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DEBATES and PROCEEDINGS

Speaker

The Honourable A. W. Harrison

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MR. CHAIRMAN: Resolution 48 passed, 49.

MR. REID: At 5:30 I was speaking on the shortage of doctors and some of the reasons why, and I was just getting into a press release when we called 5:30. This press release Mr. Chairman, Tribune, February 12th, 1962. "Doctors fight ban to move surgery help in teaching hospitals." Quote: "Manitoba general practitioners are fighting a move to ban them from assisting in operations performed on their patients in Winnipeg teaching hospitals. Teaching is carried out at Winnipeg General, Children's, St. Boniface General and Deer Lodge Hospitals. Doctor C.C. Ferguson, Professor of Surgery at the University of Manitoba has sent letters to these Winnipeg hospitals asking them to ban general practitioners from acting as assistants at surgery. He claims general practitioners interfere with the hospital teaching program. He also says that the presence of general practitioners may be an inducement by the surgeon to obtain more patients. Doctor A.A. Campbell, President of the Manitoba General Practitioners Association called the move to oust doctors from the operating room a plan to discredit general practitioners." He goes on to say, "this is just a move whittling away our privileges. The general practitioners are already prohibited from doing most types of surgery. They're required to turn their patients over to specialists. At the moment many general practitioners attend operations as assistants to surgeons, they are then able to collect a fee." One hospital official explains that what really happens in many cases is that the general practitioners are just standing around and collecting their fees. What is needed is some adjustment in the fee schedule so doctors can collect the fees for the good work they do before the patient reaches the operating table. At the moment they are forced to act as assistants to collect their fees. Doctor Ferguson, a surgeon himself, maintains he is interested only in insuring a high standard of surgery for patients and improved teaching facilities for training surgeons. We're not trying to keep the general practitioners out of the operating room," he said, "we simply want them to let the trainees have the assistant position at operations."

Well, Sir, here we have an ideal opportunity to increase our medical students, first by implementing the brief as presented by the Faculty of Medicine suggesting how more doctors could be trained and graduated. Next, the general practitioners and the Faculty of Medicine at the University of Manitoba should get together and compromise that student doctors would get proper training more efficiently and speedier; but unfortunately Sir, the question of fees enters the picture again. No doubt practice such as this keeps fees and rates of plans in private practice going up. Also Sir, it hinders young men in entering the field of medicine, because it takes them so long to graduate. I am sure that these general practitioners really have medicine at heart, and I appeal to them to permit these interns, especially young surgeons to replace them in operating rooms so we can have more graduate doctors. Every individual Sir, is entitled to a fair share of our economy for his services compared to his training and ability; but nevertheless all aspects of health and medical plans are becoming too mercenary in comparison to other aspects of endeavours in our society.

I have here Sir, some of the hospital practice that has been brought to my attention, as they exist at the present time. I understand that all hospitals are supposed to have 10 beds available for emergencies; but I understand and find out that such is not the case. When a person is taken to hospital, an emergency case, with just a public ward plan, it has been brought to my attention that many times they are told that no beds are available unless you take a semi-private, for which a deposit of $35.00 must be paid. Well Sir, if this is not a method of extortion on behalf of the hospitals, I don't know what is. First they have no beds, but if you're willing to pay extra they soon find one. Another scheme they have is one concerning people who have a medical and a semi-private plan. If they receive treatment at a casualty ward in any of the hospitals in Greater Winnipeg area they're required to pay for same; yet they would be covered by their plan if they went to a doctor's office or entered a hospital. This I can't understand either.

Another gripe the public have against the casualty ward Sir, is the way they are operated and handled. When a patient is brought in in a dangerous and emergency condition instead of receiving care immediately, staff is busy trying to establish, first: if the patient has a doctor

(Mr. Reid, cont'd) ..... of their own and all the rest that goes with it and so forth. Well Sir, they should be given emergency attention immediately and then they could locate their doctor and admit them with all the routine and red tape, because the hospitals at the present time Sir, need not worry about whether they are going to get paid or not. Most people are subscribers, and if not, they are covered by the province or the city or municipality, and I would like to see a more efficient service in all casualty wards in the hospitals, especially in the Greater Winnipeg area.

Well Sir, what would be a working solution to some of these problems? I have a brief here as presented by the Medical Association, January 17th, 1962. The heading: "Doctors oppose government financing." "Health services hearing told fear of interference is reason Manitoba physicians are opposed to a government financed medical care plan even if it is controlled by members of their own profession. They set their position before the Royal Commission on Health Services Tuesday, during a four hour afternoon sitting when they presented a bulky brief and submitted to questions. Dr. K.R. Trueman, President of the Manitoba Medical Association was chief spokesman. He was asked by commissioner, Professor O. D. Firestone, how the association would react to a suggestion that the monies for a medical plan be collected by government through premiums or taxes, or that the plan be administered by the Manitoba Medical Services. Such a system likely would lead to government interference eventually and was opposed for that reason," Dr. Trueman said.

The same day or next day, Sir, the provincial government presented their brief to the Medical Board and the heading says: "Roblin wants federal grant for voluntary medical plan - everyone to pay same premium." "Premier Duff Roblin called today for the federal government to help institute a voluntary medical insurance plan for all Manitoba. The Premier told the Royal Commission on Health Services it was too early to determine how much money Manitoba would need in a per capita federal grant to operate such a medical coverage plan. The first thing was to establish the principle of such a scheme he said. Then cost would have to be related to a type of benefit and premiums to be charged. Several possible schemes were being considered." Chairman of the Commission, Emmett Hall, Chief Justice of Saskatchewan, presenting a government brief to the opening session of the Commission's 5-day hearing here said:"Premier insisted comprehensive prepaid medical coverage should be available to Manitobans at premiums lower than charged under present medical insurance scheme. Federal grants would make up the difference between the cost of a voluntary scheme and a stipulated premium that would be charged."

It is evident, Sir, from these briefs, that the medical profession does not want government intervention in any plan -- not even if it's controlled by the medical profession itself, because, Sir, they believe in free enterprise and I believe the more freer they are the more enterprising they are as individuals and then they are free to charge their exorbitant fees. The provincial government is in favour of a voluntary comprehensive health plan. My party has always advocated a compulsory comprehensive national health plan, which is the only kind that will work with rates within reach of the average citizen, because everybody would help to contribute to such a plan that would be within means of all, but we must have co-operation of all parties concerned. We have the medical profession view, the province's voluntary plan and our plan for a compulsory one. I am sure, Sir, if we all got together, a plan could be worked out that would benefit everyone.

MR. CHAIRMAN: Resolution 48, passed.

MR. MOLGAT: Mr. Chairman, it seems to me that we have adopted a new practice this year, and while in some of the departments this may not matter too too much where there are very few items, in a department like this one where an item covers so many, particularly coming along to the next one for example No. 49, I think we should revert to the practice that was carried on in the past years where the Chairman does not call just the main resolution but calls the Item; otherwise I'm afraid that we will be unable to cover some of the items that some of the honourable members might want to discuss. This certainly was the practice in the past.

MR. CHAIRMAN: That is the plan -- I called 48, then I come to (a), (b), (c), (d) and then when we come into item 2 we'll call (a) 1, 2, 3. That is your ....

MR. MOLGAT: Well, if that's the practice, but that wasn't the practice I notice that was followed in the other departments so far, Mr. Chairman. I think you called just the main resolution. I didn't object then.

MR. CHAIRMAN: Well because they were just one item.

MR. MOLGAT: That's right, but now I'm suggesting we carry on the normal practice.

MR. CHAIRMAN: 48 (a) passed. (b) passed, (c) passed.

MR. DESJARDINS: Mr. Chairman, I'd just like to ask a couple of questions from the Honourable Minister of Health. It seems that it is fairly difficult at this time to receive any copies of death certificates, especially certified certificate. I tried to obtain one just last week -- I finally did get a death certificate but I was told that it was extremely difficult to obtain a certified one. I don't know why -- there might be a very valid reason. I know that for an ordinary death certificate it's $1.25 and for a certified one it's $1.50, but if you need a special, you have to state the reason why you require one and then it has to be, apparently to their way of thinking, a very good one, to have a registered one. As I say, there might be a good reason for that but I'd like to know what it is.

Now there's another thing. It's a little more of a touchy subject for me to bring this in but as you see after I ask this question that I don't stand to profit by it, but lose, I think you'll understand. I think this is a very serious matter -- it's something that has bothered me in the past. This condition exists now that a few years ago there was a change in the registration of stillbirths. The change at the time -- it was a longer period for a stillbirth and the change was to help with the medical research -- which I think is a very good reason -- but at this time now we have the fetus, the stillborn and the live birth and there is in that category, especially in the fetus, where we don't need any registration but the stillborn -- I think it has now become a case where it is very costly for a young family, they have to register the case -- it is a must -- so they are sent -- the hospitals, and I might say even the department doesn't seem too sure on this -- what has to be done -- those people are sent to a funeral home at the time, they have a bill to pay there and then there is the cemetery and the opening of a grave, even for a small stillborn that has never lived, they have to pay 20, $25.00 for a grave and an additional sum for the funeral director. It seems to me that some study should be made in this and if it was possible without hurting this medical research, if there was a possibility that these stillborn and these births -- I would say it's a little different thing if it's a live birth but at least a still born, and I would say all the stillborns, if there was a possibility that these registrations could be done in the hospital or by the health unit the same as the -- well they're registered once at birth and then at death there's another registration that is usually done by the family and the funeral director. And I think it would save an awful lot of money for those people. It's not money that anybody would profit by. You have to buy a plot in the cemetery and you have to spend money at the funeral home, and I certainly can't see the need for this. I think that more people would understand the importance of this medical research and would want to co-operate more if it didn't become too costly to them.

Now, I'm not saying that this change of the Act just last year or two years ago made all the difference in the world, I think it has created, well there was a certain period, I don't remember exactly what it is now, but I would say that if it was possible to look into this--it's something that can't be done too fast --but if that was looked into and it it was a possiblity that these stillborn registrations could be done by the hospital, or the Vital Statistics Department, the Health Unit, or anything like that,I think it would save a lot of hardship on those people.

Mr. JOHNSON (Gimli) Mr. Chairman, in reply to the question with respect to the registering of stillbirths, two years ago legislation was brought in to give uniformity across Canada. This was a uniform piece of vital statistic legislation, at the request of the expert committee, Standing Committee on this subject. The reason for the lowering of the registration was that they are trying to get further statistics as to the cause of stillbirth, this is an infant mortality statistic and so on, and they felt that these figures and causes, etcetera, would be of great value in the future. And this was the reason why we adopted it in Manitoba. There were some refinements to it which certain leading pediatricians in our community are anxious to see but they're split down the middle on some of the details. However, it was brought in for uniformity and I don't think -- I think in the particular occupation the honourable member is in he probably notices more -- but in the past I'm sure he will agree that in many instances the same practice is carried out now as it was in the past re burial and so on.

With respect to a certified death certificate I'll have to look into this probably a little further. However, I notice occasionally that I am asked to approve a death certificate, that we issue

(Mr. Johnson (Gimli), cont'd) ..... a certified death certificate to say, an insurance company or someone making inquiries. As a rule the insurance companies usually contact the person who signed the death certificate, the physician concerned, and he can supply them with a certified statement to the effect that the patient named was attended and died on that date and that is accepted, I believe, by the insurance company. But when we are written directly in the department for these certificates, I believe that, I've only had a few instances in the past year that I can recall where the department wondered whether we should issue this particular type of certificate. I think this can be obtained from the -- I know in practice this was the usual practice for the company to write the physician and get a certification.

MR. HILLHOUSE: ..... doesn't concern many members of this committee, but it deals with the marriage certificates obtained from the Vital Statistics. Now in any matrimonial cause which is brought in our Courts it's usual to file the marriage certificate which you obtain from the church and that church marriage certificate gives the name of the official witnesses. Now the marriage certificate furnished by the Department of Vital Statistics does not give that information, and I'm wondering whether or no if it couldn't be added as additional information to the certificate issued by the Vital Statistics.

MR. DESJARDINS: Mr. Chairman, still on the same question - - I don't say that this business of certificate would cause a hardship, it was just something that happened last week and I was wondering if there was any reason for that. But coming back to this other thing, I want to impress on the minister that I do agree in the change that was done in the Vital Statistics Act in the registration of stillbirth. I'm not suggesting that this is not good and if he remembers right, I also voted in favour of this change in the Act. That is not the point at all and I know that there was a problem existing before this Act came in. Maybe I wasn't clear when I stood up a little earlier. But that's not the point; this is not a question of trying to blame anything on anybody or any Act but it is something that is existing now. No doubt that with this change there are a bigger, larger percentage of stillborn and that is just a certain percentage added. But I feel that at least a study should be made of this this coming year and if there was the possibility, it's a suggestion, it's not blaming anybody, it's probably been done like that for years. But the experience that I have I definitely feel that it is a hardship.

