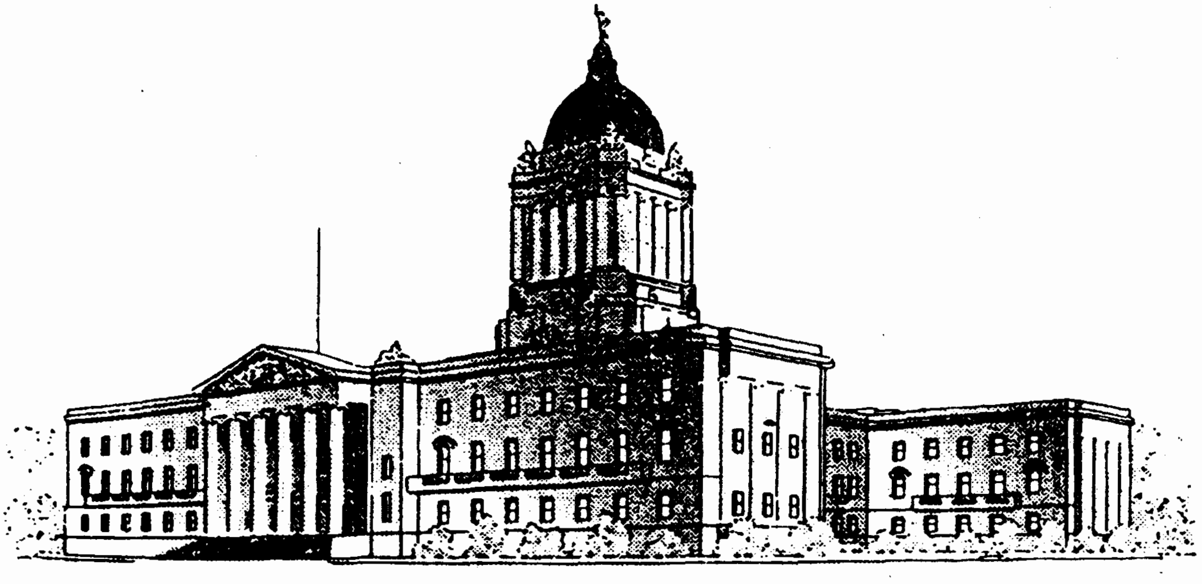
Fourth Session - Thirty-Sixth Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Law Amendments

Chairperson
Mr. Jack Penner
Constituency of Emerson



Vol. XLVIII No. 6 - 9:30 a.m., Friday, June 19, 1998

ISSN 0713-9586

MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Sixth Legislature

Member	Constituency	Political Affiliation
ASHTON, Steve	Thompson	N.D.P.
BARRETT, Becky	Wellington	N.D.P.
CERILLI, Marianne	Radisson	N.D.P.
CHOMIAK, Dave	Kildonan	N.D.P.
CUMMINGS, Glen, Hon.	Ste. Rose	P.C.
DACQUAY, Louise, Hon.	Seine River	P.C.
DERKACH, Leonard, Hon.	Roblin-Russell	P.C.
DEWAR, Gregory	Selkirk	N.D.P.
DOER, Gary	Concordia	N.D.P.
DOWNEY, James, Hon.	Arthur-Virden	P.C.
DRIEDGER, Albert	Steinbach	P.C.
DRIEDGER, Myrna	Charleswood	P.C.
DYCK, Peter	Pembina	P.C.
ENNS, Harry, Hon.	Lakeside	P.C.
EVANS, Clif	Interlake	N.D.P.
EVANS, Leonard S.	Brandon East	N.D.P.
FAURSCHOU, David	Portage la Prairie	P.C.
FILMON, Gary, Hon.	Tuxedo	P.C.
FINDLAY, Glen, Hon.	Springfield	P.C.
FRIESEN, Jean	Wolseley	N.D.P.
GAUDRY, Neil	St. Boniface	Lib.
GILLESHAMMER, Harold, Hon.	Minnedosa	P.C.
HELWER, Edward	Gimli	P.C.
HICKES, George	Point Douglas	N.D.P.
JENNISSEN, Gerard	Flin Flon	N.D.P.
KOWALSKI, Gary	The Maples	Lib.
LAMOUREUX, Kevin	Inkster	Lib.
LATHLIN, Oscar	The Pas	N.D.P.
LAURENDEAU, Marcel	St. Norbert	P.C.
MACKINTOSH, Gord	St. Johns	N.D.P.
MALOWAY, Jim	Elmwood	N.D.P.
MARTINDALE, Doug	Burrows	N.D.P.
McALPINE, Gerry	Sturgeon Creek	P.C.
McCRAE, James, Hon.	Brandon West	P.C.
McGIFFORD, Diane	Osborne	N.D.P.
McINTOSH, Linda, Hon.	Assiniboia	P.C.
MIHYCHUK, MaryAnn	St. James	N.D.P.
MITCHELSON, Bonnie, Hon.	River East	P.C.
NEWMAN, David, Hon.	Riel	P.C.
PENNER, Jack	Emerson	P.C.
PITURA, Frank, Hon.	Morris	P.C.
PRAZNIK, Darren, Hon.	Lac du Bonnet	P.C.
RADCLIFFE, Mike, Hon.	River Heights	P.C.
REID, Daryl	Transcona	N.D.P.
REIMER, Jack, Hon.	Niakwa	P.C.
RENDER, Shirley	St. Vital	P.C.
ROBINSON, Eric	Rupertsland	N.D.P.
ROCAN, Denis	Gladstone	P.C.
SALE, Tim	Crescentwood	N.D.P.
SANTOS, Conrad	Broadway	N.D.P.
STEFANSON, Eric, Hon.	Kirkfield Park	P.C.
STRUTHERS, Stan	Dauphin	N.D.P.
SVEINSON, Ben	La Verendrye	P.C.
TOEWS, Vic, Hon.	Rossmere	P.C.
TWEED, Mervin	Turtle Mountain	P.C.
VODREY, Rosemary, Hon.	Fort Garry	P.C.
WOWCHUK, Rosann	Swan River	N.D.P.

LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON LAW AMENDMENTS

Friday, June 19, 1998

TIME – 9:30 a.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Jack Penner (Emerson)

VICE-CHAIRPERSON – Mr. Mervin Tweed (Turtle Mountain)

ATTENDANCE - 10 – QUORUM - 6

Members of the Committee present:

Hon. Messrs. Pitura, Praznik, Radcliffe

Mr. Chomiak, Mrs. Driedger, Ms. McGifford, Mr. Penner, Mrs. Render, Messrs. Sale, Tweed

APPEARING:

Mr. Gary Kowalski, MLA for The Maples

WITNESSES:

Bill 30–The Pharmaceutical Amendment Act

Mr. Stuart Wilcox, The Manitoba Pharmaceutical Association

Bill 31–The Regulated Health Professions Statutes Amendment Act

Mr. David M. Sanders, Private Citizen

Bill 35–The Mental Health and Consequential Amendments Act

Mr. Ken Melnyk, Private Citizen
Ms. Carlyn Mackey, Families Advocating Timely and Appropriate Care and Treatment for Serious Mental Disorders
Ms. Dorothy Weldon, Private Citizen
Ms. Connie Krohn, Private Citizen
Ms. Colleen Cawood, Private Citizen
Ms. Theresa Wayne, Private Citizen
Ms. Maureen Koblun, Private Citizen
Ms. Susan Olson, Private Citizen
Ms. Patricia McInnis, Private Citizen
Ms. Mary Ann Haddad, Private Citizen
Ms. Joan Joyce Podolas, Private Citizen
Mr. Bruce Waldie, Private Citizen
Ms. Joan Thorogood, Private Citizen (read by Mr. Bill Martin, Canadian Mental Health Association - Manitoba Division)
Ms. Beverley Goodwin, Private Citizen
Ms. Louise Smendziuk, Private Citizen
Ms. Katherine Davis, Private Citizen
Ms. Beverley Hawkins, Private Citizen
Mr. Victor Dyck, Private Citizen
Mr. Yude Henteleff, Private Citizen
Mr. Chris Summerville, Manitoba Schizophrenia Society (read by Mr. Horst Peters, Private Citizen)
Mr. Horst Peters, Private Citizen
Mr. Bill Ashdown, Society for Depression & Manic Depression of Manitoba
Mr. Uwe Osterwald, Private Citizen
Mr. Harry Wolbert, Private Citizen
Ms. Ruth McCutcheon, Private Citizen
Mr. Gordon Nicolson, Private Citizen
Mr. Bill Martin, Canadian Mental Health Association, Manitoba Division
Mr. Rod Lauder, Canadian Mental Health Association, Winnipeg Branch
Ms. Lucie Pearase, Private Citizen
Mr. Murray Waldie, Private Citizen
Mrs. Ellen Waldie, Private Citizen
Mr. Mark Waldie, Private Citizen

Bill 57–The Regional Health Authorities Amendment Act

Mr. Gervin Greasley, The Arbitration and Mediation Institute of Manitoba

WRITTEN SUBMISSIONS:

Bill 35–The Mental Health and Consequential Amendments Act

Ms. Phyllis Wayne, Private Citizen

Ms. Darlene Dreilich, Community Coalition on Mental Health
Mrs. Barbara Gommerman, Private Citizen
Ms. Marion Josie Palamar, Private Citizen
Mrs. Dyla McGregor, Private Citizen
Ms. Yvonne Bloomer, Canadian Mental Health Association, Thompson Region
Ms. Kris Cummings, Private Citizen
Mr. Armand Manaigre, Private Citizen
Ms. Mabel Osborne, Private Citizen
Mr. Gerald M. Henry, Private Citizen
Ms. Bernice Henry, Private Citizen
Ms. Lillian Keam, Private Citizen
Ms. Angela Blacksmith, Private Citizen
Mr. James G. MacInnis, Private Citizen
Mr. Walter Labanowich, Private Citizen
Mr. Leonard Crait, Private Citizen

MATTERS UNDER DISCUSSION:

Bill 13–The Prescription Drugs Cost Assistance Amendment Act
Bill 20–The Medical Amendment Act
Bill 30–The Pharmaceutical Amendment Act
Bill 31–The Regulated Health Professions Statutes Amendment Act
Bill 35–The Mental Health and Consequential Amendments Act
Bill 52–The Health Services Insurance Amendment Act
Bill 57–The Regional Health Authorities Amendment Act

***

Mr. Chairperson: Would the Standing Committee on Law Amendments please come to order. The first order of business that we have to conduct today is electing a Vice-Chairperson. Are there any nominations for a Vice-Chair?

Mrs. Shirley Render (St. Vital): Mr. Chairman, I would like to nominate the member for Turtle Mountain (Mr. Tweed) as Vice-Chair.

Mr. Chairperson: The member for Turtle Mountain has been nominated. Any further nominations? Seeing none, I declare the member for Turtle Mountain, Merv Tweed, elected as Vice-Chair.

This morning, the committee will be considering the following bills: Bill 13, The Prescription Drugs Cost Assistance Amendment Act; Bill 20, The Medical Amendment Act; Bill 30, The Pharmaceutical Amendment Act; Bill 31, The Regulated Health Professions Statutes Amendment Act; Bill 35, The Mental Health and Consequential Amendments Act; Bill 52, The Health Services Insurance Amendment Act; and Bill 57, The Regional Health Authorities Amendment Act.

We have presenters who have registered to make public presentations on Bills 30, 31, 35 and 57. It is normally our custom to have presentations before considerations of the bill. Is it the will of the committee to hear the public presentations on all the bills first? [agreed]

I will read the names of the people who have registered. I would like to ask for one consideration in that we have one presenter for Bills 30, 31 and 57, and I am wondering whether we could hear those three presenters first before we enter into discussions on Bill 35. There are quite a list of presenters.

So I will read the list of names of the presenters. Stuart Wilcox or Ronald Guse, Bill 30, The Manitoba Pharmaceutical Association; David M. Sanders, private citizen, on Bill 31, The Regulated Health Professions Statutes Amendment Act; Gervin Greasley, The Arbitration and Mediation Institute of Manitoba on Bill 57, The Regional Health Authorities Amendment Act.

On Bill 35, The Mental Health and Consequential Amendments Act, we have Carlyn Mackey, Families Advocating Timely and Appropriate Care and Treatment for Serious Mental Disorders; Dorothy Weldon, private citizen; Connie Krohn, private citizen; Ken Melnyk, private citizen; Colleen Cawood, private citizen; Theresa Wayne, private citizen; Maureen Koblun, private citizen; Susan Olson, private citizen; Phyllis Wayne, private citizen; Patricia McInnis, private citizen; Joan Thorogood, private citizen; Beverley Goodwin, private citizen; Louise Smendziuk, private citizen; Chris Summerville, Manitoba Schizophrenia Society; Katherine Davis, private citizen; Beverley Hawkins, private citizen; Jackie Mauws, private citizen; Rod Lauder, private citizen; Bruce Waldie, private citizen; Victor M. Dyck, private citizen; Horst Peters, private citizen; Bill Ashdown, Society for Depression and Manic Depression of Manitoba; Dr. Jaye Miles or Darlene Dreilich, Community Coalition on Mental Health; Uwe Osterwald, private citizen; Valerie Price, Manitoba Association for Rights and Liberties; Mary Ann Haddad, private citizen; Ellen Kruger, Canadian Mental Health Association - Winnipeg Region; Harry Wolbert, private citizen; Joan Joyce Podolas, private citizen; Ruth McCutcheon, private citizen; David Smith, private citizen; Gordon Nicolson, private citizen; Marlene Vieno, private citizen; Yude Henteleff, private citizen; Bill Martin, Canadian Mental Health Association - Manitoba Division; Lucie Pearase, private citizen and Murray Waldie, private citizen.

Those are the persons and organizations that have registered so far. If there is anybody else in the audience that would like to register, or has not yet registered and would like to make a presentation, they can register with the Clerk's office at the back of the room.

There are some out-of-town presenters. As is the normal practice, is it the will of the committee to hear the out-of-town presenters first? [agreed]

Mr. Tim Sale (Crescentwood): I thought we had agreed to hear Bills 57, 30 and 31 first.

Mr. Chairperson: Yes, but the normal practice, as I said, has been to hear the out-of-town presenters first. I think what I will do is follow what we had initially indicated is hear those three presenters first and then hear the out-of-town presenters and then continue all the presentations, if we can have agreement on it. Thank you.

Following the out-of-town presentations, did the committee wish to consider the bills in numerical order? Basically, I think we have established what we are doing, so we do not need to ask that question.

We need to also have a consideration of time on presentations. What we have normally practised is setting a time limit of some duration during committee. What is the will of the committee? Should we set a time limit on presentations and also on questions?

An Honourable Member: Ten and five.

Mr. Dave Chomiak (Kildonan): I recognize that it has been a generally established practice in the committee to set time limits on presentations. I understand that we have been doing it on a regular basis in committee. We, in principle are not–I am certainly not in favour of limiting time. I understand though, that on the time limits that the committee is considering imposing, the Chair has at their discretion the ability to extend presentations. If that consideration is taken in mind and if the presenters feel that they can be accommodated adequately by that basis, then our opposition to time limits is not that strong.

So that is the caveat that I am putting on, because in principle we do allow the public to have their say, and we want to hear everything they have to say. But I do have a good deal of respect for the person in the Chair and his ability to allow that to occur.

* (0940)

Hon. Darren Praznik (Minister of Health): My apologies. I was opening the diabetes conference this morning, and I think I hit every red light from the Lombard Hotel here.

I think Mr. Chomiak's comments are very apt. Time limits are only there to ensure that people can schedule their speaking arrangements, and we as members impose time limits on ourselves in our various debates in the Legislative Assembly, but I would support his comments that some discretion must rest with the Chair, given the nature of a presentation. If a person, of course, is coming to an end of a conclusion and a minute or two more is needed to finish up, we certainly do not want to be rude to anyone, and we certainly want to get the benefit of their advice. So we would certainly concur with that discretion with the Chair.

Mr. Sale: I understand the discretion issue, but I would say that, in particular, The Mental Health Act is an extremely difficult and emotional piece of legislation that has a lot of consequences for a lot of people. I find the five-minute time limit for discussion to be quite arbitrary and short. I recognize that many citizens put a great deal of effort into thinking about what they want to say. We have a large committee. I think there are something like 10 of us here, nine of us here.

I would hope that if there is the need to ask or the desire to ask questions that in particular the discussion time limit be very liberally interpreted, because I do not see this as particularly a partisan issue. I see it very much as a difficult question that we have to struggle with on all sides of the House, and I do not think anything is served by limiting in particular the discussion part, because we all have the opportunity to read what is presented. It is not quite so much of a loss if we have to do some homework reading, but if there are questions, I think it would be discourteous in the extreme to people who feel very deeply about these issues if we cut them off.

Mr. Chairperson: Thank you very much, Mr. Sale, for your comments. I certainly will exercise discretion. So, with the will of the committee then, we will start the hearings.

Bill 30–The Pharmaceutical Amendment Act

Mr. Chairperson: I will ask Stuart Wilcox or Ronald Guse of Manitoba Pharmaceutical Association to come forward on Bill 30.

Mr. Wilcox, have you a written presentation for distribution?

Mr. Stuart Wilcox (The Manitoba Pharmaceutical Association): No, I do not. I have some background information that I was going to distribute for the interest of the committee, but I do not have a written presentation. I expect to be very brief.

Mr. Chairperson: We will ask the Clerk to distribute the background information. You may proceed then with your presentation.

Mr. Wilcox: Thank you, Mr. Chair. I appreciate being allowed the time to speak to you today about Bill 30. Bill 30 is made up of sections submitted by the Manitoba Pharmaceutical Association and the provincial government. Two of them are just to correct some shortcomings in our discipline procedures that we have noted since the passage of the latest pharmaceutical act in 1992. The major section that I wish to speak to is 74.1 to do with drug schedules.

The registrar, as a pharmacy–it seems hard to believe–started in 1984 down this road to try and harmonize drug schedules across the country. Prescriptions drugs are the purview of the federal government, nonprescription drugs are the purview of the provincial government. Unfortunately, it led to 10 different sets of rules across the country which did not make any sense and were very difficult for the manufacturers, for one thing.

So we undertook this many years ago. It has only been in about the last five years that we really managed to make some progress, and I am very pleased to say that we had agreement in all 10 provinces for a harmonized set of drug schedules. We then had other stakeholders accept these schedules. They included the federal government, the manufacturers, the grocery association of Canada and other groups. Unfortunately, I am sorry to say, at the eleventh hour Quebec withdrew from our national organization; however, we understand that their government is looking at the schedules that have been put forward, and hopefully they will become a law in Quebec as well as the other provinces.

To date these schedules have been accepted and are in law in B.C., Saskatchewan, Nova Scotia. I have been away for a month, but I understand that Prince Edward Island–we are only awaiting the signature of the Health minister to make it law in Prince Edward Island. In the other provinces they are in various states, but all have indications that they will go forward.

I do not know if you wish me to get into the details of the schedules, but I will just briefly mention that there would be four schedules under this harmonized act. Drugs that require prescription would be schedule one. Schedule two is drugs which would be sold only in a pharmacy and would be sold from the dispensary of a pharmacy with the involvement of the pharmacist. The third section is drugs that would be restricted to sale in a pharmacy, could be in the self-select area but must be immediately adjacent and under the supervision of the pharmacist. Schedule four is not a schedule but is everything that is not in the first three schedules which could be sold in any retail outlet.

We currently have laws in Manitoba which restrict certain drugs to pharmacies. I will not go into it unless you wish me to under questioning. It does not make sense, and it is not based on pharmacology, it is based more on marketing of drug companies. This new scheduling releases more drugs out to the other outlets. It is not a restrictive bill that would bring more drugs into pharmacies; it is releasing more out into nonpharmacy outlets for the convenience of the public.

That is my statement. I would be more than pleased to answer any questions.

Mr. Chairperson: Thank you very much, and am I correct in saying Mr. Wilcox?

Mr. Wilcox: Yes, I am the registrar of the Manitoba Pharmaceutical Association.

Mr. Dave Chomiak (Kildonan): Thank you, Mr. Wilcox. Under the subsection you refer to as 74.1, that means that Manitoba can adopt a regulation that is made in any other jurisdiction, the way the wording is written, by any government of Canada. Presumably, this will be done en masse so that is not a case–because the section says by a government in Canada. So, presumably, if B.C. makes a decision, we are not dealing with a situation where B.C. will make one–this is going to be done en masse across the country. Although it does not say that in the legislation, I assume that is what the intention is.

Mr. Wilcox: There is a group that has been put–I am sorry.

Mr. Chairperson: Mr. Wilcox, I am sorry, I delayed you. I want to make sure that your mike is turned on. When I recognize you, your mike will be turned on and it will be recorded.

Mr. Wilcox: There is a national drug schedule advisory committee, which is made up of experts in the area. They are appointed by various groups: The Canadian Medical Association, pharmacists, the grocers, the Consumers' Association. They are not there to represent those groups. They are there to make it transparent that everything is being done correctly and that no group is being favoured.

* (0950)

The drugs go to them, they make a decision, and then they make a recommendation to the provinces as to which schedule a particular drug could go into. People can appeal to this committee if they feel something is in the wrong schedule, and they make these decisions.

The federal government has basically recognized them as the authority in this area, and, therefore, it would be hoped that all nine provinces, and hopefully 10, would simultaneously accept those recommendations.

Mr. Chomiak: Mr. Chairperson, so, in general, they really make the determination in terms of the scheduling.

Floor Comment: Yes.

Mr. Chomiak: Mr. Chairperson, the definition of drugs in the act has changed as a result of these amendments. Is there any implication in the changing of the definition of drugs–and I know this is a question that is going to garner an opinion on your part, but I would like that opinion, if possible. Is there any change in the definition of drugs that may affect issues surrounding some recent relatively controversial issues surrounding definition of drugs and related matters as it relates to natural or herb products?

Mr. Wilcox: That I cannot truly answer because, as you know, they are looking. There is a national committee looking at herbal products and whether they will be considered drugs or not. I do not see that this would affect herbal medications at this present time. The reason we had to change the definition of a drug is that, as of July 1, the proprietary medicine act or Division 10 of the federal Food and Drugs Act is being revoked, and that is how drugs in Manitoba are now determined as to point of sale.

If they are proprietary medicine, they can be sold anywhere. If they are not, they can only be sold in a pharmacy, which is not good. That is not scheduling. That turned out to be marketing more than scheduling so there had to be a change in that. This is a much simpler and straightforward definition of a drug. The other one, a layperson reading it would not have any idea what that meant.

Mr. Chomiak: Mr. Chairperson, so a drug in Canada after this change will be defined as a drug that is characterized in the schedule under Section 74. Is that correct?

Mr. Wilcox: In Manitoba. I am not sure how the wording is in the other provinces as to their definition of a drug, but they would be harmonized.

Mr. Chomiak: Again, just pursuing that other line of questioning for a second. The consideration in the changes to those categories that are considered herbal or natural would be classified as nondrugs, and I would presume that they would only be considered a drug in Manitoba if they were included by reference under Schedule 74. Would that be a correct interpretation?

Mr. Wilcox: Absolutely.

Mr. Chairperson: Thank you very much, Mr. Wilcox, for your presentation.

I call next Mr. David M. Sanders, private citizen, on Bill 31. Is Mr. Sanders here? I call again, Mr. David Sanders, private citizen. Is he here? Not seeing him, we will then, if it is with the concurrence of the committee, drop these presenters to the bottom of the list and we will call them again at the end of the proceedings. Is that agreed? [agreed] So, Mr. Sanders name will be dropped to the bottom of the list. I call then, on Bill 35, Carlyn Mackey.

Bill 57–The Regional Health Authorities Amendment Act

Mr. Chairperson: I am sorry, Bill 57 I need to call. Mr. Gervin Greasley. Is Mr. Gervin Greasley here?

Have you a presentation for distribution?

Mr. Gervin Greasley (The Arbitration and Mediation Institute of Manitoba): Yes.

Mr. Chairperson: The Clerk will distribute. Mr. Greasley, you may proceed.

Mr. Greasley: Thank you, Mr. Chairman, committee members. It is not very often that our organization makes presentations, but we are pleased to have been given permission this morning. First I would like to take a moment to explain who we are and our relationship to this particular Bill 57. The Arbitration and Mediation Institute of Canada is a nonprofit organization with 1,800 members across the country who are arbitrators, mediators, conciliators, negotiators and similar practitioners.

The organization has three goals. One is to increase the use of dispute resolution as an appropriate means of settling disagreements. We do that by trying to increase public and private awareness. Secondly, we provide professional training to mediators, arbitrators, negotiators and others, and thirdly, for the clientele and consumer who requires those services, we provide referral services in each of the provinces. To ensure that we have standards that are met across the country, we have national certification, chartered arbitrators and chartered mediators, codes of ethics, and we publish training manuals for arbitration and mediation which are used not only by ourselves but by universities and by others.

Two of our publications are being used by various government levels, and I will discuss those in a moment. Our provincial office was established in Manitoba as the Arbitration and Mediation Institute of Manitoba in 1990, and since that time we have graduated 70 practicing arbitrators and 25 practicing mediators, and the names of some of those individuals would be well known to people in this room. We would like to take a moment to discuss with you also the way in which other governments are moving towards using external dispute resolution services, and we would recommend that for the Province of Manitoba.

In recent years, the Government of Canada and a number of provinces have been moving in that direction. Beginning in September, following a two-year pilot project in Toronto, the government is now requiring that all civil litigation cases coming before the court must go through mandatory attempt at dispute resolution first, and they have set a basic fee for practitioners for a maximum four hours to try and attempt that.

In Alberta, the Small Claims Court is now all done by mediation, and there are some–all the claims that are $10,000 and under–and there are some 200 mediators working now in Alberta, most of which are members of our region. In British Columbia, 80 percent of Autopac–if you are following this, the word is Autopac, as some gremlin got in there–but the Autopac claims, 80 percent of them are now done independently by groups such as our regional institute out there.

Also, they have what we call a bumping service in British Columbia. On Monday morning the court reviews the docket for the week, and if it appears that there are going to be delays in some cases, the individuals involved in those cases or their legal representatives are given the opportunity of either having it scheduled some six months hence or having it go to arbitration. There is a representative in the court with a list of arbitrators who can proceed immediately if the parties decide to go in that direction.

When the federal government cancelled the Crow rate and paid the subsidy, there were 800 disputes in western Canada, 200 here in Manitoba, and 15 of our members were appointed by the federal government to handle those cases. The federal government also, some of its departments–the Department of Health, which might be of interest to you, but Department of Natural Resources and others–also use the commercial rules of procedure for arbitration and for mediation, which are again developed by our national group, and Government Services federally is moving in that same direction.

In Saskatchewan, the Minister of Justice has what is called a dispute resolution advisory council made up of people from our region there and the Consumers' Bureau and others to discuss issues of dispute resolution, particularly prior to them becoming part of legislation, which sort of brings us now to Bill 57.

We do welcome the detailed inclusion of mediation opportunities as set out in Section 44.2 through to 44.4 of this particular bill. Given the availability of a number of highly qualified mediators in Manitoba, we would encourage the minister to establish a roster of well-qualified mediators and to select individuals from that roster on a random or on a rotation basis, so that they in turn will also gain additional experience in dealing with issues that might arise under Bill 57.

In this way the minister would be assured of continually having a group of directly operating and experienced mediators to meet the department's needs. It has, however, been our experience that preselection of only one type of dispute resolution sometimes hinders rather than helps the parties to resolve their problems. It limits their ability to reach a settlement that is most appropriate to the parties.

For example, I mentioned the western grain transition. The arbitration was mandated by the federal government in that case. We ran into a number of instances where arbitration was actually harmful to the parties, where mediation would have been a much better way to go. In reverse, of course, our members have also been involved in cases where mediation created problems for the parties that arbitration would have solved had it been used.

The overall dispute resolution processes include nine different types of arbitration, plus negotiation, conciliation, mediation, independent referees, or sometimes combinations of those processes. We would therefore strongly recommend to the minister that serious consideration be given in this bill and in future government legislation to enabling a dispute resolution process to be used, but leaving to the parties involved the selection of which process happens to be the most appropriate for the circumstances at that time. Thank you.

* (1000)

Mr. Chairperson: Thank you very much, Mr. Greasley, for your presentation. Are there any questions?

Mr. Tim Sale (Crescentwood): Thank you, Mr. Greasley. Also, thank you for the brochure; it is helpful and clear.

You are recommending something quite different than the bill contains, although building on the notion of some form of dispute settlement between the parties. What would you recommend the bill say? What specifically would you like to see it say?

Mr. Greasley: I am not normally drafting legislation. In the first case, we have arbitration which is governed by law and is binding. We have mediation which is not governed by law and is not binding except for the eventual agreement signed by the parties. So the wording escapes me at the moment, but it seems to me that either it would specify more than one dispute resolution process or refer to dispute resolution processes, of which internationally recognized or mediation arbitration, negotiation and conciliation, things of that nature.

Mr. Sale: Mr. Chairperson, you indicated that mediation normally is nonbinding, yet this process yields a binding result to mediation. Whether or not it is the mediated settlement or whether or not there is a settlement, the act would appear then to move to a binding resolution without any further processes. Do you find that an acceptable dispute settlement mechanism?

Mr. Greasley: It is one that, I guess, we are looking at prior to it actually being in place, so we can see how it works. Normally the mediation approach is that the parties do the deciding and the resolution, and usually they will ask the mediator to write down the memorandum of agreement to the conclusion they have reached. They sign that, but that then is not a binding mediation agreement, that is a contract. If there is a breach, it is a breach of contract. Normally the mediator does not make a decision, nor any external third party. For example, in arbitration, the arbitrator you expect to make the decision; in mediation, it is the parties.

This particular bill contains a section where in the end it is the minister who makes the determination providing that the parties have not done so, I presume. That is an area where we have not a lot of experience, and we are not clear how that would work.

Mr. Sale: Mr. Chairperson, would it then be fair to say that this to you appears to be a somewhat unique process that does not find parallels in other dispute mechanisms in which you have had some experience?

Mr. Greasley: Well, it is unique to me personally. I have not researched a lot of the other legislation that does not usually fall within my territory, but it is unique to myself and to the board who have discussed this. The processes, of course, that we lean to are the processes that we are more familiar with. The government of Manitoba, for example, uses national construction standard documents. In there, the process is that it starts with mandatory negotiation, and failing that, moves to mediation, and failing that, moves to arbitration and eventually to litigation. Those are the normal types of processes that we are acquainted with. As I say, it is hard to predict in advance what is going to happen if somebody dictates a mediation.

Hon. Darren Praznik (Minister of Health): Mr. Chair, just one question for Mr. Greasley. The member for Crescentwood represents this to be somewhat unique. Is Mr. Greasley aware that legislation similar in process without the mediation step actually was introduced by the government in Saskatchewan with respect to their regional health authorities act? Has he had an opportunity to study that and how it works in Saskatchewan?

Mr. Greasley: No, I have not, and as a matter of fact, I would encourage the regionalist out there to make a similar type of presentation in that case.

Mr. Chairperson: Thank you very much for your presentation, Mr. Greasley.

Bill 35–The Mental Health and Consequential Amendments Act

Mr. Chairperson: We will now move to Bill 35. I understand there are four out-of-town presenters, and I will call the first one, Mr. Ken Melnyk, private citizen, to come forward. Mr. Melnyk, do you have a presentation for distribution?

Mr. Ken Melnyk (Private Citizen): No, I do not.

Mr. Chairperson: You may proceed then, Mr. Melnyk.

Mr. Melnyk: Good morning, Mr. Chairperson, committee members. I am speaking with reference to The Mental Health Act, specifically the certificate of leave. My wife and I, we have a son that has been diagnosed–

Mr. Chairperson: Could you pull your mike up just a wee bit? Right, thanks.

Mr. Melnyk: My wife and I have a son that has been diagnosed with paranoid schizophrenia. It has been a long battle for us and a lot of learning on our own part. With the certificate of leave, from our understanding, if he enters the hospital and he would like to leave, the basis that he can is a certificate of leave which would maintain his medication. If he changes and decides not to take his medication, he would have to be readmitted back to the hospital.

I know there is some opposition to the certificate of leave, based on our son's rights and freedoms. Our son, his rights and freedoms consist right now of living in substandard housing. He thinks he is God, and this is an individual that should be given the decision to not take medication? He has a serious disease. It is not a psychological problem. It is not a behavioural problem. My wife and I have been told, in many instances, that he is just a bad kid. Well, we have found out otherwise–a serious disease.

We would like to see that the certificate of leave be maintained. Like I say, the rights are–I do not object to anybody's rights and freedoms. Everybody is entitled to them, but if people cannot make proper decisions for themselves due to a mental illness, I do not know who is going to look after him. We have to worry at night when the phone rings if it is going to be the police and we have to come and identify a body. It is very difficult for me, but I would ask for your consideration in maintaining a certificate of leave.

Mr. Chairperson: Thank you very much, Mr. Melnyk.

Hon. Darren Praznik (Minister of Health): I just wanted to thank the presenter for coming here–I know it is a difficult thing to do–and his support of this particular provision which will allow that certificate to continue. Thank you, and to you and your family best wishes. It is a difficult time.

Mr. Dave Chomiak (Kildonan): I also thank you, Mr. Melnyk. It is very difficult to deal with this issue, and I appreciate the fact that you came forward. As we have all stated, if there is anything positive from this whole process, it is that there is more education of the public by this process, so they know that it is so much easier if you have an injury or a broken arm or a broken leg, to see the cast or the bandage and people can recognize that someone is sick, but it is a little more difficult when there is a disease in the brain, and people are not nearly as understanding. There is still much too much of a stigma, and I do not want to make this any more difficult.

Aside from the provisions and the issues of the certificate of leave, are there any other provisions in this act that you have had an opportunity to review, or is there any other advice that you can give to us as the legislators with respect to the whole area of mental health in Manitoba?

Mr. Melnyk: Specifically, I really cannot say. We have just recently had a meeting the other night with the Winnipeg Hospital Authority in changes that can be made into some procedure. We have to deal with items of patient confidentiality, the legalities surrounding–well, again, the refusal of treatment. Our son can just refuse treatment. Our specific situation is our son currently has not even been able to get admitted into hospital because according to our son, he does not have schizophrenia. This is a problem that we are having to try and overcome, so I guess it would be hard to answer that question properly.

Mr. Chomiak: Just for the understanding, how old is your son?

Mr. Melnyk: He is 22.

Mr. Chomiak: And it was the typical experience of going through his behaviour problems and psychological problems, and then when he became in his teens, you realized that something major was wrong. Is that the–

Mr. Melnyk: In all honesty, he is my stepson. I have just been recent to the situation in the last number of years. Based on the history and what I have seen through my experience with being associated with the family, yes, it has been ongoing. You have seen it as a little odd.

I was able to convince him into Health Sciences Centre emergency two years ago. He sat in the hospital for five to seven hours before he was seen. We had a hard time keeping him there. When he got in, he had like a five-minute diagnosis. They asked him if he was homicidal or suicidal. He said no; we walked out the door.

