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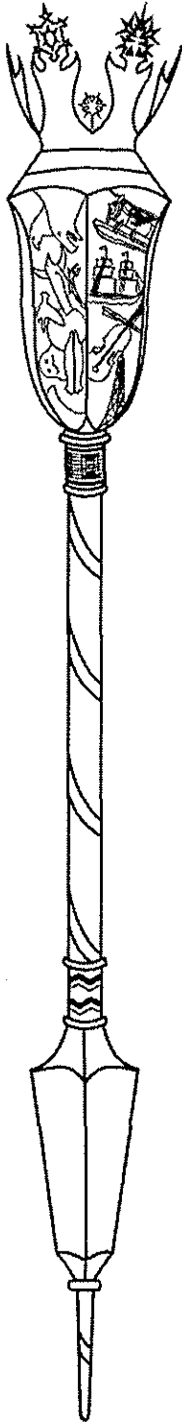

17th Legislative Assembly of the Northwest Territories

Standing Committee on Social Programs

Report on the Review of
Bill 55: *Mental Health Act*

Chair: Mr. Alfred Moses

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Legislative Assembly
Standing Committee on Social Programs
Assemblée législative
Comité permanent des programmes sociaux

October 7, 2015

SPEAKER OF THE LEGISLATIVE ASSEMBLY

Mr. Speaker:

Your Standing Committee on Social Programs is pleased to provide its Report on the Review of Bill 55: *Mental Health Act* and commends it to the House.

Alfred Moses, MLA
Chairperson

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**STANDING COMMITTEE ON
SOCIAL PROGRAMS**

**REPORT ON THE REVIEW OF
BILL 55: *MENTAL HEALTH ACT***

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STANDING COMMITTEE ON SOCIAL PROGRAMS

REPORT ON THE REVIEW OF BILL 55: *MENTAL HEALTH ACT*

INTRODUCTION

Bill 55: *Mental Health Act* will replace the existing *Mental Health Act*, which is out of step with national and international standards. Notably, the new *Act* will authorize the use of community-based psychiatric treatment and provide better protection for patient rights by establishing a review board for hearing complaints.

The Standing Committee on Social Programs thanks the Minister of Health and Social Services for introducing Bill 55 within the life of the 17th Legislative Assembly. This is a significant achievement. The Bill was referred to the Committee on June 2, 2015. The public hearing with the Minister was held on August 24, 2015. The clause-by-clause review was held on October 5, 2015. With the Minister's agreement, twenty-seven motions to amend Bill 55 were passed at the clause-by-clause review. These amendments are discussed below, along with a large number of recommended actions.

During its review, the Committee heard from well over one hundred residents and stakeholders. Public meetings were held in Yellowknife, Inuvik, Norman Wells, Tulita, Fort Smith, Fort Resolution, Hay River, Kakisa and Fort Providence. Seventeen written submissions were received from the Northwest Territories chapter of the Canadian Bar Association; Elaine Keenan Bengts, the Northwest Territories Information and Privacy Commissioner; the Status of Women Council of the NWT; Jane Arychuk, President of Aurora College; the Union of Northern Workers; the British Columbia Civil Liberties Association; Chief Joachim Bonnetrouge of the Deh Gáh Got'ie First Nation; James and Connie Boraski and Ian Henderson; an advocate for the rights of persons with disabilities; a social worker in private practice; and a handful of GNWT employees, community advocates, and private residents.

Bill 55 generated a vast amount of commentary and criticism. More than fifty potential amendments were brought forward for consideration, along with roughly twice that number of recommended actions. During the review, the Committee simultaneously laboured over the intricacies of legal terminology and kept the big picture in view, enumerating recommended actions that, if implemented, will usher in a healthier future for the people of the Northwest Territories.

NEW LEGISLATION IS NOT A CURE-ALL

In the communities visited, discussion about the proposed legislation was often eclipsed by testimonies of struggle to overcome trauma, abuse, addictions, family violence and community dysfunction. The people's pain was plain to see, and

seemed to stem from a few primary sources: the colonial history of the Northwest Territories, the legacy of residential schools, and failures in the provision of mental-health services.

