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Wednesday 25 November 2015

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Mercredi 25 novembre 2015

Standing Committee on General Government

Mental Health Statute Law Amendment Act, 2015

Comité permanent des affaires gouvernementales

Loi de 2015 modifiant des lois relatives à la santé mentale

Chair: Grant Crack
Clerk: Sylwia Przezdziecki

Président : Grant Crack
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

Wednesday 25 November 2015

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Mercredi 25 novembre 2015

The committee met at 1608 in committee room 2.

The Chair (Mr. Grant Crack): Good afternoon, everyone. Sorry for the delay. I'd like to call the Standing Committee on General Government to order. I'd like to welcome you all this afternoon.

SUBCOMMITTEE REPORT

The Chair (Mr. Grant Crack): As you are probably aware, the subcommittee met on Thursday, November 19, in order to determine how we would proceed through the public hearing process, and we have a report that we should put before committee prior to the commencement of the public hearings. Is there anyone interested in moving the adoption of the report and reading it into the record? Mr. Colle.

Mr. Mike Colle: Your subcommittee on committee business met on Thursday, November 19, 2015, to consider the method of proceeding on Bill 122, An Act to amend the Mental Health Act and the Health Care Consent Act, 1996, and recommends the following:

(1) That the committee hold public hearings on Bill 122 in Toronto at Queen's Park on Wednesday, November 25 and Monday, November 30, 2015, during its regular meeting times.

(2) That the Clerk of the Committee, with the authorization of the Chair, post information regarding the committee's business with respect to Bill 122 in English and French on the Ontario parliamentary channel, on the Legislative Assembly website and with the CNW newswire service.

(3) That interested people who wish to be considered to make an oral presentation on Bill 122 should contact the Clerk of the Committee by 12 noon on Tuesday, November 24, 2015.

(4) That the committee Clerk schedule witnesses on a first-come, first-served basis.

(5) That groups and individuals be offered 10 minutes for their presentations, followed by up to nine minutes for questions by committee members—three minutes per caucus.

(6) That staff from the Ministry of Health and Long-Term Care be invited to appear in the first witness spot on Wednesday, November 25, to provide a briefing on the current process by which patients can be detained in psychiatric facilities under the different certificates in the Mental Health Act, and how the new certificate of continuation proposed in Bill 122 will alter that process.

(7) That staff from the Ministry of Health and Long-Term Care be offered 30 minutes, including time for questions by committee members, for the briefing to the committee.

(8) That the deadline for receipt of written submissions on Bill 122 be 5 p.m. on Monday, November 30, 2015.

(9) That amendments to Bill 122 be filed with the Clerk of the Committee by 12 noon on Tuesday, December 1, 2015.

(10) That the committee meet on Wednesday, December 2, 2015, during its regular meeting time for clause-by-clause consideration of Bill 122.

(11) That the research officer provide the committee with a briefing paper on Bill 122, with a focus on the Ontario Court of Appeal decision to which the bill responds, by Wednesday, November 25, 2015.

(12) That the Clerk of the Committee, in consultation with the Chair, be authorized to commence making any preliminary arrangements necessary to facilitate the committee's proceedings prior to the adoption of this report.

I so move the subcommittee report.

The Chair (Mr. Grant Crack): Mr. Colle has moved adoption of the subcommittee report. Is there any discussion? There being none, I shall call for the vote. Those in favour of the subcommittee report? The subcommittee report is carried.

MENTAL HEALTH STATUTE LAW AMENDMENT ACT, 2015

LOI DE 2015 MODIFIANT DES LOIS RELATIVES À LA SANTÉ MENTALE

Consideration of the following bill:

Bill 122, An Act to amend the Mental Health Act and the Health Care Consent Act, 1996 / Projet de loi 122, Loi visant à modifier la Loi sur la santé mentale et la Loi de 1996 sur le consentement aux soins de santé.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Grant Crack): This afternoon, we have three delegations before the committee, the first being, according to number 6 in the subcommittee report—there was some discussion to have the Ministry

of Health and Long-Term Care come before us to discuss some particulars of the process currently being used and the process proposed in Bill 122. So at this time I would like to welcome representatives from the Ministry of Health and Long-Term Care to the table. We have Mr. Sean Court, who's the acting director of the strategic policy branch, strategic policy and planning division, and Mr. Liam Scott, legal counsel, deputy minister's office, legal services branch.

According to the subcommittee report, we have 30 minutes for this presentation. I would imagine that somewhere around the 20-minute mark or before, we can commence questioning or comments from members of the committee.

Welcome, gentlemen. You have up to 30 minutes.

Mr. Sean Court: Thank you very much for the invitation to present to the committee today as you begin your public hearings on Bill 122, the Mental Health Statute Law Amendment Act, 2015. My name is Sean Court. I'm the interim director of the strategic policy branch within the Ministry of Health and Long-Term Care. Our branch is responsible for mental health and addictions policy on behalf of the ministry.

I'm joined today by my colleague Liam Scott, counsel with the ministry's legal services branch. Liam will be taking you through the circumstances leading to the proposed amendments, the current processes by which patients can be detained in a psychiatric facility under the different certificates under the Mental Health Act, and the impact of the proposed new certificate of continuation that has been proposed under Bill 122.

By way of context, the proposed amendments have been scoped to respond to the Ontario Court of Appeal's decision in the case of P.S. v. Ontario, which my colleague will provide you more detail on. So I'll turn things over to Liam.

Mr. Liam Scott: Thank you to the Chair and to members of the committee for inviting the ministry to speak to you today. Again, my name is Liam Scott, and I'm legal counsel with the Ministry of Health and Long-Term Care.

Bill 122 would, if passed, amend the Mental Health Act and make one complementary amendment to the Health Care Consent Act in response to the Ontario Court of Appeal decision in P.S. v. Ontario, which I will refer to in the course of my remarks as the P.S. decision. The P.S. decision found that the provisions in the Mental Health Act that allow a person to be involuntarily detained for more than six months in a psychiatric facility violated section 7 of the Charter of Rights and Freedoms—life, liberty and security of the person—unless a mechanism is put in place by which a person can seek a review of the conditions of his or her detention so as to ensure that they are the least restrictive in the circumstances commensurate with the reason for their hospitalization.