* (1010)

He started in an out-patients program where he did not have to attend and, consequently, he ended up in jail. He got into an altercation of violence where he could not remove himself out of the situation. Being backed into the corner–I think everybody here in a time of distress of sane mind would have a tough time dealing with being backed into the corner. Here is an individual that was sick, and it ended up in an altercation, and now he is criminalized. We have gone through the sentencing and probation periods and everything. He is still on probation, but this individual is still not getting treatment. He is getting medication prescribed to him currently; however, he does not take it because he does not have schizophrenia. All of us, the rest of society, are crazy, not him.

So these are some of the issues that we have to deal with, trying to actually get him to take medication. This, again, would be consistent with the certificate of leave. If we can get him into hospital, we can get him taking medications. At least if he does not take his medication, he can be brought back in.

Mr. Chomiak: Thank you, Mr. Melnyk. I am sorry to take you through this, but I think every time we go through this, every story we hear is a better education for all of us here. Hopefully all of these stories can help make the whole system better. I just thank you.

Mr. Chairperson: Thank you very much for your presentation, Mr. Melnyk.

I call next Chris Summerville, Manitoba Schizophrenia Society. Chris Summerville. I understand, Mr. Peters, that you are going to be making a presentation on Mr. Summerville's behalf.

Mr. Horst Peters (Private Citizen): I would like to do that, yes.

Mr. Chairperson: Could we ask you to wait then, because you are not an out-of-town presenter?

Mr. Peters: Sure.

Mr. Chairperson: I will call you when you come up on the list. Thank you very much.

I call then Jackie Mauws, private citizen. Jackie Mauws, is she here? Seeing her not, she will drop to the bottom of the list. Mary Ann Haddad, private citizen. Is Mary Ann Haddad here? Seeing her not, she will drop to the bottom of the list. I will call then the first person on the list. Carlyn Mackey, Families Advocating Timely and Appropriate Care and Treatment for Serious Mental Disorders. Carlyn Mackey, would you come forward, please? Have you a presentation for distribution?

Ms. Carlyn Mackey (Families Advocating Timely and Appropriate Care and Treatment for Serious Mental Disorders): I will after the presentation.

Mr. Chairperson: Thank you, you may proceed.

Ms. Mackey: Good morning, honourable members of the Manitoba Legislative Assembly. It is an honour to be here this morning. My name is Carlyn Mackey, and I have a loved one diagnosed with paranoid schizophrenia who has barely managed to survive the existing mental health system.

Many hopelessly have succumbed to suicide or have been criminalized because of untreated brain diseases categorized as mental illness. Many continue to insidiously deteriorate because of inadequate or faulty mental health legislation which obstructs their right to treatment.

I am speaking to you today on behalf of a grassroots group of very concerned and committed families who have found it necessary to advocate for our loved ones on the issues of barriers to treatment, both legal and systemic. This group calls themselves Families Advocating Timely and Appropriate Care and Treatment of Serious Mental Disorders. We will be forever grateful to caregivers in this province who have shown genuine concern for our loved ones' plight and have offered us the support and insight that has brought us here today. In particular, we commend the Schizophrenia Society of Canada for speaking out last fall urging all provincial governments to review any mental health legislation which obstructs necessary treatment for the mentally ill.

We are convinced that neglect of our loved ones, due to inadequate and faulty legislation, must stop now. As legislators, you are responsible for enacting adequate and just laws to protect all the mentally ill, to protect all their rights, including the right to timely and appropriate care and treatment. You have no less of a responsibility to enact legislation to also protect the public. We support Bill 35.

We acknowledge The Mental Health Act is a two-edged sword to protect the competent person's right to refuse treatment as well as the right of very ill persons to receive necessary treatment to restore and maintain their sanity. The balance of these rights is of grave concern to many, including families of the mentally ill. The proposed certificate of leave is intended to provide a treatment of choice for a specific minority of high-risk, consenting, voluntary patients to receive necessary treatment in a less intrusive manner in the community. The certificate of leave is not involuntary legislation. Invoking the certificate of leave is entirely dependent on the patient's consent in keeping with the desire of the patient for less intrusive treatment. No consent, no certificate of leave. It may mean then that the patient will require longer hospitalization, because without the conditions of the certificate of leave, which could include follow up, monitoring and medication, the patient would be deemed high risk for relapse. It may mean more intrusive treatment. This is reality. This is the reality of serious mental illness.

Originally, the act was predicated on patients being treated in institutions and hospitals. The mentally ill now reside in the community where they rightfully should, but unfortunately many still reside in the new institutions of the '80s and '90s: the streets, the jails of our communities. Mental illness did not disappear with the closure of institutions. The institutions merely moved locale.

Given the present unbalanced Mental Health Act, it is often easier to access treatment through the criminal system rather than through the health system. We are told 15 general psychiatric beds have been eliminated at the Selkirk facility to make way for as many forensic beds. If the act is to continue to protect the rights of all the mentally ill to receive necessary treatment in the community, it too must follow the patients where they now reside.

The proposed certificate of leave amendments are entirely compatible with policy to deinstitutionalize. If this two-edged sword is not to discriminate against a particular high-risk group, adequate legislation to protect them is absolutely required. The present faulty, inadequate certificate of leave discriminates against a particular group of mentally ill in that it prohibits, by law, a choice of treatment for high-risk, voluntary, consenting persons on the basis of legal status and place of residence. Legalized discrimination can no longer be tolerated. We must have an amended certificate of leave.

We anticipate that you will hear a lot about rights today. If we are going to get into the rights issue, we would like to point out that voluntary hospitalized patients have been deprived of the right to choose the benefits of the certificate of leave for too long. We could have had a little rights advocacy on this issue some time ago. Why are there now proposals to eliminate this choice of treatment option only when the amendments to correct the act are proposed? Was it somehow more acceptable when it was faulty? Coercion? Of course persons choosing not to elect for the certificate of leave will be faced with consequences, but is that not the risk of choice? Is life not all about choice and responsibility, even for persons with mental illness? Is coercion applied only to some choices and not others? What about the right to choose to refuse treatment? Is that also coercion? Who could possibly benefit and what agenda is met by faulty legislation or elimination of the certificate of leave altogether? We have made it our business in recent months to ask these questions, and frankly, we are very confused and disturbed by what we have discovered about the state of mental health advocacy in this province.

* (1020)

I would like to address the omission of an amendment regarding an office of mental health advocate at the end of this presentation. In the meantime, I will let you draw your own conclusions regarding why our group has been formed and why we are here today speaking for our helpless loved ones. If we are worried about invasion of patients' rights, we must be concerned about all patients and all rights. Short of a mental illness act or community treatment orders such as Saskatchewan has enacted, the amended certificate of leave is a reasonable proposal to balance the act at this time. Failure to act now to stop the tragic consequences of inadequate and faulty legislation will invite serious consideration of more restrictive alternatives such as described above.

These alternatives are very real in provinces where there has been failure to adapt their legislation to reality. Just glance over to Ontario, where legislators are struggling with 72 amendments to their mental health act. Let us not let things get out of hand in Manitoba. Let us practise a little mental health here. Let us stop deluding ourselves into thinking that we can continue to sacrifice the needs of the minority for the wish list and the wants of the majority. Let us cut the denial and rhetoric and face reality. As long as helpless people continue to fall through the cracks of The Mental Health Act, justice will demand that the act be balanced. No one has anything to gain by tolerating and minimizing neglect, harm, abandonment of voiceless, helpless people. There is a limit to the spin that can be made to justify harm and injury. The certificate of leave must be amended. Failure to do so is certain erosion of rights, the right to treatment.

Who benefits from the nonconsumer status of untreated mentally ill persons, which persist because of a faulty, inadequate Mental Health Act? When one is a nonconsumer falling through the cracks, one consumes nothing. It is called mental health on the street, in jail, mental health outside the health system, a cheap way to run the mental health system, indeed. Offloading has its limits, would you not say? But all of you are on record wanting an effective health system. Is there anyone else who could possibly have anything to gain by legislation which effectively creates a nonconsumer status for the mentally ill?

You as legislators will be asked to protect the rights of the mentally ill. Fair ball. But I ask you: does that include the rights of nonconsuming, untreated mentally ill the right to remain insane, the right to rot on the street, sleep under bridges, pick out of garbage, the right to beg, the right to remain unable to cope with life's ordinary demands, the right to be neglected, to be harmed, the right to deteriorate, the right to live with the horrors of disabling delusions, hallucinations, paranoia, fear and anxiety, the right to psychosis, the right to loss of freedom in jail? I could go on.

I ask you just what rights are we talking about. It certainly is the right to choose a treatment option, I would hope, for a vulnerable, high-risk people who wish to protect themselves from predictable deterioration. Is fear of deterioration one of the fears we are hearing about? Do politicians have the luxury of ignoring the rights of the minority for which the act fails? We do not think so in the long run at least, not when accountability enters the picture. Accountability and responsibility is what these amendments are all about.

Our society has demonstrated in recent months that they intend to hold their legislators accountable for failing to protect its citizens against harm and injury. I refer you to the blood supply debacle. Voiceless, helpless mentally ill may not seem to be much of a threat in regard to compensation, but their families will not be sitting idly by when they know legislators have been informed and failed to act out of political expediency. As of June 1998, consider yourselves informed.

Zero tolerance for harm and injury must be assured in act 35 in the same way we have legislated zero tolerance for spouse abuse, drunk driving, seatbelts, and even limitations on smoking. Preventing harm and neglect requires legislation, it would seem. Some citizens have had to forfeit lesser rights for the greater rights of others. In the mental health arena, the rights of those in most need will have to be addressed accordingly.

Mr. Chairperson: Can I just interject here? We are running a bit beyond the time? Could you just speed up a wee bit?

Ms. Mackey: All right. I should have asked. I have an eighteen and a half minute presentation, and I should be finished pretty soon.

Mr. Chairperson: Thank you.

Ms. Mackey: Do I have your permission?

Mr. Chairperson: Proceed.

Ms. Mackey: Thank you. In the mental health arena the rights of those in most need will have to be addressed accordingly. We will have to acknowledge, oh, so painfully, it seems, that some mentally ill have very urgent illness issues to be responsibly dealt with in contrast to those whose problems are social, in contrast to those who need less because they are not as sick. The Mental Health Act may be a misnomer. Perhaps the mental illness act would be more precise, but nevertheless it is about addressing illness issues, not social issues.

The mental health community will have to come to terms with concepts of illness and health that presently divide it at the expense of helpless people. This weakness in the mental health advocacy is very tempting for politicians to do nothing. We ask you to resist this temptation. Don your legislator caps and vote with your conscience. People are being harmed. People are dying because we have an unbalanced law. Yes, we have deficient services, but services are an issue of policy, not legislation. Elimination of the certificate of leave and replacement with assertive co-ordinated comprehensive programs like PACT is not the answer here.

Even our present highly skilled personnel of the crisis mobile unit often cannot intervene in a timely and appropriate manner. If these units are handicapped by inadequate legislation, how can we expect more programs to resolve the problem for those who cannot access them voluntarily as it is? Without the backing of a legal mechanism to facilitate safe re-entry into the community without an amended certificate of leave, the PACT proposal simply will not accomplish what it is intended to do. Once again, we will have a service only accessible for persons with sufficient insight into their illness. Once again we will be pouring more money into programs which fail those most in need. PACT is a good idea and we support it only with the backing of an amended certificate of leave.

Have you tried convincing someone who believes themselves to be God or is absolutely sure the FBI is on their trail that the PACT approach would solve their problems? Have you tried to do it assertively, co-ordinated and in a comprehensive manner? If you have and have succeeded, stick around. I think we can give you a job, but do not give up your day job yet. Experience tells us that the voluntary community programs are not enough for those in most need. We did not have experience to guide us when we emptied our institutions, and you all know where that landed the mentally ill: disaster resulting from good intentions but nonetheless disaster. Good ideas are not enough this time.

What is the alternative to failing to amend the certificate of leave? Well, first of all, longer, more restrictive hospitalization. Is that what deinstitutionalising all about? I think not. We were supposed to be heading toward community treatment, were we not? Is that not what the advocates were recommending? Get out of hospitals. Has that now changed to get out of treatment? What erosion next?

Secondly, failing to amend the certificate of leave which will help persons to re-enter the community safely will surely assure continuation of the notorious revolving door syndrome. You know that scenario, where patients are allowed–emphasis on "allowed"–to reach dangerous levels of deterioration, require repeated crisis intervention, followed by years of rehabilitation in long costly hospital beds. You know how the revolving door works. You are admitted through emergency two and three times a year, attempt suicide several times, only to return to the community where you are unable to cope because the services are only for people with insight, and you do not have that important commodity.

* (1030)

Fifteen percent of persons with schizophrenia alone suffer with serious loss of insight. This translates to over 1,500 persons in Manitoba. Untreated schizophrenia and other psychotic illnesses raises that number significantly. Picture yourself now suddenly struck down by a serious mental illness. Let us call it schizophrenia. You have a brain disease. You have a chemical imbalance which affects the function of your brain. Your brain disease is a neural biological brain disease like Parkinson's, like Alzheimer's disease and multiple sclerosis. Do these people have to play this revolving-door game to get timely and appropriate care and treatment? Gosh, that would be a disaster, would it not? So why is it okay to abandon persons like you, with neurobiological brain disease categorized as mental illness to the shameful and disgusting revolving door? Could it have anything to do with stigma, discrimination and plain ordinary ignorance of mental illness permeating the system itself? Or is it just mismanagement of taxpayer dollars? Anyway you slice it, the revolving door will have to go. The fallout from an amended certificate of leave, prevention of relapse and reduced need for hospitalization will have the added benefit of reducing that revolving-door syndrome. Saskatchewan's more stringent community treatment orders have reduced their revolving-door games by 50 percent.

If you have any difficulty accepting my word for the cost of the revolving-door syndrome in human and economic terms, I refer you to the report of the Manitoba Centre for Health Policy and Evaluation, released in 1994, entitled The Utilization of Medical Services for Mental Health Disorders, Manitoba 1991-92. Clearly, psychotic disorders predominate. Treatment is often delayed because the legal intervention to prevent deterioration is inadequate. Doctors tell us that our loved ones are not sick enough for them to intervene. Withholding treatment on that basis would constitute malpractice for any other disease. Unfortunately, being told that our loved ones must hit bottom is more appropriate for addiction therapy, not severe brain illness. That so-called bottom has often been at the end of a rope. We do not think we have entered into assisted suicide for the mentally ill yet.

Of course, there is also that not so uncommon practice of premature discharge into unsafe conditions in the community. Have you noticed the street people, the homeless, of which 40 percent are estimated to be mentally ill? They are not eccentric persons living lifestyles of choice, as some would like to portray them. They are people with brain disorders, lacking coping skills to safely care for themselves. They are the ones exercising their so-called rights, all dressed up in those rights with nowhere to go but the sleeping accommodation of bridges, the choice of soup kitchens to dine in and a wide array of streets and avenues to languish in. There are many choices available to demonstrate your dignity and personhood, inanimate objects like parking metres and lamp standards to talk to. No shortage of job opportunities; pan-handling or picking up cigarette butts off the street can be quite rewarding occupational therapy.

Choices abound when you are abandoned to rot in rights. You can choose to dress in the style of a tramp because you have no money to buy adequate clothing. What money you are given through the welfare system you cannot manage due to your uncontrolled illness, so you end up in unsafe squalor. You have the choice of fending off sexual predators and resisting assault, of course, but with your distorted perception of reality, your judgment is skewed and you are very vulnerable at the best of times.

When do the rights kick in? You probably did not even know there were amendments to The Mental Health Act, did you? And if you did hear about them, maybe you thought your privileged lifestyle would be threatened and your rights violated. Are you going to be able to speak at the Legislature to tell them about your fears and the protection of your rights? No professional should be required to break the law to practice ethical medicine. If all treatment of disease of helpless persons were dependent on laws which allowed for dangerousness rather than need as a criteria for intervention, I am afraid we would all be in for trouble.

As long as it is just the mentally ill, it seems we can tolerate inadequate laws. Well, the mentally ill are in serious trouble with an imbalanced Mental Health Act. We do not tolerate neglect and abuse of similar neurobiological brain diseases like Parkinsonism, multiple sclerosis, Alzheimer's. Do we have a multiple sclerosis law which restricts treatment for competent persons? Are families of Alzheimer's disease patients told their loved ones will have to get sicker or hit bottom because of the Alzheimer's act? Is negligence and abuse of untreated, helpless Parkinsonism victims excusable because of the Manitoba Parkinsonism act? Should any act block treatment of treatable disease when the patient wishes to avoid neglect and harm of falling through the cracks or revolving through the system. The medical profession is often cited as misinterpreting the law, and sometimes they do. However, in the case of the certificate of leave, they have interpreted it very well. In its present state, it is useless to provide community living. As a result, very few doctors use it. The solution lies in amending it so it is workable, not in doing away with it.

Publicly funded advocacy would reasonably be expected to advocate for both rights and needs of seriously ill persons. Publicly funded advocacy should be expected to advocate for all mentally ill, be they consumer or nonconsumer. Publicly funded advocacy would be expected to advocate for all pertinent rights, including the right to receive treatment to restore and maintain one's sanity. You may suspect that these expectations have not been met. Our group has formed for that very reason.

Regarding the issue of the government's omission of a legislated office of advocacy, we would like to say the following: Manitoba's mental health advocacy is in a state of fragmentation. If a legislated, impartial advocate is not to be included in the amendments as recommended, then it is incumbent on this government to ensure that publicly funded advocacy be accountable. It should be a matter of policy that all publicly funded advocacy be inclusive.

Regular review of publicly funded groups responsible for family and consumer education is absolutely necessary if all the interests and the rights of all the mentally ill are to be served. Today you are listening to your constituents. Today you will weigh the credibility of arguments put before you. You must listen and vote with your hearts and your minds. Mental illness does not respect class, intelligence, education, occupation, sex, or race. Persons with serious brain disease have lost so much by virtue of a disease they did not choose. They are now at your mercy. Justice for this minority rests with a yes vote for amendments to the certificate of leave.

You have an awesome responsibility indeed. Vote for your friends and neighbours. Vote for your families and future generations who will inherit this legislation. Vote for your constituents. You must set aside your politician's role and take on the dignity of a legislator. On behalf of voiceless people who ask you to vote for the amended certificate of leave, in addition we ask this government to provide clear regulations to guide interpretation of the act. We ask for accountability and responsibility.

I will distribute these copies, if you wish, for your perusal.

Mr. Chairperson: Thank you very much, Ms. Mackey, for your presentation.

Mr. Chomiak: Thank you, Ms. Mackey. That was a very extensive presentation, and we thank you for it. Just a couple of points of clarification: you are saying that the present provisions of the certificate of leave as contained in the present Mental Health Act are not adequate, and you are clearly advocating for us to vote in favour of the amendments that are now contained in this act that would improve the conditions on the certificate of leave. That is correct, is it not?

Ms. Mackey: The inadequacies I refer to are the certificate of leave at the present time. It is faulty and inadequate. It is a reasonable option at this time, we believe, that it be amended. It should be given a fair chance to be amended.

I did refer to the dangerousness aspect of The Mental Health Act. We are fortunate in Manitoba to have also the provision for deterioration. We do not have a problem in the sense that–provided it be interpreted properly. So that is why we are asking for regulations for proper interpretation of the act.

The issue of inadequacy is basically the certificate of leave.

Mr. Chomiak: Just one other question: you made reference during your presentation to the community treatment orders that are present in Saskatchewan. Can you perhaps provide to the committee a brief description from your understanding of how that process works in Saskatchewan?

* (1040)

Ms. Mackey: I think, from my understanding, the difference basically with the Saskatchewan community treatment orders and the certificate of leave proposed for Manitoba is one of consent. In Saskatchewan, I understand there is no consent. It is an involuntary legislation, whereas in Manitoba there is consent, so therefore our legislation would not be considered involuntary. It would not be forced on the person; it would be conditional to their consent, and I think this is a very important point that we are looking at. We have provisions already for involuntary patients. We do not need them in the certificate of leave. If, indeed, the person is an involuntary patient, there is the option of hospitalization.

So the idea of the amended certificate of leave is to provide lesser intrusive treatment in the community, which is what we all want I think. If a person is deemed noncompetent or an involuntary patient, there are provisions in the act already to deal with that if they are properly interpreted. So it is the inadequate certificate of leave that we presently have that has tied the hands.

I have had the experience, and many families I have talked to, where we have asked doctors, well, why can you not put our son or daughter on a certificate of leave if you are afraid of what is going to happen, because they tell us they do not think they are going to be able to manage in the community? They are high-risk people. It is another matter why they are being turned out of the hospital, but when we get past that hurdle, if they are going into a community–which we do not have any control of–we then ask, well, could you not invoke the certificate of leave? They tell us they cannot, because it contradicts itself presently in the legislation where the involuntary treatment in part of the legislation says that it has to be in a hospital. Well, if they are going to be turned out as an involuntary person to the community, that is contradicting the other part of the legislation.

So I think doctors felt very vulnerable in using that act because it was not clear and it was faulty. It is inadequate for the needs for which it was proposed, and it must be amended, and by amending it, applying to voluntary consenting patients, this does not add to the burden of involuntary legislation. It remains voluntary, and if the person does not wish to have a certificate of leave, it will not be issued.

The mentally ill, I think, are expected to make choices and live with their choices. So I think we cannot have it both ways. We cannot say, well, you can have choices, but you are being coerced. To be coerced means that you do not have a choice. You have a choice. If you are not able to live in the community without the safeguards of the certificate of leave, then I guess your only other choice is to remain in the hospital, which I think is unfortunate.

But that is the reality of mental illness. I mean, we are dealing with a very serious problem, and there is responsibility on the part of caregivers to protect these people. The programs in the community are geared for voluntary patients only, and when you return to the community and start to deteriorate, you lose your insight and you do not have that capacity to make the choices in your best interests. So you have to now wait till you become dangerous. So it is that choice that a person has to safely return to the community and avoid the pitfalls that they have repeatedly fallen into. The criteria for the certificate of leave is one that is going to apply only to a very restricted high-risk group. It is not applicable to the majority of people who have mental illness.

Mr. Chairperson: Thank you very much, Ms. Mackey. Mr. Minister, for a final response.

Mr. Praznik: I just wanted to thank Ms. Mackey for her work and the work of her association. I know we have had discussions, and I thank her very much for her presentation today because it brings to the table the rationale behind these amendments and provides, I think, a great deal of insight into what we are trying to achieve in this particular situation of balancing various interests and rights of individuals, including the right to treatment. She has articulated that very well, and I thank her.

Mr. Chairperson: Thank you very much. I want to remind the committee that we have a very significant number of presenters before us, and I would hope that we could, somewhat at least, contain ourselves to the time lines that we have established for presentations as well as for questioning.

I am going to call next Dorothy Weldon, private citizen. Is Dorothy Weldon here? Would you come forward please? Have you a presentation for distribution, Ms. Weldon?

Ms. Dorothy Weldon (Private Citizen): I will distribute them after.

Mr. Chairperson: Thank you. You may proceed then with your presentation. Welcome to the committee.

Ms. Weldon: Honourable members, I support Bill 35 and specifically Sections 46(1) through 48(3), the certificate of leave. Today I speak as a mother, a mother who agonizingly watched her son rotate through the system from diagnosis in 1989 till death in 1997.

My son took his life last July. On initial diagnosis he was prematurely released to the community with absolutely no insight, and the doctor knew he was not going to appear for his monthly injection. He deteriorated. On his second committal, three years later, he did reach insight. He was kept on medication for a year through the justice system, having been charged with a misdemeanour. Haldol, the medication he was on, had horrendous side effects. With his doctor's knowledge, my son stopped taking his medication when his court case was dropped. Laying a charge was a way of accessing treatment that was condoned by support organizations of the time.

Extreme paranoia, serious deterioration, severe psychosis. In spite of all he endured, my son was not able to access appropriate treatment. On his third involuntary committal, he once again gained insight. The new medication was good. Side effects were negligible. Regardless, it was too late. Too much deterioration had taken place. He came to know just how much he had lost. As far as appropriate rehabilitation, there was a one-year waiting list.

We, the system, failed him. On first diagnosis he could have been kept in hospital until insight was reached. On second committal, the new medications were available. Why was he not switched? On third committal, there should have been rehabilitation services available. I commend the Health minister for bringing The Mental Health Act to review. For 10 years we have had a faulty legislation that has resulted in our doctors not being able to use the certificate of leave for what it was intended, a method of recall, to assist the severely affected mentally ill live more independently in the community and to ensure an appropriate level of medication compliance, a tool to help prevent deterioration.

COL is a choice option intended for the 15 to 20 percent of our severely mentally ill who have lost their ability to make good decisions and have little insight into their illness. If they are to be returned effectively to the community, we must provide the certificate of leave to meet their needs. They need our protection. They need help to remain compliant with medication, and without a method of recall, all the services known to us will not assist this particular segment of the mentally ill population. Rotating through the system, premature discharge without a method of recall for the severely ill results in irreparable deterioration. This must be prevented.

By legislating the recommended certificate of leave, we could reduce the frequency of the revolving door syndrome resulting in improved prognosis for a percentage of our very seriously ill, and we could also realize a reduction in hospital days due to shorter and less frequent hospitalization. By choosing responsibly, you will have an opportunity to provide a segment of the mentally ill in our province, the extremely ill, with a voluntary treatment option that will provide recovery of insight and competence, an opportunity to provide them and their families with hope.

You cannot ignore these very sick, difficult to treat people. You cannot clothe their need to treatment in rights and services. Their need for treatment must be the primary concern. You must provide our doctors with the tools to practise good medicine. You must accept the responsibility to the 20 percent, those severely affected by mental illness, and you must be responsible to the families and to the community. The death rate by suicide must be reduced. Thank you.

* (1050)

Mr. Chairperson: Thank you very much for your presentation, Ms. Weldon. Are there any questions? Thank you again for your presentation.

I call next Connie Krohn, private citizen. Have you a presentation for distribution?

Ms. Connie Krohn, Private Citizen: Yes, I do.

Mr. Chairperson: Would the Clerk please distribute? Ms. Krohn, you may proceed with your presentation.

Ms. Krohn: Honourable members of the Manitoba Assembly, my name is Connie Krohn, and I am in support of Bill 35. My son, affected with schizophrenia, is the youngest of four children, and from the time he was 12 years old his behaviour was different and very upsetting to the rest of the family. His school grades dropped drastically, and he became extremely difficult to handle. That was 14 years ago, 14 years of battling with schizophrenia and all the issues that surround it, talking with guidance counsellors, child psychologists, social workers, police, psychiatrists and various other health care workers.

In many instances they lacked knowledge and the skills to help or assist us. At one meeting I was told by a psychologist: just learn to get along. The change in my son's personality was frightening, and by the time he was in his late teens he was confused, belligerent and obnoxious. People with schizophrenia are unable to speak up for themselves and therefore do not receive the necessary attention. Does something drastic have to happen before they receive appropriate care? My son is an involuntary patient. He does not see himself as being ill.

In the summer of 1995, he had a psychotic episode. He was 23 years old at the time and living on his own. He had a certificate in welding and managed most of his own affairs. He often had delusions and hallucinations, and after his break with reality, was diagnosed as schizophrenic. Severe schizophrenia causes loss of insight, and therefore my son is noncompliant to treatment. No treatment, or a repeated band-aid solution, causes further deterioration and is harmful to him. This would be neglect and abuse due to inadequate loss to provide and protect him. Clearly, the laws are failing to protect my son.

In the last two years, my son has been hospitalized seven times. Think of the cost of admittance and discharge and add to that the expensive medication that is often not used. At this point, we should question what sound judgment is. If a patient cannot speak up in his own interest, does he then not have the right to timely and appropriate care, or is he doomed to substandard living in one room in a poor area of town? The revolving door syndrome where patients go in and out of the hospitals is costing us too much. It would be more beneficial to spend this money on research and prevention of schizophrenia.

Education would lessen the stigma attached to this disease and help families to support their ill sons and daughters. My son is on a certificate of leave since last October, and this has been a survival saver to him and the family. Unfortunately, this certificate of leave is for only one year. What is going to happen when my son is taken off the certificate of leave? His health worker already told me he expects problems. Will my son again be on the street?

In my opinion, the certificate of leave should be made available to all vulnerable, high-risk people with schizophrenia and others with serious brain disorders. If the patient is too ill to realize he or she needs the medication, then the person should be able to stay on the certificate of leave in order to receive treatment or to be hospitalized till he gets some insight into his illness. Also, a follow-up program with authority of legislation is desperately needed to ease the patient back into a normal community setting, with some work or program for him or her to do on a daily basis. However, the very best programs would be inaccessible to the very ill patients with schizophrenia. Because of lack of insight, these patients have no reason to inquire about the programs, and thus cannot request help. Therefore, these programs would be good only for the reasonably healthy patients.

My greatest concern is what happens to the very ill, mentally ill patients. They cope with poverty, malnutrition, poor health, isolation, assault and often jail. These people are often taken advantage of because they are vulnerable to predators. Appropriate programs are important towards improving the quality of life for persons with schizophrenia. It is help for the whole family and the community where he resides. Thank you for your attention.

Mr. Chairperson: Thank you very much, Ms. Krohn, for your presentation.

Mr. Chomiak: Thank you, Ms. Krohn. I appreciate your sharing your story with us and helping us to gain insight. Aside from the issues you raised and the story that you told of your son, I take it the other key component of your presentation is that even if a major community-based program like PACT or some other related program were in effect, even if there were all kinds of programming in effect, regardless of that, it is your opinion or your experience that your son, and a minority of others, still would require the provisions of the certificate of leave in order to function in the community. Is that a correct interpretation?

Ms. Krohn: That is correct.

Mr. Chairperson: Thank you very much, Ms. Krohn, for your presentation.

Before I ask the next presenter, what is the will of the committee? Do we want to adjourn for an hour or thereabouts at 12 and then continue the presentations after one o'clock? Is that agreed? [agreed] Just so that the people waiting there know what sort of arrangements they can make.

We will then proceed with the presentation of Colleen Cawood, private citizen. Colleen Cawood. Would you come forward, please. Have you a presentation for distribution?

Ms. Colleen Cawood (Private Citizen): I do not.

Mr. Chairperson: No.

Ms. Cawood: You will have to listen to me.

Mr. Chairperson: Welcome to the committee, and you may proceed.

Ms. Cawood: Good morning, Mr. Chairperson, and honourable members of this Legislature. It is a privilege to stand before you this morning, a nervous privilege, but nonetheless, a privilege.

To understand my perspective on the proposed Mental Health Act and the amendments to the certificate of leave, I believe it would be helpful for you to hear a small bit of my story and who I am, and the impact of your decision of Bill 35 and what that would have on me. For, unfortunately, not by any design of my own or by anything of my own doing, I am a consumer of the mental health system, for I have been diagnosed as having a bipolar mood disorder. Some of you folks may be more familiar with the term "manic depression."

Do not let these folks fool you into thinking that every mental disorder there are degrees of differences. Every mental disorder is a serious disorder, and please, do not rank my illness as being any less than some of these families, sons or daughters. Any disease that robs anyone of living life to its fullest is very serious, and I have lost years of abundant living to this serious disorder.

I am a middle-aged, well-educated family woman who has one professional degree from the University of Manitoba and is currently studying towards a certificate in theology at the University of Winnipeg. My loving and caring partner of 20 years and I have one gorgeous twelve-and-a-half-year-old son. My mother suffers from paranoid schizophrenia and is not able to be much of a support for me in my personal struggle. She and my father's approach and their handling of her disease is differently handled than my husband and I. Mom and dad have decided to stay strictly within this medical model, heavy-duty drugs by injection with little or no services or supports, and that is their decision, and we need to respect that.

* (1100)

My decision, on the other hand, my husband, child and I live in the suburbs of River Park South. We pay our mortgage and our bills on time. We have never relied on social assistance, and I know what it is like to live within a balanced budget. I belong to a supportive and caring community. I realize that I am truly blessed and that I am not a typical profile of a mentally ill person. I know this, and I thank God each and every day for the long-standing relationships, for the economic stability, for adequate housing and transportation, for my personal faith in everyday supports that I am so fortunate to have in my life. For I know, for me, therein lies the elements for my personal recovery. It is not just in my Paxil, which is my antidepressant. It is not just in my lithium, which is my mood stabilizing drug. My recovery is dependent upon these very, very important supports and services that my family and I have worked so very hard to obtain and maintain.

My family and I have our dreams and hopes and disappointments like any other normal family and are looking forward to going through life through the good times and the not-so-good times together. I am hoping that this scenario sounds quite familiar, and it is not too drastically different from your own, for you and I are really not that very different. Contrary to television and how the media sometimes portrays mental illness, I have never committed a psychotic crime. I am not a murderer. There is not a full moon out tonight, is there? I do not have any dead bodies stuffed between the drywall in the studs of my home. My brain simply does not produce a balanced amount of chemical, and, yes, I need chemical drugs to keep me balanced. Too much of this certain chemical, I become manic, and too little, I become depressed. Please hear me. I am not against drugs, for they are a necessary part in many people's recovery, mine included; however, they are only a part, a very small part in the larger picture.

There is so much more to the health of an individual than the medical. Drugs are not everything, hardly. The supports and services which we, the consumers, think as being so crucial to our recovery are simply not being addressed here. One only needs to consider the source of this act, families, the health system, psychiatrists. It is not the people or we consumers directly. We, who would have to live under this law and feel its repercussions directly, we, the consumers of the mental health system, want your political efforts and government monies to be focused on developing community supports and services, not forcing people back into the medical treatment and passive compliance. I know from my personal experience how important these community supports and services are, for I would not be here without them. I know in my heart of hearts that these were the catalysts to my recovery and still are in maintaining my mental wellness today.

I am a rational woman. I know when I am getting sick and I know when I am getting better. I have had the experience of taking some medication, the very same medication, at two separate times. Once it was working and helpful, and the other time it was not–for some unknown reason. Unlike some other consumers' experience, my current doctor and psychiatrist, they listen to me. I was in control. Even though I was losing my control, I was still in control. I was telling them what was working, what was not working. It was evident to me how I was feeling and how I was functioning.

I have tried everything, and I do mean everything. My physician's only request was that I be honest and tell him what I was doing so that he could document my trials. Reflexology, traditional Chinese soups and teas, herbs, eastern meditations, you name it, I have tried it, but my doctors recognized and realized that the meds would only work when I had tried and done everything that I needed to do and try first.

I was lucky. My case is exceptional, I do not disagree, but you need to hear that personal choice and personal readiness is the best medicine that anyone can prescribe. I know this from personal experience: that drugs work better and do their thing more effectively when the human spirit is engaged voluntarily and not forcefully. The certificate of leave is forcing chemical compliance. You would not force cardiac patients to take their drugs. You would not force diabetics to take their insulin. Even cancer patients are given the choice to control their life and their meds. Why would you take this basic right and freedom of choice away from us who suffer from a mental illness?

I find this piece of legislation personally disempowering. It rapes the individual's control of their own life in health decisions, and it gives it to some nebulous, undefinable, medically modelled treatment team. What gives them the right, or anyone for that matter, to control my life, to control my treatment? The certificate of leave? No, thank you.

Well, I guess I have to stay here and answer questions.

Mr. Chairperson: Thank you very much, Ms. Cawood, for your presentation.

