Second Session - Thirty-Fifth Legislature

of the

Legislative Assembly of Manitoba

STANDING COMMITTEE

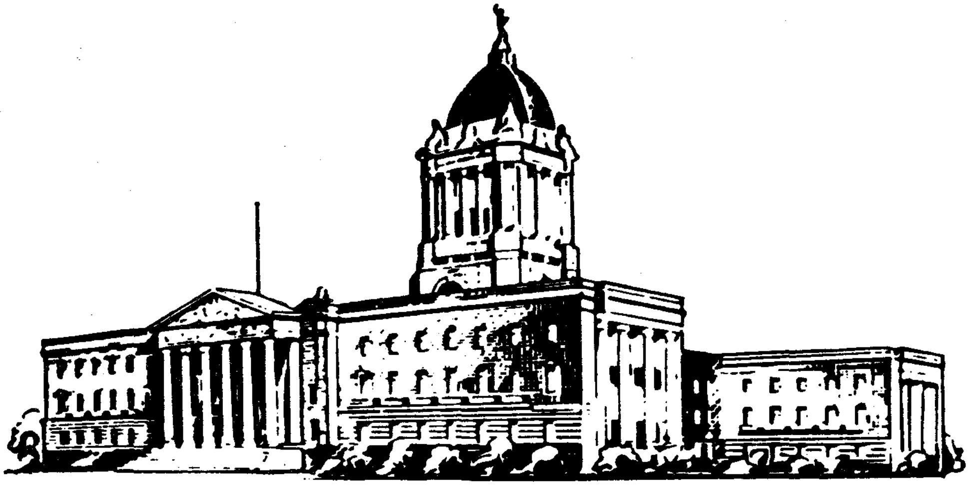
on

LAW AMENDMENTS

---

40 Elizabeth II

Chairman
Mr. Jack Reimer
Constituency of Niakwa



VOL. XL No. 1 - 8 p.m., TUESDAY, JUNE 25, 1991

MG-8048

Printed by the Office of the Queens Printer, Province of Manitoba

ISSN 0713-9586

MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Fifth Legislature

LIB - Liberal; ND - New Democrat; PC - Progressive Conservative

---

NAME	CONSTITUENCY	PARTY
ALCOCK, Reg	Osborne	LIB
ASHTON, Steve	Thompson	ND
BARRETT, Becky	Wellington	ND
CARR, James	Crescentwood	LIB
CARSTAIRS, Sharon	River Heights	LIB
CERILLI, Marianne	Radisson	ND
CHEEMA, Gulzar	The Maples	LIB
CHOMIAK, Dave	Kildonan	ND
CONNERY, Edward	Portage la Prairie	PC
CUMMINGS, Glen, Hon.	Ste. Rose	PC
DACQUAY, Louise	Seine River	PC
DERKACH, Leonard, Hon.	Roblin-Russell	PC
DEWAR, Gregory	Selkirk	ND
DOER, Gary	Concordia	ND
DOWNEY, James, Hon.	Arthur-Virden	PC
DRIEDGER, Albert, Hon.	Steinbach	PC
DUCHARME, Gerry, Hon.	Riel	PC
EDWARDS, Paul	St. James	LIB
ENNS, Harry, Hon.	Lakeside	PC
ERNST, Jim, Hon.	Charleswood	PC
EVANS, Clif	Interlake	ND
EVANS, Leonard S.	Brandon East	ND
FILMON, Gary, Hon.	Tuxedo	PC
FINDLAY, Glen, Hon.	Springfield	PC
FRIESEN, Jean	Wolseley	ND
GAUDRY, Neil	St. Boniface	LIB
GILLESHAMMER, Harold, Hon.	Minnedosa	PC
HARPER, Elijah	Rupertsland	ND
HELWER, Edward R.	Gimli	PC
HICKES, George	Point Douglas	ND
LAMOUREUX, Kevin	Inkster	LIB
LATHLIN, Oscar	The Pas	ND
LAURENDEAU, Marcel	St. Norbert	PC
MALOWAY, Jim	Elmwood	ND
MANNESS, Clayton, Hon.	Morris	PC
MARTINDALE, Doug	Burrows	ND
McALPINE, Gerry	Sturgeon Creek	PC
McCRAE, James, Hon.	Brandon West	PC
McINTOSH, Linda, Hon.	Assiniboia	PC
MITCHELSON, Bonnie, Hon.	River East	PC
NEUFELD, Harold, Hon.	Rossmere	PC
ORCHARD, Donald, Hon.	Pembina	PC
PENNER, Jack	Emerson	PC
PLOHMAN, John	Dauphin	ND
PRAZNIK, Darren, Hon.	Lac du Bonnet	PC
REID, Daryl	Transcona	ND
REIMER, Jack	Niakwa	PC
RENDER, Shirley	St. Vital	PC
ROCAN, Denis, Hon.	Gladstone	PC
ROSE, Bob	Turtle Mountain	PC
SANTOS, Conrad	Broadway	ND
STEFANSON, Eric, Hon.	Kirkfield Park	PC
STORIE, Jerry	Flin Flon	ND
SVEINSON, Ben	La Verendrye	PC
VODREY, Rosemary	Fort Garry	PC
WASYLYCIA-LEIS, Judy	St. Johns	ND
WOWCHUK, Rosann	Swan River	ND

LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON LAW AMENDMENTS

Tuesday, June 25, 1991

TIME — 8 p.m.

LOCATION — Winnipeg, Manitoba

CHAIRMAN — Mr. Jack Reimer (Niakwa)

ATTENDANCE - 11 — QUORUM - 6

Members of the Committee present:

Hon. Mrs. Mitchelson, Hon. Messrs. Orchard, Praznik

Messrs. Alcock, Cheema, Connery, McAlpine, Reimer, Mrs. Vodrey, Ms. Wasylycia-Leis, Ms. Wowchuk

APPEARING:

Gregory Dewar, MLA for Selkirk

Donald Rodgers, Director of Psychiatric Services, Department of Health

John Biberdorf, Legislative and Program Analyst, Mental Health Division, Department of Health

Joanna Knowlton, Counsel to The Public Trustee, Department of Justice

WITNESSES:

Anthony Dalmyn, Canadian Mental Health Association, Manitoba Division

Bill Ashdown, Society for Depression and Manic Depression in Manitoba

Gordon MacIntosh, Manitoba Association for Rights and Liberties

Chrys Rak, Private Citizen

Sid Frankel, Manitoba Association of Social Workers

John Walker, Psychological Association of Manitoba

Catherine Medernach, The SUN Network

Caroline Sehon, Citizens for Quality Mental Health Care

Annette Osted, Registered Psychiatric Nurses Association of Manitoba

Verne McComas, Manitoba Schizophrenia Society

MATTERS UNDER DISCUSSION:

Bill 3—The Coat of Arms, Emblems and The Manitoba Tartan

Amendment Act

Bill 5—The Mental Health Amendment Act

Bill 43—The Workers Compensation Amendment Act (2)

* * *

Mr. Chairman: Order, please. Will the Standing Committee on Law Amendments please come to order. This evening, the committee will be considering Bill 3, The Coat of Arms, Emblems and The Manitoba Tartan Amendment Act; Bill 5, The Mental Health Amendment Act; and Bill 43, The Workers Compensation Amendment Act (2).

It is our custom to hear briefs before consideration of the bills. What is the will of the committee?

Hon. Darren Praznik (Minister of Labour): Mr. Chair, if I may suggest, because I understand that there are no presenters for Bill 3 and Bill 43, and they are bills in which there was an indication of substantial agreement when they received second reading, and perhaps we can deal with those clause by clause to allow the appropriate staff who are here for ministers, et cetera, to deal with them and then we can proceed to the presenters, because there is a rather substantial list on The Mental Health Amendment Act and it is a very substantive act.

Mr. Chairman: Is it the will of the committee? Agreed.

I will read the list of presenters for Bill 5 though, and should anyone else wish to appear before this committee, please advise the Clerk of Committees and your name will be added to the list. As I said, these are the presenters for Bill 5:

* (2005)

Mr. Anthony Dalmyn with the Canadian Mental Health Association; Mr. Doug Fyfe, Private Citizen; Mr. Bill Ashdown and Mr. Ben Hanuschak, the Society for Depression and Manic Depression in Manitoba; Ms. Barbara Wiktorowicz, with the Alzheimer Society and Family Resource Centre of Manitoba; Ms. Pat Trottier, Private Citizen; Mr.

Gordon MacIntosh, Manitoba Association for Rights and Liberties; Mr. Sid Frankel, the Manitoba Association of Social Workers; Dr. John Walker, the Psychological Association of Manitoba; Ms. Catherine Medernach, The SUN Network; Dr. Caroline Sehon, Citizens for Quality Mental Health Care; Ms. Chrys Rak, Private Citizen; Mr. Jeff Gunter, President and Mrs. Annette Osted, The Registered Psychiatric Nurses Association of Manitoba; and Mr. Verne McComas, Manitoba Schizophrenic Society. This last one was a walk-in presenter.

Bill 3—The Coat of Arms, Emblems and The Manitoba Tartan Amendment Act

Mr. Chairman: Did the minister responsible for Bill 3 (The Coat of Arms, Emblems and The Manitoba Tartan Amendment Act; Loi modifiant la Loi sur les armoiries, Les emblèmes et le tartan du Manitoba) wish to make an opening remark?

Hon. Bonnie Mitchelson (Minister of Culture, Heritage and Citizenship): Mr. Chairperson, I think that Bill 3 received a fairly substantial report on second reading and I would like to proceed directly to the bill. I do not know if we want to -(interjection)- bill by bill?

Mr. Chairman: Does the NDP critic for Bill 3 wish to make an opening remark? Does the Liberal critic wish to make an opening remark?

The bill will be considered clause by clause. During the consideration of the bill, the title and the preamble are postponed until any other clauses have been considered in their proper order by the committee.

Clause 1—pass; Clause 2—pass; Preamble—pass; Title—pass. Bill be reported.

Bill 43—The Workers Compensation Amendment Act (2)

Mr. Chairman: We will now proceed to Bill 43 (The Workers Compensation Amendment Act (2); Loi no 2 modifiant la Loi sur les accidents du travail). Did the minister responsible for Bill 43 wish to make an opening statement?

Hon. Darren Praznik (Minister of Labour): Yes, Mr. Chair. Just very briefly, this particular bill, as I am sure most members are aware, is the biannual indexation of benefits. This process of indexing benefits for over 5,200 WCB recipients has been in place since the early 1980s. The indexing numbers are based on the consumer price index. Each of the categories goes up appropriately.

I would like to thank both opposition parties for their assistance in the speedy passage from the House to committee. Should any members have any specific questions, staff is available to answer them.

Mr. Chairman: Did the NDP critic for Bill 43 wish to make an opening statement? Did the Liberal critic for Bill 43 wish to make an opening statement?

The bill will be considered clause by clause. During the consideration of a bill, the title and the preamble are postponed until all other clauses have been considered in their proper order by the committee.

Clause 1—pass; Clause 2(1)—pass; Clause 2(2)—pass; Clause 3—pass; Clause 4—pass; Clause 5—pass; Clause 6—pass; Clause 7—pass; Clause 8(1)—pass; Clause 8(2)—pass; Clause 9—pass; Preamble—pass; Title—pass. Bill be reported.

* (2010)

Bill 5—The Mental Health Amendment Act

Mr. Chairman: Ladies and gentlemen, we are now going to move to Bill 5, The Mental Health Amendment Act (Loi modifiant la Loi sur la santé mentale). I would like to call upon the presenters at this time. Before we begin, the honourable minister.

Hon. Donald Orchard (Minister of Health): Mr. Chairman, I wonder if I might ask committee members that given that we have in Bill 5 a proclamation date of September 1 and we are running very, very close to being able to achieve the September 1 proclamation, if we can proceed rather expeditiously with the bill. We may have to delay the proclamation date at third reading, but we believe we might still be able to achieve September 1 proclamation.

I would ask my honourable friends, the opposition critics, that given the number of presenters we have to Bill 5 tonight, and I know at least some of the presenters have interest and have suggested amendments, I want committee to know that we have a number of amendments, nine in total, to present clause by clause tonight.

Thirdly, because Dr. Don Rodgers—we just had a retirement gathering for Dr. Rodgers tonight—and Dr. Rodgers has been consistently part of the amendments to Bill 5, that I wonder if we might—because a number of the presenters would want to stay as we initiate clause by clause and the amendments to the bill that I would propose—consider a reasonable time limit on the presenters so that all can present in a reasonable amount of time and then be here not until the wee hours of the morning. The last time we did amendments to The Mental Health Act, in 1987 I think, we were here until about four in the morning before we finished off.

So I wonder, given the interest in the bill, given the interest by some of the presenters tonight in amendments that I would propose, that we could consider a reasonable amount of presentation time. I do not know what to suggest, maybe half an hour or thereabouts? Would either of the critics have any objection to that?

Ms. Judy Wasylycia-Leis (St. Johns): Mr. Chairperson, we really do not see the necessity of imposing time limits at this point. I think we have a reasonable number of presenters, not an inordinate number on the list. This is a serious matter. It is one that has generated a great deal of community interest and it is our view that we should allow these individuals and organizations to make their presentations and to consider the time remaining in terms of whether or not we are able then to deal with amendments. It is our view that without holding up this bill, without interfering with the goal of a September 1 proclamation date, we could easily spread this process out, if necessary, to consider amendments later on this week.

However, it would still seem, given the number of presenters, that it may be possible to consider amendments after these presentations have been made.

Mr. Gulzar Cheema (The Maples): Mr. Chairperson, as the minister has said, I do not want to see the same mistake as in 1987. At the same time, we have presenters and most of them are going to represent many organizations and I am sure they will be responsible for their time and I do not want to limit any time.

Certainly, I think we should give them the most opportunity to explain and then we can question them. There are only 12 of them and if we have to come back the next day, I think we should come back. I certainly do not want to rush and repeat the same mistake as in 1987.

* (2015)

Mr. Orchard: Mr. Chairman, the only reason I suggested that is that a number of the presenters would have to come back should we not deal clause by clause and have the amendments presented. I think in the interest of their time, if we could achieve the clause by clause this evening—I know there might be a number of individuals in the presenter group tonight who would be interested in the amendments and would not—I suppose they would come back, but in the interest of convenience for them and their time commitments and evenings away from family, we might consider trying to present those amendments tonight. That was my concern.

Mr. Chairman: Okay, there will not be time limits on the presenters, then.

I would just like to point out to the presenters that the presenters who have written copies of their brief pass them along to the Committee Clerk so that she may ensure that there are sufficient copies for the committee members.

At this time I would like to call upon Mr. Anthony Dalmyn with the Canadian Mental Health Association. You may proceed.

Mr. Anthony Dalmyn (Canadian Mental Health Association, Manitoba Division): Mr. Chairman, Mr. Minister, members of the committee, I am presenting on behalf of the Canadian Mental Health Association, Manitoba Division, which is a national organization maintaining an intensive interest in all aspects of the support, care and treatment of persons diagnosed as having mental illness or mental disability.

Prior to this evening, we prepared a brief, some 42 pages in length, which has been deposited with each member of the committee. Additionally, our executive ensured that copies were available to all members of the Assembly. In view of that and in view of some other developments that I am going to comment on, I do not feel obliged to speak to Bill 5 clause by clause nor, indeed, to review the brief page by page. Indeed, I hope to be well within a half hour, subject to questions and comments from committee members.

I propose to direct my remarks first to the process of the amendments. Secondly, I propose to examine what I would characterize as a lost opportunity or lost time to make more progress in developing what CMHA views as the first priority which is community mental health services legislation. I will have comments on specific sections of the brief.

I will begin by thanking the minister, by thanking both opposition critics for their time in meeting either with me or with other members of CMHA. I would also like to thank Mr. Toews, Dr. Biberdorf, Dr. Rodgers for their time and assistance. I think it would be opportune for me as well to thank Dr. Rodgers for his time over the past three years. Dr. Rodgers had to preside over a difficult and experimental process. There were differences of opinion on occasion between Dr. Rodgers and myself. I felt that I was always treated, and all committee members were treated, by Dr. Rodgers with the utmost of respect. I wish to thank Dr. Rodgers in the presence of the committee for his efforts.

This brings me to the question of process. The bill that is before you, Bill 5, is the result of two processes of study and consultation. One process was the Major Amendments Committee; one was called the Minor Amendments Committee. Both committees emerged from an administrative problem, maybe called administrative debacle, the hasty proclamation of Bill 59 at the beginning of March 1988. The Major Amendments Committee was an experiment in consultation with community groups on the terms of mental health legislation. The Minor Amendments Committee was a more traditional departmental committee looking at administrative issues and examining potential law reform issues.

* (2020)

As matters have developed, it is the view of CMHA that probably consultation on all issues would have been fruitful. The process of consultation led to certain conflicts of view, but it was ultimately a fruitful exercise in improving the quality of legislation and ensuring that legislation meets the interests of the persons affected.

I indicated at the beginning that CMHA has a qualification on the entire amendments process. We have now gone over three years working on major and minor amendments. The delays have been partly due to certain disagreements on the committee, partly due to national and provincial issues pre-empting the agenda.

Attaching no particular blame, I want to make the observation that what we were doing was an exercise in tinkering with Bill 59 which, in turn, had been an exercise in tinkering with the 1965 Mental Health Act. Because it was an experimental process, it was time consuming, it was difficult. I believe that out of the major amendments process was evolved an initiative toward discussion of community mental health services legislation. I respectfully suggest to this committee and to the Legislative Assembly that any future discussion of The Mental Health Act be done in the context of an evaluation of the mental health system.

Certain members of this committee will remember that previous Health ministers commissioned a departmental working group which reported in 1985 under the name of the Pascoe Report. I think what is required is to examine those conclusions, to update them to 1991, and to put them in the context of the evolution of Manitoba's mental health system into the 1990s.

We have, in the view of CMHA, been limping along since the 1960s with a dilemma. When we entered the '60s, more than 3,000 people were being treated or looked after in the provincial mental health centres. All sectors were in agreement that we should have deinstitutionalization, and we have achieved substantial deinstitutionalization. All interested parties in the '60s and '70s were in agreement that additional resources should go to hospitals to develop modern psychiatric wards or facilities. That has been done.

What we have not caught up with is the need to support and care for individuals with mental illness and disability in the community to ensure that their stay in hospital, which is an intrusion into their lives, is kept to a minimum and done only in the appropriate circumstances. This involves a legislative component, but it also involves a service component.

What we did in 1987 and 1988 was legislate that no one should be in hospital unless that person was dangerous to himself/herself or others and needed hospital care. What we have not done in this province is develop the community services to ensure that is backed up, and we are left in many, many cases with agonizing choices. A person goes without appropriate professional support and assistance, without paraprofessional or nonprofessional support and assistance until there is a very serious crisis, and suddenly the very intensive and expensive resources of the hospital are brought to bear. The person is stigmatized as having been institutionalized in a mental hospital. This, I say to the committee, should not continue.

I come now to the third part of my submission, which is the discussion of some of the issues emerging from Bill 5. I can draw your attention to page 17 of the brief in which there is a commentary on Section 17 of Bill 5 which affects Sections 24(1), 24(2) of The Mental Health Act. For the members of the committee who are not aficionados of mental health law, let me try to explain, in my words, the issue.

A person becomes hospitalized. That person may be in any of several possible states of thinking and acting. A person may recognize the need of hospitalization and be there voluntarily. The person may be there involuntarily. The person, although present in the hospital voluntarily, may nevertheless be experiencing a very severe episode.

Under the terms of Bill 59, once a person is a patient, voluntary or involuntary, before further treatment can be done the person must be assessed. Treatment will not be done unless the person has been assessed as incompetent to make treatment decisions according to the criteria of the act.

Under the terms of Bill 59, once the assessment of incompetence is done, the Public Trustee is called upon to grant what is called a substituted consent. Bill 59 operates on the principle that mental health care, like any health care, will be done on the basis of consent. If you go to a doctor, the doctor makes a recommendation. You say yes or no, whether it is burning off a wart or major surgery. The person consents.

* (2025)

The problem in mental health is that on occasion and I say on occasion, some persons, and it is a minority, cannot make proper treatment decisions. The decision of the Legislature in Bill 59 of 1987 was that consent to treatment will not be dispensed with, it will be sought from somebody else who is supposed to be looking after the interests of the patient.

The decision in Bill 59 was to use the Public Trustee. The Public Trustee's office was increasingly distressed by the dilemma of decision making. They felt they did not have the resources to investigate and do the job properly and that they were usurping personal decisions.

What Bill 5 will do is use the Public Trustee only as a last resort. After a person is assessed as incompetent, you will use instead a family member who has been in personal contact within the past year and the Public Trustee only as a last resort. There is a hierarchy or ordering of family members. There is provision for common-law spouses as opposed to spouses who have gone through the lawful ceremony of marriage.

The model for this is drawn from the Alberta act and, to some extent, from the Ontario Mental Health Act. This issue inspired a great deal of debate in the Major Amendments Committee accepting the principle of substituted consent. The question is who should make the decisions? Can we say, in all cases, that a family member will be the correct person?

CMHA has been approached by a number of small self-help groups. There have been letters to the editor of the Winnipeg Free Press that I have seen complaining about this. In certain instances, a mental illness episode can be the result of domestic stress or indeed domestic violence, or it may be the by-product and result of years of sexual abuse. The question is should the family member who has been involved in the dynamics of the situation make the treatment decisions?

In Ontario the system allows a person, in anticipation of becoming incompetent through mental illness, to appoint someone else to make treatment decisions, to allow a personal choice and option. There have been bugs in the administration of this process in Ontario, but it seems to CMHA that, in principle, the Ontario model is better than going directly to the family members. Let us say that in 75—let us say that in 90 percent of the cases the family member will be the best decision-maker because they have the best knowledge. In certain instances the family member will not be the appropriate decision-maker.

This is not necessarily an issue that is confined to mental health, you will see in CMHA's brief reference to the deliberations of the Manitoba Law Reform Commission. The Manitoba Law Reform Commission floated a discussion paper a year ago. They called for submissions by November, and from that timetable, in my judgment, we may expect that they will have a report in the hands of the Attorney General any day, if it is not there already. The convention is that the Attorney General gets the reports 30 days ahead of their public release.

The Law Reform Commission is looking at the issue not only in the context of mental health legislation, but in the context of all health care. Should any person be able to make a living will saying "no heroic measures," or should they be able to appoint someone to make treatment decisions and, if so, under what conditions, and should this extend to the mentally ill?

* (2030)

However, when we have their report we then have a potential period of at least a year or two, in my estimation, before there will be any legislation, if there will ever be any legislation. CMHA's frank preference is to deal with what I would term the power of attorney issue in Bill 5. I know the minister has been kind enough to give us access to the assistant deputy and to his staff in the directorate and, indeed, to the minister in person. I am anticipating the minister is going to have a problem with CMHA's proposal, but I have explained our concern and I hope the committee has a proper understanding of it and sees the weight and gravity of our concern.

Another issue of importance can be flagged at page 25 of the brief dealing with the reform of the appeal procedures. If a person is made an involuntary patient, they have a right of appeal to a review board. That was new in 1987 in Bill 59. If a person is assessed as incompetent to make treatment decisions, they have a right of appeal to the review board. How fast do you get to the review board? The first months after the proclamation of Bill 59 were a disaster. The delays in getting before a review board were as much as six months. Some patients took court challenges to try to overturn all of Bill 59. There is a decision of Mr. Justice Scott, now the Chief Justice of Manitoba, upholding the general validity of Bill 59, but also being critical of the delays in the appeal process. Those court cases highlighted a deficiency in Bill 59: It does not say how quickly an appeal should be brought on.

Bill 5 goes in the right direction. It says that an appeal should be brought on within 21 days. That apparently is something that the review boards are working close to now. The problem is that 21 days is still too long. The provisions of the Ontario act are seven days. Ontario administers its review boards somewhat differently than Manitoba does, but in CMHA's view there is nothing to prevent Manitoba administering its boards as effectively.

The importance of this is not simply in the case of someone who is wrongly put in a hospital. It has to do with the disruption in a person's life, with self-esteem, with utilization of resources, with the fact that a person, who is in there on involuntary status and should be voluntary, who might be able to function in the community, is occupying a bed that might be used by someone else who is being turned away at that very moment but has important implications for the system, has important implications for individuals and for their rights and their self-esteem and their well-being and their proper care, and it has implications for the system. We consider that it is an important issue.

Bill 59 and Bill 5 also leave somewhat of a conundrum. Now that we have a deadline, what happens at the end of the deadline? Is the person automatically a voluntary patient? It is a problem. It is not a problem that I personally have been able to come up with a satisfactory solution, because you do not want necessarily to interfere with effective treatment that is justified on the basis that 21 days have simply gone by.

On the other hand, you do not want to force people to hire lawyers and apply to the courts for habeas corpus when they are fully justified in seeking a change in their status from involuntary to voluntary or seeking some alteration or modification of their treatment. I will leave that issue with you.

A third issue, and I preface this by saying it is not necessarily a matter for gutting that part of Bill 5 that I am going to talk about, is the orders of supervision. I went to some trouble and I explained the operation and history of orders of supervision for 25 percent of this long brief, from pages 30 to 40. I am not going to repeat all of that now.

There have been some problems in practice. An order of supervision is an order made by the provincial psychiatrist which has the effect of transferring decision-making power from an individual to the Public Trustee who fulfills a role that is described under legislation as committee of the person. There have been some problems about whether the Public Trustee may admit someone to hospital, whether someone who is admitted to hospital under an order of supervision as opposed to a conventional involuntary admission has rights of appeal. These may have been isolated errors of administration. We have drawn these to the best of our ability because CMHA does not have automatic access to all of this information. We function on a complaints made or information received basis. We have not been able to investigate this fully. We have drawn it to the minister's attention, we have drawn it to the attention of the departmental staff, and I hope that we have explained our concerns clearly on that. I think I have already explained to the committee the fundamental problem.

When you have an order of supervision and decisions are made to hospitalize someone, or to treat someone in hospital, to make a decision about where they live, you are potentially running into two conflicting pieces of legislation. Part 1 of The Mental Health Act says that if you are an involuntary patient you have to meet certain criteria and you have rights of appeal. If you are a patient of any kind and you are going to be treated, you have to be assessed first as incompetent and you can appeal the finding of incompetence. If it is done under an order of supervision, we are in a gray area.

Personally, I would hope that the more specific legislation which is the Part 1 of The Mental Health Act would prevail and pre-empt the order of supervision, but it seems that there have been a few problems in practice.

Having addressed those three high points with the committee, I propose to leave it. There are other areas that have been canvassed in our brief.

On the other hand, I understand the minister is proposing a series of nine amendments on clause-by-clause reading and I am quite hopeful that the other concerns that are mentioned in our brief will be addressed in some fashion in the minister's amendments. I am keeping my fingers crossed without knowing what the minister is going to do.

Before I retire, before I run from this microphone to give someone else a chance, are there any questions?

Mr. Cheema: First of all, thank you for your presentation, and as you have said, extensive consultation has taken place for the last two years and definitely has been a remarkable improvement over 1987. As you have pointed out very clearly, it is going to be very—

Mr. Chairman: Excuse me, Dr. Cheema, could you bring your mike closer? Thank you.

Mr. Cheema: —difficult to have a bill which will satisfy everyone. I think our intent has to be to make sure that the patients' lives are protected as well as the health care providers' rights are protected, and at least we can work towards that.

I just want to touch on a couple of points you have raised. The first point, you have said, who should be the deciding factor if the immediate family member is not capable, or there is a problem with the family member, or there are some allegations, or there is some difficulty of contacting a family member? So who do you think then will be the next person to be contacted, and what should be the time limit on that aspect?

How long should one wait before the treatment would commence if you cannot get hold of a family member?

* (2040)

Mr. Dalmyn: CMHA's preference, rather than looking to who do you go to after the family, of course, is to go to a person nominated by the individual before the individual becomes a patient.

As far as a time limit, I note first that the act provides and has always provided for necessary emergency treatment. I also note that the act refers in many places to allowing up to 72 hours for observation and assessment. I hope in some ways that answers the member's question. If a patient, first of all, assuming we go to a power of attorney system or that the province of Manitoba can go to a power of attorney system, or whether or not the province goes to a power of attorney system, if you are going to look for a family member there should be a reasonable period to contact the family member before it is assumed that the family member is not available or unwilling and, before you go to the Public Trustee, keeping in mind that if a person is undergoing a severe crisis, in an emergency the hospital has emergency treatment powers.

Mr. Cheema: Mr. Chairperson, can you tell me that—you have said that the person could designate an individual to take care of the treatment responsibility. How can a health care provider, say, in a given hospital, if a person comes there, has been either certified or admitted under the involuntary patient, and the facility or health care provider cannot get hold of the family member, then where do you go?

I mean, how can a person appoint somebody to take care of the treatment after the fact, after this person has been in the hospital? If that person is not capable of making other decisions, how can he make a decision for someone to say, this person, suppose person "a," should be responsible for my treatment? I really do not understand that. I would like you to probably explain and maybe try so that I can get a better understanding that we can improve this bill.

The second question is: What is the reasonable time limit, as you have said, a reasonable time, in terms of any patient?

Mr. Dalmyn: The honourable member's question has raised several concerns, one of which, I believe, is the administrative concern. If we have powers of attorney, how is the hospital to identify the power of attorney and authenticate it?

At present the Ontario hospitals operate on the basis that a person may deposit a document with the hospital when they are known to be competent and they are not patients of the hospital. In the metropolitan Toronto area, where there are several receiving hospitals, a person apparently has to deposit the document in several places.

I would have thought that in Manitoba, with a more compact population, it would be possible as an administrative matter to lodge these documents with a central agency, probably keyed to health care services, coded in the computer at MHSC under a person's number. The documents are on file with MHSC or deposited on file with some subagency at 1200 Portage out of the Mental Health Directorate. That is about all it takes.

As far as the other concern raised about the reasonable time, I think there is a point to be made both ways. You indicated, well, how do you know where to get a hold of the family member. I think that perhaps is no bigger problem. That may even be—let me put it this way. Getting a hold of a family member may be a bigger problem than getting a hold of a specific individual identified by the person who becomes a patient, which is indexed and identified in a central registry. I think, to be practical, in many instances the individual who is going to need this particular accommodation may be known to the hospital and they may very well have records of the family member. Given that the act allows up to 72 hours for assessment, I do not think it is unreasonable to allow 24 or 48 hours or even 72 hours to contact a family member on the proviso that effective and appropriate care can be delivered to the patient, or emergency care, so the patient does not affect the care and well-being of others on the same ward.

Mr. Cheema: Mr. Chairperson, I have another concern which is a very practical one, and I know the Minister of Health (Mr. Orchard) has received a concern also on the same matter. I will try to explain—which is a major practical problem. Suppose a patient goes to hospital and is admitted to a psychiatric facility but also has a medical condition, a very acute medical condition, and within the present act you cannot initiate the treatment. So who should be making a medical decision on a patient who has been already certified? It leaves a practical problem to treat a patient inside a facility, and that has happened recently. So I would like to know your views, how we can address that issue.

Mr. Dalmyn: The honourable member's question in some ways touches on the concerns of doctors and health care providers who present it to the Law Reform Commission. I know that the honourable member is a member of the medical profession. If someone is brought in to you unconscious, without any mental health repercussions whatsoever, how do you obtain consent to treatment? You do not. You have to proceed, and the law protects you to the extent that you administer reasonable, non-negligent care to an unconscious person who is brought in. If, however, that person has religious scruples to certain medical treatment and happens to be carrying a card in their wallet, according to the Ontario Court of Appeal you can be sued for saving their life.

