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Monday 30 November 2015

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Lundi 30 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

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON GENERAL GOVERNMENT

COMITÉ PERMANENT DES AFFAIRES GOUVERNEMENTALES

Monday 30 November 2015

Lundi 30 novembre 2015

The committee met at 1400 in committee room 2.

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.

The Clerk of the Committee (Ms. Sylwia Przezdziecki): Good afternoon, honourable members. Owing to the absence of both the Chair and the Vice-Chair, it is my duty to call upon you to elect an Acting Chair. Are there any nominations?

Ms. Ann Hoggarth: I'd like to nominate Daiene Vernile, please.

The Clerk of the Committee (Ms. Sylwia Przezdziecki): Does the member accept the nomination?

Ms. Daiene Vernile: Yes, I do. Thank you.

The Clerk of the Committee (Ms. Sylwia Przezdziecki): Okay. Wonderful. Are there any further nominations?

There being none, I declare nominations closed and Ms. Vernile duly elected as Acting Chair of the committee. Will you come and please take the chair?

The Acting Chair (Ms. Daiene Vernile): The Standing Committee on General Government will now come to order. Good afternoon, members, and welcome to all of our stakeholders who are here with us this afternoon. We are here to discuss Bill 122, An Act to amend the Mental Health Act and the Health Care Consent Act.

We have our first delegation here—

Mr. Jeff Yurek: Point of order.

The Acting Chair (Ms. Daiene Vernile): Yes, Mr. Yurek?

Mr. Jeff Yurek: Before we get into deputations, just quickly to raise a point of order for Hansard: We received this letter from the Ministry of Health. My question to them was whether or not they consulted with the Ontario Medical Association in drafting this bill. They've sent a letter saying they did on September 24. This bill was read in the Legislature on September 23. So the point is that they did not consult with the OMA during the development of this bill. I just wanted to bring that forward after reading this letter we received—

The Acting Chair (Ms. Daiene Vernile): Mr. Yurek, that is not a point of order.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Acting Chair (Ms. Daiene Vernile): I would like to call now on our first delegation: the Registered Nurses' Association of Ontario. Please come forward. Make yourselves comfortable. You will have 10 minutes to speak to our members. Begin by stating your names and start anytime.

Mr. Tim Lenartowych: Wonderful. Thank you very much, Madam Chair. My name is Tim Lenartowych. I'm director of policy with the Registered Nurses' Association of Ontario. I'm also joined by my colleague Dr. Michelle Acorn, nurse practitioner. Michelle is the lead nurse practitioner at Lakeridge Health in Whitby. We both extend our gratitude to the standing committee to be able to provide our feedback on Bill 122. I will begin our presentation and will ask Dr. Acorn to share her experiences as a practising NP. Also, I'll refer you to a written submission that we've also provided that goes into greater depth on our remarks.

RNAO, of course, as you likely know, is the professional association that represents registered nurses, nurse practitioners and nursing students within Ontario.

RNAO understands that Bill 122 is in response to a court decision and that a deadline is looming. However, the Mental Health Act was first passed in 1990. This statute has not kept pace with the dramatic evolution of the health system. Today, the treatment of mental illness has transitioned away from a biomedical focus to one that is person- and family-centred, interprofessional, holistic and recovery-focused.

In the context of Bill 122, we are here to offer some pressing improvements that we feel will enhance the effectiveness of the bill for Ontarians. However, we also urge the government to undertake a more thoughtful update of the Mental Health Act, with meaningful consultation with a broad range of stakeholders, including those people with lived experience as well as their families.

RNAO welcomes provisions in Bill 122 that will enable nurse practitioners to serve as clinical members on

the Consent and Capacity Board. Nurse practitioners are highly educated and experienced professionals who are involved in the assessment of patient consent and capacity on a daily basis, as well as the treatment of mental illness. They will make exceptional clinical additions to the CCB panels to respond to all matters within the CCB jurisdiction.

However, there is a glaring gap in Bill 122 regarding the composition of the CCB panels, and that is the admission of registered nurses. The role of the RN has been growing, and it is reflected in the baccalaureate entry-to-practice requirement as well as the imminent scope-of-practice enhancements that have been committed to by Premier Wynne as well as Minister Hoskins. We know that there are over 4,000 RNs that focus specifically on mental health within the province. These RNs have developed clinical expertise through education and extensive experience. They are often the first point of contact for persons receiving in-patient psychiatric care, and provide long-term follow-up and monitoring for those with chronic mental illness.

Many of these RNs are educated at the graduate level, and also there are over 1,000 in Ontario who are voluntarily certified in psychiatric and mental health nursing. Thus, we recommend in the strongest possible terms that Bill 122 be amended to enable RNs with expertise in mental health to seek appointment as clinical panel members on the Consent and Capacity Board. Appointment to the board occurs through a competitive merit-based process and we trust that the CCB will appropriately assess any application made by an RN, a nurse practitioner or a physician to ensure that the integrity and the expertise of the committee is strengthened.

While the government indicates that the intent of Bill 122 is narrowly focused on the implementation of a court decision, RNAO is compelled to identify a serious patient and public safety risk outside of this decision and the opportunity to remedy it through an amendment to Bill 122. At present, section 15 of the Mental Health Act authorizes a physician to complete an application for psychiatric assessment, known to us as a form 1, under conditions where there is reasonable cause to believe that individuals are at a serious risk of harm to themselves or to others through an apparent mental disorder.

NPs are autonomous professionals and often practise in isolated areas with vulnerable populations. Given that NPs serve as entry points to the health system for thousands of Ontarians, such as through nurse practitioner-led clinics, emergency departments, long-term care and community clinics, RNAO feels that restricting the ability to initiate a form 1 to physicians presents a significant safety hazard. At present, if a patient who appears to be suffering from a mental illness presents to an NP, indicating that he or she is at risk of harming themselves or someone else, the NP is severely limited in their response, posing a risk to the individual accessing care as well as the community.

Authorizing NPs to initiate a form 1 is consistent with the scope of practice of nurse practitioners and aligns with the evolution of the health system. It promotes putting patients first, especially their safety, and it protects the public interest. It improves access to greatly needed care, and it will increase the safety for families and individuals in the community.

Thus, we urge the committee to revise Bill 122 to amend section 15 of the Mental Health Act to authorize NPs to initiate an application for psychiatric assessment, also known as a form 1.

Once again, RNAO greatly appreciates this opportunity and asks for your consideration of our feedback.

It's now my pleasure to ask Dr. Acorn, nurse practitioner, to speak to the impact of RNAO's feedback from a clinician perspective.

Dr. Michelle Acorn: Great, thank you. Good afternoon, everybody. My name is Dr. Michelle Acorn and I'm a nurse practitioner. I'd like to thank the standing committee for the opportunity to contribute as a front-line clinician to RNAO's expert analysis and recommendations to strengthen Bill 122.

In my practice, I work as the lead nurse practitioner at Lakeridge Health in Whitby, as the most responsible provider where patients are admitted under my care and other nurse practitioners' care directly. This is at the Whitby site, which is also a nurse practitioner-led hospital, as you're aware. Patients are admitted under our care throughout their hospital course, from admission and treatment until discharge.

I regularly assess my patients' capacity to provide informed consent for care delivery. I have the ability to appear before the Consent and Capacity Board to inform panel deliberations. I am there to provide an expert clinician voice on consent and capacity issues. However, until now, I am not able to seek a professional appointment to this board.

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The health system is rapidly changing, and access to timely and expert board hearings is critical. Nurse practitioners are ready to participate in the existing comprehensive, merit-based competitive process for professional appointment, and I urge you to support this provision within this bill.

I care for patients on a secured dementia unit, among many other populations. Most of these seniors are afflicted with chronic diseases, including mental illness. The responsive behaviours of dementia are managed by both non-pharmacological and pharmacological options. If de-escalation is unsuccessful, the safety of patients, families and staff can be compromised.

In episodes of delirium—you may know it as acute confusion—and psychosis, patients may require a form 1 to be completed for psychiatric assessment. As Mr. Lenartowych mentioned, currently only a physician can complete these mental health forms. This affects access, accountability and consistent care. The patient's experience is fragmented, and care duplication results.

How is the patient affected, more importantly? They must be transferred to another hospital to be assessed in the emergency room and then by psychiatry to complete

a form 1. The therapeutic relationships and the established goals of care are undermined due to system gaps.