Mr. Chomiak: Again, thank you very much for helping to inform us by telling us your story. It is fairly clear from your presentation that you do not wish us to pass the provision dealing with the certificate of leave. What about the other provisions of the act? Do you have any opinion or any viewpoint with respect? Because this is a rewrite of the entire act, do you have any comment or advice on any of the other sections for us?

Ms. Cawood: Not specifically. I am for anything, though, that gives people choice and that empowers people. So please consider that when looking over this piece of legislation.

* (1110)

Mr. Chomiak: Mr. Chairperson, can I take it from your presentation, having said that, and I know this might be difficult and it is probably easier for us because we deal with legislation all the time, but if we accepted your recommendation and removed the section on certificate of leave provisions, presumably there would be some that would say that there is a gap. Now I have heard it argued that the gap would be dealt with, or could be dealt with, by more intensive community-based programs.

I would take it from your presentation that the gap could be filled by providing consumers or patients with a variety, a menu of alternative remedies and alternative courses of action, and basically more control. If you were sitting here drafting the legislation or if you had the occasion, would that be how you would approach it?

Ms. Cawood: Most definitely. [interjection] Sorry. Most definitely. I am a spontaneous kind of person; I respond. We are for increased services and supports. We really, really question the need for certificate of leave if these things were adequately in place and used.

Mr. Chomiak: I think a final question: how would you deal with the arguments of those that you have heard previously with respect to those individuals who are deemed at some point–the argument that they are deemed incapable of making a decision with respect to choice?

Ms. Cawood: That would be like my mother. I guess the way that our family handles it is, you call it an advocate at the beginning of any kind of process. I do recognize, and I do know severe mental illness. I have lived with it. I will not tell you for how many years. A few decades, so it is not like I am not aware and I am living in never-never land. I know what serious illness is like. I have lived with it too long, but I also know the same medication, when it is taken, through my mother as well as my own example, when it is taken willingly or if it is taken forcefully, the very same dosage, the very same medication, and the effects are like night and day. Whether the brain produces a chemical that is counter to the medication or not, I do not know. But personal will and choice is crucial.

Mr. Gary Kowalski (The Maples): I really appreciate your presentation. Today, for me, it gave me a different face to mental illness, and I have seen it as a police officer for over 25 years. A lot of times my perception was shaped by the worst-case scenarios, the crisis situation with people in crisis. I guess I forget about the thousands of people who are dealing with it and are successfully dealing with it. I think in your presentation you mentioned how the media reports and my perception, the public's perception many times is jaded. Because of that, we do not see the face of all the people who are handling mental illness and living productive, fulfilling lives, so I really appreciate your presentation.

The one thing you said during your presentation is that your situation, you said it is exceptional because of the supports you have had and that, and I imagine mental illness like many other illnesses have a continuum from the best case to the worst-case scenario. Can you see any degree of mental illness where a certificate of leave would be required?

Ms. Cawood: Honestly, no.

Mr. Chairperson: Thank you very much. We have gone past the limitation that we had established before. I am going to recognize Mr. Sale with a final question.

Mr. Tim Sale (Crescentwood): Mr. Chairperson, I think you responded to my question to my honourable colleague beside me here, but I just wanted to be clear whether your objection was an absolute objection in principle or whether it was to do with inadequate drafting to make the use of a certificate sufficiently constrained, that it would clearly only be able to apply to people who had no insight at all into their condition when they were in that condition.

You have made a very strong case that you have insight and you have supports and I appreciate your acknowledging that, but I was wondering whether your objection was absolute or whether it was relative to what you might consider loose drafting of this?

Ms. Cawood: I am absolutely against it. I recognize it is for a small percentage of the mentally ill, and for such a minority it is giving away more power to psychiatrists who misdiagnose, to drugs that do not work, who are unsympathetic when you say that they are not working. I am totally against it.

Mr. Chairperson: Thank you very much, Ms. Cawood, for your presentation.

I call next Theresa Wayne. Welcome to the committee. Have you a presentation for distribution?

Ms. Theresa Wayne (Private Citizen): I will later.

Mr. Chairperson: Could you bend the mike down just a wee bit? There, that will be great. You may proceed then with your presentation. Could you pull the mike down just a wee bit more? That is good.

Ms. Wayne: I am short. Good morning everyone, Mr. Chairperson, all honourable members of the Legislature. I am Theresa Wayne, and I thank you for the opportunity to speak here today. I was listening to the radio this morning and thinking about the Manitoba Marathon coming up. I thought, well, one humorous way of looking at the certificate of leave for me is, as I have seen in a poster a few years back that always stuck in my mind, sometimes you can be so far behind you think you are ahead because you cannot see the people in front of you who have already turned the corner. I guess that is just how I feel about the certificate of leave, is that anyone who would propose this, it is like you are putting mental health back 100 years, because I see it as unjust, not moral and not facilitating any kind of spiritual process of growth.

Mr. Vice-Chairperson in the Chair

I am very interested. I have a BA with a major in psychology, and I am also very interested in theology. What I have attempted to do is to marry theology and psychology. I believe that everyone has a spiritual life and is a spiritual being, and I see that relying on a medical model and putting everything in terms of medication and having that the main factor is very debilitating and takes away from choice.

Also, people take a negative attitude towards their caregiver. They do not look into their illness. They do not learn about their illness. They do not have an active, empowering role to get better, and they feel oppressed. So, for me, a certificate of leave is like putting a gun to their head. How is it less intrusive? If something is intrusive, it does not matter whether you are in the hospital or in the community. If you get a bee sting and you change the setting, you are still hurting. So it is extending the walls of the hospital into the community.

I do not see it as being less intrusive but rather more intrusive. In fact in Saskatchewan, where this law has been put into place, one person felt they were being punished by their doctor, and they subsequently committed suicide because they felt they had no freedom in the community. They felt very, very stigmatized. I can certainly sympathize with that from my own experience.

Also, there has been no definitive proof that serious mental illness is like schizophrenic depression, anxiety disorder or anything like this. It has never been totally proven that there is a genetic or even biological basis for it. There are many theories, and it is easy that doctors want to believe this, because it kind of ties in with keeping their organizational turf. Peter Bragen [phonetic], who has written the book, Talk Psychiatry, which I think everybody should read–and I think if you read that book, you will have a totally different understanding of what is going on in psychiatry. He is the president of the National Institute of Mental Health. Basically it shows you all the myths of psychiatry and how all the pharmaceutical industries are tied into it, and therefore, when that happens, it is natural that they are going to want to rely on drugs.

That is something that they can do, and they do not have to worry about community supports, because if you give somebody a drug, it ties in with the technological advances we like to see in society. It is a quick fix. You do not have to worry about people's housing, poverty, their social networks, whether they have friends, whether they have food to eat, because all you do is you give them a prescription.

It is like we have gone backwards, because in the olden days when they said we will empty out the institutions–they said we have got these miracle drugs, let us empty out the institutions. We will give people these drugs, and they are going to be fine. Well, they sent them out in the community, and there were no community supports and the people were not fine. Now we are saying: well, let us do the same thing again. If we just get people to take these drugs–and as far as I can see, the only reason for having the certificate of leave is so that people will take their medications–you are going to be right back to square one because people taking their medications alone are not going to get better. It is going to keep some people sick. The other thing is a lot of people are on the wrong medication and they have been misdiagnosed and when they stop taking their medication, people think that they are relapsing and being sick. Actually what is happening is they are suffering withdrawal symptoms from their medication. It is possible that some people need to go through that withdrawal period in their medication in order to get better, but it is not a sign that they need to be on those medications forever.

* (1120)

If you do not go through those withdrawal symptoms and get off those medications at some point, you are going to be on those medications for the rest of your life. I do not believe that people need to be on medication for the rest of their life because I believe there are other ways of recovering. It has also been shown that biological changes in the brain are affected by other things other than drugs, and the same results that you get from taking Prozac was also achieved by people doing jogging, by people doing biofeedback, by people doing other forms of behavioural therapy, also produced different changes in the brain. So it is not just drugs alone that will affect your neural things. We all know that jogging will increase your endorphins and things like that, so to say that drugs are the only way and the only route to health, I think is very wrong and people can get stuck in that system. I think it is a really terrible system.

The other thing for people who say to me, well, you will deny my son the opportunity of living in the community if he does not have a certificate of leave and he is going to deteriorate, right now there is no law that says your doctor cannot phone you, that there cannot be someone to go out and say how are you doing. There is no law that stops that. It is that the people in the mental health system do not want to be bothered. People go there and they say I am getting sick, I want to go into the hospital and they turn them away because they say, oh, well, you are not sick enough. They wait until they get really sick and have a crisis and then they dump them into the hospital.

It is the people on the front lines that need to be trained differently. They need to be there. They need to be compassionate, so when people go to the hospital and say I am getting sick, they need to offer them some supports. There needs to be community supports. Maybe they do not even need to be admitted to the hospital but they need help and those services of help are not there for them. We assume that people are either supposed to live out in the community or they are supposed to be in the hospital, but there is an in-between ground to that. They can have advocacy services, they can have supports, they can have other people there for them, they can have someone to phone them. If we had community walk-in clinics then we could call someone up if someone was having a crisis. Maybe someone needs someone to spend a night with them. Maybe someone needs some money to help buy them some food. Maybe they are having a crisis just because they run out of money or, like Paul Carling was here and gave a very neat example which is like common sense. If someone has a problem and they cannot get to work, and their car is broken down and they are going to have a crisis and have a nervous breakdown and end up in the hospital, why not just help them get their car fixed. Give them money to tide them over, avert the crisis, help them phone their employers, say they are going to be late, help them over that crisis, do not wait until they have a nervous breakdown and lose their job and end up being in the hospital for two months. Do a common-sense thing.

But what our mental health system has done is it has said oh, we could not do that to consumers. They will be taking advantage of us. If we give them money once, they will feel they are entitled to it. They will want money all the time; they will be manipulative. They will think it is coming to them. No, we do not have a kind, compassionate way in dealing with consumers. We are punitive; we are always so afraid to give. It is always, we think, oh, consumers are acting out and doing this to get attention. They are manipulative. It is not true. When people need help, they ask for it.

Even in the case, if you look, when the person went on the Toronto subway and killed someone, he went for help first, and he was turned away. How would a certificate of leave have averted that, if he went to the hospital and he was turned away? It is the people in the hospital, it is the community health, it is the doctors, it is the psychiatrists who need to be there to accept people when they need help. So a certificate of leave would not have helped those kinds of situations.

So why would families be advocating for a certificate of leave? Why would you give your son or daughter a stone when they ask for a loaf of bread? People, it has been shown, do not do well under force, and they get sicker when they feel that they are being threatened. People panic and people often get sicker if they feel that they are being forced to do something that they do not want to do. It does not facilitate growth. It does not facilitate them finding ways to empower themselves and discover their personality and their way of living as full human beings and developing their potential. So those are just some feelings I have about the system. I could write a book on it. I have lots of books on it. I could go on really forever, but I do not want to go on forever because I know there are a lot of people who would like to speak here. I really hope this act is not passed because I want to see other things in place.

I think it only legalizes the revolving door syndrome. If we have problems finding beds for people now, and we turn people away, how are we going to find beds for people? Where are we going to find the police to go and pick these people up? We already have problems with the police plugging up the emergency rooms, and they are saying, well, this is not the police's job. And then we say, well, we have criminalized mental health and we have the police doing all this work. Why are the police doing all this work? Because the doctors and nurses are not doing it, because they are not there for the people and we do not have people that are compassionate.

If you have a doctor who says, do not phone me because it is going to cost you $25–I mean, someone who is in poverty and living on social assistance does not have enough to eat, he cannot access the service. We can provide care a lot cheaper than $21.95 for 15 minutes, which works out to about $88 per hour for someone who sees someone for 15 minutes, hands them a prescription and goes out and does not care to check on them, whether what they do with the rest of their life, does not care to see whether they have a telephone, does not know if they are living in poverty, does not help them to quit smoking, does not help them to do healthy things in their life.

Mr. Chairperson in the Chair

You have all these psychiatry patients sitting in ghettos, smoking and drinking coffee, and all they care is that they come in for an injection, but what have they done to improve the quality of their lives? Nothing. Because it is based on the medical model. These miracle drugs are supposed to help you. These miracle drugs were miracles to the other people. They were not miracles to the patients. All it did was you had patients in the hospitals. It stopped their symptoms. It made them into zombies. You sent them out in the communities. They were zombies in the communities, and they could not function. Now we are saying, let us keep them taking these drugs, and if they do not take these drugs, then we will send them back to the hospital. So I do not see it as an answer.

Mr. Chairperson: Ms. Wayne, just to remind you, you are now about 11 minutes.

Ms. Wayne: Okay. I am coming to the end. I will just share my own personal story, which has been a living hell for me, which I am really happy to get out of. The psychiatric system abandoned me. It was not there for me when I needed it. I found other ways of help. I found ways to recover without drugs, although I did use them. I think they are useful at times, and you can use them as floaters.

When I was 11 years of age I was admitted to an adult psychiatry ward. I suffered severe traumatic stress syndrome. Although the certificate of leave was not in place at that time, effectively the system operated for me like a certificate of leave because I was told: you have to take these drugs for the rest of your life, and if you do not you will be back in the hospital. So I thought, well, this is a misunderstanding. I am going to take these drugs because I want to get out of the hospital and all the other patients told me what to do, so I did that, but when I got home I found that my parents had been brainwashed by the doctors and were saying: you have to take these drugs for the rest of your life. So there was war.

I did not want to take them, so I ended up back in the hospital. So I was being treated for schizophrenia like for two years. It is very hard when you are going through adolescence with all the other problems, and that happens. Then I was told that I definitely did not have schizophrenia and that I should never have been treated for schizophrenia. In the process of that, the doctor who told me that left, and he left me without any supports. I was very stigmatized and suffered for a very long time. I had a very hard time getting out of the system. I developed a very negative attitude towards psychiatrists because they took away my childhood. It was like the rape of the mind. So I fought for years and years and everybody said: oh, go to another psychiatrist. You have to try them all. You cannot judge them. They are different.

Well, I went and went, and I went to so many, and they were all the same because none of them understood what I had gone through. None of them wanted to understand, none of them wanted to admit the system had made a mistake and none of them–I got about 10 different diagnoses, by the way. Nobody helped me recover, to the point where I finally went to Toronto. I got someone, a walk-in clinic doctor in Toronto, to finally send me home and say take some time off and have a rest, which I did. I started to recover, and then I tried to go to psychiatrists again, because I did not want to give up on them. I did not want to write them off, but it is like how many times are you going to touch a hot element before you realize that you are going to get burned every time?

For me they were not there, because I wanted to recover without drugs. There was nobody there that would help me recover without drugs. So my family doctor sat down with me one day and said: you know, if there is a good psychiatrist in Manitoba, I do not know where you would find them, but they are not there for you so let us do this together. We did it together, and I did it with the help of my church. I did it with the help of the Canadian Mental Health Association. I did it with the help of a really good nun, because I actually believed it for awhile. I believed it. I thought, well, maybe I really do need these drugs. One day she said: Theresa, no wonder you cannot get on with life, you are always tired because you are zombied out. She helped to get off of them to take that risk and I got off of them. So I am in recovery and I am very happy.

As a result of that, I can celebrate Halloween, Christmas, Easter and Canada Day. I feel like a free citizen because all the time I was under psychiatry, I felt constantly oppressed. I felt like I was not like everybody else and life was a living hell. The bounds of the hospital had entrenched into my community so I was living in the hospital in the community, living a living hell.

I am really happy my journey with psychiatry is over. I hope it is not as bad for everyone, but I advocate for–I think, like I say, drugs can be useful and that people should have the option of using them. I ask you to please not bring this bill in because I would rather see community supports, education of the clergy, people go on health retreats. People do not always need drugs when they have a mental illness. Definitely, one of the other problems I have with this bill is that there is no provision for advocacy, and people definitely do need advocacy. I also find that there are enough things in place already, having involuntary commitment, and also people can have health care directives. I would rather see that as an alternative to the certificate of leave.

* (1130)

I feel that what would be the point of putting in another law–just in closing–when the laws we already have we are not using them. We have people on the streets, like the person who died in Eaton Place. We have people who are a harm to themselves, and we are not going to pick them up. If we see people like that, then why did someone not compassionately go out and bring them into hospital and help them? We have not used the laws we already have, so why should we bring in another law that is going to harm a lot of people and has the potential to do a lot of damage?

In closing, I have this little poem, which I really like, and I just want to read it because so many of the mentally ill are faceless, nameless and homeless, and I think they should be treated with compassion and kindness. If they were treated with compassion and kindness, they would not have such a fear of the system and they would not be in denial. Part of the reason they are in denial is because they do not want to get the help because they know what waits for them when they get to the hospital. They are often so abused.

There are shadows in the city/Shadows leaning against buildings/Shadows lying on the sidewalk/Sleeping on city grates/They are shadows of street people/The shame of a nation/They are God's very own/Faceless, nameless, homeless/Shunned by their fellow men/Few see their suffering or relate to their pain/As you scurry about the city/Checking your agenda/Confident of your plan/The shadow that you tripped on was a homeless woman/man/Once proud members of society/Somehow fallen through the cracks/Lost/confused/searching/Is there no way back/Christ said these too are my children/Lift them to their feet/Lest the shadow of their body hide my view of you from me

Mr. Chairperson: Thank you very much for your presentation, Ms. Wayne.

Mr. Chomiak: Thank you for your presentation and also for sharing your story. I had a whole series of questions I meant to ask, but as so often does, I think your poetry covered a lot of ground actually. I wanted, though, to sum up whether or not–you are obviously opposed to the provisions of the certificate of leave, and I take it from one of your arguments–is one of your arguments that by putting in the certificate of leave that all of the other issues that you identify of a better accessibility, better reaction from caregivers, alternative methods being offered, advocacy being offered, that the certificate of leave will be used in lieu or in place of those kinds of programs?

Ms. Wayne: Yes, I feel it could be. I feel that, if the certificate of leave is in place, people may use that and they will not put other community services in place. I also feel that even if the other community services are in place, that that certificate of leave stigmatizes a person and that if you had those community services in place, you would not need a certificate of leave, because there would be people out there checking on that person, if they were deteriorating. There would be people to say are you okay? Do you have money? Do you need better help in finding a new place to live? If your father and mother have died, do you need us to help you make funeral arrangements? Do you need us to go to the funeral? If your sister is suffering from something, can we help you?

If there is tragedy in the family, if you have some problem, people would have somewhere to go, so then why would you need to have a certificate of leave?

Mr. Chairperson: Thank you very much, Ms. Wayne, for your presentation.

I call next Maureen Koblun. Maureen Koblun. Have you a presentation for distribution?

Ms. Maureen Koblun (Private Citizen): Yes, I do. I will do it after I have my talk.

Mr. Chairperson: The Clerk will distribute.

Ms. Koblun: Honourable Chairman–

Mr. Chairperson: Could we just wait till we start distribution of the presentation.

Ms. Koblun: I wanted to do it afterwards. Okay, thank you.

Mr. Chairperson: Okay, if we do it after, that is fine, too. You may proceed then with your presentation.

Ms. Koblun: Yes, the thing that I am doing is done very simply. It is an overview of how I feel about the mental health system and other concerns. I sort of divided it up into different sections.

Introduction: I am presently a mental health consumer. I am also on leave from work with a mental health disability, long-term disability, as I work for the Province of Manitoba, so the civil service. The disability pension is definitely much better than welfare or CPP, which a majority do not have. I could bring my credentials with me, but it would be hard to bring my 17-by-24-inch plaque from a junior achievement award.

Advocacy: The Mental Health Act should be written to empower the mental health consumer. There are also issues with the bill that need to be addressed. Although there is no mention of an advocate, it is necessary to protect the rights of the consumers who usually have so little power. The advocate informs the consumer of his or her rights and advocates for the patients if necessary. The psychiatrist is not always right and should be challenged on occasion.

Certificate of leave: Although there is a division about the certificate of leave, we must examine the problems it can cause. The potential passing of the certificate of leave raises many questions, and I would like the help of the Legislature to solve them. Also, where is the money going to come to implement this bill? We should revisit in a year to evaluate this clause if it is passed.

There are a number of questions I will ask the members here: (1) When a person is recalled on a certificate of leave, will there be a bed available? (2) Will the person pick up the person and deliver the person to the admitting clerk or the emergency room? (3) Will the police have to stay in emergency until the person is assessed? (4) Will the police use the special handcuffs for psychiatric patients as I have seen in my work at provincial court? (5) What else does the treatment plan have besides medication? Are community supports included and are they there? (6) Who signs the certificate of leave besides the doctor? How much control and power should he have? (7) Should a patient be forced to take medications against his will if the patient refuses to take it? Negotiations about medications is enough. A doctor cannot get inside the patient's mind and thinking. (8) What other systems will be affected and additional costs incurred, police force, Department of Justice, et cetera? How much money will be spent in administrative costs in the mental health community? Although there are many other problems to be solved, a consumer must be given community supports in order to live the best life he can.

Prevention: We cannot always have everything right away, and we can understand that. But, for example, we need more mental health workers in order to monitor patients and prevent crisis situations now. An example of prevention can be related by the following story. A person's toes have been cut. No one attends to the wound and it becomes infected. Attempts by the patient to take care of it fail. Eventually the wound turns into gangrene. When the doctors finally operate, they operate up to the knee. Where was the doctor in the first place now that the damage is done? Mental health supports and early preventions allows for better mental health, and the potential to become well is increased. Early prevention is also less costly, and the money could be used more effectively.

Summary. We need to have co-ordination of mental health services in the community. If psychiatrists are overworked, maybe we should hire psychologists for less money, and it could be paid for by medicare. Although patients need to be monitored, let us see how this fits into the present system. Parents will not live forever to take care of their kids. Mental illness can be a reoccurring illness. The community will eventually be responsible for the well-being of the consumer. These consumer supports include housing, employment, medication, food, recreation, et cetera. Inviting a person to exit the hospital on a certificate of leave can open up a new bed for a patient who is in crisis. This, I have overheard, with my doctor discussing this. What happens if the person needs to be readmitted, taking a turn for the worse. Patients are responsible for their own lives, but especially the community resources must be there to help them along to become functional in mainstream society.

Conclusion. The power over the mental health consumer is in the hands of the few who think health, mental health is everybody's business. Anybody on this committee can become mentally ill. Do you want to be helped in this present or future system of mental health?

Mr. Chairperson: Thank you very much, Ms. Koblun.

Mr. Chomiak: Mr. Chairperson, I have a comment and then a question. My comment–and just for yourself and other members of the public–following the public presentations, there is another stage of the bill that is clause-by-clause consideration where we go through each item of the bill on a clause-by-clause basis. I do not suspect that will take place today. I suspect it will take place next week.

* (1140)

What happens in the clause by clause is the minister has the officials here and we, as legislators, have the opportunity to ask of the minister specific questions, and I know the minister is taking note of this as well. I just want to assure you that we, on your behalf–if you cannot attend–will ask all of the questions that you have posed today. We just want to assure you that we will undertake to do that, and the minister is undertaking to have his officials available to provide those answers. So we will have an opportunity to pursue those very valid points that you raise and anyone else who is going to be raising these issues in committee and query the minister and his staff as to those ramifications. So I just want you to know that. I thank you, as well, for your presentation.

Now, my question is, having heard your presentation, do I take it from your experience that you are not in favour of the provisions or the certificate of leave, or that you–

Ms. Koblun: I am not in favour–

Mr. Chairperson: Ms. Koblun.

Ms. Koblun: Yes, sorry.

Mr. Chairperson: I want to make sure that your mike is turned on, and if I do not recognize you, your mike will not be turned on.

Ms. Koblun: Okay. Thank you. Yes, I do believe that it is not necessary to have the certificate of leave. I believe that the emphasis should be on prevention, and we need guidelines to help people before they get to the certificate of leave. If we do not have those supports before we get into the certificate of leave, the prospects of being more ill, mentally ill, by the longer time you stay out of hospital and by the time the certificate of leave is invoked.

Mr. Chairperson: Thank you very much, Ms. Koblun, for your presentation.

Ms. Koblun: Thank you. These are for presentation. That is a copy of my speech.

Mr. Chairperson: Thank you very much. I call next Susan Olson, private citizen. Susan Olson would you come forward, please. Ms. Olson, have you a presentation for distribution?

Ms. Susan Olson (Private Citizen): No, I do not.

Mr. Chairperson: Thank you, you may proceed.

Ms. Olson: Mr. Chairman, ladies and gentlemen, I am here today to support the certificate of leave. I am speaking to you as a mother who has for many years watched an evil disease take over my daughter's life. Three and a half years ago, my daughter was diagnosed with schizophrenia. We have been one of the fortunate families that have received timely and appropriate treatment. My daughter has been cared for within the hospital system where her illness can be monitored and treated. She is a voluntary patient.

For a brief time, she was released into the community where she refused to take her medication. The decline was very rapid. Within weeks, she was readmitted to the hospital. This is the plight of people with serious brain disorders. When the doctors decide that it is time to release a patient, they are turned out into low-rental, inadequate housing where there is no support system and no care. As The Mental Health Act states, all people have the right to refuse treatment.

Mr. Chairperson: Could I interject? Could you pull your mike up just a wee bit closer? That is better, thank you.

Ms. Olson: When a social worker goes into a situation, an apartment situation where a patient has the right to refuse to be seen by that social worker–and in most cases this is what happens. The small group of people that I am lobbying for will definitely discontinue taking their medication, and they will begin to deteriorate to the point where they will have to be rehospitalized, and it starts all over again. The revolving door syndrome is a fact. Each time a person suffering from an illness is allowed to deteriorate to this stage, not only is irreparable damage done, the cost to the health care system escalates.

In Winnipeg alone, 133,000 people suffer from mental illness. Of that number, 13,300 suffer severe mental illness. These are the people I am concerned about here today, that 2 percent of the population whose rights are denied by the existing Mental Health Act. Actually, it is a smaller percentage than that. I am concerned about my daughter, personal.

With the proposed certificate of leave, I believe in my heart that these people will have a better chance at maintaining a life outside an institution, or, God forbid, incarcerated in a psychiatric unit within the prison system. I live in hope that my daughter will one day be able to live in the community, but I also live in fear that when she does she will be one of the ones who falls through the cracks and is allowed to slide back into that horrible place in her mind where mental illness places her.

Suicide is a word that many of us do not understand, but for too many of our children it is an answer. We are asking you to help us and our children by implementing the certificate of leave so they may get the treatment that is their right. Thank you.

Mr. Chairperson: Thank you very much for your presentation, Ms. Olson.

Mr. Chomiak: Thank you again for coming and telling us your story. Your daughter's status right now, you indicated that she presently is on a regime.

Ms. Olson: My daughter is hospitalized at the present time.

Mr. Chomiak: Has she been continually hospitalized, or has she lived in the community for an extensive period of time?

Ms. Olson: No, she–

Mr. Chairperson: Ms. Olson, I know how difficult it is. I used to stand there and make presentations, so I know how you feel.

Ms. Olson: She was released into the community for a very short period of time. She refused to take her medication. She deteriorated very rapidly and was returned to the hospital, again voluntarily.

Mr. Kowalski: As the presentations are coming forward, we almost have two different schools of thought here, very strongly. So I am trying to clarify in my own mind the position. You attribute your daughter's deterioration mainly to the fact that she did not take her medications, yet from Colleen Cawood, who made a presentation, she talks about the nonpharmaceutical way of dealing with these things and the importance of the supports as opposed to just the drugs.

If there had been more supports for your daughter, if her situation–I do not know what supports could have helped her. Is there anything that could have helped her other than the drugs?

Ms. Olson: When my daughter was first taken into the hospital, she was very delusional. What support could help her? Who could reason with her as to where she was? She hears voices. She does not respond to people speaking to her asking her what her problems are. She is not capable of communicating, so the support systems are no help to her.

There are support systems, and when she goes out into the community, refuses to accept it. As it stands now, a social worker or a crisis unit team can only see that person if they agree to it. If they deny that access, there is nothing they can do about it.

Mr. Kowalski: So how would your daughter's situation be different if she was released under a leave of certificate?

Ms. Olson: Presuming my daughter will be well enough to leave the hospital, she will be cognizant. She will not be hearing these voices anymore. Her medication has increased her ability to be more reasonable. With the drugs, she has gotten a lot better, and I am hoping it will be a lot better from here on as well. She requires the medication. Schizophrenia is a lifelong illness, and to the degree that my daughter has it, medication is the only thing that is going to keep her mind clear. Yes, when she goes back into the community, she will need her medication to keep that mind clear.

Mr. Kowalski: But the leave certificate does not put the drugs in her mouth. How does the leave certificate make her take her drugs?

Ms. Olson: My understanding of the certificate of leave is that when a patient is released from the hospital, they must follow a regime of taking the medication and seeing the doctor. If they are not seen or heard from for a couple of weeks or so on, they are going to be recalled back to the hospital to be checked. With the medication, the lengthy absence of medication, the deterioration builds, so it is best to nip it in the bud.

Ms. Diane McGifford (Osborne): Ms. Olson, thank you for your presentation. I missed your statistics, and

I wondered if you would mind repeating the numbers. I think you gave a number for those suffering from mental illness and then those suffering from severe mental illness.

Ms. Olson: Okay. In Winnipeg alone, 133,000 people suffer from mental illness. Of that number, 13,300 people suffer severe mental illness. That is in Winnipeg alone.

Ms. McGifford: Could you tell me, or do you know the percentage of those who are severely mentally ill who are also schizophrenic?

Ms. Olson: I am sorry. I do not have that information.

Mr. Sale: Just a brief question, thank you. You focus on the certificate. Do you have any views on the advocacy issue? A number of presenters have raised the question of the need for better treatment of access to an advocate function in the act. Do you have any comments in that area?

Ms. Olson: I strongly believe in advocacy. People need somebody to speak out for them when they are not capable.

Mr. Chairperson: Thank you very much for your presentation, Ms. Olson.

Ms. Olson: Thank you.

* (1150)

Mr. Chairperson: I call next Phyllis Wayne. Phyllis Wayne is not here?

Floor Comment: She is not here, but I have her letter.

Mr. Chairperson: Could you bring the letter forward. We will accept it as a written submission and we will have it recorded, if that is the will of the committee. Thank you.

I call then next Patricia McInnis. Patricia McInnis, have you a presentation for distribution?

Ms. Patricia McInnis (Private Citizen): No.

Mr. Chairperson: Thank you. You may proceed.

Ms. McInnis: Honourable members of the Legislative Assembly, first of all, I cannot give a–

Mr. Chairperson: Could you pull the mike down just a wee bit, just bend it down. That is better. Thanks.

Ms. McInnis: I cannot give you a professional presentation. I have never done anything like this in my life before, so it is very difficult. First of all, I am a homemaker, and I am also a caregiver for a sick husband. Recently, one of my grown children has been diagnosed with a mental problem. I have had a friend for almost 40 years whom I have been with in the good times and the bad times almost daily who has had a profound effect on my life, and she suffers from schizophrenia. So that is my involvement.

I am very frightened now that I, too, as a parent will now deal with this, and I have been dealing for almost three years with a physical illness where my husband and I have received such wonderful care through the health system, such gentleness and respect and kindness and always treated so well. I did not see any of that for my friend in almost 40 years. I thought the treatment was so inhumane. She was treated very roughly by people in the health care system, so I have prepared this.

I believe that in all situations, force and coercion must be used as a last resort instead of as a matter of course. We must take up the Christian challenge of mental illness and surround those who are ill with the same love and understanding we give to those who contract illnesses such as cancer or heart disease, and I have experienced that. As we learn more about the different types of mental illness, it is evident that definite physical factors are involved. People with mental illness are suffering from brain disorders which indicate a physical basis. We must try to understand mental illness with both our head and our heart and treat those afflicted with a loving, healing attitude to help them learn and gain control over their illness.

Remember, mental illness is not contagious, but love, understanding, respect and support will be. Thank you.

Mr. Chairperson: Thank you very much, Ms.

McInnis, for your presentation.

Mr. Chomiak: I also would like to thank you for a heartfelt presentation and for bringing your experience to us. You said that force and coercion should be used as a last resort. Having said that, do you have an opinion on the provisions contained in this act as it relates to the certificate of leave?

Ms. McInnis: Well, from what I have read and having somebody who has just entered into this, I will hope that everything preventative can be done, that there would never be any need for anything that would take away those choices and her liberty. We just do not have the right to do that.

Mr. Chairperson: Thank you very much, Ms. McInnis, for your presentation.

It is four minutes to the hour, what is the will of the committee? Should we rise and then reconvene at one o'clock? [agreed] Thank you. We will recess then till one o'clock, and we will return here.

The committee recessed at 12 p.m.

After Recess

The committee resumed at 1 p.m.

Mr. Chairperson: Could the committee come to order again.

We have an out-of-town presenter who has now arrived. Her name is Mary Ann Haddad, and I wonder whether the committee would want to hear her now. Agreed? [agreed] Then I will call Mary Ann Haddad to come forward. While she is coming forward, just a note here that person No. 6 and presenter No. 14 would like to be dropped to present between 22 and 23; just a note for the committee's consideration.

So if I should miss them or appear to miss them, I would with your consent drop them to that position. That does not change the order except it moves the others up by two, and then later on, of course, defers that. So they would be moved to just after 22, between 22 and 23. That will be Rod Lauder and Ellen Kruger.

Then we have Joan Joyce Podolas. She has a job interview at 3:30, and she was wondering whether she could present before that. Is that all right? [agreed] Okay, I will call her then after the out-of-town presenter who is before us now.

Mr. Sale: Mr. Chairperson, could you clarify which list we are working off of?

Mr. Chairperson: I am sorry, I have a new list here which is updated.

The first name on your new list would be Joan Thorogood, but we are adding the last one to head that up.

Mr. Praznik: It is just a question. I see Ms. Haddad's presentation also indicates that Jackie Mauws is a writer, as well, so is this a presentation on behalf of both, Mr. Chair?

Floor Comment: We worked together on the presentation.

Mr. Praznik: Okay, because I think Jackie Mauws' name was also on the list.

Mr. Chairperson: And she will be presenting?

Floor Comment: No, she is not.

Mr. Chairperson: She is not presenting.

Floor Comment: No. I worked in concert with her.

Mr. Chairperson: Okay, great, that clarifies that.

Mr. Sale: Mr. Chairperson, my question was because the order in the new list is different from the order in the old, so where are we starting? We are starting from the top of the new list after the out-of-town presenter?

Mr. Chairperson: Yes, with the exception of Mary Ann Haddad and No. 16. I would propose that we hear Ms. Haddad and Ms. Joyce right after. Ms. Haddad and Ms. Joyce in that order. Okay.

Mrs. Shirley Render (St. Vital): Mr. Chairman, can you give me the list of the first three presenters? We have got another presenter that has a time problem also, and my understanding was that he was going to come on at one o'clock, so just so we know the order of the first three presenters. We agreed to this before the break.

Mr. Chairperson: Could you give us the name?

Mrs. Render: The name is Bruce Waldie.

Mr. Chairperson: Bruce is not here right now, I believe. Is he? Okay, we will hear him then, if it is the will of the committee, right after Mark Waldie–or after Ann Haddad. Is that agreed? [agreed] He would be the third person then. Sorry about that.