First, I will address the scope of these proposed amendments. These proposed amendments would not affect patients who are detained under the Criminal Code, who are referred to as forensic patients. These proposed amendments also would not affect any involuntary patients detained in a psychiatric facility for less than six months. So they would only affect patients detained in a psychiatric facility involuntarily for more than six months.

I will now provide some background on the Mental Health Act and certificates under the Mental Health Act.

The Mental Health Act provides for involuntary detention of patients in psychiatric facilities, which are designated under the Mental Health Act, where those patients are suffering from a mental disorder that likely will result in (a) serious bodily harm to the patient or to another person; (b) serious physical impairment of the patient; or (c) substantial mental or physical deterioration. This detention is referred to as civil detention.

A physician may make an application for a psychiatric assessment of a person if the test under the Mental Health Act is met, which is authority for seven days for a person to be restrained, observed and examined in a psychiatric facility for up to 72 hours. This is referred to as a form 1.

The attending physician in the psychiatric hospital, who must be a different physician from the physician who completed the form 1, must assess the patient to determine whether the patient should be released, if the attending physician is of the opinion that the person is not in need of care and treatment in the psychiatric facility; admit the patient as a voluntary or informal patient to the hospital; or admit the person as an involuntary patient to the hospital.

The form used to admit this patient as an involuntary patient to a psychiatric hospital is referred to as the form 3. The form 3 allows for a person to be detained, restrained, observed and examined as an involuntary patient in a psychiatric hospital for two weeks.

The Mental Health Act currently allows for repeated renewals of a patient's involuntary status by what's called a certificate of renewal, or a form 4. It provides for a one-month time period for a first certificate of renewal for the form 4, two months under a second form 4 and three months for a third or subsequent form 4. Note that the P.S. decision, which I will describe in greater detail shortly, struck out the words "or subsequent" from the Mental Health Act, limiting the amount of time by which involuntary patients could be involuntarily detained in a psychiatric facility.

There is currently no limit to the number of certificates of renewal. As a result, a patient can be involuntarily detained in a psychiatric hospital for long periods of time.

The Mental Health Act provides that on each renewal of a patient's involuntary status—so when a form 3 is issued or any of the form 4s are issued—the patient is entitled to a review of that status before the Consent and Capacity Board, which I will henceforth refer to as the CCB for short.

The only question that the CCB considers in these hearings is whether the patient continues to meet the conditions for involuntary admission or continuation as

an involuntary patient; i.e., whether they should continue to be detained or released or whether they should be transferred to another psychiatric facility.

Currently, the CCB cannot make orders dealing with the patient's residual liberty, such as privileges on the ward, supervised or unsupervised access to the community, temporary leaves of absence, access to vocational, recreational or translation services. The inability to make these types of orders was raised as a concern by the Ontario Court of Appeal in the P.S. decision.

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I will now discuss the P.S. decision. P.S. has been civilly detained at Waypoint psychiatric facility for over 19 years, and he has frequently appeared before the Consent and Capacity Board to have his involuntary status reviewed. As noted in the court's decision, he was involuntarily detained under the Mental Health Act after serving a five-year penitentiary sentence for sexual offences involving children.

While the CCB over the past 19 years has consistently affirmed that P.S. posed a risk of harm and should continue to be an involuntary patient, they commented that P.S.'s disability and the relatively low security risk that he posed to other adults did not warrant his continued detention in the maximum-security unit at Waypoint. The CCB at these hearings also repeatedly expressed frustration over its inability to make orders respecting the lack of ASL support services—American Sign Language support services—for P.S. and the lack of action on the part of Waypoint hospital in facilitating a transfer to a less secure facility.

On December 23, 2014, in the P.S. decision, the Court of Appeal granted a declaration that the Mental Health Act provisions permitting the involuntary committal of a patient on an involuntary basis for more than six months are unconstitutional unless a mechanism were to be put in place by which the conditions of detention could be addressed. The court struck out the words "or subsequent" from the Mental Health Act in the certificate process I mentioned to you earlier, limiting the detention of involuntary patients in psychiatric facilities to six months.

At paragraph 127 of the decision, the court noted, in part, as follows: "The CCB's inability to tailor conditions of detention to meet the individualized circumstances of long-term patients 'constitutes a statutory gap' that 'can lead to overly restrictive, prolonged and indefinite detentions thereby rendering the impugned scheme overbroad'.... The CCB lacks the required authority to 'make orders regarding security, privileges, therapy and treatment, or access to and discharge into the community.'"

The court also found a violation of Mr. P.S.'s section 15 equality rights arising from the lack of ASL interpretation services.

The court suspended its declaration for 12 months until December 23 of this year, 2015, to give the Legislature time to bring the Mental Health Act into compliance with the charter; in other words, to put in place a mechanism for the CCB to make individualized orders that address these types of "residual liberty" concerns regarding the conditions of long-term patients' detention in psychiatric facilities.

I will now provide a summary of the proposed amendments in Bill 122 and how the certificate of continuation would work with the existing process.

For the certificate of continuation, the amendments would, if passed, make it possible to detain a patient involuntarily in hospital for more than six months—I will refer to these types of patients as long-term involuntary patients—on a new form, a certificate of continuation, which would apply after the expiry of the patient's third certificate of renewal or third form 4.

A certificate of continuation would allow a long-term involuntary patient to be detained for a three-month period similar to the current form 4 in the Mental Health Act. Subsequent certificates of continuation would allow a patient to be detained for further three-month periods if the patient continues to meet the test for an involuntary patient under the Mental Health Act.

The amendments would provide new powers to the Consent and Capacity Board. The amendments would provide additional rights to long-term involuntary patients in the form of enhanced powers for the Consent and Capacity Board when considering the continued detention of patients who have been involuntary patients for more than six months. The amendments would limit the CCB to making one or more of the following orders when it confirms a long-term involuntary patient's certificate of continuation:

(1) transferring a patient to another psychiatric facility if the patient does not object;

(2) placing the patient on a leave of absence on the advice of a physician;

(3) directing the officer in charge to provide a different security level or different privileges within or outside of the psychiatric facility;

(4) directing the officer in charge to provide supervised or unsupervised access to the community;

(5) directing the officer in charge to provide vocational, interpretation or rehabilitative services.