I also provide long-term-care nurse practitioner support in the community. With the new attending nurse practitioner positions advanced by RNAO and funded by the ministry, it would be a shame to continue to hamstring nurse practitioners by legislative barriers, despite possessing the knowledge, skill and judgement to assess and complete the necessary mental health forms. Indeed, a senseless waste of human resources, access delays resulting in sub-optimal patient experiences or harm by the need to transfer care, and blurred professional accountabilities would be the ripple effects.

The Acting Chair (Ms. Daiene Vernile): You have one minute to go.

Dr. Michelle Acorn: The solution is to enable full scope of practice to facilitate consistent and comprehensive navigational access to safe and quality mental health care for Ontarians. This must include authorizing nurse practitioners to complete the necessary mental health forms.

Imagine if you or one of your loved ones was in distress and came to the nurse practitioner. This could be the one window of opportunity to ensure safety and quality of life. What would happen if this moment was lost? Thank you.

The Acting Chair (Ms. Daiene Vernile): Thank you very much, Dr. Acorn. We now have some questions for you, but first I would like to ask our members or anyone who is sitting in the room today if you find the photography distracting. I've been asked to put this before you. Are you okay with having your pictures taken? Okay.

Our first questions for you are from our PC caucus.

Mr. Jeff Yurek: Thank you very much, Chair. You're doing a wonderful job so far—

The Acting Chair (Ms. Daiene Vernile): Thank you kindly.

Mr. Jeff Yurek: —even though you ruled me out of order.

Laughter.

The Acting Chair (Ms. Daiene Vernile): Keep trying.

Mr. Jeff Yurek: Thank you very much for coming in today. It's interesting as we see the evolution of nurse practitioners, as they take a greater scope of practice in our communities. I wouldn't mind if you could touch a little bit more on filling out a form 1 and the necessity in rural and northern areas. If you can touch upon the reasoning—how hard it is to actually get a hold of a doctor?

Mr. Tim Lenartowych: Well, first off, the one option is that you could try to seek a physician for that. You'd have to do it, of course, in a timely manner, because the individual may be in a state of distress—and that isn't always possible. As you wait for that physician, the individual is free to leave of their own free will because they're not under a form at that time.

The other options anywhere, really, but not just specific to rural areas, could be you could go before a justice of the peace to seek a form 2, which in the context of having a patient there in your setting at that particular period of time is completely unrealistic. The third and probably more probable option is you can involve the police, which can have very significant impacts on your therapeutic relationship with the client. Certainly from our perspective, we want to see these individuals receiving care within the health care system, not necessarily having to go through the police to get that. I'm also sure that there are some members of the police who may be hesitant to provide that assistance, given the fact that they may then have to stay in the emergency department for several hours or however long to accompany that individual.

Dr. Michelle Acorn: Thank you, Tim. I would add to that, too. As the nurse practitioner, we are the most responsible provider, given any setting: community, rural, urban, hospital—long-term-care and retirement homes as well. If you're practising in a community health centre, a family health team, a nurse practitioner-led clinic, a hospital or in long-term care, whether it's urban or rural, the nurse practitioner knows the patient. They have a therapeutic relationship established with them. They know their baseline and their health trajectory, as well, and are able to assess capacity and elements of risk and an effort to de-escalate that. They certainly are able to complete the form 1, and obviously they would try to mitigate that if all else is possible, but if a safety issue or threat is in place, that could be easily utilized right now. We complete many other forms, and mental health should be one of those as well.

The Acting Chair (Ms. Daiene Vernile): Our next set of questions for you are from our NDP caucus.

M^me^ France Gélinas: I will ask you a question—I think you started to answer my question even before you heard it.

Dr. Michelle Acorn: Good.

M^me^ France Gélinas: There is a group of people out there who are very opposed to having their loved ones or themselves having a form 1. They're very opposed to this. So when we look at bringing in a nurse practitioner being able to sign a form 1, they see this as a form of—"There's going to be more and more of those, they're not going to be appropriate and this goes against our liberty." What can you tell those groups to reassure them?

Dr. Michelle Acorn: It kind of goes parallel with informed consent and capacity for decision-making, which we're able to assess as well. But if there's an imminent threat of danger, many times when we establish a relationship with patients, we go over what the areas of concern are, and safety being one of those in terms of when we actually need to bring in safety institutes at that point in time. So we certainly are able to do that. We would communicate that as well, but also we have to ensure safety, and we're continuing with the patient along that line.

Tim, what would you add to that?

Mr. Tim Lenartowych: I think the primary objective of any health care provider, whether it be a nurse

practitioner or an RN, is to provide patients with clear and open communication, and if you're approaching it from a patient safety perspective, I think you might get better receptivity to it and also—the intent of a form 1 is, at most, a 72-hour involuntary admission, and in that time it's really meant to generate an assessment. So not to try to minimize those concerns as, "Well, it's only 72 hours"—but certainly there would be opportunity within that 72 hours if patients and families strongly agree that they could have that opinion voiced and addressed.

M^me^ France Gélinas: And would that be for every primary care nurse practitioner or would it only be for nurse practitioners who have the extra psychiatric training?

Dr. Michelle Acorn: No, it would be for every nurse practitioner. I'm actually both a primary care nurse practitioner and an adult nurse practitioner as well. So if you have the knowledge, skill and judgment to be able to do a mental health assessment, certainly it would include those as well.

Obviously, if somebody didn't feel that they had the confidence to do that, we practise in an interprofessional arena so you'd be collaborating with anybody along the way that you didn't feel—just like when you instituted the form 1, obviously you're going to be working with a full interprofessional team to continue on—perhaps maybe that wasn't required or it no longer is required and could be discontinued.

The Acting Chair (Ms. Daiene Vernile): Our final questions for you are from our Liberal caucus. MPP McMahon.

Ms. Eleanor McMahon: Thank you very much for coming today, and thank you for the work that you do as well. I think it's remarkable and important.

In your presentation—there was a lot in there. It's very substance-driven. You talked about issues regarding access, accountability and consistency of care. Would you mind expanding on that a little bit? I think you were talking about it in the context of the form 1 situation.

Dr. Michelle Acorn: For example, I work at Lakeridge Health Whitby where patients are admitted under my care as a nurse practitioner. I'll give you an example of a secured unit right now. If there is a point where safety is threatened to the point of physical violence for patients, staff or families at some point in time, if we are not able to de-escalate that, we try through non-pharmacological measures. We've all been trained in many, many things such as gentle persuasion or sometimes different medication modalities. We try to do a de-escalation first. Very rarely, to be honest with you, in my 27 years of practice, have I ever had to get to that point, but there have been three points. I've also had a youth—we look after people who have mental health challenges—who needed to have emergent ECT therapy, for example. We worked with the patient and the family when they were no longer able to care for themselves and make those decisions. The result was working with a physician at that point in time, a psychiatrist who received a form 1. We did share care because the patient wanted me to remain in their care, and we were able to transfer them to receive emergency ECT on a form and then transfer them back. To this day, he remains in contact with me and thanks us for saving his life and being involved in his care in a respectful, dignified way. But that was a safety threat, where he was at risk of dying.

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The Acting Chair (Ms. Daiene Vernile): Thank you very much. I thank you very much for coming and speaking before this committee today. I invite you to take a seat in our audience, if you wish to.

ONTARIO HOSPITAL ASSOCIATION

The Acting Chair (Ms. Daiene Vernile): I would like to call on our next presenters, from the Ontario Hospital Association. Please come forward. Have a seat. Make yourselves comfortable.

Please begin by stating your names and start anytime.

Ms. Kristin Taylor: My name is Kristin Taylor and I'm vice-president of legal services and general counsel at the Centre for Addiction and Mental Health. Here with me today we have Robert Desroches, vice-president, clinical services, at Waypoint Centre for Mental Health Care; and Kendra Naidoo, who is legal counsel at CAMH, along with myself.

We're here today on behalf of the Ontario Hospital Association, a body that represents Ontario's 147 publicly funded hospitals. The OHA and its member hospitals support the ongoing commitment to improving mental health care across the province and appreciate the opportunity today to speak to the standing committee regarding Bill 122.

To begin our comments, we want to stress our ongoing commitment to ensuring that mental health patients receive the care and services that are the most appropriate for them. We also fully acknowledge and accept the importance of ensuring that the legal rights of our long-term involuntary patients are met throughout the course of treatment and, as such, support the principled approach to the amendments leading us to Bill 122.