We have before us Mary Ann Haddad. Have you a written presentation for distribution?

Ms. Mary Ann Haddad (Private Citizen): Yes.

Mr. Chairperson: It is already distributed. Good. You may proceed.

Ms. Haddad: Mr. Chair, Mr. Praznik and committee members. This presentation contains also a story of one person's journey in the mental health system.

Life has turned around in a very drastic way for me, going from facing each day with dread and impending doom, to now I am employed, am enjoying life socially and spiritually and living well. You will understand as my presentation goes on where, as I make this presentation and as I go on on this note, I have questioned why the proposed changes to The Mental Health Act have frightened me so much, as I am no longer involved in the system as a consumer. I realize that I am frightened because of all the other Jackies out there who may lose their lives if this law comes into effect.

I heard a number of comments made in the media addressing this act in the past number of days. Public sways say, yes, and this is a good route to go. This is not a surprise considering the negative media coverage the public receives on people dealing with mental illness. Most times, the headline itself screams for more restrictions and controls to be placed on an individual. What is often neglected to be mentioned is that the person has a lack of supports in place, people they can trust to help them in their time of crisis, and their cries for help and intervention went unheeded.

I believe the system does need to change, but a change that allows the person experiencing problems to lead and guide their own recovery; not one that controls them and keeps them only existing. I am vehemently opposed to the proposed community committal in the new act, referred to in the previous act by the term "certificate of leave," because the balance of power is in the hands of doctors, not in the hands of persons experiencing problems.

A psychiatrist recently expressed that people will have the choice to sign or not to sign. With the choice not to sign meaning continued hospital stay until it is signed, this does not sound like a choice, but coercion.

I do not know how many of you, ladies and gentlemen, have directly experienced the control of committal.

When a person is hospitalized for problems with mental health, the person feels very vulnerable and wants to feel better. So, if a doctor comes to you and says that something will help you, and to sign a paper, what would you do? The reality is that too many times people are given a wrong diagnosis and label. Consumers speak over and over again in regard to how many times their diagnosis has changed. There is much difference between being treated for one illness and having another. It is like treating someone for diabetes when they have epilepsy.

I now would like to mention of my personal experience in the mental health system. At the age of 22, I walked into the system, hoping and believing that I would be helped. I believed, as so many of us are taught to believe, that doctors know best. Unfortunately, they did not. I was given a label and put on very strong psychotropic drugs. For 11 years or more, the drug amounts continued to be increased, until I was taking 29 various drugs per day. Many times, I could not complete a sentence, as I could not remember what I wanted to say. I became addicted to other drugs as well, attempted suicide, seizured during the overdoses, and sitting on the couch or sleeping was my life in those years.

As well as regular visits to the psychiatrist and being in and out of hospital, every day I faced the possibility of death head-on. What was there to live for? When I read up on my label, it was very disheartening indeed. I was told of and given an opportunity to attend a native healing week and with the support of good friends was able to attend. One of the greatest revelations I had during that week was that I could not think or process like the other people in my group, so I began to take myself off the medication, unbeknownst to my psychiatrist. It was during that time also that a counsellor who had been working with me expressed another opinion of what diagnosis I may have been dealing with. What I was dealing with were abuse experiences by me in the past. Being heavily medicated blocked the recovery work I needed to do.

* (1310)

I took myself off drugs with the help of the Addictions Foundation of Manitoba. I was able to begin to work through the painful issues of my past and with the support of people who believed in me and my recovery. For this, I am very thankful.

To expect a person to take charge of their own life and to recover while being controlled by others is to me an oxymoron. I have talked to a number of consumers who have been given the wrong label. To be forced on drugs because of the wrong problem does not make sense. To give people less control of their own lives is inhumane treatment.

The repercussions of Bill 35 will, in my opinion, do much more harm than good, and I believe that everyone can experience some recovery. I believe that life can be better than it is. I believe that the system needs to have better community supports in place and that to give more control to psychiatrists will be very harmful. Why will people want to go for help with this threat hanging over their heads? I believe that consumers and professionals can work together to create a system which empowers and leads to recovery, and I believe this because I have found life.

I would like to add a few additional thoughts to this as well. I would like to say that to the many silent voices who are crying out to be heard, the voices of people living with mental illness, the system continues to dictate to, rather than be inclusive of individuals in the decision-making process.

The Mental Health Act has been under review for a while. A committee was struck and held over 50 meetings over the past two years. There was not one meeting that was held open, which provided a forum for input. There were no meetings held in the rural areas that had an opportunity to be involved outside of the mental health advisory council. If this is to be considered a process in which caring and trust is fundamental to facilitate in the health and wellness of individuals, we seem to be missing the mark. It has been stated that timing is such that it is the window of opportunity to make changes by government.

I ask where is the window of opportunity for the individual? We need to take a look at what we as a society will be leaving as a legacy and how we will be remembered 20, 50, 100 years from now. What statement will we have made? Yes, we have moved from physical restraints and chains and shackles, but have we really moved that far from the restraints or limitations of the institution with the proposed changes and implications of Bill 35, the limitation we are placing on a segment of our society to have a voice to actually be able to become well and responsible for their own recovery process? I am another voice who speaks against Bill 35. Thank you.

Mr. Chairperson: Thank you, Ms. Haddad, for your presentation. Are there any questions? Thank you again.

I move, then, next to Joan Joyce Podolas. Ms. Podolas, would you come forward, please. Am I pronouncing your name correctly?

Ms. Joan Joyce Podolas (Private Citizen): Yes, you are. You are one of the few.

Mr. Chairperson: Thank you. Have you a presentation for distribution?

Ms. Podolas: I have to ask, I think, the Clerk to copy it for me.

Mr. Chairperson: We will distribute them after, if that is all right with you.

Ms. Podolas: That is perfectly fine with me.

I would like to begin by saying thank you to my guest behind for letting me come forward and speak. My job interview is very important.

Mr. Chairperson: You may proceed.

Ms. Podolas: I just want to be all prepared so I am not fiddling once I start. I am kind of nervous.

Mr. Chairperson: Do not be. We are more nervous than you are.

Ms. Podolas: I can guarantee you, I do not bite. I started my speech. I thought I was going to be reading it this morning, so I will leave that part of it out.

Honourable members, thank you for the opportunity to speak on Bill 35, The Mental Health and Consequential Amendments Act.

I would like to begin by sharing with you my family story in brief simply because my family circumstances are before the courts. Also, I would like to share a family tragedy and a very close family tragedy that, thank the dear Lord, had a happy ending.

I have been blessed with six beautiful children, five boys and one girl. I was a potential candidate for the final RN graduating class that is graduating from Red River Community College Tuesday of next week. The beginning of my not being successful in accomplishing my lifelong dream of becoming a registered nurse came crashing down on my world February 6, 1996. I have a little background information for you.

At this time, I was going strong in my second term of year I nursing. I had successfully passed and completed my first term of year I nursing, which started late August 1995 and ended one week before Christmas, December 1995. I accomplished this under circumstances that most people would not. Also, I would like to say I was sole parent occupant of my residence with my six children. My husband was in Shamattawa. He returned home against my wishes late December 1995 just after I had completed my first term of year I nursing. Needless to say, my two-week break was no break at all.

My break and light at the end of the tunnel was starting my second term of year I nursing. My children still had a week of their holidays left. My family situation started falling apart at home. My daughter started having acting out behaviours which in no time at all became full blown and ended up in her being admitted to hospital. Even though this was absolutely devastating to me and my family, I still held my family together, remained a full-time student, tended to my family's needs and went to the hospital to visit my daughter faithfully. That is the end of background information.

February 6, 1996, I stayed home from Red River. It had to do with basic needs. The family needed food. I had a conversation with my husband. I pleaded with him to leave. I told him that was all he had to do. He said: I know, but I have to check out the legal implications of it first. At this, he walked out the door.

I got the children up and off to school. A family member came, and we went and got groceries. I came home, put the groceries away, and put the roast in the oven. At this point, my husband walks in the door. I make eye contact with him and immediately he looks away and goes in the other room. I go to my bedroom, close my door, and proceed to call my daughter at the hospital to let her know I will be in to visit after supper. There is a knock on my bedroom door. I open the door, and there are two police officers standing there. I promptly tell my daughter I have to go: Bye, I will see you later. To make a long story short, I got to take a ride in a police car. I was interrogated and agreed to have a psychiatric assessment.

I would like to refer my honourable members now to page 10, more specific, Sections 10(1), 10(2), 10(3), 11(1)(a)(b), page 11, (c)(d). Because of confidentiality and my family circumstances being before the Court of Queen's Bench, I can only comment on Section 10(1), specifically, the first two words, "any person." I strongly recommend to you that stating "any person" is wrong. Let me tell you of the damage that those words alone caused for myself and my family, and maybe you will agree.

* (1320)

First and foremost, I would like my honourable members to keep in mind that any person can walk into the Law Courts and spout off a mess of lies. I was not doing anything wrong or breaking any law the day the police came to my home and arrested me, unless there is some law against being a full-time nursing student and working your fingers to the bones and using your brain to its fullest capacity, all in the name of making a better life for your family. Maybe it is that word "stress." Maybe there is only so much that one person is allowed to carry before affirmative action is taken.

I can assure my honourable members, if I carry that word "stress" into the next millennium, it will be as a friend, not as a foe. Take my word for it. For your mental and physical health, it works in your favour. My apologies for my sense of humour. A friend of mine told me to guard it, so I thought I would give it a try.

Let me go now to the real destruction of the words "any person." This made my home a very unsafe place for me to be. This resulted in me removing myself and my younger children from my home and my community of 18 years. The domino effect of my daughter's stay in the hospital, a bad decision made by a significant person in my daughter's care and a bad decision made by two other parties, resulted in my daughter overdosing under the professional care of a system I entrusted her to. The happy ending I spoke of at the beginning is my daughter survived her near death experience. This is the only good thing that came out of my daughter's hospital stay. These words destroyed a mother's love and killed my lifelong dream. My family is torn apart, but I am happy to say I am carrying through on recommendations made by a fine lawyer in building a bridge that hopefully will lead us strong and united into the next millennium.

Now, I would like to speak to you briefly on our family tragedy. For the purpose of this report, I will call him Richie Rich. Richie Rich was a mental health consumer. He is not here with us today because his body was found at a house. His death was treated as a suspicious death. There was a long and lengthy investigation. Then the investigation was closed. I would like all of us in this room to keep in mind that my brother is not dead as a result of his mental illness. He is not with us anymore because of a system that failed.

We all have to share the blame, doctors of mental health, consumers of mental health, government, society in general. A physically ill person carries no stigma. With the millennium just around the corner, let us strive for a healthy vision for the mentally ill and give them a vision of compassion and love, respect and dignity, similar to how we brought in community policing.

Let us all, again, pull together as one and stand behind the mentally ill and give them a basic human right, equality. Thank you honourable members, Mr. Chairperson, and guests.

Mr. Chairperson: Thank you very much, Ms. Podolas, for your presentation. Are there any questions? Thank you again for your presentation. I call next Bruce Waldie. Bruce Waldie? Have you a presentation for distribution?

Mr. Bruce Waldie (Private Citizen): Yes, I do.

Mr. Chairperson: The Clerk will distribute. In order to preserve a bit of time, I am going to ask you to proceed while they are distributing.

Mr. Waldie: I will be as brief as possible. Five days before Christmas 1997, my father was admitted to hospital because of schizophrenia. My father does not have schizophrenia. He was admitted to hospital because he had been assaulted by my brother who suffers from chronic paranoid schizophrenia. This was a foreseeable and, in my opinion, preventable event. It is not the first time that my brother has exhibited violent behaviour, nor is it the first time that he has been involved with the police.

* (1330)

When a person suffers a mental illness, their thought processes are affected. In many cases they may have difficulty forming accurate perceptions of the world around them, and their judgment may be based on false premises. While these facts are well known, they are sometimes not taken into account when expecting people with mental illnesses to make decisions which are in their best interests.

Because their perception of the world is altered, the world they see may not be the same world that you or I see. In spite of this, they are often expected to make choices which they are not equipped to deal with. In the name of freedom and individual rights, they are often left to languish in poverty and in isolation. Because his rights must be respected at all cost, my brother lives on welfare, in an unkempt apartment, isolated from his family and afraid of those around him. His liberty has allowed him to shut himself up in a world where his only companions are the voices in his head and where the transformers on the hydro poles are surveillance equipment set up for the sole purposes of watching him.

Are these truly the things that he deserves? Does he deserve to be branded a criminal with a criminal record because of a mental illness? Does he not deserve a chance for a better life? Now, I know that today's medical system does not have a cure for my brother. I know that he probably will always suffer from schizophrenia, but I also know that a caring and responsible health care system can help him to lead a better, healthier, and more fulfilling life.

If we truly live in an enlightened and benevolent society, it is our moral responsibility to help those who cannot help themselves, and it is your responsibility as legislators to enact laws which make it possible. I urge you to strengthen the provisions of The Mental Health Act which would allow the certificate of leave to be used more readily, to make it more readily available to those who need it and to put into effect regulations which would give my brother the support he needs to live in the community. I urge you to listen to the families of people suffering from mental illness, for it is often they who know best and understand the needs of their loved ones. I also urge you to make better provision for the treatment of the involuntary mental patient who may not always know what is in his best interests.

My brother does not need to be locked up. He does not need to be kept away from the rest of society. What he does need is a consistent, ongoing, helping hand. You have the power to provide the community mental health services he needs. Whether he realizes it or not, he needs your help. Please do not let him down. Thank you very much.

Mr. Chairperson: Thank you, Mr. Waldie, for your presentation.

Mr. Chomiak: Thank you, Mr. Waldie, and just to yourself and to the others who presented, again, thank you for making a part of your life understandable to all of us and, hopefully, more understandable to the community at large that needs to know all of these stories.

It is clear in your presentation that you support the provisions of the certificate of leave. Do I take it from your last paragraph that you are also advocating more community-based mental health care? Is that also a part of your submission?

Mr. Waldie: Yes, it is absolutely so. Right now, my brother has not been in the treatment of any psychiatric care worker since 1993. When he decided to stop taking medication, he did it on his own. Since then, he has suffered significant deterioration. If a social worker is begged to go to his house, and it is my parents who beg them to go to his apartment, he will tell them to 'f' off and lock the door. He suffers malnutrition. He has on numerous occasions knocked my parents to the ground. He does not hold down a job. He does not have friends. He does not regularly communicate with people. When he was receiving treatment and getting help from the mental health system, he led a far superior life.

Let me just change the subject for a second. Most of you here wear glasses. I am very shortsighted and I cannot see anything without my glasses. If I take them off, I do not have a clue who you are. I can look out here. I may not recognize Mr. Radcliffe. I may not recognize Mrs. Render. I may not recognize Mr. Gaudry. I do not know who they are. I may not know if you are smiling at me or if you are scowling at me. I do not know if you are pointing a gun at me or if you are just holding a pipe in your hand. I am not capable of making that judgment because my ability to discern what is going on is impaired. It is impaired by my glasses taken off.

When you have schizophrenia, and when you have many other mental illnesses, your ability to perceive the world around you is impaired. You do not see necessarily what is going on. In spite of the fact that we know this, I have personally heard, and I know that my dad and mom have heard this many times from psychiatrists, that they have to respect my brother's rights and not do what is best for him because that would not be respecting his rights.

That does not make sense to me. It just does not make sense to me. I have lost a brother. I cannot see him anymore because I am the incarnation of Satan. I cannot go and visit him. I cannot help him. I cannot help my parents. Why do we have a system like that? Sorry for digressing from your question, sir.

Mr. Chairperson: Thank you very much, Mr. Waldie, for your presentation.

Mr. Waldie: Thank you.

Mr. Chairperson: I am going to ask the Clerk to distribute some of the presentations that were left with us this morning, and I am going to call Ms. Joan Thorogood. Ms. Joan Thorogood.

Mr. Bill Martin (Canadian Mental Health Association) (read by Ms. Joan Thorogood (Private Citizen) : Mr. Chairperson, Ms. Thorogood cannot be here today. She is ill. I have her presentation, and I can leave it with you. I know that she would like it read. If that is your wish, I will read it. It is in your hands.

Mr. Chairperson: If you wish, you can read it, although it is for the committee's edification. If you distribute it, it will be published in Hansard and will be part of the record. So what is the will of the committee? Do you want it tabled? [interjection] Okay, if you would like to read it for us, would you?

Mr. Martin: Certainly.

Mr. Chairperson: What is your name?

Mr. Martin: My name is Bill Martin.

Mr. Chairperson: Bill Martin. Bill Martin will then present for Joan Thorogood. Would you proceed, please?

Mr. Martin: With the inspiring words of Nelson Mandela, I wish to begin speaking to you today. Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us. We ask ourselves, who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people will not feel insecure around you. We were born to make manifest the glory of God that is within us. It is not in just some of us, it is in everyone. As we let our light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others.

Having to survive over 18 years as a consumer of services in the Manitoba mental health care system, I believe that my insight may serve to educate and enlighten you with regards to some of the concerns and issues we consumers face and obstacles we encounter through our endeavours to sustain mental health. My impressions of the Manitoba mental health care system formed during years of hard work. Personal experience and knowledge was ingrained through the treatment and care I received on a continuing basis through numerous psychiatric hospital admissions and outpatient care. I feel great empathy towards fellow consumers as I am all too aware of the devastating effects caused by mental illness. I also feel great despair and sorrow as these people are confined within a system that, in my personal opinion, can be summed up into three words: horror beyond comprehension.

My reliance upon the Manitoba mental health care system commenced in June '79 at age 16, when I was admitted for care in an adult psychiatric ward of a local Winnipeg hospital. I was in need of immediate medical attention as I was experiencing severe psychological difficulties. Weeks prior to my admission, I was violently raped. Due to a traumatic state of total helplessness, I was incapable to disclose to anyone that this crime had occurred. Prior to my admittance to hospital, my parents sought help for me in advice through Klinic Community Health Centre. Immediately after an assessment by a Klinic crisis worker, it was reported to my parents that I was acting like a rape victim. My parents, acting on the advice of Klinic staff, brought me to the hospital for care. My psychiatrist was informed immediately by my parents of the Klinic crisis worker's statement that I was acting like a rape victim. Subsequently, I was diagnosed to be suffering from a mental illness known as acute schizophrenia. I was described as being in a nearly catatonic state.

I was sedated with a vast array of psychotropic medications, some used in conjunction with others. These potent drugs included stelazine, sparine, chlorpromazine, valium, etrafon, nozinan and promazine. On the fourth day of my admission, I began a prescribed course of electroconvulsive therapy, also known as shock treatment, which resulted in 10 treatments in total during this admission. The electroconvulsive therapy I received was extremely traumatizing. I can best describe it through a poem I had written titled "These Were Not My Choices":

I still remember the horror/I remember it like a death camp/As I lay motionless, too fearful to move/On a stretcher/As they put the rubber mouthpiece in my mouth/And the intravenous needle into my vein/I still remember thinking that they were executing me/As I feel the zizzing feeling, as I go under/And knowing I am being electrocuted to death/Because I am so bad.

* (1340)

All memory of the rape was blocked from my consciousness for 14 years, preventing my ability to deal with and recover from the trauma and the ravaging effects it had on my state of mental health. Through the years, I refused medications and treatments I found intolerable. Different drugs were prescribed and replaced and the diagnoses changed. The initial diagnosis of acute schizophrenia was, in 1981, changed to schizoaffective psychosis, which later became changed to bipolar affective disorder, also known as manic depression. I began to wonder if they would eventually run out of labels for me.

Despite my reservations, I tried very hard to be the model psychiatric patient. I strived to be polite, obedient, and compliant, as I was filled with nothing but blinding gratitude, complete trust, and total faith to the system and its care providers. During the times of my hospital admissions, I became the victim of three separate incidents of sexual assault, which included two incidents of rape, all of which occurred while I was under the influence of psychotropic medication prescribed for my current state of psychosis. Regretfully, my disclosures to hospital staff resulted in punitive action for me. Immediately following the disclosure of one particular incident, I was ordered by staff to remain in my room and was allowed out of the room for only short periods of time. I was denied access to all visitors including family members who had been led to believe, by reports from the mental health staff, that I was experiencing a setback. My telephone calls became limited to three calls per day. My medication was changed and dosages increased. I was interrogated and harassed to recant the statements I had made previously during my disclosure to staff.

During this time, I agreed to receive more electroconvulsive therapy. It was stated that the treatment would be very beneficial to speed up my recovery process and discharge date. It was only through the intervention of my mother, during a coincidental phone call to staff, that this treatment was cancelled. Thanks to my mother, she kept her promise I had years ago asked her to make me, a promise that I would never again be subjected to endure the trauma of electroconvulsive therapy. I felt a horrendous amount of shame and guilt for several years after this incident occurred. I was treated like and made to feel like the promiscuous slut of their ward.

After the last sexual assault occurred at a different Winnipeg hospital, I felt I was in danger and in desperate need of protection. After the hospital staff neglected the urgency of my request, I, myself, was forced to contact the Winnipeg police department through 911. Two police officers immediately came to the facility to investigate my complaint. Some time after disclosing a lengthy and stressful statement of my recollections to the officers, I was to learn that nothing could be done to ensure my safety by means of removing or relocating the perpetrator off the ward. Stated to me by an officer of the Winnipeg police department months after the incident occurred, when I questioned the inaction, he explained that their hands were tied due to the fact that the psychiatrist in charge of my care at the time reported to them in her statements that I was mentally competent during the time this incident took place. Furthermore, she stated that any sexual contact that had occurred was, I quote, consensual sex between two consenting adults. She also reported that my sexual acting out was part of my illness.

Needless to say, I now understand why my efforts to protect myself on this ward became negated and futile. After I was sexually assaulted and still a patient on the ward, I was humiliated even further as I was forced to literally beg to have the psychiatrist's approval in order to receive an HIV test for myself. Being a medical doctor, who I assume would have taken the Hippocratic oath, she stated to me in a professional and intimidating manner that I was at virtually very minimal risk of contracting the virus and felt I did not need an HIV test as my exposure to the perpetrator's bodily fluids had occurred only through oral transmission.

I have done a lot of soul-searching in the past few years trying to come to terms on an emotional level for the care I received within this system. It brings me grief. I can no longer find forgiveness in my heart, and this knowledge shatters my soul to know the reasons why, for I simply can no longer excuse the actions of a government that permits this archaic system of health care to exist in Canada, jeopardizing the lives of human beings, Canadian citizens. It continues to remain incompetent, arrogant, abusive, coercive, negligent, disempowering, uncaring, self-fulfilling, stagnant, extremely dangerous.

Presently, I am receiving intensive psychological therapy in my ongoing attempt to recover from the years of mental health care. During these years, had I been placed on a certificate of leave and been legally forced to comply with any of its stipulations, I know that I would not be here speaking with you today. I would not be on therapeutic, psychotropic medication. I would not be in recovery. In fact, I firmly believe that I would be in one of your long-term, provincial mental health care facilities, such as Brandon or Selkirk, weaving baskets for the rest of my life.

The Manitoba mental health care system is in crisis need for drastic reform, positive change, and a radically new perspective and attitude. Mental health consumers, under the law of our great nation, are entitled to receive appropriate and adequate health care. Yet under the current system in Manitoba, appropriate and adequate health care is not being provided to consumers of mental health services throughout the province.

To begin to provide appropriate and adequate health care for consumers of mental health services, we must first recognize and encourage the special needs of persons with mental health challenges.

These are only a few of the recommendations that need to be implemented in order to bring about positive changes in a system that will provide appropriate and adequate health care and that will ensure that the rights of every Canadian citizen dealing with mental health issues are upheld: (1) updating of and ongoing education of all mental health care providers; (2) the integration of psychology and psychiatry in a clinical setting to provide comprehensive treatment and therapy; (3) separate wards or facilities for male and female patients to provide a safer environment on the wards conducive to healing and recovery; (4) disability allowances that will make provisions for the specialized needs of the consumer and adequate living resources; (5) organized community-based supports provided by a network of mental health care providers, community mental health nurses, social workers, counsellors, et cetera, to be provided for every consumer; (6) availability of 24-hour, seven-day-a-week community crisis team intervention.

We need a more humane, sophisticated and dignified system that will be able to practise prevention, not detention, as part of a consumer's treatment plan, not a certificate of leave which will force the consumer to nurse the needs of an ailing system. The certificate of leave will not heal our ailing system. It will not serve as an effective band-aid over our system's bloody wounds. It will only cause these wounds to fester longer and grow deeper.

The certificate of leave is dangerous, as it allows an even greater imbalance of power over the lives of an already powerless population. The implementation of the certificate of leave has the potential to be lethal, as has been reported in the case in the province of Saskatchewan. Given the psychological effects of psychotropic medication and the symptomology of mental illness, an individual's agreement could be gained through coercive means.

It took me two days and a competent state of mind of listening and participating in a discussion at a conference hosted by the Canadian Mental Health Association in April of this year before I could begin to decipher and fully comprehend the totality of it. With or without an advocate present, there is no way to ensure that every single person, every single competent person should be expected to be able to make an informed decision regarding their choice of signing it.

Dr. Biberdorf, who was a guest speaker at the conference on the certificate of leave, stated during his speech that we could expect to see the certificate of leave to be used with reluctance among psychiatrists. I question and caution the therapeutic benefit to the patient of anything that is used with reluctance, as my fear is rooted in the fact that I was initially administered electroconvulsive therapy used with reluctance.

* (1350)

I am adamantly opposed to Bill 35, the certificate of leave, for reasons which I have stated. In reaching your final decision, I would like to encourage each and every one of you to be extremely cautious and to please seriously consider the negative repercussions that its implementation would have on the lives of Manitoba citizens. As a private citizen, as a consumer of services, as an equal human being, I do not yet need another revolving door to go through in this inadequate system, and certainly not one that would lead me in its rotations forever.

Mr. Chairperson: Thank you very much, Mr. Martin, for reading Ms. Thorogood's presentation into the record. Are there any questions or comments? Thank you very much again.

I call Beverley Goodwin, private citizen. Have you a presentation for distribution? I will ask the Clerk to distribute, please. You may proceed with your presentation.

Ms. Beverley Goodwin (Private Citizen): Mr. Chair, committee members, I am Beverley Goodwin. I am not a member of any mental health organization at the present time. I am a member of an ad hoc committee of people who, because of their experience, personal or professional, with the mental health system, believe that the system is flawed. We started to meet as a group (1) to learn about the present system and its deficiencies; (2) to identify some of the areas which are of concern to us; (3) to understand the experience of consumers who are the users of the system and their families' concerns; and (4) to facilitate change.

We realized that it was necessary for some of us, because of this proposed new mental health act, to share our firmly held belief that the system as it is presently constituted is inadequate to meet the needs of the people it is intended to serve and to offer some suggestions for improving these inadequacies.

I am here to put a face to mental illness. This is my daughter, Carolyn. She could just as easily be your daughter. I want to ask you to view my daughter Carolyn as one of your own children or grandchildren. I treasured my daughter, my family treasured Carolyn, just as I am sure you treasure the gift of your own child. Carolyn was 27 years of age, single. She had graduated from high school with Grade 12. She took additional upgrading at the Adult Education Centre because she felt the need for a stronger educational background. She then went on to take her university, majoring in psychology. She dropped out of university approximately one and a half months prior to her finals. Many of her scholastic experiences were positive. She excelled in sports, music and most academics. She had many friends, all types, from varied backgrounds.

She was often trying to help, to be the go-between and support to friends having troubles. She had part-time employment from the age of 16. At each place of employment she was promoted to positions of responsibility. The last employment which she held was a position from which she derived the greatest pleasure, and she looked forward to a career in hospitality. She was constantly complimented on her ability to make people feel comfortable, her sense of loyalty and responsibility toward those around her, family, friends, employees and employers.

I am sure you will agree I have painted a picture of a very special person, someone who could just as easily be your daughter. However, she is mine.

On October 7, 1996, Carolyn attempted suicide. She was taken by a friend to the emergency ward of one of

Winnipeg's hospitals. My husband and I were contacted some six hours after she had been taken to hospital. We had absolutely no previous experience with the mental health system. After many hours in emergency, we were led underground through large steel doors into a centre which would become her domicile for the following four months. Because she was over 18 years of age, we had no authority whatsoever in the decisions over her care and treatment. We became onlookers during our child's illness.

We were introduced to Carolyn's primary nurse. I might add her primary nurse was a great support to Carolyn from day one and remained an important support to her throughout her illness. It was explained to us that the hospital would not be able to begin treatment therapy until after the drugs began to take effect, that sometimes the patient may respond positively to the mind-altering drugs and sometimes they do not, in which case another drug is tried and the patient again has to wait at least three weeks to determine whether the new drug will be effective.

* (1400)

Once it was determined that Carolyn would require abuse therapy, that too could not begin until after the medication began to take effect. Unfortunately, Carolyn never encountered a drug which helped to pull her out of her situational or clinical depression. A greater part of her time in the hospital was spent in bed. She would venture out for a smoke, sometimes played the piano, went to group therapy–not for abuse–and eventually got involved in the woodworking program. She explained to me that in woodworking, although most of her time was spent sanding her project, it was the only time she felt free from her depression and the weight of thinking about her problems. Since Carolyn's death, the woodworking program has been discontinued.

Visitation at the hospital psychiatric ward was between four o'clock and eight. I never felt that the family and friends visits were encouraged. The ward was usually devoid of visitors when I was there. On one occasion when I came for my daily visit, I heard a voice saying–as I was walking with head down–you do not have to come here every day. I looked up and said, pardon me? The nurse repeated, you do not have to come here every day. Of course, the thought that ran through my mind was, am I the problem? In any case, Carolyn and I talked about it. I explained that anything I could do to help her to get better I would do. We decided I would not visit the following day. However, by the time I got home, Carolyn had left a message to say if she was a mom, she would be there every day, too, so would I please come.

What started out to be two weeks of treatment and back to work on a part-time basis was now turning into months. My husband and I, family and friends, were beginning to be more concerned and wanting to know much more about her treatment and care. On the one hand, to question the doctors about her treatment might jeopardize her care, and yet on the other hand, things were clearly out of hand.

I wanted to set up meetings with her treatment team, but this could not be done. Carolyn was over 18 years of age and considered competent to make decisions about her treatment and her welfare. On the other hand, her treatment team, which I believe is placed in a conflict of interest, was able to advise and guide her on all matters. We were put in touch with a social worker and made an appointment to meet. I came to that meeting with a list of 20 or 30 questions and concerns dealing with everything about her treatment, length of treatment, support, employment, living arrangements once she was released and inquiries as to how her family should be involved in the long-term treatment plan.

We were absolutely assured that the hospital system is set up to provide all the necessary support she would require, and she would know how to access these supports. We were told that her treatment would be over a much longer period of time than previously expected, and although we wanted to take her into our home, support her and encourage her until she was well, that she would be better served to be living on her own as she is an adult. Because she would be without income, the hospital would assist her in applying for such programs as welfare temporarily and CPP disability long term. She became totally overwhelmed in her attempts to complete all the forms and also to accept the psychological aspects of going on welfare and disability. Her first disability, a cheque, arrived three months after her death. At no time were we told that there were or that there are different types of treatment available, treatment alternatives which are not available in Manitoba, treatments which are available only if you have sufficient money to go outside of Manitoba.

One day Carolyn phoned me from the hospital very upset. Her treatment team had breached a trust and she had gone to one of the members demanding an apology. He refused and told her, if she did not like it, she should go elsewhere. She also demanded to see her records and was told she could not see them until he had time to vet the file.

She and I talked about the pros and cons of her changing doctors. She really did not want to have to start all over. So, with my blessings, I suggested that she would have to give her treatment team a chance to earn her trust again, a recommendation, of course, which I regret very much. If we heard it once, we heard it a thousand times: they tell me I have to be responsible and independent

Other than for Carolyn and her treatment team, no one that I know of was asked about Carolyn and her not being responsible. Her family would not have described her as not being responsible. Her friends or employers would not have described her as being irresponsible. She experienced relationships where she was abused, and, yes, abuse involving intervention by the police. Was she being blamed somehow for those abuses? When she attempted to get counselling support for this particular abuse assault, she was unable to access the system the police had suggested she call because, from what I have since learned, the lines are often busy and/or overloaded or are not working.

I have subsequently learned that had she eventually accessed that system, help would not have been forthcoming because the assailant had pleaded guilty and the counselling therefore would no longer be available to her. The hospital, near the end of her stay, indicated that they were going to teach Carolyn how to make friends her own age. In retrospect, Carolyn had so many friends, friends quite frankly who simply did not know how important a visit would be or how to access the psychiatric health care facility, the inhospitable system which the taxpayers have helped to create.

At this time she did begin to make new friends at the hospital. One of them, when she wanted to end the relationship, became an experience of harassment. She had mentioned this problem to the hospital; she had also talked about it to me. She decided to tell this person that, if he had anything to say, it must be discussed with a professional present. I was in Vancouver at the time; however, she did speak to me on the telephone on Monday night, the 17th of March, explaining that she had an appointment the following day, March 18, with a professional and this individual. She intended to confront the issue of harassment and had prepared a couple of pages of questions for the meeting. She arrived for her appointment at 2 p.m. The doctor forgot the appointment. Carolyn went home to her flat with no one to share her pain and consumed a month's supply of mind-altering drugs.

I am here to challenge you. We are about to enter into the 21st Century. I urge you not to discount what I am saying. It could just as well be your daughter or your son or your granddaughter or your grandson. I would suggest that it is timely that we take our draconian thinking towards the mentally ill and mental illness, change our perverse attitudes toward the mentally ill and begin to treat people with mood disorders with the degree of respect, dignity and care which is provided to other Manitobans and Canadians who suffer from other health-related illnesses.

Odd as it may seem, there are numerous diseases which are stress related such as heart, stroke and cancer. Do we deprive these individuals of their rights to control their own destiny? If they do not adhere to the doctor's instructions, do we have them picked up and involuntarily admitted to hospital? Surely if we can get our hearts and minds around issues such as AIDS, we must be capable of getting our hearts and minds around the issue of mental illness.

Should a family member or other person advocate on behalf of the mentally ill person? Should a patient and family members be informed about the alternative treatment models? Should a suicidal patient have access to enough prescription drugs to kill themselves?

Should our children be safe in our hospitals, free from harassment, physical abuse and rape? At the present time, they are not. Presently, if your child is under 18 years of age, you can be his or her advocate. If your child is over the age of 18, she or he has no advocate even when the parent is willing to provide support.

Does the doctor and treatment team place itself in a conflict of interest by being the one who determines whether your child is competent or incompetent, advises the patient whether the spouse or parent should be involved in the treatment plan, provides the diagnosis for the consumer, determines the treatment plan, the prescriptions, deals with the agreement for the certificate of leave and possibly the committal of the consumer? The doctor/treatment team is also involved in advising the consumer patient in matters concerning living arrangements, money matters, employment matters, welfare, CPP, criminal matters and abuse. Please keep in mind I am speaking about a loved one who is unwell, ill. I believe that the control here weighs far too heavily in favour of the hospital with little or no empowerment for the consumer patient and their family.