The point I am making is that I do not know that you can expect The Mental Health Act to provide a mechanism to deal with all other possible health care that a patient may undergo considering that the present state of the law is such that there is no mechanism. We come close to it and this is why sometimes orders of supervision have been used. Under an order of supervision, the Public Trustee, as committee of the person, can make all health care decisions, but an order of supervision is supposed to operate, in principle, in the community. I do not know what the overlap is, and I understand as well that we can get into issues of administrative flexibility about putting the person in a nonpsychiatric bed, but designating it psychiatric for specific purposes.

Mr. Cheema: Mr. Chairperson, I think it is very important that the committee realize that there are practical problems and the health care provider and the facilities get into trouble once in a while and it becomes very difficult to provide the care and make a decision at the crucial time.

My next—just a final comment, or I am asking your opinion on this issue about the review boards. As you have outlined, we should be having members not from the same facility and that is reasonable, I think. That is the way it should have been from Day One.

Second, what we are asking is in terms of whether we should be reviewing patients every three months rather than six months and giving the option to a patient so that he or she can file an application for a review instead of six, for three months. What do you think about that idea?

Mr. Dalmyn: That has to be addressed in an operational context. You will be dealing with a population that is called the psychogeriatric population. As a result of historic policies, there are some patients who are long-term patients at Selkirk and Brandon. They are entitled to regular review, but they have nowhere else to go. If there were somewhere else for them to go, then a review might very well result in their being changed from psychiatric facility status to some character of personal care status.

As matters stand now, I do not know that a more frequent review is necessarily going to be helpful, considering that the initial reviews are the important ones that affect most people. I hope I am being practical. I am also demonstrating that CMHA is not necessarily wildly libertarian or in favour of reviewing everything at every stage.

Ms. Wasylycia-Leis: I also would like to thank the Canadian Mental Health Association, Manitoba Division for this brief and this presentation, and also for your advice and assistance to all of us over the last number of months leading up to this stage in the process. I also want to thank you for the persistence of CMHA over the last number of years, persistence which is quite incredible, quite remarkable. You have persisted in making the concerns of the community known to all governments. You have worked with political parties of all stripes, and you are still at it. I appreciate your efforts.

At the same time, I want to say something I said during the debates on second reading that I am the first one to indicate that previous administrations, the NDP included, have not been as receptive as they should have been in terms of moving on major changes to our antiquated and institutional-focused legislation. As I have said in the debate, I hope this is the year that we can start to make some significant changes and move to a truly community-based reformed mental health system.

On that point, I would like to ask if—you make the general comment about this legislation, about these amendments being tinkering with the present model, the present antiquated legislation, and I sense from the brief a real regret that we are not at the stage where we have before us a legal document that sets the stage for community-based health care delivery.

Could you indicate for us the benefits of going the legislative route in addressing the whole agenda of community-based reformed system?

* (2050)

Mr. Dalmyn: The benefit of going legislative—

Mr. Chairman: Mr. Dalmyn.

Mr. Dalmyn: Sorry, Mr. Chairman. I forgot your role in this matter. The benefit of a legislative, rather than an administrative approach to community mental health services lies first in establishing the administrative machinery rather than dealing with ad hoc administrative machinery that is liable to disappear in an administrative rearrangement or to have its authority undercut. There is an identified agency or agencies.

It establishes a level of public expectation and legitimacy; it gives real meaning to mental health legislation. To return to a point that has been made many times by many persons and not just by CMHA, The Mental Health Act is not a mental health act. It is what you might term gatekeeper legislation. Part I and some parts of Part IV decide under what circumstances a person gets to be an involuntary patient in a psychiatric facility. It deals with treatment of voluntary and involuntary patients, and then we have the order of supervision layer which deals in a very limited way with some forms of treatment in the community. By and large, the main focus of The Mental Health Act is what might be termed medical/legal gatekeeping. Because of that, in spite of all public education and all good intentions, there is a stigma associated with any contact with the mental health system.

It is CMHA's hope that by putting all mental health issues within one umbrella act and one agency, we can put hospitalization in perspective as a particular and necessary and intensive means of care for some individuals, but put it in a perspective as to when it is to be resorted to and what realistic alternatives exist.

By defining and creating a specific agency, you can move in an authoritative way, an empowered way to create necessary professional services and to create a framework for the nonprofessional services—I am reluctant even to use the term "service"—the mechanisms of personal security and support for individuals with a mental illness or disability or mental health problem.

Historically in Canada, the Department of Health has become identified less as a department of public health than as a funder for the medicare system and the medicare system operates in its own way with its own priorities. It is more necessary in the mental health field than in any other aspect of health care to identify the supports for individuals that are collateral to medical care and to develop those.

We are at a very primitive stage in providing necessary support services that do not involve hospitalization and medical care in this province.

Ms. Wasylycia-Leis: Just on that, we have a less polite way of saying what you have just said in your last point, and we feel we have a department of health care costs and not a department of health care. Having said that, I will not get into a debate; we have been doing that for the last two weeks -(interjection)- so why start now, right.

Is this area of bringing forward legislation providing for the organization of mental health services so novel in terms of Canada and indeed internationally, that we are at such a preliminary stage in terms of legislation in that regard?

Mr. Dalmyn: Mr. Chairman, without going through it jurisdiction by jurisdiction, several of the nations in the European economic community, several American states have found the way to start to develop these services. In Canada, the Province of New Brunswick has established what might be termed an experiment with a mental health services commission. So it is not completely novel, but given the fact that most Canadian provinces are in more or less the same place historically and not necessarily resource-wise, CMHA works province by province. We have had more success in some provinces or a more receptive audience in certain governments or in certain health administrations, and there has been more or less progress.

I cannot say Manitoba lags far behind other provinces. I cannot point to other provinces being greatly ahead of us, but New Brunswick particularly has taken an initiative, and we can look to several American states for either legislation or administrative agencies or both.

Ms. Wasylycia-Leis: I am wondering if you could indicate whether or not you feel that The Mental Health Act, if amended according to Bill 5, would mean any less challenges on a charter basis. Would it be any more charter challenge proof, I guess is my question.

* (2100)

Mr. Dalmyn: Speaking less as a representative of the Canadian Mental Health Association and speaking more as a lawyer who has done the odd bit of charter work, I would say that these are small improvements which go some distance to further charter proof the 1965 Mental Health Act. I mentioned that there had been a court case in 1988. I am not satisfied that it has by any means or any stretch of the imagination resolved all of the outstanding issues. I can see issues emerging under Bill 59 as it stands or as amended by Bill 5, depending on the facts of a particular case and something being put before a court.

Ms. Wasylycia-Leis: With respect to your suggested amendment dealing with Section 17 and the recommendation for a more positive wording in terms of the right to make decisions respecting treatment, to me that seems—I cannot imagine that there would have been much disagreement to that notion in this whole consultation process. Is that in fact the case?

Mr. Dalmyn: I do not wish to leave the committee with the impression that there was a great deal of disagreement with it. It is one of those areas that everyone seemed to have the same understanding. Then when we looked at the act and when we looked at Bill 5, I realized it was worded a certain way, and this had never been properly addressed. I raised it at that time which, in some ways, it was unfair to the committee and to departmental staff.

Ms. Wasylycia-Leis: Mr. Chairperson, with respect to this whole issue of designated consent giver versus a listing of family members to be consulted, one of the concerns that has been expressed is whether or not moving in the direction of designated consent giver or the idea of a living will might result in liability, might result in considerable litigation efforts, lawsuits and so on. I am wondering if any more litigation will be the result of implementing something along the lines of an amendment, in terms of designated consent giver, as opposed to this present arrangement in Bill 5 vis-a-vis family members.

Mr. Dalmyn: I would not worry a great deal about any more litigation considering the provisions of Section 94, 95 and 96 of The Mental Health Act and the way those sections have been interpreted by the courts. Anyone acting under the authority of the act is protected from suit unless they are shown to have been acting without good faith and reasonable care.

Indeed, there is a very unique mechanism which does not seem to be available to any other class of defendant in a law suit in Manitoba, to cloak the court with jurisdiction to dismiss a suit on a very preliminary and interim basis.

I do not necessarily approve of 94, 95 and 96 of The Mental Health Act. I note that at least one justice of the Manitoba Court of Appeal suggested several years ago that those sections collectively were unconstitutional, but for the time being they stand, and as long as those sections stand, I do not think that a variation between power of attorney or family member or Public Trustee is going to create any risk of increased liability for the hospitals.

Ms. Wasylycia-Leis: I would like to ask for the opinion of the CMHA here in Manitoba in terms of a suggested amendment around the issue of designated consent giver, and I am going to present to Mr. Dalmyn the roughly—an amendment along the lines of the Ontario mental health legislation and ask him for his comments on the following:

That in fact we consider amending Section 17 of the bill:

(a) by striking out the proposed Clause 24.1(1)(b) and substituting the following:

(b) the patient's designated consent giver or the patient's nearest relative, if the patient has no guardian; and

(b) by adding the following after the proposed subsection 24.1(1):

Designated consent giver

24.1(1.1) A person who has attained the age of 18 years and is mentally competent to do so may in writing and in the presence of a witness designate a person who has attained the age of 18 years and is apparently mentally competent to make treatment decisions on his or her behalf,

and then the following two conditions being listed:

Conditions

24.1(1.2) A designation under subsection (1.l)

(a) may be subject to such conditions as are set out in it; and

(b) may be revoked at any time on delivery of a notice of revocation in writing to the medical officer in charge for delivery to the designated consent giver.

I am wondering, I know I have read this quickly, if Mr. Dalmyn could give me perhaps at least an indication where CMHA might come down on that kind of an amendment.

Mr. Dalmyn: Mr. Chairman, it is the thrust of CMHA's submission that we would support that type of amendment in principle. I did not come armed with suggested wordings because it appeared from discussions with departmental staff and indeed with the minister that we were not necessarily going to be looking at it.

What you read to me sounds good. I would prefer to run it by a legislative draftsperson and have them structure it in terms of what goes into a definition section and what goes into the operative section of the act. I think it is not necessarily going to be a difficult amendment. It is something that could be done with even a few hours work, looking at the model of the Ontario legislation and dovetailing it to Manitoba's.

Ms. Wasylycia-Leis: Yes, just a few more questions, Mr. Chairperson. I am wondering in terms of Section 10 of Bill 5, on the issue of voluntary patients treated without consent and denied appeal. I notice in the brief that your organization suggests that the reference to 72 hours is perhaps a mistake in terms of the drafting of the legislation. I am wondering if that really is the case or if there is a strong feeling within the hospitals of Manitoba that such a provision is required in terms of the administrative responsibilities and so on of institutions.

Mr. Dalmyn: My judgment of the matter is that Section 10 is the result of an oversight by the Minor Amendments Committee. I am hopeful that the minister is going to address this among his nine amendments, because it seems to me that it was such an obvious mistake, and I made the case for that in the brief.

Before going on, Mr. Chairman, I say that with all due respect to the members of the Minor

Amendments Committee. Going through this legislation can give one a very severe headache, and you can lose track of what a different section says as you work on something else. So mistakes can be made quite innocently, and I am sure it is the routine experience of a committee such as this that someone catches something at the last minute immediately before clause-by-clause reading concludes.

Ms. Wasylycia-Leis: The question pertaining to Section 17 of Bill 5, the issue of protection of the rights of the voluntary patient—in your brief you present us with two options for dealing with this problem. You suggest that we might look at stating that the provisions of Sections 24(1) and 24(2) apply to involuntary patients only, but you also present us with the option of stating that a voluntary patient subjected to involuntary treatment be allowed to appeal. Does CMHA have a preference, and could Mr. Dalmyn perhaps explain the consequences of each option?

Mr. Dalmyn: Our preference is the latter, which is clarifying, confirming the right of appeal. In pure principle, in a perfect world and with perfect community resources and supports we would likely say that you cannot give involuntary treatment to a voluntary patient. The voluntary patient is free to go unless the hospital staff assess them as dangerous.

However, we do not live in a perfect world, and CMHA has become concerned that we will be forcing hospitals and physicians to designate more people as involuntary, which can have a severe impact on their future medical care, on their self-esteem and well-being. We do not want to force doctors to stigmatize people in the interest of giving them care. So I think our best solution, in today's world, is to make sure that it is well understood that a voluntary patient who has been called incompetent and is getting involuntary treatment, involuntary from that patient's perspective, because somebody else, a family member or the Public Trustee, is making the treatment decisions, has the right to pursue an appeal.

The act, as presently worded, seems to give them that right. The problems that are described in our brief may very well have been isolated errors and mistakes. I think we just wanted to drive home the point that if there is going to be an involuntary aspect of someone's care, we should ensure that due process is observed and that we empower individuals as far as possible by giving them access to review boards and the alternate panel of expertise available there to ensure that they are getting the appropriate treatment for them.

Ms. Wasylycia-Leis: There is nothing now, I believe, in the legislation that suggests to the review board that it should not accept appeals from voluntary patients. Is this not something that could be dealt with through firm direction to the review board?

* (2110)

Mr. Dalmyn: The answer is complex because the gateway to the review board is getting the forms. An individual on a hospital ward has to get the forms from the hospital staff. This involves more than an administrative direction to the secretary of the review board as to what paper he or she is going to process. It involves educating the nursing staff of their obligations to make the forms available and to ensure that no one inadvertently gives a patient legal advice, well, you are voluntary, you cannot appeal, or I am not going to give you an appeal form because you cannot appeal or something like that.

It is broader than just dealing with the review board. It falls outside the strict bounds of the Department of Health. We are dealing with hospitals which have, as we know, a large degree of autonomy and it may be necessary, if only for educational purposes, to put some sort of statement in the act.

Ms. Wasylycia-Leis: On to Sections 26 and 27 of Bill 5 and your concerns about the delay in schedule of appeals to the board of review, a concern which we in the New Democratic Party share, although we may have been part of the problem back with Bill 59 in 1987. However, I think the case has been made for a much tighter time period in terms of dealing with appeals. We have taken note of Ontario's provisions for requiring each hospital to start the appeal process by seven days and to rule one day after the hearing.

This issue does seem to generate a lot of debate in Manitoba. I note in the couple of paragraphs on the Mental Health Services Report in Manitoba by the Manitoba Health Organization, a report of May 1990, that concern is expressed about the preparation required for a review board hearing being time-consuming, sometimes found to be unnecessary because the patient had been discharged or at least recovered, blah, blah, blah.

I would like to know, is the concern about an improved appeal time period a result of logistics in terms of the size of this province and how our communities are spread out? Is it something administrative in terms of institutions and the time required, or is it indeed something more philosophical and fundamental?

Mr. Dalmyn: The issue of the time for a review hearing presents issues of philosophy and pragmatism. Philosophically, you would want a review hearing to be conducted very quickly, at least on an interim basis, to ensure that something completely inappropriate is not being done with a more detailed hearing perhaps to follow in a few days.

Had we had that type of system when Bill 59 was proclaimed in 1988, we would have had severe practical problems in Manitoba. We seem to have worked the appeal time down to a few weeks notwithstanding administrative problems about how you schedule a panel. This is one of the areas addressed in Bill 5 that I did not comment on, but the opinion of departmental counsel on the terms of Bill 59 had been that you had to appoint your review boards in three. If you did not get the three named in the Order-in-Council, you did not have a valid review, and this meant you had only a certain number of panels to work with. Now we are going to go to the same model as the Labour Board where you pick one from each pool as long as they are not disqualified, and you get on with the hearing.

One would hope that with this system in place, we can look at less than three weeks time for a hearing. I do not know whether it would be overly optimistic to legislate on the basis that by September or October we will be in a position to be looking at one-week or 10-day delays once the administrative changes, once the rostering system is in place, and that is why I felt our suggestion of a seven-day period like Ontario is not inherently unreasonable.

The fact that we are at three weeks now is after a lot of effort and in spite of the administrative burden of the fixed three-member panels that was instituted by Bill 59, so I am hoping for shorter times and I am expecting shorter times.

Ms. Wasylycia-Leis: On Section 45 of Bill 5 you raise a great number of concerns about existing provisions and about the amendments being proposed. I am wondering, would we be better off without these amendments at this time until we can get on with a more thorough and substantive way to address this whole area?

Mr. Dalmyn: The honest answer is that as difficult as the order of supervision process is, it can be improved and Bill 5 proposes an improvement. CMHA would like to see much greater improvements, and I think for the third time—because we said this in 1987 on Bill 59; we said it on the patchwork, the December amendments the following year—we say it now for the third time. The order of supervision process confuses the issues of mental health or treatment of mental illness and protection of vulnerable persons.

Without meaning disrespect to the legislative draftsperson, we have a very elegant legal solution where we cram everything into these boxes, but that does not correspond to the type of problems that vulnerable people have in the real world. This entire field needs a lot more thought, and I do not think that continuing to use The Mental Health Act is fair and appropriate. I would suppose that the order of supervision system at some point will attract Charter scrutiny.

Ms. Wasylycia-Leis: You raise a concern on page 25, but I do not believe you make a suggestion for an amendment in that area, and that is with respect to the 72 hours for a regular involuntary psychiatric assessment of a person. If I understand that, it causes me concern if one starts to think about translating it into real life circumstances. I think what it means is that my spouse, or maybe better put, the minister's spouse, could arrange for a peace officer to take us in and apply for psychiatric assessment and keep us there for 72 hours, and treat us and drug us, and we would have little options in that 72-hour time frame. That does seem to be a real concern. I am wondering why you did not suggest an amendment in terms of that time period, or are you suggesting amendments.

Mr. Dalmyn: The page reference that the honourable member made was correct. The honourable member appeared to me to be raising something that was not addressed in the Major Amendments Committee's work. It was addressed in the submissions on Bill 59 in 1987. It has to do with how a person becomes a patient in a psychiatric facility. -(interjection)- I am sorry. I was distracted by the table talk.

* (2120)

Bill 59 picked up on what was already in the act previously. How do you get somebody into a psychiatric facility? One mechanism is that a physician, having seen the person, makes application for psychiatric assessment. If a person who appears to be having a mental illness crisis will not go to see a physician, then a concerned person can go before a magistrate and swear out an information which has the result of having the person examined by a physician. This is now, after Bill 59, in Section 8 of the act.

Once the person gets to a physician, the physician determines whether the person should be assessed by a psychiatrist. A physician cannot admit anyone to a psychiatric facility. The physician's application under Section 8, however, does operate, as the honourable member has pointed out, as a nonappealable order for 72 hours. When we asked in 1987, why 72 hours?—and I cannot attribute names to this, and it has nothing to do with the present minister; this was Mr. Desjardins presenting at that time—someone whispered in his ear and he said, well, we need as much as 72 hours because the psychiatrist may not be on call on a long weekend. That is not an acceptable rationale for legislation. That is the background of why I took a potshot at the 72 hours.

A psychiatric assessment does need time. It is not done on the spur of the moment. It can take several hours but, considering that this is done on the assessment a the G.P. and, if it is a G.P. in the North or in a rural area and you are going to move the person several hundred miles, whether from Portage la Prairie to Brandon or from The Pas to Selkirk, you are beginning to look at some very drastic implications.

So to have a nonappealable, nonchallengeable 72-hour detention on the say-so of a 27-year-old intern on emergency in a remote medical station, who may not have taken a psychiatric rotation, can present problems.

Mr. Cheema: Mr. Chairperson, I just wanted to ask the presenter to qualify, because I think his statement, probably I may have some disagreement here, and not to leave something on the record which may or may not be correct, because I think if Dr. Rodgers is here he would be very willing to say that, and I think that is the case, that even the interns and anybody who sees a patient, suppose a fifth-year student, has to be reviewed by either somebody who has a full licence, so that clarifies the whole situation. The member for St. Johns (Ms. Wasylycia-Leis) raised the issue that some family member can get a warrant for somebody, bring that person to hospital, so that means the person is automatically locked for 72 hours. That simply is not true.

The patient has to be seen by at least one person, one physician, and if that physician is not satisfied, the patient is discharged. I think we are just leaving something on the record which probably is a misunderstanding, but I would like the member for St. Johns to clarify that, because I think it may cause some concerns for individuals that if there is a fight in the families, somebody can phone a magistrate and say, so-an-so person is not doing well, so put him in a hospital. I do not think that is true; that is not a fact.

Mr. Dalmyn: There are two different problems here, and I am sorry if I confused them. First of all, the question of what the magistrate does is a matter within my knowledge. You can end up, not necessarily with marital disputes, but it happens in marital disputes, it happens in intergenerational disputes over the ownership of farmland. I have seen this happen. A family argument gets blown up and someone swears that the person they are in an argument with is crazy. So they go to a magistrate. Now, what part of the province are you in, and where is the person going to be examined? If the magistrate accepts the information and issues the order, the police force, be it the RCMP or a municipal force, will have to pick the person up and take them to a medical practitioner.

Now we have some administrative issues here because, depending on the region of the province, the preference may be to take the person to a psychiatric facility instead of to the nearest G.P. That should not be happening.

Then you reach the next stage. Once you get to the G.P., and I point out that you may have gotten to the G.P. by a trip from Swan River to Brandon or longer, that G.P. has the power to "commit" for 72 hours for assessment. Under the act it is called an application for assessment. The legal effect is, the person goes for 72 hours, and I am saying that there is no necessary uniformity in how doctors will deal with this. I hope the training is good. One of the mandates I believe of the provincial psychiatrist's office is to ensure standardization and quality, but you never can tell.

Mr. Cheema: Mr. Chairperson, I think I still have to disagree with the presenter and with due respect because that means that every physician who is licensed by the college, and if he has a full licence and has a training in what he or she is satisfying all the requirements, that means if that person is certifying somebody, if he or she finds that patient needs to be admitted and whether that has been brought by the family member or somebody else, I think that is the way it should be.

You know, I think we have to take care of the patient first, and the patient should come first irrespective of where the source of patients bringing to the hospital. I think the question here is whether that person has a problem and the person needs to be in a hospital, that is the issue.

The 72-hour issue has been discussed in 1987, and there are some practical problems. We have a shortage of psychiatrists. We have a geographical distance from Winnipeg and every town does not have a psychiatric facility. So I think we have to look at the practical issue and make sure that we do not do something in a fashion that it will simply make things impossible.

I just want the presenter to know that I think that is some of the practical aspects of daily life.

Mr. Dalmyn: I appreciate the honourable member's remarks. It is better to have qualified assessment by a doctor than to have no assessment at all. I come back, however, to something I said earlier, the rationale for the 72 hours. That length of time has never been completely clear to me.

The well-being of the individual is certainly paramount and the well-being has to be measured on several scales. If the person is indeed suffering a substantial disorder of thought so as they need medical care, then let the due process lead to the correct and healthy conclusion. What frequently happens is that a person will sit that length of time before someone can see them. It has been my observation that the Criminal Code gives a common criminal or a person accused of crime, who statistically later may be found to be guilty, 24 hours maximum before a bail hearing.

Mr. Cheema: Mr. Chairperson, just a final comment. I do not want the presenter to take my views in a negative fashion, because I think what we have to do then is ask the Minister of Health (Mr. Orchard) to have so many psychiatrists in the hospital system so that the regular certification can be made which is not possible. I just wanted the committee to know that there are practical problems. I think we have to be careful about some of the issues with which people who provide the care have to face from day to day.

Mr. Dalmyn: I understand the honourable member's concerns. I agree and CMHA agreed in 1987 that in some ways the terms of Bill 59 were unfair to the medical profession in putting a double burden on them as both caregivers and legal decision-makers, which in some ways distort the therapeutic relationship.

Mr. Chairman: Are there any other further questions?

Ms. Wasylycia-Leis: Just one more. First a comment, I think this dialogue we have just had is an indication of—is really the essence of this debate, and that is finding that balance in terms of our mental health system between the good of society and protecting the rights of individuals. I think the concerns of Mr. Dalmyn on behalf of the CMHA are an attempt to correct that balance, to try to ensure that for once in our history we consider the rights of patients and do everything in our power to empower those individuals and communities.

A last question which relates to all of this. It is an issue I do not believe that is touched on in your paper, but was suggested by another individual, I believe to all of us, and that has to do with respect to involuntary patients. A suggestion was made that the treating psychiatrist give comprehensive written information on every drug that the psychiatrist was planning to use on all involuntary patients, to the patient and to anyone who was being asked to give consent on behalf of the patient before obtaining consent to treatment. I am just wondering if that is an area we should be looking at, was it considered by CMHA, and whether or not it is feasible in terms of the system and legislation.

* (2130)

Mr. Dalmyn: Mr. Chairman, I do not know whether it is feasible. I think the principle of informed consent requires a caregiver, be it a G.P. or a psychiatrist, to give appropriate information to any patient. If the patient has a substituted consent giver, then the information should go to the substituted consent giver.

The proposed amendments in Section 17 of Bill 5 which will impact 24 and new 24.1, 24.2, would seem to put an increased burden on a mental illness caregiver to provide detailed information to a substituted consent giver. I do not know how much information is customary and when it becomes counter-productive. In the whole general medicine field we have seen some tension between law and medical practice. We have seen a certain amount of criticism of older and perhaps European-based models of medical caregiving where the doctor goes in a very magisterial fashion and does not provide a lot of information. The trend appears to be to make sure that any patient gives an informed decision.

I would not want, to come to the point of the honourable member's question, to legislate that each aspirin has to be described in detail in advance. One has to be aware of the exigencies of practice. However, when a change in treatment occurs, informed consent should be obtained. One would hope that is the requirement of the law already. If there is any suggestion that it is not, obviously more details have to be spelled out.

Mr. Chairman: Thank you very much for your presentation, Mr. Dalmyn.

Mr. Orchard: Mr. Chairman, not that I want to keep Mr. Dalmyn on his feet any longer. First of all, in observation, I want to thank the CMHA for their participation on the Major Amendments Committee and subsequent discussions we have had since the introduction of Bill 5 and some of the concerns expressed in the brief.

One question though, it is my understanding that the model proposed by the member for St. Johns (Ms. Wasylycia-Leis) in terms of designated consent giver is basically, I think, the Ontario model. Am I correct in my understanding that that issue is under review with a possible deletion from the act and an incorporation into a—how would I phrase it?—into a designation for across-the-health-care system, not narrowed specifically to provisions under The Mental Health Act?

Mr. Dalmyn: The minister's information may be more detailed than mine. My understanding is that Ontario has opened up a broad review of advanced directives and other related medical consent issues. Their process is not necessarily different from what the Law Reform Commission has undertaken. I would prefer to put it in that context. They are looking at broad rules across the province and, if, as and when they get them, they will tailor what is in The Mental Health Act to meet the general rules. I would not necessarily put it in the perspective that they are looking at dumping what is in their act. They would dump it when they get something better and something across the board. That is as accurate an assessment as I can give, and I do not know if the minister has any better information.

Mr. Chairman: Thank you very much, again, Mr. Dalmyn.

Mr. Dalmyn: Before sitting down, I would like to thank again the minister who has maintained a most hands-off attitude but has been entirely supportive of consultation. I would not want to leave with the impression that the process of consultation was not worthwhile. I said at the beginning, I felt we were working on something that was of perhaps secondary importance. I believe the process of consultation has been worthwhile. The previous minister who opened it and this minister who has encouraged it and fostered it through some friction and hardship, the process of consultation deserves to be applauded. It is a welcome initiative in Manitoba.

Mr. Orchard: Thank you, sir.

Mr. Chairman: I would like to call on Mr. Doug Fyfe. Then we will call Mr. Bill Ashdown and Mr. Ben Hanuschak.

Do you have written copies of your brief?

Mr. Bill Ashdown (Society for Depression and Manic Depression in Manitoba): No, Mr. Chairman, I do not.

Mr. Chairman: That is fine. You may proceed at your convenience then.

Mr. Ashdown: Thank you. In deference to the hour—

Mr. Chairman: I am going to ask, are you Bill—

Mr. Ashdown: I am sorry. I am Bill Ashdown. I am the executive director of The Society for Depression and Manic Depression in Manitoba. As I was about to say, in deference to both the hour and the weather, I will try and keep this extremely short. I rather suspect that the process is getting a little wearying for all concerned.

Let me start right at the top. Our society is not in the mental health business. We are in the mental illness business. The difference is that we are not dispassionate bystanders, we are not do-gooders, we are not social activists. We are the patients and the family members of patients who are affected by two specific mental illnesses, depression and manic depression. These two illnesses constitute the vast majority of psychiatric admissions in the province. So we have more than just a passing interest in this act because it is us, it is ourselves, it is our loved ones who are going to be affected by the legislation.

The society that I represent has two primary interests, two purposes. The first is to provide support, understanding and assistance to those suffering from these disorders and their family members, to help them to understand and accept their illnesses, to learn to treat them and to cope with them and to get on with their lives. The second is to develop a public awareness of these illnesses, of the social, biochemical, and psychological factors in depressive disorders, thus eliminating the enormous social stigma still associated with them.

(Mr. Gerry McAlpine, Acting Chairman, in the Chair)

I do not particularly want to spend a lot of time on the details of the bill. That has been done elsewhere and to considerable good effort by the CMHA. Our position on the bill in question is very simple. We want the bill to pass and we want it to pass as soon as possible and, in asking for this, we are not ignoring the very real and potentially serious problems that this bill presents. We recognize that the bill does not effectively address the subject of alternate or substitute consent in its entirety. We see that there are possibly serious shortcomings to the nearest relative provisions, and we are concerned that certain questions of time limits are still unanswered. We hope that these or most of these will be dealt with in the proposed amendments and clause by clause. Despite these problems, we believe this act is an improvement over the existing legislation.

We are very gravely concerned that prolonged debate over this bill will take away from the very real needs and concerns of the mentally ill and their families: the need for more effective treatments and facilities; the need for a mental health system that adequately serves the needs of all Manitobans, instead of the present system which is effectively limited to within the Perimeter Highway around Winnipeg; the need for enhanced training and education of health care professionals in recognition and treatment of mental illness.

To put it very bluntly, we want to see this bill passed so that it cannot serve as an impediment to the speedy development and implementation of further legislation to improved mental care in Manitoba.

Ladies and gentlemen, that is it, as simple as we can put it.

The Acting Chairman (Mr. McAlpine): Thank you very much, Mr. Ashdown. Are there any questions?

Ms. Wasylycia-Leis: Mr. Acting Chairperson, I think we have the message, and I would like to ask a couple of questions since we will be getting into the amendment stage either tonight or later this week.

First of all, with respect to the question of designated consent giver. If you had your druthers and if it was the best of all worlds for your association, would it be preferable to move towards a designated consent giver as part of this legislation as opposed to simply leaving it at the list of designated family members?

* (2140)

Mr. Ashdown: We recognize that the list of designated family members creates some considerable problem. It creates a problem both in time frame, that is, who has been in contact with the patient soonest or farthest, whatever. It also creates the potential for enormous difficulties within family situations which may in fact have contributed to some degree to the patient's illness.

I understand that there is in train a process through the Manitoba Law Review Commission, a process whereby the whole subject of substitute consent is being looked at on a much broader issue than simply limited to The Mental Health Act. I would rather suspect that when that process becomes legislation, it will take precedence over this act as most human rights legislation seems to. But obviously in a perfect world, yes, we would like to see an alternate consent or substitute consent clause somewhere that would allow the patient in a time of good health to appoint a representative who could act on his behalf and make some of those treatment decisions on his behalf. Whether that is practical at this point in time or not, I cannot say. My concern quite frankly is to see that the process does not become bogged down in the minor, if you will, technicalities of what one particular clause says over another.

