what the hon. minister is trying to do with regard to this role of the therapist, and, in trying to expand the type of people that are available to deal with mental health problems. I fully concur that the medical profession per se is never going to be able to deal with the broad implications of mental health, whether it is drinking or a wide variety of things. And I don't know where you would draw the line between physical and mental health. I don't think you would draw one.

But it is really this question, when you say the therapist could be better qualified to judge than a physician as to whether the person should be detained for 24 hours against his will. It may well be true if we knew what the qualifications were going to be. But this is what the Legislature has been asked to do; it has been asked to delegate this authority to an undefined group of people with undefined qualifications. We have something like 1,700 doctors in Alberta that is a general figure because I haven't heard the recent figure who now have this legal power. We do not have any idea how many more we are asking to extend this to, nor what the qualifications of these people might be. I fully appreciate that in the final analysis the Government is accountable for it. And I certainly don't intend to make a major issue out of the question, because I think there is need to move in this direction. But it does leave me to wonder if, at least until we as members of this legislature, including the minister, have a better idea of exactly the qualifications and the number of these therapists, their abilities and what they are going to be doing, there should not be the need for an endorsement on the part of a physician on the admission certificate of the therapist. I think where this is going to come up in most cases in the rural areas where there isn't the concentration of physicians. And a therapist might be a public health nurse as the Minister said, is maybe the only person available to do it. But I think, on the other hand, in most parts of Alberta it is not unreasonable to ask, at least at the outset, that the therapist find someone, perhaps a doctor, who could endorse the

certificate for commitment. I would feel much happier, personally, on seeing the broadening of this power to a larger group of individuals, to detain people against their will in the interests of ascertaining within 24 hours if they have a mental health problem. But the question of admission versus transmittal and convenience and examination certificate is a pretty fine line when it comes to the issue of interfering with the citizen's private rights for a period of even 24 hours.

So I think there is something to be said, at least at the outset, for seeing such a qualification go into the legislation. Then, once we have these therapists in existence, we have a better idea as to what it we are dealing with, who we are delegating such powers to, what their qualifications are, and so forth. We can then look to changing the Act. But certainly at the outset, the physician's judgment still remains the accepted public criteria. I quite frankly have to say that if some 23 year old social worker came in to me about something and I didn't like it and I told her "fuddle duddle," if she wanted to commit me for 24 hours I would be pretty unhappy about it. And I think we all have to deal with people in every day walks of life, in particular in the political arena, where you get constituents with all sorts of complaints, and they may figure at times that you are a little queer and vice versa. But that is not the basic justification for a social worker, on that sort of an exchange of views arriving at the conclusion that a person should be committed.

And this is where you talk of social workers, this is to say that I am not picking them out, but certainly the public is not going to accept very readily judgment from that type of person until the individuals involved have, I think, a higher degree of public acceptance and the public has a lot more confidence in what these people are going to do for them. So I would like to suggest that the government certainly consider this, at least at the outset, for the legislation: that a qualification be placed on a therapist to form some sort of a seconding or condoning of the detention for 24 hours by a licensed physician. It still happens to be the public criteria for this action at the present time as to whether or not the therapist is better qualified than the physician to make that judgment. I don't think there is any way of arriving at a logical conclusion on that issue without some experience on which to base the judgment.

DR. PAPROSKI:

I would just like to make a comment on this particular item. There certainly seems to be undue anxiety from the hon. members opposite regarding the therapist. I think the hon. members should realize that mental illness stretches from the mild illness, the psycho-social problems, to the severe psychotic problems. I don't think that anybody misunderstands that aspect. There are many qualified personnel in the Province of Alberta and in Canada presently participating in treating mental illness. When I say treating, I am saying prevention, diagnosis, treatment, rehabilitation, and teaching. These people, as the hon. minister has mentioned a number of times -- and just to reinforce this item -- are voluntary people. They are people who are psychiatric nurses, social workers, psychologists, psychiatrists, medical doctors and many others. With this in mind, recognizing the fact that these people are treating and involved in the whole gambit of therapy from prevention, diagnosis, treatment, rehabilitation, and teaching, right now for mental illness, it should not be so difficult for the hon. members to accept a therapist as being one of those with special qualifications, as will be defined by this special board which will be made up by those people, who in fact, are already involved in this area.

Now, the question here is, that some of these people are being used adequately, and some of them are being used inadequately. In other words, a nurse, a social worker, who has been doing a very good job, may very well be in a front line of mental therapy. We have social workers right now practising in our society who, in fact, are counselling, offering psychotherapy for mental illness, and in fact, preventing serious problems. This is also true with psychiatric nurses. Now, what this bill does is say this: medical care surely is multi-disciplinary, surely it is team approach in the '70s, surely it is community involvement, and surely we realize there are other people besides medical doctors that can and do treat mental illness very, very well. We realize that we cannot produce enough medical doctors to handle this problem, and we also realize that these other people are doing an excellent job and they are professionals. So we say, let's formalize this into an act, and this act is formalizing these people and saying, you will be called a "therapist".

Now, the next question arises, what is a therapist? Well, surely, the same people, who are now involved to varying degrees in treating these people with mental disorders of varying degree of intensity, will formulate and define this quite clearly, I am sure, to the public. And if we don't trust them to do that

now, then we, in fact, should not trust them to handle our problems even at this stage of the game and yet they are handling them very well: the nurse, the social worker, the psychologist, psychiatrist, and so forth. So what I am saying is that there is a wide variety of trained personnel, and the therapist will be defined. This act formalizes this area of multi-disciplinary approach, defines a therapist, and will bring it back to the community so that the community will have other people involved who are able and capable. In fact, right now, they will upgrade their training, or define their training so that society, and the citizens at large will not have any anxiety that, in fact, they are quite capable of making an assessment of a mental disorder, and have that patient conveyed to an institution for the therapy. And I hope the institution is not an institution, but a "special care" type of community home.

With that statement I would like to ask one more question of the hon. minister, and this is the concern I have: whether he is considering this at this time, or whether he is going to leave it the way it is. The Registration Board, as I understand it, does not have a member of the Department of Psychiatry or the Association of Psychiatry. This is a concern because as I stated yesterday, the college of Physicians and Surgeons may very well appoint a physician, who does not necessarily have that x degree of expertise as a psychiatrist. And they have expressed a concern to me that they would like to be sure that one of that registration board is a psychiatrist. In fact, a member of the College of Physicians and Surgeons could be included also. I would like him to express his opinion on that item.

And if I could speak on this 24 hour item which is another concern of mine, maybe he could express his opinion on that. I think 24 hours frankly, is inadequate. I would like to see 48 or 72 hours. And I base this on a number of concerns. As a practising physician for some 15 years, I have seen patients who, in fact, one minute they are unstable and they have a mental disorder, the next few hours they are very stable. And this is a temporary item, and 24 hours to me would indicate it might be too short, and in fact, this patient might be discharged before he has been properly assessed.

If he is admitted for only 24 hours -- and I am pleased to see it is amended from 12 to 24 hours, incidentally, because that is an improvement -- the patient may be sedated when he is admitted to the facility, and sedation may be mild, or moderate, or quite a bit, and if it is quite a bit, the sedation may take from 8 to 12 hours to wear off. But, as a matter of fact, after that, the patient may have some temporary remission, and there may be a further delay in making an assessment and that patient may be ruled as not having a mental disorder, and discharged. At least the decision has to be made. The staff observation is another problem. I think that when we are observing the patient for 24 hours -- assuming that he is admitted at 6 o'clock, in the evening, until 6 o'clock the next day -- this can pose a serious staff problem because not only the existing staff have to assess him and survey him very carefully to make a critical decision whether he is to be admitted or discharged, but an expert over and above the therapist might have to be called, and that expert might not be available. I am talking about a psychiatrist. I would suggest that again here is a concern.

The other item of concern is a relative who really feels that this patient has a mental disorder, rightly or wrongly, would be really concerned to have that patient back on the doorstep within 24 hours without a period of time of adjustment to see whether this patient is going to stay there for a while or come back. Then here he is, 24 hours later, right on the doorstep, and the same problem is there and she is not sure, or he is not sure, as the case may be. I am asking the minister to immediately respond to this as I think there is a concern here expressed by a number of citizens. Certainly it is a concern of mine, based on my medical practice, that maybe 24 hours should be extended to 48 or 72, although I am grateful for its extent to 24.

MR. TAYLOR:

Mr. Chairman, I have three points. The first one, is the matter of the stigma. I agree entirely with the hon. minister that there should be no stigma, but the fact remains that in many people's minds there is a stigma, even when a person is treated for depression, whether it is in a mental hospital or whether in a psychiatric ward of a general hospital. We only have to look at what happened to Eagleton in the United States to realize that hundreds of people became concerned simply because he had admitted himself in a depressed period for treatment. This is a sensible thing to do in my mind and there should be no disgrace. I was quite discouraged with the fact that his leader let him go simply because he had been attending to his own better mental condition. The point I am trying to make is that it is going to take a long time before

everyone accepts the fact that when you have treatment of this nature there is no stigma. As far as I am concerned, a person can spend five years in a mental hospital in Ponoka. To my mind, there is no stigma. It is just as sensible as spending three months in an ordinary hospital for a stomach ailment. Or, as my hon. colleague says, as spending four years in the legislature. There is no more stigma attached to one than there is to the other. But I'm trying to emphasize the point that a person can't go and get this type of treatment without some housewives or some househusbands (on account of womens' lib) who are going to make something up.