If your child's doctor knows that a criminal offence was committed against your child prior to admittance to hospital, do you feel as a parent you should be informed about it? Should there be a requirement for the doctor to report these criminal acts to the authorities when they are revealed through therapy? When it is determined that a greater part of the mental health problem has been caused by abuse, would you be satisfied that your child has to wait for the mind-altering drug to take effect before proceeding with abuse therapy? Do you believe that your loved one should receive immediate in-depth counselling by highly trained staff?

I challenge you to learn about the different treatment models which are available in other jurisdictions. I challenge you to find out why psychoanalysis was de-insured in Manitoba. I challenge you to find out why so many psychiatrists have left the province in the last few years. Does their departure have anything to do with the fact that Manitoba hospitals offer only the chemical treatment model to the mentally ill? I challenge you to consider whether preventive measures such as counselling at an earlier stage in a child's development would not prevent people from suffering the pain which the mentally ill have to suffer.

* (1410)

I must share with you the fact that since Carolyn's death, I have had so many friends and acquaintances share with me their pain over their own mental illness or that of a loved one. I am shocked at the rate of incidents of mental illness. I am shocked that so many people I know live with such pain and silence. It is too quiet a silence. I will not rest until I know these people can shout out about their pain. I will not rest until you hear their voices.

This article from the Free Press, Saturday May 2: Insurance companies shy away from stressed out MDs. Stressed out doctors are being looked at by insurance companies as lame ducks and not the good risk they used to be, says a psychiatrist who treats physicians. A study found two-thirds of the physicians who tapped into disability plans did so for emotional or psychological reasons. Insurance companies are denying insurance to doctors who admit they saw a psychiatrist during medical school. We must realize doctors too are human and therefore are susceptible to mental illness. This policy could just as easily be the denial of insurance to teachers, lawyers, or politicians. Can we be assured of the best possible treatment from our doctors when in fact some medical practitioners, including psychiatrists, are denied treatment for their own emotional and psychological needs?

Bill 35, first of all, let us call it what it is. It is not a mental health act but a committal act. Bill 35 is an erosion of a person's rights. When we are dealing with consumers whose main problems stem from self-esteem and rejection issues caused often by years of abuse, the erosion of these rights is one more abuse by the system.

Throughout Bill 35 there are clauses which read "is likely to cause serious harm to himself or herself or to another person." I have known numerous individuals with medical problems, and they have knowingly not carried through with very important instructions by their doctors. Their health problems have often been the result from stress. These consumers have most definitely contributed to the worsening of their condition.

Mr. Chairperson: Could I just interject a little bit. I have allowed more than twice the time that we had indicated, and I am going to ask you to hurry a bit.

Ms. Goodwin: I will rush. Actually I would just like to comment, if you do not mind, I am taking maybe 20 minutes out of your life. My daughter has been taken out of my life forever. Thank you.

If the patient is going to cause harm to another, then the law must apply just as it would with individuals outside the mental health system. I would recommend that a person's fundamental rights must not be placed in jeopardy, as proposed in Bill 35.

Mental competence presumed at age 16–I find it deplorable that in this day and age when anyone under the age of 18 is not permitted by law to purchase tobacco and to consume or purchase liquor that the drafters of the legislation would believe the public would support legislation which would permit a 16-year-old to make treatment decisions when we are speaking about the consumption of mind altering drugs which are fatal when taken improperly.

Competent to consent–throughout this document there is reference pertaining to whether a person is competent to consent. Firstly, I do not believe that the doctor can both determine competency and provide other facets of treatment. I realize that the certificate of leave would require the approval of another psychiatrist. However, I view this action as purely procedural. Secondly, the mentally ill have been poorly served for too long. The time has come when the mentally ill person must, in my opinion, have an advocate for all decisions, preferably a family member, and, in the absence of a family advocate, then an advocate who cannot be seen as in a conflict of interest.

Peace officer's duty during examination–I have great difficulty with the use of police in these matters, and I would suggest we must find another more sensitive method of response for persons requiring supervision.

Criteria for issuing a leave certificate reads: 46(4)(d) "the treatment or care and supervision described in the leave certificate can be provided in the community." It is obvious to us here that the services which are needed within the community are nonexistent. The mentally ill are shunned by the community, often forced to live in poverty or if, employed, often ill treated by co-workers and employers. They are usually living on welfare or disability with the cost of their medications consuming the better part of their cheques, even with Pharmacare. When families attempt to supply some of the supports, they are often discouraged by those individuals involved in the treatment plan, and in Carolyn's case, because: they tell me I must be independent and responsible.

I am sure you realize I have little faith in the present mental health system. Unfortunately, I do not believe that this legislation is going to improve the situation for the patient. I believe that Bill 35 gives further power to the doctors and diminishes the rights of the patient. Because of this proposed bill, I phoned a friend of mine to inquire how her adult child, who is living with schizophrenia, is doing, and she explained, well, quite well for a change. I asked that she explain. It turns out that he has had a heart attack. Now, he has a real illness; therefore, he qualifies for community supports which are not available to the mentally ill. Her son's well-being is taken care of by the community supports available to the medically compromised. He has companionship, help with household duties and meals everyday. The system is providing caring supports, and he is doing surprisingly well.

This act does provide for the concerns of families of schizophrenics for the enforcement of the chemical treatment plan for their children. I do wonder if the community supports were readily available to schizophrenics if this would be less of a problem than I am led to understand it to be. Keep in mind schizophrenics represent a small percentage of the patients who are suffering a mental illness. This act will, however, be applicable to all mentally ill consumer patients in Manitoba.

In closing, I would ask that you not pass Bill 35. I would like to see a white paper or a full public inquiry on mental health in Manitoba. We need to be seeking to draft an impressive Mental Health Act which will see us into the next century, legislative changes which adequately address the problems and support the mentally ill to wellness. I believe that it can be done. I hope that you will be courageous enough to see that it is done.

I would like to end with my daughter Carolyn's last written words: what is the sense if the people who are supposed to help me forget? It will be easy for everyone else to forget.

Mr. Chairperson: Thank you very much, Ms. Goodwin, for your presentation.

Mrs. Render: Thank you very much for your presentation. Do I understand you correctly that one of your main reasons for not agreeing with the certificate of leave is that it puts huge restrictions on a person's rights? Is that your main reason?

Ms. Goodwin: Well, that is certainly one of them. The other is that we have never developed a system of supports in the community to test that model and determine how effective that would be, and as I used the suggestion, the illustration of my friend's son, he is doing much better, oddly enough, with these kinder, gentle supports. It does not solve the problem, but it helps the person maintain themselves better in the community, so I do not see the certificate as a solution.

Mrs. Render: The reason I asked was simply because of the presenter, a few before, Bruce Waldie, who mentioned another person's rights. So is it right for us necessarily to give rights to a person who may not be mentally competent and jeopardize somebody else's physical well-being? In this case, a father who was attacked. So I just asked the question because the other presenter made the exact opposite statement of you, and I guess I would also ask that when there is severe mental illness, that does affect the insight of a person with the illness, so that individual simply cannot properly assess a situation. I am not disagreeing with your comment on community facilities.

Ms. Goodwin: The ideal act would be one that is customized to each person's needs. This act, I believe, does meet some of the needs, I believe–and I do not deal with schizophrenic people. I do not have that problem at the moment, but I do believe that the act would work against those who are compromised with other mental illnesses. I believe that Bill 35 would diminish the mentally ill, and, in my opinion, the mentally ill have enough to contend with without having to live with the contents that are contained in Bill 35.

* (1420)

Mr. Chairperson: Thank you very much, Ms. Goodwin, for your presentation.

I am going to ask the indulgence of the committee that we try and revert to the limitations on presentations and questioning because we have a long list before us. It will be a long night if we allow the presentations to run the length of time that we have just experienced. With the indulgence of the committee, I would ask that you allow me to indicate to the presenters a minute or two prior to reaching the 10-minute limit what their limitations are.

Mr. Chomiak: Mr. Chairperson, the only point I was going to make is that we might be able to accommodate longer presentations if we as questioners would limit our questions at some point, so we might want to use that flexibility to allow presenters who want to make their point. So we might acknowledge or signal that to you as chairperson and then still allow the person to make the points that they want to make. That is just an option that I think we might consider.

Mr. Chairperson: We had before indicated 10 minutes and five minutes. In this case, we were just over 30 minutes in total. So I will attempt to see whether we can put some time restraints on some of the presentations.

Louise Smendziuk. Have you a presentation for distribution?

Ms. Louise Smendziuk (Private Citizen): Yes, I do.

Mr. Chairperson: Thank you. Ms. Smendziuk, am I pronouncing your name correctly?

Ms. Smendziuk: Yes, wonderfully. Thank you.

Mr. Chairperson: You may proceed with your presentation.

Ms. Smendziuk: Mr. Chairman and members present, as a concerned citizen, an advocate for persons with mental illness and a former health professional, I am pleased to have this opportunity to present to you on Bill 35.

At present, I am involved with a group of like-minded concerned citizens who have been drawn together through a shared experience. Our shared experience is a profound one. We, in one way or another, have faced the inadequacies of the current mental health services system. In some instances, it is our strong belief that the gaps within the system resulted in the unnecessary loss of loved ones. Our loss has resulted in a common vision and a strong commitment to work toward the renewal and reorganization of the system as we know it.

It is common knowledge that the positive energy produced by persons who share a traumatic experience can be directed toward a common good. Such energy can hopefully be directed to relieve the mental anguish suffered by those advocating on behalf of loved ones experiencing acute or chronic mental health problems.

It is no secret that mental health and well-being have received more attention in the past two decades than at any other time in our history. I respectfully submit that I or any member of this committee hearing these presentations may be affected in the future.

I have some issues that are of grave concern to me and arise from my personal experience. They are: (1) emergency services; (2) lack of co-ordination of available service; (3) treatment focus; (4) fiscal responsibility; (5) professional standards and accountability; (6) public awareness and education.

Bill 35, which in reality is a committal act not a mental health act, provides for a legal mechanism whereby a person's rights are restricted. Bill 35 diverts attention from the pressing issues I have just enumerated and focuses on a quick fix, supposedly for a minority group of mentally ill people who are a threat to themselves or others. But the experience of consumers recognizes that Bill 35 will have wide ranging influence on all persons suffering a mental disturbance.

Well-intentioned authors of this bill have succumbed to the same belief perpetuated by too many health care professionals as well as psychiatrists, the myth that biologically based psychiatric illness can only be fixed with drugs. This restrictive approach has serious consequences. The real issues of community supports that need to be addressed have been put on the back burner, while drugs have become a credible tool for social control. It is essential that we gather insight, insight in a community sense, all the factors that influence an individual's state of mental well-being.

The mentally ill are a marginalized, disenfranchised group who will be forced to go underground to avoid the confinement and drug therapy they do not want. The well-intended certificate of leave arouses fear and suspicion in consumers who have had experience with our current mental health services, fear of being forced to take a drug whose side effects are worse than the symptoms of their illness, the chemical cloud that not only diminishes their quality of life, but those associated with them. Alternate therapies must be made available.

Emergency services, as they currently exist, do not meet the needs of a person in crisis. Self-referral or accompanied referral of one with an acute mental illness is sabotaged in the emergency department, departments lacking both qualified personnel and treatment resources to deal with a mental crisis. The overriding excuse for nonadmission is a shortage of beds. The lack of alternate resources to deal with the crisis becomes a pressing issue. Ineffective emergency services results in escalated costs, both human and financial.

I would like to share an experience. I accompanied to the Health Sciences Centre emergency a beloved friend in crisis due to her addiction to alcohol and cocaine, an addiction that was the result of her need to dull the pain of sexual assault that occurred in adolescence, a core issue of her mental illness. After three and a half hours of waiting, it was obvious no help was forthcoming. Her sister and I were left to our own resources. After a night of anguish at home, she was returned to hospital the next morning. A doctor friend advocated for her admission to the chemical withdrawal unit. How many people in crisis have someone with the sophistication and personal contacts to advocate on their behalf? My recommendation would be to establish 24-hour crisis intervention centres with qualified staff in accessible, geographically strategic areas of the province.

The second concern I have is co-ordination of services. The lack of co-ordination of the services presently available leads one to believe that the right hand does not know what the left hand is doing. An atmosphere of territorialism and reluctance of the resources to work together compounds the difficulty of receiving appropriate care. It is impossible for healing to occur when the services are so fractured. This results in systemic and personal resources being wasted.

* (1430)

Another illustration, the friend previously referred to was seen by the following resources. At the Health Sciences Centre, it was the Chemical Withdrawal Unit for crisis intervention, and, after a week, was discharged to River House, a centre for women with addiction, where she remained for 30 days over the understaffed Christmas season. At the end of that time she was pronounced recovered and was discharged. A private psychiatrist, whom I implored to treat her, could see her once a month. In between appointments, she was to listen to tapes to quell her distress and anxiety. Her private physician also saw her and prescribed medication to help her sleep in an amount that would be her undoing.

Her mentor from Alcoholics Anonymous tried valiantly to be present to her without much success, to the dismay of her anguished family who had been excluded from the therapeutic process, a process that ignored her addiction to cocaine and the core issue of her illness, which was the sexual assault. The point I am trying to make is that there was no co-ordination of her care. She took matters into her own hands when the pain became too intense. She committed suicide.

My recommendation, then, would be to establish a communication network, as well as accessible co-ordinated community mental health facilities with skilled professionals, facilities that treat patients in a holistic manner available to provide services before a crisis occurs and involves the people who support them.

My next issue of concern is treatment focus. People seeking help for mental illness do so not only to survive but to regain their life, not an existence enveloped in a chemical straitjacket. The deinsuring of psychoanalysis during Don Orchard's term as Minister of Health has had serious consequences for people suffering mental illness. The focus on drug therapy as a means of dealing with mental health issues has camouflaged, inhibited and, in many instances, delayed or prevented the healing process.

I do not reject the use of drugs, if administered appropriately. But, if drugs are used to the exclusion of talk therapy, I question the underlying intent. It is not surprising that the certificate of leave is met with resistance and suspicion by many consumers. Bill 35 may be genuinely intended as a positive intervention, but from the consumers' point of view, relative to their experience with the system, is interpreted as a coercive legislation to impose further control on their lives.

I would recommend establish cost-effective, insurable alternatives that meet the needs of mental health consumers, reinstate psychoanalysis as an insurable option.

Mr. Chairperson: You have now gone 10 minutes.

Ms. Smendziuk: I have another seven to go. Thank you.

Fourth is fiscal responsibility. The major and drastic changes currently undertaken within the health care system are being initiated as a cost-saving and responsible use of financial resources. Appropriate community-based facilities specifically designed to meet the needs of mentally ill persons would be such a cost-saving measure. Mental health needs are equal to physical health needs. There should be no discrimination between the two where rehabilitation is concerned. Resources for meeting basic human needs must be available in the communities, such as safe housing, financial assistance, counselling, opportunities for socialization, employment, et cetera. The mentally ill person deserves respect for the productive aspect of their lives and their desire to return to that healthy state of being. They are prevented from doing so if the community supports are not there. I recommend establishing a community support specific to the needs of mental health consumers.

My fifth point is professional standards and accountability. Who do the person in pain and their family look to for help? How can people be assured of a quality of services? Psychiatrists, psychologists, social workers and nurses adhere to standards of conduct established by their professional association. Many others outside these disciplines provide counselling services with no accountability to a professional body. Visible standards and accountability of caregivers involved in the treatment team are lacking. Without visible standards, the consumer and the family are prevented from challenging the treatment approach. The lack of accountability, powerlessness of the consumer, the lack of involvement of the family and the absence of a mediator, combined with the protection from liability in Section 118 of those operating under The Mental Health Act, leaves all the authority and power in the hands of the authorities, even if they are wrong or neglectful.

Because there is not a standardized practice, the disparity among the mental health workers can often result in contradictory intervention and/or inappropriate treatment plans. Accredited training programs and standards of conduct for workers in the mental health field who do not belong to a professional organization are necessary. It is believed by many that the concentration on drug therapy in the treatment of mental illness has been a factor in the loss of professionals in Manitoba, whose preference to utilize talk therapy, which validates the consumer and permits him or her to retain dignity and self-direction, a vitally important factor in any mental health program. Emphasis on the drug therapy model also impacts negatively by restricting training and educational opportunities in our universities. The human resources who teach talk therapy have left the province.

My recommendation: Establish training programs and standards for those working with consumers of mental health services.

The sixth and last point I wish to make is regarding public education. The stigma associated with mental illness is phenomenal. Even those in the medical profession fear disclosure of mental illness, and when it occurs, they conceal it under the guise of a physical ailment so they can access their disability insurance. Admission of psychiatric treatment renders them uninsurable by some insurance companies. What a negative message that conveys, reinforcing the fear and ignorance associated with mental illness. The low priority given to addressing the treatment needs of mental illness is further reflected in the lack of community supports available.

Public ignorance towards this segment of our population compounds their problem. When we restrict efforts to expose in a clear and understanding way the plight of these individuals, our sense of compassion is displaced with a judgmental, critical and punitive attitude. This negative view inhibits open and honest dialogue with mental health consumers and protects the system from serious reflections and consideration of the consumer's experience which demands a shift in the existing paradigm.

My recommendation would be to establish a public education program that utilizes existing technology to advantage–television, radio, the Internet. Make written information as available as bus schedules. Teach people how to access existing services.

In conclusion, I hope the concerns I have raised will convince you that Bill 35 is not the answer to the inadequacies that exist in our mental health services. I urge you to act courageously in addressing these inadequacies and extend to the public an opportunity to actively participate in the solution of these problems. A white paper or a public inquiry on mental health issues in Manitoba would be a constructive initiative. Thank you.

Mr. Chairperson: Thank you very much, Ms. Smendziuk. I am wondering whether the committee was serious about taking the question period time and allowing it for presentation. This really is what we have done here, as we are actually even a bit over that time.

Mr. Chomiak: Mr. Chairperson, I do have questions, but I do recognize–I mean this presentation was so thorough and had recommendations and was so useful that I am prepared to give up my questions to allow the presenters to make the points that need to be made.

Mr. Chairperson: Thank you very much.

Ms. Smendziuk: Thank you.

Mr. Chairperson: Thank you very much for your presentation.

I call next Katherine Davis. Katherine Davis, have you a presentation for distribution?

Ms. Katherine Davis (Private Citizen): No, Mr. Chairman, it comes straight from my heart and soul, and there I will leave it and then go on my way.

Mr. Chairperson: Thank you very much. Would you proceed then with your presentation, Ms. Davis.

* (1440)

Ms. Davis: I will try to keep within the time frame. As the previous speaker has spoken, I can almost repeat the same feelings and thoughts that she has mentioned. I am very much akin to her line of thinking and her care. I do not wish to give you a lot of I's today. I am not doing a dissertation. I can use a few, and I do want to give you a little bit of a background, and then I wanted to leave a brief summary of concern.

I have a great deal of ambivalent feelings about this bill, and yet I am trying my hardest to remain open-minded and open to new ways of thinking and approaches. I am trying to show faith in other people's ways of thinking.

The reason I am so ingrained in my particular mindset is because I have gone through four generations of this illness. I have seen a grandfather and a father and a son and me deal with it. Two of us have recovered, of the latter two generations, me 70 percent outside the health care system. My son has recovered 97 percent, all within excellent care in the health care system.

In that line, I would say, if it is your intention, if after all this debate–first of all, I am very disappointed the psychiatrists are not here. I have talked to a lot of them individually, including in Saskatchewan and Manitoba on a one-to-one across the table, and it is very interesting what they have to say and the reasons they are saying the things they are and where they are coming from. In fact, the majority of us do not understand why they are reluctant to use this. I would say some words are more powerful than reluctant.

However, Dr. Andrew and Dr. Biberdorf will go out in their fine manners and try to encourage some of these reluctant psychiatrists to indeed try, see. In that, I am not opposed to that. I think the certificate of leave, there is a part of me that sees it as profoundly disrespectful, short-sighted and counterproductive. I wish we were going another direction in terms of community supports, et cetera.

The other part is to show trust in a psychiatrist, perhaps two, from a mental institution, not to be instigated from a community, to show faith in two psychiatrists sitting down with a wonderful medical team, a joint decision process with family input and family intake and feedback. I think that is very important. I never want to see this decision made by a parent. It is hard for me to trust psychiatrists because I have seen so much personal destruction, and yet I have seen so much good.

The reason I say I want this to be a decision made in that setting only is because too many of us who have been sick with this illness have come from too many homes that have made us so sick, and our only chance of recovery was escaping the home–living on the street at age 18 was safer for me than in the home–finding someone finally who loves me and provides me with a new family, and I heal because of the sociological supports in my life. So I look at this illness as a biopsychosocial spiritual illness, and I approach it from a holistic perspective.

At the same time, I realize the government has spent an awful lot of money on The Mental Health Act Review Committee. We have sat for hours and the debate could go on and on. So if one was to apply the certificate of leave, try it–if that is your decision, I would hope one would start with kind of a pilot project, a test evaluation process going on. I know a psychiatrist in Manitoba that readily would use this approach, a certificate of leave, in a small rural setting, and it will work quite effectively according to him. I know other urban psychiatrists will say, they will tell me quite bluntly, it is a piece of–and I will not go any further.

So I would see a test project of perhaps in the first year five patients, for example–I am just shooting this out to you, ladies and gentlemen, and I am going to leave it–putting five on a certificate of leave who meet the criteria, putting five as they usually deal with it without the certificate of leave. At the end of the first year, the hospitals could do this, psychiatrists could be accountable, could record–I assume you have to present them with some financial–they are swamped, and you have to provide them with some rewards for this kind of project. I want a test evaluation, and I am not a research methodologist. It is soft science; it is not hard science. I would like to speak in terms of mathematics, but I cannot.

Then, after the second year, I would like to see another five put on and another five not put on. At the end of those two years, whether you pass it today or not, this week or not, the pressure is on you, I realize. The media are providing only one or two sides of the story. Consumers are not even being exposed. I mean, they are being interviewed, but they are not being recorded. So five and five, and five and five. After two years we do an evaluation. We do an evaluation in terms of quality of life, the existence; the government has to provide these psychiatrists with the support services that they ask for. They say: I will need this to support this person in this community, and if after those two years it looks like, with those 10 individuals on certificate of leave, they have indeed built up the necessary support systems.

It can work as it works in Israel because the psychiatrist goes right out to the home twice a week in Israel, and the mother is–please fax in your machines, ladies and gentlemen–a mother is sent all the way across half the universe to be with her son if you are from Israel. So what I am saying, if you provide sufficient supports for those 10, those first 10, that is a pretty good start. That is a pilot project. I am not a research methodologist, and it is a soft science. But it is trying to get away from the emotions. You know, this is like the abortion issue; it could go on and on forever. So we have to start with something. I am asking the government to start with a pilot project to be initiated by the advisory committee on mental health free forum who will choose–I am thinking of people like Reg Toews. I am thinking of people like Dr. Ivey. I am thinking of people like Dr. Barakat to form an evaluation team, not from the university setting with all their different theoretical backgrounds, okay? We do not want to get into that–that is ad nauseam infinitum.

But provide for at least five the first year and five the second year, what we think might work. Do an evaluation after two years, and then another mental health–we are not going to solve this problem with our generation. We might improve it a bit; we might make it even worse. But, in my opinion, over four years we have come a long way in terms of this illness. I want to say very hopeful things to these families who are in this panic, this frantic state at the beginning of the illness.

My son did recover, and he did go back to university. His higher studies are in chemistry and calculus, believe it or not. Dr. Newman scratches his head. We do not know, but my son's body has taken 700 milligrams of Clozaril for 10 years and we do not know what is happening to his kidneys and his liver. We both donated our brains to the Clarke Institute to whoever wants them. I think the recovery will be 75, 80 years from now in terms of DNA research and the passing of it through generations.

Mrs. Shirley Render, Acting Chairperson, in the Chair

So I am saying, if we instigate this now, the only peace of mind I have, as the consumer first, a mother second, a granddaughter third, is that we do it in caution. This is to be a benevolent enabler. And we have to evaluate it. We have to see how effective it is. We can start with a small pilot project. It would mean a lot to parents who are in this state right now. It would relieve some of this pressure that is coming from the public. We know we need a balance. So I have mixed feelings. In one sense, I am so angry I could spit nails and my Russian ears are turning red. In another sense, I am saying, well, another generation comes along; perhaps we can try it a little bit different.

* (1450)

In my opinion, for some cases it is worth a try, but I want it evaluated and I want a commitment of the government to provide those support services that would enable it to work. If they do not have it, we are not in Israel. I really encourage you to study their model. I really do. Go home on your fax machines. If you have nothing else to do this weekend, study the Israeli mental health model.

I wish you all very well in your decision-making process. I want to compliment you all for taking the time. It has been an exhausting procedure for you all.

I can see that on your faces. I want to thank you for giving a consumer the chance to be heard. Thank you.

The Acting Chairperson (Mrs. Render): Thank you very much, Ms. Davis. I wonder if you would just wait half a moment, and I will see if there are any questions. Actually, your presentation was again so thorough and you managed to come right to the minute.

Ms. Davis: It is straight from the heart, and I am very concise.

The Acting Chairperson (Mrs. Render): Thank you very much.

Ms. Davis: Okay. Thank you.

The Acting Chairperson (Mrs. Render): I call up the next presenter, Beverley Hawkins. Is Beverley Hawkins here? Do you have a presentation to be distributed?

Ms. Beverley Hawkins (Private Citizen): I just have what I hold up.

The Acting Chairperson (Mrs. Render): Okay.

Ms. Hawkins: Psychiatry and I have had a long history.

The Acting Chairperson (Mrs. Render): Ms. Hawkins, are you ready to begin?

Ms. Hawkins: Yes.

The Acting Chairperson (Mrs. Render): I just want to make sure that Hansard starts recording.

Mr. Chairperson in the Chair

Ms. Hawkins: Okay. We have had a long history, psychiatry and I. I started out as a nursing student, Health Sciences was Winnipeg General. When I was 17, I got the nervous breakdown diagnosis, the schizophrenic reaction diagnosis, had the conventional therapy, shock treatments, deep insulin therapy. At the end of that scenario I managed to graduate and get my RN. I never went back to a psychiatrist's office again, never took another therapy from a psychiatrist again, married a husband who was in chartered accountancy, decided that was not his life's role, went into chiropractic. I nursed, put him through college. We have six children today. All of them adults, all of them with university educations, except for one. I am here today because of that one.

I consider myself a survivor of psychiatry. Okay? He is a nonsurvivor. It is getting worse, my friends. If I had the money, you would all have a copy of this in front of you. I do not mind sharing my material and leaving it for anyone who might like it. I understand that this group is making a vote on Monday in the House here passing carte blanche what is in front of you. I say, there is no hurry to pass nothing. Sit on it. This is another book I will leave with you for anyone who would like to peruse this over the weekend. The Truth Shall Set You Free. You are all elected politicians here at this board, and I am a Canadian citizen. This process is what it is all about. Okay?

Freedom of speech. I will leave that book for anyone who wants to look at it. This is Maclean's magazine. Recently, everything that currently psychiatry is giving mind-bending drugs for is not what is wrong with the brain, and I quote, flurry of discoveries. It turns out the receptor genes are basically all normal in schizophrenics. We are giving them mind-bending drugs and zombieing them out of their brains.

Brain chemistry and memory boosting. I am currently being disallowed to visit my son for the last eight months. Granted, I am an activist. I am furious. I would like to strangle some of them, but it really would not be in keeping with my supposedly Christian stance in life. Anyway, learn which vitamins, minerals, amino acids, nutrients are catalytic, are synergistic to balance brain chemistry. I made an appointment at the Victoria Hospital hoping that maybe I would find another route. There is not one route in this city of Winnipeg. He never heard of brain chemistry and nutrients; he gives drugs for schizophrenia.

Where Jim is right now, I think he will have a heart attack because he is showing liver damage. The lady who presented here a short while ago discussed clozapine her daughter was on. Well, they had to quickly take her off clozapine because her whole body quickly take her off clozapine because her whole body system was falling apart on the product. This is Jim.

I am a Rotarian. One of the first rules of a Rotarian is: is it the truth? I tell you, it is a pack of lies. This was Jim a few years after he got the big diagnosis at the Grace Hospital, went through about six psychiatrists there because they were all quitting and doing whatever they were doing. The very first dose of the drug they put him on, I went there, his skin was gray, and he said I do not know what they are doing to me, but they are killing me. He was 14 or 15. I trusted medications; it sounds so innocent. Medications sounds so innocent. Not innocent. These are not innocent drugs. We are going to have to wait until a lot of psychiatrists are in their graves before things are going to change.

Do not rush anything on Monday, sit on it. You are going to have to change a lot of information. Dr. Abraham Hoffer, 35 years of research, ran a hoosegow in Saskatchewan.

Mr. Chairperson: Could you move over just a bit, because we want you to be recorded.

Ms. Hawkins: Yes, Dr. Abraham Hoffer, one of the first physicians, psychiatrists to say, whoops, come on now, deep insulin therapy and shock treatments, come on, this is not working, and he discussed the brain's need for nutrients. He is a breakaway factor in psychiatry today, and psychiatry has totally thumbs-downed that whole thing.

We are nearly broke trying to get through to somebody, mostly psychiatry. We have taken our son and had him analyzed at a clinic that has done 40 years of research on this problem. They have profiles. They know what these chemistry profiles are. They know exorbitant nutrient therapy has effect, that you can decrease the doses.

Do not worry about policemen and all those things. I have been removed from institutions by the police for giving my son nutrients. I have been–never mind, you have had a long day. It is not a pretty picture.

When Jim was still this good, after two or three years of treatment, he tried out at the armed forces. They gave him an IQ test, and he scored way too high for them. They said, besides, you have schizophrenia, and we are not interested. Today, my son is nearly like a zombie.

Shock treatments. Ernest Hemingway, he put a gun to his head after a few shock treatments, because it destroyed his creative life. Well, if he had waited five years, his memory might never be quite right again, but it will start clicking better. I could have told him that.

* (1500)

I suggest–and I will leave this material and anyone who wants to borrow it, look at it, is most welcome to–do nothing on Monday. Pass nothing. Sit on it. I never came here to be emotional. I was going to try very hard to be just rational.

We live in trying times, but I will read one thing. The truth shall set you free. We are the power in everyone. We are the dance of the moon and the sun. We are the hope that will never hide, and we are the turning of the tide.

I am telling you, I have never read a book in my whole life and I am a Bible student. This book blows my mind. If you do not own it, you might want to get it. I will leave it here. You can get the title, the author, whatever. Thank you.

Mr. Chairperson: Thank you very much, Ms. Hawkins, for your presentation. Are there any questions? Thank you again for your presentation.

As I indicated before, we would drop Rod Lauder to after 22. The next person, then, to present is Mr. Victor M. Dyck, private citizen. Victor M. Dyck, is he here? Would you come forward, please. Have you a written presentation for distribution? The Clerk will distribute. Mr. Dyck, you may proceed.

Mr. Victor Dyck (Private Citizen): Mr. Chairman, ladies and gentlemen of the Legislature, over the past 20 years I have experienced the very significant changes that have taken place in the mental health field from various vantage points; firstly, as a parent of a mentally handicapped person; secondly, as board member of Friends of Schizophrenics, Manitoba Schizophrenia Society and Friends Housing; thirdly, as a member of numerous government committees dealing with mental health problems; and last, but not least, by maintaining contact with other affected persons and their parents.

In my view, the Manitoba Mental Health Review Committee has come up with one of the most advanced pieces of legislation in the mental health field. The changes have relevance to the continuing and increasing trend of treatment in the community rather than institutions. It is my sincere hope that legislators will set aside party-related considerations and vote for the passing of Bill 35 without substantive changes.

What I see in this new act, without going into details, is a reflection of a caring society providing treatment for the mentally disadvantaged with a clear purpose of giving careful consideration to the patients' wishes. However, as a very last resort, a mechanism is in place to care for the person when the illness prevents a patient from deciding what is best for him or her. Off the record, I have seen a lot of doctors who had problems with this type of thing on what to do. The buck stops somewhere. Similar to our reaction when we care–I go back again. However, as a very last resort, a mechanism is in place to care for the person when the illness prevents a patient from deciding what is best for him or her, similar to our reaction when we care for an Alzheimer's patient who might be disoriented.

It is my hope that arising out of this act and its subsequent regulations, we will see more funds allotted toward the welfare of the mentally disabled living in the community. Perhaps it will be possible to establish assertive treatment outreach teams which remain in touch with the patients who are placed in the community with very limited ability to care for themselves. The nature of their illness often renders them completely unable to look after themselves at unpredictable times. You never know when.

One reads about similar team treatment approaches all over the world and elsewhere in Canada. Examples are Assertive Community Rehabilitation Program, Ottawa; Assertive Community Treatment, Dane County, Wisconsin. Similarly, the Bridge Program in Chicago is being written up as another successful assertive case team management program.

Bill 35 and its regulation can in its spirit be an act to enable such programs which are designed to help a mentally disordered person to regain and maintain his or her human dignity and which are also designed to use the very necessary enforcement portions of the act at a very last resort. It is great to see that parents of mentally disordered persons have had an input into the changes reflected in Bill 35. In my experience, patients with caring parents have had the best success rate in coping with the illness. Parents have also been the originators of the schizophrenia societies in Canada as well as Ami Quebec.

In reading Best Practices in Mental Health Reform discussion paper researched by the Clarke Institute of Psychiatry and published by Health Canada, a reference is made of the importance of parents and family groups inclusion in mental health issues.

As I go over the last 20 years of being involved in this field, I can think of hundreds of situations where the provisions of Bill 35 could have resulted in more appropriate treatment of severely mentally disabled patients. It is essential, in my mind, that Bill 35 be passed without substantive changes.

Mr. Chairperson: Thank you very much, Mr. Dyck. Are there any questions? Thank you again, Mr. Dyck.

Before I call the next person, I have a request here. A person by the name of Yude Henteleff, who is listed here as No. 21 on the list, has to leave before 4:30. What is the wish of the committee? Do you want to hear him before 4:30? Could we hear him right now then? [agreed]

Mr. Henteleff, would you come forward then, please. Have you a presentation for distribution, Mr. Henteleff? Could we have the Clerk distribute? Mr. Henteleff, you may proceed.

Mr. Yude Henteleff (Private Citizen): Thank you very much, Mr. Chairperson, ladies and gentlemen. I only received a copy of the bill the day before yesterday and managed only to consider it yesterday, so I wish I had had more opportunity to look at it in many more respects than I did. I have addressed the bill primarily in respect to what I consider to be its serious infringement of individual's rights as provided for by

Sections 7 and 15 of the Charter. I would like to remind you that Section 7 of the Charter provides that everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

In Section 15, the Equality Rights section provides that every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability, and the courts have made it very clear that there is a very heavy onus on governments seeking to limit the fundamental equality rights of an individual granted by these sections.

* (1510)

In the leading case of Regina versus Oakes, the Supreme Court of Canada set forth a test to be applied. In that case, Chief Justice Dickson stated that to establish that a limit is reasonable and demonstrably justified–and I now speak of the limits that are being imposed by this act upon individuals with mental handicaps–two central criteria must be established.

First, the objective that limits the right must be of sufficient importance to warrant overriding a constitutionally protected right or freedom. The standard must be high in order to assure that objectives which are trivial or discordant with the principles integral to a free and democratic society do not gain protection of the Charter. At a minimum, the objective must relate to concerns which are pressing and substantial in a free and democratic society.