The factors that the CCB would have to take into account in making an order would be:

—the safety of the public;

—the ability of the psychiatric facility or facilities to manage and provide care for the patient and others;

—the mental condition of the patient;

—the reintegration of the patient into society;

—the other needs of the patient; and

—that any limitations on the patient's liberty be the least restrictive commensurate with the circumstances requiring the patient's involuntary detention.

The CCB could make one of those new proposed orders in response to an application by the patient or on its own motion. However, note, as I said before, that an order to transfer a patient would require that the patient not object to that transfer. The CCB could also make the implementation of the above new orders subject to the

discretion of the officer in charge, to give the officer in charge flexibility to tailor a general order to a patient's changing circumstances.

In order to respect the patient's right to consent to treatment and the physician's obligation not to provide treatment that he or she does not consider to be efficacious, the CCB could not make an order directing a physician to carry out psychiatric or other treatment or require that a patient submit to such treatment.

However, the amendments would provide that if a physician agreed to provide treatment for a patient and the patient consented to the treatment, the CCB could make an order contingent upon that agreement and consent of the physician and patient. For example, if the CCB, under its new orders, wished to put a patient on a leave of absence and the physician provided evidence to say, "I would agree to prescribe this neuroleptic medication to the patient," and the patient said, "I agree to take the neuroleptic medication," then the CCB, in its order, could take note of the agreement of the physician and the patient in issuing its order.

The officer in charge would also be able to take a temporary action contrary to a CCB order when there's a risk of serious bodily harm to the patient or to others. If, however, the temporary action exceeded seven days, the officer in charge would be required to apply to the CCB to vary, confirm or cancel the order. In addition, a long-term patient or the officer in charge would be able to apply to the CCB to vary or cancel the CCB's order. The CCB would hear the application if the CCB is satisfied that there has been a material change in circumstances.

I will now speak as to the timing of CCB hearings. Similar to the current scheme under the Mental Health Act, the long-term involuntary patient would be entitled to request a review of his or her involuntary status after each certificate of continuation is issued. There will be a mandatory review of the patient's involuntary status when the first certificate of continuation is issued at the six-month-and-two-week mark—because the first form 3 is for two weeks—and every year thereafter.

The long-term involuntary patient can apply for one of these new orders any time he or she seeks a review of the renewal of their certificate where he or she has not applied in the last 12 months or where the CCB is satisfied that there is and has been a material change in circumstances.

The CCB would also be able to hear an application to transfer a long-term involuntary patient made by the officer in charge or the Minister or Deputy Minister of Health and Long-Term Care at any time.

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Independent assessments: The CCB would be able to order an independent assessment of the patient's mental condition or his or her vocational, interpretation or rehabilitative needs.

For community treatment orders, the bill provides that if the CCB at a hearing is advised that a physician has issued and completed a notice of intention to issue a CTO—which is a form 49—then the CCB would be required to consider that notice of intention to issue a CTO when they review a patient's involuntary status. The CCB would not have the power to order a physician to issue a CTO and take on responsibility for managing that patient in the community.

Rights advice: Patients would receive rights advice as to these new orders of the CCB, and there is a statutory provision providing for that in the bill. A regulation-making authority is also proposed to require that rights advice be provided to a patient or category of patients with respect to the new orders and governing the timing or content of any rights advice that is provided.

There are some other related amendments. The proposed amendments in Bill 122 would allow physicians and nurse practitioners to sit on Consent and Capacity Board panels for less complex hearings, not on certificate of continuation hearings. This would free up existing psychiatrist capacity for the more complex hearings anticipated by these amendments. The proposed amendments also contain transitional provisions to assist the CCB in addressing these new hearings, when and if the proposed amendments come into force.

Thank you. Sean and I would be pleased to respond to any questions you have at this time.

The Chair (Mr. Grant Crack): Thank you very much. We shall start with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you for coming in and giving us the overview. I guess the first question to ask is, did you have a consultation with the OMA and the Ontario Psychiatric Association regarding the changes to the Consent and Capacity Board, and their thoughts, before you brought this forward?

Mr. Sean Court: As part of the development of the proposed amendments in Bill 122, the ministry did consult with a number of stakeholders. We consulted with patients, patient rights advocates, the Mental Health and Addictions Leadership Advisory Council and key stakeholders.

Mr. Jeff Yurek: Were the OMA and the Ontario Psychiatric Association included?

Mr. Sean Court: We spoke with the speciality psychiatric hospitals and we spoke with a group of psychologists—

Mr. Liam Scott: Psychiatrists.

Mr. Sean Court:—psychiatrists, sorry—but I don't specifically know that they represented that organization's interests directly or if they represented a group of concerned individuals as a subset of that broader group.

Mr. Jeff Yurek: So the OMA wasn't—did I miss that?

Mr. Sean Court: To the best of my recollection, we didn't have specific consultations with the OMA.

Mr. Jeff Yurek: Okay. Is there any other reason that you didn't include any other changes to the Mental Health Act? I mean, we've had lots of committees. We had an all-party select committee brought forward by the Legislature which gave recommendations a number of years ago that are waiting for some form of legislation,

one way or the other, and discussion in the Legislature. Why didn't you take the time to incorporate those pieces of legislation?

Mr. Sean Court: The direction, as part of our approvals process, was to move forward with the introduction of amendments that were specific to the P.S. v. Ontario case. We heard from lots of different groups, as part of our consultations, about potential additional amendments that range from very narrow technical amendments, which would have resulted in a cleanup within the act, for example, all the way to bigger policy direction changes that could be potentially introduced through the Mental Health Act. That would include potentially implementing the recommendations of the select committee.

Mr. Jeff Yurek: Wouldn't you think, though, that you kind of opened the door to actually include other amendments when, in fact, you changed the construction of the Consent and Capacity Board, which technically doesn't really have anything to do with the P.S. case?

Mr. Sean Court: Sorry; by introducing amendments that change the powers of the Consent and Capacity Board, we're not responding to the P.S. v. Ontario decision? I'm just trying—

Mr. Jeff Yurek: You've changed the composition of the board, when really the case wasn't asking you to change the composition of the board; it was more so to take a look at the certificates and ensuring the person has the liberty.

Mr. Liam Scott: Those amendments, we would say, are related, because it's anticipated that these new hearings will be complex, they will likely be longer, and this type of amendment would enable the Consent and Capacity Board to allocate its resources.