The second point I would like to mention is that if the hon. minister would give the assurance that the hon. Member for Edmonton Kingsway just gave us, that all of these therapists who are treating people for mental illness are trained people, my fears will vanish. It is the fact that the hon. minister has not given us any assurances that perhaps we should have had the benefit of the regulations under 5.2, where the board will be establishing standards of training and experience of persons. If we knew what that was, then I think the general public of this province would feel at ease if they know he or she is qualified. The only fear is that people are going to be given this authority to admit someone to a psychiatric ward, to detain him for 24 hours against his will -- possibly more if it is extended, as the hon. member mentioned many times might happen. I have no doubts at all about our public health nurses and the other persons mentioned by the hon. member. I think that is fine. That is what we have been trying to argue and trying to persuade the Minister that it is in his best interests to make sure that a qualified person is appointed, and that those persons have minimum requirements. The third point that I want to make is that, while I am interested in the Minister protecting himself, I am more concerned about the rights of the person who is committed, who is detained against his will. Under our individual rights bill, I think it stands out conspicuously that those people have rights, and we don't want to trample over them with somebody who is not qualified. It would be better if we accepted the recommendation of the hon. Member for Wetaskiwin-Leduc that it was approved by a doctor. Everyone knows doctors are highly qualified. Maybe their judgment isn't any better than the judgment of others but people have confidence in their doctors, generally speaking. This would take a lot of the fears away from the general public in regard to having the possibility under the loose way in which therapist is outlined. They're afraid of having somebody who was ill-prepared to carry out the functions and duties of a therapist as outlined in this bill.

DR. PAPROSKI:

One comment on that in response to the hon. member -- and I thank you for the remarks -- is that I hope not only that these people are in fact treating now to some degree mental illness, whatever the degree may be. I think the hon. minister really intends that these people be evaluated and upgraded to even a better level, if necessary, and I ask him to respond to that comment.

MR. HENDERSON:

My comment is in response and I certainly have no quarrel, Mr. Chairman, with the remarks of the hon. doctor. All the remarks about treatment, assistance etc. are fine. But this does not come to grips with the basic root of the legal prerogative, the legal issue involved of this legislature delegating the authority to an undefined group of people with undefined qualifications to detain a person for 24 hours against his will. All we are saying is that at this point in time, according to the accepted standard for doing this, the judgment is left to a physician. I don't say that he is God and that he is always right, but I have more confidence, at least at the outset, that he is more apt to be right than wrong than the therapist where I do not know who he is going to be at all. I would like to suggest to the government to consider that rushing into it by opening this way initially might, in the final analysis -- it's only going to take one hubbub over one person being detained by one therapist in the early stages of this program to set the whole thing back in the public judgment.

In my mind it seems to be far more logical, as far as the legislature is concerned, as far as the government is concerned, to simply put this qualification in the act at the outset. I don't care whether you want to put it in there for a period of three years, and provide in the act that it will terminate and then be done on the therapist basis. But I would rather see it in the act that the physician's consent is required and the matter could come back before the legislature for amendment at the government's discretion. I don't think it will do any harm; it won't impede the development of the program, and it could also avoid some undesirable public reaction to this program misfiring just because these people we don't know who they are, what their qualifications are going to be -- have detained a person against their will, and there is a

real public outcry. I just suggest that the government think about it before they rush into it. It has nothing to do with casting aspersions on the capabilities of these people that treat patients, and what not. Someone pointed out that the AA probably have a good or better record of treating the problem of alcoholism, which in my mind is a mental health problem. The alcoholics don't as a group think so, in my discussions with them. But that is their prerogative. I don't quarrel with them. But AA have as good a record in treating the problem of alcoholism as anybody does in the professional circle, so it is not a case of an element of professionalism versus non-professionalism. That doesn't get into the argument. I would like sincerely to suggest that the government at least seriously consider the suggestion that at least at the outset a physician's approval should be required on the certificate of conveyance and examination.

DR. BOUVIER:

One point. I am not nearly as concerned as many of the other people from this side about the qualifications of the therapist, but one point, though, that may help clarify the matter or make it worse, depending on the minister's answer, is this. We have seen that therapists can have convictions attached to their licences. Is it not possible that some of these less qualified therapists may not have the power of committal? might help clarify the matter, or it might make it worse, depending on the minister's answer. We have seen where therapists can have conditions attached to their license. Is it not possible that some of these less qualified therapists might not have the power of commital?

DR. PAPROSKI:

The anxiety expressed by the hon. Member for Wetaskiwin-Leduc is well founded; it is understandable. I am sure the hon. minister is quite aware of this, as all of us are. But that anxiety is exaggerated because, as I stated before, these people are already involved. The purpose of the board in setting a standard is exactly that, to assure that the therapist is, in fact, acceptable by the various professions. If we could just accept that item -- if you don't accept that item then I suggest to you that we are not accepting the fact that these various people, the social worker, the psychologist, the nurse, are presently involved in mental health and illness.

MR. CRAWFORD:

Mr. Chairman, I do think the discussion that has just taken place is very useful. It has been brought fully now to my attention exactly what some of the concerns are and some hon. members have even made statements that, if certain types of assurance could be given, their fears could be allayed. I hope now to be able to do that.

I think, in respect firstly to the hon. Member for Edmonton Kingsway, that I will deal with the remarks that were made with regard to membership on the registration board and the suggestion that a member of the Association of Alberta Psychiatrists be included. I did respond yesterday (and am rather inclined to stay with that response) that with the presence of the Director of Mental Health or his designate on the Board that will prove to be adequate for the purpose; the only concern here is not to fail to have the representative of the Association referred to, but we are getting to the point where the Board would soon be getting too large if many more were added.

I think it is very necessary that the Director of Mental Health or his designate be on it; certainly it is true in this respect to the act, as it will be in many other respects, that if we find that is not serving the purpose then consideration could certainly be given to the suggestion made by the hon. Member for Edmonton Kingsway.

I do want to thank him for shedding some light on the question of the period of detention, the changing of that from 12 to 24 hours, and for remarking, as he has done, on the concerns expressed about a period of as long as 24 hours. From his own experience and practice he has been able to tell us that that period of 24 hours is hopefully going to be enough, but that he fears in some cases it won't be long enough. Therefore, I think, hon. members, you can see the process, and it is a difficult process, of arriving at the period of time that should be set. Of course, this referral for examination then may or may not then set in train the events that follow subsequently, with a committal for a substantial period of time of up to six months with renewals. At the present time, however, when that commitment is made, it could end up being for a much longer period, and the hon. members will see as we go through the act that the sort of horror story that we have all heard of over the years of somebody

being committed and left for indeterminate periods of time in an institution will not be possible under the procedures that are laid out in the act.

I think that the Committee should reflect upon what is being proposed as something that we are recommending as a process which is really an evolution right here in this Committee now. The whole idea is that if we are to bring about change it must be a change that evolves. It is neither cut and dried along the old lines, nor cut and dried along the lines that we now imagine to be established, because we don't know everything about it yet. The evolutionary process that I spoke of began, of course, with the workings of the Committee of representatives, the unique committee I have referred to so many times in this House, drawn from various areas of professional and volunteer workers; areas of competence in the mental health field in Alberta. It began, of course, with the workings of the committee of representatives - the unique committee I have referred to so many times in this House - drawn from various areas of both professional and volunteer workers, areas of competence in the mental health field in Alberta. Working with people in the division of Mental Health of the Department and Health and Social Development it slowly began involving first Bill No. 83. Then it bgan the assessment, after last spring's introduction of the bill, of the representations that were made by various people across the province, took the suggestions of the groups including all of those we have been mentioning as being members of the Therapist Registration Board, pieced all of these together, and came up with the amendments we now have. This was all part of the evclutionary process and I submit to hon. members that it's still going on here right now. We're still thinking without our minds closing any doors about how this might work best. It will still continue to evolve when this committee and this session of the legislature has dealt with the matter. It will be something that will receive attention that won't be surpassed in the degree of diligence that the government will show by any other thing that we undertake.

I did want to say that one of the ways I feel fears could be allayed -- and the hon. Member for Drumheller did say that if he had the same understanding of matters as the hon. Member for Edmonton Kingsway, that people who are now basically active in these types of roles in the province would also be those who are registered by the registraticn board, and would therefore be the ones who would be carrying out the duties of a therapist, that his mind would be much at rest. I assure him that the interpretation given by the hon. Member for Edmonton Kingsway, is one of those misunderstandings that I just didn't sense until both hon. members spoke on it, one after the other. I sense it fully now. The anticipation indeed is that persons who have sort of grown up in the field in a functional way but happen to be outside of the establishment that has been carrying on this work up to the present time are those people who are very carefully and cautiously, one by one, going to be given these responsibilities to discharge and only those of them who fulfil the requirements laid down by the registration board for them to be registered. So that even many, many members of these groups that we are speaking of drawing the therapists from may never be certified or registered as therapists and may never have any of the powers of that we speak of. I think that last comment deals with the point made by the hon. Member for Lac La Biche-McMurray too, that those who are the less qualified perhaps wouldn't have the power of committal. I think the answer is implied in the statement that those who don't reach a certain qualification would never be registered in the first place.

(Section 5.1 to Section 5.11, and Section 6 not amended in the Act, were agreed to, without debate.)

Subsection 6(1)

DR. PAPROSKI:

Mr. Chairman, let me speak on this one item briefly. I am asking the hon. minister if he would comment on this. My concern here is that the word 'regional' is used and, this may be petty in fact, but I don't think it is, because it communicates a certain feeling. I would ask him if he would consider changing 'regional' to maybe 'community areas' rather than 'regional areas'. I feel, and in fact know, that the community, as central core concept, is people, where people live, where people do their things and so forth. Whereas regionalism means and implies administration. It is implying, in fact, another layer of bureaucracy in front of people. Recognizing that even if you change the community areas this in fact still leaves it as an administrative definition. But I think that people in a community area would feel more comfortable knowing that they are allowed possibly to participate and that they belong in the community. In other words, I think it is about time we broke down some of these words and not only acted in this direction, which we are by decentralizing and going to the community level, but also indicate this by words

and utilize the word 'community' rather than the word 'regional' mental health area.

I would also like to have some assurance that the various boundaries for these areas will be co-terminous with the hospital districts wherever possible.

MR. CRAWFORD:

Mr. Chairman, I think the hon. member is asking me, in a way, to anticipate what the regulations under Section 6 would say. I have no hesitation in responding briefly to that. The actual powers of the Regional Mental Health Council would be those given to it by the regulations. The previous subsection would indicate that it has a large advisory role, which to me, speaks of co-ordination rather than administrative control. I think we have to look at the situation the way it is now and realize that we have a provincial delivery system for mental health, which is centered around two major treatment hospitals, which are provincial hospitals, and which are referral centers for the whole province.