Now the only reason for this, the government is not even sure, everybody that I contact, well they've never given me a satisfactory answer. The hospitals don't know themselves, and I feel it's just the idea of the registration. If you have registration, most of the cemeteries will insist on a special grave. Now if this could be done, like now all the births are registeredright in the hospital. There's somebody from the Department of Health, from the Health Unit, that will go out there and take all registrations. Well it seems to me that that could be done -- it might add a little bit more work to the hospital, but most of the time they fill those forms anyway -- and I think it would be a good thing because then the stillborns could all be treated the same as a fetus; and if an individual would like to have a burial for his baby, that is a stillborn, that's fine. But I think the people should realize that they don't have to. Now certain hospitals treat these, maybe there's a cremation and others, well we will bury these limbs and fetus and so on, and I think the stillborn could be done. It won't be any work for the cemetery; there won't be any registration so therefore they won't need a special grave because they have to fill a burial permit and send it back to the department. The people will not need the help of the funeral home, in this case the funeral director, and a lot of this will be done a lot easier. The hospitals that use cremation, well, that's all for the fetus; it will be done very easily. You'll have your registration. All this is done. In other words, it comes to this that the registration will cost anywhere from $50 to $100 just for the sake of registering the stillborn. I know that the department is interested in the value that the stillborn has for medical research, and I'm all for this, but I think that this could be looked into this coming year and I think that we could greatly help. And this was the practice in the past. I'm not trying to push one party against the other. I just think it's a good suggestion; I think it's something worth looking into and that it would help an awful lot of people, and you'd have your registration. I'd be the only one suffering by the way -- losing on that.

MR. CHAIRMAN: (c) - passed, (d) - passed.

MR. MOLGAT: Mr. Chairman, in (b) I notice a substantial increase in the supplies, expenses and renewals. Has the Minister some particular expansions there?

MR. JOHNSON (Gimli): This is because of the Vocational Rehabilitation Agreement which

(Mr. Jobnson (Gimli), cont'd) ..... comes into effect on the lst of April. Last year we passed the item under Schedule "R" of the Co-Ordinators Agreement which is being altered making more funds available for vocational rehabilitation and the department decided to take the greatest advantage of this by readjusting the two grants that we see here. Our medical rehab grant is around $130,000 and if you add the 104 that you see there to the $22,000 under "alternative care" you get roughly the utilization of the medical rehab grant. Now with the Vocational Rehabilitation Agreement which is altered to allow greater use in vocational training, we were able to get $47,000 more under the Vocational Agreement than under the Medical Rehab Agreement and this money is being used for an increased grant to the Manitoba School of Physiotherapy, a little more for the Society for Crippled Children and Adults and an increased grant to the Canadian Arthritis and Rheumatism Society. The way the Vocational Rehabilitation Agreement Act works is that we can get the social workers' salaries paid for who are in the active job of getting people back into employment or getting them on their feet and job training and so on. So we were able to get more money through the grant in this way and redistribute our monies to make more money available to these four agencies in the community. That's the reason for that substantial increase. Incidentally, this total vote this year of three twenty three is up from about $162,000 in '58-'59 and the big bulge, of course, is this year making use of this new agreement. My staff advise me we're using this to the maximum through this rehabilitation program at the present time. The other good thing about the Vocational Rehab Agreement is it has no ceiling. Under the Medical Rehabilitation Agreement we have a ceiling; we have to live within -- live under the grant each year. They won't expand it if we put in more. So we've been able to use funds out of the Medical Rehab and readjust these figures to give bigger grants to the four rehabilitation agencies.

MR. MOLGAT: What does the alternative care section cover?

MR. JOHNSON (Gimli): This covers the Director, the placement officer, the accountants, stenographer, clerk, medical consultant -- there are seven people. It's the same staff as last year. The increase is mainly due to the $6,800, is it, in the supplies, in the total vote rather, is due to the -- at this point as you know we've had the City of Winnipeg health department as the agency in Greater Winnipeg for licensing and providing the medical care to the provincial patients or the patients in the nursing homes in Greater Winnipeg, and there's an increased billing from the City of Winnipeg this year of $6,600, and a further increase to be attributed to the slight increase in the occupational program carried out by the Winnipeg School Board of $600 plus increased rental for the program for this year. Through this we put the money here into alternative care, they transfer it over to the city in addition to the monies that are paid through welfare for the city staff to carry out this function. We are able to get some of this out of the rehab grant. That's why we put it under this item, this is where it belongs but we get the money from the medical rehab grant because we can use the medical rehab grant for medical care purposes in a rehabilitation program. This is how we get the fund and it's used in this way. The City of Winnipeg do rent church auditoriums and so on to have activity areas for many of the ambulance patients in some of the nursing homes and also they provide the doctors and so on, and we're able to recover some of this from Ottawa under the medical rehab grant by putting it in this appropriation.

MR. MOLGAT: Mr. Chairman, the matter of nursing homes is to be discussed under this item then, or under health division?

MR. JOHNSON (Gimli): Well I think this would be as good a place as any.

MR. MOLGAT: What is the situation now of the so-called private nursing homes, Mr. Chairman? I've had a number of requests from some of the people who are in the nursing homes, and I think the Minister has himself had some representations made to him, asking that they be granted rates that would permit them to operate on a business -like basis and claiming that they can provide care at lower rates actually than what is provided, for example, in the sanatorium and in those facilities there. Now has the Minister investigated this? Has a decision been reached in this regard?

MR. JOHNSON (Gimli): Well, I think you can realize that about two years ago when we set up the division of alternative care and housing, we asked our staff to make recommendations and studies and so on, and at that time, if you recall, we had the rate-setting body set up to set the rates in all these institutions, and with the Willard report, we rather awaited the presentation

(Mr. Johnson (Gimli), cont'd) .... of the Willard survey to sort of map out Manitoba's care pattern for the future, and in the meantime have been continuing to set these rates. Now these institutions we're talking about in the Greater Winnipeg area fall largely into two major categories - - the proprietory type of home and the charitable or church-sponsored type of institution. We have set rates recognizing, as we do under the hospital plan for example, a certain equity of the owner in the establishment in giving them a rate. That is -- I forget the figure that was set at the beginning -- and the problem in the past year has been -- now the city of Winnipeg health department have been in this field for years, and have been licensing these institutions for us in the past and have been laying on medical care for these patients.

We're at the crossroads at the present time and this year we are setting the rate, I think it's the end of March that they have to be all set for the coming year, and we are a little, frankly, reluctant to go along, in certain cases, with major renovations, improving these in the per diem rate in certain of the institutions. Our studies have shown, and I could report to the committee, that some of these institutions are very admirably suited for medical care elements; others are suited mainly for ambulatory patients requiring a minimum of care, the up and about type of older patient. As I've indicated before, these are largely frail, elderly people. As in the past year, as the beds opened up in the St.Boniface-St. Vital Sanatorium area, the City of Winnipeg, working through and with the hospital plan and alternative care department, suggested that the sicker people in many of these institutions and homes be sent to the municipal hospitals for assessment, where we had the built-in medical assessment team, to get an assessment to the sicker people, and approximately 100 to 150 of the sicker people in the homes were placed in St. Boniface Sanatorium as these beds became available. We have at the present time a classification pretty well of: (a) whether they're proprietary or non-proprietary homes; (b) whether they care for sick people or ambulant people, and prior to any, or provincial cases that come to our attention, going into these homes, we demand assessment prior to their movement and this is really of necessity in this area.

Our plans are to swing to a combined program -- we're looking towards it in Greater Winnipeg, where we'd have the central assessment team and we are at the present moment talking to the rehabilitation hospital people that we have to become more and more concerned in this area. I think we will continue to set the rates for the coming year as we have in the past year and give probably more emphasis to a firm categorization of these institutions. As the Manitoba Survey Board reported, possibly the future of the proprietary homes, with respect to caring for sick people, is uncertain, because I think as we create more, and have more chronic facilities available, the sicker element, and I think we all believe, the people who are sick, in constant need of medical nursing care, really should, if possible, be under an MHSP facility. If they do not require constant medical and nursing care but really a form of self-care and self-help in daily living, they should be in a care institution which lends itself to that type of thing, and then, of course, the ambulatory home.

Now, I don't want to sound as though I'm avoiding the question as it was put to me, however, this has been the big area where we had so -- as I've described -- so many elements of medical care under one roof and we're finally sorting these out. At the same time we must remember that many of the nursing homes in Greater Winnipeg, some of them have rendered a very excellent service over the years, and many of them have rendered excellent care, and many of these will continue to be used until we create the program facilities that we envisage. But there's going to be more and more control I'm sure from the provincial level with the classification of these institutions as to what type of care they should be carrying out. We're not encouraging too much large expenditures by private operators to develop their homes without some guidance from us, and I hope to meet shortly, as a matter of fact, with the Nursing Home Association to bring them completely into the picture. But at the present time their budgets being received and processed by the accountant and alternative care division.

MR. MOLGAT: Mr. Chairman, these homes of course are all inspected by the department, I take it? Now does the rate vary then, from home to home depending on the budget of each one?

MR. JOHNSON (Gimli): Yes the rate does vary, Mr. Chairman. They vary in the capital equity that's in the building, the type of construction, the value of the building itself. The big factor, of course, is the care element, the number of staff required to look after sick people if that's the case and, for instance, I guess our biggest institution in Greater Winnipeg looking

(Mr. Johnson (Gimli), cont'd) ....after so many of these people is Hospice Tache in St. Boniface, where we have a certain rate depending on -- along the lines of the MHSP.

MR. MOLGAT: Mr. Chairman, these rates when set for the private types of institution are set so that the proprietor presumably has a profit left in operating is that correct?

MR. JOHNSON (Gimli): Yes, I just haven't got the formula at my fingertips that we worked out with them, but we did give -- I forget what it was -- around 7% of the capital equity that's allowed to be claimed in the amortization in the per diem rate. We had to recognize the fact that they had some equity in here, but we kept it to the minimum, and I think this is the concern we have, that these people who have been in this field for many years are very anxious to know just what is their future role going to be in this area, and I think you'll have to agree with me it's been a very difficult area. It grew like Topsy without any direction really in the past. A person went into this because -- and many of them are people who went into it because they like to look after old people. They do an excellent job. On the other hand, we have to complete the sorting out of the classification of these care facilities and I think, in all fairness, those charitable and voluntary and other institutions who are in this and doing a good job, are coming to us for guidance and these are the people that we'd like to see creating these facilities of various kinds.

On the proprietory side, I still think there are people who prefer to go to these. People who have the means, who want special types of care; but I think it's up to us in looking at and classifying these institutions to say what we are willing to pay for and what type of care we envisage that institution as carrying out, whether it's ambulatory care or bed patient care, etcetera.

MR. MOLGAT: The rate that the government sets of course is only for those patients that the government sends there or those patients who are there and then become wards of the government. Any individual who goes there on his own means, the government does not interfere at all with the rates?

MR. JOHNSON (Gimli): No, Mr. Chairman, and in practice, we set a per diem rate on the institution and we'll pay for our patients there, and very often some of these care facilities have special accommodation set aside to cater to those who wish private accommodation.

MR. SHOEMAKER: In the field of alternative care, I think the Minister last year referred to this home-care and pointed out what they were doing in England and the Continent in this regard. I believe this is one field in which we are lagging behind, so to speak. I think it is most desirable that as many people be looked after in their own homes as is possible. I know that there are many persons in the province, particularly widowers and widows, who are unable to look after themselves -- they're probably not eating the proper food, and so on, and they eventually land up in the hospital. I wonder if the Minister could tell us what is being done in this field and how it has progressed in the last year. And when he's at it too, could he tell me whether the federal government is sharing in the cost of the attendant services, the home nursing service, the drugs, the medications and so on. I suppose that this type of patient would be covered under social allowances or medicare -- I suppose they would -- but I would like to hear if the federal government have recognized their responsibility in this particular field and just what the program is.

MR. JOHNSON (Gimli): Mr. Chairman, with respect to the Honourable Member for Neepawa's question, in the field of home-care as you know, the real experience in this field came from the pilot project that was begun at the General Hospital in Winnipeg under a federal health grant through this department, and this has continued to be highly successful. I have before me some figures -- the report of home-care medical program at the out-patient department at the Winnipeg General Hospital: From October 1st, 1960, to September 30th, 1961, the savings in hospitalization for these 158 patients who are carried on a home-care program from 232 cases; for example in over 38 months it saved 29,000 days of hospital care or 23,000 days of nursing home care, and translated into dollars and cents these are fantastic figures. These people felt, as I reviewed with the committee a year ago that to be really successful these home-care programs should be hospital based in order to have all the facilities and so on of the hospital available to that patient on a home-care situation. They looked after some extremely sick people at home under this type of program, of all types of illness, and we are very interested in this of course.