It's our shared and ultimate goal to have our patients recover such that they can return to the community and live full and fruitful lives. In order to support the work of the standing committee, we will present four recommendations for you to consider, recommendations that we believe will strengthen the proposed legislation while also ensuring that hospitals are appropriately situated to continue providing the best care to our patients.

Mr. Robert Desroches: Thank you, Kristin. The first area that I'm going to cover is delivering appropriate care and minimizing risk to patients. Ensuring long-term involuntary patients are safe and receive care that is appropriate to their needs is the primary concern of Ontario's mental health facilities.

While the OHA understands that the intent of Bill 122 is to offer additional procedural protections for patients when they are detained under the Mental Health Act, we

also believe that it is important not to disrupt the clinical relationship between a psychiatrist and patient. We believe this clinical relationship is vital to ensuring that there is sufficient flexibility to respond to patients' needs in real time.

The focus of the clinical team at a mental health facility is to try to improve the patient's condition and ultimately reintegrate patients back into the community. The OHA believes that the clinical team's judgement is critical and should be the key consideration in these cases.

The OHA supports the inclusion of specific references disallowing the Consent and Capacity Board from directing or requiring a physician to provide any treatment to the patient, and the patient to submit to such care. However, as written, the proposed Consent and Capacity Board authority may interfere with the clinical team's discretion to develop the patient's plan of treatment on an ongoing basis.

The granting of leaves of absences, changes in security levels and privileges, and decisions regarding supervised and unsupervised community access all have an important clinical dimension. The OHA believes that Bill 122 should be amended to ensure that orders are made with the final determination to be left to the discretion of the clinical team.

Ms. Kristin Taylor: In keeping with my colleague's comments regarding the clinical context of our patients being a prioritized consideration for the CCB, our second recommendation is focused on how Bill 122's procedural framework can assist us in doing that.

Bill 122 sets a very high threshold for hospitals that may wish to vary an order of the CCB. Specifically, a hospital is only able to vary or change an order if the implementation of the order would cause a significant risk of harm. It is our view that this threshold is too high, and I'd like to give an example. In this example, CAMH is ordered by the CCB to provide patient X with an unescorted pass into the community. However, on a specific day, the patient is telling his clinical team that he wishes to abscond or go AWOL. The clinical team is of course concerned by this and doesn't believe that a pass is the appropriate thing to do on that day. However, they would not assess the risk of this to be significantly high to the extent that it would meet the threshold presently defined in Bill 122.

Decisions relating to placement, privileges, community reintegration, assessment and treatment are all part of clinical judgment and are adjusted in accordance with the clinical progress of the patient. These decisions are made on an ongoing basis and may fluctuate frequently.

As presently written, the process for varying or rescinding a CCB order would require an application to the CCB. It's our view that this is an onerous process and a drain on our scarce resources.

Our recommendation to you would be to replace that threshold with a more flexible process that would allow the clinical assessments to determine the process of the CCB orders and determine whether or not they're appropriate to the patient as they present in the moment to the clinical team.

Our third recommendation is addressing the proposed changes to the CCB's focus and mandate. In Bill 122, the CCB is given very similar authority to that of the Ontario Review Board, an administrative tribunal with an oversight role for individuals detained in hospital after an interaction with the criminal justice system.

While the OHA supports providing the CCB with the authority to ensure that patients' fundamental legal rights are protected, we're concerned that the focus and mandate of the ORB are sufficiently different than those of the CCB. As such, using an equivalent ORB analytical framework in CCB decisions is not appropriate.

The ORB's focus is on criminal conduct that's deemed to be a risk to public safety. It's our view that this framework, applied to a long-term involuntary patient under the Mental Health Act, is not appropriate. While involuntary patient status under the Mental Health Act can relate to risk of serious harm to oneself or to others, it typically relates, in long-term patients—to applicable where they are hospitalized to prevent a serious relapse.

The OHA believes that it's crucial to account for the contrasting philosophies and purposes behind the CCB and the ORB review processes. The very language of public safety in Bill 122 creates a whole distinct set of considerations that relate to criminal conduct and punishment, that does not apply in the civil mental health context. This may serve to further stigmatize our vulnerable patients.

The OHA would recommend that Bill 122 be amended to focus on the treatment prospects of involuntary patients and remove language referring to risk to public safety.

Mr. Robert Desroches: The final recommendation we'll be making today relates to the system capacity and hospital resources. This is an important consideration to ensure that Bill 122 is implemented successfully.

The OHA supports the requirement for the CCB to consider the ability of the psychiatric facility or facilities to manage and provide care for the patients and others. This will help to ensure that hospitals have the ability to implement the CCB's orders.

At the same time, it is important to stress that the proposed framework will increase costs, and hospitals have limited ability to absorb these additional costs. Staffing resources remain an important concern with respect to Bill 122. Staffing ratios are carefully calibrated to reflect a patient's needs, the safety of staff and to manage risk. CCB orders have the potential to disrupt these ratios where there are orders to change security level or detention conditions. Hospital staff are also needed for escorts and supervision where there are orders for community access. It is unclear who will offer or bear the cost of vocational, interpretation and rehabilitative services where the hospital does not have them in place.

With respect to system capacity, the OHA is concerned that the CCB orders may impact patient flow. In particular, capacity and the provincial forensic pro-

grams may be impacted where the CCB deems these forensic beds to be the appropriate places for civilly committed patients. Transfer orders also have the potential to impact capacity at individual hospitals, as the ability to take on new patients may be limited.

The OHA recommends a careful assessment of system capacity, staffing resources and patient needs be conducted, including the impact of the proposed changes to the Mental Health Act. Decisions cannot be made in isolation. The available resources for vocational, interpretation and rehabilitative services must also be considered.

1430

The Acting Chair (Ms. Daiene Vernile): You have one minute remaining.

Mr. Robert Desroches: Okay. We hope you have found our comments helpful. Thank you for your time. We're pleased to answer any questions.

The Acting Chair (Ms. Daiene Vernile): Thank you for wrapping up and being right on time. Our first questions for you are from MPP Gélinas.

M^me^ France Gélinas: Thank you very much for your presentation and for the recommendations. They are very useful to us, as we draft amendments.

In your last comments, you were really concerned about resources. Were you consulted before the changes in the tabling of Bill 122?

Mr. Robert Desroches: Do you want to take that?

Ms. Kristin Taylor: We were able to provide feedback. I believe that the OHA was consulted, to the extent that they provided feedback—after the bill, I believe, had been introduced, though.

M^me^ France Gélinas: Okay—

Ms. Kristin Taylor: Oh, they say it was before. Sorry.

M^me^ France Gélinas: Okay. I would be interested in knowing if you were consulted before, because you would have been the only one. We haven't found anybody who has been consulted before. Everybody saw the bill, and then dialogue started. If you have been consulted before, please let us know.

The bill was introduced a little bit over a month ago. We've been talking about it. Have you had an opportunity to look at the financial impact that would have on your organization, or on the hospital mental health system as a whole? A piece of legislation is not that useful if you don't have the resources to carry it out.

Mr. Robert Desroches: I will respond to that question. I would say no; I don't think we've looked at those specific numbers.

As referenced in the presentation, there are concerns about the implications. For example, if the Consent and Capacity Board were to order certain privileges—for example, for a patient to go into the community—and if it wasn't at the discretion at the hospital, and we're having to implement those privileges, that may come at a cost to operations by having additional staffing resources escort that patient into the community. I think that is a primary example.

What the specific cost implications would be—I think that time will tell for that, but I'm confident that there would be cost implications if there is not discretion left with the hospital.

Now, discretion left with the hospital, I think, has to be in the best interests of the patient as well. There's a balance to be achieved there as well.

The Acting Chair (Ms. Daiene Vernile): Thank you very much. Our next questions for you are from our Liberal caucus. MPP Hoggarth.

Ms. Ann Hoggarth: Good afternoon. Thank you for you presentations. My uncle was a guard at the old hospital and lived on the road below, so I spent a lot of summertime there and loved it there.

I understand that the Ontario Hospital Association mental health council was consulted twice about this bill, on August 11, 2015, and September 18, 2015. I know that, like you, our Minister of Health—one priority for all of us is the protection and the safety of all Ontarians.

I just want to ask you a question: Could you please explain your proposal and why it's necessary?