If the idea of the community is the ideal of the future, and it may well be, surely a logical intermediate step is to speak, at least in the sense of empowering the Lieutenant Governor in Council - because it is not mandatory to establish the regions - of establishing that intermediate level of co-ordination. Of course, in the sense of co-ordination a voluntary service is also co-ordination of the treatment programs of the province in that area too. I do think that every time anyone says 'regional', there is always a quick enough reaction that can be had of alarm from some quarters that see a change in their jurisdiction in regard to matters that were considered local. I continue to give assurance, whenever that comes up, that that is not the intention. It is not meant that a centralizing motivation be involved in any way. The reference was made in the Blair Report of the need to have co-ordination outside of the two major centres in Edmonton and Panoka and to use the other various parts of the province on a regional basis to bring services that don't exist there to people in those areas. I think I can assure the hon. member that the idea of regions will not stifle any local initiative. We would move very cautiously with them and they would not be generally imposed. They would be the sort of thing that we would like to work out where all of those in a given part of the province can see some advantage in working together instead of working in smaller groups.

I think that in specific answer to the hon. member I would like to see it go ahead in the form that it is now. I made a similar remark in respect to some other matters that have come up that we would like to work with it for a while. We think it will work. If experience teaches that the way we should be moving in the direction that the hon. member's remarks imply then certainly that is what we want to do.

MR. NOTLEY:

I would if I might just persue this a little further. I am not sure if I understood the hon. minister correctly. When you talked about the regional areas, Mr. Minister, you referred to the fact that we had two major centres. Now, surely, we are talking about more than two regions. I am wondering if we could perhaps have some idea of your thinking as to how many regions you feel are practical in the province. Are we talking about six, eight, twelve, fifteen, or something in that order? Also, I was not quite sure if I followed you when you suggested that -- let us just take Dr. Paproski's point for a moment, of making this co-terminous with the hospital districts. Are we talking about the possibility of some council at this level, as well as the over-all regional level.

Let me illustrate by citing Peace River area. I assume that the Peace River area would be one mental health region. But would it be possible, or am I misinterpreting what you say, that in, for example, the Fairview hospital area, they could have a 'sub' mental health council. I am just wondering if you could perhaps clarify these matters for me. Then there are several other points I want to raise under the subsection.

MR. CRAWFORD:

Mr. Chairman, I can clarify, I hope, those two points. First of all, as to regions. There is no intention to sort of unroll a grid across the province and establish regions that way. It is something that would be done on a selective and progressive basis. It would occur over a period of time. As a certain area of the province appeared ready to deliver its services in a certain way, then it may become a region. Right now, without any formal declaration of regions, we

have the treatment patterns going in and out of certain communities in the province. Naturally, we know that the services of this type exist in every major centre. When I referred to the original two referral centres for more intensive psychiatric and related care, I did not mean to imply that there were not services available in Lethbridge and in Calgary and in Red Deer and in several other communities. I think the example of the Peace area is a good one. What we have done there, without going really to anybody in Grande Prairie or Peace River or Fairview and saying, "You are now part of the region where we will draw the terminal boundary here," (we have not thought that was the important thing) is to begin to serve the area and program the soon-to-be unfolding new services in the Peace area.

Basically by building up the mental health manpower in the area we are helping the whole region and they will be there whether any region is ever declared as such or not; whether there is any co-terminus arrangement or not; whether there is ever any real arrangement worked out. But we will also have in the area a co-ordinator who will have a very sensitive role. His job will be to try to make sure that from this base that moves into the Peace area the necessary services do indeed reach out to the various communities. This is where, as I say, it can be an advantage to services in a community. There has been an attempt made at working in the region even if it is not, as I mentioned, nailed right down on the line as to where it is.

Also apart from reaching out to communities that might not otherwise have it, would be an attempt made in the larger centers like Grande Prairie and Peace River to do away with duplication in the volunteer areas. A day care operation could, for example be worked out with one of the hospitals as opposed, say, to the guidance clinics in the area and The ending of duplication in the major centers, the reaching out into the other centers where the services had not existed before, and the using of the idea of that being a region for which this group based in Grande Prairie and later based in Peace River later will make their important moves and take their important initiatives. At the same time without going into every detail throughout the province, I don't think that is intended, Medicine Hat is another example of a place where a slightly different approach is being used but which is also an area, region if you like, where we could see a central base in the vicinity of the province where services could be brought both there and to the environs for a number of miles in each direction to the ultimate benefit of the people in that area requiring that type of help.

So I would say both to the hon. Member for Spirit River-Fairview and the hon. Member for Edmonton Kingsway that community services are not distinctly endangered by what is proposed. The question specifically was; "Could there also be a council in, say, a local community?" I think that the situation is in the local communities is that they either don't have any services, or they do have a local sort of committee or a local sort of arrangement, maybe it is based at their hospital, maybe in the doctors office, or what have you. Maybe it is based with a travelling service of some sort. But whatever is there is serving the community, perhaps inadequately, the alternative being that it is not being served at all. We certainly do not want to endanger any community based thing and don't really believe it will endanger it. I think it will support it.

MR. NOTLEY:

I certainly appreciate the need for flexibility. I am just wondering in terms of the local people in a given area -- let's take the Peace River region -- what steps would they take to try and develop or have set up a mental health region in that part of Alberta? This is permissive legislation, I appreciate that. But what steps can the local organizations take in terms of moving the government into this approach in that particular part of the province or any other part of the province? What I gather from your comments is that it is all very permissive. You can move as you feel necessary. But my question to you is: to what extent is the local input there? How does it operate? What steps do local people take in order to get an area proclaimed as a mental health region?

MR. CRAWFORD:

Mr. Chairman, the regulations would outline that type of procedure if it were seen necessary to be outlined. The way that I see the situation developing, for example in the Peace, is that our first step would be taking our guidance clinics, which have had greater or lesser success in various communities throughout the province, as bases of operations, although responsible to the government in the sense that they are arms of the department, nevertheless they would be oriented towards the community where they happen to be in and building on their own increasing resources, as well as the resources in the community.

Now it would be up to a community to say that they found the services adequate or not, of course, in their particular situation. I can see that if the services that are provided are generally felt by the community to require an additional type of input that they feel can be made in the community, they may feel a need for co-ordination with the expanded role of the guidance clinic. They may, at that point, decide that the real answer is a region. If they are at that point there is no question in my mind that all they would have to do is, within the context of the regulations as they are finally passed, signify what they could foresee as being the region that they would be involved in and approach the government on it.

Naturally, whatever we do will be based on an attempt to have the services flow freely in individual communities -- to have a combination of both the government and the services of the local hospital board. The question of whether or not there is a medical practitioner in a community is relevant, for example, to whether or not a travelling service should maybe escalated within that particular community. All of those things taken into account we would reserve the right, if we saw an overwhelming need in one area and a moderate need in the other, to serve the overwhelming need first. So, of course, it won't be a matter of stamping each approach that may be made by people who are having a particular type of organization in their area embasing the region but it would certainly be something that we will pursue vigorously at every chance.

MR. NOTLEY:

I certainly agree that the principle behind the idea of a Regional t) Mental Health Council. It seems to me that this is one of the more important points that are being brought up in this legislation. However, I don't see much difference here. I am wondering if you have considered any other approach to the appointment of the Regional Council other than appointment by Lieutenant Governor in Council. I realize that it is essentially an advisory body but it is because of that factor, because I believe it is important to tie in as broad a representation from the community as possible, that it appears to me that there might be some merit in some type of representation from the local elected bodies of one kind or another in a given region. I realize it is a little difficult to delineate the qualifications at this time for Regional Council but I am wondering if you have been able to give some consideration to how we could make these things as representative as possible and rather than just the appointment by the Lieutenant Governor in Council.

MR. CRAWFORD:

Mr. Chairman, naturally my experience on this ... varies according to the degree of confidence that all of the members have and what the Lieutenant Governor in Council does. I think there isn't anyone on this side of the House that doesn't have the feeling that the Lieutenant Governor in Council will rereview the Council to see that the representation is community based and that the right interested people, the associations that are active, the professionals that are active in the area are properly reflected in whatever Regional Council there may be. But I would add this; although I don't see at the outset such rapid developments in this area that we would look for in a better established arrangement, I would still say that we would certainly give consideration to them in the future amendments of this legislation and keep the sessions making some adjustment in that respect.

MR. DIXON:

Mr. Chairman, I wonder if the minister could tell me if you have appointed a full time psychiatrist in the Medicine Hat clinic?

MR. CRAWFORD:

Mr. Chairman, there is no appointment by the government to the clinic. There is, in Medicine Hat, at least one full time psychiatric specialist in private practice. No, there is only one, according to my recollection, but he has shown great leadership in the community in the whole area of mental health. It is a very sucessfully functioning service at the present time.

MR. DIXON:

The reason I asked that question, Mr. Chairman -- I was reading the annual report of the Board of Visitors and this is what they have to say about Medicine Hat, "The facility of the Medicine Hat clinic is adequately and generously housed. The staff, however, consists only of a psychologist and a social worker. Until a psychiatrist has been secured it is not suggested that other

additions to the staff be made. With the appointment of a psychiatrist the clinic could assume wider responsibilities."

In your speech to the Alberta Medical Association in September you stated, "Let me graphically illustrate the impact these changes will have on a previously under-serviced area in the province. In Medicine Hat, for example, we have just appointed, with the co-operation of the Medicine Hat Planning Group an experienced director of mental health, who will shortly have a staff of 10." Contrast this with the Guidance Clinic of two years ago when only one person was on the staff to serve the city population. But I am just wondering here; you have one group of people who are recommending that you don't appoint staff until you have a full-time psychiatrist and according to your own statement back in September plans are in the works for at least ten people to be employed by the clinic. I just wondered if maybe there is an explanation for this. I would like to hear it.