The federal authorities have finally agreed to share in the administration of a hospital based home-care program, but they will not share with the program once it's into the community unless it's placed on a universal basis and available to everyone in the province, and we're right

(Mr. Johnson (Gimli), cont'd) .... now in the midst of planning a central type of facility that can be universally available in Winnipeg to take full advantage of this federal requirement. We're working on this right now as a matter of fact.

The VON's of course, as I indicated in my introduction, have increased their services about 14% in the past year in Greater Winnipeg in carrying out home-care visitations. There are something like 260 patients on home-care with social allowance assistance -- under the Social Allowances Act, where VON services are laid on -- this is in addition to the 100-odd cases carried by that particular hospital. The federal authorities, however, will not pay for home-care in the community at this time except probably on a pilot basis and on a universally available type of program, which is what we're trying to develop. In addition, of course, to this home-care, you have the monies under the rehab grant to the various rehabilitation agencies who are all helping indirectly to maintain people in the community; and then of course we have our traditional polio load under the Director of Rehabilitation where we have -- I think it's 38 or 40 patients with polio on home-care in the community. In addition to that selected severe cases which have come to the Director's attention, for which there is no alternative assistance in the home situation.

We will continue to pursue the home-care concept as I indicated in my introduction home-care in itself should be exploited as much as possible. One of the things that tends to favour these programs being based on the hospital is that when the patient becomes acutely ill, as long as there is assurance of getting the patient directly into the hospital and so on, there is more acceptance by the people to accept the sicker people into their homes. I do admit that this has been developed to a high degree in the Old Country and it's something that we're going to have to pursue further and we have quite a few plans in this area.

MR. SHOEMAKER: Mr. Chairman, on another matter, I have had doctors tell me -- more than one -- that it would be quite possible for them to prevent or discourage patients from going to the hospital by prescribing certain expensive drugs and in many cases the patient is unable to pay for the drugs that the doctor feels are necessary. Now they know that they're covered if they enter the hospital so they send them to the hospital for three or four days or a week and then of course the drugs are included. Now I know the medicare program or the social allowances program has helped a great deal in that regard, or I feel it has anyway. I feel too on that subject that there are a great number of people in the province that don't know that medicare is available and perhaps the government should advertise that fact a little more than it does, if it's doing what I think it does. I would like to hear what the Minister has to say in that regard, and if there's a program that could possibly take care of these cases where, in the doctor's opinion, he could prescribe probably $30.00 worth of drugs and save $150 worth of hospital bills. It sounds to me as if we might spend 20¢ and save $1.00 type of thing. I wonder if the Minister could inform me on that.

MR. JOHNSON (Gimli): This opens up a very great area. As you know, we had no experience in this area in the province really until we instituted our medicare program and it has brought up many areas of concern to the medical profession and the pharmaceutical industry and everyone else, and certainly to the department in paying for these drugs. To those on medicare, of course, the formula is distributed to the profession, etcetera, and we're reviewing and revising this all the time.

This point which the Honourable Member for Neepawa brings up is a very important one. Certainly I know from my own experience there are many times you're called into the country and your patient may have a slight virus pneumonia and some proper medication given on the site saved the hospital bed and the hospital costs too. However, for the recipients of social allowance we do have the program. The patients in Greater Winnipeg -- if the physician feels that the patient is not able to afford the medication -- can be maintained on an out-patient basis. Of course, they very often send them to our teaching hospitals where the drugs are supplied. In the rural areas there is a little discrepancy in that these hospitals teaching and large university clinics aren't readily available. However, this is something we discussed at the time of our Royal Commission brief; itleads youinto a thousand areas of investigation which we're looking into. Our own feeling is that a very hard look has to be taken at the drug industry at the federal level. I think we should proceed cautiously in this area and as we extend medical care benefits to the semi-indigent, as you would call it, or the person who is not in receipt of social allowance but not in a position to purchase his medication, that the provision of drugs is a very imprtant adjunct; and this again is something

(Mr. Johnson (Gimli), cont'd) ...where we'll need some federal assistance in controlling the cost of drugs to the people of Manitoba and in complementing also at the federal level, medical care programs including provision of essential life-saving drugs.

MR. ORLIKOW: Mr. Chairman, where is the item for medicare?

MR. MOLGAT: Before we leave the matter of nursing homes. Insofar as the private nursing homes are concerned, the situation, I gather from the Minister, is that there is no final policy established at this time. That the likelihood is that the government will not encourage: (a) the renovation of present facilities or (b) the construction of new facilities. Is that correct?

MR. JOHNSON (Gimli): There's no grant formula towards assisting proprietary nursing homes.

MR. MOLGAT: I wasn't talking about the grant formula, Mr. Chairman, I was talking about the policy that the government will adopt insofar as making use of these homes. As I understand it now, by and large they are removing from these homes the patients and putting them, for example, in the sanatorium. Now if this policy will continue then quite obviously these homes will come outside of any work insofar as the department is concerned. Now is it the policy of the department to continue removing people from these homes?

MR. JOHNSON (Gimli): The department hopes to explain to the Nursing Home Association its policy in the very near future. I think, in general, it can be said that in classifying and setting per diem rates in these institutions and in being responsible for the placement of the greatest majority of people that utilize these facilities, or a large proportion of the patients going into these homes, that we will be classifying these homes into preparatory homes and those homes run by charitable and voluntary and other public non-profit agencies. And the per diem rates in the meantime if patients are placed -- we have to set per diem rates in all of them at the present time until such time as we decide just what type of care each particular home should be providing in the future as fare as we're concerned. We can't utilize the expenditure of public funds to have high cost care laid on in a multitude of proprietory nursing homes when we may only have the need to use a few of them, and I think we have to be perfectly honest with them in this regard. And while government policy has not been firmly established with these people, we have continued to place patients in these homes and I think now that we have enunciated a firm policy of carrying on with the recommendations of the Willard Survey this answers half the problems.

MR. MOLGAT: Mr. Chairman, is it correct then to say that the government policy is to discourage the use of these private homes?

MR. JOHNSON (Gimli): I wouldn't use the word "discourage." I would use the word -- we'll certainly utilize these facilities that are made available as we need them for the type of care we need.

MR. MOLGAT: Mr. Chairman, how soon does the Minister expect to meet with the Association of Nursing Homes and clarify the policy?

MR. JOHNSON (Gimli): ..... few of them rather recently and told them that I regretted that I haven't had a firm policy to enunciate at this time. However, a very great deal of planning is going on at the present time and I hope that sometime in April at the latest, we should be able to call in the officials -- I've been reluctant to talk to individual operators. I felt that we should talk to the Association as a whole.

MR. SCHREYER: Mr. Chairman, we are on rehabilitation I understand and, of course, it's taken for granted that everyone subscribes to the need and the benefits that come out of a good sound rehabilitation program. But I don't think we can get away from the fact that close as we try to keep the co-ordination in the provincial department from the agencies in the field such as the Society for Crippled Children and Adults, there still exists a considerable gray zone where one isn't just sure how to help certain people who are in need of rehabilitation of one kind or another. I would like the Minister to tell me just what one does in a situation or a case where a young adult is turned down by the Society for Crippled Children and Adults after several months of working with them trying to provide some training education, and they find after several months experience that the person is "untrainable." They definitely say so. So that's pretty well the closing of the gate, a person is deemed to be untrainable. What then? Parents attempt to make application for disability allowance in the hope that something could be worked out and the application is rejected on the grounds that the person is -- and this has to do with mental competence or incompetence -- the young adult is deemed to be not mentally disabled, yet the Society for Crippled Children

(Mr. Schreyer, cont'd) .... deems him to be untrainable. What, in a situation like that, what does the rehabilitation program of this department have to offer?

MR. JOHNSON (Gimli): Mr. Chairman, I'd like to speak to this matter because certainly in the area of rehabilitation and the co-ordination of agencies, I can assure the Member for Brokenhead that we in Manitoba despite all our limitations really are unique in the comprehensiveness of the program and the co-ordination with which it is carried out. The five major agencies that the Co-ordinator in Rehabilitation here works with is the Society for Crippled Children and Adults, the Compensation Board, The Canadian National Institute for the Blind and the Sanatorium Board of Manitoba. They've got it down to the point where very little duplication of efforts going through -- any one of the voluntary agencies that reaches a bottleneck can get in touch with the Co-ordinator but it's pretty well understood now just where they direct patients. And using the out-patients department, using the Social Allowances Act, using the resources of these five agencies the Director of Rehabilitation told me recently that not one case which had come to his attention or the attention of these agencies had not been given -- not one of them had lacked for medical consultation, the necessary prosthetic appliances and pretty well a comprehensive program.

The type of individual that the member has brought up is a difficult one. In the annual report he will see that the agencies in the past year, I think of all those, over 300 were rehabilitated to gainful employment, there were 110 where the resources of the agencies were used up and it was found they were not rehabilitatable to employment because of the -- the greatest factor is the one the member raised is the area of mentally, possibly incapacity. And this is the thing that is bothering us. However, the disability allowance -- if you look at most of these cases, I'll say this first -- if you investigate these carefully you'll find that it is really something that's been neglected over the years, an individual, because of the lack of early investigation and treatment and follow-up, is gravitated to a position where it's almost a constitutional inadequacy, you can't find job training for it and so on.

What we need in this area are the type of thing that the Member for St. John's could brief you on very well, is the job training for simple employment or sheltered workshop type of situation. These are the people that cannot be placed in dependable employment; they need support and follow-up. The disability pension is given -- some of them can qualify for that pension, but it is a joint federal-provincial pension and the patient has to have three criterion: 1. permanent disability that will not get better and the panel ask themselves does it interfere with normal living. And here's where there's a breadth of difference between in most cases what the federal authorities interpret as normal living and what you and I would consider normal living. As long as the chap can get along, in many cases they've been turned down. In others there's been more acceptance latterly for more of these people to get support by means of a disability pension. But then there's that fine dividing line between pensionability and employability and a lot of hairs are split over that. But in the main, the very type of facility for the job training or the workshop sort of thing is the challenge before us and this really comes under mental rehabilitation to a large degree. In other cases we hope that the creation of the rehabilitation hospital with the type of program we're going to place on there where we're going to have people who are disabled, say other than mental disability, and possibly even some of them, placed in occupational therapy and group therapy sort of thing to draw out a potential that might enable the department or the agency dealing with that person to find some niche in life for that person to fall into. And I do have high hopes for our rehabilitation hospital in that respect.

MR. SCHREYER: Mr. Chairman, could I simply ask the Minister, the latter facilities he was referring to, when will they become operational? I think I missed that.

MR. JOHNSON (Gimli): On March the 5th they started to take their first patients into group occupational therapy to work out some of the kinks. We hope it will be fully operative in the next month or two.

MR. SHOEMAKER: Did I understand the Minister to say that the Old Age Assistance and Blind Persons' Allowances Board, that is the Examination Board, were becoming a little more liberal in their attitude towards some of the cases that are coming before them. Now I have said in the past that in order to qualify for total disability pension that you had to have one foot in the grave and the other one on a banana peeling or you wouldn't qualify. Now I hope that there has been some relaxation in that because the Honourable Member for Brokenhead has

(Mr. Shoemaker, cont'd) .....brought up a subject that comes to my attention at least once a week, I think, and that is there are quite a number of people who -- the Society for Crippled Children and Adults they have done everything they can and about all that can be done now is to try and maintain their present state of health so it wouldn't deteriorate any more -- that's about all you can do for them -- and somehow or another give them enogh money to get by on. If they don't qualify for pension of some kind then they don't qualify for Social Allowance if they're under a certain age, and it seems to me that as life expectancy becomes greater that you have a greater number of this type of person. I hope that I heard him correctly when he said that the Examination Board was going to take a new look at some of these.