Secondly, even if a sufficiently significant objective is proven, then the party seeking to invoke limiting these rights–as this government, in my view, is attempting to do by this act–must show by clear, pursuasive evidence that the means chosen are reasonable and demonstrably justified. In each case, the courts will be required to balance the interests of society with those of individuals and groups.

Now, the court laid down the following three criteria which you are obliged to follow, because, as I am sure you are well aware, the Charter of Rights and Freedoms is the supreme law of this land, and every bit of legislation is subject to the commandments laid down by the Charter.

First of all, the measures adopted must be carefully designed to achieve the objective in question. In other words, they must not be arbitrary, unfair or based on irrational consideration. Secondly, even if there is a rational connection, the means utilized–and this is really critical for your consideration–should impair as little as possible the right or freedom in question. Thirdly, even if an objective is of sufficient importance and the first two elements are satisfied, it is still possible that because of the severity of the effect of the measure on the individual or the group of individuals, the measure will not be justified even for the purposes it is intended to serve. In other words, the more severe the negative effect of the measure on an individual, the more important the objective must be if the measure is to be reasonable and demonstrably justified in a free and democratic society.

Persons with mental disabilities are clearly a group that are socially, legally and politically vulnerable, and, in fact, the courts have said that. Accordingly, Sections 7 and 15 clearly apply to them. They are a minority, and the courts have also said that the specific purpose of the Charter of Rights and Freedoms is, in fact, to protect the interests of the minority against what is perceived to be in the interests of the majority because they are particularly vulnerable and particularly powerless. So for the vast majority of people with mental handicaps, they cannot express for themselves what it is that they wish. They have others to come and represent their interests, all the more reason for you to take enormous care in not in any way compromising their rights.

In considering, therefore, the courts have said this: whether any rights under Section 15 are being prejudiced, the courts have made it clear that the substance of the practice must be considered. Matters such as human dignity, self-respect and the right to be recognized as human beings equally deserving with all other human beings of concern, respect and consideration must be taken into account.

I think I want to say this to you, as well, before I get into an analysis of the section which, I think, really compromises people's rights to the extent that, in my view, there is a very clear breach of the Charter in these sections, and you lay yourself open not only to being considered by the community as breaching these fundamental rights but, quite frankly, Charter challenges. I cannot help but feel that, with the haste that this bill is being processed, there is some perception that the public generally considers itself being compromised by not having people with mental handicaps placed in an environment where they are compelled to do things beyond their wishes.

Unfortunately, we more and more move into a society controlled by technocrats and by technologists. It is perceived that medicine is the cure of all things or that the computer is the cure of all things, and we seek what I describe as a single-solution approach, the magic pill that is going to cure everything. The magic pill is not medicine. The magic pill or the kind of early identification and preventative care which has been identified and in fact which apparently, for whatever the reasons are, too many governments–not just this one–are not prepared to put it into effect. What they were prepared to do was to deinstitutionalize–and we know full well the consequences of that–and without providing the sustaining systems within the community to sustain the very individuals they cast out into what is a wilderness for them.

I, therefore, would like to now deal with certain of the sections which I think breach the Charter. Section 12(1)(a)(iii) appears to authorize a peace officer to take a person into custody if the officer believes on reasonable grounds that the person "has shown a lack of competence of care for himself or herself." First of all, as someone else said, I have no idea what qualifications a peace officer has and whether they are qualified, even if the grounds are reasonable, to in fact make that kind of judgment call.

Subsection (ii) does correctly quantify the degree of competence as to the degree or lack of competence of the individual in question. It seems to me that there should also be some quantification of lack of competence in Section 12(1)(a)(ii); in other words, add the words "has shown a gross lack of competence" because if it is only the most minor degree of lack of competence, this particular section enables those persons' rights to be compromised. So surely at the very least there should be that level or such an extensive level. The second thing, there should be some outline as to what a peace officer's degree of competence should be.

Section 12(1)(b). Pursuant to Clause 12(1)(a), as you will have just noticed, the peace officer must base his decision on reasonable grounds of belief. However, in subsection (b), it simply states that the peace officer simply has to be "of the opinion that the person is apparently suffering from a mental disorder." Now why there is that inconsistency, I do not understand. On the one hand, he is supposed to have reasonable grounds, but not in this section. It seems to me, therefore, at the very least, in this section as well, it should be worded, namely, the peace officer believes on reasonable grounds. At least, to some degree, the peace officer is held accountable because if it is only based on his opinion–it does not take very much to have an opinion–and there is no basis to challenge him or her or make him or her accountable.

The next area is General Requirements for Involuntary Examination and Assessment. In Section 14, there should be an obligation on the part of "a peace officer who takes a person into custody for involuntary mental examination under section 11 or 12 or an involuntary psychiatric assessment under section 9," not only to promptly inform the person who is taken into custody under this section, but also to promptly inform the nearest relative as defined in the act.

You heard earlier that at the very least there should be somebody either who is a mentor or who is responsible for or who feels responsible for being immediately identified, and that is why the nearest relative is identified in the act. For some reason that I do not understand, in order that the nearest relative or whoever is close to this individual, because it is listed in order of priorities as you note, and quite deliberately so, because I want to make sure that every opportunity is taken to identify somebody who has some connection, and yet in this instance there is no obligation for that to be done. I urge that that be the case.

With respect to Section 17(1) when the psychiatrist admits a person to a facility as an involuntary patient in accordance with this section, again notification of that should be promptly provided to the nearest relative as defined in the act. Again, with respect to 21(1), the same should be reposed upon the attending psychiatrist if the person intends to issue a renewal certificate. That again is to promptly notify the nearest relative of such an action.

Treatment decisions, patient's right to make treatment decisions. Section 26 provides as follows: "Except as provided in this Act, a patient of a facility has the right to consent to or refuse psychiatric and other medical treatment." On the face of it, Mr. Chair, that sounds as if in fact you are really respecting the wishes of the individual. I have therefore the following, and I have repeated–let me reiterate the point that I made earlier–

* (1520)

Mr. Chairperson: Mr. Henteleff, I just want to make you aware that you are over 10 minutes already, 10 minutes is a very long period of time. What is the will of the committee? Do you want to allow the continuation? [agreed]

Mr. Henteleff: Thank you so much. I will try and rush. I hope you will bear with me because I really do consider these are really important sections for you to consider.

Section 27(1), it provides the attending physician shall determine whether the patient is mentally competent to make treatment decisions as soon as is reasonably possible after the patient is admitted to a facility. As is the case with other sections, such a decision should be made within a certain number of hours following the admission of the facility. For example, pursuant to Section 20(2): "A person must be released within 72 hours of first being detained in the facility unless, within that time, he or she is admitted as a patient." Similarly it seems to be, in this situation as well, it is critical and in the person's best interest–and, by the way, when I use "person," I do not mean just the individual himself; I mean his extended family. I do not consider they are separate. I consider, as the act does, that they really are a family unit and as such the family unit being responsible for each other, the closest family unit available should be notified. So that should be the case here too.

I would suggest that, in this instance, a decision should be made, for example, say within 48 hours, unless somebody thinks that is too short a time, but it surely would not take more than that to make that critical notification because there is after all such a long list of individuals, it should not be too difficult to make that kind of contact.

Pursuant to Section 27(2)(b), in making his or her decision, the attending physician is required to consider "whether the patient's mental condition affects his or her ability to appreciate the consequences of making a treatment decision." I think there should be a stronger onus upon the physician than what appears to be provided for in this particular section. It seems to me that what should be provided as proof is the patient's mental condition significantly affects–there should be some responsibility, not just simply to base an opinion on a lower common denominator, but on a much higher common denominator in the interests of the patient's rights as an individual. So it significantly affects his or her ability to appreciate–and I would add–the full consequences because what if there is just one. It may be really irrelevant in terms of the whole context of what that individual's situation is like. So those are the two changes I would suggest there.

Pursuant to Section 27(4), on receiving a certificate from the attending physician, as the patient's mental competence, the medical director is obliged to send a copy of the certificate to the patient and to persons authorized by Section 21. Now Section 21 simply identifies a person's proxy and identifies a committee appointed under the court. It seems to me also–and I will come back to this–the section should require that the reasons listed by the attending physician in support of such a certificate should also be provided to the patient and to the persons. It is not enough just to provide the certificate. Again, I am deeply concerned about accountability, because with accountability comes responsibility for your actions. Again, I would urge not just a certificate, because the section is not clear. The certificate and the reasons for it must be provided.

There should also be some requirement upon the medical director to provide a copy of the certificate and of the physician's opinion supporting the patient and the person authorized to make treatment decisions within, say, 48 hours after it is filed with him by the attending physician. In that way, the patient and such authorized person would be promptly notified of that decision.

Pursuant to Section 27(5), after the certificate has been filed, the attending physician is required to periodically review the patient's condition. We know how terribly understaffed most of these institutions are, very often to the total detriment of the individual. Therefore, in order to ensure that the principles of fundamental justice are being carried out, there should be specific time limits set out in this section within which such review is to be carried out. In other words, there should be every assurance that a person is not being held one moment longer than is actually required.

Treatment decision by others–Section 28(1). It has been recalled that pursuant to Section 27(4), while an individual is a patient in a facility, the right to consent or to refuse psychiatric and other medical treatment is in effect negated if the medical director receives an opinion from the person's physician that such person is not mentally competent to make such treatment decisions. Furthermore, pursuant to Section 27(4), the medical director shall be obliged to send a copy of such certificate to persons authorized to make treatment decisions on that patient's behalf under Section 28(1). But the problem is that Section 28(1) only defines two individuals. One is the proxy and one is a committee appointed by the court.

Well, as you know, the proxy is very limited. It has got to be one which is drawn specifically under the provisions of The Health Care Directives Act. Well, it seems to me that, for example, if there is no proxy, then the treatment decision can be made on the patient's behalf by those two people I have just identified. If the court is satisfied, and this is what really puzzles me, that the person is incapable of personal care and needs decisions that have to be made on his behalf, what does personal care mean? It means the hairdresser, it means the podiatrist. Does it mean when a person is not capable of cleaning their fingernails? I mean, I really do not know what that means.

Quite frankly, I assume there might be someone who talks about what personal care means, but it should be defined. It seems to me it should be very personally and carefully and definitively identified. It just leaves such a huge open door for a person's rights to be breached. A more precise and appropriate definition of personal care would be where a person, for example, is unable to look after their condition to the extent that their physical condition may be significantly affected or compromised.

Pursuant to Section 28(1)(c), if there is no proxy or committee, then the treatment decision may be made on the patient's behalf by the patient's nearest relative. In order for the nearest relative to be qualified to make such decisions, Section 28(3) and (4) set forth the conditions that are applicable and which must be complied with. Pursuant to Section 28(4), a person who makes a treatment decision on a patient's behalf, in other words, a patient's relative, other than the Public Trustee or proxy, has to do so in the patient's best interests. Section 28(5) sets out what a person referred to in Section 28(1), namely the patient's proxy or patient's committee, must take into account, having in mind what the patient's best interests are.

But, you know what? Those foregoing sections are absolutely, totally confusing. Section 28(3) and 28(6) make reference to the patient's nearest relative and what their obligations are but make absolutely no sense, because the only persons authorized to act on behalf of an incompetent person are those authorized by Section 28(1), because Section 28(1) only says a proxy or committee. It makes no reference at all to the nearest relative. So what is the sense of having all those other sections at all? It simply does not make sense. It is totally confusing. It would only make sense, that is, Section 28(3) and Section 28(6), if the patients nearest relative was to be added to Section 28(1) as a further authorized party.

Section 28(4), which refers to decisions on a patient's behalf, only refers to a person and not a patient's nearest relative by virtue of its reference to Section 28(1). Therefore, Section 28(4)–you will forgive me for doing it this way, but there is no other way I can make this analysis on your behalf–by its reference to subsection (1) of 28 only applies to the patient's proxy or, if there is no proxy, the patient's committee. So you will see the confusion that is inherent in all of these sections.

With regard to Section 28(5), I fully agree that the person making that decision should have regard for the relevant circumstances identified. But having in mind the serious consequences of invading a person's right to security of his own body and privacy, there must be some guarantee that, in fact, the person did take these factors into account. It is not enough just to say, Mr. Chair, that he should. What certainty do you have that they have? There is only one way, and that is by having that person sign a statutory declaration to that effect, and I use the words "statutory declaration" because it has some force and effect under the Canada Evidence Act. Otherwise, it really is a meaningless requirement.

* (1530)

Furthermore, it seems to me that in determining the treatment decision to be made by the physician and to ensure that such decisions are in the patient's best interest, such physicians should also be obliged to take those four factors into account, not just the nearest relative, not just the proxy, not just the committee, but the physician as well, and this is what they are:

(a) whether the patient's condition will be or is likely to be improved by the treatment–responsibility, accountability.

(b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment–responsibility, accountability, patient's rights.

(c) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient–again responsibility, accountability, patient's inalienable rights to privacy.

(d) whether the treatment is the least restrictive and the least intrusive treatment that meets the criteria set out in the foregoing sections, and that is critical. That is absolutely fundamental. There is far too great a tendency that the pill will serve everything, and we know the consequences of that.

Shock treatment was going to cure everything. It empties people's minds. We know what happened in a certain mental institution in Montreal where people were unknowingly taking LSD in furtherance of science and how tragic that was for people that we know from Winnipeg.

With regard to Section 28(6), when a patient's nearest relative makes treatment decisions on a patient's behalf, the section provides that the physician may rely on the person's statement as to his or her relationship. Does that mean if the patient's proxy or the patient's committee happens not to be the patient's nearest relative, then the doctor cannot rely on the treatment decision made by such proxy? And why should the doctor not be obliged to comply with that decision? If the act permits for these people to participate and be responsible for and on behalf of that individual, why is the physician given the right to totally disregard? If, in fact, you want to leave that in, at least have the physician sign a statement indicating the reasons for his decision, and they better be substantive and they better be substantial, and that should also be stated in this section.

In Section 28(7), there is something structurally wrong with this paragraph. I assume the intent of this clause is that if the physician had made reasonable inquiries and 72 hours is then passed from the commencement of those inquiries, and the person still cannot be found, then he can proceed. Well, that is not what it says; there is something wrong with the structure of it. To make the intent clear, it should read: after reasonable inquiries are made and the person cannot be found within 72 hours from the commencement of making such inquiries.

With regard to Section 28(8), it seems to me rather strange that when the physician, for good reason, is obliged to determine whether there is someone qualified under the act who can make treatment decisions for someone who is not competent, then nevertheless he is not obliged to determine whether the patient has appointed a proxy or made a health care directive. That is what that section says. It seems to me astounding, despite the fact that he is supposed to make reasonable inquiries, but if he decides or she decides that they should not, they do not have to. I really wish someone would explain to me, Mr. Chairman, the rationale for that. Again, it is totally inconsistent with the previous sections and again totally does not make sense. At the very least, the physician should be obliged to make reasonable inquiries to determine if there is such a qualified person and then be accountable for the fact as to whether the inquiries he or she has made in fact are reasonable. Otherwise, Section 28(7), which seems to give some rights, they are all taken away.

Section 29, Administering Treatment. This seems to be totally in conflict with certain provisions of Section 28 and particularly Section 28(7) and 28(8). Section 29(1) states that, except as provided in Section 29, an attending physician shall not administer treatment to a patient who is not mentally competent without the consent of a person authorized to make treatment decisions on the patient's behalf under Section 28(1), namely the proxy or the patient's committee appointed by the court. Yet Section 28(7) and 28(8) enable the physician to do exactly that, even if he has not inquired as to whether the patient has appointed a proxy or made a health care directive. It is more than confusing. Quite frankly, it is insulting to the rights of the individual.

There is, furthermore, a qualification of Section 29(1) whereby pursuant to Section 29(2), "pending consent on a patient's behalf or an order of the review board or the court, psychiatric treatment may be given without consent to a patient in order to prevent harm to the patient or another person." I am concerned about this clause because it is worded so broadly. There are all sorts of different levels of potential harm, and, again, the physician making that decision should be obliged to apply all the considerations set out in Section 28(5). That is the one, if you remember, before–I will just leave it with you. Such physician should as well be required to provide written reasons supporting the decisions made. Also, the degree of contemplated harm must be demonstrated as being significant. Furthermore, the section should provide that, where the treatment includes medication, it should be quite specifically noted in the medical report by the attending physician as to why this particular medication is being used, the expected results, and for how long it is intended the medication be applied. There should also be the additional requirement of regular re-evaluation to determine whether the medication should be continued.

I would suggest, therefore, that some of the same language that is used in 29(4)(b), as to when force or mechanical means may be justified to restrain a patient, apply as well to a situation where it is deemed the medication should be provided, namely, in terms of the use of the medication: a description of the medicine to be used, a statement of the period of time during which the medication was or expected to be utilized, a description of the patient's condition that required the medication to be applied or continue to be applied. That would, then, prevent the patient from receiving medication they should not and again provide for accountability and responsibility.

Now Section 29(5) seems to me to be worded the most peculiar way. I do not know, it may have come from an 1895 statute or somewhere, namely that you have to demonstrate that there will be a danger to patient's life or to the patient's limb or to a patient's vital organ. I mean, there may be all sorts of confusion as to what a patient's vital organ is, for example. Is it his brain? Is it some other part? I do not know. Surely the more appropriate way is to state that there is a serious danger to the patient's mental or physical status or condition. This is really an antiquated form of language. I happen to know where it comes from. I think the veterinary act.

I am sorry. I ought not to make fun of Legislative Counsel. I know that he took my comment in all the spirit that I intended.

Review of Treatment Decisions. In Section 30(2), it is noted the physician must justify the treatment decision recommended on the basis as set forth in 30(2)(a), namely the patient's mental condition will or is likely to be substantially–notice the words–improved by the treatment. Section 30(2)(b) should also require that the patient's mental condition would not substantially improve or is not likely to substantially improve without the specified treatment. In other words, if you want to have a consistency of approach, why the two sections do not follow each other, I really do not understand. One provides what I consider to be appropriate protection, and the other does not. They both should. Again I do not understand this inconsistency.

With respect to Section 30(2)(c), again, this is a subjective matter, that is, the anticipated benefit from the specified treatment outweighs the risk of the harm to the patient. In order to ensure that the patient's interest is well protected, it should require simply more than that the anticipated benefit outweighs the risk of harm, by what? By half of one percent? A quarter of one percent? A tenth of one percent? It seems to me it should require the anticipated benefit must significantly outweigh the risk of harm in order, again, to protect the individual's interest.

Section 30(4) provides that the review board shall consider the wishes of the patient expressed about the treatment while mentally competent. It seems to me that, under the circumstances, the review board should also consider the views of the proxy or the committee or the closest relative as to what they consider should be in the best interests of the patient, and appropriate notice should be given to them to attend. In other words, all through this there should be a fundamental stream, if you wish, of identifying the nearest relative together with the patient as being part of the family unit.

Again, furthermore, as set forth in Sections 31(2) and 30(4), it should also require that the board, before it makes its decision, shall consider all the relevant circumstances including whether the patient would now, given the circumstances, alter his or her express wishes if competent to do so.

Finally, the question of confidentiality of clinic records. Section 36(1), for some reason, which I do not understand, the patient's proxy is omitted from the list of individuals whose consent should first be obtained. In so many other instances of substance, the proxy in fact is required to be notified. Why not here? I really do not know. For example, Section 28(1), where actual treatment decisions are made on the patient's behalf, the patient's proxy is given first priority, and if there is no proxy, then the patient's committee. Maybe there was some thought that divulging records was not as important as treatment decisions.

Let me assure you, as a lawyer who has been involved in a few human rights issues, the whole question of inappropriate release of records to individuals who should not have them can have profound effects on an individual, and particularly in our society because our middle-age attitude–middle-aged attitude, not middle aged but from the Middle Ages' attitude towards persons with mental handicap–for many, far too many people, it is still sitting there in that black hole.

There is no reason for distinguishing between those persons who are qualified to represent the patient's interest as between Sections 36(1) and 28(1). In fact, if you read Section 36(2)(d), disclosure of the medical records made without a patient's consent in fact can be made to persons described in Section 28(1). So, again, there is an inconsistency which is really hard to follow.

* (1540)

I am also further concerned with the following provision of Section 32 which in my view unnecessarily or inappropriately intrudes upon a person's right to privacy. With regard to Section 32(b), as is provided in 36(2)(a), the record should only be provided to the medical director of another facility–and this section does provide the medical record of another facility who has care of the patient to have all these records–for the specific purpose only of assessing or treating the patient. If they require it for any other purpose, they should not have it. Then they must first demonstrate that in fact it is for the purpose of assessing or treating the patient.

36(2)(c) permits a person who is providing health care to the patient to receive such information and, to the extent necessary, to provide that care. Again, the provision of health care covers a very broad area, as I said earlier. Who is it? The pharmacist? The podiatrist? I do not say that in any demeaning way, but they are not the kinds of persons who should have these kinds of records. Yet, if they ask for it, according to this, they are providing health care; they have a right to ask for it.

Furthermore, who determines the extent to which the records should be provided under each particular circumstance? This should be clarified. It seems to me that sub (a) and sub (b) of 36(2) more than adequately cover the provision of records which are involved in the patient's care. 32(2)(g) provides that the director should be given the records. It is suggested it is for the purpose of carrying out his or her duties. Why? What are those duties? What is important about that person's duties that this individual's private, personal records–and you will notice I said "this individual's".

Let us not forget that. That person's records as well, with equal rights of access, unless in some way–and it has to be demonstrated–access will compromise the individual himself in some significant way. Again, this is very broadly worded and could very well lead to abuse.

36(2)(i). This enables the register to be provided to a person for research purposes. I find this extraordinarily objectionable. Does this apply to every person who falls ill? Of course it does not. Yet why are the mentally handicapped sought out as a group of persons whose rights can be infringed upon to this extent? I find it an absolute abomination of individual human rights. I cannot think of a greater example of discrimination between those who are mentally handicapped and those who are not. Simply because a person has been determined to be mentally incompetent is no justification that there should be such a gross intrusion of their privacy. I do not care what the rationale is, and I do not care what the safeguards provided are. There is simply no fundamental right for this to happen.

Then 36(ii). This permits the private medical records of an individual to be used by the facility treating that individual for a purpose of peer review by a standards committee. I am again just astounded. I know of no other person with any physical handicap anywhere, any legislation which permits their records to be used for peer review. It is astounding. It is a totally deplorable and unjustifiable intrusion on a person's right to privacy.

36(2)(n). This permits the lawyer acting on behalf of the facility or on behalf of a person on staff who, for example, may be charged with negligence or something, to gain access to these records. Well, these are, after all, confidential, personal records of the individual. Let us not forget that. The professional is responsible to him, not the individual responsible to the professional. Let us keep in mind the hierarchy here of who is responsible to whom, and who is the powerful and who is not the powerful. It is the patient that must always, at all times, be considered to be the powerful person. The medical people are only there as people of resource and nothing else. So I see absolutely no justification for permitting the lawyer, in total conflict of interest by the way, because if there is a right of access of some kind to gain access to those records. There are appropriate rules of court. Let those rules of court apply.

36(3). Second last one. We note that every disclosure must be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed. There should be an additional requirement on every person who is specifically permitted by the act to have the records not to copy them, not to share them or disclose them to any other party.

36(4) only provides this protection where clinical records are used as evidence in investigatory or disciplinary proceedings. It should be much broader than that for the reasons I have just given.

In my view, Mr. Chair, and ladies and gentlemen, all these foregoing sections are unjustified gross breaches of a person's fundamental right to security of the person. It simply boggles one's mind that they are even proposed. It speaks volumes–I have to say this–of this government's view of persons with mental disabilities as not really counting for much. If I had had more time to look at the act, I am sure I could have had more to say.

Mr. Chairperson: Thank you very much, Mr. Henteleff, for your presentation.

Mr. Chomiak: Mr. Chairperson, I just want to reflect some of the comments, and my colleagues as well, that imagine what you would have reviewed if you had had more than one day to look at this act. I note the minister and I had a discussion, and one of the reasons we have talked about extending your time limit is because you were the first presenter to actually deal with the legal issues concerning this act. The minister indicated to me that he was going to have his legal staff review all of your comments and report back to the committee when we next meet, so we thank you very much for a very useful analysis of the act from a legal perspective.

Mr. Henteleff: If the committee wishes, I would be more than happy to look at it further and come back to you and share our thoughts with you.

Mr. Chairperson: The committee will share that with the minister, and if the minister so wishes to consult further with you or have you consult with him, I am sure he will notify you. Thank you very much, Mr. Henteleff.

Mr. Henteleff: Thank you for your indulgence.

Mr. Chairperson: I call next Mr. Horst Peters. Mr. Peters, will you come forward, please?

I am going to indicate to committee, though, that I am going to look at my watch fairly carefully, and I am going to indicate to the presenters at the eight-minute mark that they are reaching 10 minutes. Unless the committee directs me specifically to further the hearing of individuals, I will cut off the presentation at 10 minutes, and we will then open for questions.

Mr. Peters, have you a presentation for distribution?

Mr. Chris Summerfield (Manitoba Schizophrenia Society) (read by Mr. Horst Peters (Private Citizen): Actually, I do. I have two of them here. If you recall from this morning, I had asked to read Mr. Chris Summerville's presentation on behalf of the Manitoba Schizophrenia Society.

Mr. Chairperson: Let me ask the committee then whether it is with their indulgence that we allow Mr. Peters to make the two presentations, for Mr. Chris Summerville as well as Mr. Peters's presentation. Agreed? [agreed]

Mr. Peters, you may continue. In the meantime, we will ask the Clerk to distribute the presentations. You may continue.

Mr. Peters: Thank you very much for this opportunity. I have learned many things here today, the most important of which is if I am ever involved in this process again, I will find an appointment for 10:30 in the morning so I can get the hell out of here, but anyway.

Members of the legislative committee–and this is Chris Summerville's presentation–forgive me for my absence today as I am in Alabama at a family reunion. As executive director of the Manitoba Schizophrenia Society, I speak as a consumer, as a family member, as a mental health provider and as a person who has many friends who suffer from a mental illness.

* (1550)

When talking about The Mental Health Act, we are talking about family members of the human race, people who suffer from a mental illness. I ask that, as you listen to the various sincere presentations, you ask not what illness the person has but what person the illness has. I also remind you to ask: what does the person with a mental illness need to recover?

We at the Manitoba Schizophrenia Society are consumers, family members, service providers and members of the public who wish to alleviate the suffering due to schizophrenia. Schizophrenia is a biochemical brain disorder in the same category as Parkinson's disease and Alzheimer's. These are known in the scientific world as neurobiological brain disorders. Eighteen of the–whoops, I think that is supposed to be 1 percent. That is the way it came through on the e-mail. Sorry.

One percent of the population suffers from some form of schizophrenia. There are many myths about this devastating illness. It is a myth that schizophrenia is a split personality. It is a myth that it is caused by bad parenting. It is a myth that it is caused by poverty. It is a myth that most people with schizophrenia are violent. True, a small, a very small percentage of people with schizophrenia are violent. According to Health Canada, this small group of people are characterized by three predictors: medically noncompliant, use of alcohol and drugs and a history of hostility and violence. Again, this is only a small portion of people with schizophrenia. It is a myth that everyone who has some form of schizophrenia must take some medication, and it is a myth that medication is all that a person with mental illness needs.

Schizophrenia is treatable, though not curable as of yet. It is most important to understand that the treatment of schizophrenia is as follows: No. 1, antipsychotic medication which treats both the positive and negative symptoms of schizophrenia is foundational. Most people with schizophrenia need to take some type of medication, but the side effects from the antipsychotic medication can be horrendous. We must not forget that these medications are some of the most powerful in the world and can affect a person for life with horrible side effects.

Number two, medication is not enough. For the effective treatment of schizophrenia, we know that relapse prevention is greatly increased by the person with mental illness engaging in what is called psychosocial rehabilitation. This has to do with assisting the consumer to come to grips with their mental illness. It involves looking at self-identity, how to live with the illness, stress management, conflict management, vocational rehabilitation, life skill development, et cetera. Psychosocial rehabilitation is not an option. It is not a question of choosing between medication and psychosocial rehabilitation. There have to be community supports and services in place that the consumer can utilize in their recovery. Adequate housing and income assistance are also part of recovery.

Number three. Just as important in the management of schizophrenia is the involvement of the family. Studies have indicated that those consumers whose families involve themselves in psychoeducation support have the greatest chance of recovering and managing their illness best. Psychoeducation is where the family learns how to support their loved one with mental illness. They look at their family system and coping style, whether it is constructive or destructive, specifically the issue of expressed emotion on the part of the family must be reduced. Expressed emotion is when the family is too involved with and controlling of the consumer, wherein the consumer loses autonomy and the ability to make choices.

Again, it cannot be emphasized too much that all three of these disciplines are most important in the treatment of schizophrenia. Fundamental to these disciplines is the empowerment of the consumer to live a life of recovery as demonstrated by Dr. William Anthony of Boston University. Thus, as to the recommendations of The Mental Health Act Review Committee, the Manitoba Schizophrenia Society affirms all the recommendations of the committee. As to the certificate of leave, we support the recommendations. Unfortunately, and Chris stresses "unfortunately," a very small percentage of people with schizophrenia will need involuntary treatment and voluntary community treatment due to a lack of insight and their persistent, serious mental illness.

Again, I emphasize a very small percentage of people with schizophrenia will need the provision of the certificate of leave. At that, it is a last resort when all else has failed. However, in supporting the certificate of leave, I remind you that the legislation specifically reads: that the treating psychiatrist is to prescribe not only treatment but what support and services in the community that the consumer should avail himself or herself to in preventing relapse.

This part of The Mental Health Act, the certificate of leave, is powerless and inhuman if it just relies upon medical intervention and does not utilize community supports and services, such as the Program for Assertive Community Treatment. The PACT model has proven most effective in the treatment of those with persistent and serious mental illness. Even the Mental Health Branch of Manitoba Health recognizes the importance and effectiveness of the PACT model. Again, I re-emphasize, the certificate of leave must be a benevolent enabler for the consumer. This can only happen when the supports and services are in place in the community. Government is not responsible for every death of a person with mental illness, but government is responsible to have in place a system that is effective and enables the consumer to access valuable services both in the hospital and in the community.

The Manitoba Schizophrenia Society also favours the initial recommendation of the Mental Health Act Review Committee concerning the role of an advocate. It is most crucial that an advocate's office be established that primarily represents the consumer. All consumers should have access to an advocate who can help them to understand their rights and the execution of The Mental Health Act. An advocate is most important whenever we are restricting people's rights as listed by the Canadian Charter of Rights and Freedoms.

During these sessions, you will hear about timely and appropriate treatment. Remember that the only persons qualified to determine what kind of treatment and when it should be given is by the consumer's psychiatrist in consultation with the consumer's support team of community mental health worker, psychologist and family.

The certificate of leave–

Mr. Chairperson: You have two minutes left on your presentation.

Mr. Peters: Okay. Oh, gee, he is long-winded.

The certificate of leave must not be used for political means of controlling family or to fix an unhealthy family system. The use of the certificate of leave is not about controlling eccentric behaviour. It is to prevent serious harm to self and others. Some consumers are deathly afraid of the certificate of leave. They remember the trauma, the straitjackets, the forced depot injections. They fear the loss of their rights and freedoms. Some consumers have burned on their memories the terror of rape and assault committed by people who are supposed to provide a healthy, safe environment in which to get well again; again, the necessity of an advocate's office.

The issue today is not the Manitoba Schizophrenia Society or our colleagues, the Canadian Mental Health Association. We affirm the mandate and mission of the Canadian Mental Health Association and the Manitoba Network for Mental Health. The issue is not about timely inappropriate treatment. The issue is not even about the role of family members who bear an unbearable burden of losses and grief. The issue is about a benevolent way to come to the rescue of a small minority of people with schizophrenia who will, at some time, lose insight due to their illness and will need the treatment, supports and services so as to get better.

People with severe mental illness will not get better if they do not have access to proper medication, community supports and services, better housing, effective vocational rehabilitation and empowered to make choices, when and how to utilize these services. Thank you for allowing this presentation to be read. Chris Summerville.

* (1600)

Mr. Chairperson: Mr. Peters, you may continue with your presentation.

Mr. Horst Peters (Private Citizen): Okay. I would like to make a little comment on time here. I have been here all day, and I have noticed the opinions are very polarized here. It has been this afternoon where we have heard from family members who are on both sides of the issue of the certificate of leave. I believe I am going to be the first consumer to come out in support of the certificate of leave, and I would like to have a little leeway here with the time. I also need that time in order to deal with my own anxiety, which is skyrocketing.

Mr. Chairperson: Just before you proceed then, the minister has a comment.

Mr. Praznik: I just wanted to say to the presenter, I think for all of us every time we are in that position, we have the same anxiety. So if it helps to relax, you know you are not alone in it.

Mr. Peters: Well, I appreciate that. One of the things that I have been going through and that I am very pleased with is that since the end of November last year I have been basically medication free except for the odd use of anti-anxiety medication, which I was too busy to take this morning or even to think of. So we will struggle along.

Mr. Praznik: Mr. Chair, while I have the floor, just to say: you are doing a very fine job, and there is no need to be worried about your presentation. It is very genuine, as have been all presenters today. This can be a very daunting experience. For those who have been around awhile, we are used to it, but it is your opportunity to speak, and we are just your neighbours and friends around this table, so there is no need to be anxious about it. I want to say all the presenters have been very good in bringing their very difficult stories and experiences to this table. It is appreciated by, I think, all members of all parties in this committee. So thank you. I just wanted to say that so you do not have to worry about being anxious.

Mr. Chairperson: Thank you, Mr. Minister. Mr. Peters, you may now proceed.

Mr. Peters: Okay. Thank you very much. Even though I wear a number of hats and am associated with a number of agencies in the mental health system, right now I am here to speak as a private citizen. I am a consumer of mental health services and have been since I was diagnosed in the spring of 1990, although intervention and treatment 30 years earlier would have made a difference in my life. I am a father of two children aged 12 and eight. They already suffer from mental health difficulties, and I belong to a family with a history of mental illness that goes back many generations. This history includes depression, manic depression, schizophrenia, anxiety disorders and alcoholism. There are some extended family members that I do not even know enough about and cannot find anything out about them because they were kept hidden in the back rooms of their homes in very small villages in Germany.

I was a member of The Mental Health Act Review Committee, and I support Bill 35, including the certificate of leave proposal. I do, however, have some concerns about the legislation as it currently stands. First of all, the definitions of nearest relative and spouse, and especially following the previous presenter, this is a personal issue for me. There needs to be protection for the individual against the nearest relative and/or spouse that has their own agenda separate from what the individual would want for themselves. The definition in the legislation currently does not seem to address these potential conflicts of interest, and even the clauses that we were just walked through, to me, are not strong enough. My own experience has been that a few months prior to my wife asking me for a separation and divorce, she attempted to have me hospitalized and institutionalized. I do not like that experience, and I do not want anybody else to risk that experience either.