MR. CRAWFORD:

Yes, Mr. Chairman, the government did not precisely follow the course recommended by the visitors committee in the report that the hon. member has just read from. I have a good regard for all four members of the committee, and have known some of them for some years. If I am not mistaken, not one of them is a psychiatric specialist themselves and they have come up with, although a highly regarded, nevertheless a layman's judgement, if that would be a good thing for the attorney in Medicine Hat. The presence in the community of a full-time psychiatrist in private practice does appear to serve the community. The number of psychiatrists in a community the size of Medicine Hat, its environs being around 50,000 people, is not that many.

The reference the hon. member made to the appointment of a co-ordinator is one that I touched on briefly in answering some questions in respect to the Grande Prairie Peace area. This is a new concept to have in the area a person in the broad area of mental health, who is able to bring a co-ordinated approach to services throughout the area; and to try to bring about the co-operation between private agencies and government, between the hospital, people in private practice, people in medicine and psychiatry in the area. The hon. member answered a good part of his question and expressed his concern about the level of people in the Medicine Hat area, just by reading from my speech. It becomes apparent that many more times the amount of services that had previously been provided there are in the process of being provided now and in the near future. Really the only item outstanding is whether or not we would follow the recommendations of the psychiatrist acting in the clinic there; but the decision does not necessarily lie there.

MR. HENDERSON:

Mr. Chairman, I certainly want to say that I support what the minister is trying to do with the question of competence. I presume that in effect the way I read it continue to try and carry out the same thing we envisioned when calling the planning council, and I think in two or three ministerial orders we have had one set at Peace River, one at Lethbridge, one at Calgary and the question was whether Medicine Hat should have one of its own. I presume that these orders have been received by the planning council and have in fact been placed before the board. I certainly concur with the approaches taken. I also concur and support the minister's suggestion that we should not get bogged down in question of drawing boundary lines around the regional planning system, because it is my experience that as soon as one starts talking that way, everybody wants to spend all their time arguing about the boundary lines in geographical terms and the objective that one is trying to achieve gets lost in the shuffle somehow. You never get beyond the argument about the boundary lines. I have found in trying to set up one or two of these planning councils that this came to the fore all the time and it is really incidental to the basic objectives. The boundary will evolve of its own accord, based on the way people travel between communities within the province. I certainly support the minister in what he has said about the function and the manner in which the regional councils will be established because they aren't something that can be force-fed upon the public. There has to be demand within the community for the service, and if there is a demand these problems will straighten themselves out. And trying to impose it by injecting a decree -- I am convinced -- in the long run will backfire. So, again I support the hon. minister.

There is something I would like the hon. minister to elaborate on somewhat, however. I must say I looked with some concern on the decision of the government to expand the guidance clinic, particularly if it is to be a decentralized organization throughout the province. The experience with government -- I think this is true, no matter who the government is, and it

isn't offered as a criticism. But when you start setting up a decentralized provincial program such as this, decentralized throughcut the province, it soon gets bogged down in bureaucracy, and some of the damnest things start to happen that defy logic and common sense completely. While I certainly endorse the service that the guidance clinc tries to provide, it certainly had been my view, when I sat in the chair the hon. minister now occupies, that in the long run the guidance clinic should be part of the local system and under local authority.

But I see now that there has been a tremendous expansion to the guidance clinics as a provincially operated organization rather than something that would eventually become integrated into a community. For example, I recall, and I think this is going to come up in places like Medicine Hat, once they do get a psychiatrist, and the way the law reads, unless it has changed, you have to have a psychiatrist in charge of the ward in the hospital before you extend the legal prerogatives of detaining a person for an extended period of 30 days, or something like this, for treatment. I hope we are not going to have therapists making those kind of decisions. So I assume that psychiatrists are still necessary, and as soon as the psychiatrist does take roots in the community, whether it's Peace River, Grande Prairie or Medicine Hat, you are immediately faced with the demand that the man, if he is up with the times and will want to use a therapist for follow-up consultations and so on within the community and within the family, and a lot of the work that the guidance clinics do now they soon find themselves in competition with the hospital or the community based institution which also wants to extend its services into this area.

I recall, for example, that there was a lot of pressure, I don't know if its still there, from the Foothills Hospital to get into this area. In a sense, competitions develop , and it only seems logical to me that in the long run the role of the guidance clinic -- well the government may feel that it should be expanded at this point of time -- but if one wants to talk about developing an integrated regional or community type of health service one must talk community as something that goes beyond the boundaries of one town. Certainly sooner or later this service has to be integrated into the community service because it becomes, if it doesn't, a bureaucracy that results from a provincial administration which just kills it. Now if that's to be the basis of the approach then I would suggest myself, to the hon. minister, that he is going to get into some real pitfalls in expanding the guidance clinics as an emergency basis to try to make it look as if he is doing something -- and I don't say this facetiously, because I know there is a lot of pressure on the hon. minister to get on and do a lot of these things. But to try and integrate these things into a regional model or a local model of some sort for delivery of the service, is going to produce some real problems if a tremendous amount of competition gets into it. So I would very much appreciate it, Mr. Chairman, if the minister could elaborate very briefly, and possibly even more briefly than what I have taken to state this, on just what he foresees is the function of the guidance clinic in the immediate future and in the long term.

Secondly, I can see the need, possibly on a short-term basis, for expanded guidance centers in rural areas outside of Calgary and Edmonton. But I can't see the basis for an expanded guidance group inside Edmonton. I think if they had it in Calgary and Edmonton, it should be under local authority and be based in the community as part of the integrated system. But I get the feeling that all of these things are being expanded, based on Calgary and Edmonton. This is what seems to evolve. So, is it going to be expanded in the rural areas, is it going to be expanded in Calgary and Edmonton and in the rural areas, or is it going to try to get what service they can under the guidance groups under those two central positions? Are we going to hold the guidance groups down in the major urban areas so those who use the regional guiance clinics can come to grips with a faster rate, with the province in mental health in the rural areas, and hopefully in the long term, see the guidance clinics integrated into a I think if they have it in Calgary and Edmonton, it should be under local authority and be based and included in part of the integrated system; but I get the feeling that all these things have been expanded if based in Calgary and Edmonton. This is what seems to evolve, and so is it going to be expanded in the rural areas? Is it going to be expanded in Calgary and Edmonton, and are the rural areas simply going to try to get what service they can of the guidance clinic out of those two central positions? Are they going to hold the guidance clinics down in the major urban areas with a view to using the guidance clinics, and come to grips at a faster rate in the province with mental health in the rural areas, and hope that in the long term, the guidance clinics are integrated into a local model of some sort when giving service?

MR. DIXON:

Mr. Chairman, just one other point I wanted to touch on with the minister: it may have something to do with the guidance clinics in the areas and the new

approach by the government tc try and get more community participation throughout Alberta. I have taken this for an example, that according to the administrator of the Alberta Hospital at Oliver, there are about 275 patients who could be released there immediately to fcster homes if they were available. This is something I think that the government and legislature should become very much concerned about, if you think cf people in institutions who could be turned into the community into foster homes. I was wondering what part the government planned for regional areas to encourage this foster home outside the major cities of Calgary and Edmonton.

MR. CRAWFORD:

Thank you, Mr. Chairman. First of all, as to references made by the hon. Member for Wetaskiwin-Leduc, I see the expanded rcle of the guidance clinic in the way that it has already been projected by me, I believe here, when I mentioned the Peace Block in Medicine Hat I did not mention that St. Paul is to have a guidance clinic. I do not look upon it as something that will be used to expand intensive treatment bases that already exist in Calgary and Edmonton. As a matter of fact, I think the fact that the hon. member has raised the reference between Calgary and Edmonton will cause me to review the expansion plans that are being drawn up at the present time for the whole system, and to see the part that Calgary and Edmonton play in that. I think he has put his finger on an important point in saying there is more validity to using the guidance clinics as an immediate vehicle where the services are not already intense. That is certainly the intention. The situation would have to be looked upon as one where you have the need, not just the pressure, which of course does exist because of the need, but the actual need of the people in the various areas for some service of this type. You have an existing vehicle to provide it to you and you intend to use that. The hcn. member suggested that maybe that would be a temporary arrangement. I think that is entirely possible, I think it could work out in the future. There will be more of a community involvement, more of a community responsibility, directly for the services provided by guidance clinics in these various areas; but for an immediate drive to achieve certain goals in these various areas, here is a vehicle to be used. We think it's a workable and usable vehicle and are in fact using it. Of course, I would have to say that I wouldn't be doing that unless I believed that the guidance clinics could orient themselves satisfactorily to the community; and to the fact that the system already exists and to the fact that it is a vehicle that we can use without creating some new system which might take us longer.

All of those things taken together have satisfied me that it is the workable proposal to expand the services in that way and some of the fears expressed would not come to pass.

In regard to the number of patients that are in the Alberta Hospital, Edmonton, that could be released to foster homes, I think that one of the overall objectives was laid down by the Blair Report, and was laid down in our policy announcements since last year, which deem to reduce the populations of the two major treatment centres at Ponoka and Oliver; and useful progress in that respect has already been made. But cf course when the patient loads are reduced and these people are being discharged -- and that has been happening -- they have been going to the places where a person goes when a person is discharged. Now some of them are able to go home, some of them are not. They do go out to special care centres operated, I believe, primarily in Edmonton and Ponoka -- in the communities that are involved -- and some of them have some follow-up services available there. It hasn't been possible as at the present time to restore all of those that could be discharged, and all I can say is that the process that is underway will be continued. I believe that we will succeed in discharging as many people as can safely be discharged over a period of time.

MR. CHAIRMAN:

No further questions? Back to the act as printed, not the amendment.

[Section 6, subsections 1 to 5, were agreed to.]

[Section 7, subsection (1)(a) was agreed to.]

Subsection (1)(b)

MR. BENOIT:

Mr. Chairman, in subsection (b) there seems to be a word missing. "Hearing and considering applications from persons, whether they are formal patients not" -- "or not"?

MR. CRAWFORD:

I am sure the hon. member is right, Mr. Chairman, there should be an "or" there. I am glad to have been able to give him the opportunity to get his "or" in.

MR. CHAIRMAN:

I trust you agree with that Mr. Benoit?

[Section 7, subsection (2)(a) to (d), were agreed to.]

[Section 7, subsection (3) was agreed to.]

[Section 7.1, subsections (1) to (3), were agreed to.]