MR. JOHNSON (Gimli): Mr. Chairman, the Honourable Member from Neepawa must realize that the real liberalization of the policies he's talking about occurred about 1958 and the records show the greater percentage of cases and the greater numbers who have been received and accepted under the disability allowance program and I think I spoke about a year or two ago under .. where the very problem which the Honourable Member for Brokenhead brought up was pursued by myself with the federal authorities re the restriction on those cases where the patient wasn't disabled other than his long-standing mental component. We got more acceptance of these people in the last two years than ever existed before. I have repeatedly hoped that my honourable friend from Neepawa would some day understand the spirit of the Social Allowances Act in which, despite the pension, if there is need, extra need should be given despite the old means test under the DA old age assistance, etcetera, and he knows that this is going on. I'm sure he understands it, and I don't know what he was trying to draw me into here with this comment that he finally thought that there was a liberalization occurring in the granting of these pensions. We are now on a par with the other provinces in the percentage of these people accepted on our DA roles largely because, as I say, of the acceptance of the mentally incompetent, to a point. This is a very, as I've indicated, a difficult area under DA because you're always measuring between employability and disability where there's no real physical disability it's compounded. I would just like to leave this with the committee. I think that our -- I would hope that our vocational rehabilitation agreement will be of some value in assisting this type of person to pursue rehabilitation with the facilities that we're creating in that we can give some assistance here and I believe -- I may be a little off base -- but I'm quite sure that this very type of case can be pursued and probably assisted under the vocational agreement because this is a job-training, job-placement program and leaves a real berth for those who are incapacitated to a degree mentally.

MR. DESJARDINS: Mr. Chairman, I know that the Workmen's Compensation Board comes under another department, but if I'm not out of order, I'd like to ask the Honourable Minister, what ties, if any, between the Compensation Board and the rehabilitation program of his department. It seems that at the present, the Compensation Board has this approach, this hard, cold insurance-adjuster type of approach -- is he an insurance adjuster -- and I'd like to know where the line is -- (interjection) .. It seems that as soon as the Board can knock off a pension until there's practically nothing and it falls on the head and it practically becomes a charity under the -- either the welfare -- I guess it is under this same rehabilitation program that we're talking about now, and I don't feel that it's good for the morale of the individual and it's certainly a mix-up. By this, I want to make it plain that I'm certainly not criticizing the staff of either the Compensation Board or especially the Rehabilitation program, but is there a liaison between the two? Is there a certain line where one takes over? It seems that now the rehabilitation program -- the Compensation Board just drops these people and the Rehabilitation Board seems to say -- the program I should say -- "Well we'll try to help you. We have no commitments, nothing." I don't know, there seems to be something lacking. I know this is a very, very difficult thing, and it will probably never be resolved to everybody's satisfaction, but I think it definitely is a problem.

MR. JOHNSON (Gimli): In the area of rehabilitation, Mr. Chairman, the Workman's Compensation Board is responsible for adults disabled in industrial accidents and this program, of course, is financed by the contribution of employers, isn't it, so it's really an occupational injury program. But it is one of the -- we often, for instance the Society may, the Compensation Board often refers to the Society for certain, say, prosthetics for these people, or special training which the Society may have and pays for it, but it's our co-ordinators job to co-ordinate these various agencies. For instance, the Compensation Board is heavily involved and interested in our rehabilitation program that we're contemplating at the rehab hospital. It's important to

(Mr. Johnson (Gimli), cont'd) ..... them that their amputees, and so on, receive the very best in rehabilitation and they will receive this through the rehab hospital and so on. But they have their set role in the treatment of occupational and work injuries, but we do co-ordinate our services between all the agencies that I have mentioned previously. For instance, the Compensation Board's responsible for these disabled adults; the Society is responsible for all physically disabled children and adults that don't fall within the terms of reference say of the Compensation Board or don't fall within the services of the Canadian National Institute for the Blind, or the Sanatorium Board, which is responsible for all ex-TB patients who require rehabilitation services. You must remember that a rehabilitation service is really any kind of service that's of help to a disabled person. For example, medical treatment, including surgery or physiotherapy or speech therapy or occupational therapy or providing of prosthetics and so on, and they are provided by these many agencies. But the co-ordinator's job is to make sure that no other agency is duplicating the service in payment and kind that the Compensation Board are giving for an individual. They'll pay for theirs and the Society will pay for their responsibilities but we don't duplicate the place where the person goes to get the service -- if you get what I'm getting at -- there's no duplication of that service.

..... continued on next page.

MR. CHAIRMAN: Resolution 48 -- Passed. Resolution 49. 2(a) Psychiatric Services: (1) Administration.

MR. WRIGHT: Mr. Chairman, this afternoon I asked the question, or at least I mentioned the pioneering work done at the Montreal General Hospital in regard to the use of beds under two shifts. In other words, a person could go to work and then return to the hospital for treatment and for sleep. Now I understand the Allen Memorial Hospital in Montreal has reversed their pioneering idea of having people go there all day for treatment and return to their homes for sleep. I'd like to ask the Honourable Minister if there is any plans afoot for trying this in Manitoba?

MR. JOHNSON (Gimli): Mr. Chairman, my honourable friend is referring to the Allen Memorial Institute in Montreal. He was the one who conceived the day hospital idea. This is something which I have indicated in my opening remarks that I think has a role, a real role, especially in the care of the mentally ill. The psychiatric staff of the department are very keen to get on with the creation of a psychiatric facility in Greater Winnipeg, as we have told you about, and their hope at that time is that we could utilize our present psychiatric institute as a day treatment hospital. These are our plans when they are formulated. The municipal hospital group, who have some staff there who are very conversant in chronic care, they, too, are interested in developing a half-way house type of concept -- two or three days a week -- and the types of place where semi-ambulant people can come for care during the day -- occupational, physiotherapy and medication, possibly, and then back to their home. These are plans, and I can assure the honourable member that I think we in Canada -- when Dr. Allen conceived of the day hospital, it's being adopted all over Europe -- but we, back here in Canada, are pretty slow at picking up the threads, but it's a point well taken.

MR. ORLIKOW: Mr. Chairman, I wonder if the Minister could tell us what the staff is in the administration. How many there are; what their duties are; and so on.

MR. JOHNSON (Gimli): In the psychiatric hospital, the psychiatric institute that we have to learn to talk about, there's the Director of Psychiatric Services, and there's four medical officers -- psychiatric -- three of whom are fully qualified; psychologists, 2; social workers, 3; occupational therapists at that hospital; plus electron catharlographer consultant. The total provincial staff, the establishment there is -- the total establishment, 16; 13 is on the staff of that hospital. As the honourable member may know, for instance at night the psychiatric resident at theGeneralis on stand-by during the night hours, and it's run as an integral part of the setup over there. This year we're recommending for occupancy April 1st, another Medical Officer III -- psychiatric; a clerk-stenographer; and a recommendation for a Medical Officer IV -- research and alcoholism program. Those are the staff at the psychiatric.

MR. ORLIKOW: Mr. Chairman, is that the hospital in Winnipeg mainly -- the staff?

MR. JOHNSON (Gimli): This is just the Winnipeg facility.

MR. ORLIKOW: I wonder, Mr. Chairman, if the Minister could tell us if there is any change in the past policy where the entire hospital was locked; where a person went to visit and the front door was locked; you went up on the elevator, every ward was locked; and the patients were served food -- they weren't supplied with a knife and fork -- the food was all cut up before they got it and so on; or whether there's been a change or whether a change is being contemplated. I don't want to be critical about past practice if it's changed, but I think that policy and that practice was at least 50 years behind the times.

MR. JOHNSON (Gimli): I would like to tell my honourable friend that the care and treatment that I have seen given at the psychiatric hospital on my visits there are no more backward than any of the facilities I have also had the pleasure to visit in other jurisdictions. The food is excellent. They're kind, humane -- real live people up and about, walking; they're excellent psychiatrists; they're running a very good program. They try to -- in asking the provincial psychiatrist for a note, he said that due to the use of more modern therapeutic means in the last few years, which includes as open a policy as possible. You must remember this is the facility to which most of the severe cases are directed in the initial stage, and I was told that both here and in other jurisdictions you simply don't have everyone on an open ward. You do have to have certain closed facilities. Having interned there, I remember and I can well recall the conditions which the honourable member is talking about. Heavens, it's only in my time that we used to put them in ice in the bathtub and a little paragoric and a little morphine -- that's all

(Mr. Johnson (Gimli), cont'd.) ..... you had. Today it's entirely different. You've got a bright colorful room — I'd be glad to take you all over there -- although I hope we would all come back again. There's a great increase in activity of patients — this is the key thing. The volunteers are going in there, as I indicated earlier — the Share people -- three times a week. Many patients, he tells me, who were previously quite regress and took very little part in any activity, are now in a position to do so. Such taking part in activity is, of course, one of the therapeutic measures leading to rehabilitation of the patient.

Many of the tranquilizer drugs used have researched through our own institution. Yes, we actually do research and we do a fair amount of research, that I missed up on this afternoon, and they have been found effective in the treatment of patients. The use of these drugs has increased the number of patients discharged from the hospital who are still on treatment and receive their supply of drugs from the hospital. I would point out that in the out-patient departments of the three hospitals, that is Brandon, Selkirk and Winnipeg, there were 1,779 patients seen and they made a total of 6,834 visits last year. Fifty-two percent were new patients. The provincial psychiatrist reports that in the past five years much of the increase in out-patient attendance has resulted from follow-up care of former in-patients, who are now continuing in the community on drug therapy. The treatment policies carried out are showing these marked results. Actually, in addition to staff, really the increases in the psychiatric appropriation this year are largely drugs and food. Giving a snack at bedtime to 4,000 patients can cost many thousands of dollars. The Honourable Member from St. John's can take, I'm sure, a great deal of comfort from knowing that things are improving steadily in that institution.

MR. ORLIKOW: I don't want to be difficult, but I still would like to know how much of that hospital is closed. I'm not an expert -- I know that there's a difference of opinion between psychiatrists. Some psychiatrists, including the head of the Allen Memorial Institute, simply don't believe that there have to be any locks, but I'm not going to get into this argument. I'd like to know how much of the hospital is locked and how much is open; and I would like to know whether the practice I mentioned which took place as recently as two years ago, whether that also continues. Two years ago a person I know who was a patient was served all their meals in the manner in which I mentioned, and I want to suggest that that is not a modern, by any stretch of the imagination, a modern method of treatment. Now if the Minister -- I don't mind standing it over if the Minister wants to --

MR. JOHNSON (Gimli): The honourable member discussed this before, but in talking to the both staff here, whom I consider tops -- some of our people in this province and in other areas -- there are the two extreme points of view. I am advised simply and frankly that to go all the way with all the patients all the time, as some would do, you do get a higher suicide rate that they're not prepared to cope with; and that in a very active small centre such as this, that you do have to have a certain number of lock-up facilities for the very disturbed patients; but I think this varies. The day I was there, not too long ago, there was one ward where I questioned the Director concerning the care there and this was explained to me that, in the opinion of himself and his colleagues, they certainly had to have some lock-up facilities. I would point out to the member, too, that in checking into this at one of our two large institutions the other day, about 700 out of the 1,200 patients were on open wards but the rest required detention due to reasons which, as you say, I'm not an expert either, which I was advised was a must. But for people to say that you can put all of them on open wards holus bolus just doesn't seem to be the case in this province and the combined attitude of all the people in Manitoba.

MR. E. GUTTORMSON (St. George): Under what item shall we discuss the charges made by the Pharmaceutical Association against some of the doctors in Winnipeg?

MR. JOHNSON (Gimli): I don't know. Start in -- let's have it now -- get it over with.

MR. GUTTORMSON: Mr. Chairman, charges were levelled by the Pharmaceutical Association earlier this year about certain doctors were using code so the patient would have to purchase the drugs from their own drug stores. What action has been taken by the government, if any, in this regard? Can the Minister tell us?

MR. JOHNSON (Gimli): Yes. In this connection, the first time this administration, or we had heard of this was during the Royal Commission hearing when the Pharmaceutical Association made this charge. On writing the College of Physicians and Surgeons of Manitoba, who are the disciplinary body under The Medical Act, charged with the discipline of the medical

(Mr. Johnson, (Gimli), cont'd.) ..... profession, they advised me that the incident which was referred to had occurred some years ago with respect to one product which had been pursued by the College at that time and they thought to the entire satisfaction of the pharmaceutical industry. The Pharmaceutical Association -- I then contacted them and in view of the fact I wasn't -- at least I received a letter from the College back telling me this had happened some time ago and they had made repeated enquiries to the Pharmaceutical Association to name the time and place of these events and make specific charges as to who was carrying out a coded prescription practice, claiming they knew of no other incident, and that in their correspondence with the Pharmaceutical Association no other specific charges were made. The Pharmaceutical Association no other specific charges were made. The Pharmaceutical Association -- I then wrote to them and asked them to describe in more detail just what they were recommending to the Royal Commission, and received a letter from the Pharmaceutical Association suggesting the possibility of a citizen committee to look into the allegations which they had made. I then had written to both the Pharmaceutical Association and to the College and suggested to them that they sit down at one time and one place together and give me the allegations each way clearly so that we can understand what the situation is all about. When I received that reply, I advised both associations, we would then decide what further steps we may take to look at this matter or whether to form a committee or not. I'm not entirely clear yet, despite letters from both associations which I'd be glad to table in the House, as to what the exact charges are or what the real problem is. The profession advised me they don't know of any coded prescription practice going on at this time.