We have mentally ill people out there who are not being effectively treated because the system does not work particularly well. It is those people that I would respectfully suggest that we pay attention to and limit our efforts in terms of the paperwork. To me, to us, the care and treatment of the suffering patients are much more important than the technicalities on how we get them there.

Ms. Wasylycia-Leis: From your experience in terms of dealing with the clients and members of your association, have you run across situations where the nearest relative may, in fact, not actually be able to act in the best interests of that individual or where a more distant relative might be a more suitable caregiver or person for giving consent than a closer, nearer relative?

Mr. Ashdown: Let me say that, yes, I have run into that circumstance. I have also run into the circumstance where a patient is so ill that he—the corollary of that is he does not recognize that the nearest relative involved is, in fact, acting on his best interests. It is very difficult to determine on an overall case which is best. It has to be taken on a case-by-case, patient-by-patient basis.

Ms. Wasylycia-Leis: Although we do not know the amendments, at least I do not know all of the amendments that the minister is going to be proposing at this stage, I am wondering if your association has any priorities in terms of amendments that really must be addressed in terms of Bill 5.

Mr. Ashdown: Our priorities are—well, let me put it to you a little differently. We are not so much concerned with the process as we are with the result. We see that in Manitoba the system is so fractured and operates in such a limited fashion, particularly in rural Manitoba, that we tend to focus a great deal of our attention on that. Rather than saying which particular part of the amendments should be done first, I would respond by saying that it is a bit like diagnosing an elephant by feeling the toenail. You have to look at the whole problem and find a whole solution for it. I can appreciate that the amendments are fairly important, but last year in this province we lost over a hundred people to death by suicide as a direct result of depression. I would respectfully suggest that the treatment of those patients is considerably more important.

Ms. Wasylycia-Leis: Would the member be able to tell us if there are benefits in terms of improved legislation to address the concerns you have raised and preventing the suicides that the member talks about? Does the legislative route play a part at all in terms of your concerns?

Mr. Ashdown: In answer to the honourable member, I would—it is my fervent hope that we will shortly, within the province, embark on what has been termed a community mental health services act. Some conversations to that end have been held this past winter through the Department of Health. I believe very strongly that the potential of that act is very great and could do enormous good, particularly in rural Manitoba, to alleviate the lack of treatment facilities for the mentally ill in those areas. That to me is a major priority. I tend to look upon this process of amending this particular act as being one step in a very long process of change, and I do wantto express my sincere concerns that we cannot as a province get stuck on this step of the process because the further steps are, frankly, much more important and are very much overdue.

Mr. Orchard: Mr. Ashdown, I appreciate your comments. One of the—and I should have brought this up with up with Mr. Dalmyn. Although we recognize there can be some difficulties with nearest relative designation in terms of incorporating it into the act, we think it is, even despite instances where it may potentially be less than satisfactory—I am trying to choose words pretty carefully here. Two processes are in place, as you indicated, the Law Reform Commission study which, hopefully, will guide us through a larger consent giver and directive giver.

(Mr. Chairman in the Chair)

Secondly, in instances, particularly in the case because I was quite concerned where circumstances—for instance, if the nearest relative happened to be an abuser of the individual, that would be inappropriate. I am advised by staff that the best interest judgment of the admitting physician would come to bear, of course, providing the individual could adequately communicate the concern about the nearest relative if that nearest relative happened to be one who was an abuser of the individual. I thank you for your presentation, Mr. Ashdown.

Mr. Chairman: Thank you very much, Mr. Ashdown.

Mr. Ashdown: Thank you, Mr. Chairman.

Mr. Chairman: I would now call upon Ms. Barbara Wiktorowicz. She is with the Alzheimer Society and family resource centre of Manitoba.

I would like to now call upon Mrs. Pat Trottier, private citizen.

Mr. Gordon MacIntosh of the Manitoba Association for Rights and Liberties. Do you have a written brief, Mr. MacIntosh?

Mr. Gordon MacIntosh (Manitoba Association for Rights and Liberties): Yes, Mr. Chair. It is being distributed.

Mr. Chairman: Thank you very much. You could just give us one moment, and we will just distribute it. You may proceed.

Mr. MacIntosh: Mr. Chair, honourable members, I am from the Manitoba Association for Rights and Liberties. The brief sets out the aims of the organization. I am chair of the Patients' Rights Committee which seeks improved protection for the rights of health care consumers, and in particular, the committee and MARL seeks to sensitize the health care community or to fine tune the health care system to ensure that it is adequately responding to the needs and inherent rights of individuals in the system.

MARL commends the government for having struck the Major Amendments Committee and Des Connor of the Patients' Rights Committee represented MARL on that. MARL was one of a few organizations which had representation on the Major Amendments Committee and it is hoped that MARL was able to contribute in a meaningful way to those deliberations.

* (2150)

The amendments now proposed to The Mental Health Act do not represent any major change in public policy direction in the province. It is urged that the valuable time the government does spend regarding the health care system, and the mental health care system in particular, should be devoted in the future to the development and implementation of health care services legislation. It is hoped that that type of legislation will ensure a full range of mental health services in the community is accommodated, structured, provided for. A comprehensive mental health care policy is required affecting the comprehensive areas of prevention, assessment, treatment and rehabilitation.

Public policy must also be developed to protect vulnerable persons. In this regard, MARL has recently issued a report on patient advocacy in the province of Manitoba from which MARL has developed a proposal for a patient advocate commission to deal with complaints and concerns of patients. I have brought copies of that report here tonight and I will have that distributed to each of the caucuses. MARL has requested a meeting with the government, in particular the Minister of Health (Mr. Orchard) and the Attorney General (Mr. McCrae) and will be meeting with the opposition regarding the advocacy commission proposal, as well as other issues in the near future, hopefully no later than in September.

(Mrs. Rosemary Vodrey, Acting Chairman, in the Chair)

Regarding the amendments before this committee, MARL generally applauds the amendments which allow the involvement of family to participate in decision making. It is certainly a great improvement over the role of the Public Trustee in the existing law. MARL applauds the recognition given to the patients' best interests set out in Section 24.1(4) of the bill and, as well, the requirement for a detailed record set out in 24.2(5).

I might also just highlight that improvements to confidentiality in Section 32 of the bill are commended. Now having said that, I do not think that government often gets commended when it does something right, and I do not want to understate the comments I just made. I also want to commend the minister for facilitating the role of the Major Amendments Committee and in listening to its recommendations. It was a consultative process, which is good.

MARL does have some major concerns, and it has addressed its collective mind to three areas. The first one regards the patient's choice. MARL recommends that the patient must be given the legal authority to determine who can make treatment decisions on the patient's behalf. Now the definition of nearest relative—and we are familiar with that, it is set out in Section 2—defines who other than the patient has the legal authority to make treatment decisions for incompetent patients.

This pecking order does not take into account the patient's own concerns or choice. It does not take into account the realities of relationships, a common-law relation. There I am talking about which is less than six months in duration or not immediately before admission, or a friend may, for example, be the true choice and the most effective decision maker.

I have heard it said, well, how can an incompetent patient possibly name someone? How could they have such a choice? Incompetence under the act is defined as being incompetent to understand treatment decisions, not understand who they want to make decisions on their behalf. It is a lesser test. MARL submits that the right to make that choice is inherent. It is a human right. It is a right that one possesses by nature of being a human, and it must be accommodated in the legislation.

The second area of concern is the time limitations that affect one's liberty. An involuntary psychiatric assessment should be conducted within 24 hours, not 72 hours, as set out in Section 15 of the act. Notice of a hearing of a review board to consider a patient's application, as set out in Section 26.5(6) of the bill, should be given within three days, not seven, of receipt of the appeal. A hearing should be commenced within seven days, not 21 days, of the receipt of the application.

We recognize that the number of days are to some extent arbitrary, but I think MARL was making it clear that the time limits set out in the current act and set out in the bill are unsatisfactory. Furthermore, there should be a requirement that the review board should be required to make a decision as soon as possible following the conclusion of the hearing and, in any event, not later than 24 hours following the conclusion of the hearing.

The rationale: The length of time a person must endure a denial of liberty before the checks on that denial can be implemented are unacceptable. Review board procedures are now well established and, in light of the experience in this area, in this province, and in light of the legislation in Ontario, MARL believes that the reduced time frames are workable and are called for.

This is an extremely important point. I get calls on a fairly regular basis from people who are users of the health care system and who are in an involuntary status, and I do not think that one single issue is as important to the individual as this one. There is a certain sense of hopelessness among many when they look at the time periods that are set out, and I urge this committee to give serious consideration to an amendment in this regard.

The third area of concern is the role of the Public Trustee. MARL commends the reduced role for the Public Trustee, but there is still a role. The Public Trustee does not have the skills, the resources, the understanding of the individual to make an informed decision to allow for treatment. Unless there is enduring power of attorney legislation—and that alone is not enough, because enduring power of attorney legislation will only be voluntary legislation. One does not have to go out and appoint someone to make decisions for them. Unless there is an advocate that is available to act in the best interests of the patient, unless there is vulnerable person's legislation, there should be some check, some assistance—to put it in a more positive frame—to the Public Trustee, to enable the trustee to make a good decision which is truly in the best interests of the patient.

We have seen people who have gone through the mental health care system, are still in it, who have taken drugs for periods of time. They are suffering the side effects, and they are wondering, they are trying to rationalize what happened, trying to understand the process. I think that whole process becomes so confounding if a treatment decision is made by someone who has not adequately studied the pros and cons. My understanding of the role of the Public Trustee is that the Public Trustee is basically relying on the psychiatrist's opinion, and there is basically a rubber-stamping of that opinion. What other opinion is there available to the Public Trustee? I am sure there may be a little more time that is required on the part of the Public Trustee, but that time is critical. We are talking about a person.

I have no further comments unless there are any questions.

* (2200)

Ms. Wasylycia-Leis: I would like to thank Mr. MacIntosh and the Manitoba Association for Rights and Liberties for taking the time to present a very thorough brief on this legislation, and I would like to begin by asking a question pertaining to the first area of concern for MARL and that being the question of who can make treatment decisions on a patient's behalf. I would like to ask the same question I asked Mr. Dalmyn from CMHA, and that is the association's views of the kind of amendment I had suggested in terms of the Ontario legislation. I do not need to read it again; I am sure Mr. MacIntosh heard it. I would like to get a sense of MARL's position on that kind of a wording for designated consent giver.

Mr. MacIntosh: Madam Acting Chair, what I heard sounded good. I have not read it, and I would not want to give any conclusive response to that without reading it carefully, but it sounded like it reflected the needs of the individual as best as could be expressed in the legislation.

Ms. Wasylycia-Leis: Again, I would like to raise a concern that has been brought to our attention about the fact that going this route may lead to litigation, lead to malpractice suits. I am wondering, as a member of MARL and as someone with some legal experience, if you could indicate to us whether or not going this route of a substitute consent model is going to lead to more litigation and malpractice suits than going the route, as proposed in Bill 5, of a list of designated family member.

Mr. MacIntosh: When I read the proposed section in the bill, I have Charter bells ringing. I had an experience of dealing with one individual whose decision maker would have been No. 4 in the pecking order; the brother or sister would have been entirely unacceptable to the patient. I think as a lawyer my advice would be to consider whether there was an infringement of a section of the Charter, a denial of liberty. I think there is an argument available—it would depend on the circumstances, of course—but certainly I think the legislation as proposed invites considerations of application of the Charter.

The Acting Chairman (Mrs. Vodrey): I would just like to make an announcement. Hansard has requested a two-minute recess to change the reel-to-reel tape, so we will take a short recess—two minutes—and we will resume then. We will resume with Mr. MacIntosh.

* * *

The committee took recess at 10:04 p.m.

After Recess

The committee resumed at 10:11 p.m.

(Mr. Chairman in the Chair)

Mr. Chairman: Can we call the meeting back to order, please?

Ms. Wasylycia-Leis: On the question of the substituted consent model, it has been suggested that there might be problems proceeding with implementing such a model or an idea in one piece of our health care system. I am wondering if there is a problem proceeding, if the member from MARL perceives a problem in terms of instituting such a concept in our mental health legislation while we are working in terms of a more broad implementation in terms of the health care system.

Mr. MacIntosh: I do not think that it is worthwhile waiting for living will legislation in the province. As I said earlier, the living will legislation only facilitates the legal recognition of living wills. It does not require someone to make or execute a living will. Therefore, living wills legislation may not ever come into the picture in many situations in the mental health system. I do not understand why this legislation cannot accommodate the patient's choice.

Ms. Wasylycia-Leis: Skipping over to your concerns in terms of the role of the Public Trustee, I would just like some clarification in terms of the amendments that you are suggesting. Maybe I will ask that first and then perhaps make some or ask for some comments vis-a-vis the suggestions that CMHA is proposing in terms of amendments for this area.

Mr. MacIntosh: I am sorry, I just did not catch your last comment.

Ms. Wasylycia-Leis: Yes, I would like to hear some general comments in terms of MARL's position on amendments to this area and after that, I would also be asking for some reaction to some of the suggestions from CMHA, Manitoba.

Mr. MacIntosh: Mr. Chair, we asked that there be independent medical opinion required to be solicited by the Public Trustee. My understanding is that these kinds of requests are not so frequent that it would require a staff position in the Public Trustee's office. I believe that independent medical opinion is available within the health care provider community, and I do not know if the legislation has to be much more extensive than requiring independent medical opinion.

I think that the words speak for themselves. I would defer to the advice of Legislative Counsel in that regard.

Ms. Wasylycia-Leis: Yes, I appreciate that comment and I will be looking forward to some reaction both from the minister and Legislative Counsel in terms of an amendment that makes reference to independent medical opinion.

There has been a suggestion from CMHA in terms of a four-part amendment to help fix up this whole area, and I will just briefly run over them and ask for a reaction.

The suggestion is basically, if I understand this proposal, to draft an amendment that states that: Where the Public Trustee receives an order of supervision of a person under this section, he or she shall not consent (a) to admit the person to a psychiatric facility or (b) to the person receiving psychiatric care in a hospital.

That is one part. The next part is where the Public Trustee receives information from the position under Clause 1.2(c) that: A person is not mentally competent to make treatment decisions, the Public Trustee shall, before consenting to any treatment or care under that clause, give notice to the person and the nearest relative of that person of the information received from the physician.

A third part is that: The Public Trustee shall make each treatment decision required under Clause 1.2(c) on the basis of the criteria set out in subsections 24.1, 3 and 4 and, finally, that where a physician informs the Public Trustee under Clause 1.2(c) that a person is not mentally competent to make treatment decisions or where the Public Trustee consents to treatment or health care for the person under that clause, the person may appeal to the review board established under 26.4.

I realize that is a quick overview of those suggestions. I am wondering if you would have any reaction or comments in terms of amendments along those lines.

Mr. MacIntosh: MARL would not oppose those four suggestions, although the third one, that the decision will be made in accordance with the factors set out or the best interest factors, it is my understanding—and I am subject to correction—that is required to be taken into consideration under the bill.

Regarding the other three factors, I think the restriction against admission decisions is important and regarding consent to care in a hospital. I think the real problem facing the Public Trustee and the system is that the Public Trustee needs someone independent from the permission-seeking psychiatrist. They need some assistance. They need some guidance, a second opinion. That is really, I believe, the crux of the problem.

Ms. Wasylycia-Leis: A final question, just in terms of the general work of MARL right now with respect to patient advocacy. Would legislation in this area dealing with patient advocates and so on be a way to address some of the outstanding concerns, the concerns not addressed by Bill 5 or the existing Mental Health Act in terms of better protection for the rights of patients and a better, clearer move towards a community based reformed mental health system?

Mr. MacIntosh: MARL is now beginning a process of discussion in the community and with legislators on this concept. I do not want to talk too long on this topic although it is, I think, an important topic. The report that I distributed to the critics and to the minister looks at the health care system's protection of patients' interests in Manitoba today, and it comes to certain conclusions after looking at the different models of advocacy that have been used in other jurisdictions. I think the conclusion in the report is very clear, and it forms the foundation of MARL's position. A patient-advocate system must be put in place which represents the best interest of the patient. In other words, similar to a lawyer-client relationship where the advocate will not second-guess the needs of the patient, but will be someone who outside of the facility or outside of the bed will represent that patient's best interest.

Ontario in particular, I think, in the mental health system has a similar advocacy system. We propose an advocacy system which is independent from the ministry of Health, preferably by reporting to the Legislature. Perhaps it could be functioned in the Ombudsman's office, or it could be even reporting to the Attorney General.

* (2220)

In fact, Ontario, by coincidence, has just a few weeks ago introduced an advocacy act which proposes a very similar type of advocacy function in that province, and the advocacy office reports to the Minister of Citizenship. If that is the model that is accepted, then the user of the mental health system can use that office, can rely on an advocate to represent the patient's best interests. The advocate may be the one who is appointed by the patient to make treatment decisions. It could solve many of the problems. I might also add that it would provide a forum for users of the system, and I think that users of the mental health care system in particular are among the most vulnerable in the health care system. I think, perhaps, residents of nursing homes are also very vulnerable, but it would provide a method of redress and would also help to identify areas of problem in the health care system. I think it would rationalize the health care system in terms of responsibilities of health care providers.

Mr. Cheema: Mr. MacIntosh, thank you for your presentation.

I have three questions, very specific. The first one, you have mentioned the incompetent patient may well be able to express a preference. Can you give me some idea of what you mean by that statement?

Mr. MacIntosh: I guess we have to talk about what the word "incompetent" means. Incompetent under The Mental Health Act, in Part 1, is set out in this bill in Section 24(3), and there is a test there. You know, if the patient does not understand the condition the patient is in, the nature and purpose of the treatment, and so on. So incompetence is measured by those criteria.

The criteria for determining whether a patient is competent to appoint someone to make decisions on that patient's behalf is a different criteria, and I suggest it is a much lesser test. They do not have to understand their condition, their treatment, the risks and the benefits—some very complex thought processes. The patient need only know who they can trust, who they think can act in their best interests. I suggest that—and as Mr. Dalmyn said, it is a minority in the system who are incompetent. Of those who are deemed incompetent under this legislation, there will be a significant minority who are incompetent to appoint someone to act in their best interest.

Mr. Cheema: Mr. Chairperson, I think it still leaves a number of questions. As we know, our population is aging, and from time to time the health care providers who are asked to make a decision are incompetent. Sometimes people make a decision this person may not be able to make a decision for financial affairs, but still can make a decision to designate or make certain other decisions.

In mental health, I think it is a different issue. I think somebody who is in the hospital, who has been admitted under involuntary admission, has a serious problem and does not understand the medication, and you want that person to make a decision in terms of who should be taking care of, whatever person that individual wants to be designated, that person should be responsible to make a decision? I find it very difficult really to comprehend that aspect. I think there are practical problems, and I just want you to be aware of that.

Mr. MacIntosh: Mr. Chair, if I may just briefly respond, I think that knowing who one can trust is a very basic, almost intuitive, decision—I do not know if that is the right word even—much more intuitive than the ability to decide on questions of treatment and risk.

Mr. Cheema: Mr. Chairperson, the other concern I have that Mr. MacIntosh has said that we should review—the hearing process should be within seven days. Basically, we are talking 72 hours of initial and later on four days, so it is a very difficult in certain circumstances to assess the efficacy of any treatment within four days if we have a major problem. So I think it does put the professionals at a larger risk to make a good medical judgment within four days of treatment and changing and going through so many papers, so many forms, and then explanations, which are very important. Then we must realize that they are acting in the best interest of the patient and should be given enough time to make a good judgment on behalf of the patient. That is a practical problem. I do not know whether you want to comment on that or not.

My third question, the observation is for the third independent opinion. We are already—you know, the people are concerned that you have to have two individuals and you have to have a 24-hour and then 72-hour time, and then the hearing process is there. You want to have another person to make assessment. Do you not think that would delay the process further? What you really want to achieve to hasten the process?

Mr. MacIntosh: Well, certainly the purpose of the recommendations are not to make the decision making of health care providers easier, but it is to provide more of a balance between the rights of the individual and the system. I know, as a student of the legal system, that one's actions expand or delay, expand given the time requirements that you have.

I believe that the review process and the assessment process will be refined, and it can accommodate a change in time frames. That will be the new regime, and there will be changes made not only in protocol, procedures, logistics, but also in the thought process. It will become truly a priority. I think that principle has to be reflected, prioritize those decisions, prioritize those logistics.

Mr. Cheema: Mr. Chairperson, the final comment. I do agree with the intent that we have to make sure patients' rights are protected, but I think we must realize that to achieve the best possible health status of the patient the balance must be maintained and given adequate time coverage for the professionals to do the best possible job.

I do not think we should lose sight from that aspect, because the professionals who are taking care of patients are also equally concerned. I do not think they are there in any way to delay the process, and they are not acting in the best interest of the patient. So I think we should be very careful when we are dividing these days, and when we are talking about three to seven days and it is only a four-day period, four-day period for adequate medical management. For a first-time patient who has been in the hospital, it may need more time than that. That is a practical problem. I just wanted to express my views on that. Thank you.

* (2230)

Mr. MacIntosh: Mr. Chair, just a brief response. MARL certainly does not question that the health care professionals are not looking out for the best interest of the patient, although we do have concerns that some aspects of the system, some requirements do not.

Mr. Chairman: Thank you very much, Mr. MacIntosh.

It has been brought to my attention that one of the presenters is from out of town and it represents quite a drive. I was wondering whether we might move to her out of sequence. So I call now Ms. Chrys Rak. Is it the will of the committee? Agreed. I will now call on Ms. Chrys Rak, No. 11.

Do you have a written presentation?

Ms. Chrys Rak (Private Citizen): No, I do not.

Mr. Chairman: You may proceed at your convenience.

Ms. Rak: I want to first thank you for moving me forward. It is late for me.

I am here to address the closing of the Selkirk school of mental health. I am one of those poor souls who had hoped to enter that school this fall. I had been working at this for the past three years. The abrupt and sudden closure of this school has affected myself very emotionally and very seriously in that it was as though the rug was pulled from beneath my feet.

You will just have to bear with me.

I think closing this school in Selkirk is a mistake for a great deal of Manitobans, a large population of them living within the Winnipeg area, especially the would-be students like myself who cannot relocate to Brandon or other facilities. When I was called for an interview in Selkirk, one of the interviewers told me—I believe her name was Ruth Enns—that the average student age is 28 and that this career choice is usually a second career choice, which means these would-be students are probably settled and have commitments within the Winnipeg area and cannot relocate, which is my case. I am sure it affects a great deal of others and possibly future students.

If this decision to close the school was made earlier in the year, the timeliness has locked me out of a lot of other possible opportunities. For instance, in my particular case, I cannot get into any R.N. programs because it is way past their closing date, as is some of the university faculties. So this career decision that I have been working on for the past three years is literally taken away from me. I think this was not a decision I had made just overnight, but over a great deal of time. I think mental health will suffer because there are probably more people like me who cannot take this program in Brandon. There will be nothing in the Winnipeg area.

Mr. Gregory Dewar (Selkirk): Why did you choose the psychiatric nursing profession?

Ms. Rak: They are for various personal reasons. Without getting into the personal reasons, generally speaking, I thought I could contribute something to this field.

Mr. Dewar: Can you explain to us why you chose Selkirk over Brandon?

Ms. Rak: I thought I had made that clear, perhaps not. I am married and I have two very young children. My husband works here in the city. We cannot relocate, and I definitely cannot and will not commute back and forth to Brandon.

Mr. Dewar: So you have not applied to the Brandon school, or have you applied to the Brandon school?

Ms. Rak: I had already gone for an interview with the Selkirk school. It was April 8. At that time, I was waiting for the reply when the bombshell was dropped. Then the school contacted me and advised me that they would transfer my file to the Brandon school, which they did. I got a response that I was accepted, but I will have to refuse. I cannot go there.

Mr. Dewar: So the closing of the school in Selkirk ended this career opportunity for you?

Ms. Rak: Yes, and not just for me. I am sure there are a lot of other people because this is not an occupation—from what I have spoken with the staff at Selkirk, normally on the average this is not a first career choice. It is usually a second career choice for older students. The point I want to make is they are probably committed within the Winnipeg area. There is nothing for them if Selkirk—

Mr. Edward Connery (Portage la Prairie): Ms. Rak, I can appreciate your concerns. In Portage la Prairie, the previous government closed the school of psychiatric nursing in Portage la Prairie, also, and there were many people from that location who were taking that opportunity to have a career. I just would not want it to be on the record that this government has closed that facility crassly. In fact, when we closed the school of psychiatric nursing in Portage, it was the only one for the mentally handicapped, and they kept both psychiatric schools of nursing for the mentally ill in Brandon and Selkirk.

I sympathize with you, but it is not the first closing of a psychiatric nursing school in Manitoba. I think it was '86 that the previous government closed the school of psychiatric nursing in Portage la Prairie, and it was the only one for the mentally handicapped. I wanted to put that on the record.

Ms. Rak: I think Portage la Prairie is still within the Winnipeg area. Brandon is not. Closing the Selkirk school—

Mr. Connery: I would be quite happy to have the minister reopen the school of psychiatric nursing in Portage la Prairie if that was ever feasible.

Mr. Orchard: Ms. Rak, you indicated that you are from out of town. Where is it that you live?

Ms. Rak: I live in West St. Paul, the Rural Municipality of West St. Paul.

Mr. Orchard: You have indicated that in pursuing a nursing career, other than registered psychiatric nursing, that there are no available training spaces in St. Boniface or Grace or Misericordia in the registered nursing two-year program.

Ms. Rak: I have contacted St. Boniface and the Health Sciences Centre for the registered nursing program and they have stopped taking applications for the '91 program, I believe it was March 31. The baccalaureate program of nursing at the university, the four-year program, I believe they close their doors May 1.

Mr. Orchard: Have you contacted either Misericordia or Grace hospital?

Ms. Rak: I felt contacting St. Boniface and Health Sciences Centre would be enough. These are R.N. programs. These are not RPN programs as my first choice was and has been for the past three years. I was hoping to enter this program. I had never anticipated that this school would close considering it has been in operation for 70 years. I read the paper. I did not see anything to indicate that there might be a closure.

For three years I have been taking credit courses at the University of Winnipeg to lighten my workload. I was even called for an interview on April 8 where I am sure if the staff of Selkirk had known about the closure they would not have gone that far. The abruptness of it—it is very, very disappointing and it affects people like me, and probably others, who may have perhaps wanted to choose a career in this field and have some energy to give to this field. Mental illness, in my opinion, is on the rise. I cannot see why closing a school would lessen this.

* (2240)

Mr. Orchard: Thank you for expressing your concerns, Ms. Rak.

Ms. Wasylycia-Leis: Yes, I would just like to put a couple of comments on record, first to thank Ms. Rak for coming all the way in to make this presentation and to express the impact of this particular decision on her life and I think, indeed, on this whole service area.

With respect to the member for Portage la Prairie's (Mr. Connery) comments, without getting into the whole issue in terms of the closing of the school at Portage, I think at least we can conclude that if an error was made at that time, then two wrongs do not make a right. I think the issue before us is a question of consistency in policy development and program delivery.

We have before us amendments to legislation purporting to take us further in that direction of protecting the rights of patients and moving us a step closer to a community-based delivery system. The concerns being expressed here are that we are not getting consistent messages. We are not getting an overall planned approach to a very serious issue. I think Ms. Rak's comments in that regard are important and should be taken seriously.

Mr. Chairman: Thank you very much for your presentation, Ms. Rak.

Ms. Rak: I just wanted to add that I made a few phone calls to inquire about why this was done. In my queries I found out that there is a 98 percent employment rate for registered psychiatric nurses.

Why pick on this group? There is not a surplus. There is going to be a need for them.

Mr. Orchard: Ms. Rak, I would very much like to spend the rest of the evening debating the issue with you. Yet, unfortunately, we are here, and there are a number of presenters that wish to present to Bill 5. I appreciate receiving your comments regarding the school of psychiatric nursing. It is the second unfortunate closing, and that has affected you. I have heard your concerns and I thank you for presenting them this evening.

Ms. Rak: May I ask you one more question before I leave?

Mr. Chairman: Presenters do not ask questions, Ms. Rak.

Ms. Rak: Perhaps you will address this comment then. As a citizen of Manitoba living within the Winnipeg area, what educational facilities would you have for a large majority of Manitobans living within the Winnipeg area?

Mr. Orchard: Ms. Rak, again, thank you for your comment. I suppose people in Thompson, people in Dauphin, people in Brandon would question why not all educational programs are available close to their communities where they live to avoid the disruption of coming to Winnipeg to undertake training. One of the issues that government has always challenged is in trying to provide balanced opportunity for enhanced and higher education throughout the province. That is the decision that we embarked on with enhancing the Registered Psychiatric Nursing Program in conjunction with the university of Brandon.

Thank you for you comments.

Mr. Chairman: Thank you very much.

I would like to now call on Mr. Sid Frankel, the Manitoba Association of Social Workers. I believe we have a brief. We will just hand it out here if you will just give us a few seconds.

Mr. Sid Frankel (Manitoba Association of Social Workers): Sure.

Mr. Chairman: Mr. Frankel, you may proceed, thank you very much.

Mr. Frankel: Mr. Chairman, let me first say that I am very pleased to be able to bring you the comments of the Manitoba Association of Social Workers regarding Bill 5.

We were not invited to be members of the Major Amendments Committee, but the minister assisted us in making a presentation to the committee, and Mr. Toews when he became assistant deputy minister did involve us in some of the consultations, and we are pleased about that.

We are especially pleased that some of the concerns we raised with the Major Amendments Committee are indeed reflected in Bill 5. First, we are pleased to see that Section 26(4)(c) will be amended to provide safeguards against arbitrary cancellation of a certificate of leave and the resulting reinstitutionalization.

Similarly, we were pleased to note that Section 25 has been amended to remove the power of the review board to order treatment contrary to the wishes of an involuntary but competent patient.

Third, we are pleased to note the amendment of 26.4(1) to render it incumbent upon the Lieutenant-Governor-in-Council to establish the review boards.

Fourth, we support the amendment to 24.1 which does empower relatives of incompetent patients to provide substitute consent for psychiatric treatment. We feel that this is a large improvement over sole consent by the Public Trustee and, we feel, will benefit the majority of patients.

However, it does little for significant but small numbers of patients who are not in contact with caring and benevolent family members. Nevertheless, we feel that further improvements in these areas of mental health legislation could be made by limited and practical amendments to Bill 5 and will briefly review these.

First, 26(1) deals with certificates of leave for involuntary patients who continue to meet the criteria for civil commitment but require treatment which can reasonably be offered outside of the psychiatric facility. We are concerned that in the present act this bill is permissive rather than compulsory. In essence, we think thatthe attending physician should be required, not only permitted, to issue a certificate of leave when the treatment can be reasonably and safely provided outside of the hospital.

* (2250)

Second, Section 26(1) requires that the patient or the substitute consenter for the patient must consent in writing to the certificate of leave. We support this, and we think it probably raises the probability that there will be compliance with that certificate, but in order to insure that the patient is properly informed, we think that the psychiatric facility should be obligated to provide a written statement of the treatment plan which will be implemented during the tenure of the certificate of leave.

Third, Section 26(3) deals with extensions to a certificate of leave. However, it is silent as to the criteria which must be met in order for such extensions to be issued. We think that it should be clarified that extensions can only be utilized when patients continue to meet criteria for involuntary admission. This includes the necessity that a patient be suffering from a mental disorder or continue to suffer from a mental disorder, be likely to cause serious harm, be in need of continuing treatment, and be unwilling or incompetent to consent to voluntary outpatient treatment.