Like the existing *Mental Health Act*, the new *Act* will focus primarily on treatment of people with psychiatric disorders. Each year in the Northwest Territories, roughly two hundred patients are involuntarily admitted into our territory's four designated facilities, located in Yellowknife, Fort Smith, Hay River, and Inuvik. Like the existing *Act*, Bill 55 is silent on the topic of addictions and substance abuse, even though these problems often coexist with psychiatric disorders. Indeed, it is ironic that, despite its official title, the Bill defines a "mental disorder" but does not define "mental health." In any case, the reality is that mental health and mental illness exist on a continuum. Likewise, mental-health services include a spectrum of activities, from prevention and early intervention to therapeutic counseling and in-patient hospital care. So, in the words of one NWT resident, "what we need is a companion *Act* for the *Mental Health Act*. This here is a Mental *Illness* Act. We need a Mental *Wellness* Act. There's a bit of funding here and there, but it's really just a patchwork of services." For all intents and purposes, the Mental Health and Addictions Action Plan may be thought of as that companion *Act*, and, to that end, the Committee is calling for substantial enhancements to it.

At the public hearing, the Minister admitted that "there are gaps in our current mental health system and residents are falling through the cracks; it is clear that change is urgently needed. This legislation will fill in those gaps and modernize the current mental health framework." The Committee agrees that there are gaps in the system, but does not agree that new legislation will address them all. In fact, this sort of claim only generates false expectations. As legislation goes, Bill 55 is better than the existing *Act*. But by itself, new legislation offers no guarantee of better services. Accordingly, if this report contains a primary take-home message, it is that new legislation is not the cure-all solution. By way of illustration, the Committee learned that the Department's implementation plans include spending an additional $500,000 annually on new positions at headquarters, with no new allocations for services in the communities. Under such circumstances, the scope of positive change will be modest at best. Overall, stronger political will, more effective leadership, and substantial new funding will be required if mental-health services are going to be delivered when—and where—people need them.

ABORIGINAL CULTURE AND THE ROLE OF ELDERS

In an eloquent statement at the public meeting in Fort Providence, Chief Joachim Bonnetrouge said, "the *Mental Health Act* should be written for the people it serves." The Committee wholeheartedly agreed and made a point of incorporating provisions on aboriginal culture and the role that elders play in promoting mental and emotional wellness.

The preamble to the current *Act*, which was not carried over into Bill 55, recognizes the many cultures of the peoples of the Northwest Territories and stipulates that an

elder must be consulted when an assessment is being made about the mental state of an aboriginal person. The Committee asked why the preamble had been removed, and the Department responded by citing concerns that it might be used to interpret the legislation in outdated or unintended ways. The Committee disagreed with this logic, asserting that respect for culture is never out of date. The Department also noted that the *Official Languages Act*, which came into force after the current *Mental Health Act*, carries obligations to provide interpretation services and deliver services in a culturally-sensitive manner. Accordingly, the Department argued, any mention of culture in the new *Mental Health Act* is unnecessary. Once again, the Committee strongly disagreed. Sidestepping the problem of the preamble's ambiguous legal status, the Committee sought instead to incorporate a number of legally-binding principles, including the principle of respecting people's culture, language and religious upbringing. Another culturally-relevant addition to Bill 55 is the requirement that the chair of the review board appoint an elder as a cultural advisor if an applicant requests it.

PRINCIPLES OF THE *ACT*

As mentioned, the Committee introduced a motion to incorporate legally-binding principles that will assist in the interpretation and administration of the *Act*. These principles respond to a wide range of stakeholder concerns. The first asserts that there are to be no unreasonable delays in making or carrying out decisions affecting a person under the *Act*. The second asserts that decisions under the *Act* should respect a person's cultural, linguistic and religious upbringing. The third states that least restrictive measures should be used, taking into consideration the safety of the patient and other people. The fourth speaks to the importance of family and community involvement in the care of people with mental-health issues. The fifth speaks to the matter of mental competence, asserting that patients should be supported in making their own decisions for as long possible. The sixth and final principle pertains to personal privacy, underscoring the fact that information about a person's mental health is—whether we like it or not—fraught with stigma, and should be handled with the utmost respect for privacy. At the clause-by-clause review, the Minister concurred with this motion and confirmed that these principles are consistent with the intent of the legislation.