MR. GUTTORMSON: Would the Minister be kind enough to table those letters please?

MR. JOHNSON (Gimli): Yes.

MR. DESJARDINS: Mr. Chairman, it seems that this would be the proper place to speak about the pollution on the Red River. It seems that -- (Interjection) -- Where is that? Well, it's health division -- could the Honourable Minister tell us then where that will be discussed?

MR. JOHNSON (Gimli): The Control Commission on Environmental Sanitation.

MR. DESJARDINS: All right.

MR. HAWRYLUK: I would like to take this moment to express something of the experience that some of us had about a year ago when we were invited during Health Week to visit the institution at Selkirk. One cannot help but commend possibly the Minister himself, or his foresight and possibly personal attention he has given in regard to some of the things that I saw personally at the institution. To me, and I believe to a number of members who visited that institution about a year ago, it was a revelation to see the kind of care and the freedom that these people were getting there. According to the descriptions of mental institutions that one would read from time to time, one visualized that the people, once they got into this institution, were kept locked in cells and given no chance of freedom -- away from all activities, both mental and physical. I can't help but say that I was very much amazed to see that some of these people were actually treated as human beings. We were told at the time when we did talk to the doctors there -- we were allowed to ask questions -- there appeared to be a definite lack of more trained personnel and certainly more psychiatrists. It appears that the Manitoba Psychiatric Association, about two months ago, presented a brief in which they claimed that the mental care in this province is not adequate enough. Now I know this is a big challenge to any Minister of Health, maybe not only in this province but possibly some of the other more backward provinces, in a sense, because definitely the records of some of the provinces are very, very good. But I'm just wondering whether we can feel that something is being done more in that regard, the rehabilitation of the mind of these people not the body, and it appears that the Manitoba Psychiatric Association does have certain grievances which I believe the First Minister is fully aware of. I don't want to read this because it's far too much to read here, but I was just wondering if something definitely is being planned in the very near future.

Now some of the things that I could mention, and this particularly is the one that disturbs me because I have, in my experiences as a teacher, have come across some very badly disturbed children. It appears here, --it states that treatment facilities for several disturbed children are urgently needed. Now I believe it has been brought to our attention that there are teenage people --young people at the institutions. I'm just wondering, Sir, how much is being done in regard to these teen-agers particularly and how much can we look forward to more trained

(Mr. Hawryluk, cont'd.) ..... personnel, more psychiatrists, because there's a definite need, and particularly where we find that from time to time the records show that these people who go in there for a period are not there indefinitely as was the case many years ago. Once a person was assigned to an institution, and when I recall it used to--well I got the impression that they were locked for good, for life, but today we find that they're there for a period of a year or two or less, given drugs, treatments, and they do come out to take their place in the world. I think definitely that is progress in the right direction, but I feel that there are certain inadequate problems here that should be answered in regard to this particular case.

MR. JOHNSON (Gimli): Mr. Chairman, this takes us back to probably explaining in a little more detail what I tried to say all in one gulp yesterday. We certainly recognize the need for facilities for the treatment of the acutely disturbed child or younger person. I regret to tell the House that one of the things brought to my attention recently was, and to the chagrin of the provincial psychiatrist, a nine-year old child in the psychopathic facility--or in the phychiatric institute as we know it. I've already spoken with the Board of the Children's Hospital where in the next few years we do hope to develop more facilities, including a facility for the treatment of the acutely disturbed youngster. The Children's Home are keen to get on with the creation of a facility for the child who, say needs a month or two in an acute facility and needs probably a prolonged period of active treatment or custodial care. They feel that this is the role they should be filling. We have again asked the Society for Crippled Children who are constantly in need of having some of their cases assessed psychiatrically, and again the Association for Retarded Children who need children assessed psychiatrically, that these facilities be centralized and all these medical skills, say at the Children's Hospital in the Greater Winnipeg area were--the same facilities could be used by all the agencies who come across cases, finding them, and using this as their central core of medical knowledge and skill in this field. This is a very great need.

I think when we visited that institution we also saw the older concept of the patients who have, say been in a facility in the province, at Brandon or Selkirk, for 25 and 35 years. As I said yesterday, the hope is thatwithin 10 or 15 years we can reverse this completely in that these people, we think, largely have accumulated it in this way because of older concepts of care. I'm happy to report that some of these people, one or two people after 25 years in Selkirk have been sent home with modern therapy. As I indicated in my remarks, the whole secret depends on getting adequate staff and supporting them in out-patient type care. When the psychiatrists tell you that with adequate staff, and even now with the minimum staff we have because they're dedicated and working their hearts out, 90% of the people who come to our facilities for an acute illness go home, but we've got to support them in the community.

Now perennially I catch the wrath of the member from St. John's because we haven't got more psychiatrists. Well this goes back to the high school. The medical profession is competing for the high school graduate today. Last year we only graduated 35 medical men. We graduated 90 in 1952 with 35 students graduated in medicine. With all the hundreds of areas or the many exciting and probably more dramatic areas thatthese boys will pursue, there is competition for the graduate to enter psychiatry. As I indicated this afternoon, my staff advise me that as a training program, we're offering very attractive programs. We'll take a boy graduating in medicine and pay him over $6,000 a year in his first year of training; $7,600 in his second year; $9,600 in his third year. I think that's right--the figures may be a little out but it's substantial. But this isn't enough. I think that as we become known as a province that's on the march in this field that we're going to create facilities in the community where there's a challenge to these men and it will be a greater attraction to them to come into the psychiatric service. But we are in competition for students; we're in competition for the medical graduate. It's not only in Manitoba; it's world-wide--everywhere you go. Britain is anticipating the same things as I saw when I was there. They have about the same number of beds, the same kind of beds we have at the present time. They're trying to break out with day hospitals, half-way houses, facilities in the community, and they're perennially bugged with staff. I think the exciting thing that I was trying to convey yesterday and the thing that--I haven't got the answer anymore than probably any other Minister of Health in Canada--but we do know, and it's my firm feeling, and conviction, that it's worth our while if we can attract them by hook or by crook to get on with an active program because it will mean a halving of our mental health population in 15 years. This is a

(Mr. Johnson, Gimli, cont'd.) ..... stimulating thing to anticipate. I'm sure I've talked to the provincial psychiatrist a dozen times in the past year about staffing, etcetera. We'll just have to keep on doing our best and, despite this, I think we're building these new facilities with the hope that these people will show up so that we can have them staffed.

MR. HAWRYLUK: Mr. Chairman, thank you very much for some information there. As you are aware, and I think the members are aware of the big field that's opened up, for example in the teaching profession, right across Canada there's a new member of the staff of junior high and high schools being introduced, a person by the name of a counsellor. Now this counsellor is usually a teacher who takes a special kind of a course. This particular person could be in a large school, could be a male or female, and his or her sole job is to actually give counselling to disturbed people. I'm just wondering if it's necessary, for example, due to the fact that you cannot get what you call a recognized MD psychiatrist, is it necessary that you have to get one in order to be a sort of a counsellor, from trained personnel, say from social workers who could go to that field which I think you might be able to get more rather than just depend on, say the acknowledged MD psychiatrist. I think there are a lot of social workers that would be more than happy to take an extra course or two in that particular field and fit into the kind of a job that you have in mind, particularly when you can't attract the MD into the profession today. I certainly would advise you to possibly branch out in this particular field and get people who are definitely interested in dealing with people and individuals. That would be an incentive for you to have some of them in your various mental institutions here in Manitoba, because it is being done right now in the various schools across Canada. These are taken from experienced teachers, and I can tell you the counsellors today in some of our high schools are doing an excellent job because we do have disturbed people in the high school level. They have, to my way of thinking, have prevented a bulk of them being either expelled or suspended because of certain reactions at home or disturbed minds. They are doing a doggone good job. I'm just wondering, as a suggestion to you, Sir, that possibly if you can't get the medical doctor who does not want to go into the field of psychiatry, to get a lot of social workers who possibly would be very glad to go into that particular field. Secondly, are these teen-agers, for example, who are taken to these institutions, are they segregated from the what you call the confirmed type of mentally disturbed adult? I certainly wouldn't want to see some of them intermingling with what we'd called a confirmed mental patient, as we do have, unfortunately, as far as our teen-agers who are in the various gaols today who are allowed to stay incarcerated with some of the more renowned criminals. I wonder if that's being done as far as your teen-age disturbed persons in some of your institutions?

MR. JOHNSON (Gimli): Mr. Chairman, I think the acutely disturbed youngster--I think everything possible is done these days to treat that patient very actively without gravitating to a large institution. Certainly our older teen-agers in our larger facilities and depending, of course, on the type of illness. But I do concur, and the psychiatrist advised me that with more psychologists these people can do a lot of the ground work and save a lot of man psychiatric hours, and of course the strength in getting mature qualified psychiatric social workers is to keep the people in the community, as our cohort study that has been carried out in Brandon reveals. This, of course, is the concept we're following through in our community mental health program where we have psychologists, social workers and psychiatrists on the team. I would hope that my honourable friend would encourage all his members in the teaching profession who are dedicated and want to make a contribution in the area of mental illness to come and take their course in psychology and come with us. I was impressed when I went to the Child Guidance Clinic in Winnipeg, where actually through the Health Plan we contribute largely to the salaries of the people in that facility, there are a total of 21 social workers and psychologists working out there. It just sort of taught me that if you can bring mental health facilities into the greater Winnipeg area on an active basis, you will attract people like that to come and work with you, and this is another reason for saying maybe it isn't always the money we're offering, it's the working conditions and case loads and so on.

MR. CHAIRMAN: ..... Brandon Hospital.

MR. ORLIKOW: Mr. Chairman, I wonder if I could get some breakdown on the number of staff. All we have in the civil service was, I think, 476. What are the categories; what are the qualifications; and I wonder if the Minister could tell us, and this of course would cover both

(Mr. Orlikow, cont'd.) ..... Brandon and Selkirk and possibly also the Manitoba School for Mentally Defective Persons, do they carry on a training program for staff--in-service training? Is it training on the job or is it voluntary? Does everybody have to take it?--(interjection)--Beg pardon?

MR. JOHNSON (Gimli): ..... your last question?

MR. ORLIKOW: Do all the staff have to take the training? Is it training on the job or off the job? Are they paid while they're taking it, and so on? I want to agree with the Minister that the whole program will make or break on the kind of staff that we have. Now if we can't get staff from outside, surely we can do considerable about training staff once we hire them. The reason I ask this question, Mr. Chairman, is that there's such a tremendous difference in the total staff in our institutions, Brandon and Selkirk, as compared to the two large Saskatchewan institutions at North Battleford and Weyburn, where their figures for this year would indicate that they have about a third more staff--about 50% more staff than we do.

MR. JOHNSON (Gimli): Mr. Chairman, the total establishment at Brandon is 476 people. Compared to last year, there are 16 new positions at Brandon and there's 24 at Selkirk. There are the two psychiatrists, qualified; there are 9 other psychiatric officers, or medical men; psychologist dentist, Medical Officer 2. One of them, this is a more a treatment--physical illness and so on. The technicians, the 13 occupational therapist instructors; the Research Analyst I--this is in biochemistry of mental illness; 7 occupational therapy aides; 166 attendants. If you recall, two years ago when we brought in The Psychiatric Nurse Training Act, we reorganized our training program in the three institutions to give uniformity of training under a Director of Nursing. There are 97 institutional nurses in Brandon and 58 pupil nurses. These are the girls who take the two-year training. Nurses' aides are non-students who just receive in-training. Our Bursars, whom we reclassified to Administrative Officer I's, last year I think it was, have been given more authority in order to relieve the Superintendent of many of the day to day tasks. However, both superintendents feel, to keep the medical orientation of the institution, they have to become involved to a degree in the policy of the administration, but we've tried to, by reclassifying the bursars as administrative officers, give them more authority in signing the chits for, you know, all the day to day labour that the superintendents were doing. Then the rest is cooks, laundresses, two welfare workers in the instutution, etcetera. We're adding a pharmacist at Brandon this year due to the increased load of drugs, and hoping to get him to assist with the organization of the pharmacies of the other two institutions. I think the members realize last year we added 20 other staff. This year the new positions are another occupational therapy instructor, 10 institutional nurses, and an extra intern, clerk-steno, cook, laundress, and as I mentioned, the pharmacist. There's 16 more in this appropriation than last year and we have had no--two of the psychiatrists here, one of them has been placed in the community mental health program. I would point out we have five medical officers, 3 psychologists, 6 junior medical officers in training, 3 institutional nurses, 3 clerks, 2 welfare workers and 9 social workers or 11 workers in the community mental health program. I would point out that this community mental health program, as I said last year, we started out using the two large institutions as the base hospital, sending out the team of the psychologists, social workers and doctors into the community. This year we're adding 7 more--another team to that community mental health group. I hope that would answer the question for the honourable member.