Subsection (4)

MR. KING:

I just wonder if the hon. minister would take a moment at this time to explain to us whether or not he envisions review committees which would be serving for a fixed period of time subject to considerable turnover at the end of that term or whether or not these might, once initiated, serve for fairly long periods of time and enjoy a good deal of continuity. I am not sure what might be the merits or otherwise on either side.

MR. CRAWFORD:

Mr. Chairman, the role of the review panel is of course not so similar to that of an ordinary board of any other type that a term appointment is considered to be necessary. I would foresee that, similarly to the way that it operates now where the appointments are held in the review boards at the two hospitals for a period of time, they would be made without a term and that it would not be any more necessary in those cases than in other cases where appointments are made to have an undue turnover. It would not be desirable to have an undue turnover, and I wouldn't expect that to happen.

[Section 8 to Section 10.1, Sub-section 1, were agreed to without debate.]

Section 10.1, Sub-section 2

MR. KING:

Again I have just a brief question. In Section 10.1, sub-section 2, what would be the reaction of the hon. minister to add to the end of that sub-section a phrase that might read, "and from time to time, and in any case, at no greater intervals than six months, to review the level of security." I am not proposing it as an amendment now until I have your reaction and it may not seem to be a problem but one of the things that does from time to crop up in . . . is that the level of security is determined for a person as a patient and there have been regretable incidents where the staff have not come back to consider a search into that person's state of health or otherwise, and he has suffered a certain level of security long after it ceased to be necessary in that particular case. These are circumstances we hope will never happen, but there is a history of them, it seems, in almost every jurisdiction where people are trying to provide mental health care to people.

MR. CRAWFORD:

Mr. Chairman, if the hon. member wishes to suggest an amendment which, I think, does not conflict in any way and can only add to the usefulness of that subsection then he would still have to submit it to you in writing. I would react by saying that I have no objection to that and would be willing to have it go ahead, and I would suggest that 10.1(2) might be briefly held until later and the honourable member could submit his suggestion in writing.

MR. CHAIRMAN:

Very well. I believe Mr. Dixon wanted to make a comment. Is that the same section?

MR. DIXON:

Yes, the same section, Mr. Chairman, to the minister. A number of us, from both sides of the House, were in Oliver for a view of the establishments. I am

glad I said from both sides of the House. Some of us were concerned by the fact that there was an elderly patient there that had been in a coma for about a week and in all probability did not come out of it .

I was wondering, what is the general practice now when you have a patient who is in a more or less terminal illness, who would not need security of any kind; what he or she would need would be just active treatment. I was wondering if we could put in a clause somewhere here that if a situation like that arose then that patient should be transferred to an active treatment hospital which I feel would be a lot easier for the relatives to visit. I think it would be nicer for the patient too because he or she is beyond any treatment that they could give him as far as the Mental Health Act is concerned or beyond the security for which he was probably put in there in the first place. I was wondering if the government had given any consideration to a situation where a patient is in that condition; that they do move them in to the nearest active treatment hospital as I mentioned, for the convenience of the relatives and also, I think, as a favour to the patient. Of course if he does get back on his feet and does require further treatment they could always move him back. But we have had a number of problems over the years -- I don't think so much in latter years, but before they used to try and get rid of senile patients by sending them to Ponoka or Oliver as a convenience, and I know some have been referred back to the active treatment hospital by the superintendents of Ponoka and Oliver. But I was thinking of the case of the patient that has to lie there for three or four weeks in a coma before he may pass on. Wouldn't it be more humane, and more kind to move him into an active treatment hospital?

MR. CRAWFORD:

Yes, Mr. Chairman. I think the hon. member has touched upon something which doesn't necessarily relate to legislation. It relates to it perhaps in this sense, that there are provisions for the discharge of patients who don't require treatment, of course, and when they are discharged, they may indeed be discharged anywhere, and the example that the hon. member gave is that of a person, who because of a deterioration in his physical health, no longer required treatment in a mental facility. Therefore he should be discharged. If he was discharged, being in an apparent terminal illness -- and this would be subject to it being safe to move him, because there is medical treatment in the Alberta Hospital, of course -- but subject to his being able to be safely moved the normal procedure would be to move him to an auxiliary hospital if there was a vacancy. I would think that in the particularly hard case that the hon. member referred to maybe the difficulty was that this particular step had not been taken as soon as it should have been. The policy, I think, that the staff there is quite alert to now, is to make the discharges when possible, so I do not think an actual clause in the act would is required. We'll get to the sections on discharge in due course and if it does seem to the hon. member to be essential to add something at that point, I think that would be an appropriate time.

MR. CHAIRMAN:

Agreed with subsection 2?

MR. CRAWFORD:

. . .for the hon. Member for Edmonton Highlands to do.

MR. KING:

No, it was not that one.

MR. CRAWFORD:

On 10.1(2).

MR. CHAIRMAN:

He had spoken on subsection 2 but. . .

MR. CRAWFORD:

We have one other held already, Mr. Chairman, under section 1 actually, the definition section. Maybe we could hold this one until he has given you his amendment and then deal with both of them maybe near the end.

MR. NOTLEY:

Mr. Chairman, before we move on to the admissions, I'm just wondering if the hon. minister would tell us how many review panels you anticipate appointing. I take it there would be at least two. Are you thinking of half a dozen or so, and if not, are there going to be any arrangements for travel expenses for people who want to make representation on behalf of a patient?

MR. CRAWFORD:

Mr. Chairman, I suppose the answer to the question is that there would be as many review panels as necessary. I think at this point that is about the only answer I can give. I can foresee that Calgary would certainly have enough cases to examine, even though there isn't a major institution there, that they would require one. But beyond the three I can't really hazard a guess at this point. We will have to see what changes may take place in the population of the centres and just how much is actually going to be involved in making periodic reviews which will now be a mandatory requirement. We may find we need more than one review panel for all of them because of the requirement to make periodic reviews. We will have to be prepared to appoint them as required. If there is travelling required, of course, that will be covered.

DR. PAPROSKI:

Mr. Chairman, I wonder if the hon. minister would say where the form of admission is now. It is removed from the booklet and I just haven't found it. The form of admission in the book is on page 5 section 11 and it should be just about here. I don't see it or is that the same?

MR. CRAWFORD:

Mr. Chairman, the hon. member will have to give me a few minutes to find that.

DR. PAPROSKI:

Is it in there now, Mr. Minister?

MR. CRAWFORD:

Mr. Chairman, the informal admission procedure has been carried forward. Maybe if we could leave it on that basis, we would be encountering it. I will try to find it before we reach it.

MR. CHAIRMAN:

Mr. Minister, at this time the hon. member, Mr. King, has given me the following. I'll just read it out to you so that we could refer to it later. If you want a copy of it, the addition of the phrase, "And to review the necessary level of security at intervals of not more than six months." We'll refer to that later.

[Section 11 (a) was agreed to.]

Section 11 (b)

DR. PAPROSKI:

Mr. Chairman, this particular section gives me some concern and I would like to get a response from the hon. minister for clarification. The clause states as it does on page 19, section 11 (a) and (b) which I completely agree and concur with. I would like to see consideration be given to another clause be put in that would state something like this: "Where a therapist and a physician or two physicians examine a person who is of the opinion that he is suffering from a mental disorder and requires care, supervision, and control although not presenting a danger to himself or others but for his own welfare, he, in fact, should be admitted." What I am saying here is this is fine. This is for the extreme case that we have included now; but in the extreme case (and there are many of those), whether they are alcoholics, drug addicts, mental disorders, and so forth, there are many of these cases who never, in fact, present danger to themselves, but require and would benefit from care in a facility. Societies, families, and so forth would then be alleviated of the stress of guarding that person for a necessary period of time. In other words, what I'm saying is if this patient, or the person primarily involved, is reluctant or unable to make a judgment and say, "I want to be admitted to a facility", and, in fact, requires care such as this, he is the one who is going

to benefit. As a matter of fact, this judgment is made on the basis of one therapist and one or two physicians, whatever the case may be. Personally, I prefer two physicians or two therapists or a combination of one.

I would like to go on and discuss this a little further because I know there is a little bit of concern here, in respect to The Bill of Rights and so forth. That concern is certainly shared by me and I think it is a very important and critical decision. I can accept it the way it is. However, I am somewhat concerned. I am saying here that time does not present a danger, when the patient can voluntarily admit himself. This is great providing he voluntarily admits himself. But I'm suggesting that that mentally disordered patient (and there is a small but very important group) will not make that judgment. Those people who are practising in the area of mental health know very well what I'm talking about, because all the discussion, the coddling, and the encouragement in the world will not make a bit of difference to get that patient to admit himself. This frustrates not only the professionals who are dealing in this area, but many citizens, and, as a result, causes a considerable amount of distress, as I have mentioned. Yes, it would be ideal if this person would voluntarily commit himself and I support that area. But this is not the case for this type of patient. There are other people, I'm sure, in the assembly who may say, "Well this is going to result in undue abuse of this section because there are many mental disorders that will be committed formerly and, in fact, have no choice. I say to that, that this could be abused the way it is too. I am sure it is not going to be. The intention here by any therapist is obvious, and that is to provide care, control and supervision and do this with all sincerity for that individual. Surely that individual would expect that of society and expect that his rights are protected because he cannot, in fact, make a judgment although he does not present danger. Now the protection of that individual, of course, is assured even more by the fact that I am recommending two individuals rather than one. Here it says, "A therapist or a physician". I am suggesting that if there is not any danger, let us have two therapists and two physicians. Now there are others I am sure that will say, my God, anyone could be committed if you have such a section. I say that that is ridiculous. We know very well that the mental disorder would have to be defined. by a therapist and a physician, two therapists and two physicians or a therapist and a physician as stated. Naturally, it is important that everybody be encouraged to be committed voluntarily if possible. But, as I have stated, this is not so in these particular cases and there is no danger of abuse any more than there could be abuse under this particular section. What I am saying here is that the act is great. It has all the characteristics that I really support in every dimension and I would support this even if it were left this way. But the fact remains that although we have improved the conveyance of many mentally disordered patients to facilities, they have to present danger first. And then there is a block, namely that a patient may not, in fact, present danger but still has to be committed for therapy.