<u>Recommended Actions</u>

1. That the Department of Health and Social Services ensure that its operational practices align with the principles of the new *Mental Health Act*.

FAILURES AND GAPS IN MENTAL-HEALTH SERVICES

Over the course of the review, dozens of people described their lack of trust in the Government's provision of mental-health services. Fighting back tears, one community advocate bravely asserted, "Silence means approval, so I can't be silent." In another troubling case, a young man who suffered a brain injury following a motor-

vehicle accident has been placed in the North Slave Correctional Facility because there is no suitable care facility in his home community. The man's father is overwrought with frustration because service gaps have effectively led to his son's criminalization rather than his rehabilitation.

Accounts like these line up with the data the Committee received on the Community Counselling Program. Over the past five years, roughly thirty percent of its front-line positions have been vacant for twelve months or longer. Three of these so-called permanent positions—in Wekweti, Aklavik, and Fort Resolution respectively—have been vacant for five consecutive years. With such inconsistent coverage, the number of resulting service failures is virtually incalculable. All too often, residents have no one to approach for guidance, counseling or aftercare. All too often, referrals for other mental-health services simply do not happen. This is unacceptable. The Department must renew its efforts to recruit and retain qualified workers.

The proposed legislation, like the current *Act*, does not give patients the right to receive services. Rather, it allows for the provision of voluntary services on a discretionary basis. The Committee identified serious concerns in this area. A tragic illustration is the case of a teenager who died of self-inflicted injuries in April 2015 shortly after being discharged from Stanton Territorial Hospital. He had repeatedly sought mental-health services, but his symptoms were dismissed and he was sent away without a plan for follow-up treatment. A second illustration is the case of a young woman who attempted suicide and was brought to a nearby hospital. She was treated and admitted overnight, only to be released the next day with no apparent plan for follow-up care or counseling. These cases point not only to gaps in the provision of community-based mental-health services but also to possible deficiencies in clinical practice standards.

On a positive note, community-based services, when available, can make a significant difference. One resident described going through a bad patch of depression and anxiety attacks. "I went to the doctor and got pills, even though I'm not much of a pill-popper. But there was a mental-health worker and for three years I got counseling. She really helped me a lot." The Committee is therefore calling for substantial enhancements to the Mental Health and Addictions Action Plan, as indicated in the following recommended actions.

Recommended Actions

2. That the Department of Health and Social Services review its clinical standards and protocols for the release of voluntary patients, including the use of risk-assessment screening tools and provision of follow-up care.

3. That the Department of Health and Social Services renew its efforts to recruit and retain front-line mental-health workers, targeting positions with long-standing vacancies.

4. That the Department of Health and Social Services guarantee access to safe and affordable housing for front-line workers as a way of strengthening recruitment and retention.

5. That the Department of Health and Social Services ensure appropriate housing is available for patients being discharged from designated facilities, including patients receiving psychiatric care under community treatment plans.

6. That the Department of Health and Social Services strengthen efforts to re-establish a residential addictions-treatment facility for the Northwest Territories or establish a pan-territorial facility.

7. That the Department of Health and Social Services expand its outreach, ensuring that healthcare workers provide services in remote communities on a more frequent basis.

8. That the Department of Health and Social Services offer mobile treatment services.

9. That the Department of Health and Social Services introduce a comprehensive aftercare and relapse-prevention program for use by counsellors across the Northwest Territories, based on the model developed by Shepell, a national mental-health organization.

10. That the Department of Health and Social Services ensure that individuals with a criminal record for a violent or sexual offence are not denied access to southern residential-treatment facilities.

11. That the Department of Health and Social Services work with the Department of Education, Culture and Employment to develop "integrated community plans" for Aurora College students who have mental-health issues.