Fourth, with regard to this issue of substitute consent for psychiatric treatment for inpatients found to be incompetent, we also favour the introduction of a provision for the patient, while competent, to appoint any competent adult of his or her choosing to provide such consent. We feel that this allows for the maximum exercise of the patient's right to consent, recognizing the limitations related to their incompetence at the time that the treatment is being recommended, and we note that this mechanism is available in other jurisdictions. Our information from our sister organization in Ontario, the Ontario Association of Professional Social Workers, is that despite some rough going at the beginning, this provision is working quite smoothly in Ontario and has been valuable for, at least, some patients.

Fifth, we think that there should be some additions to 26.10(1)(b). This is the section that requires the officer in charge of a psychiatric institution to effectively advise all patients of a number of rights. We are essentially recommending that this list be expanded to include what you see before you, quite a mundane list of rights, but these are important rights for people to be informed of when they do experience the situation of a hospitalization.

They include the right to religious freedom and practice, the right to wear their own clothes, the right to have access to individual storage space, the right to see visitors daily, the right to have reasonable access to telephones and so on. Our understanding is that some of these rights are established in other legislation or through judicial precedent or through practice tradition. We think it is useful to clarify their application to patients in a psychiatric facility and to ensure that patients are informed of these rights.

Sixth, Bill 5 amends 26.6(1.1) to require that the review boards commence a hearing related to a patient-initiated application within 21 days of its receipt by the board. We are certainly pleased to see some deadline, but we agree with some of the other associations presenting that 21 days is simply too long to offer recourse to many of those raising legitimate appeals.

Finally, some matters that are outside of the scope of Bill 5, some more major reform issues related to mental health legislation in Manitoba. We would urge the minister to initiate a consultation process that includes all of the interested parties to look at some, what we think are, desperately needed reforms.

The first relates to the need for a comprehensive legislative statement of the complete structure of services which should be provided. This can have the effect of bestowing support for the whole range of required services. The minister has several times announced his intention of enhancing community-based mental health services in Manitoba and has taken some action in that regard, but Manitoba's mental health legislation provides support to only one element in the service system, and that is inpatient care. Outpatient care receives only limited and indirect sanction under the certificate of leave provisions which we have just alluded to.

The proposal of providing a legislative mandate for the complete continuum of mental health services has been implemented in many other jurisdictions. For example, in the 1960s the State of California passed the Short-Doyle Act. It requires delivery of an array of services: community education and consultation, crisis intervention and emergency care, 24-hour treatment and care, day treatment, outpatient treatment, continuing support and long term episode support.

In Manitoba, The Child and Family Services Act legally mandates in-home services to children as well as substitute care in foster homes or in residential care facilities. This is not a foreign idea. It is one that has been born on Manitoba's soil and could be applied to the mental health area. We feel that Manitoba's Mental Health Act should be amended so as to provide sanction for at least the following: mobile crisis intervention, outpatient care, partial hospitalization and inpatient care.

Secondly, we would like to suggest that consideration be given to utilizing involuntary outpatient treatment as a substitute for involuntary inpatient treatment when the patient meets the criteria for civil commitment, that is, if the patient is mentally disordered, is likely to cause harm, is in need of continuing treatment but is in need of treatment that can reasonably and safely be provided in the community outside of a psychiatric facility. There is strong evidence that patients who meet these criteria or many such patients can be treated as effectively and safely without hospital admission as with admission. There is also evidence that outpatient treatment is often more cost beneficial and that patients' families are not additionally burdened by such outpatient treatment substituted for inpatient care.

Just to clarify, we also wish to note that this proposal is different than the amendments to Section 80 contained in Bill 5. Our proposal would limit these provisions to patients who meet the criteria of dangerousness and unwillingness or unsuitability to consent.

Thirdly, patients in a psychiatric facility are often in a very vulnerable position. They generally experience a loss of autonomy. They are living in a highly restrictive setting. They often feel intimidated by the institutional surroundings. All of these things add up to the fact that they need active assistance from someone independent of the facility in discerning and securing their rights. This leads us to recommend that there should be a legislative basis for an independent patients' advocate. The role of the advocate would be to ensure that the patients understand their rights, to assist them in securing legal assistance, in appealing to the review board, complaining to the Ombudsman or the Human Rights Commission, taking any other action that is necessary to secure their rights. We note that the Minister of Family Services (Mr. Gilleshammer) has today announced the intention to create a child advocate's office which we hope will have some of these characteristics. This may be an opportunity to extend this policy intent to the mental health area.

Mr. Chairman: Thank you very much. Any questions?

Ms. Wasylycia-Leis: Thank you, Mr. Frankel, on behalf of the Association of Social Workers for this brief and presentation which I found to be very interesting and innovative in terms of the whole field of mental health. You have raised, basically, a number of issues that fall under this whole area of a community-based—or a legal framework for a community-based delivery system.

I do not know if the minister is open to amendments. Many of the sections you have suggested changes around are not being amended in Bill 5. I am afraid that the minister may have something to say about that, but certainly the chairperson may rule us out of order if we attempt to amend in areas other than those delineated in Bill 5. However, I think you have made some very important recommendations.

I am wondering, what would your advice be in this, given what we are faced with? Should we hold out and fight for some very major changes to The Mental Health Act, or should we attempt to refine and improve Bill 5 to the best of our ability in this limited context?

Mr. Frankel: I do not think it is an either/or situation. As we have said, Bill 5 contains some improvements to The Mental Health Act and no serious disimprovements, so we feel that Bill 5 is supportable and we have talked about some of the sections we think are especially supportable.

We have raised a number of other, quite minor issues which we did raise with the Major Amendments Committee which are not reflected in Bill 5. If the rules accommodate it, and if there was consensus, we would think that some of this drafting could be done quite quickly. We understand there is a consensus that a more major reform must occur. We take the minister at his word that he is going to continue to enhance the community-based mental health system. We feel community-based legislation provides an important policy lever for him in doing this. Our hope is that this action will also be initiated.

* (2300)

Mr. Cheema: Mr. Chairperson, I just want the presenter to know that the issue of the community-based mental health act, the issue of the community-based health reforms in mental health, has been the focus of attention for the last three years. As you know, all three political parties have been advocating on that aspect.

I just want us to move into that bill as a separate bill and have all the consultation done and make sure that we do not end up with the same problem that Ontario has. There somebody brought in a private member's bill. It is a very complex issue. I would be very hesitant to combine them both, and then we may lose the whole touch. I would rather see a separate bill for the community-based mental health and then have a full consultation. As the minister has said inside the House, they have already started the process, and I just want to bring to your attention that we are aware of that.

I certainly make note of your fourth point that a person should be able to choose the care provider when they are competent, and certainly I think that would clarify a lot of problems which are some of the practical problems I outlined earlier. I am sure that when the consultation is done on the community-based mental health, we can bring more ideas to that. Thank you for your presentation. It is just a comment.

Mr. Orchard: Mr. Frankel, in terms of the suggestions about some of the Short-Doyle Act mandating an array of services, I cannot help but think that in a number of areas, at least, maybe not all areas, we have in place, at least in some areas of the province, a number of the community-based, in large part, services. Certainly, in terms of any discussions we have had with your association and others, the intent of reform, if I can use that simplistic term of the mental health system, is to move more in that direction as a policy of government.

I would like to seek clarification, page 3, the second paragraph. Maybe I misunderstand, but basically you are saying, we would like to suggest that involuntary outpatient treatment should be utilized as a substitute for involuntary inpatient admission, but only when the patient is likely to cause harm to him or herself or others. Is that a typo? Should it have been out—

Mr. Frankel: No, it is not. Let me put that into context. When we talk about involuntary admission, we are talking about a person who meets a number of criteria. A person who is mentally disordered is likely to cause harm, is unwilling or incompetent to consent and must receive treatment which can only reasonably be offered in a hospital. There are four criteria. Our recommendation is that for patients that meet the first three of these but not the fourth, that there are some patients who will be mentally disordered, likely to cause harm, incompetent or unwilling to consent but can be treated without being placed in the hospital.

We feel that there should be the provision for involuntary outpatient treatment for those patients. Right now the admitting physician only has the choice of placing the person in hospital or not being able to require the person to participate in treatment. We feel if this additional option were provided, some people would receive treatment outside of the hospital, and there is evidence from other jurisdictions.

Mr. Orchard: I appreciate that explanation. I seek a similar clarification about three lines down: is in need of continuing treatment that can reasonably be provided without admission, and is unwilling or incompetent to involuntarily accept outpatient—

Mr. Frankel: Sorry. That should say, voluntarily. That is a typo.

Mr. Orchard: Very good. Thank you for your presentation, Mr. Frankel.

Ms. Wasylycia-Leis: Just a few more questions. First, with respect to your recommendation on page 2 for a substitute consent model. Do you or your association have any particular amendments to propose or do you have any comments with respect to the amendment that I have been raising for comment?

Mr. Frankel: Generally, we would support the Ontario model which is, as I understand it, the section which you raised for comment. The information we have from the Ontario Association of Professional Social Workers and from several advocacy organizations in Ontario is that this is working, it is having a salutary effect and there seem to be no disasters, although there are some additional administrative burdens for some parts of the system.

Ms. Wasylycia-Leis: With respect to the hearing review process, the appeal process, you have made a suggestion that—you have made a recommendation for tightening up the time frame. I am wondering if you have any specific time frame in mind.

Mr. Frankel: We think it should be as short as possible. We certainly think that it should move to what Ontario currently has—the seven-day model—but we would be pleased to see any movement down from 21 days towards the seven days.

Mr. Chairman: Any further questions?

Ms. Wasylycia-Leis: Yes. I would like to ask about Section 26.10(1)(b). Since I noticed that is—if I read this bill correctly—an area that is being amended with Bill 5 proposing an addition or a change to the rights of a patient listed. In my view, it seems that this is an area for consideration at this committee and an area open for amendment, and you have made some very significant additions or suggested additions to that list of patients' rights.

Have these additions been circulated to any other associations in the field and have you received any other comment in terms of your additions being sort of a definitive list of additions?

* (2310)

Mr. Frankel: Yes. First of all, these were derived from two sources from some legislation in other jurisdictions and from hospital social workers experienced in talking with patients in hospitals about what they would like to see very clearly stated. We have received support from several of the mental health consumers organizations and also from the patient advocate at the Canadian Mental Health Association, Winnipeg Region.

Ms. Wasylycia-Leis: So you feel that your five additions on page 2 would win support and approval from community-based mental health organizations in Manitoba?

Mr. Frankel: We believe that they would receive support from almost everyone. It is hard to imagine objections to such mundane rights, rights that we understand patients actually do have but maybe do not realize they have, and I think forward-thinking mental health professionals, modern mental health professionals who work in our hospitals and our communities would not have a problem with this list.

Ms. Wasylycia-Leis: Thank you. I raised it twice because I just want to make sure that if we do propose such changes when we get to the amendments stage that we have not left out anything, that we are as complete in our deliberations as possible.

Just a last question back on your first page, actually, with respect to 26.1 and your suggestion for adequate information available to the substitute consent giver. You have basically raised something that I had asked about earlier on in this process this evening, although this is a variation of the same theme, and that is the whole issue of adequate information available to the person who has been designated to make decisions for the patient, whether that be in the form of the Compendium of Pharmaceuticals and Specialities, as one individual suggested, or whether it be in terms of an overall treatment plan, as you suggested.

I think those suggestions make a great deal of sense. It is an area that has been neglected in our deliberations on this. I do not know again if this will be allowed in terms of an amendment that is in order. However, I am wondering if you would recommend that we strive to find some sort of a proper wording to reflect the spirit of your comments.

Mr. Frankel: Just to clarify, what we are recommending is simply that, whether the patient himself or herself—a competent involuntary patient—or a substitute consent giver is consenting to the certificate of leave, they be provided with a statement of what the treatment plan is which underlies the certificate of leave. The certificate of leave is a situation where an agreement is made between the psychiatric facility and the patient or the patient's substitute consent giver, that the patient will be released from hospital with the proviso that they do co-operate with treatment. Our plea is simply that treatment be made as clear as possible to them.

The consequences of not co-operating with treatment can be very serious. They can amount to being picked up by the police and taken back to the hospital. Some additional safeguards are introduced in this bill and we support those, but, again, we think that it would be a marked improvement again if patients could be provided with a general statement of the written treatment plan to which they have agreed. They already have to be informed of it because, as I understand it, you cannot provide informed consent unless you are informed. This would be a matter of putting what is probably already on the hospital charts into a form that could be given to the patients or the substitute consent giver.

Mrs. Rosemary Vodrey (Fort Garry): Mr. Frankel, I have a question on page 2. It relates to the second paragraph. Several presenters have made a distinction between competency to understand the medical or psychiatric treatment, and there has been some agreement that it may be difficult for a patient to grasp that; but in the distinction they have said that patients may be competent to name an alternate person to make decisions for them.

I wondered if you had any suggestions of what that test of competency might be. We heard from Mr. MacIntosh about the intuitive test, and I wondered would you suggest a legal test, a medical test? What would the grounds be for deciding that, since several presenters have mentioned that this evening?

Mr. Frankel: I think, first of all, our preference would be, just to clarify what we are recommending, that all persons, you and I and anyone sitting in the audience be given the right while we are competent to name any other competent adult of our choosing to act for us in the tragic event that we become incompetent. We would see this as the ideal.

Looking at the specifics of your question, it seems to me that it should be a similar kind of test to the test of competence to consent to treatment. For example, I think one aspect of the test would have to be whether or not the patient understood what the role of substitute consent giver involved. I think it would be a matter of looking at that decision that the patient has to make and trying to model the information that would be required to make a good decision, and to have the physician make the judgment as to whether or not the patient had the capacity to understand the information and to judge the information.

Mrs. Vodrey: Yours would be a cognitive test, then, as opposed to the intuitive test, legal test, medical test; yours would be a cognitive test of understanding.

Mr. Frankel: In some sense, I think we are talking about a cognitive operation here. I think the test would have to be cognitive. The test would be legal in the sense that the criteria would be stated in legislation; medical in the sense that medical practitioners would make the judgment; legal, I would hope also, in the sense that these decisions by medical practitioners like other decisions about competence would be appealable to the review board.

Mr. Chairman: Thank you very much, Mr. Frankel. I would like to now call on Dr. John Walker of the Psychological Association of Manitoba. We will just hand out your brief, so you can just wait one second.

Dr. John Walker (Psychological Association of Manitoba): We wanted to thank the committee for this opportunity to present the views of the Psychological Association of Manitoba respecting Bill 5, The Mental Health Amendment Act.

In coming up with the brief that I presented to you, there were several of us from the association who worked on it, including Dr. Jay Brolund, the president of the association and Dr. Jim Newton, the vice-president. They are here tonight also and may be able to help with any specific questions you ask.

First of all, we would like to say that mental health legislation is extremely important to the citizens of Manitoba. It affects many of our friends and family members. At some point in our life it may affect any one of us as an individual. It is important to members of our association because it affects the lives of our clients and patients and has an impact on our work. As members of the committee will be aware, The Mental Health Act focuses on the legal framework for providing compulsory hospitalization and treatment for persons who are of danger to themselves or others because of mental health problems. It is also providing a framework for dealing with persons who are not competent to manage their own affairs or to consent to health services.

This group is a small but significant part of people requiring mental health services. They are actually a much broader group in our society who benefit from mental health services and the needs of many of these people are not addressed in this legislation. We would like to reiterate the point made by a number of the other presenters that Manitoba really needs mental health services legislation also, which would outline a legal and administrative framework for a comprehensive mental health system for the citizens of Manitoba. The Department of Health has already started some informal work in this area, but we are hoping in future years to see a further development.

* (2320)

In looking at this issue, the Psychological Association initially encountered some difficulty in becoming part of the consultation process, which we outline in the brief and fortunately, representatives of the association were able to meet with the minister, the deputy minister and the assistant deputy minister for mental health and discuss some of these issues. We found more recently that it has been much easier to consult with the Department of Health and other groups about mental health legislation. We are very much hoping that this is a start of a very positive trend of wide consultation about changes in legislation.

In doing our presentation tonight, instead of focusing on a large number of the amendments proposed in Bill 5, we would like to focus on some conceptual issues that provide some of the background for these changes. Some of these issues can be addressed in Bill 5, but a number of the other issues will need to be addressed in future legislation and also, some of them can be addressed in administrative changes in how the system works on a day-to-day basis.

Our current mental health system places a very heavy reliance on the use of inpatient psychiatric services. The Mental Health Act includes the implicit assumption that the only appropriate place to provide assessment and treatment to individuals who are judged to require compulsory treatment is an inpatient psychiatric facility. There is very minor recognition of the possibility of providing services in other settings in Section 26(1) of The Mental Health Act on certificate of leave. We go on in our brief to outline the statements there. So the present act provides for a certificate of leave, but it does not require the hospital staff to provide one if the patient is suitable to receive services outside of hospital. This is one area that we think should be looked at in terms of amendments.

We believe that an important principle in providing compulsory assessment and treatment is that services should be delivered in the least restrictive environment in which adequate services can be provided. We would support other groups previously who have suggested that there be further provisions for treatment in the community of people requiring services on an involuntary basis.

Another very important point we wanted to make is the need for protection of people receiving services under civil commitment. These citizens are among the most vulnerable in our community. Right now we are faced with a situation where people have rights and privileges but are not aware of these rights. We feel very strongly that within our legislative framework, we should be looking at a patient advocate along the line of the Ontario model that can help people to understand and exercise their rights. This is currently in place in Ontario and was also suggested by the Canadian Uniform Law Conference in the draft Mental Health Act.

Another point we wanted to make, that we have been hearing about tonight in our discussions, is the area of treatment decisions by others, and this is Section 24.1(1). We feel that the changes proposed in Bill 5 are an improvement on the current system where there can be participation of a patient's friends, family members, in making treatment decisions. We strongly support the recommendations by other groups that we look at the Ontario model and make provisions for someone while mentally competent to appoint someone to make decisions in the case that they should become incompetent.

Another point I am going to mention, on page 4 of the brief, is the issue of patient access to clinical records. This is an area we have not heard about tonight in the part of the meeting that I have been able to attend. This is Section 26.9(4) in the existing Mental Health Act on patient access to clinical records. We believe that the consumer's right of access to health care records is a very important principle.

The present section only covers records maintained in a psychiatric facility. In our view, this provision should be expanded to cover health care records maintained in community agencies and, particularly, in independent practitioners' offices. There is no adequate reason for maintaining different policies for access to records in different settings, and this may be very confusing to consumers. We have certainly run into a number of situations where this has posed problems for consumers.

A related problem with the existing legislation is that consumers are not routinely informed of policies regarding patient access to records and limits to confidentiality. We believe that service providers should be required, in the legislation, to inform patients about these policies. In the current situation if people are not informed, then the situation of having a right that they are not aware of and not informed about does not help them a lot.

A final point we would like to make in our presentation is the issue of recognition of nonmedical service providers. An exclusive reliance on physicians to carry out many functions described under The Mental Health Act reduces the pool of well-qualified mental health professionals available to perform these functions. This is particularly a problem in rural and remote areas, but this limitation causes delays even in large centres such as Winnipeg.

The Canadian Uniform Law Conference Draft Mental Health Act outlines the use of a designated mental health professional to recommend involuntary psychiatric assessments. In many other North American jurisdictions, psychologists perform many of the functions assigned to psychiatrists in the current act, including: completing certificates for psychiatric assessment, involuntary admission, renewal or change in status, evaluating capacity to consent to treatment, providing second opinions, serving as specialist members of review boards, and evaluating competence to manage affairs.

Review boards are particularly important in the protection of the rights of persons who are subject to compulsory assessment, treatment or detention under The Mental Health Act. We are informed that there have been long delays before individuals are heard before a board. One of the causes of these delays may have been the requirement that a psychiatrist be one of the members of the board to provide special expertise in the assessment and treatment of mental health problems. We believe this expertise is also available from psychologists and that review boards should have one member who is either a psychiatrist or a qualified psychologist. This would provide review boards with more professionals to draw from in developing a prompt response to requests for review.

Individuals with severe mental health problems who require compulsory treatment usually require nonmedical as well as medical treatments and supports. There should be statements in appropriate places in the act that treatment plans should outline appropriate medical and nonmedical interventions. This will assist patients, other individuals providing consent, and review boards in evaluating the adequacy of treatment plans.

To conclude with our brief, our association supports the changes to The Mental Health Act outlined in Bill 5. We hope that the committee will be able to make additional amendments to strengthen the act in its ability to protect the vulnerable individuals who require assistance under the act. We also hope the Department of Health will maintain the mechanisms which would allow for continued amendments to The Mental Health Act as well as continue their work in developing comprehensive mental health services legislation.

Mr. Chairman: Thank you, Dr. Walker. Any questions?

Ms. Wasylycia-Leis: Thank you very much for a very strong presentation on the whole issue of a community-based mental health system.

As you have indicated yourself in the brief, you have addressed some areas that fall outside the purview of Bill 5 and we may have some difficulty trying to get amendments in those areas. However, I think that this brief should be kept within reach of the minister and that it be acted upon, treated seriously and included in the promised process for putting in place community-based mental health legislation.

* (2330)

I would like to ask a couple of specific questions. One of the statements you have made is that some of the issues of concern may be addressed most immediately by administrative changes. I am just wondering, in terms of the concerns that you and others have listed this evening, are there any that you feel could be actually dealt with, and dealt with adequately, through administrative changes?

Mr. Walker: There are a couple of areas, I think, that we see would require legislative changes and a couple that could be done, for the time being, administratively. First of all, the spirit of mental health services legislation really can start to be put in effect by continuing the government's present commitment to broaden the availability of community mental health services. So that is one that I think can come a long way with administrative changes.

Another area, I think, where there is room within administrative changes, is the one on patient access to health records. Some of the administrative changes would involve actions by hospitals and health facilities to inform people more adequately of the rules and regulations and the rights in this area. This could be done on an administrative basis. I am not sure of the extent, and it is based on my limited legal background, of how much can be done within the professional groups, but some of the professional groups have rules as far as access to records that need to be clarified. This has created some problem for consumers, I know.

I think those are the main ones that come to mind for me.

Ms. Wasylycia-Leis: On the same subject matter, it has been suggested that a couple of the concerns raised over the course of this evening with respect to Bill 5, one being the question of protecting the rights of a voluntary patient and ensuring that there is some appeal process available to a voluntary patient subjected to involuntary treatment, the other has to do with the concerns about the Public Trustee under Section 45. In both those cases, I think there has been some hint that we may be able to address some of those concerns administratively.

I am wondering if you and your association has any concerns about going that route with respect to those areas, or if you feel that they can be left to administrative resolution.

Mr. Walker: In terms of the issue of voluntary patients that you mentioned, if a voluntary patient is receiving compulsory treatment, we feel that they should have the right to make an appeal to a review board of that. We had a chance to look at the presentation that CMHA put together, and we would certainly agree with their position on that one. We feel that should be a change in the legislation.

The changes in the role of Public Trustee, the changes envisaged in Bill 5 in terms of increasing the role of substitute decision makers, we would agree with. Our preference would be to add in Bill 5 that the person could designate someone along the Ontario model. Again, that is something that needs to be in the legislation.

Ms. Wasylycia-Leis: I have not quite been able to find it in your brief. Which section deals with patient access to health records?

Mr. Walker: It is on page 4 of the brief.

Ms. Wasylycia-Leis: It is Section 26.9(4), okay.

Mr. Walker: That section number refers to the current act, not to Bill 5.

Ms. Wasylycia-Leis: I am going to try to check Bill 5 and then the present legislation to see if it is possible for us to propose amendments in that area.

Let me just ask you about an issue raised by the previous presenter with respect to adding to the list of rights to patients. The previous presenter and the Association of Social Workers made a suggestion for adding five rights under subsection 26.10(1)(b). I am wondering if you and your association have any comments to offer on that suggestion.

Mr. Walker: We would be very strongly in support of that recommendation. We have a situation now often where people have rights and privileges and are not routinely informed of those rights and privileges, and it creates problems for people. So we would be strongly in favour of putting that in legislation and ensuring that people are routinely informed of these.

Ms. Wasylycia-Leis: Just a final question, and it is a very general one. We are often led to believe that there is a difference of opinion in terms of psychologists and psychiatrists, one perhaps with an institutional bent and psychologists perhaps with a more community-based approach. Is that generally the case in your experience? From the point of view of the Psychological Association of Manitoba, where would you see us putting our energies and efforts with respect to mental health reform? That is really two big questions.

Mr. Walker: First of all, in terms of psychologists and psychiatrists, in most settings, psychologists and psychiatrists work very closely together and very co-operatively together, and I would say generally the relationships go very well. The training base of the groups is quite different though. The training of psychologists tends to happen in university settings, and much of the training goes on in community facilities and community programs, so that tends to create a certain experience base that people work with and a certain comfort with the kinds of services delivered.

Medical training very often focuses in hospital settings and in tertiary care or teaching hospitals and, again, exposes people to other kinds of settings and other kinds of populations. I think all of our professional groups sometimes are limited by our training base. The research in this indicates that people, when they complete their training, go on to do what they were trained to do. Often it is difficult for us to adopt different models and different ways of doing things. I think really progressive individuals in all of the major disciplines really are looking more at community services now.

The Psychological Association, in considering this matter over the years, feels very strongly that we have to gradually move more resources from hospital-based programs to community-based programs, and the main reason for that being that the public will be better served by that and we will be able to reach a broader base of the public.

Ms. Wasylycia-Leis: Thank you.

Mr. Cheema: Dr. Walker, thank you for your presentation. I just want to touch base on your presentation, page 5, as far as the representation of the review boards. I think it is a very interesting proposal, but I think we should be dealing with the issue in a separate bill when we are going to deal with community-based mental health, because before we bring the community-based mental health and make sure all the elements are put in there, and then I think the role of the psychologist on the review board will make more sense. I am just giving my probably personal opinion.

I think if you are involved in the decision-making process in terms of providing a care, as you have suggested, it has been done in many other jurisdictions in North America and also in Europe. I think we are behind in that respect, but it could be done very well. It will make more sense if we have a separate bill which will deal with the community based, and then we should look at the whole review process again, because then we have to review the whole process basically. Then it will make more sense to include your professional body as a major complement. It has to be. I just wanted to make those comments. Thank you for your presentation.

Mr. Orchard: Mr. Chairman, I want to thank Dr. Walker for the presentation. I guess a number of the issues that you have mentioned tonight are certainly a future agenda, particularly your comments around the use of a wider range of professional discipline in the community mental health service delivery, as Dr. Cheema has indicated.

There is one area that I think we are unable by legal bounds to deal with tonight, and that is patient access to clinical records. My understanding is we have gone as far as we can in accessibility by the patients to their records, because we do not have—this legislation does not have authority over community agencies and certainly not over independent practitioners' offices. The latter, practitioners' offices, I believe has to be dealt with through the College of Physicians and Surgeons and that legislative structure, but I appreciate your comments around the issue. Thank you.

Mr. Walker: Thank you.

Mr. Chairman: Thank you very much, Dr. Walker.

I would like to call Ms. Catherine Medernach, The SUN Network. Did you have a written—

* (2340)

Ms. Catherine Medernach (The SUN Network): I do not have copies.

Mr. Chairman: That is okay. You can just proceed then.

Ms. Medernach: For those of you who may not know, The SUN Network is a new developing consumer network in Manitoba, and while we have had the opportunity to consult with on various areas of mental health reform in Manitoba, unfortunately, this is one area that we are not involved in consultations. Although we do very strongly believe there is a need for a mental health services act and this is a committal act, my comments tonight will stick basically to Bill 5 and our concerns.

One of the big issues we have with Bill 5 certainly is consent and alternative consent. For those people whose problems may be the direct result of severe traumatic abuse by a parent, the potential for a parent to have treatment decision-making power is horrendous. The impact, the detrimental impact on a person is just unimaginable. An example of that would be people with multiple personalities disorders.

One of the things this also fails to consider is that if you are choosing the nearest relative based on geographical proximity, we are not looking at the fact that the closest relative, the person we would trust, might be separated only because of employment and might be in regular contact through the mail, on the phone, and might be much more suitable for making our decisions for us. The nearest relative may be an abusive parent, maybe an abusive spouse.

We believe that consumers should have the right to designate, preferably while they are competent, when they are not ill. This is hard to do for somebody who has never been through a crisis previously, but for many of us, crisis is a recurring phenomena. Yet, we often get to the point where we refuse treatment, because we are too far gone before anything happens.

We feel we should have the right to say, okay, I am fine today. Maybe six months from now or six years from now, I might be crazy, off the wall, and totally unable to make those decisions, but I know somebody I trust to make those decisions for me. That is not just an opportunity to refuse treatment. That is having somebody who can say for me, this person needs treatment. I authorize treatment before it gets any worse. This helps us protect ourselves from ourselves, as well as from anything else.

The assumption that underlies family consent is often that that person is and will make decisions that are in our best interests. That is not always true. Some families do not believe in mental illness. I have a friend recently who is out of a job, a single parent who is on welfare, and the welfare of her children is at risk today, because she was prescribed medication and the parent convinced her that she did not need it. There was no such thing as mental illness.

While we allow—we say there is a criteria. In the bill it states one of the criteria for deciding on the nearest relative is that this person indicate a willingness to make these decisions, but there is nothing there that says, the patient, that I have to be willing to have that person make my decisions. I think that is a very critical issue.

We can talk about competency to decide who makes those decisions, but if you have been beaten by somebody, you know. It does not take a legal test. It does not take a cognitive test. You know you cannot trust that person. It is detrimental to your mental health to have them have that power. I cannot emphasize that point too strongly. We are supportive of the Ontario model because we feel it protects our rights and our mental health interests the best.

Another section of Bill 5 that we have some problems with is regarding voluntary and involuntary status, and the knowledge that people who put themselves into hospital voluntarily can be labelled incompetent, which may simply mean noncompliant, and treated without consent, without recourse to review by the review board, without a change of their status to a nonvoluntary patient.

Those of us in the network feel that is essential. If you are going to take my voluntary status away and treat me against my will, change my status to nonvoluntary, use due process because at least that way my rights will be protected, and I will have the right to appeal whatever decisions are made, including the judgment of being incompetent to make my own treatment decisions.

There is a strong tendency in society to believe that we know what is best for other people, that we can make decisions in their best interests. And I cannot resist the impulse to use my favourite example of proof that we can be very, very wrong, and we have proven it many times that we are wrong in that assumption. My favourite example of that is Lawrence of Arabia. Captain Lawrence led the Arabs against the Turks to reclaim territory that had been historically theirs. He believed that they should have control of that territory once they won it back, not the British, and not the French, and he worked very hard and he got them there first and they could have had control. It was not on their agenda, it was not their priority, it was not their vision, so no matter how well-intended, how rightful his motivation, he was wrong. He was not operating in their best interests; he was operating according to his vision of what should be for them, not theirs.

The best way of protecting people's rights to have their own vision, to live their own lives, is to give them the right to make their own decisions, even if we do not think that those decisions are in that person's best interests. They also have the right to have to deal with the consequences of their decisions, and sometimes that is the only way people learn. Mental health consumers very often go through repeated crises before they learn how to take care of themselves and what they need. They are like raising a child. You can tell them and you can tell them, but they have to learn their own way. They have to learn the hard way, and they have a right to do that.

These are our main concerns with Bill 5: the right to make a choice; the right to appeal; and the right to be treated with respect, regardless of our inability at any given point in time to deal with our mental illness. Thank you.

Mr. Chairman: Thank you very much, Ms. Medernach.

Are there any questions?

Ms. Wasylycia-Leis: Thank you very much for that presentation.