Now the other argument for this type of a change, and I would like the minister to respond to it, is that many citizens have their dear relatives and loved ones and they know very well that they would love to have them in a facility and yet they know that they are not presenting any danger. It is as simple as that. And if we have to go by this clause alone, Mr. Minister, I am afraid that these loved ones and the relatives of these people who are so unfortunate as to have this type of a problem can do nothing about getting this patient in. With these remarks, I would like to have your comments, Mr. Minister.

MR. CRAWFORD:

Mr. Chairman, I feel that this is a subject that will concern a number of the members. The desire that I have to be amenable to recommended changes is very great, but it is not great enough to allow me to agree with the hon. Member for Edmonton Kingsway in what he has put forward. I had a case when I was practising law where exactly that happened. The dear relative who was indeed put away for a while was shortly thereafter in my office demanding law suits against all and sundry. He did not have too bad a case. They resolved the matter by getting divorced. I don't want to try to make statements of principle that are based on anecdotes only. Going on to a much larger concern, the suggestion that a person who is not a danger to himself or to somebody else should be tucked away for a while for his own good is not one that I am prepared to subscribe to.

AN HON. MEMBER:

Is that tucked away or sucked away?

MR. CRAWFORD:

It could be either, I suppose. I do not feel, Mr. Chairman, that the change the hon. member proposes can be made and don't feel the need to elaborate on it too greatly. I think the clarity of it is apparent to all. If a person is not presenting a danger to himself or others, this legislature or anybody acting pursuant to its authority must state his hand.

MR. KING:

Mr. Chairman, I would like to get at this in perhaps a slightly different way. In looking through the amendments we have before us I am still concerned about the person who may voluntarily go, for example, to a psychiatrist understanding that he is suffering a mental disorder, but not of the kind that presents a danger to himself or to others. He understands that he is ill but it is not an illness which presents danger. If upon being examined by the psychiatrist the latter is of the view that the best treatment available for this person, who acknowledges his illness, is in a facility of one kind or another, does the act in its present form, or with the amendments, provide for the admission to hospital of a person who recognizes his illness, that is, suffers from a mental disorder (11)(a), but does not meet the conditions of 11(b) that is what concerns me? What would be your reaction to this?

MR. CRAWFORD:

Mr. Chairman, the answer is no. The act does not provide for admitting a person unless with his consent in those circumstances.

MR. KING:

This is what I would like to clear up. With his consent, what is the procedure that is followed? I do not see it in the amendments and maybe you could just explain that to me.

MR. CRAWFORD:

Mr. Chairman, this will give me the opportunity to answer both the hon. Member for Edmonton Kingsway and the hon. Member for Edmonton-Highlands in respect to the reference to informal patients.

I was not entirely accurate when I said to the hon. Member for Edmonton-Kingsway a moment ago that the references to informal patients have been brought forward. The situation is that the view of the legislative council was that the reference to "informal" is redundant; that we have formal patients and patients rather than formal patients and informal patients in the act now and that this redundant word is removed. Now a patient, of course, is a person who attends at any facility or any service provided for treatment of anything. He admits himself in the same way as a person going to hospital -- he may go there and be admitted. It is only in respect to the formal patient that the act speaks out as to what must be done. In respect to a formal patient, the by-laws of the hospital and all of the usual well-established procedures for admission are there.

MR. KING:

Could I just pursue this for a moment because I am still concerned? The definition of formal patient which we have before us is "a person admitted to and detained in a facility pursuant to admission certificates, or detained in a facility pursuant to renewal certificates." Now that deals exclusively with the part of the act we are now entering, and then when I go over the page to 'patient', it says "patient means (1) a formal patient". That's the definition I have just read, or "a person detained pursuant to a warrant of the Lieutenant Governor and a person remanded to a facility pursuant to the Criminal Code", but neither the definition of patient or formal patient make any reference to self-admittance, and I don't see the procedure for self-admittance outlined anywhere in the act. That is what I'm not clear about.

MR. CRAWFORD:

On the definition of 'patient', I would have to say that I should get a further explanation of that, because it was my understanding that the reference to 'patient' included a person who was not a formal patient. I think the hon. Member's concern is certainly well expressed and I will just have to get more clarification of that before answering.

MR. DIXON:

Mr. Chairman, I have had a complaint from a resident in the city of Calgary who was admitted to a Class 'A' hospital in the city of Calgary for minor physical problems, and during the time he was in the hospital he received a shock treatment which he claimed he did not authorize and no one else authorized on his behalf. I was wondering what is the procedure -- maybe the minister or one of the practitioners in the House could clarify this situation -- because this gentleman I know has written to members on the other side of the House as well as to myself on this thing, and I haven't been able to come up with an answer as to whether a patient or his guardian has to give authorization for those types of treatment carried out in a general hospital. What is the procedure if he goes beyond that to the Alberta Hospital at Ponoka or Oliver? Does he still, or does his guardian, have to okay the shock treatment?

MR. CRAWFORD:

Mr. Chairman, the question calls upon me to give a legal opinion to some extent. I think that the general rule is that any treatment that a person undergoes can only be undertaken with his consent, and that performing treatment which he doesn't consent to could well be an assault. Now, as far as the patient giving his consent is concerned, if he is a person who was formerly declared as being incapable of giving it then no doubt that consent could be given on his behalf, perhaps by the Public Trustee, perhaps by -- if the certificate of mental incapacity said that the person wasn't able to give his consent and the consent was given that way. I believe it's given, for example, when children in an Alberta School Hospital have never talked, have never communicated, and are probably under-age to boot, and require a tooth pulled or something like that, and have no parent to give the consent, then there is in existence a formal order that authorizes either the Director of Child Welfare or perhaps the Public Trustee to make such an order. Venturing beyond that is difficult for me, Mr. Chairman, the question of whether or not to say a person in Ponoka who was given shock treatment needed to consent to it. My guess is that the formal committing of a person would mean that he didn't have to give his consent after that time.

Venturing beyond that is difficult for me, Mr. Chairman. The question of whether or not, say, a person in Ponoka given shock treatment needed to consent to it, my guess is that the formal committing of the person would mean that he didn't have to give his consent after that time.

MR. FARRAN:

I can appreciate why the hon. Member for Calgary Millican doesn't want to mention the name, but I think I know who he is talking about. He was actually committed by his children. His children swore the information, then he went before the judge, and under the old rules, two psychiatrists I think, he was committed to Ponoka. So I presume he became a sort of ward of the province. Now, his resentment is partly directed at his own children, you know, from the committal.

MR. DIXON:

Mr. Chairman, I think what the hon. Member for Calgary North Hill is saying is correct to an extent. The only thing is that according to his argument the man was admitted to a general hospital in Calgary -- and I'll get right down to cases -- for a haemorrhoid problem. He ended up getting shock treatments, and he wondered what that had to do with haemorrhoids. So what I'm trying to establish, Mr. Chairman, is that. Unfortunately, the man that he is trying to get at, the psychiatrist, has since passed on. But I think he had a point when he said that he was given this treatment against his consent when he was a patient in an ordinary general hospital. This was not in Ponoka. He hadn't been admitted at that time. So I just want clarification; I think that before shock treatments are given in a general hospital at least the next of kin or the patient himself should give the authorization, because he's arguing that he never went in there for those types of treatment.

DR. BACKUS:

Having had a legal opinion, could I give a medical legal opinion?

MR. CHAIRMAN:

If it's going to help these two members from Calgary, yes.

DR. BACKUS:

Patients admitted to a general hospital very often unsware to the patients sign on admission, and unaware to themselves, an authority to carry out such treatment as may be prescribed by the physician. However, the ruling of the medical legal people on the matter is that a patient should not be given treatment or investigations in the hospital because some patients have had lumbar punctures or the type of examination should not be given without a previous explanation by the doctor on what the treatment is and what it is for. I think on page 22 of the amendments it says that two admission certificates are sufficient authority to detain and treat the person named therein. Therefore in the admission of a formal patient the admission certificate would authorize treatment of the patient in the hospital. In this case, where the two admission certificates are signed, it is the opinion of the medical people who are treating or who fill out the admission certificates that this patient requires treatment. I think this would liberate the physcians who treat them as formal patients in the hospital from going to the next of kin or other people to get permission for treatment. The certificate by the act would authorize treatment. But in a general hospital the patient must authorize treatment. They very often do without realizing it when they sign the little thing on admission. But in spite of this, which protects the hospital and the physician, we are also taught in the medical profession that any treatment for the patient should be explained to the patient before it is given to them. I think perhaps your particular patient might have very good grounds for complaining to the psychiatrist in this case -- I gather he is no longer with us -- that this treatment was not explained to him but the hospital would have his signed authority to carry out such treatment as the physician might prescribe.

MR. FARRAN:

Mr. Chairman, since we are on this most interesting case. A sequel to the story: This poor unfortunate businessman was then confined in Ponoka for a lengthy period and was unable to obtain reviews for his release. I went up there personally to Ponoka and finally managed to give a -- you know I didn't go for treatment I went to see him -- and we finally had a review board sit and he was released. But it really underlines one of the points in this act that no longer will people be incarcerated for a lengthly period when they are not a danger to society. I think this chap was really just eccentric, I don't think he is any different now from when the treatment started. This sort of thing would not happen under the proposed act of this bill.

DR. PAPROSKI:

Mr. Chairman, if I could get one thing clear here and it bothers me so much that I must bring it up once more. Mr. Minister, I support the act the way it is. Do I understand then that if you have a mental disorder and this patient has been examined by two therapists or two physicians and they claim, in fact, that he could benefit by early therapy; but because he does not present danger to himself or others he cannot be treated because he is unwilling to be admitted due to his mental disorder, is unwilling and unable to make a judgment? Is that the way you read this?

MR. CRAWFORD:

Mr. Chairman, I don't think that I could have put it much more plainly than I did before. I say that though without any lack of regard for the additional concern just expressed and the way in which the hon. member has exemplified it It is certainly intended that, unless the person is presenting danger to himself or others, the right of any other person to limit his liberty is not intended to be extended by this legislation.