The certificate of leave is a contentious issue, and there are a variety of opinions about this issue among consumers and consumer groups. Both families and consumers of mental health services are divided on this issue. Many opponents of this legislation do so based on their personal experience of misdiagnosis and rape and abuse in a system that was supposed to help them. I believe the answer to this problem can be found in you as legislators, together with the College of Physicians and Surgeons, working together to ensure good and compassionate medical care and practice.

While I acknowledge and support the great need for a more comprehensive service system, there exists an unfortunate reality that for a very few number of people services are not enough. Due to their distorted perception of the state of their health, these people refuse to access services in the community, and an involuntary treatment seems to be the only way of providing them with lengthier stability in their mental health.

I want to inject a personal note here–personal experience. The last time I was hospitalized, once I was discharged and went back to see my doctor, and I had somebody else go with me because I was terrified of the consequences, my psychiatrist kept asking me why, why, like why did you go through this? You were doing so well. I could not answer that question, and then I was told I had cancelled seven appointments. I thought maybe I had missed one or two. I was really busy. I had gone what they call hypomanic and had a whole lot of energy and a lot of things to do, so I did not have time to go see the doctor, but I crashed and ended up in hospital. I had occasion to be able to read my file at the crisis stabilization unit. Reading that file, and a year ago when I was moving and cleaning out personal papers, I found a journal that I had written when I was severely ill, and both of those documents that I read were a real eye opener to me because, until I read that, I really did not understand the difference between my perception of reality and what other people were seeing and observing in my behaviour and what I was seeing.

So, to me, that reality of not being in the same place as everybody else is very real. I know for myself that had some kind of a treatment contract been in place that outlined for me what I needed to do and what the consequences were going to be, had I followed that treatment plan, I would have probably kept my job, I would have certainly stayed out of hospital, would have saved me a whole lot of embarrassment and would have moved my recovery along a couple of years further. Enough of the personal stuff.

I have talked to a number of consumers who in hindsight recognized that involuntary treatment was necessary to stabilize them again, but they wished the intervention could have been provided in a less intrusive and more respectful and dignified manner than involuntary hospitalization. I believe the certificate of leave will allow treatment to be provided in a less intrusive and a more dignified manner. I do have some concerns that the proposed legislation does not fit with what I recalled the review committee agreed to.

First of all, Section 46(2)(a) and (b) should be connected with the word "and." I believe that we had agreed that both those criteria needed to be met. The way it is written right now it seems it could be either/or, and that is, I think, a significant point. Section 46(3), a significant concern of consumers is the power imbalance between patient and doctor. Now we are adding a treatment team to it. This power imbalance needs to be offset by advocacy representation for the patient during the negotiations of the conditions of the certificate. The current wording is too loose. It says "patient's representative, if any." I believe the patient needs to be informed of their right to have an advocate or representative present during this negotiation, and this should be made clear in the legislation.

Section 46(4)(d)–the committee recommended that the wording should clearly state that the services required by the patient, No. 1, exist in the community; No. 2, can be provided; and No. 3, will be provided in the community. We did this with specific intentions. Right now all we have is "can be provided." We have heard over and over today that there are not enough services in the community to help people. One of the reasons we put that the services should exist and need to exist in the community is we kind of want to encourage you and challenge you as legislators to legislate yourself into action to providing some services.

* (1610)

I had a number of people comment to me that, well, legislation cannot, you know, the government cannot legislate itself into providing certain things, but I believe that this government has set a precedent by legislating itself into certain action with the balanced budget legislation. So there is a precedent there. You legislated yourself into specific action. I believe you can legislate yourself into providing the services that we need in the community. The services, the "can be provided" is included, but the "will be provided" is also important, that far too often the needs of those who have been labelled as difficult patients are not met because of behaviour problems or whatever, their noncompliance. Services in the community will not deal with these people, and people are banned from the services. We need to ensure that the services that the people need in order to live successfully in the community, that they "will be" delivered.

Section 47, the issue of a voluntary negotiated termination of the certificate between the physician and the patient has not been clearly addressed in this legislation and must be. A person and their physician should have the right to terminate the certificate if they both agree it is no longer needed without the person risking being taken back to hospital again. The treatment plan should also be open for review and revision without rehospitalizing the patient, and this needs to be made clear in the legislation.

Bill 35 is an important piece of legislation, and I encourage you and challenge you as legislators to weigh the issues carefully and provide us with a Mental Health Act that facilitates recovery, empowerment, and health and wellness for all of us. Thank you.

Mr. Chairperson: Thank you very much, Mr. Peters.

Mr. Praznik: Yes, thank you, Mr. Peters. I have to say I very much appreciated your candour and the story of your experience. In a most difficult issue like this, and I say this to all the presenters who have come forward here today, these experiences are very useful to this discussion and consideration of this bill, useful for the public debate that surrounds it, and very instructive to those of us who obviously do not deal with these issues every day. I deal with them and my critic deals with them more than our colleagues who have other responsibilities, but it is very instructive to hear these. I want to say to you and to the other presenters just how important that contribution is, that you do make a difference in being here today.

I have asked my staff. You have given us, as many have, some specific recommendations for amendment. Mr. Henteleff did as well, and I want to just assure you that over the weekend our Legislative Legal Counsel will be reviewing these proposals.

On one you just flagged about the ability to voluntarily end the certificate of leave, I looked over to

Val, our legal adviser, and she said the reason why that is not referenced is because it is a contract between the two so both parties have the power to end it. But your comments flagged with me that many may be reading this act, and it may be worth considering specifically mentioning that referencing in the act. So we are going to be going over those things. I am going to share the information from our legal people with my colleague and critic the member for Kildonan, Mr. Chomiak. We will not, I understand, be considering amendments to this bill until next week, so we have an opportunity to review some of these things. So I just wanted to assure you that your presence here today does make a difference in this bill. Thank you.

Mr. Peters: Thanks very much.

Mr. Chairperson: Thank you very much.

Mr. Chomiak: I concur in those comments. I just want to–for clarification, the references you made to the recommendations of the advisory committee, Sections 46(2), 46(3), 46(4) and 47, were those all recommendations made by the advisory committee that reviewed the recommendations?

Mr. Peters: Okay, the reference to 46(3) and the advocacy representation, that was not made by the advisory committee. I did submit a letter, following a conversation that I had with a community mental health worker in Saskatoon–the two, Dr. Biberdorf and Dr. Andrew, and I think I also sent a copy to the minister, that this needs to be in place. Earlier today we heard a couple of people refer to a story of a person in Saskatchewan who had been placed under a certificate of leave and had hung themself because they felt that they were being punished by their doctor. I had talked to the worker in this particular case. She also told me about another patient that she had, who was placed under a certificate of leave and eventually the certificate was terminated, and she carried on in the community and stopped taking her medication. The worker talked to her about it a number of times, and this patient said: well, I do not have an illness. This is just something you made up.

The worker was concerned about the person's condition, and a week following the conversation the patient called the worker again and said, you know, I realized over the weekend that I did a whole lot better on my medication, and had voluntarily gone back into the hospital or gone in to see her doctor and got medication again.

So you know, there are two sides to this issue. There are two sides to the certificate of leave, and there are different stories of success and failure on this. So the challenge is how are you going to weigh it out? But, in order to answer your other question, the issue of voluntary negotiated termination of the certificate, I do not believe that was something that we had looked at in the committee. Again, that was just something that, as I was processing the information and processing the proposal or the recommendations, I thought this is something that we are missing here. I hope that answers your question. I think the rest of it we had recommended.

Mr. Chairperson: Thank you, Mr. Peters.

Mrs. Myrna Driedger (Charleswood): Mr. Peters, thank you very much for your presentation. Having been a nurse in the health care system for a number of years and working on the fringes of psychiatry either on the ward or in emergency, this is a very challenging issue for us to deal with. Your presentation here today, as well as everybody else's that have been personally affected by it, is so extremely important, and I know difficult to talk about when you have to bare your souls like this.

Having spent a lot of time with some patients that have been in this position in the hospitals, I sincerely appreciate the efforts that you and the other presenters here are making today. So thank you very much.

Mr. Peters: Thank you. Can I beg your indulgence just for one moment? Just a couple of things with the previous presenter as I was going through the act. I referred to my difficulties with family, a nearest relative and spouse and the families being the decision makers. I know my family, if they were decision makers in my life, I would still be in a group home. I would be on welfare. I would not have a job.

I have a real concern that there is going to be too much emphasis put there, and I also have a problem with 28(8) where nothing requires a physician to inquire whether a patient has a proxy or a health care directive. It was not until my involvement on The Mental Health Act Review Committee that I found out that these things existed. That was, I guess, five and a half years after I entered the mental health system. Somebody needs to take some responsibility here to ensure that this is checked out.

I think there is also a responsibility to educate all consumers about their rights and including their right and the protection that they have by designating a proxy and filling out a health care directive, and I think that needs to come from here. That is all I can think of right now.

Mr. Chairperson: Thank you, Mr. Peters, for your presentation. I am going to deviate a wee bit from the Chairman's responsibility normally, and I am going to commend you for the excellent presentation that you have made today. I think the anxiety is now with us. I think you have transferred some anxiety here, and I would suspect that the minister and his staff are going to pay some significant attention to what you have said today. Thank you.

Mr. Peters: Thank you very much.

Mr. Chairperson: I will call now Mr. Bill Ashdown. Mr. Ashdown, would you come forward, please? I hope, Mr. Ashdown, that you have been able to conduct your business and take care of your client. Have you a presentation for distribution?

* (1620)

Mr. Bill Ashdown (Society for Depression and Manic Depression of Manitoba): No, I do not. I can make a presentation available, Mr. Chair, for distribution early next week.

Mr. Chairperson: It is only if you wish to do so. If you have one for today for the committee to consider while you are making your presentation, that is really–

Mr. Ashdown: No, I would much prefer that they sit back, put their feet up, close their eyes for a minute and take a deep breath and maybe listen.

Mr. Chairperson: Thank you, Mr. Ashdown. You have, as the others, 10 minutes to make your presentation.

Mr. Ashdown: Well I will try and do it in less, because I can see the time, and it is almost going-to-the-lake time.

First of all, let me start by telling you who we are. I do not know how many of you know our organization. We were the Society for Depression and Manic Depression of Manitoba. As of May 29, as of our last annual meeting, we are now in the process of a major name change to become the Mood Disorders Association of Manitoba.

What we are is a self-help organization. We are made up exclusively or almost exclusively of patients and family members. In terms of our staff, for instance, and our programs, we are the largest organization of our kind, not just in Canada but in the world. See it shows you just exactly how depressing it is to live in Winnipeg. We have 11 staff offices around the province. We have endless business, more business than I ever dreamed possible. We are considered to be the world's leading educators in self-help for depression and manic depression. We average about 500 presentations or meetings a year. We have been involved with mental health reform since, well, since the earliest days of Don Orchard. Our society is represented on four of the regional mental health councils, on the advisory committee for mental health reform, on endless committees, subcommittees, councils, working groups, advisory groups. It seems that every time somebody gets into an elevator there is one of us guys there to talk to them.

So we cover a lot of the waterfront, if you will. That is important because in terms of our members we represent the largest and most pervasive disorder of the brain in the world. Depressive disorders are unfortunately No. 1. These disorders affect approximately 20 percent of Manitoba's population. So we are talking of lots and lots of voters, lots and lots of citizens. We have a large responsibility in representing that kind of number.

In Manitoba, over the last 12 months alone, we have had direct contact with about–anywhere between

10,000 and 15,000 people regarding our disorders through all of our offices. Another thing I want to tell you is about the vast majority of our members. They are not the radical fringe or the perpetually ill or the very unhappy. Most people with depressive disorders, because these are illnesses that are cyclic, most of them are well most of the time. As a result, a profile of our organization looks pretty much like almost any other organization would in this country, except to err in some respects on the positive. About one-third of our members are on social assistance of one sort or another at any given time. About two-thirds of our members hold jobs, and more than 50 percent of those who hold jobs have white collar jobs. More than half of our members have at least one post-secondary degree, so it gives you a better idea of who we represent.

Now, we have some concerns with the bill, but they are not big concerns. Is it a perfect bill? No, it is not. First of all, it was made by people who are notorious for screwing almost everything they can–screwing it up almost all the time. Secondly, there had been a few bits and pieces left out. I know Horst has referred to a number of issues that are dangling or uncompleted at the present time, but the crux of the bill is the issue or at least the public crux of the bill is this whole issue surrounding certificate of leave.

Now I have been in this business for almost 11 years. I have looked at several of our bills as they have come along. I was involved with the last major revamping of the mental health bill and I can tell you from my point of view, which is the point of view of a consumer and a family member. So I do not just sit on the sidelines. I am one of the guys who could be one of the guys put into the hospital if things do not go well.

From my point of view and more importantly from the point of view of our board of directors, they do not like the certificate of leave, but they are quite prepared to see it in the act. They recognize it as being a reasonable accommodation to a very difficult series of problems. There is no magic to this. There is no magic solution to this. There is certainly no one jurisdiction anywhere in this country that I am aware of that has it right. Indeed, whenever I go travelling around the country, I keep getting questions from people who keep looking at Manitoba as though we have it right. I exist in some very strange circles, some very undiagnosed crowds, but certainly from the point of view of most of the other provinces our system is many years ahead of most of theirs, including our Mental Health Act, even without the current amendments. Certainly with the current amendments I think we will come away with a better, sleeker, more efficient product, if you will, and I think we are going to come away with a system that will allow people actually to get out of hospital earlier, not later–earlier.

One of the problems we have had is, if you have got somebody who has been seriously ill and who has been involuntarily committed, who is now on the road to becoming better, they have developed some insight into their illness, their medication has cut in, they have had some therapy, they have rubbed shoulders with some of the self-help groups, they have got some resources out there, their family have come to grips with this, that is the time that they should be going home but they are still very unbalanced in terms of are they well enough to go home yet. Well, with the certificate of leave process, you have now opened the door to allow some degree of testing that water, of early release, and may I remind you that at $1,000 a day for the average psych bed at the psych health centre, early release is definitely a good thing, speaking as a taxpayer.

It is not going to work if we do not put some of the appropriate resources into place that are referred to in the bill and that are essentially assumed in the bill. This is all going to collapse on its nose if we do not have the community services in place and to the volume that we need in place. Right now, on paper, we probably have the best set of community resources in North America. In reality, unfortunately, the people in the system know that the community resources are very limited. They just do not stretch far enough. Certainly from our point of view we would be a whole lot happier with this whole question of legislation, if we could hear from your end of the table, Mr. Minister, that we were going to get a much more enhanced community support system put into the communities, particularly put into urban Winnipeg which has such a high volume of people with major mental illnesses, because that would essentially help treat the illness at an earlier level rather than at the more acute later stage where hospitalization would normally be required.

Some words of wisdom for a Friday. I do not know how well you will take them. I do not even know if anybody is still awake at this point. I am glad you are, Mr. Biberdorf. But that, from our point of view, is where we would like to see the thing go. We would like you to adopt the bill as it sits, but we would like you to do the three or four or five other things that are not covered in that bill but that are equally as urgent to adopt in terms of increasing the infrastructure down on the ground where the people live.

Mr. Chairperson: Thank you very much for your presentation, Mr. Ashdown. Let me assure you I have been watching very carefully today, and I have not yet seen a member nod off, so I think they are all awake.

* (1630)

Mr. Praznik: I just want to thank the presenter. Although you cannot always do everything at one time, certainly the direction that he outlines is one that we recognize. Some of the changes within the hospital system are part of the plan for the Winnipeg Hospital Authority. We just have to keep moving forward as best we can.

But I appreciate his presentation, and I can tell you, I have had the chance to chat with my critic, this has been one of the probably truly nonpartisan issues to come before a committee with a very divergent set of viewpoints and very heartfelt presentations with sometimes very difficult personal experiences. As a legislator, it is one of those times when you really feel that the politics of things slip away, and you are really trying to do the right thing even though it is a difficult thing. We appreciate truly your presentation and those of many others. Thank you.

Mr. Chairperson: Thank you very much. Any other comments or questions? Thank you again for your presentation, Mr. Ashdown.

I call next Dr. Jaye Miles or Darlene Dreilich. Dr. Jaye Miles or Darlene Dreilich? Not here. Dr. Uwe Osterwald. Dr. Uwe Osterwald.

Mr. Uwe Osterwald (Private Citizen): There is no Dr. in front of the name.

Mr. Chairperson: Sorry about that.

Mr. Osterwald: That is okay.

Mr. Chairperson: Maybe I gave you a promotion.

Mr. Osterwald: Is this on tape? I am curious.

Mr. Chairperson: Yes, this is on tape.

Mr. Osterwald: Terrific.

Mr. Chairperson: Have you a presentation for distribution?

Mr. Osterwald: There was something left with the Clerk's office about a week ago. My understanding was that they were going to make 15 copies for distribution.

Mr. Chairperson: The Clerk just informs me that it has already been submitted and will be recorded.

Mr. Praznik: Mr. Chair, just for Mr. Osterwald's information, it is recorded and is transcribed by our Hansard staff. So within a period of a week or so, it will be available to the public as a verbatim record of the Legislative Assembly.

Mr. Osterwald: What I am saying here and what has been said all day.

Mr. Praznik: What you and I are saying right now will appear in written form and be there for all Manitoba history for others to read.

Mr. Osterwald: Great.

Mr. Chairperson: Mr. Osterwald, please proceed.

Mr. Osterwald: Good afternoon. Learned people used to think the earth was flat, and I am passing a very hot potato into your hands. For the record, and it is difficult, it is pronounced "Oo-vay" Osterwald. Uwe is one of the derivations I have heard over the years. I prefer just–

Mr. Chairperson: For your edification, for me it is very easy to say it because I am of German descent, and I have some friends who–

Mr. Osterwald: Not many people can handle that properly, so we went with Uwe a long time ago.

Mr. Chairperson: Thank you.

Mr. Osterwald: Or I will just put U., if somebody wants to say, hey, you, U., for the first name. That is fine, too. Okay. Getting down to business.

The first 20 years of my life I spent in a loving, somewhat sheltered immigrant home. The next 10 years, I fell into the hands of the psychiatrists, and the last 10 years, I have been in the hands of chiropractors. I am a graduate of computer science in the mid-'70s. Five years ago, my automobile was broadsided at 90. There was bleeding inside the brain, internal head injuries. I am on partial disability. For five years, it was a botched Autopac accident claim. So, as I say, I am on partial disability. I call it social insurance. Some people call it assistance or whatever other historical terms are in use. I was informed that it was a permanent injury, and it could have been a lot worse. So I will leave it at that for the moment.

Bill Gates makes his $10 billion a year, and I go and do windows for seniors at 10 bucks a shot. So that is where I am at. Twenty years ago, I was working on a programming project. I said: this will not work in the year 2000, there are two digits. The supervisor said: do not worry about it. It is a long time away. We have a deadline, just do the change and do not worry about it. Okay, you are the boss. You know.

I speak about Bill 35 with personal experience in both psychiatry and chiropractic. I have about seven minutes left to sum up a hundred-plus years of chiropractic and its place in health care, particularly its place in treating mental health problems. They have what is called the VSC, the vertebral subluxation complex, and it relates to misalignments in the spine.

I have no chiropractic training. I have done some reading on the topic. I tell people I know 1 percent of what a chiropractor knows and that is on a good day, and I do not have a lot of good days. So there you have it.

I would like to thank Ms. Hawkins. Thank you very much, and particularly Mr. Henteleff for adding some legal and other alternative insight into this, as well as everyone else who has presented.

Bill 35 has been redrafted from the original act, whenever that was put in. That process of redrafting and the content of it are fundamentally flawed. I think the bill must be sent back to the bureaucrats, the psychiatrists for significant revision. Apparently, there have been 150 community groups that have contributed to this.

Two weeks ago, the CMHA, the Canadian Mental Health Association, did not know about the chiropractic work done back in the 1930s. I was astounded. I do not say this lightly. There is a crime against humanity occurring within the boundaries of this province. The Clerk has either handed out the material or it has been on file in the Premier's Office, NDP, Liberal, et cetera, the Lieutenant Governor, for a sufficient amount of time. In that package, in the 1930s in the U.S.A., there were chiropractic sanatoriums for mental health problems. They were set up. They had an excellent success and cure rate. They were so successful that a judge in North Dakota attempted to change the mental health committal and treatment process. He was mostly unsuccessful.

I have a quote: Herbert C. Hender, M.D., chief psychiatrist at the Clear View Sanitarium around 1930 stated: "I have found that all insane patients have vertebral subluxations. I have never found one yet in the thousands examined who did not have a subluxation . . . almost everyone adjusted is benefited. Chiropractors should occupy posts in every mental hospital."

They were not able to get public funding. We like to think that we do things differently up here. Psychiatrists, at that time, preferred to continue with lobotomy, electroshock, cold sheets while the patients were strapped to the bed and straitjackets in preference to the chiropractic adjustment. It does not say much for the so-called profession of psychiatry, and this is part of the crime against humanity. Also, in the 1930s, an M.D.–I could not find my reference pamphlet–did what were called the Windsor autopsies. There were 200 autopsies done examining the cause of death and its correlation to the VSC, vertebral subluxation complex. If people died of heart disease, liver, kidneys, et cetera, the correlation was 80 percent or 90 percent, somewhere in there. It was very, very high.

Recently, there has been something going on called the torque release technique. It has been applied to the attention deficit hyperactivity disorder. There are 4 million children in the U.S.A. that have it; there are more adults. I think Ritalin is one of the cures for it, or one of the treatments for it, I should say.

Apparently, this compulsive disorder is known to be caused by a gene defect. It is the most common pediatric disorder. Now, apparently, if an EEG is done, there is abnormal prefrontal spiking on that EEG. You know, normal, normal, normal, abnormal, normal, normal. It is just part of the diagnosis, abnormal EEG. I take it the literature is correct.

With the centennial of chiropractic in '95, this torque release technique and an instrument called an integrator were introduced. It is an adjusting instrument. The chiropractor no longer has to work with his or her hands. It is a cylinder with a spring and a plunger and an adjustment, and they put it in a certain place or certain places and boom. It is very scientific now. It is a third-dimensional force torque. That is all I know about it.

* (1640)

Now, there was a person who had this ADHD, attention deficit hyperactivity disorder. The adjustment, a pre-adjustment EEG was done. The adjustment was done with this integrator in the torque release technique. Another EEG was done, and I will read you the quote: After the patient was adjusted, a post-EEG was performed. After examining the findings, Hospers said–Lasca Hospers, D.C., Ph.D., renowned neuroscientist in EEG and brain mapping of patients suffering from ADHD. Anyway, Hospers said that all of the abnormal prefrontal spiking found earlier was gone. I will repeat it. All of the abnormal prefrontal spiking found earlier was gone, and the entire EEG was now essentially normal.

As an aside, a very brief one, a little bit of shock value, and this is the other reference on file, the Latimer case in Saskatchewan, the little girl with cerebral palsy. There was a similar case documented in the U.S.A., went through the same symptoms as the Latimer girl until seven or 10 years of age, something like that, was treated chiropracticly, and now has a much better quality of life, is pain free and is becoming more normal. I call it CAP, chiropractors, allopaths and patients, allopaths being traditional medicine, allopaths, of course, being probably completely medicare funded.

As most of you probably know, chiropractors have very limited public funding, and part of the problem for a lot of people in this province is access. It costs a fair bit of money to go to a chiropractor once your 12 visits are up.

Mr. Chairperson: Uwe, you have exceeded your 10-minute time limit.

Mr. Osterwald: All right. I will begin to summarize in a moment. We are talking science and flat earth that became the round earth. Allopaths–and I will read quickly–psychiatrists, deny access to chiropractic care. You will find the Manga report that addresses lower back pain. It is like saying the Legislative Building offers washroom facilities and tourist information. Similarly, chiropractic goes far beyond lower back pain. Allopathic health practice is drug-based medicine. Their approach to health care, for the most part, does not address the cause of the disorder. In defence, I am not speaking against emergency medicine in any way. A person in a serious car crash, I am not saying anything against that.

There will always be some side effects or there always are some side effects of pills. Prescribing a pill or an injection is like having a big fire and disconnecting the fire alarm. It is like the Alberta train wreck, disconnect the warning light or the buzzer. In the process–page 8–again, what is the problem? The problem is the VSC, and I read you the quote. In the process of revision or redrafting this bill, the key question, was the Manitoba Chiropractic Association, the MCA, consulted? To my understanding, no.

Even today the practice of psychiatry is flawed and negligent. The funding of chiropractic care is flawed and discriminatory. The lack of co-operation between allopathic and chiropractic practitioners is unprofessional and lacking in adult community and professional skills. The primary problem is with allopaths. The College of Physicians and Surgeons, as recently as 1994, said chiropractors are quacks. They have upgraded somewhat; there is still no effective co-operation. Their guidelines, which they were kind enough to send me, talk about X-rays, manual therapy; chiropractic has X-rays, instrumentation analysis, heat scans on the spine to indicate VSCs. X-ray is a fundamental tool, and MDs are not trained in VSC X-ray analysis. They do not have that training.

Allopaths do not recognize the vertebral subluxation complex. They do not effectively treat the vertebral subluxation complex. It is like saying–we have been talking about recall, bill of leave, another medication. Let us try this medication, try this scenario. The fire and the train wreck. Close your eyes. We will not see the warning signal. Disconnect the warning light. Put in the ear plugs; you will not hear the warning buzzer. Disconnect the alarm, it is inappropriate. The problem is the fire; the problem is the hot axle bearing; and the problem is the VSC.

We talk about costly hospital beds–

Mr. Chairperson: I am going to ask you to wind up, please.

Mr. Osterwald: I will forgo questions, thank you. I will not answer questions.

Mr. Chairperson: Okay.

Mr. Osterwald: Costly hospital beds, let us talk money. Fifteen hundred dollars, 21 days. Twenty-one days of initial chiro care, including X-rays, is about $300. Quotes used within the chiropractic. Hippocrates: See well to the spine, for it is the source of all health, conversely, probably the source of all disease as well. Quote 2: If you take this pill when you are well, what makes you think it will make you well when you are sick. Think about it.

The cerebral palsy mother asks in the article: what would have happened if my daughter had been treated at six months, one year or 18 months? Similarly, I ask: what would be my life if in my 20s I had been treated chiropracticly instead of by psychiatrists for almost 10 years?

To begin summing up here, my computing career is ruined. I have been out of it since the early '80s. I am optimistic there is some chance of gaining some sort of gainful employment. You legislators have a difficult situation. The practice of psychiatry is scientifically and biologically flawed. It does not address the vertebral subluxation complex. The process of revision of Bill 35 did not address the VSC. The VSC is the area of expertise of chiros. Bill 35 does not provide for effective, moral, scientific change. It allows a crime against humanity to continue. You have at this moment the next hepatitis C–

Mr. Chairperson: Mr. Osterwald, thank you for your presentation. I have now allowed you to go almost 16 minutes, and we have 10 and five, including the question period.

Mr. Osterwald: I think that there have been slight grace periods. I think I can finish this in approximately four to five minutes.

Mr. Chairperson: I have given you grace. Thank you for your presentation.

I will call now the next presenter, who is Valerie Price of the Manitoba Association for Rights and Liberties. Valerie Price, is she here? Is Ms. Valerie Price here for a second time? Seeing her not, we will drop her to the bottom of the list.

Harry Wolbert. Is Harry Wolbert here? Would you come forward, please.

An Honourable Member: What happened to Ellen Kruger?

Mr. Chairperson: Ellen Kruger is going to be heard between 22 and 23. We had agreed to that before, if you recall.

Mr. Harry Wolbert, have you a presentation for distribution?

Mr. Harry Wolbert (Private Citizen): Yes.

Mr. Chairperson: The Clerk will distribute. You may proceed with your presentation, Mr. Wolbert.

Mr. Wolbert: Mr. Chairman, members of this committee. I want to thank you all for allowing me to express my views concerning the proposed amendments to The Mental Health Act. For the last seven years, I have worked with the physically and mentally handicapped, including the mentally ill, as a caregiver, respite worker and advocate. During that period, I have worked with more than three dozen mental health consumers, so I think I have a fairly good understanding of how the system works and of those who make use of it.

* (1650)

I have been concerned for quite some time about the proposed changes to The Mental Health Act. I am in support of the current philosophy of mental health reform, one that encourages services to be consumer directed. The bill, as it now stands, reflects the old way of thinking, that of maintaining power and control over people. In my opinion, the legislation is not even necessary. It is a step backwards, not forwards.

One of the more contentious provisions of the act involves changes to the certificate of leave. The changes, if implemented, would make it much easier to commit someone against their will. It would also allow the authorities to apprehend and hospitalize those patients who refuse to comply with their treatment plan. We need to ask ourselves, are patients ever justified to stop taking their medications? I think that there are times when they are. I have heard it said that mental illness is just like any other illness. Is it really? We do not deny someone with epilepsy or heart disease the right to refuse their medication, so why should we refuse someone with a mental disorder theirs?

We have also been told by the government that this section of the act would apply only to a small segment of the mental health population. What guarantee do we have that this power will not be expanded to include others? I can sympathize with the families of consumers who relapse due to their noncompliance. However, I still do not see the use of force as being the answer. Some studies have shown that forced treatment can be counterproductive. It can have a negative impact on the long-term therapeutic relationship between a patient and his therapist. Furthermore, it can also serve to discourage someone from seeking help when it is really needed. Stop for just a moment and imagine yourself in their shoes. How would you feel? I strongly believe that there are better ways to achieve the goal of compliance without the use of coercion or force.

So then, what is the solution? Well, first of all, what we need are adequate mental health services in the community, programs and services that enhance consumer independence and responsibility. More consumer-run self-help programs and approaches need to be considered as alternatives. I have found that when a consumer has a job or a day program to go to that it only serves to enhance the rehabilitation process. He feels more self-confident about himself and learns to take greater control and responsibility over his life and illness. Finally, what we all need to do, and it is an ongoing concern and problem, is to eliminate the stigma of having a mental illness.

Mr. Chairperson: Thank you very much, Mr. Wolbert, for your presentation.

Mr. Chomiak: As well, thank you for the presentation. You indicate that there are some studies that have shown forced treatment can be counterproductive. Are you referring to the B.C. study, or is there something else you could refer us to?

Mr. Wolbert: Well, I was not referring to any particular study, but I know from my own work experience and my own personal experience that this can be the case.

Mr. Chomiak: Do you have an anecdote or story or some experience that you might add to that? Is there anything you could add?

Mr. Wolbert: Like, I can speak for myself. When I was a teen and forced into treatment, it did not enhance the relationship between myself, my doctor or my family, and I feel if it had been voluntary, I might not have gone through, you know, as much of the pain and suffering as I had.

Mr. Chairperson: Any further questions? Thank you very much, Mr. Wolbert, for your presentation.

I call next Ruth McCutcheon. Ruth McCutcheon, would you come forward, please? Ms. McCutcheon, do you have a presentation for distribution?

Ms. Ruth McCutcheon (Private Citizen): After.

Mr. Chairperson: After, thank you. You may proceed, please.

Ms. McCutcheon: Mr. Chairman, fellow members, ladies and gentlemen, I am very pleased re the proposed amendments to The Mental Health Act. The amendments to the certificate of leave reflects the philosophy of mental health reform.

I represent myself, others who have been or will be unsuspecting victims of a psychotic illness, not my own, but that of my ex-husband and my two daughters who each have two university degrees and one for health education. They all are in denial. My husband was diagnosed with bipolar affective disorder or manic depression. He took medication the next two and one-half years, which was the best of our 38 years together. The others were not so sweet.

The ensuing two episodes seeking treatment were not successful at a nearby hospital. The 10 days in intensive care, he was treated as a heart patient, but he was released 16 days later without any heart damage, any heart illness, but a prescription for nitroglycerin, which really does not treat depression. Then two weeks later, he and two police officers arrived back at the same hospital with a magistrate's warrant asking for a 72-hour investigation. Ten minutes later, he was released by the same psychiatrist. After the police informed me that he had been released, I called the psychiatrist at the hospital, and he denied that he had spoken to my husband that afternoon. I was not a very happy person.

Maybe you do not realize that it is stated that at least 85 percent of divorces are due to a mental health condition, be it the person with the illness who leaves or be it the one who is trying to live with the spouse with the illness and they decide to leave. It really does keep our lawyers very busy.

As the illness is cyclical and it is progressively more acute, an in-depth assessment needs to be a mandatory part of arriving at a hospital or at a doctor's office. This means reclaiming lives with the proper treatment. Patients, and I have heard today and you have, too, from what I have read and what I have been able to observe are very hung up on the idea of medication. When you study more about it, you find that it is an aspect of this psychotic illness to reject taking drugs because after all we are well, so we do not need them. When I left the hospital last March after heart surgery I only had 14 medications to take when I got home, and a friend on his computer made a chart so I knew at exactly which hour whether I needed one, two or three or four, whatever it was, but that was necessary for my recuperation and partly why I am well enough to be hear today speaking to you.

* (1700)

The book, In the Jaws of the Black Dogs, 1994, by John Bentley Mays, who is a correspondent for The Toronto Globe and Mail, chronicles his own manic depression from his youth. He states–and this helped me very much–love is depression's most potent enemy, yet love cannot exterminate the disorder or cure it, contrary to the delusion common among those who fall in love with depressives, and this is where I fell into the illness. I thought I could make a difference towards happiness, but when we married I did not realize. I knew something had happened to this person and I knew he was not happy, but I thought we could make it go, but the illness made this impossible.

Again, there was no mechanism to get timely and appropriate care and treatment. We do need the certificate of leave. Often the person who is turned away, when they have been seeking help, engages in an activity which brings him into a court setting. No, Judge John Enns and other judges, a jail bed does not substitute for a hospital bed. This case was reported in the Winnipeg Free Press on June 5, 1998. A 33-year-old male, for the second time, was sentenced to additional time as he had an obsessive love for his ex-wife, which he expressed in a completely inappropriate and terrifying manner. There was no legal mechanism to help this person before he was back in the court system. This happened in a town, a few miles away from where I formerly lived, but Judge Enns did state: This sentence will be a time for the accused to improve mentally, so he will no longer be a person who causes fear.

Impossible. What are we talking about? Do we have to wait until there is danger? A certificate of leave would provide early intervention. The sentence this man received serves to allow his illness to negatively progress to the next episode and it will come. The law and many in the public are not properly informed.

Twenty years ago this October, a Winnipeg student was shot by a classmate. That the gun jammed prevented other killings. I have been wanting to talk to somebody about these killings, he told the reporter last week. I did not see anything wrong at the time. It did not bother me. I still have the thoughts, like violent thoughts, but it is not like I am going to kill anybody or anything because I am on medication now. And I think a lot of these kids need to be on medication.

His treatment came later after the tragedy, and I continue to quote. He said: I feel bad for the victims, but I also feel bad for those kids who did it. I know they are in the wrong and what they did was horrendous. But I think that, once they get on medication and stuff like that, seeing doctors, they can probably turn their lives around. Nobody ever thought I was going to get out of jail.

Maybe you could just for a moment pretend that you are a psychiatrist who is the head of the Canadian Psychiatric Association. I talked to him on the telephone from Winnipeg to Ottawa. I was searching. I searched in this province, and I searched outside for help for what was going on in my life. Finally he said to me: I have a problem too. I have a son who is a schizophrenic. He is out on the streets of Ottawa. He is rummaging in garbage cans to eat. He is sleeping wherever he can. I am the president of the Canadian Psychiatric Association, and the law will not let me do anything to have him treated. How do you think I feel? Yes, he made me feel a lot better because I was not the doctor, but I also was tied by the same laws that did not allow this person to get to treatment.