12. That the Department of Health and Social Services collaborate with other GNWT departments to offer cultural camps and on-the-land programs, focusing on mental health, healing, and traditional aboriginal knowledge.

13. That the Department of Health and Social Services provide respite services for family members who are providing care for mentally-ill family members.

14. That the Department of Health and Social Services employ local healthcare staff or lay dispensers in communities in order to increase patients' compliance in taking prescription medication.

15. That the Department of Health and Social Services provide a mechanism for hearing the concerns of patients and their advocates regarding prescription medication, focusing on measures to offset negative side-effects.

16. That the Department of Health and Social Services review its official languages protocol to ensure that patients are receiving interpretation services as required.

17. That the Department of Health and Social Services introduce job-sharing and part-time options for mental-health workers in order to reduce the risk of burnout and make front-line positions more attractive.

18. That the Department of Health and Social Services adopt an approach that relies on therapy and counselling as a viable alternative to prescription medication.

19. That the Department of Health and Social Services hire additional psychiatrists in order to reduce lengthy wait times.

20. That the Department of Health and Social Services hire a dedicated psychiatrist to address the needs of children, adolescents, and youth.

21. That the Department of Health and Social Services simplify job titles for front-line mental-health workers so that workers will be more approachable.

22. That the Department of Health and Social Services strengthen its services for seniors who are experiencing dementia or Alzheimer's.

23. That the Department of Health and Social Services hire additional medical social workers who can provide services at the intersection of mental health, counselling, and social services.

24. That the Department of Health and Social Services work with community agencies, non-profit organizations, and local churches to establish safe spaces where people with mental-health issues can gather and receive support.

ASSISTED COMMUNITY TREATMENT

Bill 55 includes new provisions for "assisted community treatment," also known as "ACT". Essentially, this is mandatory outpatient treatment, where psychiatric care is provided while the patient is living in the community. For each patient, a treatment plan is created where the patient, health and social-services professionals, and family members or other support persons agree to implement and monitor the plan.

Ideally, community treatment reduces the traumatic impact of hospitalization and helps the patient reintegrate into the community following a period of hospitalization. However, as the Committee discovered, there are potential shortcomings associated with this type of psychiatric care. First, despite its widespread use in other Canadian jurisdictions, community-based treatment appears to be controversial. A 2012 review of Ontario's legislation found inconclusive evidence on the benefits of community treatment. Second, because the Department has no plans to bolster resources in the communities, this option will only be available where sufficient resources already exist: in Yellowknife and, potentially, regional centres. Patients from small

communities will either have to forfeit this treatment option or live away from home. Third, community-based treatment may inadvertently expose patients to criminalization if the treatment plan goes awry or the patient is not adequately monitored. Fourth, people who agree to monitor an ACT patient may be exposed to legal liabilities. Fifth, people who agree to monitor an ACT patient may experience burnout as the burden of care is handed over to family members and other unpaid caregivers. For all of these reasons, the Committee cannot fully endorse the provisions pertaining to assisted community treatment.

Recommended Actions

25. That the Department of Health and Social Services provide à la carte options which communities may use to support the implementation of assisted community treatment.

26. That the Department of Health and Social Services ensure that psychiatrists, medical doctors, and other healthcare workers receive appropriate training in the use of assisted community treatment.

27. That the Government of the Northwest Territories take measures to limit the liability of people who agree to monitor an ACT patient.

28. That the Department of Health and Social Services monitor and evaluate each community treatment plan on an annual basis, looking for deficiencies and employing corrective actions.

HOMELESSNESS

On a per capita basis, the homeless population in the Northwest Territories is sizable—and appears to be growing. A significant number of homeless people are struggling with mental illness. The prevailing approach to homelessness and mental illness is to rely on emergency healthcare and on shelters for emergency housing. In the long run, this approach is costly and ineffective. As an alternative, "Housing First" is an evidence-based intervention model whereby permanent housing and wrap-around supports are provided to individuals who are homeless and living with a serious mental illness.[1] Canada's *At Home/Chez Soi* initiative was a five-year, five-city "Housing First" demonstration project. It examined quality of life, community functioning, recovery, employment, and related outcomes. Overall, it demonstrated that the "Housing First" model can be implemented successfully in combination with assisted community treatment. The Committee believes that aggressive action should be taken to address homelessness, especially through the use of "Housing First" initiatives.