MRS. CHICHAK:

In referring back to our discussion as to the terminology as to a formal patient, I wonder back on Page 2 you describe what a formal patient is, and then on Page 3 of the amendments you indicate in Subsection 1 what a patient means. I wonder if perhaps this wouldn't be clarified by saying "patient includes" and giving this; then it would indicate that a patient could be voluntary and doesn't necessarily fall under the terminology as you have it clarified here. This might overcome the hurdle of involuntary patient.

MR. CRAWFORD:

Mr. Chairman, what I will do is present to the House a proposal to clarify that difficulty the next time we sit in Committee on this. I think I was correct in saying that the reference to informal patient was withdrawn for the

reason given; but the result of that was that the draftsman then brought forward the definition section with only three of the four subsections because he had taken 'informal' out. It really should have been, as I now see it, a further clause that would have not brought forward the unnecessary reference to 'informal' patient, but would have included under "patient" a reference to a patient other than a 'formal' patient, where he was entitled to be described as a 'patient', pure and simple you might say, if I can use those words in reference to this discussion. He would be a patient within the purview of the by-laws of the hospital that was going to admit him. That is the point that I am going to suggest and I will bring back a proposal to the committee on that.

[Section 12, Section 13, Section 14, and Section 15 (d) were agreed to without debate.]

MR. DIXON:

I seem to be getting a number of these cases. A case in which a chap who was apprehended objected to the psychiatrist that examined him. He claims that he had no choice in saying that he did not want Dr. So and So to examine him - apparently they went ahead with the examination. Has a patient the right, at least to choose one other, if he objects to the psychiatrist who has been hired by the Crown to examine him?

MR. CRAWFORD

May I ask the hon. member at what point in the procedure, right from the point of his having been conveyed to the institution, is he referring to when he asks about his right to have another choice?

MR. DIXON

When he was picked up and taken to the cells he objected to the psychiatrist. I will tell you how it happened. Apparently this psychiatrist was on a radio program about two weeks before and the question was "would you tell a patient his true condition if he was going to die? Would you tell the patient a white lie, in other words?"

And this psychiatrist said "Yes". Well this chap in the cells said " I don't want to be examined by fellow because he lies." He objected to the fact that he couldn't have anyone else but this particular psychiatrist and he claims that he had to accept this man he had no faith in.

MR. CRAWFORD

It certainly could happen that a person would be duly certified by someone that he did not agree with. I think that is quite possible. The question is can he substitute, can he go shopping, for a psychiatrist, and bring in another one if he was not satisfied with the first one? I think that what would likely happen, if there was another one available that that would be done. But if there was not another one available there would be no requirement to meet his wishes in that regard. He could indeed be committed by someone in those circumstances, but I think the protection lies in the fact that there must be two. They do not have to be two psychiatrists but they have to be two people involved in the diagnosis. They have to testify, in separate examinations, to the points observed by them in regard to the person's behaviour that led them to the conclusion that he should be admitted. Then the various review procedures there are could certainly get him someone else within a reasonable time before a review panel.

[Section 15(1)(e) to Section 20 were agreed to without debate.]

Section 21(1)

MR. KING:

Mr. Chairman, just a point of clarification. Again here, why are we using the term 'formal patient', and restricting the issuance of a certificate of incapacity to people who are in hospitals as formal patients? I would wonder about people who are there under a Lieutenant Governors warrant, or pursuant to the Criminal Code of Canada. Is there no provision for issuing certificates of incapacity in those cases, or is that not likely to happen in any event?

MR. CRAWFORD:

Well, Mr. Chairman, the act does outline that it is a 'formal patient', and that is meant, not to encroach too far upon the rights of patients who are not

formal patients in the sense that they are voluntary. The act does want to anticipate the certificate of incapacity, of course, dealing with the right of the person to continue to conduct his own affairs. The act does want to anticipate that a person may be a patient in a facility and be perfectly capable of conducting his own affairs.

I think that the reference to the one referred under the Criminal Code, under Lieutenant Governor's Warrant is probably valid, and along with the other point raised by the hon. member, I would like to see that one held in order that I can further consider it and make a proposal in committee.

MR. CHAIRMAN:

That is Section 21? The whole section, Mr. Minister?

MR. CRAWFORD:

I don't think it is necessary to hold anything following the first sub-section.

MR. KING:

The whole section makes reference to a 'formal patient' in clause (c).

MR. CHAIRMAN:

We may as well hold that whole section then. Is that agreed, Mr. Minister?

MR. CRAWFORD:

Agreed.

[Section 21 was held.]

[Section 22 to Section 23.6 were agreed to without debate.]

MR. CRAWFORD:

Mr. Chairman, I think in dealing with that we should refer to the act as printed in Sections 24 and 25 and submit them to the committee as amended. The amendments, being as proposed in G and H on page 35, are very minor. All they do is change the reference from "facility director" to "the board" of the facility.

MR. CHAIRMAN:

Very well, then Section 24 in the act, as amended -- yes, Dr. Paproski?

DR. PAPROSKI:

I am concerned about this area because I feel that certainly communication, be it what it is, may, in fact harm the patient, as well as maybe improve the patient's condition. Recognizing that fact, the section as it reads now states that "no communication written by a patient in a facility or to a patient in a facility shall be opened, examined or withheld, etc. etc." My concern here is that, in fact, there is no judgment placed whether a particular communication to the patient may harm him or not; and we know very well, for example, a cardiac patient who is in hospital receiving a distressing communication may die from that communication. Similarly a mentally ill patient receiving a distressed communication from somebody that he dislikes, etc., may get worse; and vice versa. This communication going out of the facility may result in distress to relatives, friends, and so forth. The question that I am asking here is: would the hon. minister consider applying Section 24 to 25 in some way so that there is some discretion left up to the Board of Directors?

MR. CRAWFORD:

Mr. Chairman, I think once again the hon. member is proposing a greater evil than the one that is seen by him to exist in the legislation as it is drafted. This is a section which is directed at the liberty of the patient to receive communications and to send them. The hon. member has observed that a person may be harmed in some way by the communications he sends or that he receives and he may harm others by those he sends but surely the over-riding principle is that there shouldn't be a right to censorship and it is on that basis that I think the Section 24 as it is written should stand and I think it

is a very basic principle. I hotly dispute the suggestion that the right of censorship be introduced.

DR. PAPROSKI:

With all due respect to the minister, and I support what you have said, it still is a concern to me. Surely a patient who is normal would expect to be protected from those things that will harm him if he becomes mentally ill and is unable to judge. I am suggesting here that if I were mentally ill and a communication might disturb me, I would expect the facility and the therapist in that facility to keep those things away from me that might distress me. I am suggesting that there really should be some modification, despite what you have said.

MR. CRAWFORD:

Mr. Chairman, I do understand the hon. member's views which are very well expressed and show a genuine concern that I know is probably related to the experiences that he has had in practice; and yet I have to come to the conclusion that the over-riding principle of the right of the patient is the one that is more relevant in the consideration of this section. Although it is possible that a communication could harm the patient in some way, it is an evil that the patient and the people in the facility would rather try to live with than have extensive discretionary powers to censor mail.

[Section 25 to Section 26 (6), were agreed to without debate.]

Section 26(7)

MR. BENOIT:

"The court may make whatever order as to costs of application as it considers fit." Who does the paying, the patient who has appealed or the government or the appeal board?

MR. CRAWFORD:

Mr. Chairman, that is a normal direction to the court. It just confirms the right that is probably inherent to charge one party or the other with costs. It also provides the right by allowing them to deal with the costs in their own way. They have the right to allow no costs on either side. I don't think it could be left in better hands than those of the Supreme Court judge to decide whether there is a case where it might be argued that the patient should pay. The judge in those cases will say no, perhaps, or yes as the case may be. But it couldn't be in better hands than the man who has just heard the case.

MR. KING:

I am just concerned about the mechanics of this and would like a word of explanation from the minister. In the case of someone in a hospital, such as the Alberta Hospital, Edmonton, whose case has been considered by a review committee and who is unsatisfied with that and wants to appeal to the Supreme Court, is there going to be some direction stipulated which must be given by the review committee to a patient with respect to the manner of appeal? Also I am really ignorant in my own mind about whether or not this is the kind of thing to which legal aid would apply. What do we do about people who are patients and don't have the resources, either monetary or in terms of communication with the outside world, to initiate this appeal in spite of a desire to do so? How would that be handled?

MR. CRAWFORD:

Mr. Chairman, it would certainly be a matter that would qualify for legal aid if the person is unable to maintain his own costs in his situation. As far as the actual procedure is concerned, the bill requires that the rights of appeal be conveyed to the person. I think it is clear that it could not be done in the ordinary case without the assistance of a solicitor. There is certainly adequate information in section 26 as drafted, where it refers to the filing of the originating notice of motion and makes reference to the affidavit that must be filed in support. Any solicitor could easily draft the necessary material from that.

MR. CHAIRMAN:

[Subsection 7, 8(a)(i),(ii),(iii);(b)(i),(ii),(iii), Section 27(1) were agreed to.]

Section 27(1)(a)

DR. PAPROSKI:

A comment on this one. Maybe the minister could explain it more clearly to me and, in fact, indicate whether this is in regulations or not. There is one item in 27(1)(a). May I suggest that one insert "the relatives to be informed whether the patient agrees or not, if the person was living with the relative prior to his illness"; for fear that the relative will be caught by surprise having this patient come home without even realizing that he was even discharged. The other thing is that I am concerned that other people are not in fact informed and that includes either his personal physician or a a• therapist assigned to him in the aftercare and maybe this is contained in the regulations. May I also suggest, for consideration, that the aftercare and supervision suggested by the facility director or the therapist or the physician there should be documented and delivered, in fact, to one the physician or the therapist. That is the essential nature of my request.