MR. ORLIKOW: Mr. Chairman, I may have missed it. How many social workers would there be at Brandon and at Selkirk, and how many should there be under the establishment? If they're not filled, what steps are being taken to fill the positions with qualified people?

MR. JOHNSON (Gimli): How many should there be, did you say? And the last question?

MR. ORLIKOW: How many are there in the establishment and are we up to establishment. If we're not, what are we doing to--I'm wondering, for example, whether there are anybody--if they're not, if the Minister's contemplating some expansion of bursaries to get people who will go back to work in the hospital. I think it's just as important as getting people to work in the welfare departments at which the Minister was very successful in the last couple of years in building up the department.

MR. JOHNSON (Gimli): We're not up to strength at all in social workers--in psychiatric social workers. They're hard to come by. We transferred a couple of these social workers from our Brandon hospital into the community development team working out of the hospital. I

(Mr. Johnson, Gimli, cont'd.) ..... think our establishment will be the number of psychiatric social workers we can get. I don't think you can get enough of them. I think last year I announced in the House that we had 5. We now have 4 at Brandon--no, we have 2 occupied at the present time in Brandon. We're down there but they pinched three of them for the community mental health team in that area this year. In training we have, on bursaries and so on, we have 7 psychologists of course this year; 2 psychiatric social workers on course; and 9 physicians. These are the ones that are not in the estimates and positions that I have mentioned here. The 13 welfare workers in our community mental health program--two were taken from the Brandon establishment for the community mental health team, and two left in. The same in the Selkirk Hospital. We have 3 in the establishment at Selkirk.

MR. ORLIKOW: Mr. Chairman, do you have any plans for a crash program of bursaries or scholarships to bring up this number? As I mentioned last year, I think this is almost as important as getting psychiatrists and I think it's a good deal easier. We have been very successful--the Minister should be commended, he was very successful in getting people on staff in the welfare department to administer the social allowances program. If he used the same kind of determination and the same kind of imagination and the same key to get the money out of the Provincial Treasurer for bursaries, I think we could make some real progress.

MR. JOHNSON (Gimli): ..... to my honourable friend. We have two or three gimmicks to assist us too, this year, in getting psychiatric social workers. One, as I have mentioned, under the vocational training agreement, I think we could get 50% of the salaries of social workers if we can get them, to follow patients out of mental hospitals into the community. That is under the mental rehabilitation program, which the staff are anxious to do. Number 2, again we are competing for the university graduate today, and I think they were talking about they should have a BA plus a year in this field. And the bursaries--we have the bursaries available. Professional training grant bursaries are spent to the maximum in the last two years and, as I've mentioned, in the community mental health program we now have put 14 workers and we have 3 at Selkirk and 2 at Brandon and 2 at our psychopathic hospital. The staff are certainly after them. I know the Superintendent of one of the institutions has some ideas on training psychiatric social workers from graduate nurses, if we have to on a crash basis, but it's the matter of getting the trained personnel and training them.

MR. CHAIRMAN: (2)--passed. (3)--Selkirk Hospital for Mental Diseases--

MR. SCHREYER: Mr. Chairman, are you going (a), (b), (c), or simply passing the whole item? Under (3) (e), or rather (3) (d), farm salaries. Since we are paying $134,000 in salaries for maintaining and running the two farms at the two mental institutions, I was wondering if the Minister had information with him as to the size of the farms and the scope of operations? It's pretty significant--it's $134,000. Nineteen employees at one--16 at the other. What are the operations there?

MR. JOHNSON (Gimli): Well, I invite my honourable friend, Mr. Chairman, to come to our farms, where we have the best Holstein herds in Canada, and see the extent of them. I haven't got the total figures all on my fingertips.

MR. SCHREYER: What I was thinking of was the acreage and, in the case of livestock, the number, the size of the herds. It seems to me that in employing 35 people, it seems to make it a pretty extensive operation.

MR. JOHNSON (Gimli): I haven't got the number of cattle here. The amount of acreage in detail--I can't remember off the top of my head--large herds of course of cattle at all three mental institutions, plus quite a bit of land. I could get this information for the honourable member for tomorrow.

MR. SCHREYER: That's fine.

MR. JOHNSON (Gimli): The inventory values of the grain, feed, vegetables and livestock, etcetera, I have figures on. However, I haven't got the exact figures on the number of animals.

MR. ORLIKOW: ..... to bring in something on that whether he couldn't tell the committee if the farm is used in any way in terms of treatment. In other words, if patients work on the farm and if this has value as a therapeutic method, of course this is a separate matter; but if not, then I wonder if the Minister could make a statement to the House--I don't think we've ever had it while I've been here--on whether in the present context of the institutions, whether it's worthwhile continuing with the farm operation as a part of this or whether the province

(Mr. Schreyer, cont'd.)..... wouldn't be better off selling the land or leasing the land and cutting that part of it out, if we are in fact losing money on it. I just suggest to the Minister that possibly he could report on that aspect at the same time.

MR. JOHNSON (Gimli): I can give you the figures in detail tomorrow but I would like to say that I spoke on this last year. Just, I think the year before I came into office, a thorough study was made by the Agricultural Department and they thought it was to the financial advantage of the province to continue the farm. I had a similar study made two years ago which showed, and I have these figures because I gave them to the House last year I belive, that at wholesale prices--the value of the farm produce at wholesale prices or cost, more than exceeded the depreciation on machinery, etcetera, plus the salaries. In other words, it proved a paying proposition for the amount of produce they produced in the institutions but I'll get these figures for you just to reinforce this. Secondly, on an efficiency basis--(interjection)--Oh, no deficiency or acreage payments there. We're like the fishermen from Gimli--we don't go in for those large subsidies at this time in this area. No, I'm just kidding really. It has proved a very successful operation. I noted with respect to occupational therapy--I think when these mental hospitals were built almost every family in Manitoba had an agricultural background and these institution farms did serve as a form of occupational therapy, but I think in the modern concept they're not so much as an occupational therapy endeavour as they were in the old days, although it is a source of some activity for some of the older long-term inhabitants of the large institutions. I do understand, however, that the Assistant Deputy Minister of Agriculture advised me that they provide a very valuable extension service to the areas which they serve.

MR. SCHREYER: Mr. Chairman, tomorrow will be fine. Acreage and livestock size.

MR. CAMPBELL: Mr. Chairman, there aren't many places that I would attempt to help my honourable friend out in this particular department, but I think if the honourable members would take a look at the department booklet that's been furnished to us, on Page 51 they'll see some figures of the production on these farms. My recollection of the situation is that the experts consider that those in the mental institutions and the retarded institutions, that there is considerable therapeutic value in having the patients take some part in some of the work. I think those of us who were down at Selkirk on the visit that the Honourable Member for Burrows mentioned, recall that many of the patients were quite interested in the dairy herd there. Certainly at Portage la Prairie the inmates there do a great deal of work. Of course I guess the Portage la Prairie people are great workers anyway--and certainly they have the very best of the land there. Those institutions do combine the two activities. First, they raise crops that have a very definite value, but it is considered that there is some therapeutic value as well I believe. Now I mention only that Page 51 and 52, I think, give some figures that bear that out.

MR. SCHREYER: ..... Mr. Chairman, and it's very helpful information, but I still would like that other request being carried out.

MR. CHAIRMAN: (3)--passed. (4)--Manitoba School for Mentally Defective Persons--pass?

MR. MOLGAT: Mr. Chairman, on (4), I believe I asked the Minister some time ago about some of the news reports that came out towards the end of February regarding the staff at the Manitoba School. The Minister at that time indicated that the reports were not quite correct, but I think he did say to me that he wasn't satisfied himself with the number of staff that he had there. I wonder if he could give us some more information on that matter now.

MR. JOHNSON (Gimli): Yes, Mr. Chairman. In this type of care I really honestly feel you never have enough staff. There are, as you know this year in these estimates, a total of 51 as an increase in staff to help open the new wing. The main problem is, in any of these institutions, you never have--and I think I was referring to the fact that you never have enough staff. Concerning the allegations--now that the Leader of the Opposition has brought this up. Following the reports in the newspapers concerning the allegations re the Manitoba School--charges against the type of treatment rendered at the School and so on--I received a letter from the Medical Superintendent of the School, who said: "I am sending you a certified copy of the statement I received from the members of the delegation from the Manitoba Government Employees Association at the Manitoba School. It appears to me that whether or not all statements alleged were correct, there certainly was something said that did not reflect very well on the care of the patients whithin this institution, and I think that the fact that the members of the delegation of the

(Mr. Johnson, Gimli, cont'd.) ..... MGEA have presented the attached submissions is prima facie evidence of their concern. I feel that the Manitoba School staff have in a large measure resented any implication that their care of the patients is less than could be expected, and a definite reflection on our own efforts over so many years. I am attaching a copy from the chief male attendant as an example of the subsequent resentment against any alleged statements concerning this care at the institution." There's a signed statement here from the delegates to the convention that: "and we would say that the Manitoba School mentioned by newspaper, Dr. Atkinson's advanced humanitarian policies are well known throughout all of North America. We were merely asking for more power to his elbow in the form of adequate support in his life-long campaign to make the care of the mentally retarded in Manitoba the finest in the world." They just want to say that they hoped for more and more staff each year. However, it was--I thought I would give you a report from the chief attendant. "Please be informed that I had no knowledge whatsoever of the resolutions presented at the Annual Convention in Winnipeg. After reading the article in the Winnipeg Tribune stating inhumane treatment at the Manitoba School for Mentally Deficient had been charged at the convention, I can only term it utterly ridiculous. During conversations"--and so on--"the three delegates from the male nursing staff attending the convention"--I was told the article was worded incorrect. "In my 34 years on the male nursing staff I can only say I have always been proud of the splendid nursing care administered to patients by the male staff and will gladly, with your permission, have anyone investigate at any time for themselves the care and treatment administered to these patients. M. Stronski - Chief Attendant."

These were sent to me following the questions in the House, and I thought I would relate them to the committee on this item in estimates. I think we all are concerned that more and more staff are required in the mental institutions. I would tell the committee frankly that the turnover is just fantastic in the Department of Health in the lesser qualified positions in the various institutions. I am sure there's 16 to 20 a week coming and going in Nurses' Aides--you know, this sort of thing--and we need real dedicated people there. At the present time the total establishment at Portage la Prairie is 367, of which--this year an increase of 51.

MR. ORLIKOW: I think that the Minister raises an important question which needs to have some real intensive study, and that is, not the report in the newspaper because I think every member of this committee has attended enough meetings and enough conventions to know that the stories change and grow as they go from the delegates who have a very sincere and a very laudable idea and go to a convention, and go from the convention through a reporter and through the rewrite desk and so on--the story changes, but I think that the question which they raise is an important question. I don't think anybody would question, or I don't think anybody suggested that the treatment isn't as good as the staff can give with the staff which we have, but the question which we must ask ourselves is: "Do we have sufficient staff?" And when the Minister tells us that we have a very high turnover, I want to say that somebody qualified ought to be looking into this question of why we have a turnover. Turnover can be the result of a number of reasons. It can be the result of too low salaries. I made a quick calculation about the increase in the total salaries as shown here in the estimates and divided it by 51, and I got a figure of about ..... we're paying, then I'm not surprised that we have--that's the average rate, and if there are increases at the top, increments and so on, then the rate at the bottom is probably substantially less than $3,500 and I'm not surprised that we have rapid turnover; and if we have turnover, two things are happening. First of all, we are losing money because no employee, no matter what his job, is really worth what he's paid in the first period of time that he works. He's being trained at the expense of the employer so we lose money right there. And secondly, we are certainly losing efficiency in terms of service to the patient. It would seem to me, Mr. Chairman, that we need to have a good hard look at this question of staff and of salaries and of turnover. I am glad the Minister says we're always thinking in terms of more staff, but I wish that we would have a look at how our institutions compare with similar institutions in other provinces in terms of total staff and in terms of qualifications. It would seem to me that those resolutions--they may be poorly worded but they usually have a very reasonable beginning--and I think we ought to be looking for the cause rather than just saying "well it wasn't quite what the newspapers reported."

MR. HILLHOUSE: Mr. Chairman, if the Minister has a copy of the resolution which was

(Mr. Hillhouse, cont'd.) ..... passed at the Manitoba Government Employees Association meeting, I think it should be read to the committee so that we know what we're specifically dealing with. I would prefer to deal with the resolution as it was passed, rather than reports of what took place.