[1] *National Final Report: Cross-Site At Home/Chez Soi Project*. Canadian Mental Health Commission of Canada (June 2014). <www.mentalhealthcommission.ca>

Recommended Actions

29. That the Government of the Northwest Territories take stronger measures to address homelessness among residents who have mental-health and addiction issues, looking to the success of "Housing First" initiatives in other parts of Canada.

SUICIDE PREVENTION

During the Committee's travel in the communities, residents described their despair and helplessness in the face of suicide. They want clearer direction in how to support people who are at risk and what to do when something goes terribly wrong. The facts and statistics for the Northwest Territories show an obvious need to strengthen suicide-prevention efforts. According to the 2011 Northwest Territories Health Status Report, the annual suicide rate in the Northwest Territories is 65% per cent higher than the national rate. The same report indicates that the suicide rate in small communities is several times higher than the national average. The Chief Coroner for the Northwest Territories reported that the suicide rate for 2014 rose substantially over previous years. Furthermore, Statistics Canada data for 2010 show that the suicide rate among youth in the Inuit homelands—which include the Inuvialuit of the western Arctic—is up to thirty times higher than that of youth in other parts of Canada.

According to the latest national and international evidence, suicide is largely preventable. For this reason, suicide-prevention efforts should be strengthened and include training in Mental Health First Aid for community leaders and GNWT employees. The Government also should investigate methods used in Québec, where an aggressive provincial strategy has led to dramatic declines in the rate of suicide.

With respect to Bill 55, the Committee sought to introduce provisions to better ensure that people who have attempted suicide, or threatened to do so, receive proper assessments and follow-up care. A new provision pertains to cases where a person has recently caused, threatened, or attempted self-harm. It will ensure that the person undergoes further assessment to determine whether an involuntary admission is necessary. The Minister agreed to the motion and assured the Committee that education and training will be provided to health professionals so that the new provision is correctly administered. The Minister also explained that involuntary psychiatric assessments are completed by a trained psychiatrist or physician and is comprehensive in nature, including an investigation into the presenting concern, the history of the concern, a mental-status exam, a physical exam, personal history, direct observations, and consultation with other professionals.

The Committee also drafted a motion to establish self-harm as a criterion for involuntary admission, under the proposed section 13. However, after reviewing the draft motion, the Minister indicated that he could not concur with it. He explained that

recent harm is not a guarantee that a person will harm themselves or others in the near future, and, further, that an involuntary admission solely on this basis could result in a challenge under the Canadian Charter of Rights and Freedoms. Moreover, while the legislation in some other jurisdictions includes recent harm as a criterion for involuntary admission, it indicates that the risk of future harm must also be present. Persuaded by this reasoning, the Committee chose not to introduce the motion.

Recommended Actions

30. That the Department of Health and Social Services expand its suicide-prevention efforts across the Northwest Territories, ensuring the use of culturally-appropriate messaging.

31. That the Department of Health and Social Services develop, and widely disseminate, a protocol for small-community residents on steps to be taken when someone has committed suicide or when someone is threatening to commit suicide or engaging in self-harm.

32. That the Government of the Northwest Territories adopt a proactive approach, providing training for community leaders and GNWT employees in Mental Health First Aid or Applied Suicide Intervention Skills Training (ASIST), so that more people are alert to signs of trouble, equipped to intervene, and able to prevent situations from escalating.

33. That the Department of Health and Social Services ensure that front-line workers are appropriately trained in the use of valid, reliable, evidence-based screening tools for post-traumatic stress disorder, depression, schizophrenia, suicidal ideation, and other mental disorders.