I also wanted to acknowledge the work you have circulated to us in terms of the feasibility study on behalf of The SUN Network Board of Directors. That has been I think very helpful in terms of this whole debate and discussion.

I hear you saying two things: One, that a fundamental issue for you is the question of patient's rights and choices. In that context it seems to me you are supporting many of the suggestions that have come forward this evening for improving those provisions of Bill 5 which touch on rights of patients and would support the question of a substitute consent model and would support a better appeal process, tighter time frames, so that a patient can seek change or can seek to better his/her circumstances through that appeal process. You would support the right of voluntary patients to be able to appeal decisions about them if they are made in terms of involuntary assessments. Let me just first ask that. You would agree with those changes. Are there any others I have missed in terms of rights of patients?

* (2350)

Ms. Medernach: No, I think that is the basic thing. We really feel strongly that the right to designate an alternative decision maker is critical. As it stands, just to designate the nearest relative is really not acceptable to us. There are too many risks in that.

Ms. Wasylycia-Leis: The other thing I hear you saying, and I know you have said before in terms of your presentations, is that perhaps we may not be addressing all of the issues by focusing on this question of institutional versus community-based care, and that we may be substituting one set of problems for another set of problems.

From your perspective, where should we be focusing our efforts and attentions with respect to mental health reform? Where is the best place we could put our efforts and energies?

Ms. Medernach: I would have to say on my own behalf and on behalf of the consumers I work with through the network that institution based or community based may only be a difference in size and location. Very often when we talk community based what we are really talking about is community-based institution, because the centre of power and control is no different, that if we are looking at reform in that area the need is for much more consultation with consumers and a wide range of consumers, not focusing on specific disabilities or disorders, taking into consideration the fact that if you have a small group of consumers who are white Judeo-Christian in their value system, that they cannot consult adequately across the base of consumers who include aboriginal people, immigrants and refugees who have many more issues. I think that is where our focus is. There needs to be far more consultation directly with the people who are affected by services and changes.

Ms. Wasylycia-Leis: Just a last question in terms of a suggestion that was made from the Association of Social Workers in terms of adding to the rights of patients under Section 26(10)(1)(b), the right to religious freedom and practice, the right to wear his or her own clothes, et cetera, the right to have access to individual storage space, the right to see visitors each day, the right to have access to telephones, et cetera.

Would you have an opinion in terms of making an amendment along those lines?

Ms. Medernach: I think those are excellent additions. I do not think we often realize just how depersonalized the system becomes in dealing with patients and how much it can make a difference to have your own clothes—to have access to a phone that perhaps is somewhat removed from the nursing station is often an issue, so that you have some privacy. We would certainly support those as being very positive additions.

Mr. Chairman: Thank you very much for your presentation, Ms. Medernach.

I would like to call Dr. Caroline Sehon. We will just pass out your brief, just give us—Did I pronounce your last name right?

Dr. Caroline Sehon (Citizens for Quality Mental Health Care): Yes, you did. Thanks.

The group, Citizens for Quality Mental Health Care, would like to thank all the members of the committee for this opportunity to be able to express our concerns with regard to The Mental Health Act and Bill 5.

Citizens for Quality Mental Health Care is a nonpartisan group of mental health professionals and patients concerned with preserving and expanding adequate mental health care for Manitobans. We are particularly committed to the preservation and strengthening of community-based mental health services. We are convinced that individual patients, their families and loved ones, and society as a whole, benefit when emotional difficulties can be appropriately treated in their early stages outside traditional institutional settings. Tertiary care psychiatric services, represented by hospitalization, be it voluntary or involuntary, is often demoralizing to the patient, always disruptive to the patient's family and work life and always expensive.

In Manitoba, the importance of avoiding institutional care has always been recognized through the provision under medicare of outpatient services delivered by psychiatrists and psychoanalysts offering treatment in private practice. The aim here has been to offer psychotherapy before conditions deteriorate for the patient and before the psychopathology begins to affect the family, as well. In cases where early treatment has not been available, or has been ineffective and patients must be admitted to institutional care, legislation must assure that the patient retains the maximum of freedom to determine the range of medical procedures utilized in his or her case, as well as the maximum of opportunity to be discharged from the facility without unreasonable interference. In short, an appropriate concern with the patient's health and safety and the safety of others must be balanced by a high regard for the rights of the patient as a free individual.

With respect to the issue of patient freedom in general, we would note the following:

Number 1, with respect to Section 26.6, subsection 1.1 of The Mental Health Amendment Act covering time limits for review boards, we can see no justification in allowing a board to wait 21 days before hearing an appeal. The aim of this section must be to facilitate the rapid consideration of appeals so that institutionalization is not prolonged an hour longer than necessary. A delay of one week between the launching of an appeal and the convening of a hearing and the requirement that an appeal board report within one day of the conclusion of a hearing might be reasonable alternatives to the current language.

Number 2, we are strongly of the opinion that in Section 24.1, subsection 1 of The Mental Health Amendment Act where the families of patients are authorized to give consent to treatment, the alternative of a designated consent giver should be considered. There are situations in which a person's illness and hospitalization can be a part of complicated family dynamics or interactions where, for example, a spouse may have quite a unconscious emotional investment in the patient remaining ill and institutionalized. In any case, the crucial thing is for the patient to be able to choose an individual in whom he or she has genuine confidence, whether or not it is a family member. This would further ensure not only that the course of a patient's hospitalization is as much as possible determined by an objective concern with the best treatment, but also that the patient's confidence in the treatment chosen could be maximized.

While the matters we have been discussing are extremely important issues, we wish to conclude by emphasizing the importance of the patient's right to choose treatment. We are struck by how relatively little the act emphasizes that the patient should have, as far as possible, the right to choose from a wide spectrum of medical interventions carried out on his or her behalf. We are convinced that this is an absolutely crucial element in any adequate mental health legislation.

With respect to the issue of the right to choose treatment, we would note the following:

Number 1, we think that in Section 24, subsection 1 of The Mental Health Amendment Act the wording should be modified to affirm the patient's right to make treatment decisions. This is much stronger language than simply affirming a right to refuse psychiatric intervention.

Number 2, we wish to draw the committee's attention to Section 25, subsection 6 of The Mental Health Act relating to the matter of alternative treatment in cases, quote: where the review board decides not to authorize the giving of the specified psychiatric treatment and the attending physician is of the opinion that alternate specific psychiatric treatment and other related medical treatment are available.

* (2400)

We think this section of the act should refer to the possibility of outpatient community-based psychotherapy, including psychoanalysis, as alternatives to institutionally based psychiatric care. Failing this, the act will remain too narrowly focused on institutionally delivered psychiatric care and treatment modalities, and an opportunity will be missed to emphasize the desirability of increasing community-based mental health care.

It is perfectly obvious that, if the principle of the patient's right to determine treatment is to be more than a meaningless abstraction, there must be made available the widest range of treatment modalities. If only mechanical or drug-based treatments or minimal psychotherapy are made available, then the right of choice for patients is severely restricted. Psychoanalysis and other forms of intensive psychotherapy must be provided in the range of treatment alternatives.

We are ourselves aware of cases where patients have been repeatedly hospitalized over a period of many years. In hospital, for these individuals, their treatment consisted primarily of biologically based therapies, that is, drug and mechanical therapy, coupled with individual and group psychotherapy offered on a relatively infrequent basis.

For these individuals mentioned here the results were highly unsatisfactory. When, on release from hospital, they quite by accident were able to find treatment with a psychoanalyst or other psychotherapist, they were able to dispense with most of their medications and to remain out of hospital. This is the more remarkable, given the tendency of previously hospitalized patients to be rehospitalized. Had these patients been able to choose psychotherapeutic treatment in the first place, much needless suffering might have been avoided.

We wish to emphasize that revisions to The Mental Health Act are crucially important, especially those that strengthen the protection of the patient's right to choose; but a genuine right to choose, one that goes beyond mere words, requires the provision of genuinely alternative treatment modalities. In this regard, we must express our dismay at the government's recent attacks on psychoanalysis and other forms of psychotherapy. The availability of these therapies provides an opportunity for preventative mental health care in the community before conditions deteriorate to the point where institutionalization becomes necessary.

In the context of our discussions here, these psychotherapies also represent alternative treatment modalities that could radically increase the choices available to institutionalized patients. Far from deinsuring such services, government must continue to provide them and even extend them as part of any serious effort to improve the mental health of Manitobans. Thank you.

Mr. Chairman: Thank you, Dr. Sehon. Any questions?

Mr. Cheema: First of all, Dr. Sehon, thank you for making a presentation. I would say some of your points have been already made by some of the presenters earlier. I just want to touch bases on the last paragraph of your presentation and, specifically, as it relates to some of the decisions which have been made recently. I think it is an opportunity to have some explanation in terms of the role of psychoanalysis as a form of psychotherapy. As you have outlined, it is a very important form of treatment and, as the minister has outlined and said many times, he is very serious, and I have no doubt about the reform in the mental health care system. Once you are taking a very necessary service, as you have outlined, you have provided the data.

(Mrs. Rosemary Vodrey, Acting Chairman, in the Chair)

You asked the Minister of Health (Mr. Orchard) and he replied to the member for St. Johns (Ms. Wasylycia-Leis) and through the media and through us. I would like you to explain to the minister again today, in the very simplest way, why do you think it is such important treatment and why they are taking this treatment away from patients and basically, as you have outlined, it would save money in the long run. The psychoanalysis is a very integral part of the treatment, from the basis of many treatments being provided, and I would like you to explain to the minister and try to convince him that is not the right approach to take.

Ms. Sehon: First of all, I guess, the first statement I would like to make is that psychoanalysis is a theoretical and clinical discipline. It is really the bedrock of all the psychotherapies. All the psychotherapy is developed as a result of psychoanalytic principles. That is the first point I would like to make.

Psychoanalysis has always been an insured service. It has been included in the billing system under psychotherapy, which, in fact, is what it is. Psychotherapy is provided both in the hospitals and in the community. However, the nature of the psychotherapy that is delivered in both settings is different; frequency of sessions is different; the nature of the disorders that are being treated is somewhat different. However, we are talking about a burden of mental illness in our society and the spectrum of mental health needs in our society. Because there is a spectrum of mental health needs, we need to address them with appropriate and comprehensive mental health treatment. To exclude the most intensive form of psychotherapy from the range of services available to Manitobans would be clearly an infringement of the rights of citizens in Manitoba.

Moreover, psychoanalysts in other centres in North America provide a very important consultancy role to all mental health professionals, be they medically trained or nonmedically trained, so that in keeping with the government's statements about the necessity of the mental health reform and the necessity for social workers and psychologists to be more involved in addressing the enormous burden of mental illness, we can see that psychoanalysts and psychiatrists who are psychoanalytically oriented can have a tremendous impact in consulting and in training professionals to practise in this form.

Mr. Cheema: Madam Acting Chairperson, if Dr. Sehon can tell the committee, what is her background other than being a physician? What kind of work is she involved in?

Ms. Sehon: I am sorry. I wonder if you could repeat your question.

Mr. Cheema: Would you tell the committee that other than being a physician, which your degree is, are you involved in any community organization? Are you being trained for a community in the department of community health?

Ms. Sehon: Yes, I am doing joint specialty training both in community medicine and psychiatry. In addition to that, I have been training in the United States in Washington, D.C., to obtain further psychoanalytic training.

Mr. Cheema: Madam Acting Chairperson, I am trying to make a point to the minister that these individuals have a lot of experience, that they have a lot of background, and the minister has refused many times inside the House and in the committee that this form of treatment is not a factor. I am sure the minister will have the opportunity to question the presenter to make sure that he is satisfied or this organization is satisfied to get to the bottom of this problem, which is that this ministry is going to deinsure these very important services. Basically, that is a backward step in terms of the minister's own stated policy to have mental health reforms in the institution.

Ms. Sehon: Perhaps I could just make a comment, Madam Acting Chairperson?

The Acting Chairman (Mrs. Vodrey): Yes. Go ahead.

Ms. Sehon: Thank you. I guess one of the things I would like to state is that we have heard a lot lately about a number of issues with regard to the effectiveness of treatment. We have heard issues with regard to the quality of service delivery, and I would like to just approach the quality issue firstly. The issue of quality assurance over the years since the early 1930s has evolved considerably, and in the last four years there has been a revolution in terms of quality management. Previously, quality used to be defined from the perspective of the provider. As we know, the Deputy Minister of Health, Frank Maynard, attended a conference to deal with quality management.

(Mr. Chairman in the Chair)

Quality management is now being defined from the perspective of the consumer. I think for that reason it is vitally important that the government enact what it says it is going to do, and that is consultation with consumer groups. Without consultation with consumer groups I do not know how anyone, be they a government official or a professional, can make any statement with regard to quality or effectiveness.

An Honourable Member: Thank you.

* (0010)

Ms. Wasylycia-Leis: Thank you, Dr. Sehon, for your excellent brief and for taking time to come out this evening and stay till past the hour of midnight to make your presentation.

In your brief you have made some comments directly relating to Bill 5. I gather from your comments that you are, like other presenters this evening, concerned about the question of rights for patients and offering choices to patients. In your general comments and your tie-in with the issue right now that we are currently dealing with in the Legislature of psychoanalysis, I understand you to be raising the question of choices for mental health patients and the right to access a continuum of services or a continuum of treatment modalities, and your concern is that one of those treatment modalities is now in question, has been placed in jeopardy by the talk about deinsuring this service.

Before I even ask my question, we certainly share your concern about deinsuring this service. We are concerned about the deinsurance of any medical service here in the province of Manitoba. However, we do not have full information and research in terms of what this would actually mean in terms of being able to access a range of treatment options and particularly what it would mean in terms of psychoanalysis. I am wondering if you could give us a little more information that we could consider in terms of this fairly heated discussion in the Legislature.

Ms. Sehon: Mr. Chairperson, we have heard and we have learned in reviewing the Hansard minutes that the minister has not only considered deinsuring psychoanalysis but has also spoken about individual psychiatrists, three psychiatrists who see, I believe, 40 patients, 44 patients and 23 patients, if I am quoting the figures correctly. Clearly two of these three psychiatrists could not be analysts, because analysts would not be seeing that number of patients a week.

Clearly the government has made a number of statements that indicate that they are considering capping psychotherapy generally, and although they have made statements about possibly deinsuring psychoanalysis, we can see that their efforts seem to be much more extensive to other less intensive forms of psychotherapy.

If psychoanalysis and other less intensive forms of psychotherapy were deinsured, this would mean that really we would be talking about an essential medical service that would not be universally accessible to all the citizens of Manitoba. By that definition, we are saying that this would be tantamount to a violation of the Canada Health Act and to the Medicare Act, which was set up particularly to ensure equitable delivery of service to all Manitobans. If the service were unavailable, people who are currently in treatment would not have alternate service provisions. They might be treated by less intensive forms of psychotherapy but that would not be a treatment that was appropriately matched to their need. Some people may have to relocate.

What we really should be talking about is an expansion of psychiatric services, psychoanalytic services. It would be difficult to envisage how psychodynamically-informed psychiatrists would wish to come to Manitoba if the environment were one which did not support that form of practice.

We know that in 1985 we had approximately 24 psychiatrists who left over an 18-month period. I do not think we want to have a similar situation repeat itself. The minister has made statements that the analysts could relocate to such centres as Brandon or Selkirk to do their service, but I think that we are talking about analysts and psychiatrists who are trained to deliver a specific service to a specific patient population with a definite and legitimate medical need, who would be asked to relocate in order to provide a service to a different patient population. Clearly, this seems quite an inappropriate recommendation.

Ms. Wasylycia-Leis: You have made the comment that the reference from the minister in terms of psychoanalysts serving upwards of 40 patients could not actually be analysts, given the kind of intensive therapy involved. It is my understanding that there are only two psychoanalysts in the province of Manitoba and, in fact, one of them was recently reported on the news, Dr. Barry Miller, who has been through community medicine. He was on the news stating that he may be driven out of the province. Is that a reasonable expectation or outcome in terms of any move to deinsure psychoanalysis and what would be the impact then in terms of Manitobans?

Ms. Sehon: Mr. Chairman, we have two psychoanalysts in Manitoba. One has recently indicated, Dr. Edmundo Maia, that he has been practising psychotherapy of a less intensive form for the last several years, so that we have one psychoanalyst who is, in fact, practising analysis. Yes, you are correct that this analyst does have extensive training in community medicine as well.

I have not consulted with Dr. Miller in terms of any plans that he has to relocate or to stay in Manitoba, but I think we are all aware of the newspaper article in which he stated that he had no plans to relocate. I suppose a logical deduction, though, would be that if the service were only available to the wealthy, it would mean that the individuals who he is currently treating would no longer be able to access that service. One can expect that he may decide to relocate, and this would be really an impoverishment of the mental health service delivery system in Manitoba, rather than an enrichment which is what Manitobans need. So Manitobans who need this particular service currently or in the future would no longer have access to it.

Ms. Wasylycia-Leis: Mr. Chairperson, we have had this ongoing debate in the Legislature on this issue around the question of psychoanalysis in terms of its effectiveness. I do not believe anyone has come forward with a definitive answer. In fact, the minister has said he is waiting for some advice from the MMA and the Psychiatrists Association of Manitoba.

Can you give us any information in terms of psychoanalysis as a treatment modality? What does the research say? What does the academic community say? Is there anything more concrete than we have at present?

Ms. Sehon: Mr. Chairman, this is a very important question, because we have heard a number of statements about its questionable effectiveness stated by Mr. Orchard. I am not sure who is advising him on this. I do not believe that he has consulted with psychoanalytic spokespersons. I know that he has some consultation with the CMHA, but I would question whether they are qualified spokespersons on psychoanalysis.

So in view of certain statements that were made that appeared to us to be quite unfounded, we decided to get some consultation from the western chapter of the Canadian Psychoanalytic Society. I have with me here a letter that was written by a group of psychoanalysts in Alberta dated June 24 of this year from the Psychotherapy Research Centre of the Department of Psychiatry.

If I may quote: They state that after reviewing the discussions regarding deinsuring psychoanalysis in Manitoba, it is our position that psychoanalysis is a psychotherapy as well as a theory and a form of research, albeit a highly specialized and intensive one. As a treatment, they say, psychoanalysis has not only been utilized in the care of neurotic disorders, but also for other seriously disturbed individuals who have in fact been seeking psychoanalytic psychotherapy in increasing numbers in the last two decades.

* (0020)

They go on to say, there is also no doubt that psychoanalysis has been the treatment of choice for certain forms of disorders that cause real and debilitating psychic pain, and despite the fact that most analysands are not hospitalized, they endure the rigours of analysis because the illness renders them dysfunctional in significant ways. Furthermore, they say, in our experience, psychoanalysis is effective in treating a wide range of emotional disorders.

These people are psychoanalysts with extensive training at the Psychotherapy Research Centre. They are people who have gone through additional training to become analysts and are following internationally recognized standards of psychoanalysis. This document would be available to the Minister of Health (Mr. Orchard) if he would like to review that.

Mr. Chairman: I will have to ask for a two-minute recess at this time, because the technicians behind us need a few minutes to do some rearranging. If we can just have about a two-minute recess.

* * *

The committee took recess at 12:21 a.m.

After Recess

The committee resumed at 12:27 a.m.

Mr. Chairman: We may proceed.

Ms. Sehon: Mr. Chairperson, I would just like to tell you once again that the statements about the fact that psychoanalysis has a real outcome and that there is demonstrable effectiveness of this treatment modality come from six psychoanalysts. These are psychiatrists, fully-trained psychiatrists who have done further training in analysis, who are involved at the psychotherapy research centre, who are involved in training undergraduate and graduate medical professionals, as well as allied health professionals, and who are involved in state-of-the-art research, psychotherapy research.

Ms. Wasylycia-Leis: Mr. Chairperson, I would suggest you leave a copy of that letter or that research for the Minister of Health (Mr. Orchard) as he has made a commitment to us that he will be consulting with a number of individuals around the advisability of deinsuring psychoanalysis, and we will take the minister on his word and expect that he will consider all aspects of this issue.

I have a final question. The brief you presented and your comments to me suggest that you have raised a concern that others have raised in the course of this evening about the consistency between this government's stated goals and objectives with respect to mental health care reform, and I think all of us agree that means a continuum of service and guaranteed rights for individuals in the mental health care system.

The inconsistency appears between those stated objectives and goals and the actions of this government on a number of fronts. We have heard earlier about the closing of the psychiatric nurses education program; you are now raising the question of deinsuring psychoanalysis. We have not even touched this evening on the issue of the expansion of the psych services building at the Health Sciences Centre, but there are a number of issues which point to some inconsistencies in the government's words and actions, and call for a comprehensive plan in this whole area. Is it your recommendation that if mental health care reform does indeed address the question of choices for individuals and ensures the provision of a continuum of services that psychoanalysis be included and entrenched in that mental health system?

Ms. Sehon: Mr. Chairman, yes, clearly psychoanalysis ought to be continued as an insured service as it always has. There is an undoubted need for it to be included as one treatment modality among a spectrum of treatments that would be available to all Manitobans regardless of their economic situation, as the government has stated in their October of 1990 document, Visions for the Future.

* (0030)

Mr. Orchard: Mr. Chairman, I would like to ask the doctor a few questions. How large is the membership of Citizens for Quality Mental Health Care, how large an association?

Ms. Sehon: Mr. Chairman, the group Citizens for Quality Mental Health Care is composed of some mental health professionals, some patients, some concerned citizens. The group consists of about 15 to 20 persons at the moment. The group was formed six years ago under the name of Citizens for Quality Psychiatric Care, at the time when the child psychiatric services were being threatened in the province of Manitoba—and the child psychiatric services modelled upon a dynamic approach of being threatened in the province of Manitoba.

Mr. Orchard: Formed six years ago, when the child psychiatric services were threatened, I presume, by the Pawley administration?

Ms. Sehon: I am not sure that issue is relevant to this evening's discussion. The group is currently very concerned about your statements about the possibility of deinsuring psychoanalysis.

Mr. Orchard: Doctor, on page 2 of your brief you indicate with respect to Section 26.6(1.1) that you see no justification in allowing a board to wait 21 days before hearing an appeal. Are you familiar with the current act which was amended by Bill 59 in 1987 and the provisions for timeliness of a hearing?

Ms. Sehon: Could you repeat the name of the bill, please?

Mr. Orchard: Bill 59, which brought in the hearing process. Are you familiar with the provisions of Bill 59?

Ms. Sehon: I have not looked at the document recently, but perhaps you would like to ask me a question in regard to your concern.

Mr. Orchard: You see, I guess I am concerned about the language, first of all, because the 21 days that are proposed in Bill 5 replaces an unlimited or no time frame. Would you prefer no time frame?

Ms. Sehon: Mr. Chairperson, we go on to say quite clearly in the last statement of our paragraph: "A delay of one week between the launching of an appeal and the convening of a hearing, and the requirement that an appeal board report within one day of the conclusion of a hearing, would be reasonable alternatives to the current language."

Mr. Orchard: Okay.

Ms. Sehon: So we do specify time limits.

Mr. Orchard: Given that the current legislation has no time frame in it and given that under the current structure of the hearing process, it seems as if we can provide most hearings within 21 days. That is the reason why the 21 days was chosen. I will be dealing with that later on this evening. I can simply indicate to you that the 21 days is not allowing the board to wait that long. The boards strike their committees and have their hearings as quickly as is possible. That has always been their mandate.

On page 3, you indicate that the act emphasizes that patients should have, as far as possible, the right to choose from a wide spectrum of medical interventions carried out on his or her behalf. That is part of the approach that was announced in 1988 in the fall. Could you indicate to me in terms of a wide spectrum of medical interventions, you might deal with a number of disciplines, would you believe that the method of reimbursement or compensation for those individuals should be salaried or fee for service?

Ms. Sehon: Mr. Chairperson, this is a very complex question. It is a controversial issue that, I guess, the medical profession has a diversity of views on. I certainly would not be a spokesperson for the medical profession on this matter which is a matter of great debate from amongst medical professionals of a variety of disciplines. The point that I am trying to make here is peripheral to the point you are addressing. Our point is that we feel that unless a spectrum of available services are available, to say that a patient has a choice of treatment is an abstraction. It is rhetoric, unless that service is available.

Mr. Orchard: I note in concluding the brief that you "express our dismay at government's recent attacks on psychoanalysis." There have been a number of presentations or discussions this evening about deinsuring psychoanalysis. Are you familiar with the fee schedule and the fact that in Manitoba psychoanalysis is not part of the fee schedule?

Ms. Sehon: I am aware of the fact that psychoanalysts bill for psychotherapy. Given the fact that, by definition, psychoanalysis is a psychotherapy, I do not see any contradiction in that at all. They are billing for a service which they are providing—psychotherapy.

Mr. Orchard: That is interesting, because you finish that sentence by saying: "attacks on psychoanalysis and other forms of psychotherapy." I simply want to indicate to you, I do not know what would stimulate you to make that comment, because I have never indicated anything but psychoanalysis, for which there is no billing under the current fee schedule in the province of Manitoba, was the issue under discussion. So there was no attack on other forms of psychotherapy as you indicate in the letter.

I wonder, doctor, could you indicate to me how often one might see a patient in providing psychoanalysis to that patient? What would be the frequency of visit that the psychoanalyst would recommend or would routinely see a patient to whom they were providing psychoanalysis?

Ms. Sehon: Mr. Chairperson, I will speak from the definition of psychoanalysis and the definition of psychoanalytic practice, and then I will talk about the specific situation in Manitoba.

By definition, psychoanalytic practice is very intensive psychotherapy delivered by a psychoanalyst, and that is the definition of analytic treatment. The definition was never based on the frequency of sessions. The definition was based on the fact that you have a treater who is an analyst providing analytic treatment. Having said that, commonly a psychoanalyst provides a service on a more frequent basis than a psychiatrist who provides psychotherapy in a less intensive form. This may range from two sessions a week to three or four sessions a week.

Mr. Orchard: What is the duration of those sessions, typically?

Ms. Sehon: Mr. Chairperson, the duration of analytic treatment is highly variable. The average length of treatment, as reported in the literature, would be anywhere from four to six years. This would be the average length of treatment. I would state that many people who have seen psychiatrists who are not analysts, for less intensive forms of treatment, say, perhaps would see their psychiatrist once a week or once every two weeks, may need further treatment. So if we look at the duration of psychotherapy for an individual, it may span a longer period than four to six years, but that would be, I would say, the average range for a patient.

* (0040)

Mr. Orchard: Now, the treatment can be two to four times per week for a period of time of four to six years, and each visit or treatment, be it two or be it four per week, is of what length of time per treatment?

Ms. Sehon: Again, I will speak from what I know in the literature and from what I know in contact with other psychoanalytic communities in North America, and then I will speak again to the experience in Manitoba from what I know.

Psychoanalysts may see their patients for a variable length of time each session. If the psychoanalyst is seeing a child, they may see the child for briefer periods of time than they might see an adult, or they might see the child for less frequent times than they would need to see an adult. The length of time, I would estimate, would vary anywhere from a 45- to 50-minute session to perhaps an hour and a half. More commonly, analysts would provide the service for 45 to 50 minutes a session.

Mr. Orchard: Approximately what is the fee-for-service reimbursement for that 45- to 50-minute psychoanalytical session that is billed under psychotherapy?

Ms. Sehon: Mr. Chairperson, in the government of Manitoba, the government reimburses the physician $83.80 I believe per session which corresponds to the service that is provided by a psychiatrist. In other words, despite the fact that analysts who are fully qualified psychiatrists and have gone to further training—by training I mean that they have had their own personal analysis, that they have been seeing patients under supervision with an analyst—despite the fact that they have had this additional training, the government of Manitoba is not providing them with any additional fees. So that in point of fact the citizens of Manitoba are really deriving this service for a bargain.

Mr. Orchard: I guess if I am looking at the bargain that you have presented to me tonight, doctor, I see in an eight-hour working day the ability to see eight patients a day. If you saw those patients four times a week, that would mean the maximum patient load you could see would be somewhere in the neighbourhood of 40, and for that one might presume an approximate income of about $650 a day by five days a week by how many days a year.

That is why I ask the question of you very directly, doctor, when you advocate access to a wide range of professional services, are you advocating fee for service, or are you advocating salary? Because the salary of psychiatrists who provide care to patients in our mental health institutions and some of our acute care facilities, they do not see a maximum potential of, say, 40 patients a week. They may well see 200 patients a week, and for that they are paid approximately $90,000 a year. The issue becomes if we are to allow or to provide access to a wide range of services, how ought we to compensate those individuals providing the service? Should it be under a salary of approximately $90,000 a year or should it be at $650 a day for fee-for-service billings?

Ms. Sehon: Mr. Chairperson, I guess if we are going to talk about the method of payment of physicians, I think we have to look at the fact that as the current system stands right now, physicians who are providing procedures, who are procedurally oriented—in other words, physicians who perhaps are operating in surgical specialties are reimbursed more favourably—are paid more favourably by the current health insurance system than physicians who talk with their patients, who provide psychotherapy. There are a number of discrepancies within the reimbursement of physicians within the medical system.

I have not spoken with the rest of the people in my organization on this issue, and as I am a spokesperson for that group, I do not feel that I could comment on the collective opinion of all the people with regard to, as I have stated before, a very complex issue that needs to be addressed in a different context with further information available and further consideration.

Mr. Orchard: Mr. Chairman, I apologize to the doctor. I indicated 40 clients or 40 patients a week. In fact, if it was four visits a week, it would be eight patients for four days and possibly eight patients once a week for the Friday, so that it is not the 40 a week. I thank Mr. Alcock for that correction.

I guess then, given that you believe there is a disparity in the method of compensation, I think you indicated that psychotherapy, as billed by psychiatrists, may be a weekly or biweekly session or may be a monthly session. Would you not concur that if the outcome is similar in terms of stabilization of the individual, that the psychiatrist offering psychotherapy and achieving results with one visit per week, one visit every two weeks or one visit per month, can reasonably expect maybe a little more generous compensation on an hourly basis than a psychoanalyist who may be seeing a patient four times a week and for an eight hour day billing for eight patients, approximately $650 per day?

Ms. Sehon: Mr. Orchard, I suppose, in your comment just now you have made a number of assumptions that I would like to question. You have made the assumption, I believe—correct me if I am wrong—that you are saying that the outcome for patients who are treated with different types of psychotherapy is the same. That is the first assumption you have made which I believe to be incorrect.

Secondly, you have made the statement that the treaters are interested in stabilization. Perhaps you might indicate to me what your definition is of stabilization.

Mr. Orchard: Well, hopefully providing the ability for the individual to return to their home or to their workplace and to resume a productive lifestyle in family and in business, I believe. Is that not the objective that you have of seeing patients?

Ms. Sehon: Mr. Chairperson, I guess in your comment just now, I could infer from your statement that you see psychotherapy as being provided to patients after they have left the hospital. However, many patients do not enter institutional-based care, so to state that psychotherapy is available for patients to return to their home, many of these people are already in their home, many of these people are already working, though perhaps nonproductively. Many of the patients are on welfare and with psychotherapy can lead much more independent and productive lives and contribute more meaningfully to society, contributing to the gross national product.

I would like to come back to your point, the initial question that you posed. The objectives of different forms of psychotherapy are quite different. A treater who sees a patient once a month or less frequently or once every two weeks would not be aiming at characterological, major character change, major personality change. They might be aiming at symptom management. In other words, alleviation of symptoms rather than major structural changes in the personality so that the objectives of the treatment are quite different, so that it becomes meaningless to try and compare the outcomes of two very different forms of treatment. You know, your statement about, well, would it not be more economically feasible for the government to support treaters who see their patients less frequently, clearly indicates that you do not recognize that there is a necessity for a spectrum of community services to be delivered, a spectrum of services for a spectrum of needs.