MR. JOHNSON (Gimli): ..... a copy of that resolution, but I was trying to say to the committee that the turnover really is in domestic staff and in Nurses' Aides in these large institutions. I think, on making enquiries repeatedly to the Deputy Minister re this turnover, which he tells me has gone on since he came in as the Deputy Minister close to 20 years ago, it hasn't changed at all in pattern and apparently is quite universal in institutions of this size in caring for this type of patient in other jurisdictions, and this has been our experience. For example, in looking after the children in the smaller facilities like St. Amant ward, we're able to get a staff ratio of almost 1 to 1.8, whereas our staff ratio in our larger institutions caring for so many of these defective children, the ratio falls down with staff for these reasons. But the turnover in these two categories largely--but I'll get a copy of that.

MR. HILLHOUSE: ..... in Selkirk Mental Hospital, that is attendants toward patients.

MR. JOHNSON (Gimli): I can look up that figure for tomorrow, also, Mr. Chairman.

MR. MOLGAT: Mr. Chairman, would the Minister undertake to bring in a copy of the resolution in that case? Shall we leave this item open then for--when that comes, it doesn't matter which one. I suppose the best one would be the Manitoba School for Mental Defectives. I think the resolution applied mainly to that one institution, although it did mention the other two.

MR. CHAIRMAN: Expenditures under Mental Health Grant. Passed?

MR. ORLIKOW: Mr. Chairman, I notice that there is no expense to the province. I wonder what this is for?

MR. JOHNSON (Gimli): The mental health grant is used in many areas here, and this was established originally as a federal grant to assist in the mental health field. Incidentally, our allotments--we're making use of about an average of 95% of these grants. This is an estimate. We never know exactly from year to year just what our grant is on a national basis, but this is pretty well what it works out to. This is used in a number of areas. It's used in the employment of additional staff and purchase of equipment. We have to, in these grants, submit the method by which we're using these grants to the federal authorities and they put a ceiling on how much of this should be used for salaries and how much you can use for projects and so on. There isn't complete flexibility in this area, but employment of additional staff and purchase of equipment and supplies, for instance the following hospitals and clinics: the Psychiatric Institute, Winnipeg, Portage school, some of this is used to support most of the salaries in the Psychiatric Division of the Child Guidance Clinic, the Brandon and Selkirk Hospitals, the psychiatric out-patients, Children's, St. Boniface, and the General. It is used to assist in post-graduate training by contributing towards the salary paid by the Medical College of the university to the Professor of Psychiatry, purchase of textbooks, and the payment of honorariums to visiting lecturers. It's training of mental health personnel--physicians, speech therapists, psychologists, social workers. It finances the research in the field of mental health in the projects we have, our follow-up cohort studies; the methods of evaluating the mechanics of a ..... drugs; the treatment in Brandon; the investigation of automatic variables; there's also a study of chronic schizophrenia going on; the payment of part of the salary of the psychiatrist at a children's home in Winnipeg; and, in other words, mental health salaries, training, research, and so on.

MR. M. N. HRYHORCZUK, Q.C. (Ethelbert Plains): Does the federal government pay for the keep of Indians, Eskimos and other personnel? Where do we find that in the estimates? Wouldn't that be under recoveries?

MR. JOHNSON (Gimli): Yes, it's under recoveries. We charge--the per diem rate, I think,is $3.50 per day to the federal authorities for Indians, Eskimos and their wards. This is paid to us. It comes in under a revenue item in the Health Department here. I just can't recall where that is. I think it's in the revenue section. It's not in this part.

MR. HRYHORCZUK: Is it under any of the recoveries that are shown in the estimates?

MR. MOLGAT: ..... set by ourselves as public costs or rates set by them?

MR. JOHNSON (Gimli): No, it was $2.50 but we raised it to $3.50 about a year and a half ago. This is an average per diem rate.

MR. MOLGAT: That is the federal government did.

MR. JOHNSON (Gimli): No, we did.

MR. MOLGAT: We did, and presumably this covers our cost completely?

MR. JOHNSON (Gimli): Yes.

MR. CHAIRMAN: (5)--Passed. (6)--Community Mental Health Services.

MR. HILLHOUSE: Mr. Chairman, I'd like to deal with (e) under that heading. First of all, I would like to thank the Minister for the increased grant which he has given to retarded children outside of institutions this year. I also wish to thank him for the sympathy and understanding which he has shown to the two delegations, of which I was a member, that attended before him during the past year. But notwithstanding my personal feelings of gratitude towards the Minister, I still feel that this problem of mental retardation is only being scratched and that until such time as we have a planned co-ordinated program to deal with this matter, we will never reach anywhere near a solution of the problem. The Manitoba Association for Retarded Children recently submitted a brief to the Royal Commission on Health which met in Winnipeg in January of this year, and in that brief they clearly set out what the objectives of the association were; what the needs were; and what the problems were that had to be faced if we were to try and solve this problem.

Now I don't know whether the members know the number of retarded children in Manitoba and the figure which I am going to give is more or less of an intelligent guess, because there's never been any survey made in Manitoba nor has there ever been any survey made in Canada, but the figures with which I have been furnished by the Manitoba Association for Retarded Children indicates that, in Manitoba, children of pre-school age under 6, there is at present 300 in custodial care, 600 are trainable, 2,100 are educable; that's a total of 3,000. Children of school age, 6 to 18 years, there's 495 in custodial care, 990 trainable, 3,465 are educable; a total of 4,950. Then in the group 19 to 75 years of age, there's 513 in custodial care, 1,026 are trainable, and 3,591 are educable; making a total of 5,130 or a grand total of 13,080 in the Province of Manitoba. Now these figures may be questioned by the Minister; they may be questioned by other authorities; but they are the best figures that the Manitoba Association for Retarded Children has been able to gather. That gives you some idea, Mr. Chairman, of the immensity of the problem in the terms of numbers with which we are faced. I think that I can do no better in drawing a clear picture of what is required to meet this situation than to read the submissions that were made to the Royal Commission by the Association for Retarded Children in Manitoba.

I will not read all the briefs, but I will read parts of them. The Association said: "The Association itself, however, is basically a lay body which, through circumstances, has accepted the responsibilities of providing day classes, occupational centres, vocational training and sheltered workshops, summer camps and recreational programs for all those retarded children and adults in the community who would benefit from them, and for whom such services have been non-existent. To date, with the exception of sheltered workshops, these responsibilities have been met, but only in some areas and to some degree. Attempts have also been made to assist, guide and counsel parents of these retarded." The brief goes on to say: "Any briefs dealing with problems occasioned by mental retardation could be extremely technical and lengthy. The causes and conditions associated with mental retardation are complex and numerous and the effects severe and far-reaching. Any work aimed at the prevention or amelioration of conditions so caused, demands, or should demand the service of as many or more different professions, disciplines and governmental authorities than does any other type of human disability. To what extent and under whose jurisdiction the main responsibilities for the care and training, particularly of the dependent or semi-dependent retarded child should fall, is the main theme of this brief. It is suggested: (1) at present the full responsibilities of the different groups involved with respect to care and programming for the retarded child are not well enough defined; (2) there are large gaps as far as programs and services are concerned; (3) there are neither the facilities nor the trained personnel required to fill the gaps; and (4) since the aims of the association are accepted in principle by the government and by the public and expansion is inevitable, and since the work involved is a major undertaking of national significance, it is therefore essential that more provincial direction, co-ordination and financial assistance be given and be supported by a system of federal grants so that future development be as practical, efficient and economically sound as possible."

(Mr. Hillhouse, cont'd.) ..... The brief goes on to say, "It should be explained at this point that the retarded children who have, in the past, been the main concern of the association are those in the trainable and custodial, rather than the educable, category. One of the more obvious reasons for this is that the educable group receives public school education according to its abilities, and most parents do not actively interest themselves in the association unless they feel the need of a specific service from the association. However, lower grade children in the educable category present many of the problems of those in the trainable category which may call for further considerations in connection with placement and curriculum, for in leaving the special classes in the public schools, a number of such children are referred to this association. A number of them become recipients of health and welfare assistance; a number of them become emotionally and socially maladjusted. This group illustrates one of the many problems of adult retardation and the total problem is only recently receiving any real attention.

For several years this association has been very much concerned about total community programming for the mentally retarded. Some of the present facilities in health and education could and probably should extend their services on behalf of the retarded. But this possibly notwithstanding, the association feels that the following facilities are basic to any kind of total program:

(1) medical, psychiatric, psychological and sociological diagnostic and counselling centres to which any child in the community suspected of being mentally retarded could be referred. These centres would be utilized for:

(a) initial diagnosis and assessment in the above-mentioned areas;

(b) parent counselling after the above four assessments;

(c) the referral of children to other centres of professionals for further specialized examination or treatment;

(d) the making of the decisions about placement for schooling or training or care, or, in the case of older retardates for vocational training, workshop placements or simple employment;

(e) provision of pediatric and psychiatric social workers to advise and guide parents of the mentally retarded in matters of home-care and treatment and to assist them in reaching decisions affecting the future care or well-being of the retarded one, such personal work in the field rather than at the centre;

(f) provision for reassessment when needed and the maintenance of longitudinal case histories;

(g) registration of retarded children;

(h) research;

(i) provision for student training and field work.

(2) Provision of an adjustment and therapy program for mentally retarded children under six years of age.

(3) Day-training classes for children excluded from the public schools because of mental retardation, whose eligibility for such, from six years of age up to twenty, would be based upon the ability to benefit.

(4) In conjunction with day-training programs, recreational occupational centres for those children who, as they become older, do not adopt themselves to a formalized training program, and who would not benefit to a full day's training as might be given in the usual association day classes. The more formalized training referred to would be that which is aimed at developing higher grade trainable mentally retarded children to this extent that they would stand a fair chance of successful participation in a sheltered workshop. The recreational occupation facilities would serve the needs of those children whose parents wish to keep them at home but whose chance of employment or sheltered workshop participation were negligible. The operation of such centres to a large degree to be left in the hands of workers other than qualified teachers.

(5) Sheltered workshop. There would be two aspects to the workshop. On the one hand, would be a minority group whose training in a workshop would be designed to rehabilitate them for special placement in outside industry. On the other hand, would be the provision of work for those whose placement within a workshop might be considered permanent because although they might work reasonably effectively under close supervision, instability of an organic or emotional nature would retard the kind of close supervision

(Mr. Hillhouse, cont'd.) ..... encouragement and special attention which would not be normally available in outside industries.

(6) Provision of residential facilities either in the form of foster homes or larger units such as the Broadway Home for Girls for the placement of mentally retarded children so that they could be brought in from small or remote communities or, for that matter, from governmental institutions to attend, where none was available, day classes or sheltered workshops.

Now, Mr. Chairman, that sets out the requirements of a co-ordinated program as envisioned by an association of laymen who have unselfishly devoted their time, energies and money to a cause in which all of Manitoba should be interested. It's a cause too in which Canada should be interested. I don't consider this to be strictly a provincial problem. I consider it to be a federal problem and I consider that the federal government should contribute wholeheartedly to this cause. I would suggest that the Honourable Minister of Public Works, at least of Health, that he sees his counterpart in Ottawa; see the other Ministers of Health throughout the various provinces of Canada and see if some co-ordinated program cannot be worked out to help these children.

.....Continued on next page.

MR. JOHNSON (Gimli): Mr. Chairman, with respect to the remarks of the Honourable Member from Selkirk, I feel I should draw a couple of matters to the attention of the committee. I appreciate his interest and concern in the work of the Association for Retarded Children and the statement he has read with respect to the brief made by that body to the Royal Commission. I agree with him, and we have tried to say this in our brief to the Royal Commission, wherein we suggest that the grants that are made available to the provinces in the area of all federal health grants be made entirely flexible, and with the inclusion of mental health under the hospital plan as a proper shared item plus the grant structure. Special grants could be diverted into this very necessary area which is really snowballing in these last few years. I tried to point out in my remarks yesterday this is the area that is going to be of such importance in mental health in the future as we hope that we're able to make large strides in adult mental illness.

I would point out to the honourable member that a great deal of work is being done by the Director of Rehabilitation and the provincial psychiatrist in trying to define the real role of the department in working with the voluntary associations. We think there's a great -- as I indicated earlier -- in child psychiatry a great possibility of developing a one referral service using the same community mental health service facilities and facilities of the medical team in the acute psychiatric facilities that have been developed in Winnipeg to assess these children. I think assessment is -- they need assistance here -- professional help. Our long-term plans -- as we've indicated, the Sisters operating St. Boniface Sanatorium are now increasing as you see in this estimate -- we're increasing the capacity there to 110 this year which is a very large increase in the expenditure and we are happy to be at least going forward on this front. And we hope to continue our close association with the Association for Retarded Children to bring about a co-ordinated program where there's a minimum of duplication of the work of other agencies; a lot of short cuts, I think, can be gained by doing this and possibly if we create chronic facilities in the St. Boniface area, releasing more and more beds for the care of the sick mentally defectives in that facility out there. In the sheet I tabled today we would hope that in the trainable area to get on with the development of workshops in the future and to expand the type of facilities the member indicated under the Broadway Home type of operation.