STRATEGY FOR YOUTH AND ADOLESCENTS

During its review of Bill 55, the Committee learned that suicide is the second-leading cause of death among Canadian youth, and that roughly 20% of Canadian youth have a mental-health issue. Moreover, in about 70% of cases, mental-health problems emerge before a person reaches the age of eighteen. These facts came to light in a 2006 report[2] by the Standing Senate Committee on Social Affairs, Science and Technology. The ground-breaking report called the treatment of children and youth the worst part of the mental-health system in Canada. The report made such an impact that all Canadian provinces subsequently developed stand-alone mental-health strategies for youth and adolescents. The Northwest Territories has not yet followed suit. However, as he indicated at the clause-by-clause review, the Minister will be recommending that such a strategy be undertaken in the 18th Assembly.

[2] *Out of the Shadows at Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada*. Final Report of the Standing Senate Committee on Social Affairs, Science and Technology (May 2006).

Recommended Actions

34. That the Department of Health and Social Services develop and implement a stand-alone, multi-departmental strategy and action plan for addressing the mental-health needs of youth and adolescents, drawing on proven methods, programs, and expertise in other jurisdictions.

35. That the Government of the Northwest Territories ensure that child-protection workers, social workers and school-attendance counsellors are placed in schools, recognizing that K-12 schools are natural and effective settings for early intervention.

PATIENT RIGHTS

Under the current *Mental Health Act*, the courts are the only recourse for people who wish to have a decision reviewed or appealed. This approach is expensive, inefficient, and out of step with best practices elsewhere in Canada. The new *Act* will enhance patient rights by establishing a quasi-judicial review board for hearing complaints. Applications to the review board may pertain to such matters as involuntary admissions, findings of mental competence or objections to treatment. Every application will be handled by a three-person review panel consisting of a lawyer, medical doctor, and lay person. In response to a stakeholder query, the Committee confirmed that members of the review board will be paid for their services.

To enhance patient rights, the Committee sought two changes pertaining to the review board. The first change requires the chair of the review board to appoint an elder as a cultural advisor where an applicant requests it. The purpose is to ensure that matters are handled in a culturally-sensitive manner. The Minister concurred with this motion, but noted that the review panel already includes a lay person who will play a patient-advocate role and that the panel has the ability to call an elder as a witness at a hearing. The Minister cautioned that providing patients with the option to request a cultural advisor may result in delays or increased operational costs. The Committee therefore agreed to the inclusion of a notwithstanding clause that will allow the review panel to continue its proceedings if, in rare circumstances, a suitable cultural advisor cannot be found. A second change pertaining to the review-board provisions requires that the composition of the review board reflect the diversity and gender balance of the population.

The Committee contemplated ways of enhancing patient rights in other ways too. Initially, it drafted a motion to allow a voluntary patient who disagrees with a doctor's discharge decision to remain in the designated facility until the case has been considered by a review panel. However, the Minister explained that an order from a review panel would likely result in undue delays and hardship for the patient and unnecessary operational costs. He subsequently proposed to grant every patient—voluntary and involuntary alike—the right to a second medical opinion. The Committee accepted this line of reasoning and introduced a motion to that effect. At

the request of the Minister, a companion motion was introduced to ensure that notice of the patient's right to a second opinion is conspicuously posted.

The Committee also introduced a motion to facilitate greater involvement on the part of family members and other support persons. Recognizing that a patient's right to privacy imposes certain justifiable constraints and, further, that some patients do not want their family involved, the Committee introduced a motion that will impose a duty on the attending doctor to ask a voluntary patient if he or she would like someone to be notified of their circumstances. A companion motion was introduced to ensure that the doctor makes reasonable efforts to notify the person, and the Minister concurred with these motions at the clause-by-clause review.