Mr. Robert Desroches: A specific element of the proposal, or one in particular?

Ms. Ann Hoggarth: No. You gave recommendations and I had some difficulty following them, because in your brief, they weren't in the same order. Could you briefly tell the committee how the proposal balances patients' rights with your organization's duty to care for the patient?

Ms. Kristin Taylor: The recommendations, as they are—I do acknowledge that the submission numbers are different from the numbers that we discussed. We wanted to highlight the ones that we felt would be most helpful for the standing committee.

I think what we first and foremost acknowledge is that the recent decision of the Court of Appeal has now provided the requirement that certain legal rights be afforded to our long-term involuntary patients. We fully accept that, and we're moving forward with the assumption that there will be an extra step.

The purpose of our recommendations is to bring the amendments that are going to come to us to a level so that they are very practical for the hospitals and actually implementable—if that's a word—so that we can go forward, when we receive an order from the CCB, with the best intentions for our patients, understanding that the clinical care is first and foremost.

The Acting Chair (Ms. Daiene Vernile): Thank you very much. Our final questions for you are from our PC caucus. MPP Yurek.

Mr. Jeff Yurek: Thank you again, Chair. Thanks for coming in today and giving us a lot to think about.

Maybe you can clarify a point that was raised last week. There were a bunch of patient advocates in who spoke, and their concern with changes to the CCB was the way it's worded in the document. It seems you may have fixed it here with your one recommendation that if the board gives a direction for patient care and/or the patient refuses or the doctor needs to make a change in

order—their concern was you'd have to come back and reconvene the board in order to make that change; otherwise; they'd run afoul. Is that a concern at all, or is recommendation 3 taking care of that?

Ms. Kendra Naidoo: The recommendation to change the language of the provision that says that any orders shall be at the discretion of the officer in charge is targeted at addressing that concern. It gives some scope, as has been articulated, to respond to the changing clinical needs of the patient, both from the treatment team's perspective and from the patient's perspective. That's consistent with the discretion that the ORB currently gives to clinical teams, where all of their orders for passes, privileges or access to the community are made subject to the discretion of the hospital.

Mr. Jeff Yurek: Thank you. They also made mention last week that they think the bill is lacking certain legal input, that we're going to have another case like P.S. in the next year or so and that this bill isn't really addressing those situations. Do you have any comment? Has that come across your plate? I'm speaking of the lawyers' side of things here, sorry.

Ms. Kristin Taylor: I don't think so, at this point. I would certainly hope not, knowing how long that case dragged on, to be back at it again. I think what is being proposed with respect to the charter protections in this new legislation is very clearly there. In fact, I think what our submissions are attempting to do is to balance the protection of the rights, as I said, to the needs of the hospital to be able to operate but, more importantly, to be able to address the needs of the patient in the moment.

The Acting Chair (Ms. Daiene Vernile): Thank you very much. We invite you now, if you wish, to join the public gallery.

CANADIAN CIVIL LIBERTIES ASSOCIATION

The Acting Chair (Ms. Daiene Vernile): I will now call on our next presenter, from the Canadian Civil Liberties Association. Please come forward. Make yourself comfortable. Begin by stating your name and start any time.

Ms. Noa Mendelsohn Aviv: Thank you very much, Madam Chair, members of the committee. My name is Noa Mendelsohn Aviv. I direct the equality program at the Canadian Civil Liberties Association.

I have personally been involved and our organization has been involved in a number of mental health issues over the years. Alan Borovoy, who was the head of our organization for many years, made submissions on Bill 68, known as Brian's Law, in 2000. I made submissions on a similar bill in Alberta, Bill 31, the Mental Health Amendment Act, in 2007. I think most significantly for the purpose of this committee hearing, I worked with counsel on our submissions in the P.S. case, which you've likely heard quite a bit about and which led to the Ontario Court of Appeal last year declaring that provisions of the Mental Health Act were unconstitutional. I'll talk about that in a moment.

I want to just remind everybody on the committee—and I assume you've heard this before so I'll keep it brief that Mr. S. was locked away for 19 years. Some would say he was warehoused; some would say that they locked him up and threw away the key.

While there, almost no one knew about his circumstances. His lawyers knew—came to know; his doctors knew. Mr. S. had a hearing impairment, he had a mental health issue, he had a criminal record and he'd had a terrible childhood. Due to those various factors—the lack of interpretative services, and the fact that he was in a maximum-security facility, which was inappropriate for his needs, as found by his doctors, as found by the CCB itself, the Consent and Capacity Board—he was unable to get the services that he needed. He was unable to get the treatment that he needed. He was subjected to invasive assessments. He agreed to engage in invasive treatments—one was called phallometric testing; that may give you an idea of just how invasive it was—even though he couldn't participate in it fully because there was a sound component which he couldn't hear.

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And for all that, no appropriate services were offered for 19 years—or inadequate services—as found by the Court of Appeal. For all of that, even when he was brought before the Court of Appeal last year, and even though the Court of Appeal was horrified at what they learned, as I imagine members of this committee may have been horrified when they heard his stories—I certainly was—even at the time of that decision, he was still being held in those conditions because the board lacked the authority. There was no legal authority to address his various liberty interests. We need to be absolutely clear: These are liberty interests, which is section 7 of the Canadian Charter of Rights and Freedoms. It is that charter and that section 7 that was violated in the case of Mr. S.

Mr. S., and people like him, are held behind closed walls, with limited resources, limited access to the public, and they need access to justice. The Ontario Court of Appeal, in striking down provisions of the Mental Health Act, said that those provisions violated section 7 of the charter "by allowing for indeterminate detention without adequate procedural protection of the liberty interests of long-term patients."

It's those adequate procedural protections that I want to speak about with respect to Bill 122 today. If we want to put it in other and simple terms, access to justice must be provided—that's what the court said—and it must be provided in a timely and a meaningful manner to long-term detainees in psychiatric facilities. It's their only chance.

We're concerned that this fundamental requirement—it's what the court ordered last year—has not sufficiently been met in this bill. Therefore, the constitutionality of the act will still be at issue.

First and foremost, I think we need to speak to timeliness. It's a procedural matter but a really important one. Justice delayed is justice denied. Having to wait a

year to get an interpreter, having to wait a year to be placed in the appropriate security setting is a very long time. That's what Bill 122 has to offer. The board is precluded from hearing an application for a remedy under section 41.1 if they've made an application for a remedy—one of these special remedies—within the previous 12 months, unless there has been a material change in circumstances. So, Mr. S. would not have been able to come forward for 12 months to ask, once again, to be moved to the appropriate facility. This, obviously, is a matter of residual liberty interests and, as I said before, it's an unacceptable restriction on access to justice.

And I should point out what, I think, must be an error in the bill. The bill doesn't even say that if you went forward and asked for the same remedy under section 41.1 you can't come forward for another 12 months. It says if you come forward and ask for any remedy under that section, you can't come back to the board for one of these special remedies.

I should add as well that there's an imbalance that's not clear to us. The officer in charge can ask for a cancellation or a variance of an order, and the board can set a date and time if it came from the officer in charge of the facility. But if the individual who is living with the consequences of these decisions says that there's a material change and asks to vary or cancel an order, they have to wait for their next review, which might be three months away, and there isn't even a provision for extreme, exceptional or exigent circumstances. So what we recommend, obviously, is to remedy that. Allow the individual, ordinarily, to make their case every three months on their regular review, allow them to ask for special remedies at that time, and allow for exigent circumstances.

Secondly, the authority granted to the Consent and Capacity Board within Bill 122 is certainly an improvement over what it had. It's no longer restricted just to transfer. However, that authority does not apply to all real long-term detainees. Mr. S. himself was considered, at the time that he came before the Court of Appeal, on a voluntary but certifiable status, which means that he was voluntary until he tried to set foot off the premises and then he would have to deal with whatever, from his perspective, frightening occurrence might take place to return him.

Also, if the clock is stopped because, for example, at one point or another, consent is provided or a person's substitute decision-maker provides it, again, that person's status is voluntary.

The point is that people who are spending their time in a psychiatric facility on a long-term basis should be under the auspices of the Consent and Capacity Board. This was one of the matters that was at issue in the P.S. case, and it could be rectified here in this bill by giving the board authority over individuals like that as well, regardless of status. That's our recommendation.