MR. CRAWFORD:

Mr. Chairman, I don't think that suggestions in detail such as this one are matters that require legislation. I could respond to the hon. member by saying that certainly one of the principals in an adequate program of mental health care involves follow-up treatment and treatment available after discharge for the patient who is being discharged. I say that that will be done within the limits of the facilities' ability to provide it. To require it by legislation, I think, would be unduly restrictive. There may be cases where a formal patient, for example, doesn't have any relatives. There would be a referring source no doubt in all cases. The referring source probably would be the party's physician or a therapist who had been instrumental in his being referred in the first place. That would be the one under (b) that we mentioned as being the referring source. I think that is a realistic type of protection to suggest at this stage of the game, without making it more rigid. I am concerned that the possibility of approaching a relative in a situation where the person discharged doesn't want this is not the right course upon discharge either, and there was quite a bit of discussion in the drafting stage of this bill with respect to that particular point. Very often a mental health problem is rooted in the family and in the home, and to return the person against his will at the moment of discharge to the source of his troubles seems to me that it could, in the judgment of the person treating him at that time, be a mistake. So the person discharged would have to agree at that point, and then if both the therapist or physician discharging, and the patient agree, of course the relative would be informed. But otherwise I suggest that the information going to the referring source is the important one.

MR. KING:

I have just a brief comment to make because I understand that one of my colleagues wants to make a motion to discharge the members from this facility. I would like to ask the hon. minister why we are back to using the phrase 'formal patient' in this sentence, because it seems to restrict it unnecessarily; and in fact in 27(2) it seems to say that a patient who had admitted himself, and subsequently had been discharged, might refuse to leave the facility, and the Board would not have any way of removing him from the facility because this is restricted in this case to provision for removing 'formal patients'.

MR. CRAWFORD:

Mr. Chairman, every facility has the right to cause a patient to leave if the terms of his admittance and treatment there no longer apply. If I am admitted for an operation for, hemorrhoids say, to use the hon. member's example and that is successfully performed and I refuse to leave they will find a way without it being stated in any act. This is because the patient's status is that of a person who voluntarily admitted himself and is under the bylaws of the facility, probably a a hospital, and when the time is up he is going to go. He will be discharged and, of course, we have the right to enforce that, and so the reference here to the absence of a reference to a patient other than a formal patient simply recognizes that. A person who had admitted himself would be under the bylaws of that facility and would be discharged accordingly.

MR. KING:

Well, I just wonder, Mr. Chairman, and I won't pursue it very far -- if any particular advantage arises from its inclusion in the act. For instance, in 27(1) does it mean that when a patient has admitted himself the staff is under

no obligation to notify the nearest relative if permission is given? I just don't see what advantage it serves in this section.

MR. CRAWFORD:

With reference to discharge, so far as it relates to this act, it is intended to deal with the situation of the formal patient. He is the serious mental health problem. He is the minority, one of the few The great majority of those who will be treated in all of these facilities will not be formal patients. They will be many, many other people. In order to deal with the question of formal patients, these sections have been put in. But as for the whole spectrum of others, I suggest there is nc need to apply anything to them except the normal treatment services that are available in the facility, the normal relationship with their doctor, or therapist, his normal concerns for them, which are very great. We are all familiar with so many cases of the conscientiousness of professionals and semi-professionals in all these fields. When a person has never been a formal patient, to introduce something more structured than the doctor-patient relationship, for example, is simply not thought to be necessary; or at least if it was introduced, it would be too restrictive.

MR. TAYLOR:

The words "certificate of incapacity" bother me a little. It appears that a couple of years ago in Saskatchewan this was done with a chap who then murdered seven or nine people. When this certificate of incapacity is issued is it done for the purpose of trying to forewarn the people with whome he is going to live, or is it going to exonerate those who have issued it and free them from any liability? Just exactly what is the purpose of the certificate of incapacity if he is still dangerous to be at large? I don't imagine he would be released, but there must be something there if there is a certificate of incapacity issued. I am just wondering how fair that is to the public or am I misunderstanding what the certificate of incapacity really means?

MR. CRAWFORD:

Probably not. I think the simplest, clearest way that I could outline to the House exactly what is meant by the certificate of incapacity is related to what has long been referred to as a mentally incompetent certificate under The Mentally Incapacitated Persons Act which is treated in that legislation and in legislation setting up the office of public trustee. Its main concern is the handling of the person's affairs if he is incapable of handling his affairs. This section suggests that it is quite possible that a person who is no longer dangerous, who perhaps has the best chance of being successfully treated in some other way -- a consultative process in a day care centre, for example, or some group or family therapy outside the institution -- he has reached that point when he can make the break and go and he is no longer a formal patient. It is possible that he might still have some inability to handle, say, his financial affairs, and it might be advisable to have the apartment building that he owns still in the name of the public trustee or something like that. In that case the certificate would state that he had been released but he was still not capable. So the certificate of incapacity in that respect would continue. He has a right to take that through an appeal procedure too, and the public trustee or the review panel will have to resolve it. But it could also happen, of course, that the certificate of incapacity would be discharged at the same time as the patient, and that would be likely in most cases.

[Section 27(1) was agreed to]

Section 27(2)

MR. HENDERSON:

As far as I can ascertain -- and I am sure the hon. minister has researched this much more thoroughly that I have -- this is a new clause in the act. I cannot find it in the old act that a patient could be forcibly evicted. In fact, it is a problem at one or two of the provincial institutions where there are quite a number of people who have been in the institutions many years. They no longer have parents or relatives available who would be responsible for them and who are, in effect, lost souls, that they add to the statistics of the patient load. Some of them, as soon as they are offered the opportunity of moving, immediately revert to their previous status, become patients, and start the procedure all over again.

I can see that in some cases it is quite in order to expect the patient to be discharged. In fact, as I say, the number runs up into the dozens. This is my recollection on the subject, because I looked into it one time.

What I am concerned about is this: if we are going to evict people forcefully from these institutions, what consideration is going to be given to their well being once they are discharged? For some people Oliver is home. They have been there so long they would be lost as soon as they found themselves outside of the grounds.

MR. CRAWFORD:

Mr. Chairman, I think that the people who have been placed in that unfortunate position have perhaps come to the attention of more than one hon. member. I have had such cases described to me.

In Bill No. 83, Section 30(2), it refers to a person 16 years of age or over who is unwilling to leave and may be caused to be removed. We had some fair discussion about whether or not it was necessary to have the age at 16 or 18 because of the difference between the male and female patient, and finally decided that if it applied to every formal patient it would be the best and wouldn't involve any great change from the principle suggested in 30, subsection 2, of the bill as printed.

However, I know the hon. member's concern is what happens to the person when that occurs. I think the answer is that we can only go so far in legislation at any time, and really what we are relying on are many hundreds and thousands of people throughout Alberta who are involved in the day to day treatment of patients. I don't think we should presume that, other than the rare case of normal human errors in judgment, any doctor would, in a situation where he had been dealing with a formal patient, act in a way that would be detrimental to the mental health of that person. And I do think we have to rely on the people who are engaged in the treatment to make that judgement. We shouldn't try to find some way of judging so many unknowns in legislation.

MR. HENDERSON:

I would feel a lot happier about the hon. minister's remarks if we were aware of the fact that there are a considerable number of people - and we are not talking 16 or 18, because many of them have been around those places for two or three decades - whose adult lives have taken place within the stone walls of an institution. I think the section as it reads now is pretty brutal. I would feel a lot happier if it said where the formal patient has been discharged and refuses to leave the facility, the board with the permission of the minister, or something like this. So that it is not always the board involved, unless you are putting boards in Oliver and Ponoka. This is not a problem, particularly in the psychiatric wards in the hospitals, because when they run into a problem we end up with an admission certificate to put them in another institution which is run by the province directly, so it is not the board that is the question. I am talking about the hospitals, Oliver and Ponoka, where there are no boards. It is a bureaucratic decision that is made to dump old Joe out in the street; he is a burnt out psychotic, he is no harm to anybody else so he steps out and gets run over on the railroad tracks. Now it is going to be on someone's conscience and I would be a lot happier about the matter where the authority is going to be exercised if somebody, other than somebody within the department lower echeleon is going to make the decision, because there is not going to be a board making the decision that I am talking about the way this reads right now. Or do I gather that this would not apply against an institution that does not have a board.

MR. CRAWFORD:

Mr. Chairman, the definition section does indicate that where the facility does not have a board then it is the person in charge. We thought in drafting it, that the fact that the discharge was not proposed to be mandatory, but gave the board the authority to charge a person to be discharged, that that was adequate protection. But I have no objection to changing that sub-section to provide that even the board can only do it with the consent of the Minister.

MR. HENDERSON:

May I ask the Minister to repeat the statement that he made to start with about the legal interpretation in relation to some other clause? The Board and/or directors of the facility?

MR. CRAWFORD:

I mentioned the definition section which anticipates the possibility that some facilities will not have boards. It says the board, in that case, includes a reference to the facility director.

MR. HENDERSON:

It contains a provision that it is done with the Minister's authorization. If there is a board that is examining at the local level I have no quarrel with it; but if it is within one of the institutions run directly by the province, that before there is a forceful eviction, particularly if one of these people have been there for many years, that the matter would be examined preferably by the Minister or somebody very senior in the department.

MR. CRAWFORD:

Mr. Chairman, I have no objection to adding the words "with the consent of the Minister" after the word "may" in the second last line of sub-clause 2.

MR. HYNDMAN:

Mr. Chairman, I move the committee rise and report progress, and beg leave to sit again.

MR. CHAIRMAN:

It has been moved by the Government House Leader that we report progress. Is that agreed?

HON. MEMBERS:

Agreed.

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[Mr. Speaker took the Chair]

MR. CHAIRMAN:

Mr. Speaker, the Committee of the Whole Assembly has had under consideration Bill No. 83, reports progress and begs leave to sit again.

MR. SPEAKER:

Having heard the report and the request for leave to sit again, do you all agree?

HON. MEMBERS:

Agreed.

MR. HYNDMAN:

I move the House do now adjourn until tomorrow afternoon at 2:30 o'clock.

MR. SPEAKER:

Having heard the motion by the hon. Government House Leader, do you all agree?

HON. MEMBERS:

Agreed.

MR. SPEAKER:

The House stands adjourned until tomorrow afternoon at 2:30 o'clock.

[The House adjourned at 10:50 p.m.]