In addition, the Committee acted on recommendations from the Northwest Territories chapter of the Canadian Bar Association (CBA). The CBA explained that mentally-ill people are criminalized whenever they come into conflict with the law and end up in correctional facilities instead of medical facilities. Individuals who suffer from psychiatric disorders, the CBA continued, are frequently subjected to apprehensions or periods of detention that are virtually identical to those resulting from criminal offences. To mitigate against these tendencies, the Committee and the Minister settled on several additional provisions. First, a peace officer will be required to convey a person to a health facility without delay. Second, a peace officer will be required to inform the apprehended person, again without delay, of the reason for their detention and their right to legal counsel. Third, the peace officer will be required to facilitate the person's access to legal counsel. Fourth, in the event of a necessary delay in conveying the person to a health facility, the patient will have the right to communicate with a family member, health professional or other person. Finally, in the event of a delay, the peace officer will be required to contact a health professional to discuss the person's condition and circumstances. At the clause-by-clause review, the Minister indicated that these changes are consistent with charter rights and the intent of the legislation.

With respect to the selection of substitute decision makers, the Committee acted on concerns of the Information and Privacy Commissioner and the Status of Women Council of the NWT. Because the original language in Bill 55 would only have allowed for an express wish to be considered after the selection process had begun, the Committee introduced a change. It states that, notwithstanding the prioritized eligibility list set out in section 30, if a medical doctor believes a patient is competent to participate in the selection of a substitute decision maker, the patient's express wish must be first in priority. The Minister concurred with this motion at the clause-by-clause review, but cautioned that the change will complicate the process of selecting a substitute decision maker and place additional burdens on the Department to establish practice standards and train healthcare providers.

Recommended Actions

36. That the Department of Health and Social Services appoint a lawyer as the chair of the review board.

37. That the Government of the Northwest Territories ensure that peace officers receive cultural-competency training in the use of force, including mechanical means or medication, for apprehending, conveying, detaining or controlling individuals under this *Act*.

38. That the Department of Health and Social Services provide training for all authorized persons who apprehend, convey, detain or control individuals under this *Act*.

39. That the Department of Health and Social Services post sample applications online to guide people who are preparing applications to the review board.

40. That the Department of Health and Social Services collaborate with the Department of Justice to ensure that a psychiatrist or qualified psychologist assesses potential clients for dangerous-offender status prior to inclusion in the Domestic Violence Treatment Options (DVTO) diversion program.

PROTECTION OF PRIVACY

The Information and Privacy Commissioner provided a lengthy submission on Bill 55. The Committee asked the Minister to respond to it and then deliberated on the issues. First and foremost, the Committee determined that privacy issues pertaining to the *Mental Health Act* will largely be governed by the *Health Information Act*.

Second, the Committee observed that points of disagreement between the Minister and the Commissioner focused largely on whether privacy provisions should be contained in the statute or in regulations. Recognizing that regulations can be more easily changed and brought into force without the scrutiny of the Legislative Assembly, the Committee nonetheless concluded that privacy protections will have the force of law in either case.

Third, the Committee took up the Commissioner's concern about the Bill's failure to prohibit board members from disclosing information obtained in their role as board members. A motion to establish a confidentiality clause was introduced at the clause-by-clause review, with the Minister's agreement.

Fourth, in reference to section 56, which authorizes the creation of a registry of certificates issued under the *Act*, the Committee noted that the *Health Information Act* expressly permits the creation of such a registry. The Commissioner asked for a statutory amendment to clarify the registry's purpose, but the Committee concluded that regulations are an appropriate place to specify this. Moreover, the Committee was satisfied with the Minister's explanation that the registry will be used to keep track of the number of involuntary patients and thereby assist in long-term planning. The Minister also offered assurance that certificates will be securely filed and that only relevant information from certificates will be entered into the registry.

Fifth, in reference to the concern about law enforcement's access to certificates—and, specifically, access to the sensitive information contained therein—the Committee confirmed that federal legislation protects personal information and places obligations on RCMP officers to respect confidentiality. The Minister further indicated that unnecessary information will be redacted from certificates, a practice consistent with the Department's obligations under section 28 of the *Health Information Act*. These matters will be prescribed in regulations, and the Committee concluded that regulation-making authority relating to the apprehension of persons will include the authority to prescribe how information is shared.

Recommended Actions

41. That the Department of Health and Social Services specify the purpose of the registry in the regulations.

42. That the Department of Health and Social Services include a description of the purpose of the registry in its plain-language communication materials.