Finally, as to the composition of the Consent and Capacity Board, we think that there is room for this committee to remedy and rectify what is written about the composition, to include a mental health perspective. Currently, the composition of the CCB is simply a lawyer, a doctor and another person or two lawyers, two doctors and another person. What we're suggesting and recommending is that the perspective of the mental health community—both from the medical perspective but certainly from those with a lived experience of the mental health system—should be included in that composition.

On a substantive note—I'll mention them very quickly because I assume I have just a little bit of time left—a few issues where the Consent and Capacity Board does not have sufficient authority to grant the remedies that a person might need: First and foremost, the CCB lacks the authority to supervise the issuance of a community treatment order or, preferably, to order the creation of a non-coercive community-based treatment plan. This is a huge loss. An individual who is in a long-term facility who may be able to get a non-coercive community treatment plan or a CTO should not be spending their time locked up. And this, if we're talking about costs, would be a huge improvement not just for the lives of people who are in these facilities, but also a huge improvement in terms of what it costs the province.

The Acting Chair (Ms. Daiene Vernile): You have one minute remaining.

Ms. Noa Mendelsohn Aviv: Thank you. There is another, I think, error: that the CCB can, of its own volition, order an independent assessment of a person's mental condition, but the individual cannot request such an assessment. More significantly, the CCB is not given the authority to order treatments, medications or therapies, but only vocational, interpretation and rehabilitative services.

The CCB has a doctor in its composition. That's part of what's there. They don't need the advice of a physician. That's another recommendation that we wanted to make. What the CCB needs to be able to do is provide the full gamut. They need the flexibility to tailor to each person the least restrictive, least intrusive means. This is a person whose liberty has been taken away from them; it should be taken away as little as possible. That's our constitutional order. That's what we provide to other people in our community in various circumstances.

The Acting Chair (Ms. Daiene Vernile): Thank you, Ms. Mendelsohn. We're going to go to our questions now, beginning with our Liberal caucus. MPP Milczyn.

Mr. Peter Z. Milczyn: Thank you, Ms. Mendelsohn Aviv, for your presentation this afternoon. It was very informative.

Could you explain to members of the committee your position vis-à-vis the need to further enhance the ability of somebody to seek a review? The legislation does allow for a patient to request a review when there's any material change in their circumstance. That could be any number of things; I'm not going to list the entire gamut of it.

Is that not sufficient? Because otherwise, I don't really understand your position. Your position could be that every week, somebody could ask for the same remedy

that was just denied a week ago. I don't mean to make light of that, but I don't understand how this proposal is insufficient.

Ms. Noa Mendelsohn Aviv: If I think about the details of Mr. S.'s life when he was warehoused in the facility at Waypoint—and he was getting these treatments and getting these invasive therapies—three months is a long time; 12 months is unconscionable in my view. Even if his circumstances haven't changed, even if his functioning hasn't changed, he may come to a point where he wants a reconsideration and a review. It is his liberty and his life that's at stake. This is where and how he's living his life. It's not a circumstance that I think any of us would want, and I think we want to provide maximum protection.

It would be within the power of the CCB to say, "We've looked at this before and what we're seeing is the same," but I think that being able to bring it back before the board would be very important.

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Mr. Peter Z. Milczyn: You also mentioned in your presentation, I believe, that there wouldn't be any need to provide the medical evidence of the people actually giving the care and simply allow the members of the board to make medical determinations. I'm not a doctor, but it would seem to me that the person or persons who actually provide the care might have a broader understanding of what's going on than somebody just reviewing a file.

Ms. Noa Mendelsohn Aviv: Right. I apologize. I was rushing and that did not come out, obviously, the way I had intended. That wasn't what I was trying to say.

There is a provision with respect to leaves of absence, that they can only be granted on the advice of a physician—

The Acting Chair (Ms. Daiene Vernile): I apologize. I have to move on to our next set of questions.

To our PC caucus. MPP Yurek.

Mr. Jeff Yurek: Do you have much to say on that? I'll let you finish.

Ms. Noa Mendelsohn Aviv: Only to say that I absolutely think that physicians should be consulted, including the attending physician. There are circumstances in which abuses of various kinds, intentional or unintentional, are taking place. It's important that the CCB be able to act independently and not be dependent on receiving the advice of another physician. It is within their power to order an independent assessment. They should be able to make independent decisions as well, but they certainly—I agree—should be hearing evidence from attending physicians and otherwise.

Mr. Jeff Yurek: Thank you for that.

Ms. Noa Mendelsohn Aviv: Thank you for the opportunity.

Mr. Jeff Yurek: It seems like you have a lot of amendments or viewpoints. Was the Canadian Civil Liberties Association not available between March and August of this year to talk to the government at all?

Ms. Noa Mendelsohn Aviv: The Canadian Civil Liberties Association would have been delighted to participate in this process. The first we heard of it was about a week and a half ago.

Mr. Jeff Yurek: I'm just wondering, because you seemed to have so much to add, but you weren't consulted until November 9, two months after the bill was in the Legislature.

Ms. Noa Mendelsohn Aviv: I think it is unfortunate that we weren't able to participate earlier than this, and I can assure you, seeing as I was at a meeting on a different issue at 7:20 this morning, that the timing is not how we would have chosen.

Mr. Jeff Yurek: It's just a concern, because the Mental Health Act—there's a lot of updating that needs to occur, and we don't get this opportunity so often. It seems they've missed the boat on this one.

Ms. Noa Mendelsohn Aviv: I'll see if I can find a card, so next time it comes up, you're welcome to give me a call and I'll get involved earlier. Thank you.

Mr. Jeff Yurek: Great. Thanks.

The Acting Chair (Ms. Daiene Vernile): Our final questions for you are from our third party. MPP Gélinas.

M^me^ France Gélinas: My first question has to do with the constitutionality of what we have now. Do you think that what we have now, if we make no modifications, like you have suggested—if we don't take those into account, do you figure it will pass the constitutionality test or not?

Ms. Noa Mendelsohn Aviv: I think there are two answers that need to be given—to the question that you asked and to the question that you didn't ask but is implied in it. I believe that if a person like Mr. S., came before the court again, who was voluntary but certifiable, for example, or who had had the period of their detention cut up for various reasons so that they weren't technically under the auspices of the board and they had no accessible access to justice, yes, I believe that's exactly what the Court of Appeal was saying, that that's unconstitutional. A 12-month lag also seems to me very long. Other liberty interests, with respect to detention in the Charkaoui case before the Supreme Court of Canada—six months was considered to be too long without a review. Now, this is a residual liberty interest, so I don't know what they'd have to say in this circumstance.

I think the question that is also implied here is: When would it come back before the court? Whether it would be challenged—in the case of Mr. S.—or whether somebody else would have to sit locked up behind bars in an inappropriate place for another 19 years before they could find a lawyer who could take it forward, who could get it appealed, who could get it before a court—that's the really sad and frightening part of this, that it may take a very long time before a court gets its hands on it and says, "Come on, Ontario Legislature. You have the opportunity. Make a change that's going to be meaningful in the lives of people."

M^me^ France Gélinas: So the voluntary versus the involuntary and the time frame for sure have to be fixed—

Ms. Noa Mendelsohn Aviv: And the authorities of the board to address the full gamut of residual liberty interests, including treatments and assessments, absolutely.

M^me^ France Gélinas: Okay. You talked about wanting the perspective of a person with lived experience. I understand that other provinces have made the change, and you see this as an opportunity for us to do the same.

Ms. Noa Mendelsohn Aviv: That's right.

M^me^ France Gélinas: The nurse practitioners have also asked to be considered to be on the Consent and Capacity Board. Do you have any opinion on that?

Ms. Noa Mendelsohn Aviv: I don't have a position on that at this time.

M^me^ France Gélinas: They've also asked to be able to sign form 1s. Would you have an opinion on that?

Ms. Noa Mendelsohn Aviv: I don't have a position on that now.

M^me^ France Gélinas: I just wanted to make sure.

Then, under the community treatment orders, CTOs—I'm not exactly clear if this is something you want us to know or if this is something that you want us to change in the bill.

Ms. Noa Mendelsohn Aviv: What I said with respect to community treatment orders is that the CCB should have the authority to provide the less restrictive measure of a CTO and to supervise the issuance of a CTO. At the same time, the Consent and Capacity Board should also have the authority to order a less coercive means, such as a community treatment plan, without it being coercive on the individual—because we understand, based on the research that we've done on CTOs, that those are effective and less coercive.