MR. ORLIKOW: Mr. Chairman, if we could go back to Item (a) the Minister could give us a short report on where the community health programs -- what towns are being serviced; how many extensions, if any, are planned for next year; how many doctors we have working in this department, and so on.

MR. JOHNSON (Gimli): Working out of Brandon, Winnipeg and Selkirk is a beginning. Through institutions and local health units, the personnel from the hospitals form a working team from that institution. This is in addition to the estimates you have looked at. There are from Brandon two MD's, two social workers, psychiatric (2), one social worker, no, three social workers, psychiatric (2); and one social worker, psychiatric (3) and one stenographer; that's one team out of Brandon. Out of Selkirk - two MD's; two social workers another team of psychiatric (3) social worker; one medical officer psychiatric (3); one psychologist; another social worker; psychiatric nurse and clerk-stenographer which are the new team this year, plus the transfer of a social worker and psychologist working out of the Winnipeg Psychopathic Hospital. I think that's the complement of our team. Last year we had 31 on the two teams and this year we're adding seven more.

MR. ORLIKOW: The Minister didn't answer the whole question I asked -- maybe I didn't phrase it right. Do the patients come to the doctors or are the doctors going to other -- are these travelling clinics or what is the set-up?

MR. JOHNSON (Gimli): The set-up is that these teams work out of the -- they're based out of the hospital and they -- for instance in Selkirk the Community Mental Health team holds their clinic down in the local Health Unit, and the Public Health Nurses and the local Health Director there play a part in knowing who these people are and they see them down in the community. Also the team from Selkirk contacted all the doctors in the eastern area in the Interlake and advised them of their service and the availability of their services and they they could refer patients to them on an out-patient basis and actually going out into the community where there are Health Units to set up these clinics. The team working out of Brandon, for instance, came to Swan River when I was there last fall. They were anticipating that the Medical Director of

(Mr. Johnson (Gimli), cont'd) ..... the Health Unit would set up the clinic and the patients, many of them who might have been in the Brandon institution have been told to come there for follow-up -- they are treated and given sufficient medication to carry them fully on this program. It has met with great success. I can relate for instance the type of letter that was sent out to the doctors from the team in Selkirk where we sent psychiatric consultation services. It has been realized for some time that physicians in rural areas often experience difficulty in obtaining psychiatric treatment for their patients, particularly those of uncertain financial states -- can't afford private care or can't travel to Winnipeg or Selkirk where care is available. In the Selkirk area, where such service is available, the number of referrals for out-patient treatment or general hospital consultation has been steadily increasing. Presumably this represents a need that should be met. This hospital is part of the community mental health program and is now in a position to assist. In general we conceive of being able to have a psychiatrist and staff -- that is, a psychologist available for travel to local centres such as Pine Falls, Beausejour on a weekly basis or more often according to demand. The team could offer consultation and treatment on referral from the physician -- office space we would hope could be arranged locally. Now where we have the Health Unit set up we have the local Health Unit Medical Officer arrange the site where these consultations can proceed. I can tell the committee that I accompanied, for my own information, one psychiatrist to a home, for instance, where there were four disturbed old people in a boarding situation, or a hostel, where the matron found the patients very difficult to handle and where, without a service like this, these patients would, of necessity, been sent to an institution for care. Here, after a half a day's visitation in this facility five of these old people were successfully treated and maintained ambulatory in their own environment. We visualize this -- this is what these two teams are doing -- we hope to add this further team this year working out of these areas.

MR. ORLIKOW: Is the objective--I'm not saying that I think we should have reached it yet, but is the objective that the teams will be making regular visits in the towns on a weekly or bi-weekly or a monthly basis? Will the Brandon team--you mentioned that they were in Swan River--will they be going to Swan River on a regular basis? Will they be going to Dauphin? Will they be going to Minnedosa? This is the question which I am trying to get to.

MR. JOHNSON: Of course, this past year was the first time we got going on this. It started out slowly, for example at Selkirk, but is gaining in popularity and the case-load is becoming greater and I can see this expanding yearly.

MR. CHAIRMAN: (6) -- Pass?

MR. MOLGAT: I have some more questions here on the matter of the mentally retarded. The Minister indicated, in reply to the statement made by my colleague from Selkirk, that the Department was planning some work that we would find in the sheets which he distributed today. Is that correct?

MR. JOHNSON: Yes.

MR. MOLGAT: Right--Now I presume he means there the parts that appear on Page 6, under (b) Mental Hospital Program, which provides Portage Home for Mental Defectives, which I presume are tied in with the matter and then Other Projects--the psychiatric facilities would not be part of that, but I presume the 20-bed Children's Home and the Retarded Children's Day Centre in Winnipeg. Are those the items he was referring to?

MR. JOHNSON: Yes, that's where we're making some provision for the grants in those years.

MR. MOLGAT: Could the Minister indicate to us, for example, at the Portage Home--it shows there female residence--year of construction, '62-63. What bed capacity?

MR. JOHNSON: Portage.....

MR. MOLGAT: At the Portage Home for Mental Defectives--Page 6 of the sheet that you presented this afternoon.

MR. JOHNSON: I think, Mr. Chairman, that may be the final grant. Is it dated '62-63 opposite that Portage extension? I've lost my sheet temporarily.

MR. MOLGAT: Oh, I'm sorry. The date is indicated as '62-63. Now according to the sheet the Minister gave us this indicates the year in which the first construction grant payment will be available, so the construction presumably will start .....

MR. JOHNSON: I think--yes, this is on the renovation, Mr. Chairman, with the

(Mr. Johnson (Gimli), cont'd) ..... movement of the 180 out of -- there's been a transition there on that word -- destroying part of one of the old administration buildings and renovating it to create better accommodation on two of the floors. I think we've made provision in these estimates for some grant money to help with that facility. As you know, --I feel that's the only thing left at Portage, after this 180 beds have been opened this month. That's what that refers to there I think.

MR. MOLGAT: Well, this female residence here then is part of the 180 beds that are being opened now? Is that.....

MR. JOHNSON (Gimli): There's a little work to be done in one of the older sections where three floors were vacated because they were obsolete, and we're tearing out the top floor which has got to go and the other two floors have been renovated for patient accommodation and service areas I believe. This is where some grant monies will be required to assist in that work this year. That's what is referred to at Portage.

MR. MOLGAT: I'll tell the minister the information I'm seeking, and then it'll make it easier for him to provide it to me. What I want to know is how much additional space will be provided for either mentally defective or mentally retarded people? Now when he referred to this sheet a few moments ago, the only listings that I see here that would apply are those that I've read off. What I would like to know is how much additional space the government intends to provide at Portage under this sheet. Then the Children's Home in Winnipeg is listed as 20 beds. I presume the only space there will be for 20 people. And in the Retarded Children's Day Centre, I would be interested in knowing how many people that will accommodate.

MR. JOHNSON (Gimli): This program as visualized there includes what we hope will be a start in the development of psychiatric facilities. (a) The development in the Greater Winnipeg area, and it's anticipated this would be adjacent to the General Hospital, the acute mental facility for 150 patients with a large out-patient department. (b) In portage, when this 180 beds is completed, and the renovations to the present structure, some small amount of funds will be required to help out with the hut or the development of a facility for 70 defective boys who are in a branch of one of the old buildings at the present time. Thirdly, it would be our hope that we don't have to add any more beds at Portage. It's gotten to be quite a size now and that's it. Where we had planned to develop a further 160, our plans now are no, not to — it's quite large enough. The long-term view of the department is, and this has been discussed with the St. Boniface Hospital and our staff for the past year, has been that the Sisters are very anxious to continue their work with retarded children, especially the more severe retarded and especially those in need of medical and nursing care. We have pretty well agreed that as the St. Boniface Hospital at the present time go ahead with their plans to develop a geriatric unit adjacent to their present hospital, we wouldgradually have a transition of the present St. Vital facility into an institution for the care of the mentally ill. In this institution we would house those children under 10 years of age in need of fairly intensive care. This is the present long range plan. Following that, our survey suggested that in the future we build, in addition to following up the community health program with smaller units, we develop psychiatric beds adjacent to rural hospitals at key points such as possibly in some of the northern communities maybe.

MR. MOLGAT: .....beds, of course, will not be mainly for retarded. These will be for mentally deranged adults will they not? (Interjection) Mostly. Well Mr. Chairman, my questioning arises from the statements made by the Member for Selkirk, and that is, What are the government's plans in this matter of retarded children? It seems to me that the Minister when he refers to the sheet here surely can't be serious in suggesting that this is the plans because what it shows here is a 20-bed Children's Home in Winnipeg and a Retarded Children's Day Centre in Winnipeg. That seems to be the end of it unless he has more details that he can give us. My honourable friend when speaking indicated that there were some 13,000 in the Province of Manitoba who were retarded of some type or other. Now I appreciate they won't all be in homes, but if we're going to proceed to do something with workshops or something of the sort, surely there's got to be a further program than what's listed here.

MR. JOHNSON (Gimli): Of course my honourable friend-- I'd like to explain to him that in the past year you'll notice the estimates are up quite a bit. We're talking about two or three groups of retarded children. Many of them, as you have said, are not recognized. We feel that as we can develop community mental health, that this will serve a purpose of recognizing and the

(Mr. Johnson (Gimli), Cont'd.) . . . . assessment of these children at the local level. As we have said earlier, the need in the community here is for the development of acute psychiatric facilities, of which we have had none in the history of the Province of Manitoba -- no acute separate facilities or acute facilities for children -- designed for children -- never existed. We've got to get on with that. It's a priority. We've talked to the hospital concerned. 2. The development of the facility for longer care type of psychiatrically ill child, we hope to develop, because the Childrens' Home have operated this type of facility for 77 years. They don't visualize a very large structure. They talk in terms of 20 to 30 of these children. These are psychiatrically ill children. We want to compliment this fine voluntary organization and some grant monies in the psychiatric area have been laid aside for that purpose. So there we have the acute mentally ill and the longer term who would be cared for by the Childrens' home.

The type of facility that is mentioned in the paper in front of you is for the development -- the Association of Retarded Children visualize three programs. The day school -- these are for the trainable children, not the educable. They then have begun a day centre in the YMCA in St. James where they have started out in the past year and I think at the present time have somewhere around 40 children attending. In discussing their plans with them, we laid enough aside in the $106,000 item this year to, besides giving a grant to the children attending day schools, we would agree with them to expand their day centre up to 100 children this year. They feel that in about '63 or '64, they would be ready to proceed with the development of a sheltered workshop for the trainable child-- trainable retarded. We have had none to date, and we would have to be experimenting. In discussing our mental health plans with them, we thought we should take them into consideration in planning the urgent needs of the community and that's why it was put in there. In my latest discussions with the group, there's quite a bit of planning to be done before this is developed. It can't be developed overnight. There's the acquisition of staff and a lot of planning and ideas that will have to go into such a development, but they, in mentioning this as being a year or two away, they thought that was about the time they would be ready to proceed with this type of development, so funds have been laid aside for this purpose.

I just wanted to point out that really in the Health Department we have the child who really needs institutionalization at the bottom of the scale, and we're thinking that rather than let Portage get bigger and bigger, we could transfer a certain type of case to the facility here and make the Portage School more of a training centre -- really more of a training school for the mentally retarded. Then concurrently with that developing, with the concept of day centres and day schools, a sheltered workshop concept. This can't be done overnight and the numbers that are referred to by the member from Selkirk, this is a fact. I think the president of the national association, at the meeting in which the Honourable Member for Selkirk and I were present, gave a figure of $780 million is needed across Canada now if we were going to recognize and cope with all the retarded in this country. It's something that 10 years ago we had no facilities for in the community. It is something that we will have to develop within our ability to do so and we certainly are making a start.

MR. EVANS: Mr. Chairman, I wonder if at this point the Committee would be willing to rise and report.

MR. CHAIRMAN: Rise and report? Call in the Speaker.

Mr. Speaker, the Committee of Supply has adopted certain resolutions, directed me to report the same and asks leave to sit again.

MR. MARTIN: Mr. Speaker, I beg to move, seconded by the Honourable Member for Springfield that the report of the committee be received.

Mr. Speaker presented the motion and after a voice vote declared the motion carried.

MR. EVANS: Mr. Speaker, I beg to move, seconded by the Honourable the Attorney-General, that the House do now adjourn.

Mr. Speaker presented the motion and after a voice vote declared the motion carried and the House adjourned until 2:30 Friday afternoon.