43. That the Department of Health and Social Services stipulate in regulations that only pertinent information from certificates be entered into the registry, in accordance with section 28 of the *Health Information Act*, which states that personal health information must not be used if non-identifying information is adequate for the intended purpose.

44. That the Department of Health and Social Services regularly remind peace officers and other authorized persons of their duty to respect the confidentiality of patient information.

45. That the Department of Health and Social Services inform patients who receive services outside the Northwest Territories that they are subject to privacy laws in outside jurisdictions rather than privacy laws of the Northwest Territories.

REGULATIONS AND GENERAL CONSIDERATIONS

A large number of operational requirements will be laid out in regulations. For this reason, the Department is being strongly urged to draft regulations in consultation with the Standing Committee on Social Programs, key stakeholders, and members of the public. An area that will require careful scrutiny is the designation of authorized persons for apprehending, conveying or detaining individuals. Regulations should clearly establish who, and under what circumstances, these persons will be employed.

The Committee was encouraged to learn that the Department of Health and Social Services is developing an agreement with the RCMP regarding its role under the new *Act*. That said, the Committee is concerned about the risk of improperly trained persons being called upon in communities or situations in which there is no RCMP presence.

With the Minister's agreement, the Committee introduced a motion to define a "peace officer" within the Act, stipulating that it should mean a member of the RCMP or a prescribed person or class of persons. The Minister agreed that the definition of a peace officer in the Criminal Code of Canada is quite broad, and confirmed that the original intent of the legislation was to define a peace officer as the RCMP. A companion motion was introduced which provides regulation-making authority to prescribe other classes of persons or alter the definition of a peace officer in the future.

The Department was asked to clarify whether the medical records of a patient who is transferred to another facility will be sent along with the patient so as to prevent unnecessary repetition of requests for the patient's medical history. Departmental staff confirmed that the under subsection 96(2), the relevant records of a patient who is transferred to another facility, whether inside or outside of the Northwest Territories, must be transferred to the receiving facility. However, to strengthen this requirement, the Committee introduced a motion to ensure that the receiving facility receives the records as soon as possible. The Minister concurred with this motion.

A number of additional motions were passed at the clause-by-clause review. A pair of motions was passed to ensure that patients will not be provided with the home address of the chairperson of the review board. A motion, which was introduced at the Minister's request, replaces a phrase in subsection 84(1), and clarifies that documents being served on a patient can only be served on the public trustee and endorsed with the name of the facility if the person is an involuntary patient and has been found mentally incompetent to manage his or her estate. Finally, to correct a handful of minor drafting errors, several technical motions were passed during the clause-by-clause review.

Recommended Actions

46. That the Department of Health and Social Services consult with the Standing Committee on Social Programs, key stakeholders, and the public on the development of regulations.

47. That the Department of Health and Social Services provide training for staff on the new legislation, highlighting relevant sections of the *Act* and regulations, and giving direction on required procedures.

48. That the Department of Health and Social Services develop an agreement with the RCMP regarding their role under the new *Mental Health Act*, including cultural-competency training for RCMP officers.

49. That the Department of Health and Social Services ensure that the new *Act* harmonizes with the requirements of the Wellness Court diversion program.

50. That the Department of Health and Social Services establish in regulations that an aboriginal chief may serve as a peace officer.

51. That the Department of Health and Social Services make efforts to educate the public about mental-health issues, with a focus on informing residents of available services and reducing stigma for mental-health consumers.

52. That the Department of Health and Social Services implement a comprehensive communication plan for the new legislation, including the circulation of plain-language materials.

RECOMMENDATION

Recommendation 1

That the Government of the Northwest Territories provide a comprehensive response to this report for consideration by the Legislative Assembly in June 2016.

CONCLUSION

The Standing Committee on Social Programs thanks all stakeholders who provided comments on Bill 55 or attended public meetings.

The Committee advises that it supports Bill 55 as amended and reprinted and presents it for consideration to the Committee of the Whole.