Understand that the amendments only give discretion to the Consent and Capacity Board as to how they would staff these other types of hearings, other than certificate of continuation hearings. So psychiatrists could still sit on those hearings. But it gives the Consent and Capacity Board discretion, given that we anticipate there will be longer and more complex hearings arising out of these amendments for long-term involuntary patients.

The Chair (Mr. Grant Crack): We'll have to move on. Ms. Forster.

Ms. Cindy Forster: Before I start my questions, can we request a copy of the stakeholders and groups you consulted with during this process?

Mr. Sean Court: Okay.

The Chair (Mr. Grant Crack): Would the committee consider the request from the third party to have a copy of the list of stakeholders? Is that what you're asking?

Ms. Cindy Forster: Correct.

The Chair (Mr. Grant Crack): Okay. Any opposed? Done.

Ms. Cindy Forster: Thank you so much.

Around financial and legal resources, does the government currently provide any legal resources for hospitals during Consent and Capacity Board hearings? We've heard from some of the hospitals that they're concerned they won't have the legal or financial resources available at complex hearings because of their budgetary constraints.

Mr. Sean Court: As part of our consultations, we've definitely heard from the four specialty psychiatric hospitals that they're concerned about the implications on them in terms of resourcing. At this point in time, there are no additional resources that are contemplated to go along with the proposed amendment.

Ms. Cindy Forster: So we're not going to be giving them any more budget dollars to be able to participate in any fulsome way?

Mr. Sean Court: As I mentioned, there are no additional resources that are contemplated.

Ms. Cindy Forster: Under proposed subsection 41.1(3), which sets out the factors that the Consent and Capacity Board will consider when making an order under the CFC, will the hospitals' financial resources be included under paragraph 2, which states that the ability of the psychiatric facility or facilities to manage and provide care for the patient and others must be considered—considering your last response?

Mr. Liam Scott: Certainly, at a Consent and Capacity Board hearing, the psychiatric facility could provide evidence, under that criterion or factor to consider that the ability to manage and provide care for the patient and others is impacted by some sort of financial circumstance. That would be open for the hospital to make that argument before the board.

Ms. Cindy Forster: Who would they make that request to for those additional resources, if that was considered? If they made that plea to the board for that consideration, and the board ordered it, who would be providing that funding? The ministry?

Mr. Sean Court: Hospitals flag pressures to the ministry through our liaison branch throughout the course of a fiscal year.

Ms. Cindy Forster: According to the current legislation, only a physician can complete a form 1 under the act. Has the ministry done any consideration about extending this to nurse practitioners?

Mr. Liam Scott: That isn't contemplated by these current amendments. I'd have to ask Sean if he can speak to the other aspect of that.

Mr. Sean Court: I don't work with our nursing colleagues and nursing policy directly, so if it would be okay, I would like to get that answer back to you.

1640

Ms. Cindy Forster: Okay. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We'll move to the government. Mr. Fraser. No?

Mr. John Fraser: Yes, thank you very much. I just wanted to make sure if my colleagues had any questions.

Thank you very much for presenting to us today.

Just to rehash for the sake of the committee: This bill is a specific response to the court decision in the circumstance of P.S. That's correct?

Mr. Liam Scott: Correct.

Mr. John Fraser: We're responding to that as access to process and justice. Would that be a fair assessment?

Mr. Liam Scott: Yes. It's intended to give the Consent and Capacity Board additional powers, which will safeguard the liberty interests of patients who continue to be detained in a psychiatric facility, yes.

Mr. John Fraser: In terms of opening the membership of the Consent and Capacity Board to include physicians and nurse practitioners for cases that are not as complex—I'm doing some work in scope, so the question will go toward scope. If in fact, in any case of scope, a health care professional has to make a decision as to whether or not they have the capacity to deal with what's in front of them, whether that be a patient or a decision of a certain type, do you feel confident in how the changes to the Consent and Capacity Board can function, given those parameters?

Mr. Liam Scott: Yes. The Court of Appeal mandated that additional powers needed to be provided to the Consent and Capacity Board, and the Consent and Capacity Board, we know, in hiring additional members, will ensure that those members are trained on the new amendments and will, as any adjudicative body does, ensure that their members are properly trained as to the legal requirements.

Mr. John Fraser: I just want to add into the record: As health care professionals, they're bound by their colleges and their conscience to make decisions based on their capacity, and if they feel something is not going to be within their capacity, then they have an obligation to let people know.

Mr. Liam Scott: I believe that's correct.

Mr. John Fraser: Okay. Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We're almost right at the 30 minutes. We really appreciate you two gentlemen taking the time to come before committee this afternoon. Have a great afternoon.

ADVOCACY CENTRE FOR THE ELDERLY

The Chair (Mr. Grant Crack): Next we have, from the Advocacy Centre for the Elderly, Jane Meadus, who is the institutional advocate. Ms. Meadus, we welcome you here this afternoon. I believe you're a staff lawyer, would that be correct? Perhaps you could just introduce yourself for the record as well. You have 10 minutes, followed by approximately three minutes each of questioning from the three parties. Welcome.

Ms. Jane Meadus: Thank you. I'm just going to turn on my speaker counter here so I don't run over time.

My name is Jane Meadus. I'm a lawyer at the Advocacy Centre for the Elderly. I've been there for 20 years, and I'm the institutional advocate, which means that I deal with issues of institutionalization, whether they are long-term care, psychiatric issues etc.

The Advocacy Centre for the Elderly, if you are not familiar with us, is a legal clinic. We are located here in Toronto, just up the street, and we've been in operation for over 30 years. We provide legal advice and services to low-income seniors across the province, but mostly in the city of Toronto. We have a staff of eight, five of whom are lawyers. One of the areas that we do a lot of work in is with respect to issues of capacity and mental health.

I have provided a copy of our submissions today, so hopefully you've all gotten copies of that—and certainly if you have any questions.

We are supporting the submissions today of the Mental Health Legal Committee, which is represented here today by Marshall Swadron and Karen Spector, who will be presenting following myself.

I also wanted to recognize in the room today, over my left shoulder, at the back, Mercedes Perez, who was counsel to Mr. P.S. at the hearings—just to recognize her dedication in this case, which goes far above and beyond what is probably required of counsel. I just wanted to recognize her today.

Our submission today has three basic issues to it. I'm going to spend the most time on the first issue because I think it's the most important.