The Acting Chair (Ms. Daiene Vernile): Thank you very much for appearing before this committee. I invite you to join the public gallery now, if you wish.

COALITION OF ONTARIO PSYCHIATRISTS

The Acting Chair (Ms. Daiene Vernile): I will call on our next presenter, the Coalition of Ontario Psychiatrists. Please come forward.

Good afternoon. Please begin by stating your name.

Dr. Thomas Hastings: My name is Dr. Thomas Hastings.

The Acting Chair (Ms. Daiene Vernile): Begin anytime.

Dr. Thomas Hastings: On behalf of the Coalition of Ontario Psychiatrists, I'd like to thank the committee for affording us the opportunity to present our views today. This presentation summarizes our written submission and is complemented by a letter that has been attached to that submission from a family with lived experience.

The coalition was formed in the 1990s and represents over 2,000 psychiatrists in Ontario. We consult with other stakeholders, including the Ontario Psychiatric Association and the Association of General Hospital Psychiatric Services.

We have grave concerns about replacing psychiatrists on hearings of the Consent and Capacity Board related to mental health issues. Only three provinces allow any physician; the rest require a psychiatrist to sit on their panels; and none allow nurse practitioners. The board's expert standing comes from the specific expertise of its psychiatrist, lawyer and community membership. The board has a duty to clarify the unique and complex issues before it on a daily basis. This requires nuanced psychiatric knowledge and expertise. It is also impossible to predict the complexity of issues faced at hearings to allow for the assignment of less expert professionals to less complex hearings.

As the vast majority of mental health case law comes from appeals by patients hospitalized for less than six months, a psychiatrist is needed for all such hearings, not just those after the six-month period. Replacing psychiatrists diminishes the board's expertise, risking unfavourable judicial review if their decision is appealed to court.

Furthermore, this change proposed was not required by P.S. v. Ontario, and appears to have been added to address a shortage of psychiatrists on the board. The board changes were made without meaningful engagement of psychiatrists to help inform the ministry of the potential impact of the bill on hospital-based mental health care. This flawed process risks flawed policy.

The coalition is open to future consultation and wants to assist the ministry in solving the problem without the negative consequences of the current proposal. Potential solutions include changing the time frame for board hearings from seven to 14 days for the majority of hearings; alternatively, facilitating treatment to reduce the number of hearings related to incapable patients requiring ongoing hospitalization due to treatment refusal.

We submit that Bill 122 be modified to ensure relevant physician expertise is present at all board hearings, and continues to require a psychiatrist for all mental health-related hearings, or remove any reference to board composition changes for future reconsideration after due consultation.

Our other concern is the missed opportunity for Bill 122 to address the issue of treatment delays. P.S. v. Ontario, the decision precipitating Bill 122, identified the expectation that involuntary admitted patients will receive treatment. I quote from paragraph 195: "A dominant theme of modern mental health care policy—minimizing hospitalization and maximizing rapid return to community living. The involuntary committal provisions of the" Mental Health Act "are tailored to deal with urgent situations where an individual requires immediate treatment to avoid harm to him or herself or harm to others. Certifications typically have a short life. The short periods ... form a statutory pattern that indicates an expectation that the risk of harm can ordinarily be resolved by treatment...."

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"In the case of a short-term committal, the immediate issue for the CCB is whether or not the patient is certifiable. If he ... is certifiable, treatment will be pro-

vided and the patient will generally be released within a relatively short" time frame.

In actual fact, under current law, treatment is often delayed for months. Interim treatment orders are inadequate for reasons that are outlined in our written submissions.

In 2010, after 18 months of public consultation, the all-party Ontario Select Committee on Mental Health and Addictions, led by current Liberal cabinet minister and MPP Kevin Flynn, with representation by three other Liberal cabinet ministers—Dr. Helena Jaczek, Liz Sandals and Jeff Leal—as well as current NDP MPP France Gélinas, presented their finding. This committee confirmed "the excessive and unnecessary suffering permitted under our current legislation" and expressed certainty that these harms could be avoided through legislative or policy change, ensuring that involuntary admission must also entail treatment and "that the right to autonomy must be balanced with the right to be well."

We would suggest that an appropriate balance of rights is struck in the stated purposes of our current Health Care Consent Act. I quote from section 1:

"(b) to facilitate treatment ... for persons lacking the capacity to make decisions about such matters;

"(c) to enhance the autonomy of persons for whom treatment is proposed ... by,

"(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding...."

Linking the need for treatment with involuntary admission and permitting treatment pending appeal is in fact legislated in multiple other provinces; it's not a new concept. The government correctly notes that the majority of people in psychiatric facilities for longer than six months have mood and psychotic disorders. These disorders are highly responsive to current Health Canada-approved medications. Incapable refusal of these medications contributes to the otherwise unnecessary detention of these individuals.

A 2002 10-year Ontario study of two psychiatric hospitals found the board overturned 1.5% of over 300 incapacity findings; this suggests that psychiatrists accurately assess capacity. Fifteen patients appealed the board's decisions around finding these patients incapable to the courts, and none were successful. This confirms the board's expertise in its current composition.

In the absence of court appeal, the average delay in initiating treatment was 25 days versus 253 days for appeals. Based on a 15-day length of stay, appeals blocked treatment of 129 patients. Direct hospitalization costs per patient appeal were $90,000. Several variables make this a substantial underestimate of the actual system costs, including the increased cost per bed day since, an increasingly legalistic climate as evidenced by the rapidly growing number of Consent and Capacity Board hearings, and the recent increase in legal aid funding to support appeals independent of merit.

Indirect costs of treatment delay include longer hospitalizations, increased seclusion and restraint use, family suffering and breakdown, loss of employment and housing for the individual, legal aid fees, backups of patients in emergency rooms and courts, and potential premature discharge of patients due to bed shortages with negative outcomes, including suicide and violence to others. Preventing treatment with Health Canada-approved medication pending appeal is based on the concern that despite the board's confirming the person's treatment and capacity, some people might receive treatment the courts later find they were legally capable of refusing.

A study of all Ontario psychiatric facilities from 1990 to 2005 reviewing outcomes for all patient appeals demonstrated that this was not the case: The court reversed a finding of incapacity confirmed by the board in only three cases. All three patients were eventually legally treated. Their successful appeal nearly delayed treatment by years, during which time they remained involuntarily detained, spending significant periods in solitary confinement as a result of being untreated. Only when treatment was provided was their freedom restored. The court appeals did not prevent a single person from eventually receiving medication, so no actual benefits offset the very real harms caused by current law.

While acknowledging Justice Molloy's comment in the Gunn v. Koczerginski case, we submit that the known harms of lengthy, involuntary hospitalization caused by incapable treatment refusal of Health Canada-approved medication result in far greater infringement of a person's right to self-determination, physical integrity, liberty and security than ensuring treatment does.

We call for an amendment allowing the immediate treatment of incapable patients with substitute consent following confirmation of treatment incapacity by the board.

In closing, I share Supreme Court of Canada Chief Justice Beverley McLachlin's perspective on the right to treatment:

"Our law governing hospitalization and consent continues to grapple with the challenges of appropriately balancing the autonomy and dignity of mentally ill persons with their right to treatment.... The challenge for the law is to keep pace with medical developments and ensure that the legal regime governing mentally ill persons is responsive to the current state of scientific knowledge. Our common challenge as doctors and lawyers is to work together in addressing the problems posed by mental illness. Laws cannot heal people, only services and treatment provided by medical professionals can achieve that ultimate goal. But the law can create a social and regulatory environment that assists medical professionals in delivering their services in a manner that is both ethical and respectful of the rights and needs of the mentally ill."

We submit that the proposed amendments from the coalition meet that balance. Thank you.

The Acting Chair (Ms. Daiene Vernile): Thank you, Dr. Hastings. Our first questions for you are from our PC caucus, from MPP Thompson.

Ms. Lisa M. Thompson: I was taken by a comment that you shared during your deputation. You mentioned

that a flawed process leads to flawed policy. There's a bit of a trend here. The legislation was introduced in September for first reading, and I couldn't help but notice that your stakeholder consultation date didn't fall until October 16, 2015, so a significant amount of time after first reading actually occurred. How do you feel about that, and what could the government have done differently to get your perspective on Bill 122?