Mr. Orchard: With all due respect, doctor, I think I recognize that, and that is why I posed the question to you. I realize that you have not consulted with your association to provide me with their guidance and counsel, but I think it would be rather fundamental in the range of services that if we are going to have psychoanalysts, theoretically, who are able to bill government for approximately $3,000 per week, which is $150,000 per year give or take a dollar or two, to achieve a service level for upwards of 10 or 12 patients, to do that, to realize that kind of income over a four to six year treatment regime of four psychoanalyst sessions per week, I asked the fundamental question: In allowing that range of service to be accessed by individuals, ought we to be paying fee-for-service, or ought we to be encouraging salaried positions in those areas so that we can have, for the price of an $80,000- or $90,000-psychiatrist in one of our institutions, two psychoanalysts, for instance, serving twice as many people? Where would the choice be that you would make personally if you were in my shoes and had to make that choice, given the fact that we do not have unlimited resources?

* (0050)

Ms. Sehon: Mr. Chairperson, first of all, I would like to make the statement that the minister is incorrect in saying that I have not consulted with my association. I am not sure which association he is referring to. I have consulted both with the Manitoba Psychiatric Association and the Manitoba Medical Association. I believe that statements will be coming from them forthwith and I do not want to speak on their behalf. I am not in that position here tonight.

Secondly, with regard to, again, the question that you come back to in terms of fee-for-service or salaried positions, I think that as you have stated many times, it is important to consult with the providers of the service, so therefore I would suggest that you consult with the psychoanalysts and the Manitoba Medical Association in this regard.

Mr. Orchard: Doctor, the point I made about not consulting with your organization—I believe you indicated earlier on in the presentation that in presenting your brief on behalf of the Citizens for Quality Mental Health Care you had not sought their opinion as to whether it ought to be fee-for-service or salaried positions, because it was a controversial issue amongst the MMA, and that is what I referred to.

Doctor, can I ask you if in your professional training as a physician you are planning to pursue a career in psychoanalysis service delivery?

Ms. Sehon: I am planning to pursue a career in community mental health. I am planning to pursue a career in which I would be able to offer psychoanalytically informed psychotherapy in the community and to research ways of providing that service to individuals who need the service.

Mr. Orchard: Just one final question, if I might, doctor. In terms of providing, for instance, psychotherapy or psychoanalytical services, as you indicate, would you consider a career on salary providing those services or would you prefer, for your professional career, fee-for-service billings?

Ms. Sehon: Mr. Chairperson, I guess the statements that I make today are to be in regard to this question and to be taken in the context of the fact that I am training. I do not know what my views and regards to this issue will be several years down the road when I am in practice. As it stands right now, I think that I would prefer a fee-for-service system delivery.

Mr. Orchard: Thank you, doctor.

Mr. Chairman: Thank you very much for your presentation this evening. I now call on Mr. Jeff Gunter and Ms. Annette Osted with the Registered Psychiatric Nurses Association of Manitoba. I will just pass out this brief.

Ms. Annette Osted (Registered Psychiatric Nurses Association of Manitoba): You will note that Mr. Gunter was unable to be here this evening. I am the executive director of the Registered Psychiatric Nurses Association of Manitoba and thank you for your patience at this late time. I am really beginning to admire our elected representatives for your patience and being awake to listen to these important deliberations.

The Registered Psychiatric Nurses Association of Manitoba represents the largest single group of providers of mental health services in the province of Manitoba. We believe that mental health services should be delivered as close to an individual's home as possible and also in the least restrictive way possible.

We compliment the current Minister of Health (Mr. Orchard) and his staff for having developed the document titled Vision for the Future: Principles and Policies for Mental Health Services. The document identifies a direction for mental health services which is compatible with contemporary thought on mental illness and the services which are needed by people affected by such illnesses.

We believe that system change is necessary, and we support the proposed direction for change. We also very much believe in sound planning for, and a systemic approach to, such change. We believe that legislation is a part of the system and not an isolated component which can be addressed independently of the stated principles for reform.

We have previously expressed our concerns at the lack of consistency in policy planning and implementation in the area of mental health. Bill 5, for example, enhances legislation which guides the delivery of mental health services in designated psychiatric facilities. However, it is our position that concentration on legislation which deals with a hospital-based system is inconsistent with the stated goal of reform of the mental health services delivery system in Manitoba. We are, therefore, concerned with the lack of consistency in the development and implementation of strategies which would lead to the stated goals of reform.

We identify, as example, the sequence of events to demonstrate those inconsistencies:

In November '89, the publication of the document, A New Partnership for Mental Health, by the Minister of Health, announced the principle of partnership for significant changes to mental health services in Manitoba as well as some specific program initiatives which demonstrated a commitment to that change.

In December 1990, there was the publication of the document, Vision for the Future: Principles and Policies for Mental Health Services, by the Mental Health Division of Manitoba Health and this elucidated the principles which would govern the reformed mental health system and the policies which would guide the delivery of services in such a system. The service system which would be responsive to the needs of individuals was identified as a commitment by the Manitoba government.

In April 1991, there was a consolidation of two schools of psychiatric nursing through the closure of the school at Selkirk and a decrease by almost half of the students enrolled in psychiatric nursing education in Manitoba. This action taken prior to the development of any transition plan will seriously affect the number of graduates from the remaining psychiatric nursing education program in 1993 and '94. The decrease in intake from 70 to 45 students means that the number of graduates will be about 30 instead of the usual 50 or more. This decrease of 40 percent will affect the system just when mental health system reform should be in the process of implementation, not just in the traditional mental health system but also in personal care homes and general hospitals.

In June 1991, there are legislative hearings on Bill 5, The Mental Health Amendment Act, which addresses the operations of designated psychiatric facilities. Although the process of developing these amendments started some time ago, and we are well aware of that, we see the timing of these hearings as being pertinent to our concern about the lack of consistency in the development and implementation of strategies to effect mental health reform. While the Principles and Policies document advocates for community-based service delivery system as mentioned before, Bill 5 promotes the concept of hospital-based system.

The Registered Psychiatric Nurses Association of Manitoba believes that the government of Manitoba has identified some very positive principles and policies for mental health reform in Manitoba. However, we are concerned that the strategies which are being effected do not appear to support those same principles and policies. While that document identifies community-based system, the legislation promotes a hospital-based system. While the Principles and Policies document identifies a need for redeployment of human resources, action has been taken to decrease graduates for the largest single group of mental health professionals in the province by 40 percent within two years, before any plan to ensure sufficient personnel for the implementation of reform has been developed.

* (0100)

We do understand the realities associated with the administration of the mental health system and the need for legislation which addresses the system's legal needs of today. We are concerned however that if this type of process is continued, we will always be playing a game of catch-up—spelled c-a-t-c-h—u-p, for those of you who do not have a copy of the brief—in relation to mental health legislation in this province.

Therefore we wish to support the recommendations made by the Canadian Mental Health Association:

Number 1, that the Legislature review the CMHA concerns, amend Bill 5 and then pass it;

Number 2, that the government address the issue of guardianship of vulnerable persons separately, with due consultation and study very soon—the R.P.N.A.M. had supported that when Bill 59 was being discussed;

Number 3, that the government consult broadly and enact Community Mental Health Services legislation very soon.

In terms of that process, we would encourage the government to begin that planning process now. I know that the Mental Health Division staff would like to have a little bit of rest, but I believe that if that planning starts now, then when it is time to implement all the components of the reformed mental health system, the legislation would be ready.

In addition, the R.P.N.A.M. urges the government to apply consistency in the development of strategies for the implementation of mental health system reform and ensure a pragmatic planning process for any transitions which will be needed for such reform.

Thank you very much for your consideration of this submission.

Mr. Chairman: Thank you very much, Ms. Osted. Any questions?

Ms. Wasylycia-Leis: I would like to thank you, Ms. Osted, for spending the evening here waiting to make your presentation and then delivering it so well after one in the morning. I hope I can be as coherent as you have been in terms of addressing this matter, although it is getting a little difficult at this hour of the day. -(interjection)- Probably no chance.

You have made some very serious, disconcerting statements in terms of this whole field, in terms of the issue of psychiatric nursing education and the ability of that program to actually ensure the number of graduates necessary to meet current needs, but not only current needs, the anticipated needs under a reformed mental health system. You have mentioned that, with the amalgamation of the Brandon and Selkirk schools and the closure, specifically, of the Selkirk school, there will be a 40 percent decrease of graduates coming out of the education program. I had not realized it was that significant.

I am wondering if you could tell us specifically what that will mean in terms of our vision of a community-based reformed mental health system. What roles will psychiatric nurses play in terms of a community-based reformed system, and how will we be able to meet those needs?

Ms. Osted: There are at least three issues, and hopefully I will remember them as I am trying to address them. First of all, I think it must be identified that registered psychiatric nurses are employed in much more than the formal health care system. Registered psychiatric nurses, quite a few of them at least, 25 percent, are employed in the community services or the Family Services system under that department's auspices. Others are under the Department of Corrections, others in the school system, so there are a variety of places where registered psychiatric nurses are employed.

In terms of the Department of Health, we can only make some assumptions in terms of the actual specific numbers which will be needed. The basic principle which we use to address this issue is indeed the one which says that, when patients are moved from one type of service setting to another, that does not mean they lose the need for the provision of services. Therefore, if patients' needs have to be addressed by registered psychiatric nurses when they are in a hospital-type setting, once they are removed from that hospital setting, their needs do not go away. There may be a different way that it is planned to provide those needs that has not been identified with us or to us. If, indeed, it is considered that registered psychiatric nurses will continue to play a critical role in the provision of mental health services in Manitoba, we would much rather have preferred to see the planning for actual numbers and the research in terms of numbers which would be needed in a reformed mental health system to take place before these types of actions had taken place.

If I might, I would like to add, Mr. Chairperson, that we are hoping we will be able to develop a new partnership with the government in terms of planning for some of those issues, but meanwhile it is still an issue. We are concerned that this action was a part of a process which must be looked at by the government in terms of the problems that it creates after the fact.

Ms. Wasylycia-Leis: The minister has suggested that the closure of the Selkirk school is really an amalgamation and part of a larger plan in terms of providing psychiatric nursing education at the university level. I do not know what that all means, so I do not know how to judge that kind of statement.

Can you give us your thoughts about moving in that direction in terms of at least what you know about this government's plans.

Ms. Osted: Our professional goal certainly is to develop baccalaureate educational opportunities for the profession of psychiatric nursing in Manitoba. We are very grateful to have the minister's written support of that goal.

What we are having difficulties with, however, is the fact that certain actions were taken which have pre-empted a smooth transition and developmental process for psychiatric nursing education towards the university system. I know that the ministry is feeling it as is, especially, the profession. What we are hoping to be able to do is to initiate some activities which will prevent the people of Manitoba who need these mental health services from feeling it too much.

Ms. Wasylycia-Leis: In terms of the future needs of a restructured mental health system, I just wanted to ask a question in the context of the report that I referred to earlier from the Manitoba Health Organizations Incorporated, submitted on May of 1990 on mental health services in Manitoba.

I have not agreed with everything in this report, but it seems to me that in the area of psychiatric nursing, MHO makes a pretty strong argument for more psychiatric nurses and for more educational opportunities. In fact, on page 3 of that report, it states: registered psychiatric nurses should be fully utilized; more opportunities for occupational advancement should be available to registered psychiatric nurses; that it will be necessary to establish public case loads for community health workers; that personal care home nursing staff require appropriate training; that expansion of psychogeriatrical consultation services is desirable; that registered psychiatric nurses should be available on the continuing care team and so on.

How will it be possible to fulfill those requirements and to address those needs and meet those objectives in terms of a restructured, revamped psychiatric education nursing program, for which we do not know its final outcome but we do certainly know that in the short term, as you have said, our program will produce a serious shortfall in psychiatric nurses?

Ms. Osted: Mr. Chairman, one of the concerns that we have had is, indeed, the fact that planning for psychiatric nursing education—and certainly in terms of numbers which we might try to project in terms of what would be needed in the future, requires a lot of co-ordination and co-operation between departments.

We were gratified to see some reorganization going on in the Department of Health itself, because in the past we have had difficulties co-ordinating the goals for psychiatric nursing education and even for practise in relationship to the formal traditional mental health system and the general hospital system and the personal care home system.

So now that there seems to be opportunity for much more co-ordination and communication between all of those systems in relationship to mental health needs, we hope that we will be able to do that in a much more comprehensive way. We will have to concentrate on ensuring that the family services component is also included and the corrections component and the others. At least we will not have that same dilemma within the Department of Health, and so we were gratified to see that new approach.

* (0110)

Mr. Chairman: Thank you very much, Ms. Osted.

Mr. Verne McComas, do you have a written brief for us?

Mr. Verne McComas (Manitoba Schizophrenia Society): Mr. Chairman, I do not have a written presentation because our organization was given an opportunity to participate in the discussion that took place with all of the people who worked so hard on these amendments to develop a process that would be better for the people who suffered from a mental illness. So I thank them for that opportunity, and I want to commend the people who participated in that long, long period. I came in near the end of that effort, the last year or so, and I must say that I was impressed by the understanding of schizophrenia which was presented to the committee that was investigating changes to The Mental Health Act.

First, I would like to say that the Manitoba Schizophrenia Society is not a family support group. We are now, we hope, heading in the direction of a group that is interested and able to help people who suffer from the illness. In fact, many of our members who we have in our organization, our supporters, are people who suffer from the illness. It includes family members, and now it is widening to include a number of people in the professional field and people on the street.

We are really encouraged by that development because we feel in the past it has been an illness that has been neglected and not really talked about enough. In fact, while I am on that point, I might mention that I did not hear schizophrenia mentioned tonight, and it sounded as though the illness was not going to be affected by what we are doing when, in fact, we are going to be affected. We really want the best minds to be working on that. We want the best possible people to speak to these amendments. I welcome the presentations that have been made, not because they did not speak about schizophrenia, but because they were interested and took the time to speak about mental illness in general.

Coming back to schizophrenia, many of the things that have been raised tend to work against the people who suffer from this illness. Can I just take a moment to talk about the way the act, the proposed change to consent from family members—I just wanted to, and I understand and I agonize with some of the presentations that were made, but in many cases it can work against the people who suffer from schizophrenia. For example, it tends to suggest that parents are likely to be harmful to the people they respect and love the most. It raises that question. Any time we have put in some special provision to protect someone, it works against people who suffer from schizophrenia. It destroys the communication process between patient and family. It tends to do that. It destroys the consultive process.

For example, one of the things that seems to help people who suffer from schizophrenia is to get attention early, but it is a very nebulous kind of illness that we do not even recognize when it is first starting. In fact, when it appears in the late teens and the early 20s, it is into the stage then when the person may not be able to make a good decision about whether or not they should take a particular kind of treatment.

I guess in the committee stage I felt that the people there were quite informed, and we welcome and respect the judgment and the opinions of all the people there, but we have to come back to the questions that were studied by the committee. There were a number of psychiatrists serving on that committee, at least one from rural Manitoba, and at no time did I find that they were not looking at the best interests of all the people, including those who suffer from schizophrenia.

So in debating further changes to the Bill 5, I hope you will consider schizophrenia. In closing, I guess I would like to say that the Manitoba Schizophrenia Society has a saying that we are promoting, that we are working to alleviate the suffering caused by schizophrenia, and I cannot emphasize that enough.

I also wanted to say that our mandate as a result of a survey we conducted of our supporters—and that includes a good percentage of people who suffer from schizophrenia as well as their family members and as well as people who were in the primary care position.

The major point that came out of the survey was that the organization, the Manitoba Schizophrenia Society, should use all of their efforts at the early stages and as long as necessary to make people, and that means everyone, the public, the professionals, aware of schizophrenia because it does not seem to the people who are in these front lines, that they really understand that illness. Thank you.

Mr. Chairman: Thank you very much, Mr. McComas. Are there any questions?

Ms. Wasylycia-Leis: Thank you very much for your presentation and being here at this late, late hour.

You have expressed a concern about some of the discussion we have been having this evening about fine-tuning and amending Bill 5, the amendments to The Mental Health Act. One of the areas that has been repeated over and over again this evening is the question of the rights of patients and the right of a patient to have some say in terms of who he or she designates as able to give advice in terms of treatment.

I do not sense from the contributions this evening that anyone is trying to come in the way of an individual with a mental health illness and the family of that individual. It is my reading from the contributions that this is simply a suggestion to provide choice to the patient, to the individual, in the event that the next-of-kin, following through the list provided in Bill 5, is not the appropriate person, is not the person likely to make the decisions in the best interests of that individual.

* (0120)

In that context would you and your association favour a move to provide choices for patients, or would you prefer to leave it as it is now in Bill 5?

Mr. McComas: Perhaps in talking in generalities, it might be appropriate to have that kind of provision in there, but for people who suffer from schizophrenia, and they are the people who are going to be mainly affected by the decisions in this act—I guess what I wanted to say was that there is not anything to stop them from making a decision, but most of them deny the illness to begin with. They would not be in a position to make any kind of choice, and they would not be seen going somewhere and making that choice. Once they are into the illness, their decision-making process is hampered by the illness to the point where they can do many, many things, but they are not able to make good decisions about how they should deal with the rest of their lives. So many of them take the very drastic step of ending it.

We just do not feel that further legislation to describe how a person can not take treatment, when in fact, that maybe the early treatment might save their life. As a parent, and I am dealing with this quite frequently, personally and in the organization, I just do not see that it is going to be helpful for schizophrenia. It may help some other kinds of mental illness and this is one of the problems with The Mental Health Act. It tries to deal with too many things in one basket.

I guess I caution you to be very careful in changing something that has been talked about for three years in committee and has been discussed by people that are in the front line, the psychiatrists, the psychiatric nurses, the society for manic depression. I think you really have to listen very, very carefully to what they have to say.

Ms. Wasylycia-Leis: Just a final comment and question, I want to assure you that there is no chance that this legislation is going to die on the Order Paper. The minister is part of a government that has a majority, and he has indicated he wants to get this through as quickly as possible. The opposition has not said we will hold up the process or try to delay it to the point where it cannot be proclaimed on September 1; we are simply trying to find ways to improve the present legislation before us. I am wondering if you would like to make a final comment in terms of some of the suggestions made this evening from various groups to improve Bill 5. Do you see, as long as it does not hold up the bill, that they are acceptable, or do you find the substance of some of those recommended changes troublesome in terms of the issues you are dealing with?

Mr. McComas: I must say that when we are dealing with an illness like schizophrenia it is important that the process be as smooth as possible, and at the same time we would like to see organizations like the Manitoba Association of Rights and Liberties and other interested groups carry on with their interest in mental illness, because we do need the very best minds to decide on what is the appropriate way to handle these particular problems.

I might say, something I did not mention earlier but I really do feel strongly about, and that is that before we proceed to set up systems to handle people who suffer from mental illness like schizophrenia, we really pay attention to research and not necessarily base our decision on what seems to be working somewhere else which maybe, if you tried to replicate it, might not work here, so I really strongly recommend serious quality research for both the medical and the community-based social side of this difficult problem.

Mr. Chairman: Thank you very much, Mr. McComas.

Mr. Orchard: Mr. Chairman, I would just like to thank Mr. McComas for his patience this evening and I think in providing a very appropriate finish to our public presentations in that you have shared with us your experience with a very serious mental illness such as schizophrenia and, if I can be so bold as to paraphrase your comments, sir, the necessity of early intervention and service from medical professionals in an attempt to manage the illness of schizophrenia—very appropriate comments to end the hearings this evening.

Mr. Chairman: Thank you very much, Mr. McComas. I will call one, for the last time, Mr. Doug Fyfe. Ms. Barbara Wiktorowicz, Ms. Pat Trottier.

I would like to thank everybody for being so patient and staying with the hearings. Since all presenters have been heard from, what is the will of the committee? Shall we go to clause-by-clause consideration of the bill?

Mr. Orchard: Mr. Chairman, yes. I would recommend going clause by clause. I think that with nine amendments we can quite readily complete consideration of the bill this evening. We have had a number of staff here all evening waiting for this time, and I think it would be most appropriate to end the evening using their skills in appropriate fashion.

I want to deal with a couple of broader issues before we get into the clause-by-clause consideration. Firstly, Mr. Chairman, I recognize some consistency in a number of the presentations tonight in terms of encouragement of government to move towards a community mental health legislative model, and I accept that advice. I did not take time with each presenter, because I think most of them were familiar with the circumstances behind Bill 5, that it was not designed or was not intended by the Major Amendments Committee to create community mental health legislation but rather to repair some inadequacies of Bill 59 that was passed in 1987. I realize that there will never be complete agreement around all the issues. The consultation process took well over two years, and I think what is presented tonight—I do not think there was any major presenter who disagreed. In general, the amendment package as presented in Bill 5, with some suggested improvements, is an improvement over the existing legislation. As such, I believe there was a will across the board to proceed with Bill 5.

I cannot help but, Mr. Chairman, point out to my honourable friend, particularly my honourable friend the official opposition Health critic, the urgencies that were placed on passage of the bill by Mr. Ashdown on behalf of the Society for Depression and Manic Depression in Manitoba. I think his points were pretty poignant, not downplaying other contributions tonight from other presenters. Mr. Ashdown pointed out some very real needs of individuals affected by depression or manic depression, and that their needs would be better met with the amendments as presented in Bill 5 in place as soon as possible rather than not. I think it is in that context that we have some obligation to those presenters who have remained with patience tonight to move clause by clause, and I will explain a number of amendments that touch a number of the areas that were presented tonight.

So, Mr. Chairman, I think it would be most appropriate if we moved clause by clause.

Mr. Chairman: Does the NDP critic for Bill 5 have opening remarks?

Ms. Wasylycia-Leis: Yes, Mr. Chairperson. The minister earlier expressed some concern about doing this whole process in the dead of the night, as occurred with Bill 59 in 1987. I fail to appreciate, I guess, the need to repeat that exercise and begin this process at 1:30 a.m.

I would certainly make the recommendation that we hold this over until the morning when we have all had a chance to get a little sleep and bring a little coherency to this process. I am sure that holding this overnight is not going to come in the way of the minister's wish to achieve a September 1 proclamation date. I do not quite understand his link in terms of this whole process and that date. We are at June 25. That is a considerable time before September 1. I think that another day or two will not hurt in terms of that whole objective and agenda.

I would also point out to the minister that he may have nine amendments; others around this table have additional amendments. We do not know what total we are looking at, and I think it makes some sense to deal with this in the morning.

Mr. Chairman: Did the Liberal critic for Bill 5 have any opening remarks?

Mr. Cheema: Yes, Mr. Chairperson, I just wanted to reinforce what we have been saying for the last three years in support of the minister bringing this bill forward. We had discussion in the summer of '88, sorry, the summer of '90, last year. At that time, there was not enough time and we made commitment as soon as the bill will come to the House, we will speak on the bill.

We kept our commitment. Today, also, we have made it very clear that we would not like to change the bill in terms of the content for the community-based mental health which has a separate, whole idea and which is very important, which is going to be an extremely important bill. I would encourage the minister to continue the consultation process which has been very well acknowledged by most of the presenters today.

* (0130)

It was made very clear that most of them did have the understanding of the whole process, and I think it is worthwhile. We have repeated many times that this is one area where all the political parties can work together and especially the people from the Canadian mental health organization who have been very active from the day when we were in the official opposition in giving us all the advice, and other organizations and professional groups who have helped me to have a better understanding.

Definitely, I think the Minister of Health (Mr. Orchard) has done a reasonably good job bringing the bill forward. I think we should go and try to make the best of it. I am sure when the second bill will come, we may have to have certain changes in this bill to suit the needs of that act. I am sure there will be a few minor amendments in terms of the review boards and other things because that may reflect the community-based mental health. I do not have any particular amendments because we made it very clear.

Some of the minor things I made clear in my remarks inside the House, and the minister has taken note of a couple of them. The rest are really housekeeping, and I would have no difficulty of going through them tonight because the staff is here now and that was the understanding that was given to me earlier, and I think we could proceed.

Mr. Chairman: The bill will be considered clause by clause. During the consideration of the bill, the Title and the Preamble are postponed until all other clauses have been considered in their proper order by the committee, that the committee wish to deal with—

Point of Order

Ms. Wasylycia-Leis: On a point of order, since we are proceeding through clause by clause, I am wondering if we could have a two or three minute recess?

Mr. Chairman: That is not a point of order, but will the committee consider a two-minute recess?

* * *

The committee took recess at 1:33 a.m.

After Recess

The committee resumed at 1:39 a.m.

Mr. Chairman: The bill will be considered clause by clause. During the consideration of the bill, the Title and the Preamble are postponed until all of the clauses have been considered in their proper order by the committee.

Did the committee wish to deal with Bill 5 in blocks of clauses, with members catching the Chairperson's attention if they have amendments to particular sections?

If that is the will of the committee, shall Clauses 1 through 2 pass—

Ms. Wasylycia-Leis: I would like to move an amendment to Section 2 and it also impacts on—

Mr. Chairman: Shall we pass Clause 1 then? Clause 1—pass.

Ms. Wasylycia-Leis: With the indulgence of the committee, as I was indicating, I will be proposing an amendment to Section 2 but it also impacts on Section 17, and with the permission of the committee I would like to do the two together. They both relate to the issue of substituted consent.

* (0140)

Mr. Orchard: Mr. Chairman, as has been indicated to at least one presenter, and every time my honourable friend brought the designated consent proposal up to presenters tonight, I did not take the opportunity to indicate to each one of them, because they were all here, that the issue is one that currently the Law Reform Commission has under study. We expect a report, certainly—

Point of Order

Ms. Wasylycia-Leis: Should I not be moving the amendment first and then we have the debate?

Mr. Orchard: I thought you already did.

Ms. Wasylycia-Leis: I think I have to read it.

Mr. Chairman: Yes, you do. Read it into the record, please.

* * *

Ms. Wasylycia-Leis: I move:

THAT section 2 of the Bill be amended by adding the following definition after the definition of "clinical record":

"designated consent giver" means the person designated under subsection 24.1(1.1);

THAT section 17 of the bill be amended:

(a) by striking out the proposed clause 24.1(1)(b) and substituting the following:

(b) the patient's designated consent giver or, where there is no designated consent giver, the patient's nearest relative, if the patient has no guardian; and

(c) by adding the following after the proposed subsection 24.1(1):

Designated consent giver

24.1(1.1) A person who has attained the age of 18 years and is mentally competent to make a designation may, in writing and in the presence of a witness, designate a person who has attained the age of 18 years and is apparently mentally competent to make treatment decisions on his or her behalf during any period that he or she is not mentally competent to make those decisions.

Conditions

24.1(1.2) A designation under subsection (1.1)

(a) may be subject to such conditions as are set out in it; and

(b) may be revoked at any time on delivery of a notice of revocation in writing to

(i) the designated consent giver; or

(ii) the medical officer in charge of the psychiatric facility in which the person is a patient for delivery to the designated consent giver.

(French version)

Il est proposé que l'article 2 du projet de loi soit amendé par adjonction, après la définition de "conjoint", de ce qui suit:

"donneur de consentement désigné" La personne désignée en vertu du paragraphe 24.1(1.1). ("designated consent giver")

Il est proposé que l'article 17 du projet de loi soit amendé:

a) par substitution, à l'alinéa 24.1(1)b) proposé, de ce qui suit:

b) le donneur de consentement désigné du malade ou, en l'absence de donneur de consentement désigné parent le plus proche du malade, celui-ci n'a aucun tuteur.

c) par adjonction après le paragraphe 24.1(1), de ce qui suit:

Donneur de consentement désigné

24.1(1.1) La personne qui a atteint l'âge de 18 ans et qui est mentalement capable de faire un designation peut, par écrit et en présence d'un témoin, désigner une personne qui a atteint l'âge de 18 ans et qui est mentalement capable en apparence de prendre, en son nom, les décisions liées au traitement au cours de toute période ou elle n'est pas mentalement capable de prendre ces décisions.

Conditions

24.1(1.2) La désignation visée au paragraphe (1.1):

a) peut être révoquée en tout temps sur remise d'un avis de révocation écrit:

(i) soit au donneur de consentement désigné,

(ii) soit à l'administrateur médical responsable du centre psychiatrique dans lequel la personne est traitée, en vue de sa transmission au donneur de consentement désigné.

Mr. Orchard: Is my honourable friend going to explain the amendment, or does she—

Mr. Chairman: We move amendments with respect to English and French.

Ms. Wasylycia-Leis: I move this amendment with respect to English and French.

Mr. Orchard: Well, let us have the member.

Ms. Wasylycia-Leis: Mr. Chairperson, I would like to make a brief explanation for moving this amendment. This evening, we have heard many presentations, almost every one of those presentations identified problems with the present wording under Bill 5 in terms of provisions pertaining to consent. Just about every one of those presenters made a case, a very strong case, for a substitute consent model and I have specifically proposed a wording that follows along the lines of the Ontario model that individuals this evening commented on and indicated was an appropriate model that could be used here in the province of Manitoba and would address the fundamental issues of the right of patient to make decisions, the right of patients to have choices in terms of whom they select to be a consent giver for that person.

I believe it is a reasonable amendment. I think it is one that can be made without worry in terms of impacting on the broader health care system. It can be the forerunner to some important changes in health care legislation generally. I believe it is an improvement to Bill 5, and I hope it receives the support of this committee.

Mr. Orchard: Mr. Chairman, when my honourable friend presented this line of questioning to each of the presenters this evening, I only questioned it on one, in the interests of conservation of time, but I indicated that the Law Reform Commission has had this issue referred to them and I am informed they expect to report to the Attorney General (Mr. McCrae) very soon. Within a month of that report being received by the Attorney General, it will become a public document available to all of us.

It is with that information that it was decided—and I will not say there was unanimous agreement by any means at the Major Amendments Committee—but there was understanding that with the Law Reform Commission recommendation coming In, which would deal with the wider issue of consent giver throughout the health care system, it would be appropriate to pass legislation which would have applicability across the health care system rather than singling out those suffering from mental illness.

Some might observe possibly stigmatizing the process by singling out mental health at this stage of the game when we are so close to the opportunity of achieving consent giver status across the health care system and ever mindful of the fact that a number of—well, I should not say a number—at least one individual, I recall, tonight talked in terms of the living will provisions which are part of the Law Reform Commission study.

So given that government has already taken action in terms of reference to the Law Reform Commission, and secondly, that I think there will be substantive interest in that report and its applicability to the health care system, I would ask my honourable friend to reconsider amendment that committee and government would not be prepared to accept this amendment tonight.

Mr. Cheema: Mr. Chairperson, as we were discussing, I think it was last Monday, not last Thursday, the broader issue of the living will, and the government has given to the Law Reform Commission to study various aspects, and I would definitely agree with the minister on this one. I think it is very important to look at the broader issue because we have a number of issues in terms of the terminally ill and living will and rights of patients and how that could have an impact on the larger health problems. I think we should wait until we get the report and then have a proper examination. It is going to be a public document, and then we can make up our mind, I think. Right now, within two or three months, I do not think anything is going to be lost by waiting for the right report.

Ms. Wasylycia-Leis: Mr. Chairperson, I would like to make just a few more comments since the minister posed some questions to me in terms of whether or not I would be willing to withdraw. I think he was requesting whether or not I would be willing to withdraw this amendment.