Ministry of Health counsel today discussed the issue of what the amendments are, which are really to deal with the issue the violation in P.S.—that the Mental Health Act violated the charter as it did not protect the liberty interests of long-term psychiatric patients. They're resolving this by including a new category of certificate called certificates of continuation.

The issue that we have is that this relates only to persons who have been held on certificates of involuntary admission. It doesn't help anyone who's either a voluntary patient or an informal patient. I'm going to explain: An informal patient is someone who is admitted by a substitute decision-maker—but there are limitations. If the patient disagrees with the admission, the substitute decision-maker's consent for the admission can only take place if there's a court-appointed guardian or an attorney under power of attorney for personal care that has very special requirements. These are called Ulysses contracts, and they're very few and far between in the province of Ontario. If a family member wants to admit a patient and the patient doesn't want to go in, they have to go in via the forms that we heard about earlier today.

The problem is that in psychiatric facilities, we have a lot of people who are voluntary, but aren't voluntary. The sections here are not going to deal with that. This affects seniors a lot because what we find is that many seniors are being admitted to psychiatric facilities not under certificates, but are being prevented from leaving either because the hospital believes the senior's family can do this admission or because the hospital simply thinks it has the authority to do so.

The problem here, interestingly, is that the amendments that are proposed today are not going to help Mr. P.S. because Mr. P.S., in fact, is a voluntary patient. However, if he tries to walk out the door at Waypoint, he will be detained. So the problem is that the amendments that are being presented today aren't going to help him.

He has actually been a voluntary patient since approximately 2012. There have been hearings into this issue,

and if you refer to page 9, footnote 13 of our submission, we refer to the case where he actually attempted to go to the Consent and Capacity Board to say, "Hey, look, I'm here. I'm voluntary because I don't want to walk out the door and have the security guards come after me and pull me back and get into this big thing. So I'm agreeing to stay here, but in fact I don't want to be here." The board said, "Well, we really feel sorry for you, but there's nothing we can do for you." What we have today does not assist Mr. P.S. and it actually doesn't help the situation.

We believe that the certification or this continuance certificate, these rights, need to be expanded to anyone who is in a psychiatric facility voluntarily, involuntarily or informally who is there longer than the six months, so that everyone can go to the Consent and Capacity Board if they feel that there are violations.

The second issue that I'm going to talk about is treatment without consent. The problem with the sections, as the way they have been set out—we heard about these orders where if the patient or their substitute decision-maker agrees to a treatment that the psychiatrist wants to give, then that would be included in an order. The question is, what happens if the psychiatrist decides that that's not an appropriate treatment or the patient decides that they don't want to take that treatment anymore? Does that become a breach of the order? Do they have to go back to the Consent and Capacity Board? What has to happen?

This is an attempt to override the requirements of the Health Care Consent Act, which allow a competent person or their substitute decision-maker to withdraw consent or refuse consent at any time.

We also want to point out the issue of section 41.1(2)1 that talks about the transfer provision. There's a transfer provision in the act, and it says that it's subject to subsections (10), (11) and (12). We believe that the intent of these subsections was to ensure that the patient's well-being is primary. They have to look at issues such as if it's in their best interests etc.

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The problem is that the way that the subsections are written, a lawyer could go before a court and say that they're actually allowing to override. So if the board felt that it was in the best interest to override what the patient wanted, they can do that. We don't believe that that is the intent, but we believe that is a possible outcome if they're done as set out. So we're suggesting that we take the "subject to subsections (10), (11) and (12)" part of the legislation out.

We also wanted to indicate that the changes to the Consent and Capacity Board, with the addition of the nurse practitioners—we want to make sure that those persons have experience in the area of mental health law: not only that they are nurse practitioners but they have some expertise, some training, in the area of mental health.

We further recommend that there be some requirements for more patient-side representation on the board, especially those people who have experience outside of a hospital context, so that these persons can bring fairness and balance to the board to provide the lived experience of those with mental health issues to the board system.

So I've finished early and I'm ready for questions.

The Chair (Mr. Grant Crack): Wow.

Ms. Jane Meadus: I know.

The Chair (Mr. Grant Crack): You had a minute 30 left. Congratulations.

We shall start with the third party. Ms. Forster.

Ms. Cindy Forster: Thank you, Chair. When making an order for the certificate of continuation, the board actually is required to consider a number of things: the safety of the public, the ability of the psych facility to manage or provide the care, the mental condition of the patient, the reintegration pieces into society, and other needs or any limitations on the patient's liberty that are least restrictive under the circumstances. Do you believe that there is anything missing in these criteria or do any of these factors cause you concern?

Ms. Jane Meadus: We don't have any concerns specifically. I think there was a question about the money issue and whether that would be an issue. We don't believe that cost is something that can be looked at because it's in the charter. If the person happens to be more expensive, you can't turn someone down for health care—and you've got to remember that this is a provision of health care—because there is an issue of cost. I think that has been an issue in this case of P.S. because it has to do with translation services.

Ms. Cindy Forster: Right. I know during the debate in the House, there were some concerns raised around that issue, that when the court orders treatment, the money flows with it. There are concerns that when the Consent and Capacity Board orders treatment, those dollars won't necessarily be provided.

Ms. Jane Meadus: I certainly can't speak to the money that the hospitals are getting, but what I can say is that you can't say to someone, "You can't get medical treatment." Again, we're talking about medical treatment. This person, whoever it is, is going to be in the system already, and you can't say, "You can't give them treatment because it costs too much." If they're entitled to treatment, they're entitled to treatment.

Ms. Cindy Forster: Can you just expand a little bit more—you talked about what you thought the makeup of the board should be—the Consent and Capacity Board—around the people with lived experience?

Ms. Jane Meadus: Certainly. What we see on the board, obviously, are lawyers and psychiatrists, generally, and then community members. Often, those community members—it would be nice to have more people who have actually had experience in the mental health system as patients, so they can bring that experience, because we get a very lopsided, very hospital-based—medical practitioners: That's the perspective they bring. So we'd like to see that there be some requirements for there to be more people on the board with that lived experience in the mental health system.

Ms. Cindy Forster: Thank you.