Dr. Thomas Hastings: As the decision came out in December 2014, P.S. v. Ontario, the coalition feels that it's unfortunate that our input wasn't sought earlier, given our representation of over 2,000 psychiatrists, including consultation with other organizations that are involved in delivery of care—most affected by this bill, specifically hospital-based psychiatric patients. We feel that we may have had some suggestions that could have, at an earlier point in time, shaped the direction of the bill, perhaps in a way that would avoid some of the harms we're concerned may occur if the bill is not amended.

Ms. Lisa M. Thompson: Okay. I appreciate that. And you feel you've been able to put forward those suggestions adequately with your recommendations in the deputation documentation that you shared today?

Dr. Thomas Hastings: Yes.

Ms. Lisa M. Thompson: Okay. Thank you. We'll be taking a look at that as well.

We heard earlier today a deputation with regard to the involvement of nurse practitioners and their interest in being able to sign a form 1. Can you go back and reiterate your organization's position on that?

Dr. Thomas Hastings: What I can say is that we are in support of nurse practitioners being able to complete form 1s. The reason for this relates to the purpose of a form 1, which is to allow for a psychiatric assessment to occur. We certainly respect that nurse practitioners are highly skilled and valued professionals, that they often provide significant amounts of mental health care, including in more remote geographical areas, and that their involvement in helping patients access mental health care is at times critical. This would be one way to help patients get care.

Ms. Lisa M. Thompson: Very good. I appreciate that. Thank you.

The Acting Chair (Ms. Daiene Vernile): Thank you. Our next question for you is from our NDP caucus. MPP Gélinas.

M^me^ France Gélinas: Thank you for coming. I wanted to ask your opinion about—I think it's in there—the voluntary, as in the person is staying in for a long period of time but not on form; if he goes out, he'll get formed, but staying in voluntarily. Others have said that those people should be allowed a review in front of the CCB like everybody else. Would you agree with that?

Dr. Thomas Hastings: The question you're posing is in fact highly complicated. I would suggest that it would be exceedingly rare for a patient to be a truly voluntary patient staying in hospital for six months.

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Sometimes you run into a more complicated position where a patient is voluntary, but if they try to leave, they're certified. I don't really see that as being a patient who is truly voluntary.

I'm not sure I can say more to it than that, because it would really depend on the specifics of individual cases.

M^me^ France Gélinas: Okay. You have experience—I'm sure you've had patients in your practice who had—would they benefit from having a hearing with the CCB or no?

Dr. Thomas Hastings: Our sense is that the provisions that are currently allowed—to have reviews as the legislation suggests and in that time frame—are reasonable. I think you can have hearing fatigue in circumstances where unnecessary hearings may be called for.

The government really needs to strike the appropriate balance in terms of the frequency of hearings. I think, in that part of the legislation, we're comfortable.

M^me^ France Gélinas: At the beginning, you sort of scared me a bit when you were going through the example where the process would be so onerous that maybe hospitals that are cash-strapped may decide, basically, to put pressure on their psychiatrists so they do not go forward and hold people on form; that it would be easier to avoid all of this and let him go back into the community and let the police deal with it—because if they don't get treatment, that's usually who ends up dealing with it. Did I read that wrong, or were you telling us that?

Dr. Thomas Hastings: I'll speak from personal experience rather than from the coalition, to answer that.

I do provide mental health education across Ontario. It's my personal view that that happens frequently, that physicians are pressured to release patients for financial or reasons of backups in hospitals—

The Acting Chair (Ms. Daiene Vernile): Thank you very much. We go to our final questions for you now with MPP Rinaldi.

Mr. Lou Rinaldi: Thank you, Doctor, for a very detailed presentation today. It's much appreciated.

I have a question, and maybe you could be a little bit more specific and give us some more details. Can you explain to us the difference between complex and non-complex hearings, and why it is necessary for psychiatrists to sit on the board for complex hearings?

Dr. Thomas Hastings: That was really a reference to the government's language where they implied that hearings longer than six months were more complex and therefore required psychiatrists. It had to do with the implementation of the new duties being designated to the Consent and Capacity Board.

I actually think of it differently and think that the earlier hearings, ironically, may be more complex, because these are the patients who are still acutely unwell, where their histories are relatively new and uncertain.

It was really that the use of "complex" and "less complex" was in relation to the government's language. I feel all hearings are potentially complex. You simply cannot know in advance of the hearings what will be raised and what complexity of legal issues may be raised at hearings from the very get-go.

Mr. Lou Rinaldi: So there shouldn't be two classifications, then, as far as you're concerned?

Dr. Thomas Hastings: I don't think there should be two classifications. I think psychiatrists and psychiatric expertise, and the nuanced understanding of mental health issues, is required at every single hearing that's related to mental health issues.

Mr. Lou Rinaldi: Very good. Thank you very much.

Dr. Thomas Hastings: Thank you.

The Acting Chair (Ms. Daiene Vernile): Thank you, Dr. Hastings, for appearing before this committee today. I invite you now to join our viewing gallery, if you wish to.

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Acting Chair (Ms. Daiene Vernile): I'd like to call now on our next presenter, with the Nurse Practitioners' Association of Ontario. Please come forward.

Please begin by stating your name and start anytime.

Ms. Theresa Agnew: I'm Theresa Agnew. I'm the executive director of the Nurse Practitioners' Association of Ontario.

We have provided a slide deck for you this afternoon, and so I will quickly go over those. Some are meant as a review, to provide a very quick context.

M^me^ France Gélinas: Clerk, do we have a copy of the slide deck?

Mr. Lou Rinaldi: Yes.

Ms. Ann Hoggarth: It's in the folder.

M^me^ France Gélinas: It's in the folder?

Ms. Theresa Agnew: Yes. Thank you.

I am the executive director of the Nurse Practitioners' Association of Ontario. I am also a primary health care nurse practitioner. I've been practising in the province of Ontario as a registered nurse and as a nurse practitioner for more than 30 years. I'm here today to speak about NPAO's position on Bill 122.

NPAO is the professional association representing more than 2,600 nurse practitioners in Ontario. We also are responsible for providing evidence-based professional development, member engagement and networking opportunities as well as advocacy services. We act as the de facto bargaining agent for nurse practitioners in Ontario.

As of November 1, 2015, there are more than 2,662 nurse practitioners in Ontario. They hold a number of specialty certificates. Approximately 2,000 hold a primary health care specialty certificate; 500 with an adult specialty certificate; 200 with pediatric; and we have six who are nurse practitioner anaesthetists but are not yet certified within the college for that.

Approximately 36% of nurse practitioners work in hospital and 59% work in the community, with 3.1% working in long-term care. But we have nurse practitioners working across the health care system and in correctional facilities, colleges and universities etc.

At this point in time, nurse practitioners are able to prescribe all medications with the exception of controlled drugs and substances. Nurse practitioners are authorized to order all laboratory tests and interpret them. In Ontario, nurse practitioners are authorized to order most diagnostic imaging tests. In Ontario, nurse practitioners are also authorized to admit, treat and discharge hospital patients. Nurse practitioners are prepared at the graduate level and also must meet rigorous quality assurance stipulations set by the College of Nurses of Ontario.

NPAO supports the amendments currently proposed in Bill 122, An Act to amend the Mental Health Act and the Health Care Consent Act. NPAO supports utilizing nurse practitioners and physicians/family doctors on capacity and consent boards. This helps to ensure appropriate health human resource utilization, thereby freeing up psychiatrists for more complex cases and also, quite frankly, for direct care.

The proposed amendments recognize the significant role that nurse practitioners play in the health care system. They're currently providing safe, cost-effective and holistic patient care.

In addition, NPAO recommends that changes be made to Bill 122 to provide nurse practitioners with the authority to complete a certificate for involuntary admission; a certificate for a renewal or a certificate for continuation, as proposed; and issue and order community treatment orders. Such proposed additional changes would help to ensure the right care by the right provider who knows the client best, in the right setting, as close to home as possible, for the best value.

In the community, nurse practitioners act as the primary care provider for their clients. They know their clients best and yet they cannot refer a client for an involuntary psychiatric assessment. In other words, they cannot complete a form 1 under the Mental Health Act.

If a physician is not available—and many nurse practitioners work in remote, underserviced areas—often the police or OPP are called and the assessment is done under a form 2. Unfortunately, with no disrespect meant to my colleagues in law enforcement, this can sometimes have the unintended consequence of escalating the threat of harm and/or traumatizing the client, leading to further complications.