I want to indicate to the minister that I would like to continue on with this amendment and try to persuade the minister and his colleagues and the Liberal Health critic to give serious consideration to including such a provision in this legislation. I fail to see how introducing such a forward looking measure will jeopardize any ongoing dialogue and plans to consider such a provision for the health care system generally. As I said earlier, it seems to me it can only be helpful to that process, and provide some leadership and necessary innovation at a critical time in our history of the mental health system. I reiterate that in just about every presentation tonight, support was given for such an amendment to Bill 5. In fact, just about every presentation tonight suggested that it is regrettable that we are not at the point in our history where we are actually discussing a legal or legislative framework for a community-based mental health system and that we are failing our community and people suffering from mental illness by not acting more quickly and with haste in terms of this area.

It seems to me that given we do not have the opportunity tonight to discuss and approve such far-reaching, broad-based legislation, that the least we can do is take a few steps forward in that direction and indicate our sincerity to the communities so concerned about this issue by instituting and implementing a substitute consent model in this legislation.

Mr. Chairman: Is there leave to have Dr. Rodgers address the committee? Leave. Dr. Rodgers.

Dr. Donald Rodgers (Director of Psychiatric Services, Department of Health): I think to say that in the amendments committee there was 100 percent agreement that substituting consent was desirable in one way or another. I think the reasons that the minister has mentioned are probably the basic ones. It was felt with the Law Reform Commission doing the work they are doing, and we have been in contact with them and going along with them, that it would satisfy what we wanted without pointing a finger at mental health as the only one needing this.

The Ontario experience has not been good despite what was said by one of the presenters tonight. Diane MacFarlane, who is the executive director of mental health services, and Sandra Scarth who succeeded her, both communicated to me that they were having a great deal of difficulty and they have, in the past year, developed the committee that is looking at making it broad and deleting this from The Mental Health Act.

It would seem the consensus across the country—in Nova Scotia, not New Brunswick—where it is operating, they are quite happy. They have a two-witness form system in a central registry, which are some of the basic things required for it to work. The problem in Ontario, probably because of the population, one, and the size of the population—the age range was a little lower—is that some people appeared at hospitals. There was no way of knowing whether they did or did not have this. Somebody would come and say, I have given consent to this person. They had no way of establishing this, so we are just saying they are ignoring it, more or less.

Logistic problems, that is I think with the Mental Health Information Management system being developed in Manitoba, that the commission—we should be able to get around that. In terms of waiting, it has been suggested by one presenter that it might take two years for this to go through the Law Reform Commission into a bill. We have been told by them that it is a very short bill. It is one page, a page and a half in Nova Scotia, and that it could be presented next fall.

We do not have any sense of urgency. The review board has very few appeals where somebody who is incompetent had appealed consent. The situation—it is an important issue but is it not something that is an everyday problem. In fact, it is a relatively small problem in terms of mental illness, so that waiting another five or six months does not seem a major obstacle. Again, and I say that we all agree, some form of substituted consent is wanted and needed, whether it is individual to mental health or whether it is part of general health. My own option would—that is why our committee did not agree one way or the other. The suggestion to go to the Law Reform Commission's findings was made by one of the presenters tonight who suggested this bill at this time. It was not suggested by government; it was suggested by one of the outside consultants or the members.

* (0150)

Mr. Chairman: Thank you, Dr. Rodgers. On the proposed motion moved by Ms. Wasylycia-Leis:

THAT section 2 of the Bill be amended by adding the following definition after the definition of "clinical record":

> "designated consent giver" means the person designated under subsection 24.1(1.1);

THAT section 17 of the bill be amended:

> (a) by striking out the proposed clause 24.1(1.1) and substituting the following:
>
> (b) the patient's designated consent giver or, where there is no designated consent giver, the patient's nearest relative, if the patient has no guardian; and
>
> (c) by adding the following after the proposed subsection 24.1(1):

Designated consent giver

24.1(1.1) A person who has attained the age of 18 years and is mentally competent to make a designation may, in writing and in the presence of a witness, designate a person who has attained the age of 18 years and is apparently mentally competent to make treatment decisions on his or her behalf during any period that he or she is not mentally competent to make those decisions.

Conditions

24.1(1.2) A designation under subsection (1.1)

> (a) may be subject to such conditions as are set out in it; and
>
> (b) may be revoked at any time on delivery of a notice of revocation in writing to
>
>> (i) the designated consent giver; or
>>
>> (ii) the medical officer in charge of the psychiatric facility in which the person is a patient for delivery to the designated consent giver.

(French version)

Il est proposé que l'article 2 du projet de loi soit amendé par adjonction, après la définition de "conjoint", de ce qui suit:

> "donneur de consentement désigné" La personne désignée en vertu du paragraphe 24.1(1.1). ("designated consent giver")

Il est proposé que l'article 17 du projet de loi soit amendé:

> a) par substitution, à l'alinéa 24.1(1)b) proposé, de ce qui suit:
>
> b) le donneur de consentement désigné du malade ou, en l'absence de donneur de consentement désigné parent le plus proche du malade, celui-ci n'a aucun tuteur.
>
> c) par adjonction après le paragraphe 24.1(1), de ce qui suit:

Donneur de consentement désigné
24.1(1.1) La personne qui a atteint l'âge de 18 ans et qui est mentalement capable de faire un designation peut, par écrit et en présence d'un témoin, désigner une personne qui a atteint l'âge de 18 ans et qui est mentalement capable en apparence de prendre, en son nom, les décisions liées au traitement au cours de toute période ou elle n'est pas mentalement capable de prendre ces décisions.

Conditions
24.1(1.2) La désignation visée au paragraphe (1.1):

> a) peut être révoquée en tout temps sur remise d'un avis de révocation écrit:
>
> > (i) soit au donneur de consentement désigné,
> >
> > (ii) soit à l'administrateur médical responsable du centre psychiatrique dans lequel la personne est traitée, en vue de sa transmission au donneur de consentement désigné.

All those in favour of the motion, say yea. All opposed, say nay. In my opinion, the Nays have it. The motion is defeated.

Clause 2—pass; Clauses 3 through 8—pass. Shall Clauses 9 through 12 pass?

Mr. Orchard: Mr. Chairman, I have—

Mr. Chairman: Does the minister have leave to make amendments to the bill?

Mr. Orchard: I beg leave to make amendment.

Mr. Chairman: Could I ask the—shall we pass Clause 9?

Mr. Orchard: Indeed.

Mr. Chairman: Can we pass Clause 10?

Mr. Orchard: No.

Mr. Chairman: Clause 9 is passed.

Mr. Orchard: I move, both in English and in French:

THAT section 10 of the bill be struck out and the following is substituted:

Subsection 17(2) replaced and substituted
10Subsection 17(2) is repealed and the following is substituted:

Psychiatric assessment
17(2) A psychiatrist shall make an assessment within 72 hours after the filing of an application under subsection (1), and if the prerequisites for admission as an involuntary patient as set out in subsection 16(1.1) are met, the psychiatrist shall complete a certificate of involuntary admission.

Exception
17(3) Despite subsection (2), if a patient has been a patient of the psychiatric facility for more than 72 hours when the application is filed, the assessment under subsection (2) shall be made within 24 hours after the filing of the application.

(French version)

Il est proposé que l'article 10 soit remplacé par ce qui suit:

Remplacement du paragraphe 17(2)
10 Le paragraphe 17(2) est remplacé par ce qui suit:

Evaluation psychiatrique
17(2) Dans les 72 heures qui suivent le dépôt d'une demande en application du paragraphe (1), le psychiatre procède a l'évaluation et remplit, si les conditions prévues au paragraphe 16(1.1) sont satisfaites, un certificat d'admission en cure obligatoire.

Exception
17(3) Par dérogation au paragraphe (2), l'évaluation qui y est prévue est faite dans les 24 heures qui suivent le dépôt de la demande, si le malade se trouve déjà au centre psychiatrique depuis plus de 72 heures au moment du dépôt.

I think to explain the amendment, Mr. Chairman, that was one of the issues that was identified in the brief where there was some potential in consistency, where one who is already in an institution could be by the amendment that was proposed in Section 10, subsection 17(2), would be detained up to 72 hours waiting for assessment. That section was designed only to be applicable to new admissions.

The inconsistency with an individual already within the institution was pointed out, and this amendment is an attempt, I think, to bring that concern to the act to address the issue of a patient already in a psychiatric facility for the 72-hour period of time.

Ms. Wasylycia-Leis: Mr. Chairperson, I need some considerable clarification on this proposed amendment, because I fail to see how it addresses the concerns expressed by many of the presenters this evening in terms of the provisions pertaining to voluntary patients being subjected to the—I fail to see how this addresses the concerns about voluntary patients treated without consent. The presenters this evening have clearly suggested that 72 hours is much too long a period, and the recommendation that I heard was to change that, in fact, to 24 hours.

I do not understand how these two sections together 17(2) and 17(3) address that issue and ensure that that the 24-hour objective is adhered to as suggested in the covering overview comments in terms of the minister's amendment. I will need some clarification in terms of that issue.

Mr. Orchard: Well, Mr. Chairman, my honourable friend, if she refers to The Mental Health Act as amended in 1987, will find psychiatric assessment under 17(2) had no time frame under which that assessment ought to take place. When we agreed that was inappropriate, and that we ought to put a 72-hour time limit which was consistent with the involuntary admission procedure, that was the genesis behind the 72 hours.

However, we were dealing with voluntary patients in this case and the issue was pointed out to us, are you then potentially exposing a voluntary patient who has already been in the facility, undergone an assessment, to a further 72-hour potential detention, if you will, or retention within the facility pending an assessment? For a voluntary patient who was there for a period of time, that was deemed inappropriate.

So what we have done in Section 17(2) is improve The Mental Health Act by putting 72 hours in place. It was unlimited before and if my honourable friend's concerns were the retention of an individual for an unreasonable period of time, surely she must agree that consistency in 72 hours is an improvement as provided in Section 17(2). Where the concern was expressed that that could apply to one who had already been in the facility for a period of time, we agreed and hence Section 17(3) where that assessment must be made within a 24-hour period of time.

* (0200)

Ms. Wasylycia-Leis: Mr. Chairperson, this may be an improvement from Bill 59, which left it wide open. The minister has addressed that by putting in a specific reference to having an assessment completed within 72 hours. That is precisely the issue which many individuals took umbrage with this evening. The suggestion made by many this evening and that we have made previously in discussions around this matter was to put in a provision within 24 hours when we are talking about voluntary patients being kept in terms of a psychiatric assessment. I do not see how this addresses the concerns, to have to ensure that assessment takes place within 24 hours. Unless I am missing something the minister has said or mixing up some issues, I have yet to understand where the significant progress is.

Mr. Orchard: I will attempt to explain the genesis behind this. Under the legislation that was passed in 1987 there was no time limit put in place. Without an amendment, my honourable friend's problem would be greatly exacerbated and I think my honourable friend would have to admit that putting in 72 hours, which is consistent with the time frame on an involuntary assessment, that would be an appropriate amendment. It was consistent with the amendments made in 1987.

Now, if my honourable friend says that this is inappropriate, I suppose one of the options available to us tonight would be to delete Section 10 and leave the act as written with no time limits, but I hardly think that would be consistent with my honourable friend's concerns, and every step of the way this is an improvement.

Let me give my honourable friend an example. Where an individual presents themselves for voluntary admission, and within one hour of that voluntary admission decides that they do not wish to admit themselves, but in the ongoing admission procedure it is observed by medical professionals that the individual ought to be involuntarily committed, that change in status can be achieved and the 72-hour assessment time invoked. That is the circumstance under which 72 hours would be invoked, which is consistent with all other involuntary admissions.

In the case where a voluntary admission who had been in a facility for longer than 72 hours wished to have the status changed, or have their circumstances of admission changed, then the 72 hours as provided in the amendment in Bill 5 would have permitted up to 72 hours further commitment. That has been reduced to 24 hours, which was the concern expressed, I believe, throughout the piece. So, my honourable friend, if she does not understand that is an improvement, surely my honourable friend would admit that even straight 72 hours is an improvement over the legislation from 1987 and the amendment to Bill 5 that I am presenting tonight is an improvement over that.

Ms. Wasylycia-Leis: As I said earlier, this may be an improvement from Bill 59. That is not the issue right now. We are dealing with a series of very intense and serious presentations around the questions of voluntary patients and the length of time that they can be detained in terms of an assessment being carried out.

Time and time again it has been suggested that for this act to be consistent in terms of its treatment of voluntary patients, it would make sense to not delete this section of Bill 5, but to amend it and to change it to substitute—strike out 72 hours and substitute it with 24 hours. That would be consistent with the kind of presentations we have heard. That would be consistent with other provisions of the act which allow a voluntary patient to leave a facility by his or her own self.

Mr. Rodgers: I was not present at the "night of the long knives" in 1987, but I am told that originally it was five days wanted and this was reduced to 72 hours, the purpose being and supported at that time by people who—some wanted a shorter time now—felt there ought to be time to get collatoral information, to talk to families or relatives in order to make a sound judgment rather than rushing it. As you might be aware, before that a medical certificate was written which went to a magistrate which then put somebody in the hospital. To improve this, the period of time with two decisions, one a physician and one a psychiatrist, was decided upon—very good for person's rights and for the ability to have a proper assessment. My understanding is that is why it is 72 hours now. Why it was not 24 hours or was not the five days, I do not know. I was not there, but that seemed to have been the compromise that was agreed upon, 72 hours.

My own experience at Health Sciences is that the average is 2.8 hours, not 72 hours, except in some occasions of new patients, because most of the patients are rehospitalizations. With newer patients it can run to half a day, but there is a very strong effort made to get information and do that second assessment. To go the full 72 hours is unheard of, as far as I know, because there is are psychiatrists on call seven days a week that are available. The intent was to give time for a proper examination and not an immediate committal. The 72 is just a guesstimate by the people who were there at the time.

Mr. Cheema: Mr. Chairperson, I have some personal experience dealing with this kind of situation almost on a daily basis for the last three or four years. I think it is an improvement, because when a patient is in the hospital on a voluntary basis, and if the patient is doing fine and they want to go home, the law does not say that you have to keep them. If you find that patient's status has to be changed, I know there is a clause that within 24 hours, I think that is a reasonable time to assess the patient and make a judgment. I think that really helps if the patient is already there, you have all the data, you want to contact the family and everything else, so I think it is in the patient's own interest to have some time frame to have the best judgment made.

I do not see any really major problems with that in terms of the time of 24 hours and the 72 hours which is a practical problem in terms of the shortage of psychiatrists and also in smaller communities. You do not have physicians, so what are you going to do? Are you going to fly a psychiatrist from here to, say, a smaller community and bring the patient back? It is going to cause more problems. I think that in terms of, at least, we have 72 hours. That will cover from Friday morning to Monday morning. That gives coverage and also helps the health care facilities to provide the care. I think we should give it a try and see how it works.

Mr. Chairman: On the proposed motion of the—

Ms. Wasylycia-Leis: I would like to propose an amendment to the amendment to the amendment to delete 72 hours—

Mr. Chairman: Is this a written amendment?

Ms. Wasylycia-Leis: I will write it out.

* (0210)

Mr. Chairman: All amendments must be written out and in both languages. Do you have that for circulation? Does the member have a motion to put on the amendment to the amendment?

Ms. Wasylycia-Leis: It will just take a moment to quickly draft.

Mr. Chairman: We have to make copies. Do you have copies for the members?

Mr. Orchard: Do you have to have your motion in writing before it is voted on, Mr. Chairman—as I suspect it will not survive?

Mr. Chairman: Yes, you do. It has to be in writing in both languages for presentation.

Mr. Orchard: Why did you not have this amendment ahead of time?

Ms. Wasylycia-Leis: Pardon?

Mr. Orchard: If it was such a concern, why did you not have your amendment ahead of time?

Mr. Chairman: Ms. Wasylycia-Leis, we will discuss it when it is properly put before the committee.

Point of Order

Ms. Wasylycia-Leis: There seems to be some concern about why I did not have this ready ahead of time. I would like to indicate that I did have an amendment prepared changing the 72 to 24 hours, and it is available in two languages. However, the minister brought forward—

Mr. Chairman: I would remind the honourable member that is not a point of order. It is a dispute over the facts. We will discuss it once the motion is put to the committee.

* * *

Mr. Chairman: Copies will have to be made so we will maybe take a two-minute recess.

* * *

The committee took recess at 2:12 a.m.

After Recess

The committee resumed at 2:22 a.m.

Mr. Cheema: Mr. Chairperson, I just wanted to talk about a practical problem. It may not be a problem—

Point of Order

Ms. Wasylycia-Leis: I was just wondering if I should not move the amendment to the amendment before we debate?

Mr. Chairman: Okay, right. Sorry.

* * *

Ms. Wasylycia-Leis: I move in both English and French:

THAT the proposed subsections 17(2) and 17(3), as set out in a proposed amendment to section 10 of the Bill be amended

(a) in subsection 17(2), by striking out "72 hours," and substituting "24 hours"

and

(b) by striking out subsection 17(3).

(French version)

Il est proposé que les paragraphes 17(2) et (3) proposés, énoncés dans un amendement proposé à l'article 10 du projet de loi soient amendés:

a) au paragraphe 17(2) par substitution, à "72 heures", de "24 heures";

b) par suppression du paragraphe 17(3)

Mr. Cheema: Mr. Chairperson, I will try to explain in very simple words why I think it is not going to be practical. It may be possible in the city of Winnipeg and—where Dr. Rodgers has said it takes about two to six hours to have this thing done. But somebody, just suppose, for example, comes into Dauphin, and the general practitioner by law is covered to see the patient the first time but the second time the certification must be done by a qualified psychiatrist. The member for St. Johns (Ms. Wasylycia-Leis) knows full well we do not have many psychiatrists, and it will be impossible to get anybody there and fly back and forth.

I think we are not going to do any good to those patients if we adopt that amendment, unless we have a special provision in which we have to ask the College of Physicians and Surgeons to change their laws to accommodate some physicians to certify. I think that is the next issue.

If the member for the St. Johns wanted (Ms. Wasylycia-Leis) her amendment to be accepted, then I think she has to ask for the amendment in the—for the College of Physicians and Surgeons too and ask them to change certain regulations so that certain physicians could be able to certify.

Mr. Chairman: On the proposed subamendment to the amendment put forth by the Honourable Mr. Orchard, subamendment moved by Ms. Wasylycia-Leis

THAT the proposed subsection 17(2) and (3), as set out in a proposed amendment to section 10 of the Bill be amended

(a) in subsection 17(2), by striking out "72 hours," and substituting "24 hours"

and

(b) by striking out subsection 17(3).

(French version)

Il est proposé que les paragraphes 17(2) et (3) proposés, énoncés dans un amendement proposé à l'article 10 du projet de loi soient amendés:

a) au paragraphe 17(2) par substitution, à "72 heures", de "24 heures";

b) par suppression du paragraphe 17(3)

All in favour, say yea. All opposed, say nay. In my opinion, the Nays have it. The subamendment is so defeated.

On the proposed motion by the Honourable Mr. Orchard

THAT section 10 of the Bill be struck out and the following substituted:

Subsection 17(2) repealed and substituted
10 Subsection 17(2) is repealed and the following is substituted:

Psychiatric assessment
17(2) A psychiatrist shall make an assessment within 72 hours after the filing of an application under subsection (1), and if the prerequisites for admission as an involuntary patient as set out in subsection 16(1.1) are met, the psychiatrist shall complete a certificate of involuntary admission.

Exception
17(3) Despite subsection (2), if a patient has been a patient of the psychiatric facility for more than 72 hours when the application is filed, the assessment under subsection (2) shall be made within 24 hours after the filing of the application.

(French version)

Il est proposé que l'article 10 soit remplacé par ce qui suit:

Remplacement du paragraphe 17(2)
10 Le paragraphe 17(2) est remplacé par ce qui suit:

Evaluation psychiatrique
17(2) Dans les 72 heures qui suivent le dépôt d'une demande en application du paragraphe (1), le psychiatre procède à l'évaluation et remplit, si les conditions prévues au paragraphe 16(1.1) sont satisfaites, un certificat d'admission en cure obligatoire.

Exception
17(3) Par dérogation au paragraphe (2), l'évaluation qui y est prévue est faite dans les 24 heures qui suivent le dépôt de la demande, si le malade se trouve déjà au centre psychiatrique depuis plus de 72 heures au moment du dépôt.

On the proposed motion, shall the motion pass? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it. The amendment is carried.

Clause 10 as amended—pass; Clause 11—pass; Clause 12—(pass); Clauses 13 through 16—pass. Shall Clause 17 pass?

Mr. Orchard: Mr. Chairman, I would move:

THAT the proposed subsection 24(1), as set out in section 17 of the Bill, be amended by adding "consent to or" after "has the right to".

(French version)

Il est proposé que le paragraphe 24(1) énoncé à l'article 17 du projet de loi soit amendé par adjonction, après "a le droit", de "d'accepter ou".

Mr. Chairman, if I can read the amendment, that would have the amendment reading:

Except as provided in this section and in sections 24.1 to 25, a patient of a psychiatric facility has the right to consent to or refuse psychiatric or other medical treatment.

I think that was one of the suggestions made this evening.

Ms. Wasylycia-Leis: Yes, I would like to indicate support for this amendment. We had also proposed and had requested the drafting of this amendment. I am pleased to see that we have been able to agree on something this evening.

Mr.Chairman: Shall Clause 17 pass as amended? Oh, pardon me. We have to pass the amendment first. I am sorry.

Moved by the Honourable Mr. Orchard

THAT the proposed subsection 24(1), as set out in section 17 of the Bill, be amended by adding "consent to or" after "has the right to".

(French version)

Il est proposé que le paragraphe 24(1) énoncé à l'article 17 du projet de loi soit amendé par adjonction, après "a le droit", de "d'accepter ou".

With respect to both English and French, shall the amendment pass—(pass). Clause 17 as amended—(pass).

Clauses 18 through 20—(pass). Shall Clauses 21 through 24 pass?

Mr. Orchard: No, Mr. Chairman. We can pass Clauses 22 and 23.

Mr. Chairman: Clause 21—pass; Clause 22—pass; Clause 23—pass.

Mr. Orchard: Mr. Chairman, I would propose an amendment to Section 24 of the bill. I would move:

THAT the proposed subsection 26.4(6), as set out in section 24 of the Bill, be amended by striking out clauses (c) and (d) and substituting the following:

> (c) is a psychiatrist or physician who is treating or has treated that person;
>
> (d) is an officer, employee or staff member of the psychiatric facility in which that person is being treated; or
>
> (e) is a lawyer who is acting for or has acted for that person.

(French version)

Il est proposé que la paragraphe 26.4(6) énoncé à l'article 24 du projet de loi soit remplacé par ce qui suit:

Admissibilité
26.4(6) Les personnes indiquées ci-dessous ne peuvent faire partie du comité du conseil de révision qui est chargé d'étudier une requête:

> a) le conjoint de l'auteur de la requête;
>
> b) les personnes qui sont apparentées, par le sang ou le mariage, à l'auteur de la requête;
>
> c) le psychiatre ou le médecin qui soigne ou qui a déjà soigné l'auteur de la requête;
>
> d) les cadres, les salariés et les employés du centre psychiatrique dans lequel est traité l'auteur de la requête;
>
> e) l'avocat qui représente ou que a déjà représenté l'auteur de la requête.

Mr. Chairman, the intent here is that it was argued that, as well, membership on the review panels was appropriately restricted in Clauses (a) through (d) but that we ought to also consider the exemption of a staff person who may well be working at the psychiatric facility, so that is added and I believe meets concerns expressed this evening.

Ms. Wasylycia-Leis: Mr. Chairperson, we would indicate our support for this amendment. It is also an area in which we were proposing an amendment.

Mr. Cheema: Mr. Chairperson, I just want to indicate support, because we have outlined those concerns during the second reading and some of the presenters had made similar comments.

Mr. Connery: I want to indicate my support for the amendment also, Mr. Chairman.

* (0230)

Mr. Chairman: On the proposed amendment moved by the Honourable Mr. Orchard,

THAT the proposed subsection 26.4(6), as set out in section 24 of the Bill, be amended by striking out clauses (c) and (d) and substituting the following:

> (c) is a psychiatrist or physician who is treating or has treated that person;
>
> (d) is an officer, employee or staff member of the psychiatric facility in which that person is being treated; or
>
> (e) is a lawyer who is acting for or has acted for that person.

(French version)

Il est proposé que la paragraphe 26.4(6) énoncé à l'article 24 du projet de loi soit remplacé par ce qui suit:

Admissibilité
26.4(6) Les personnes indiquées ci-dessous ne peuvent faire partie du comité du conseil de révision qui est chargé d'étudier une requête:

> a) le conjoint de l'auteur de la requête;
>
> b) les personnes qui sont apparentées, par le sang ou le mariage, à l'auteur de la requête;
>
> c) le psychiatre ou le médecin qui soigne ou qui a déjà soigné l'auteur de la requête;

d) les cadres, les salariés et les employés du centre psychiatrique dans lequel est traité l'auteur de la requête;

e) l'avocat qui représente ou que a déjà représenté l'auteur de la requête.

With respect to both English and French, shall the amendment pass—pass; Clause 24 as amended—pass.

Ms. Wasylycia-Leis: I would like to move in both English and French

THAT the proposed section 26.5(1), as set out in section 25 of the Bill, be amended by adding "voluntary or involuntary" after "the admission and treatment of a".

(French version)

Il est proposé que le paragraphe 26.5(1), énoncé à l'article 25 du projet de loi, soit amendé par adjonction, après "du traitement d'un malade", de "en cure volontaire on obligatoire".

Mr. Chairman: Shall Clause 25 pass then? This amendment that you put forth—

Ms. Wasylycia-Leis: It is an amendment to 25.

Mr. Chairman: Oh, Section 25. I am sorry. I was looking at 26, sorry.

Ms. Wasylycia-Leis: To explain briefly, this is an issue that I had signalled earlier as an area that we wish to move an amendment. It pertains to ensuring the protection of the rights of the voluntary patient equal to that of an involuntary patient. In the presentations tonight, particularly the one from the Canadian Mental Health Association, Manitoba Division, two suggestions were indicated with a preference for this particular amendment. I would suggest that it is not an area that can be left to administrative discretion or regulation. It is something that should be entrenched in legislation, and I would so move it.

Mr. Chairman: Does Mr. Biberdorf have leave to address the committee?

Mr. John Biberdorf (Legislative and Program Analyst, Mental Health Division, Department of Health): The problem we are having with your suggested amendment is that a voluntary patient typically would appeal their voluntary admission by walking out the door. I think what we propose is a change in the regulation itself, in the form: the application to review board so that a voluntary patient will have access to the review board to hear an appeal on treatment, but not on admission.

Mr. Chairman: On the proposed motion by Ms. Wasylycia-Leis

THAT the proposed section 26.5 (1), as set out in section 25 of the Bill, be amended by adding "voluntary or involuntary" after "the admission and treatment of a".

(French version)

Il est proposé que le paragraphe 26.5(1), énoncé à l'article 25 du projet de loi, soit amendé par adjonction, après "du traitement d'un malade", de "en cure volontaire on obligatoire".

Shall the motion be passed? All in favour, say yea. All opposed, say nay. In my opinion, the Nays have it. The proposed amendment is defeated.

Clause 25—pass; Clause 26—pass; Clause 27—pass.

Clause 28.

Mr. Orchard: I would propose an amendment to Section 28 of the bill. There has been some discussion around the issue of commencement of the hearing process discussed by a number of individuals this evening. Mr. Chairman, basically the discussion was around 21 days as being the—when it is enshrined in legislation, 21 days would become the automatic lapse of time for undertaking of a hearing.

I recognize the concern by presenters. One of the reasons why we have some difficulty, in terms of being able to arrange the hearings within the 21-day period that was proposed in Bill 5, was the roster. We did not have a roster system, in terms of our membership, for the review panels. They were, as specifically named, in the Order-in-Council. That caused some difficulties in terms of bringing all three individuals together.

So what we proposed was 21 days, because now with amendments—that is our current ability to have a hearing, but we expect with the roster system that is introduced as part of the amendments, that by the end of this year we will be, we think, at having a hearing within 14 days.

What I am proposing in this amendment is that we remove the reference to 21 days in Bill 5 and substitute an amendment which would allow us, by regulation, to establish the time frame. The regulation we would pass immediately would state 21 days and with experience with the roster system, and possibly November or December, we would replace that regulation specifying 21 days with 14 days, because we expect that we would be able to accomplish that. That would save coming back and going through the process of an amendment in the act. Then, should we be able to further decrease the time in which we can strike and hold a review, we would pass regulation which would bring that maximum time frame down even further.

I move in both English and French

THAT section 28 of the Bill be struck out and the following substituted:

Subsection 26.6(1.1) added
28 The following is added after subsection 26.6(1):

When hearing must begin
26.6(1.1) A hearing in respect of an application made by or on behalf of a patient shall begin as soon as reasonably possible after the application is received by the review board under subsection 26.5(1), and in any case within the period of time prescribed by regulation.

(French version)

Il est proposé que l'article 28 du projet de loi soit remplacé par ce qui suit:

Adjonction du paragraphe 26.6(1.1)

28 Il est ajouté, après le paragraphe 26.6(1), ce qui suit:

Début de l'audience
26.6(1.1) Le conseil de révision commence l'audition des requêtes qui lui sont présentées en vertu du paragraphe 26.5(1) par des malades ou en leur nom dès que possible, mais toujours au cours du délai fixé par règlement.

So this enables us to—we will pass a regulation upon proclamation of this act instructing the 21-day time frame. We would anticipate replacing that regulation stating 21 days before the end of this calendar year with one specifying a 14-day case as we have experience and mature the roster system of striking the review committees. That avoids the necessity to come back and open the act at every time that we find ourselves able to undertake the review panel hearings in a shorter period of time.

Ms. Wasylycia-Leis: Mr. Chairperson, well, the minister is asking us to take a leap of faith and to trust him that the length of time will be no greater than 21 days. With this kind of open-ended wording, in fact, there are no guarantees. There is no entrenched provision to ensure that the process takes place within a certain period of time.

The minister is suggesting that the flexibility will allow him to get down the time frame to a reasonable period of time without reopening the act each time. We would have preferred a specific reference to change this section from 21 days to seven days, which has been the recommendation from most individuals and organizations who have presented this evening and prior to this evening.

However, not wanting to take the time of the committee, in terms of proposing an amendment to the amendment to the amendment as we have just done, I would ask the minister if he could give us some clear indication when he would expect to get this period of time from 21 days down to 14 days and then, thereafter, to seven days?

* (0240)

Mr. Orchard: Mr. Chairman, in presenting the amendment, I indicated that currently we are at 21 days and that would be the regulation which would accompany proclamation of this Bill 5 come September 1. I would expect, and I am advised by staff that, with the roster system in place and a meeting they held this week with the chairs of the roster system, that they expect that by the end of this calendar year they would be able to achieve a 14-day period of time and be within that consistently.

I indicated, in presenting the amendment, that should we be able to reduce that time further, we would propose yet another regulation.

Mr. Chairman: On the proposed motion put forth by the honourable Mr. Orchard, in respect to both English and French:

THAT section 28 of the Bill be struck out and the following substituted:

Subsection 26.6(1.1) added
28 The following is added after subsection 26.6(1):

When hearing must begin
26.6(1.1) A hearing in respect of an application made by or on behalf of a patient shall begin as soon as reasonably possible after the application is received by the review board under subsection 26.5(1), and in any case within the period of time prescribed by regulation.