The Chair (Mr. Grant Crack): Thank you very much. We shall move to the government. Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for the work that you do. I have two areas I'd like to talk to you about. I'm interested in "voluntary," "involuntary" and "informal." Very quickly, do informal and voluntary patients currently come before the Consent and Capacity Board? Is that a routine thing?

Ms. Jane Meadus: No.

Mr. John Fraser: They don't. Okay, so they have not—in any circumstances?

Ms. Jane Meadus: I'd have to check. There may be a very, very minimal number to do with children, but generally no.

Mr. John Fraser: Okay. Why is that?

Ms. Jane Meadus: Why don't they have the ability to come in front of the board?

Mr. John Fraser: Yes.

Ms. Jane Meadus: Because of the protections that are built into the act, supposedly—so if you're a voluntary patient, that, by definition, means that you can leave. The problem is that, for example, voluntary patients are told that they can't leave. So people are often made voluntary in order to get around having hearings. That's not an uncommon thing that we hear.

Mr. John Fraser: Okay. And the change in status with P.S. from involuntary to voluntary—it's parsing in a way, because he is involuntary in the sense that if he changed his mind, he would become involuntary right away.

Ms. Jane Meadus: That's correct. So the fact that he is being co-operative means that he has lost all his rights.

Mr. John Fraser: Yes. The second thing is, I was interested in your comments with regard to nurse practitioners. Just so I can characterize it, you had comfort as long as the person had the requisite expertise in mental health to be part of that decision-making body.

Ms. Jane Meadus: That's right.

Mr. John Fraser: In your request for more lived experience on the board, would that include families? Are you speaking specifically of patients or are you speaking of people who have had an involvement from the perspective of a caregiver, power of attorney, family?

Ms. Jane Meadus: We would be speaking specifically of patients.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Grant Crack): We shall move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks very much for coming in. You raised a point, and I wanted clarification. If, under the bill, the consent board agrees to an order for treatment and somewhere down the road, within a week or two weeks, something has gone wrong with the treatment and the psychiatrist wants to change it, are you saying he has to go back to the board to have that? Or is that the grey area where we might end up with another court case?

Ms. Jane Meadus: That's a grey area; absolutely. What happens if the psychiatrist changed or what happens if, for example, the patient starts to take their medication and then they're having side effects so they change their mind? What is the status? Under the Health Care Consent Act, you can refuse. Under this, it's not as clear.

Mr. Jeff Yurek: Who would make that decision? Where would that fall under if someone's going to say, "We've got this order; you can't change your mind"?

Ms. Jane Meadus: Our position would be that that requirement should be removed—that they should be allowed to withdraw their consent.

Mr. Jeff Yurek: Okay. Another thing that I found concerning: You're saying that a lot of seniors are being admitted into our psychiatric facilities.

Ms. Jane Meadus: Yes.

Mr. Jeff Yurek: And the reasoning is—is it because of dementia and stuff?

Ms. Jane Meadus: Because of dementia and behavioural issues. They're coming into psychiatric facilities either from the community or from long-term-care homes into behavioural units, into geriatric units, into regular populations. When we speak to the seniors or their families, we're finding that they're not being admitted, frankly, as either an informal or as a voluntary or involuntary—they're just admitted by the hospital without any, really, review of their rights at all.

Mr. Jeff Yurek: To me, I wouldn't think that would be the optimal place for seniors to be placed.

Ms. Jane Meadus: It's not the optimum place, but sometimes it's the only place, unfortunately.

Mr. Jeff Yurek: You mentioned that this bill doesn't help people like Mr. P.S., so do you think that after it's said and done and this bill is passed as is, we're going to be back here in another few years with another P.S. case, possibly?

Ms. Jane Meadus: Absolutely. Mr. P.S.'s case is not over. He absolutely could be back, because he doesn't have any right of review. If this passed today, he would not have a right of review tomorrow.

Mr. Jeff Yurek: Okay. Thank you.

Ms. Jane Meadus: Thank you.

The Chair (Mr. Grant Crack): Thank you, Ms. Meadus, for coming before our committee this afternoon. We appreciate it.

MENTAL HEALTH LEGAL COMMITTEE

The Chair (Mr. Grant Crack): Next we have the Mental Health Legal Committee. I believe we have the chair with us, Mr. Swadron, and another lawyer—that will be great—Ms. Spector.

Interjections.

The Chair (Mr. Grant Crack): I like lawyers.

We welcome you both. You have 10 minutes to make your presentation, followed by approximately three minutes of questioning from each of the three parties. Welcome.

1700

Ms. Karen Spector: Good evening, Mr. Crack and members of the standing committee. I would like to thank the committee for the opportunity to address Bill 122. This is Marshall Swadron, and I'm Karen Spector, and we're here on behalf of the Mental Health Legal Committee.

The MHLC is a province-wide association of lawyers and community legal workers that was founded in 1997 to promote and protect the rights of psychiatric consumer-survivors. Our lawyer members represent clients in all areas of mental health law and at all levels of court, including the Supreme Court of Canada.

The MHLC makes submissions to government respecting provincial and federal legislation, and our lawyer members regularly represent clients before the Consent and Capacity Board and in appeals from the CCB and so deal with the Mental Health Act and the Health Care Consent Act on an everyday basis.

Finally, Bill 122 was introduced in response to the Court of Appeal's decision in P.S. v. Ontario. The Mental Health Legal Committee was an intervenor in that case and made oral and written submissions to the court.

The proposed legislation will have a profound impact on some of the most vulnerable members of our society. There needs to be sufficient legal oversight to ensure proper accountability over the state's power to subject persons to long-term psychiatric detention.

The MHLC supports the expansion of the oversight powers of the CCB to safeguard the rights and autonomy and dignity of long-term detainees. However, Bill 122 does not fully address the unconstitutionality of the provisions of the Mental Health Act, and if this bill is enacted as drafted, it would leave the government vulnerable to further constitutional challenge. Therefore, we urge this committee to consider further changes.

In our oral submissions, I will focus on five areas of concern. However, we will be preparing written submissions which will be submitted by November 30. I also want to thank the ministry for speaking with us a few days ago, prior to this meeting.

First, the scope of the CCB's expanded review powers in section 41.1 remains deficient. In particular, the proposed amendments only expand the powers of the CCB when confirming a certificate of continuation. The proposed amendments continue to reinforce the binary, then, between confirming or rescinding that exists in the current Mental Health Act. So although the proposed powers provide some legal flexibility for people who still require detention in hospital, it doesn't address the situation where a patient no longer requires detention in hospital but is not ready for outright release without supports.