Nurse practitioners are currently authorized to admit, treat and discharge hospital patients. Nurse practitioners in hospitals across Ontario now act as the most responsible practitioner for patients while in hospital. Yet, they cannot refer a client for an involuntary psychiatric assessment. To me, this does not make sense, and there needs to be an alignment of the legislation.

In long-term-care homes, nurse practitioners also act as the attending practitioner and/or the most responsible practitioner. Some of those patients sometimes need to be formed for their own safety and for the safety of other residents. As nurse practitioners cannot yet complete a form 1, they often have the resident transferred to an emergency department, where they may be assessed by someone who does not know them as well, does not know the context and does not know the potential for harm to self or harm to others that that resident may have.

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In conclusion, NPAO is proposing support of these amendments, as nurse practitioners currently work across all practice settings, certainly including mental health and addiction. We are a self-regulated profession, adhering to standards of practice, and we must also assess our own competence, knowledge and skill in various areas of expertise.

Nurse practitioners are increasingly providing primary care services in underserviced rural and remote communities throughout Ontario, including 25 nurse practitioner-led clinics that provide care to over 65,000 patients across Ontario. Nurse practitioners often work with the most vulnerable populations, including orphaned patients, some of whom have very complex needs.

We believe that nurse practitioners know their patients best and enabling authority is safer for patients, reduces harm and promotes better outcomes. Thank you.

The Acting Chair (Ms. Daiene Vernile): Thank you very much, Ms. Agnew. We begin our questioning for you with our third party.

M^me^ France Gélinas: Well, you were in the room when Dr. Hastings was talking about the need to have psychiatrists on the Consent and Capacity Board. What are the arguments for and against? He made a compelling case that you never know what's coming and you need the expertise of a psychiatrist to get it right, and the body of evidence so far shows that they got it right, most of the time. Do you see a risk if we now open it up to family physicians and nurse practitioners?

Ms. Theresa Agnew: I think that in an ideal world, the optimal situation would be to have psychiatrists involved on the Consent and Capacity Board. However, the population of Ontario, currently at about 13.6 million people and widely dispersed geographically, doesn't always permit that.

I'll speak from personal experience. I worked up in the Moose Factory zone and I provided care to the people of four small communities there: Peawanuck, Attawapiskat, Fort Albany and Moosonee. There, we had a psychiatrist who was able to fly in to that community once a month.

When I think about what Ontarians are faced with in terms of the need for services and what is currently available, I do think that it makes sense, from a health human resources perspective, that nurse practitioners and/or family physicians could be involved in consent and capacity.

M^me^ France Gélinas: So would you see a nurse practitioner who has a qualification in psychiatry called to the Consent and Capacity Board?

Ms. Theresa Agnew: Yes, absolutely. I know that you heard earlier from my colleague Michelle Acorn. Michelle has done a great deal of work on assessment of clients with dementia. We have other nurse practitioners as well who have expertise and have done their doctoral work in caring for people with psychiatric disorders.

M^me^ France Gélinas: There are people who feel that form 1 should not be used because they do not want to have a psychiatric assessment against their wish, and to give nurse practitioners the opportunity to do this will just increase the number of people. What do you say to them?

Ms. Theresa Agnew: It would actually provide the most appropriate person, a person who likely knows that client, has a relationship with that client and has been involved in their care rather than, unfortunately, sometimes having to call the police or the OPP to have that involuntary assessment.

Again, I will draw from a personal experience without giving any identifying information. I had a client in my own practice who had paranoid schizophrenia, who had gone off her medication and was posing a risk to both herself and members of her community. We didn't have a physician available, and I had primarily seen this client and had assessed this client within the last seven days and a physician had not. I did end up having to call the police to bring that client into custody so that she could be assessed.

I went at my lunch hour to see how things were going. There were four ambulances, five police cars, a SWAT team, a police officer rappelling down her apartment building. She had apparently barricaded herself into her apartment but was additionally traumatized by the entire experience, whereas I could have gone myself and assisted her and taken her to hospital.

The Acting Chair (Ms. Daiene Vernile): Thank you very much. Our next set of questioning for you is from our Liberal caucus. MPP Kiwala.

Ms. Sophie Kiwala: Thank you very much for appearing here today. I very much appreciate your testimony. As somebody who had worked for seven years, previous to coming to this role, in a federal constituency office, I've been exposed to quite a number of individuals who have suffered from rather severe mental health issues, and I can totally relate to the last case that you just identified. We have a frequent flyer that comes to our office and regularly avails herself of emergency services, so I can see the benefits to having nurse practitioners provide the additional services when you are so familiar with the cases.

What I would like to focus on for this question is, the legislation is being amended to allow nurse practitioners to sit on the board to hear non-complex hearings. I'm wondering if you can elaborate a little bit more on why this is so important.

Ms. Theresa Agnew: I think that it's important now but it will become increasingly important with the so-called greying of our society, and with more individuals within our society facing issues of dementia and requiring capacity hearings, and also having family members who are concerned about their ability to make an informed consent. I see this as an issue which we have to be proactive about and we have to have a better way to respond across the province.

Ms. Sophie Kiwala: Again, I just want to say thank you for the work that you do in the communities. I can certainly say that I echo the same goodwill towards the nurse practitioners in Kingston and the Islands as well;

they do amazing work for us. So thank you for being here today.

Ms. Theresa Agnew: Thank you.

The Acting Chair (Ms. Daiene Vernile): Our final set of questions for you are from our PC caucus. MPP Thompson.

Ms. Lisa M. Thompson: Thanks again for being here. You've made it real in terms of how nurse practitioners play such an important role in the overall mix in front-line health care. Again, thank you for that.

It's interesting to me: Given the significant role that you play, I did not see where your organization was consulted with after the legislation was developed. I'm just wondering if you could share your thoughts as to why that happened.

Ms. Theresa Agnew: We were made aware of Bill 122 approximately a week and a half ago.

Ms. Lisa M. Thompson: Oh, for goodness' sake.

Ms. Theresa Agnew: We would have been more than pleased to provide a consultation prior to this and prior to the first reading of Bill 122, but we were not called upon to do so.

Our organization is fairly small and lean, so I don't think that this slipped between the cracks, unfortunately.

Ms. Lisa M. Thompson: Okay. I appreciate it very much. We certainly will take your recommendations and thoughts forward as we build our amendments.

Ms. Theresa Agnew: Thank you very much.

The Acting Chair (Ms. Daiene Vernile): Thank you very much, Ms. Agnew, for appearing before this committee today.

Committee members, before we adjourn for the day, I have couple of important announcements to share with you. Please take note of this: The amendments to Bill 122 need to be filed with the Clerk of the Committee by 12 noon on Tuesday, December 1, 2015—that's tomorrow; and that the committee is going to meet on Wednesday, December 2, 2015, during its regular meeting time for clause-by-clause consideration of Bill 122.

Are there any questions or any feedback?

M^me^ France Gélinas: Can we ask Hansard to work as fast as their little fingers can to get us the Hansard of the—I tried taking notes as fast as I could; some of those people speak way faster than I'm able to write down. Even if they gave us a draft, it will be better than my notes.

The Acting Chair (Ms. Daiene Vernile): Can we speak to that? How soon do you think that will be filed?

The Clerk of the Committee (Ms. Sylwia Przezdziecki): There are channels by which the committee can request that the committee Hansard be prioritized. I believe this was already done for the public hearings on Bill 122, which means that after the Hansard for the House is complete, then the next committee they would work on would be ours. There was a priority put on last week's meeting too. The House is always the priority; it's available the next day. Once the House Hansard is put to bed, they can start working on this committee.

M^me^ France Gélinas: Okay, good enough. Do your best. God bless.

My next question is that when—actually, it was Cindy who was there for me last week. We asked for a copy of the list of the stakeholders and groups that were consulted before Bill 122 was tabled, and I don't seem to have received that.

Interjection.

M^me^ France Gélinas: It should be on my desk? Are you talking about this here?

The Acting Chair (Ms. Daiene Vernile): Yes.

M^me^ France Gélinas: So that's it? Okay.

The Acting Chair (Ms. Daiene Vernile): Committee members, thank you very much. It's been a pleasure sitting with you this afternoon. This committee stands adjourned.

The committee adjourned at 1531.

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