(French version)

Il est proposé que l'article 28 du projet de loi soit remplacé par ce qui suit:

Adjonction du paragraphe 26.6(1.1)
28 Il est ajouté, après le paragraphe 26.6(1), ce qui suit:

Début de l'audience
26.6(1.1) Le conseil de révision commence l'audition des requêtes qui lui sont présentées en vertu du paragraphe 26.5(1) par des malades ou en leur nom dès que possible, mais toujours au cours du délai fixé par règlement.

All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it. The amendment to the motion is passed.

Clause 28 as amended—(pass); Clause 29—(pass); Clause 30—(pass). Shall Clause 31 pass?

Mr. Orchard: Mr. Chairman, I have an amendment to Section 31. I would move in English and French

THAT section 31 of the Bill be amended by striking out the proposed clause 26.9(3)(j) and substituting the following:

> (j) the standards committee of a psychiatric facility, including a medical staff committee established for the purpose of studying or evaluating medical practice in a psychiatric facility; or

(French version)

Il est proposé que l'article 31 du projet de loi soit amendé par substitution, à l'alinéa 26.9(3)j), de ce qui suit:

> j) au comité des normes d'un centre psychiatrique, y compris un comité formé de membres du personnel médical mis sur pied pour étudier ou évaluer la pratique médicale dans un centre psychiatrique;

The amendment is proposed by, actually, Grace Hospital and the proposed wording contained in Bill 5, Clause (j) was an attempt to allow clinical records to be used in evaluating and monitoring the quality of care rendered in psychiatric facilities and in ensuring that appropriate standards are maintained with respect to services provided to psychiatric patients.

Unfortunately, the provision fails to do this because the standards committee of a general hospital is restricted under The Hospitals Act to medical practice only. Therefore, the proposed wording is offered as an alternative. This will enhance the opportunity for a patient appeal process.

Mr. Chairman: On the proposed amendment moved by the Honourable Mr. Orchard in English and French:

THAT section 31 of the Bill be amended by striking out the proposed clause 26.9(3)(j) and substituting the following:

> (j) the standards committee of a psychiatric facility, including a medical staff committee established for the purpose of studying or evaluating medical practice in a psychiatric facility; or

(French version)

Il est proposé que l'article 31 du projet de loi soit amendé par substitution, à l'alinéa 26.9(3)j), de ce qui suit:

> j) au comité des normes d'un centre psychiatrique, y compris un comité formé de membres du personnel médical mis sur pied pour étudier ou évaluer la pratique médicale dans un centre psychiatrique;

Shall the motion be passed? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it. The amendment is accordingly passed.

Clause 31 as amended—pass. Shall Clause 32 pass?

Mr. Orchard: Mr. Chairman, I have two amendments actually to Section 32. The first amendment that I would move in both English and French

THAT the proposed clause 26.9(3.1)(a), as set out in section 32 of the Bill, be amended by adding ", including its legal advisors and assistants," after "who receives it".

(French version)

Il est proposé que l'alinéa 26.9(3.1)a) énoncé à l'article 32 du projet de loi soit amendé par adjonction, après "qui les reçoit", de ", y compris ses conseillers juridiques et leurs aides,".

The intent here is to protect further the confidentiality of medical records which may well be made available to disciplinary committees in hearing patient complaints against inappropriate service delivery or malpractice or review of medical practice.

This further extends the confidentiality or the protection for confidentiality of those records, not only to those professional members on the review and disciplinary committee but to their assistants and advisers who may well, in the course of the review of the disciplinary hearing, have access to those records and files. It extends the protection of patient confidentiality.

Mr. Chairman: On the proposed amendment moved by the Honourable Mr. Orchard with respect to English and French

THAT the proposed clause 26.9(3.1)(a), as set out in section 32 of the Bill, be amended by adding ", including its legal advisors and assistants," after "who receives it".

(French version)

Il est proposé que l'alinéa 26.9(3.1)a) énoncé à l'article 32 du projet de loi soit amendé par adjonction, après "qui les recoit", de ", y compris ses conseillers juridiques et leurs aides,".

Shall the motion be passed—pass.

Mr. Orchard: Mr. Chairman, I have a further amendment to Section 32 and I would move, both in English and French

THAT the proposed subclause 26.9(3.1)(b)(iii) as set out in section 32 of the Bill, be amended by striking out "sealed in a separate file and stored in a safe place" and substituting "returned forthwith to the medical officer in charge".

(French version)

Il est proposé que le sous-alinéa 26.9(3.1)b)(iii) énoncé à l'article 32 du projet de loi soit amendé par substitution, à "scellé dans un dossier distinct et conservé en lieu sûr, à la fin des procédures", de "retourné à l'administrateur médical responsable dés la fin des procédures".

What this amendment is proposed to do is to compel, after a disciplinary hearing, the return of those confidential patient files back to the psychiatric facility from whence they originated. That, I think, one could appreciate, further strengthens the confidentiality of those records.

Mr. Cheema: Mr. Chairperson, I just want the minister to clarify that it should be probably to a medical officer in charge of the facility rather than just this very vague—I think it should be there, too—of their particular facility.

Mr. Orchard: Mr. Chairman, I think we are covered on it, in terms that the medical officer in charge is specified and attached to the given facility.

Mr. Chairman: On the proposed amendment, moved by the Honourable Mr. Orchard, in English and in French:

THAT the proposed subclause 26.9(3.1)(b)(iii), as set out in section 32 of the Bill, be amended by striking out "sealed in a separate file and stored in a safe place" and substituting "returned forthwith to the medical officer in charge".

(French version)

Il est proposé que le sous-alinéa 26.9(3.1)b)(iii) énoncé à l'article 32 du projet de loi soit amendé par substitution, à "scellé dans un dossier distinct et conservé en lieu sûr, à la fin des procédures", de "retourné à l'administrateur médical responsable dés la fin des procédures".

Shall the amendment be passed? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it.

Clause 32 as amended—pass; Clause 33-pass; Clause 34—pass.

Shall Clause 35 through 38 pass? Shall Clause 35 pass?

* (0250)

Some Honourable Members: Yes.

Mr. Chairman: Shall Clause 36 pass?

Some Honourable Members: Yes.

Mr. Chairman: Shall Clause 37 pass?

Ms. Wasylycia-Leis: I would like to move, in both English and French

THAT section 37 of the Bill be struck out and the following substituted:

Clause 26.10(1)(b) amended

37 Clause 26.10(1)(b) is amended

(a) by striking out subclause (iii) and substituting the following:

(iii) to communicate with the Public Trustee if the Public Trustee is committee of the patient,

(b) by adding the following after subclause (iv):

(v) to religious freedom and practice,

(vi) to wear his or her own clothes, to keep and use his or her own personal possessions including his or her own toilet articles,

(vii) to keep money in his or her possession and spend reasonable sums for canteen expenses and small purchases,

(viii) to have access to individual storage space for his or her private use,

(ix) to have visitors each day,

(x) to have reasonable access to a telephone, to make and receive confidential calls or to have calls made for him or her.

(French version)

Il est proposé de remplacer l'article 37 du projet de loi par ce qui suit:

Modification de l'alinéa 26.10(1)b)
37 L'alinéa 26.10(1)b) est modifié:

a) par substitution, au sous-alinéa (iii), de ce qui suit:

"(iii) de communiquer avec le curateur public si celui-ci est le curateur du malade,"

b) par adjonction, après le sous-alinéa (iv), de ce qui suit:

(v) de pratiquer la religion de son choix,

(vi) de porter ses propres vêtements, de garder et d'utiliser ses effets personnels, y compris ses articles de toilette,

(vii) de garder de l'argent en sa possession et de débourser des sommes raisonnables afin de couvrir ses frais de cantine et ses achats mineurs,

(viii) d'avoir accès à un lieu d'entreposage individuel affecté à son usage personnel,

(ix) de recevoir des visiteurs tous les jours,

(x) d'avoir accès, de façon raisonnable à un téléphone, de faire et de recevoir des appels confidentiels ou de faire faire des appels.

Mr. Orchard: Mr. Chairman, I appreciate the intent my honourable friend has in bringing forward these additional amendments, but with few exceptions those privileges or opportunities as proposed in the amendment are available right now and have been for a number of years within the facilities. The caution that has been passed on to me in terms of the clothing item—there might be some personal endangerment of leaving an individual with a belt or a necktie, so that by enshrining that in legislation you might run into circumstances where unfortunate events might ensue with the individual if they were equipped with a belt with which to potentially hang themselves, to put it bluntly. Although I do not like discussing those issues, they from time to time do happen.

Given that, for instance, with a growing cultural mosaic in Manitoba, one might reasonably add as a legislative amendment, language provisions, and I think the list could be quite exhaustive before we are finished.

I think as much as possible all of these provisions are made available to individuals who are within our psychiatric care facilities. It is not as if we run 19th Century mental health facilities where a person is manacled and subdued to severe and brutal and unusual treatment, as may have been the case 100 years ago. Most of our psychiatric facilities are there with caring professionals who provide these, plus a number of other privileges to the patients, as long as they are resident in the facility.

Although the intent has all the wholesome good intent of having one's heart in the right place, there are some concerns, as I expressed, in terms of the clothing aspect, and a range of personal possessions. For instance, there are faiths as part of our multicultural community that have, as part of their ceremonial dress, kirpans and I do not know whether my honourable friend would suggest that as a personal possession, one ought to retain that, as a committed patient in a psychiatric facility.

I simply, in making some of these brief comments—those are only just the first-blush observations that I would make to my honourable friend. I think my honourable friend maybe ought to consider her own caution earlier on that some of the amendments we make at five to three in the morning, we may end up regretting later on, and this may well be one of them. I would decline support of this amendment even though I know my honourable friend's heart is in the right place and the intent is there.

Ms. Wasylycia-Leis: Mr. Chairperson, in response to the minister, I think it would be fairly accurate to say that he is being fairly nitpicky about this proposal. It is clear that in terms of possessions available under this provision to an individual, certain precautions can be taken and requirements put in place to deal with the kind of situation that the minister refers to. He also makes the point that many of these rights are now afforded to individuals in our psychiatric facilities.

I think, as was mentioned over and over again this evening when this question was put to individual presenters and organizations, although some of these rights may now be established in other legislation or provided through practice and tradition, it is certainly useful to clarify their application to patients in a psychiatric facility and to ensure that patients are informed of them.

So, Mr. Chairperson, I am pleased to present this amendment. I am pleased that it was raised this evening, and I hope that it is taken seriously.

Mr. Orchard: Mr. Chairman, I realize, for instance, the one point I recall very vividly tonight of access to a private phone, absolutely no question, and I would venture to say that should the individual have required that access, the phone would have been granted.

My honourable friend would probably appreciate that some individuals who are patients in psychiatric facilities might possibly have a difficulty in that they use the telephone to harass family members or other individuals and, by granting access to a phone by legislation, one might in fact exacerbate individual's problems in the community.

For instance, some individuals are committed for psychiatric treatment because of religious delusions, and exposure to religious freedom as expressed here may be detrimental to their care and their rehabilitation.

Indeed, some visitors may be unwelcome to the patients and, under this legislation, would be able to point to this and say, well, you know we have a right to visit.

What I am trying to say to my honourable friend as she shakes her head is that when you put these provisions in legislation, then you cannot, where necessary, make an exception, because you contravene a law. That is why from time to time it is much better to have these privileges as part of the staff management of patients so that they can make the individual decisions which vary significantly in the examples I have already given to my honourable friend.

Enshrining it in law means that you cannot, for instance, prevent an individual from placing harassing phone calls. You may not be able to prevent a suicidal individual from hanging themselves with their own belt. You may not be able to present a person suffering from religious delusions, to take them away from the religion that is causing the delusions under the freedom of religion aspect. You may run into a difficulty with, for instance, a patient whose ceremonial dress, as I indicated, is a kirpan and may endanger other patients.

So that there are many issues and, I think my honourable friend would have to indicate that with the careful consideration, these ought not to be enshrined in legislation but ought to become policy of the individual and respective psychiatric facilities. I am told by staff who have been in the care delivery field of mental health services for many, many years that in fact these privileges are already there for patients who will use them.

Mr. Chairman: On the proposed amendment moved by the honourable member for St. Johns (Ms. Wasylycia-Leis) with respect to English and French,

THAT section 37 in the bill be struck out and the following substituted:

Clause 26.20(1)(b) amended

37 Clause 26.10(1)(b) is amended:

(a) by striking out subclause (iii) and substituting the following:

(iii) to communicate with the Public Trustee if the Public Trustee is committee of the patient,

(b) by adding the following after subclause (iv):

(v) to religious freedom and practice,

(vi) to wear his or her own clothes, to keep and use his or her own personal possessions including his or her own toilet articles,

(vii) to keep money in his or her possession and spend reasonable sums for canteen expenses and small purchases,

(viii) to have access to individual storage space for his or her private use,

(ix) to have visitors each day,

(x) to have reasonable access to a telephone, to make and receive confidential calls or to have calls made for him or her.

* (0300)

(French version)

Il est proposé de remplacer l'article 37 du projet de loi parce qui suit:

Modification de l'alinéa 26.10(1)b)
37 L'alinéa 26.10(1)b) est modifié:

a) par substitution, au sous-alinéa (iii), de ce qui suit:

(iii) de communiquer avec le curateur public si celui-ci est le curateur du malade,"

b) par adjonction, après le sous-alinéa (iv), de ce qui suit:

(v) de pratiquer la religion de son choix,

(vi) de porter ses propres vêtements, de garder et d'utiliser ses effets personnels, y compris ses articles de toilette,

(vii) de garder de l'argent en sa possession et de débourser des sommes raisonnables afin de couvrir ses frais de cantine et ses achats mineurs,

(viii) d'avoir accès à un lieu d'entreposage individuel affecté à son usage personnel,

(ix) de recevoir des visiteurs tous les jours,

(x) d'avoir accès, de façon raisonnable à un téléphone, de f11re et de recevoir des appels confidentiels ou de faire faire des appels.

Shall the amendment pass? All in favour, say yea. All opposed, say nay. In my opinion, the Nays have it. The motion is defeated.

Clause 37—pass; Clause 38—pass; Clause 39—pass; Clause 40—pass.

Mr. Orchard: Mr. Chairman, I wish to move an amendment in both English and French

THAT subsection 26.12(2), as set out in section 41 of the Bill, be amended by striking out "subsection 80(1.1)" and substituting "subsection 80(1.2)".

(French version)

Il est proposé que le paragraphe 26.12(2) énoncé à l'article 41 du projet de loi soit amendé par substitution, à "paragraphe 80(1.1)", de "paragraphe 80(1.2)".

This was a cross-referencing error in the bill and merely corrects and properly identifies the subsection number.

Mr. Chairman: On the proposed motion put forth by the Honourable Minister of Health (Mr. Orchard), in respect to English and French

THAT subsection 26.12(2), as set out in section 41 of the Bill, be amended by striking out "subsection 80(1.1)" and substituting "subsection 80(1.2)".

(French version)

Il est proposé que le paragraphe 26.12(2) énoncé à l'article 41 du projet de loi soit amendé par substitution, à "paragraphe 80(1.1)", de "paragraphe 80(1.2)".

Shall the motion pass? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it. The motion is passed.

Shall Clause 41 as amended pass?

Ms. Wasylycia-Leis: I have a further amendment on Clause 41. I move in both English and French

THAT the proposed subsection 26.12(2) of the Act, as set out in section 41 of the Bill, be amended by striking out "Upon" and substituting "Subject to subsection (2.1), upon".

AND THAT the following be added after subsection 26.12(2):

Public Trustee not to consent to treatment
26.12(2.1) Where the Public Trustee receives an order of supervision of a person under this section, he or she shall not under the order of supervision consent

(a) to admit the person to a psychiatric facility; or

(b) to the person receiving psychiatric treatment in a psychiatric facility.

(French version)

Il est proposé que le paragraphe 26.12(2) de la Loi, énoncé à l'article 41 du projet de loi, soit amendé par substitution, à "Sur", de "Sous réserve du paragraphe (2.1), sur".

Il est proposé qu'il soit ajouté, après le paragraphe 26.12(2), ce qui suit:

Interdiction
26.12(2.1) Lorsqu'il reçoit un ordre de surveillance à l'égard d'une personne en vertu du présent article, le curateur public ne peut envertu de l'ordre de surveillance consentir:

a) à l'admission de la personne dans un centre psychiatrique;

b) à ce que la personne reçoive un traitement psychiatrique dans un centre psychiatrique.

To briefly describe this amendment, the members may recall that in our deliberations tonight, considerations and concerns were raised with respect to the role of the Public Trustee. This is an attempt to amend Bill 5 to ensure that there are limitations in terms of that role. It is consistent with some of the recommendations made, and I believe that it is both in order and widely supported by those involved in this field.

Mr. Orchard: In Section 45 of the bill we are proposing amendments which clarify the Public Trustee's powers. I am informed by legislative counsel that the intent is accomplished in the amendment I will propose on Section 45, and the language is possibly more appropriate in my amendment and, with all due respect, they accomplish the same thing. If I could beg my honourable friend's indulgence to withdraw this amendment, we will pass the amendment in Section 45 of the bill which accomplishes the same purpose.

Ms. Wasylycia-Leis: With the understanding that my amendment be resubmitted if I do not find this issue addressed in the minister's amendment.

Mr. Orchard: Mr. Chairman, if my honourable friend was to be confronted with that circumstance, she could propose her amendment at third reading.

Mr. Chairman: Is there leave to have the member withdraw her amendment?

Ms. Wasylycia-Leis: With that proviso.

Point of Order

Ms. Wasylycia-Leis: On a point of order, I had made a suggestion to the Chair, notwithstanding the minister's comments. I am assuming that, unless the minister wants to give us a description before I withdraw my amendment, I would be happy to withdraw it at this point and resubmit it if I felt it had not been addressed in the amendment.

Mr. Orchard: I think my honourable friend has the amendment to Section 45 as part of the package that I gave to her earlier this evening. All I can indicate to my honourable friend, not having the advantage of being trained in the law, that legal counsel indicates to me that the intent of the amendment I am proposing is the same as what my honourable friend is proposing, but the language has been crafted appropriately. I indicate to my honourable friend if she finds that my amendment does not meet, as I have indicated from legal counsel, the purpose that she is proposing, she has the opportunity to propose the amendment at third reading in the House.

Ms. Wasylycia-Leis: Given that statement on the part of the minister, I would like to keep my amendment and have it voted on at this point.

* * *

Mr. Chairman: On the proposed motion moved by Ms. Wasylycia-Leis, in respect to English and French

THAT the proposed subsection 26.12(2) of the Act, as set out in section 41 of the Bill, be amended by striking out "Upon" and substituting "Subject to subsection (2.1), upon".

AND THAT the following be added after subsection 26.12(2):

Public Trustee not to consent to treatment

26.12(2.1) Where the Public Trustee receives an order of supervision of a person under this section, he or she shall not under the order of supervision consent

(a) to admit the person to a psychiatric facility; or

(b) to the person receiving psychiatric treatment in a psychiatric facility.

(French version)

Il est proposé que le paragraphe 26.12(2) de la Loi, énoncé à l,article 41 du projet de loi, soit amendé par substitution, à "Sur", de "Sous réserve du paragraphe (2.1), sur".

Il est proposé qu'il soit ajouté, après le paragraphe 26.12(2), ce qui suit:

Interdiction

26.12(2.1) Lorsqu'il reçoit un ordre de surveillance à l'égard d'une personne en vertu du présent article, le curateur public ne peut consentir en vertu de l'ordre de surveillance:

a) à l'admission de la personne dans un centre psychiatrique;

b) à ce que la personne reçoive un traitement psychiatrique dans un centre psychiatrique.

Shall the amendment pass? All in favour, say yea. All opposed, say nay. In my opinion, the Nays have it. The amendment is defeated.

Clause 41 as amended—pass; Clause 42—pass; Clause 43—pass; Clause 44—pass. Clause 45.

Mr. Orchard: I would like to propose an amendment to section 45 of the Bill. I move both in English and French

THAT the proposed subsections 80(1.2), (1.3) and (1.4), as set out in section 45 of the Bill, be struck out and the following substituted:

Other powers of Public Trustee

80(1.2) When the Public Trustee is the committee of a person described in clause (1)(b), (c) or (d), the Public Trustee may

(a) determine where and with whom the person shall live either temporarily or permanently;

(b) commence, compromise or settle any legal proceeding that does not relate to the estate of the person; and

(c) consent to medical or psychiatric treatment or health care on the person's behalf if

(i) a physician informs the Public Trustee that the person is not mentally competent to make treatment decisions given the criteria set out in subsection 24(3); and

(ii) the person is not a patient in a psychiatric facility.

When Public Trustee is nearest relative

80(1.3) For greater certainty, nothing in clause (1.2)(c) affects the right of the Public Trustee to make treatment decisions on behalf of a patient under Part I in circumstances where the Public Trustee is the patient's nearest relative.

Limitation on Public Trustee's powers

80(1.4) The Public Trustee shall,

(a) when exercising any power conferred by subsection (1.2), consult with the person's nearest relative when reasonably possible; and

(b) when exercising the power conferred by clause (1.2)(c), do so in accordance with the best interests of the person having regard to the principles and the criteria described in subsections 24.1(3) and (4).

Consent

80(1.5) The Public Trustee may only place a person pursuant to clause (1.2)(a) with a person who consents to the placement and the person may on reasonable notice to the Public Trustee withdraw his or her consent and the Public Trustee shall then make a new determination under clause (1.2)(a).

(French version)

Il est proposé que les paragraphes 80(1.2), (1.3) et (1.4) énoncés à l'article 45 du projet de loi soient remplacés par ce qui suit:

Autres pouvoirs du curateur public

80(1.2) Lorsqu'il devient le curatueur d'une personne visée à l'alinéa (1)b), c) ou d), le curateur public peut:

a) déterminer où et avec qui la personne doit habiter, que ce soit de façon temporaire ou permanente;

b) intenter ou régler des procèdures judiciaires qui n'ont pas trait aux biens de la personne ou encore faire des transactions à leur égard;

c) consentir au traitement médical ou psychiatrique ou aux soins médicaux au nom de la personne

(i) si un médecin l'informe que la personne n'a pas la capacité mentale de prendre des décisions liées au traitement, compte tenu des critères prévus au paragraphe 24(3);

(ii) si la personne n'est pas traitée dans un centre psychiatrique.

Plus proche parent

80(1.3) L'alinéa (1.2)c) n'a pas pour effet de porter atteinte au droit du curateur public de prendre, en application de la partie I, des décisions liées au traitement au nom d'un malade, même s'il est le plus proche parent du malade.

Limitation des pouvoirs du curateur public

80(1.4) Le curateur public

a) consulte, dans l'exercice des pouvoirs que lui confère le paragraphe (1.2), le plus proche parent de la personne, dans la mesure du possible;

b) exerce les pouvoirs que lui confère l'alinèa (1.2)c) au mieux des intérêts de la personne en tenant compte des principes et des critères prévus aux paragraphes 24.1(3) et (4).

Consentement

80(1.5) Le curateur public peut, en application de l'alinéa (1.2)a), placer une personne uniquement auprès de quelqu'un qui y consent. Ce consentement peut, après remise d'un avis suffisant au curateur public, être retiré. Dans ce cas, le curateur public procède à une nouvelle détermination en application de l'alinéa (1.2)a).

Earlier this evening, it was argued that those individuals under an order of supervision who are residing in the community and the Public Trustee is consenting to their health care that firstly, the Public Trustee should consent with the individual's nearest relatives and secondly, the Public Trustee should adhere to the best-interests criteria when making a decision.

That is addressed in subsection 80(l.4). It was the reference I made—

Mr. Chairman: If I could just interrupt for one moment. There is a typing error on the section consent, the second last word is "Public Trustee."

Mr. Orchard: How do we correct a typing error, Mr. Chairman?

* (0310)

Mr. Chairman: Is there leave to correct it?

An Honourable Member: Leave.

Mr. Chairman: Leave. So we will just correct it here.

Mr. Orchard: Mr. Chairman, as I indicated, there were concerns expressed earlier on, and the Public Trustee is compelled with this amendment to first of all consult and then to act in the best interests. I think the best-interests criteria would mitigate against in probably most, if not all, circumstances, the circumstances of the abuser's nearest relative having opportunity to consent for care, which was objected to by presenters this evening.

Mr. Chairman: On the proposed motion of the honourable—

Ms. Wasylycia-Leis: Just a question, I would like to know where in this proposal the minister feels he is addressing the issue of ensuring—of addressing the intent of my motion for the Public Trustee not to consent to admit anyone to a psychiatric facility, or consent to psychiatric care in a hospital. I am just not sure if that is covered or where it is covered.

Mr. Orchard: Mr. Chairman, I will let a representative from the Public Trustee's office clarify that for my honourable friend.

Mr. Chairman: What is your name?

Ms. Joanna Knowlton (Counsel to The Public Trustee, Department of Justice): Joanna Knowlton.

Mr. Chairman: Joanna Knowlton. Does Ms. Joanna Knowlton have leave to address the committee?

Some Honourable Members: Leave.

Mr. Chairman: Leave. Joanna Knowlton, please.

Ms. Knowlton: The issue of the Public Trustee consenting to placement in a psychiatric facility where there is an order of supervision is certainly one that we recognize as being a problem and are prepared to deal with on an administrative basis, by instructing that anybody who has capacity in the office to give consent will not give consent to that kind of placement, that it will not be done under an order of supervision.

Mr. Chairman: On the proposed motion moved by the Honourable Mr. Orchard in respect to English and French

THAT the proposed subsections 80(1.2), (l.3) and (1.4), as set out in section 45, the Bill, be struck out and the following substituted:

Other powers of Public Trustee

80(1.2) When the Public Trustee is the committee of a person described in clause (1)(b), (c) or (d), the Public Trustee may

(a) determine where and with whom the person shall live either temporarily or permanently;

(b) commence, compromise or settle any legal proceeding that does not relate to the estate of the person; and

(c) consent to medical or psychiatric treatment or health care on the person's behalf if

(i) a physician informs the Public Trustee that the person is not mentally competent to make treatment decisions given the criteria set out in subsection 24(3); and

(ii) the person is not a patient in a psychiatric facility.

When Public Trustee is nearest relative

80(1.3) For greater certainty, nothing in clause (1.2)(c) affects the right of the Public Trustee to make treatment decisions on behalf of a patient under Part I in circumstances where the Public Trustee is the patient's nearest relative.

Limitation on Public Trustee's powers

80(1.4) The Public Trustee shall,

(a) when exercising any power conferred by subsection (1.2), consult with the person's nearest relative when reasonably possible; and

(b) when exercising the power conferred by clause (1.2)(c), do so in accordance with the best interests of the person having regard to the principles and the criteria described in subsections 24.1(3) and (4).

Consent

80(1.5) The Public Trustee may only place a person pursuant to clause (1.2)(a) with a person who consents to the placement and the person may on reasonable notice to the Public Trustee withdraw his or her consent and the Public Trustee shall then make a new determination under clause (1.2)(a).

(French version)

Il est proposé que les paragraphes 80(1.2), (1.3) et (1.4) énoncés à l'article 45 du projet de loi soient remplacés par ce qui suit:

Autres pouvoirs du curateur public
80(1.2) Lorsqu'il devient le curateur d'une personne visée à l'alinéa (1)b), c) ou d), le curateur public peut:

a) déterminer où et avec qui la personne doit habiter, que ce soit de façon temporaire ou permanente;

b) intenter ou régler des procédures judiciaires qui n'ont pas trait aux biens de la personne ou encore faire des transactions à leur égard;

c) consentir au traitement médical ou psychiatrique ou aux soins médicaux au nom de la personne

(i) si un médecin l'informe que la personne n'a pas la capacité mentale de prendre des décisions liées au traitement, compte tenu des critères prévus au paragraphe 24(3);

(ii) si la personne n'est pas traitée dans un centre psychiatrique.

Plus proche parent
80(1.3)L'alinéa (1.2)c) n'a pas pour effet de porter atteinte au droit du curateur public de prendre, en application de la partie I, des décisions liées au traitement au nom d'un malade, même s'il est le plus proche parent du malade.

Limitation des pouvoirs du curateur public
80(1.4) Le curateur public

a) consulte, dans l'exercice des pouvoirs que lui confère le paragraphe (1.2), le plus proche parent de la personne, dans la mesure du possible;

b) exerce les pouvoirs que lui confère l'alinéa (1.2)c) au mieux des intérêts de la personne en tenant compte des principes et des critères prévus aux paragraphes 24.1(3) et (4).

Consentement
80(1.5) Le curateur public peut, en application de l'alinéa (1.2)a), placer une personne uniquement auprès de quelqu'un qui y consent. Ce consentement peut, après remise d'un avis suffisant au curateur public, être retiré. Dans ce cas, le curateur public procède à une nouvelle détermination en application de l'alinéa (1.2)a).

Shall the amendment pass? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it. The motion is accordingly passed.

Clause 45 as amended—pass; Clause 46—pass; Clause 47—pass; Clause 48.

Mr. Orchard: Mr. Chairman, I have an amendment to Clause 48 of the bill, and I would like to move both in English and in French

THAT the proposed section 106, as set out in section 48 of the Bill, be amended by renumbering clauses (h), (i), and (j) as clauses (i), (j) and (k) and by adding the following as clause (h):

(h) for the purpose of subsection of 26.6(1.1), prescribing the period of time within which a hearing of the review board shall begin;

(French version)

Il est proposé que l'article 106 énoncé à l'article 48 du projet de loi soit amendé par substitution, aux actuelles désignations d'alinéa h), i) et j), des désignations i), j) et k) et par adjonction, après l'alinéa g), de ce qui suit:

h) fixer, pour l'application du paragraphe 26.6(1.1), le délai au cours duquel doivent débuter les auditions du conseil de révision;

This is the initial 21 days that I will pass by regulation effective September 1st as proclamation of this legislation. With advice from senior staff, in terms of recent meetings with chairs of the review panels, who expect to be able to amend or rescind that regulation, specifying 21 days and replace it with 14 days this calendar year—this additional clause in the ability to craft regulations will empower me to do that.

Mr. Chairman: On the proposed amendment moved by the Honourable Mr. Orchard, with respect to English and French:

THAT the proposed section 106, as set out in section 48 of the Bill, be amended by renumbering clauses (h),(i), and (j) as clauses (i), (j) and (k) and by adding the following as clause (h):

(h) for the purpose of subsection of 26.6(1.1), prescribing the period of time within which a hearing of the review board shall begin;

(French version)

Il est proposé que l'article 106 énoncé à l'article 48 du projet de loi soit amendé par substitution, aux actuelles désignations d'alinéa h), i) et j), des désignations i), j) et k) et par adjonction, après l'alinéa g), de ce qui suit:

> h) fixer, pour l'application du paragraphe 26.6(1.1), le délai au cours duquel doivent débuter les auditions du conseil de révision;

Shall the amendment pass? All in favour, say yea. All opposed, say nay. In my opinion, the Yeas have it.

Clause 48 as amended—pass; Clause 49—pass; Preamble—pass; Title—pass; Bill as amended—pass.

Is it the will of the committee that I report the bill as amended? Agreed.

The time being after 3 a.m., what is the will of the committee?

Mr. Orchard: Mr. Chairman, might I thank those individuals with perseverance and patience of sticking around until 3:20, and particularly thank you to all the staff who were here tonight both from my ministry, from the Public Trustee's office, from legal counsel, Hansard staff and staff of the House.

This has been a long evening, but I think the conclusion of the evening is that we have offered to Manitobans improvements in The Mental Health Act to better serve their mental health needs with the passage of this bill. I thank the honourable members for their co-operation and would move that committee rise.

Mr. Chairman: Committee rise.

COMMITTEE ROSE AT: 3:18 a.m.