Under the proposed amendments, unless a physician recommends a leave of absence or a physician is about to issue a community treatment order, the CCB has no new authority to order discharge to the community short of a direct revocation of the certificate of continuation.

Access to CTOs depends on the availability of resources in the community and a physician willing to supervise them, so some patients will remain without access to that means of integration. The decision to discharge a patient into the community with supports then remains within the discretion of the doctor and hospital and is not subject to a review by the CCB.

The CCB would not have jurisdiction akin to the powers of the Ontario Review Board in respect of persons who are conditionally discharged, and this should be addressed. In addition, leaves of absence and CTOs are not the end goals of reintegration; living in the community and accessing mental health and other rehabilitative resources without legal compulsion are. Means of ensuring that all patients have access to community living and appropriate rehabilitative services and supports must be part of the ministry's plan if the changes are to have any kind of practical benefit.

The second concern relates to the barriers that exist in accessing the new powers, and the Advocacy Centre for the Elderly spoke to some of this. The proposed amendments restrict a patient's ability to apply for an order in terms of both timing and frequency. A patient can only access these expanded powers upon the completion of a certificate of continuation and then they are restricted to applying and accessing these powers once every 12 months, unless there's a material change in circumstances.

From the perspective of a vulnerable person, restricting such applications to once a year is not reasonable. A year is a long time when you're detained in hospital.

There's also a possibility that a patient may never reach a certificate of continuation. A patient may be continually detained for long periods of time, but afforded brief periods of voluntary status which then serve to restart the clock on the CCB review process.

This loophole that currently exists is already being misused by physicians who seek to avoid mandatory hearings for long-term patients, and could be equally misused upon the implementation of certificates of continuation.

The amendments do not address the phenomenon of the lack of access to review by persons who are held notionally as voluntary but who would be prevented from leaving hospital if they sought to do so. Such powers would not be available to many long-term detainees, including P.S., who have agreed at times to remain in hospital voluntarily. Such powers should be accessible not only to involuntary patients, but to patients who are voluntary but not permitted to leave—de facto involuntary.

Third, we would like to also support the Advocacy Centre for the Elderly in that the composition of the CCB should be broadened to include persons with lived experience in the mental health system. This is important to ensure the patients' perspective is reflected in the CCB decisions and contributes to the expertise of the CCB.

I wanted to point out that the province of Nova Scotia specifies having consumers of mental health services as members of their mental health tribunal. Specifically,

section 65(2)(c) of Nova Scotia's Involuntary Psychiatric Treatment Act provides that the governor in council shall appoint the members of the review board, including from a roster of persons who expressed an interest in mental issues and "preferably are or have been a consumer of mental health services." That's a good example. The province of Newfoundland and Labrador has similar requirements. The MHLC urges this committee to adopt similar language used by these other provinces in respect to Bill 122.

Fourth, the authority to order an independent assessment is also deficient. The MHLC supports the addition of section 41.1(8), which grants powers to order an independent assessment. However, the provision lacks the ability for the CCB to direct the terms, such as the timing and who will bear responsibility for payment of the assessment.

There is also an issue of who conducts the assessment. All parties, including the patient, need to agree to the person ordered to conduct the assessment. The assessment should not be ordered over the objection of the patient. The term "independent" should also be defined, as the assessor should not have any connection to the detaining facility.

Finally, the type of independent assessment that the CCB may order should not be restricted to the enumerated list currently proposed, and should also include, at least, powers to order assessments of a patient's risk, reintegration and educational needs.

The fifth and final concern is that the CCB should not be permitted to order treatment, as provided for in subsections 41.1(4) and 41.1(5). The MHLC is concerned about a situation where there is a treatment impasse between a patient and their attending physician and the patient feels they are not being afforded the appropriate treatment opportunities to progress towards their reintegration.

In those circumstances, the MHLC submits it is necessary for the CCB to have jurisdiction similar to the Ontario Review Board to make orders ensuring that treatment opportunities are provided, including power to explore new treatment opportunities, question a treatment plan, order a re-evaluation of treatment approaches or explore alternative treatments where necessary. This kind of authority will ensure that there is sufficient oversight over discretionary decision-making of doctors and hospitals regarding conditions of detention, including treatment. However, that kind of power that I've described does not amount to jurisdiction to order treatment.

To conclude, we strongly urge this committee to make the necessary amendments to Bill 122 to promote access to justice and ensure that there are adequate safeguards to protect the rights, autonomy and dignity of vulnerable persons. We also emphasize the importance of resources to community reintegration. The amendments will be an empty promise unless the ministry devotes the financial resources necessary to build and maintain community care infrastructure. We await an indication from the government that the necessary resources will be devoted to the integration of long-term detainees and ensuring their success in the community.

Thank you for your consideration of these submissions.

1710

The Chair (Mr. Grant Crack): Thank you very much. You were right on time. Well done.

We will start with the government. Ms. Vernile.

Ms. Daiene Vernile: Thank you very much for your presentation.

My first question for you is: How will the proposed amendments address the Court of Appeal decision?

Mr. Marshall Swadron: I think that the amendments will certainly require that a long-term detainee receive an additional set of processes and have additional considerations made with respect to their access to services directed toward their rehabilitation.

If we look at the prior powers of the Consent and Capacity Board and the proposed powers of the Consent and Capacity Board with respect to long-term detainees, we can see that there's a broadening of the authority. There will still be some aspects of the court's decision. The Court of Appeal was very clear that this whole idea of a short period of voluntary status or restarting the clock was not an acceptable solution. To the extent that the Consent and Capacity Board right now doesn't have access to people who are held notionally voluntary but de facto involuntary, that gap or loophole is going to remain and the Court of Appeal's concerns about it have not been met.

Ms. Daiene Vernile: We've heard some voices make the argument that the Mental Health Act now is open and we should be doing more to address other issues involving mental health. From your point of view, can you tell us the importance of seeing the legislation having greater focus?

Mr. Marshall Swadron: It depends on what we want to do with our mental health legislation. From our committee's perspective, we see the most important response to mental health needs in the province being one of resources, not the use of legislation to increasingly regulate and increasingly require coercive-type services.

The problem, if we look at it from that perspective, is one of people being met at the wrong place in the continuum of needing care. They're not being met when they want care. There aren't voluntarily accessible and attractive services in the community. They are being met when they don't want care; they're turned away when they seek it. The same problem is there. We don't see services at the right place, which is where people are seeking them.

Legislation isn't going to fix that. That's a question of resources. The more we want to pass laws that regulate this, the more we want to insist that people receive services that are imposed on them as opposed to services that they would seek earlier on in the process—I think we're actually heading down the wrong road.

The Chair (Mr. Grant Crack): Thank you very much. We appreciate it.

We shall move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. Were you part of the consultation process that the Ministry of Health did before creating this bill?

Mr. Marshall Swadron: Approximately two and a half weeks ago, after the bill was already presented—after first reading—we were consulted, and we were happy to participate at that point. We, of course, would have been happy to have input earlier, but it's better late than never.

Mr. Jeff Yurek: I didn't hear any thoughts brought forward at all—what are your thoughts on the new composition of the capacity board, the changes which had nothing to do with the P.S. case?

Mr. Marshall Swadron: We consider them to be responsive, although they go a little further than they have to to deal with the P.S. needs. They do deal with the composition of the board.

We're of the view that the board has to really ensure that it has expertise. Training is one thing, but if you look at, for example, the composition of the Ontario Review Board and you look at the Consent and Capacity Board, some of the forensic-type experience that's presently on the Ontario Review Board may have to be brought in so that people know what resources are available, know how the expertise that we already have in reintegrating people that are long-term detainees in the Criminal Code process—the not-criminally-responsible process—can be brought to bear in the civil process.

Mr. Jeff Yurek: I heard that it's going to be another expense of resources just to deal with this change with the capacity board. I imagine, in the silo of mental health, there's not going to be any money to fill that resource. It's going to be taken from somewhere in the system.

Mr. Marshall Swadron: If I can suggest a few things: It's not necessarily more resources. If you are looking at long-term detainees who may be detained, like Mr. P.S. was, for 19 years, some way to have gotten him out of the system earlier would have saved hundreds of thousands of dollars. So that is not really the issue. We can repurpose a lot of things. We have CTO coordinators, for example. These are a resource, but they're only available to people on CTOs. They could be repurposed. They could be used in additional ways to ensure integration of people into the community successfully.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Grant Crack): We'll move to the third party. Ms. Forster.

Ms. Cindy Forster: My question is for Ms. Spector. I wanted to delve a little bit more into your comments about the Consent and Capacity Board not being allowed to order treatment and that a body should be put in place similar to the Ontario Review Board that would address the issue of treatment. How do you see that working? Would it be another board that actually just deals with the issue of treatment based on decisions that come out of the CCB?

Mr. Marshall Swadron: I'll answer, and I think Ms. Spector can add as well.

We're not suggesting that there be some other board. We're suggesting that treatment remain a decision between physicians and capable patients and substitute decision-makers in the event of incapable patients. We're not suggesting that that go anywhere other than to the Consent and Capacity Board. What we're looking at is some of the powers that the Ontario Review Board has and is able to use effectively and making sure that those kinds of powers are also available to the Consent and Capacity Board.

Ms. Cindy Forster: I see. The other question that I had was—well, it was probably more of a comment than a question.

We currently don't have enough resources in the community for people living with mental health issues. In my own community, we had a supportive housing model that we had funding for for 20 years that suddenly ended at the end of 20 years. We now see people with mental health issues who have never had a visit in 20 years to our psychiatric units suddenly cycling in and out of them. So when you talk about having community care infrastructure, are you talking about bricks and mortar or are you talking about programs and support, human resources?

Mr. Marshall Swadron: It's both. If we look at the circumstances of P.S., a group home may have been just what he needed, and it would have been vastly less expensive, when we're talking about resources, than the kinds of services that he had and would have been happy not to have. So that's still a piece that has to be put in place.

I can also add, just by way of update, that Mr. P.S., to my understanding, has actually moved within Waypoint to a secure unit but no longer maximum-secure. I think it is a matter of progress that he's actually held as an involuntary patient as of today. That means he would have access, but it was for months and even years that he just could not access the Consent and Capacity Board.

Ms. Cindy Forster: Thanks. Chair, just before you adjourn, I have one question.

The Chair (Mr. Grant Crack): Are you done the questioning?

Ms. Cindy Forster: I'm done, yes.

The Chair (Mr. Grant Crack): Okay. Thank you very much. We really appreciate both of you coming before our committee this afternoon and sharing your insights.

Ms. Karen Spector: Thank you so much.

Ms. Cindy Forster: I understand that amendments are to be in to the Clerk by noon on Tuesday. When will the Hansard be ready so that each of the parties has the deputations in our hands to actually prepare amendments? I would like to suggest that it be by Friday morning.

The Chair (Mr. Grant Crack): Ms. Forster is requesting that Hansard be made more rapidly available for this committee due to the timelines as set out in the subcommittee report. I'll need to consult.

Interjections.

The Chair (Mr. Grant Crack): With reference to your request, we'll keep in mind that the Hansard from

today should be made available prior to Monday, as we do have another day of public hearings. There is a possibility of that. The committee could request that the Hansard from this particular committee be a priority, keeping in mind that it's always the House that is the priority and what happens in the House takes precedence.

I would ask the Clerk, then, to make Hansard as readily available as possible so that we can move forward with the filing of amendments in the clause-by-clause consideration.

Ms. Cindy Forster: So when can we anticipate receiving that?

The Chair (Mr. Grant Crack): I would say at the earliest convenience, and I will ask the Clerk to ask those responsible for Hansard to provide that as quickly as possible.

Ms. Cindy Forster: I would suggest that this is a very important bill that affects a lot of people who live in our province with mental health issues, and it's pretty hard to actually prepare amendments if you don't have a Hansard in hand of the presentations and the questions and answers that were exchanged here today. So I hope that we actually get it before our cut-off.

Mr. Jeff Yurek: That's fair.

The Chair (Mr. Grant Crack): Okay, thank you very much. There's no further business. I would just ask the Clerk to make Hansard as readily available as possible.

I want to thank you all for the great work that you did, and thank you to the presenters this afternoon. I look forward to seeing you on Monday. This meeting is adjourned.

The committee adjourned at 1722.

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