Today it was said that we do not know about the genes. According to the Clarke Institute in Toronto, two genes have been identified. They suspect that there is a third. They are hoping to find it. They also are hoping that within three or four years there is a strong possibility that detection with DNA will be made available. There is more to come.

Mr. Chairperson: You have used up your 10 minutes. I will, however, give you the same leeway that I have given the other presenters.

Ms. McCutcheon: One paragraph.

Mr. Chairperson: If you want to go five minutes into your questioning time, it is your prerogative.

Ms. McCutcheon: Thank you.

Mr. Chairperson: Proceed.

Ms. McCutcheon: The answer to helping people and their families who fall through the cracks is to have a system that ensures that the real need for help is there all the time. Until our mental health system is organized, provided with more funding, more well-trained psychiatrists to give them ongoing treatment and psychotherapy, this will not achieve the positive effect on treatable but not curable illnesses. Society does need to have some positive structure. I thank you.

Mr. Chairperson: Thank you very much for your presentation.

Mr. Praznik: I just wanted to thank the presenter for her contribution here today.

Mr. Chairperson: Thank you very much.

I call next–[interjection] Maybe what we should do then is that, before we call the next presenter, as agreed to before, we recess till six o'clock, and we will come back then after six o'clock and continue the hearings. Is that agreed? [agreed] Thank you. We will recess then till six o'clock. After we reconvene, I will call David Smith.

The committee recessed at 5:07 p.m.

After Recess

The committee resumed at 6:02 p.m.

Mr. Chairperson: Could the committee please come to order. As I indicated, before we recessed, the next person I would call would be David Smith. Is David Smith here? Is David Smith here? If not, we will drop David Smith to the bottom of the list. I call then Gordon Nicolson. Is Gordon Nicolson here? Would you come forward, please.

Have you a written presentation for distribution? The Clerk will distribute. You may proceed, Mr. Nicolson.

Mr. Gordon Nicolson (Private Citizen): Good evening, Mr. Chairperson, honourable members.

Mr. Chairperson: Good evening and welcome.

Mr. Nicolson: Thank you. In the matter of Bill 35, The Mental Health and Consequential Amendments Act, referring to Section 46, I respectfully submit the following. I know that our government will have deliberated extensively and sought much wise counsel before bringing forward legislation that affects the fundamental rights of citizens under Sections 7 and 15 of our Constitution. Various stakeholders will have sought to advocate for the certificate of leave provision, some citing concern about the deteriorating condition of a loved one, and some for the issue of public safety. Doctors and other professionals might also see the certificate of leave as necessary for effectively helping certain individuals.

To the best of my knowledge, there are no such deliberations taking place for the general medical system, but I wonder if doctors do not sometimes wish that they could utilize a version of a certificate of leave with a seriously ill heart or cancer patient for their own good, a fleeting thought at best, I should think. No, they must rely on their ability to educate and otherwise persuade their patients who resist an optimum course for recovery. No government would seriously contemplate this kind of legislation for citizens who refuse adequate treatment for serious general medical conditions, many of which are directly related to lifestyle. Incidentally, it is my understanding that lifestyle is not a significant factor in the genesis of mental illness. It is a factor in the course of the illness and in recovery.

If you accept my information, then we have patients with serious, mostly preventable lifestyle-related conditions who cost our medical system millions of dollars each year who have no threat to their liberty associated with their treatment, and we are here today contemplating legislation that diminishes fundamental rights to a group that struggles largely but not wholly because of a genetic predisposition and environmental factors that were not in their power to influence. Something seems wrong with this picture. Clearly it is no less painful for family and treatment personnel to watch a heart patient die in their 40s or 50s because they refused to exercise or stop smoking, drinking and eating Big Macs. Their survivors are devastated and their lives are stressed to the max as they witness the downhill slide of their loved one. The various addictions also come to mind.

I am not here today to belittle the concerns of family and others who agonize over the deterioration of a loved one, but why are we discussing a certificate of leave for people who receive service in our mental health system? The cynical view, and I think I have confessed some guilt here, is that we can. Recipients of service, as a group, are not sufficiently organized and mobilized to be able to obstruct the passage of undesirous legislation. There is a history of detaining and otherwise coercing people with mental health problems. They are inevitably under the care and scrutiny of doctors, mental health workers and others who record and judge their level of functioning. Indeed, there is a large bureaucracy involved in their lives, a formal organization that can and will, from time to time, deliberate on matters such as the certificate of leave. This bureaucracy can be successfully lobbied for such a provision, unlike I suggest the general health system.

This is all taking place in a society that, in the main, still has lingering fears about mental illness and still stigmatizes and labels as "less than" people who struggle with mental health problems. I know that in the last several years our mental health system has evolved for the better. My observation is that there is a certain spirit of trust between consumers and providers of service from the Minister of Health on down. I realize that only a few people will feel the direct effect of the certificate of leave, at least at first, so I think it is realistic to invoke the slippery-slope theory in this instance. But I think the effect of such legislation will go far beyond what it is intended for and, rather than enhancing service, will, in the long run, detract from the spirit of co-operation that is gradually improving in the system. It will not improve, we can be sure, the necessary high level of trust that is imperative in an empowerment process.

I am afraid that the intention of this paradox, of freedom through constraint, will fizzle in the shadow of mistrust that will inevitably begin to loom over the recipients of service, as friends and acquaintances begin to be rehospitalized against their will.

Please let me take you back to my opening remarks, that our government will have treated this matter with the seriousness that it merits; this, because when implemented in a treatment plan, it encroaches on constitutional rights that we generally take for granted.

I request that you take the same earnestness and resolve, and apply it to the creation of a mental health system that would push the onerous aspects of a certificate of leave into obscurity, while retaining the laudable notion of effective treatment planning.

Of course, this is easier said than done, but we are well on our way. I am quick to acknowledge that we are resource rich. What, then, are the problems? What can we do?

Going back to the treatment plan; this usually focuses on the proper use of medications and referrals to an array of other services. Social workers, nurses, financial workers and mental health workers, along with community self-help groups, are often brought into the picture. But is this co-ordinated into a comprehensive, creative solution for the patient? I think that this is often not the case–at least for individuals whose illness affects their ability to accept and access the components of these often fragmented plans. Fragmented, because the focus is on compliance with medications, leaving other aspects of service relegated to a subordinate or supportive role at best. One might turn the equation around, postulating that effective planning around housing, education, employment and other social factors would greatly enhance the probability of a client utilizing the much-needed medication.

That is why we need to cease thinking primarily in treatment terms, in a medical model that overly emphasizes medications. We need to shift to a model that reflects a social-systems approach, wherein medical interventions are but one part and on an equal basis, not above, the other several interventions needed to complete a unified approach to mental well-being.

This cannot be achieved if the status quo remains. Patients who are doing well are often doing so in spite of the current system, showing great ingenuity in their quest for an acceptable quality of life.

I contend that there is a need for a one-stop model, with easily accessible entry points strategically placed in our communities. Such a model would have teams in community-based facilities, comprised of all service providers needed for effective assessment, planning and interventions on behalf of, but mostly with, clients who come for help.

Such teams would also include financial workers and would have very close linkages with housing and employment programs to the extent that, other than the physical location of staff, they were perceived to be as much a part of the team as the in-house service providers.

* (1810)

I think the financial worker being directly on the team is crucial. Financial workers must get frustrated, or even disgusted at times, as they issue cheques to some landlords who care less about the state of their rental units. As part of a team, and with an appropriate mandate, financial workers could refuse rental agreements for premises that did not meet prescribed standards. Financial workers would become knowledgeable about the need for decent surroundings in the recovery process of their clients.

Imagine how much better a doctor would feel about stabilizing their patient, more properly called a client, in such a service model. They would know that the client would stay with that particular team, connecting and trusting in a manner that is difficult to achieve in the present system. The effect of their work would not be virtually negated, as it often is, because the client would not return to the same environment that contributed to the relapse but to an improved situation that was developed on a basis of mutuality with the whole team.

Similarly, all workers on the team would derive better job satisfaction as they saw their contribution impacting in synergy with their colleagues' work. Burnout would be less of a factor, absenteeism would go down and productivity would go up. Team co-ordination might well be a separate discipline in such a system, possibly coming from the area of social work where a system approach is well understood. An atmosphere of trust, openness and acceptance would foster creative ideas that could be offered to clients.

This would take a great deal of political will because of well-known factors such as fear of change and protection of turf. It might, in fact, be more difficult a road than the road we are on today. However, there is an inertia for positive change and much experience to draw on were this government to embark on such a worthy journey. We need, hopefully for the rarest occasions, legislation to deal with situations where there is a need to detain a patient because all other measures have been exhausted. We should not link such actions to treatment.

As I said before, no such legislation in the general medical system would even be contemplated, much less enacted, even though the pain and cost to family members is often enormous. If we do enact the proposed amendments that affect liberty and single out a group to be treated differently under the law, then we are morally bound to create a system wherein the use of such provisions are minimized. Thank you.

Mr. Chairperson: Thank you very much, Mr. Nicolson, for your presentation.

Mr. Chomiak: I would also like to thank you, Mr. Nicolson. You said some things that some other presenters had said, but you also raised some new issues. It was very interesting the way you linked it together, and so your presentation has been most useful. Thank you.

Mr. Nicolson: Thank you.

Mr. Chairperson: Thank you very much, Mr. Nicolson.

Next, I call Marlene Vieno. Marlene Vieno, not here. She will drop to the bottom of the list then. I call next then Bill Martin. Welcome for the second time, Bill.

Mr. Bill Martin (Canadian Mental Health Association, Manitoba Division): Thank you.

Mr. Chairperson: I presume this is your own presentation.

Mr. Martin: This is mine, yes.

Mr. Chairperson: Thank you very much. Have you a presentation for distribution?

Mr. Martin: I do.

Mr. Chairperson: Would you distribute, please. You may proceed.

Mr. Martin: I think you know who the Canadian Mental Health Association is, but I would just like you to be made aware again, I guess, that we are active all over the province. We have independent boards operating all over the province, and on those boards are family members and consumers. The association has been grappling with this issue of certificate of leave for quite a long time. Initially, my board, the divisional board was in favour of the certificate of leave with some provisions. We were in conflict with our sister organizations in Ontario and Alberta, in particular, but that was our position.

Our national board has been hung on this position for years and finally just developed a position which is at the back of the paper that I provided to you. Nationally, the association really has not taken a stand for or against, but what they have said is, really what we need are community supports. They have not taken a stand because they recognize how important it is to keep a unity going toward improving mental health systems, and they did not want to start a battle with care providers or family members or consumers.

Be that as it may, our board did change its position and went to a position against the certificate of leave as a result of a study that we did. We brought together approximately 30 people, consumers and family members, and spent a day and half trying to get their point of view on it. By the end of the day, we had become convinced that while the problem was very real, and the problem that all of the family members described today was very real, and we sympathize with family members–we know it from experience–but we just do not think that this is the right solution, and that is what I would like to take this time to talk about.

I should mention, as well, that the brief that you have before you is a combination of a brief with myself and the next speaker, and I am going to talk on some of those things and not on others. So if I skip something, you will know why that is the case. I also should direct your attention that there is a submission from Father Monty at one of the Catholic churches in there, and he had asked that I make you aware of his opinion. I do not intend to read it; I draw your attention to it.

I will repeat myself a little bit. In terms of the certificate of leave–if I can go back just a bit more before I start that–we tend, overall Bill 35 is fairly good legislation. There are some things that we think should be changed in terms of period–you have to wait for reviews and stuff like that–but, by and large, we have fairly progressive committal legislation in Manitoba. I think the goal of legislation should be to get a person treatment as quickly as possible, but there should be due process protection, the Mental Health Review Board. Now 10 years ago we did not have that. So, by and large, the act as it exists, as far as committal goes, is not too bad. It has some pieces that are missing that my colleague will talk about in the next presentation.

Now, in terms of the certificate of leave, the problem really is well presented. You know, it is ill people languishing, deteriorating, suffering, even losing their lives, and something has to be done about that. The suffering of families is immense, as you have heard today. The question is, what? I direct your attention in there to our national paper, which was extensively researched, and it has some good background information for you to consider or consider my remarks today.

But the basic thing, I guess, the reason the board changed their mind can be divided into three things: No. 1 is that we were convinced by this group of people who have been patients of the mental health system that their goal is to recover, and they convinced us that having this community committal inhibits their recovery in a very dramatic way. We also believe that our committal legislation, as I mentioned before, is such that it provides an adequate remedy for stepping in when a person has lost their good judgment.

The last thing that we believe is that there are systemic changes possible which will remedy so much of this situation. So I would like to expand upon those, and then I would be delighted to answer questions.

In terms of recovery, what I learned from talking with those folks and with other people is that recovery from mental health problems is possible. It is a very complex thing. It often occurs without medical treatment, but it often occurs with medical treatment. It is sometimes retarded by treatment, inappropriate treatment, and recovery is always best when it is built on trust. A person's attitude is critical to recovery. You can take anybody–there is the story of a mother who gets cancer and her babies are little. The doctor says, you are going to die next week, and she says, I do not think so. After they have gone through high school, she dies. You know, the will to live and the will to go are so incredibly important, and I think this is probably more true in mental illness than in anything else or at least equally.

* (1820)

We also heard many incidents reported where there has been misdiagnosis, you know, where a person has said, I was given this treatment for five or 10 years, and they did not feel they had any recourse or good action to appeal it–in the past, that was more true. We do have a Mental Health Review Board now so that is one good piece we have in there–but they felt that this certificate of leave would be such that they really would not be able to appeal that very well, particularly if they did not have an advocate or they did not have a friend, they did not have somebody to stand beside them. The system tends to be so busy. You know, there are good people in the system, good psychiatrists, well-meaning, well-intentioned, well-trained people, but they have 40 or 50 people to see. Once you get someone out of place, out of mind, and if they do not take their medication, you can send the police to make them take it. Then that problem is more or less solved. So that is one physician who does not have to advocate for a real good place for those people to live or the right for them to work or all those other things that make life worthwhile and recovery possible.

It is a little bit like having the strap in school. If you have a teacher who is overworked and they can use the strap and Johnnie is acting up, they do not bother to find out that perhaps Johnnie is getting beaten up at home, because they bring out the strap, and, whack, behave. Well, the analogy has been put to us by consumers that it is exactly the same thing. That is how they view it, and, if they view it that way, that inhibits their recovery.

Many, many people in the mental health system fear and mistrust the system. The woman whose report I read to you has been sexually assaulted I think in all of the hospitals of Winnipeg to date. You would think that if your daughter or your wife or your mother would go into the psychiatric ward of a hospital for treatment for mental illness it would be the one place you would be safe from sexual assault. It is not true. It is going on now. It just went on last week. That very individual whose report I read to you was assaulted just two days ago. Her parents took her out of that hospital because they said: this is not a safe place to be.

It is just amazing just how unresponsive a system can be. You know, the simple solution is simply to separate men and women. You know, these are psychotic people who do not have control over what they are doing. They do not have judgment. Why in the world do we continue to put them together in wards when over and over again people complain: I have been sexually assaulted, I have been raped on the ward.

Anyhow, when I talk about fear and mistrust, it is a very real thing in people's minds, and if they say: I was controlled in the hospital, I could not leave and I was raped there. Now the long leash goes out and says, well, we will control you out there too, and they just say: no, thank you. I would like not to be controlled. I would like to be supported.

So I guess the challenge then is to enhance trust and safety and at the same time to ensure that when all else has failed to ensure that committal can happen quickly. That was my second point. Manitoba has legislation where that can happen fairly quickly. Other provinces, you have to be of danger to yourself or someone else, but in Manitoba you can also be in danger of substantial deterioration.

Surely to goodness, someone who is eligible for the certificate of leave, who has been in and out of the hospital maybe 10 times, who is a high user of the system, who has deteriorated over and over again, and he or she is discharged and he disappears or whatever, and the physician has reason to think that that person is not taking their medication, do they not have grounds to go to the court, to write an order and say: I think Bill is in danger of substantial deterioration. He has not come to me for medication.

Have I taken up all my time?

Mr. Chairperson: Yes, you have taken up your 10 minutes. However, if it is the will of the committee, we will allow you to continue during that period of time that we normally designate for questions. Go ahead and continue.

Mr. Martin: The delay in that happening is really systemic and organizational. Either the beds are not there, the doctor is too busy. I know for a fact that some of the beds in the hospital are filled with people who are not severely ill. That continues to happen. We have no way of prioritizing who gets in with the most need, no effective way, not amongst all of our hospitals. It might happen just in one, in the Health Sciences Centre, where the most needy are, but some of the urban hospitals, that is not true.

So that is a systemic reason. I have seen situations where people have gone to the hospital and begged to be admitted, and they have said: I am sorry, you are not ill enough. So they go away and then they do not want to come anymore. They have lost judgment. So the police then bring them in, and then it is the systemic problem that at that point they may have to wait 10 to 12 hours to be seen in there. Now, these are just simple management problems. So far, we have made a tremendous beginning in mental health reform, but we never addressed the co-ordination and the management at that level. It has been a total failure. We have outlined some of the solutions to that also in this paper.

I guess my third point is that systemic remedies are available. It is not a new idea. It was presented several times over the last decade in reform that the point of entry to the system should not be to the hospital. The point of entry should be to a community health clinic who is accountable and responsible for the well-being, let us just talk of these people who might be subject to the certificate of leave.

So if you are the team of people that work at that clinic and I am your patient, then your job is to make sure that I live successfully in the community. So you do not abandon me for three months after I get out of hospital, because your job is to see that I live successfully in the community. So if I do not show up where I usually show up, then one of you comes and talks to me, finds me, finds out what is going on. Maybe I had a job, but I needed a vehicle to get to it, and my vehicle broke down. Well, if you had control of the money, you could say we will lend you $100 to get your truck fixed so you can keep your job, Bill.

Now, this sounds like a radical idea, but it is working in very, very many places. Can you imagine the saving that would happen if you as a team had access to this money that might be used to pay the $1,000 hospital bill once I get there, if you had access to that money to lend me some money to fix my truck so I could keep on working, and then I would pay it back? We have this on record. This actually has happened.

If I get out of hospital and I say to my doctor I do not want to see you again; I did not like that treatment; yes, I am stabilized but, no, thank you, I am finished with the mental health system, what the mental health system now says is arrivederci or whatever it is, good-bye, and they let me wander out there for months. None of you will come and see me if I say, look, I do not want to see you, and people will say, well, I have a right to refuse treatment. I guess I do, but I am abandoned.

You know, in Dane County, Wisconsin, 30 years ago, they started a program called Program for Assertive Community Treatment, and when people get lost they go and look for them. If they are not keeping a good place to live, they help them have a good place to live. They help them get a job. Sometimes they will go and see a person 10 times in one day who is in high need. It all comes out of that pot of money. But when you think about spending $1,000 a day and some people are in the hospital for 30 days or 50 days, it really makes sense.

But you go and you provide it in a supportive way, and if you are on my treatment team and, you know, I, for some reason or other, do not like blondes, then Mr. Chomiak might come and see me. He is a runner and I am a runner, so we might get along. You find a way to support me in a gentle, supportive and kind way. Then if I start to deteriorate, well, one of you is a psychiatrist. Say that is you, sir. Then Dave would say I think you better come and see Bill; it seems like he is deteriorating. So you come and see me and the two of you talk to me and say, Bill, you know, it seems like you are becoming ill. Why is that? Well, da da da da da da. We think you should change your medication. Dr. so-and-so is here, and he can do that. Okay, I will try that. Or if I become resistant, then The Mental Health Act has all kinds of levers to put me in hospital and change my treatment, if I am resistant. You do not need to have this law hanging over me.

* (1830)

The final thing about that is that this team that I am talking about that you folks would be on would not have to go through emergency. You would be the physician who was part of this team that keeps track of me and many other people, and if I needed to go in there, then it is just like that, right through. You do not need a medical write-up. You do not need a medical assessment because that is all on file, and, of course, you have been seeing me.

The final thing–and you should like this if you are responsible guardians of our tax dollar–is that this team has the money to support those folks. So every time you send me off to hospital, you have to write a cheque for $1,000, and I am still on your caseload. I am your responsibility, so you are over at the hospital talking to that doctor, saying, hey, is Bill not ready to come out yet? What does he need to survive in the community that we can do cheaper, because we cannot afford to keep him in this hospital? Besides that, there are other people who need that hospital bed.

Do you not think that is a glorious idea? It has been around for 30 years. Is it not time we tried that in Manitoba? Instead of this draconian, I think, good-intentioned, legal remedy, we need a systemic remedy. It is a way you spend the money.

Okay, I realize I am running over. If, after all of that, you decide to proceed, as you may well do, then who knows, a certificate of leave may be a helpful thing, but there are some serious flaws in this certificate of leave. In Saskatchewan, where they have a certificate of leave, they say that the community services exist for that person and will be provided for that person. This legislation is very faint in my opinion compared to that. It says the services can be provided. Well, "can be" does not count much.

The other one, which was provided by one of the previous presenters, is if you are going to do it, evaluate it. None of the mental health reforms in Manitoba have been evaluated. More importantly, the hospitals have never been evaluated. You know, the place where we spend all the money, we have never said does this bring a good outcome? We have never, ever done an evaluation on that. We might have an evaluation and accreditation. Is the floor clean? Are the doors big enough? Are the beds just so and so? Is there enough staff per square foot? That is done, but does this change the outcome in people's lives? Do we have less hospitalization, a diminution of symptoms? Do we have more successful living? Our hospitals have never been evaluated by that, but I can tell you if they had been, they would have failed miserably, not because there are not good people there–because we have the best, I believe–but because the system, the way it is organized, is dysfunctional.

My final point–this is it; it is only two sentences–is that I have made a study of mental health reform over the last 15 or 16 years that I have been involved in it, and it has never happened without political direction, never. What you folks do and say and decide is incredibly important. If you say we want these services evaluated by such and such a time, then the bureaucracy–I used to work for the Department of Agriculture years ago and then we loved pleasing our minister, so if you guys say do it, it will happen. So if you are going to initiate the certificate of leave, then say we want it evaluated, we want that evaluation one year from today on our laps that will tell us whether it has made a significant difference and outcome. Okay, I am finished. Thank you.

Mr. Chairperson: Thank you very much, Mr. Martin, for your presentation. I am going to allow for some questions if there are any questions.

Mr. Chomiak: Thanks, Mr. Martin, and thanks for the submission. In your experience, and I know that CMHA has done a fair amount of work in the area of PACT, et cetera, and since you are, I did not realize, an ex-bureaucrat, could you give us any projection or time frame to get a fully functioning PACT program, you know, not necessarily even optimum, but a functioning one? What are we talking? Will this take six months, 12 months, 18 months?

Mr. Martin: With your direction, you know, your imperative, we could have this going very quickly. You already have the components. You know, you have initiated a Mobile Crisis Team, a Safe house, a Crisis Stabilization Unit, we have hospital and we have intensive-case management, but it all tends to operate separately. What you need is a demonstration project, a trial project, and put a little bit of cash in the management to manage those existing services, so I think you could do that. You could have that running, John, three months, easily. It is the will, it will not even be the money.

Mr. Chairperson: Thank you, Mr. Martin, for your presentation.

Mr. Martin: Thank you very much.

Mr. Chairperson: Next I call Mr. Rod Lauder. Mr. Rod Lauder, I might remind the committee, was delayed from No. 6 to No. 22 and a half, or a quarter, I should say, and the next one I will call will be Ellen Kruger, who we also delayed from this morning. Mr. Lauder, have you got a presentation for distribution?

Mr. Rod Lauder (Canadian Mental Health Association, Winnipeg Branch): The bulk of my presentation is actually going to carry–is given to you in the CMHA Manitoba presentation. Just to provide a moment of relief for you, I am also here in my role as the board chair for CMHA Winnipeg Branch, not as a private citizen, so you can strike Ellen off of your list, and that is the role in which I will be speaking to you today.

Mr. Chairperson: Have you a presentation for distribution?

Mr. Lauder: Mine is part of the CMHA Manitoba brief.

Mr. Chairperson: Okay, thank you very much. You may proceed then, Mr. Lauder.

Mr. Lauder: There may be a few additional comments. Just to follow up very briefly on the certificate of leave before going on to some other points. I think it would be worth the committee's while to look at the Saskatchewan legislation. There are at least two other key points that are missing from the Manitoba provisions that are present in the Saskatchewan provisions.

One of them is that there is an automatic kick-in of advocacy, which I will talk about, in the form of an official representative, which, in our view, is weak in the Saskatchewan legislation because that advocacy kicks in after the certificate of leave is issued, or the community treatment order, rather than before the community treatment order. But we do like the idea of having that mandated, legislated, that you would have an automatic kick-in of an advocacy support for people who are going to undergo this kind of provision. It exists in the Saskatchewan legislation.

Secondly, a second psychiatrist is required in Saskatchewan; only one is required in Manitoba. The first psychiatrist issues the community treatment order in Saskatchewan, and then the second psychiatrist also has to conduct an examination of the person. Both have to be done within 72 hours of seeing the person–or the certificates have to be done; and, with the second psychiatrist, it is a certificate in support of the community treatment order. It, again, provides an additional safeguard to the individual.

So, having said that, I want to then retreat a bit into the presentation you have from CMHA Manitoba and talk about the first three points. The first point is around the legislative preamble–or legislated preamble. The very first experience I had in working in the field of human services was attending something that actually Tim Sale, when he was at the Social Planning Council, put on, which was a five-day planning and management of human services. Wolf Wolfensberger was the speaker, and he pointed out that it was really critical that we have preambles in legislation because preambles are powerful ways to positively direct and shape policy that interpret legislation both today and in the future.

Original rationales are often forgotten by subsequent generations; thus, when the original Mental Health Act was drafted, probably back at the beginning of the century, the rationales at the time were based on the eugenics movement, which found, and was concerned about, mentally defective people overrunning us by undue propagation and procreation of the masses so that we would be overrun by people who were mentally defective. That philosophy continued on in the legislation unconsciously until it was revised in the last 15 or 20 years. Thus, law in human service practice will often continue after the rationales have ceased to be valid or relevant, and including a statement of purpose and principles reduces the chances of this phenomenon occurring.

* (1840)

Over the last decade, Manitoba Health has produced a number of documents that outline purpose, values, policies and components of mental health system. For example, in 1997, the Core Health Services in Manitoba states that those who suffer from mental distress receive the care, services and support they need to live in optimal independence and healthy status and emphasize consumer's rights of choice, building a support network, encompassing families, friends, employers, church and other groups, and accessibility, accountability, co-ordination and evaluation.

Several jurisdictions in Canada have integrated vision, values and principles into the preamble of their mental health legislation. For example, the New Brunswick Mental Health Services Act, passed in 1997, does have a preamble. You can see that there, and I will just read a couple of them.

Whereas one of the purposes of mental health service is to promote self-reliance and lessen dependence on formal systems of care;

Whereas a balanced network of institutional and community-based mental health services are required to ensure timely delivery of mental health services;

Whereas the principle of most appropriate and least restrictive treatment should follow in the provisions of mental health services;

Therefore Her Majesty–and so on.

In Manitoba we have seen this with The Vulnerable Persons Act, so there are precedents even within Manitoba for doing this, and thus the first recommendation that we want to make is that a preamble be added to Bill 35 which would clarify the legislative purpose and values behind it.

Secondly, in terms of community mental health services legislation, when we think about the rationales that there are probably five reasons to legislate at least according to the Review of Legislation for Community Based Mental Health Services and Programs, which is a document that was a federal-provincial-territorial advisory network on mental health which did a thorough international review of legislation and gives direction to the design of all mental health services, not just involving medical treatment. Community mental health services legislation has and is being developed in Canada, the United States and Britain. In that document it is suggested that there are five reasons to legislate. One is to indicate the state of advancement of the mental health system and that there are three related premises to that: one is that the content of legislation is a gauge of the system that is in place; secondly, that an intimate relationship exists between mental health legislation and current and projected development of the mental health system; and thirdly, that legislation, if it is to be effective, should reflect accurately the current state of mental health programs in the jurisdiction, in this case in Manitoba.

I would suggest that this legislation, as it exists now, does not reflect that focus or the focus of reform. Secondly, it is to signal the importance of community mental health care, again if we look at even just the subject headings of this bill, you would not necessarily understand or be clear just from looking at the subject headings that community mental health care is what we are focused on here. Thirdly, to ease public accessibility to, and information about the mental health services, the right to them and to other community rights and entitlements; again, that is not terribly clear in this bill. Fourthly, to confer powers that would not otherwise exist in order to protect persons carrying out governmental functions from legal liability for acts which would be illegal if unauthorized by legislation; that this act does extremely well. Fifthly, to impose duties on persons who would not otherwise have them; that this act does some ways well and, as Yude Henteleff pointed out earlier, in many ways it does not. In fact, it sends the opposite message that sometimes: do not worry; we will not leave you on the hook for something you decide in terms of the way you support or serve this person.

In fact, the other piece there is that the original rationale for this–and I just take this from the report of the Mental Health Act Review Committee–was that the assistant deputy minister responsible for mental health services agreed to amendments to existing legislation, agreed that amendments to the existing legislation should await the implementation of mental health reforms throughout the province. Once implementation was well underway, the department would be in a better position to assist and augment the reform process by making changes to the mental health legislation. The reform process had brought about a reduction of an emphasis away from institutional-based model of care to one which emphasizes community-based care. So again the question then raises, why do we not see that reflected in this legislation?

Building the Future of Mental Health Services in Manitoba, a Manitoba Health document of 1992, stated: As Manitoba health reform continues towards our goal of providing community-based services and the size of services provided in Manitoba evolves, it is clear that the legislation mandating services to the mentally ill will also have to evolve with additional amendments or perhaps even replacement of the current Mental Health Act with a different statute. The recommendation then that we have here is that the government of Manitoba produce for public review a draft community mental health services act designed to provide detailed and distinct legislative underpinnings for the development of a comprehensive community-based mental health system.

The third and last point that I will speak to is around advocacy and advocacy services. The Canadian Mental Health Association, Winnipeg branch and Manitoba Division, is concerned that the current legislation is being brought forward for consideration without any plan for or concurrent legislation to establish mandated, independent, impartial advocacy services. Earlier Tim Sale asked one of the presenters whether the review committee had made recommendations about this, and in fact the answer I think was no, but the answer in fact is yes.

The Mental Health Review Committee's final recommendations included seven recommendations regarding advocacy, and I want to read these into the record. These were: a centralized mental health advocate office be established to address all mental health issues; the office advocate for all mental health consumers, both inpatients and those residing in the community; the office have jurisdiction in all mental health programs, including those that are publicly funded and those operated by private agencies; the office advocate on behalf of parents, friends and care providers of consumers; the office proactively advocate for system-wide changes in addition to reacting solely to complaints and concerns; the office be legislated external to The Mental Health Act and report directly to the Legislature, similar to the Ombudsman, and that cost-effective options be examined prior to implementation of this office.

With the exception of the recommendation of the mental health advocate's office acting on behalf of parents, friends and care providers, CMHA is supportive of these recommendations. We do not support that one because the potential for conflict of interest would be enormous if this recommendation were made part of any mental health advocate's mandate.

Since there has been no mention of any concurrent legislation, we must then look to see if advocacy supports are in place in the legislation before us. No such supports are ensured. In New Brunswick's mental health act, there are four pages of the act devoted to outlining the rights and responsibilities of patient advocate services. The Lieutenant Governor in Council has the authority to designate persons, services, or organizations as patient advocate services. The minister also, under the Mental Health Services Act that was passed in 1997, has wide legislated investigative powers.

In Saskatchewan, legislative provisions, as I have mentioned earlier, for official representatives or lawyers are in place to advise and assist people in understanding and exercising their rights and obligations. For example, an official representative is automatically appointed for anyone under a community treatment order. Also, anyone admitted to a facility under medical certificate will receive a visit from an official representative within 24 hours. In Ontario, patient advocates, again mandated through legislation, are available to voluntary and involuntary individuals.

Thus, given all of the above and based on historical evidence regarding the mistreatment of individuals with mental health problems, provisions must exist to ensure mandated, independent, impartial advocacy services are provided.

The recommendation here then is that the passage or proclamation, and again I harken back and think about The Vulnerable Persons Act, which took at least a couple of years to proclaim after it was actually passed, that the passage or proclamation of Bill 35 be delayed contingent upon appropriate legislated advocacy safeguards to ensure that the rights of individuals affected by the act are enforced and protected.

Mr. Chairperson: I have allowed you to exceed the time limit significantly, and I thank you very much for your presentation.

Mr. Lauder: I am done.

Mr. Chairperson: I am going to ask Mr. Chomiak whether he wants to pose a question.

Mr. Chomiak: Thank you also for the presentation. I have a couple of brief questions. The questions are brief. That may not mean the answer necessarily has to be.

My first question is, you reference to the original '92 document, the framework and the creation of the community mental health act. Would you be advocating or suggesting two separate acts or one act within another act? Is there a sense of that?

* (1850)

Mr. Lauder: We are in a dilemma in terms of the recommendation, and the dilemma, of course, is, as well, is this thing going to go ahead regardless or not? In New Brunswick, there are two separate acts. You have the Mental Health Act and you have the Mental Health Services Act, so there is the possibility for that there.

It seems to me–and I am going to step back a bit and say, just speaking from a personal perspective, that it would seem to make sense to as much as possible include those in one act, the services and otherwise. I think, as Bill Martin said, one of the things he said–and I think he was pretty careful, if I am not mistaken, in his choice of words. He said this is excellent legislation for committal, as opposed to excellent legislation in terms of reflecting those five principles or reasons to legislate that I mentioned earlier, that if what part of your purpose here is is to ensure that this act reflects the state of the art for mental health services in Manitoba now and points to a direction in which you want to see a vision, in fact, of the future through a preamble–that is one way you set the vision–and through a vision of what we are committed as a government to do to assist people with mental health issues, then one would be hard-pressed to say, gee, you ought to go ahead with just what you got.

Mr. Chairperson: Mr. Chomiak, with a final question.

Mr. Chomiak: In fact, I am going to drop my question, Mr. Chairperson, and impose and ask for an opinion on this. I would like your opinion on this, Mr. Lauder. I have melded together two recommendations, something that you suggested and something Mr. Martin suggested. I want to just try it out.

We talked about community supports being in place. That has been evident from a lot of presentations. You talked about the Saskatchewan experience where there has to be two psychiatrists who must both examine and provide for the community treatment orders. I just thought of an interesting–notwithstanding that you are opposed to the certificate of leave provisions–amalgamation of those two ideas. Prior to a certificate of leave being issued, a psychiatrist must go through the process, et cetera. Secondly, a community expert or a community person must agree to the plan and must ensure that the plan is in place prior to allowing the certificate of leave, and, in that sense, you would meld together both issues.

I am just throwing that out as an idea just to see if you have any comment on that.

Mr. Lauder: Well, it is an intriguing idea. Let me read you a little bit from the Saskatchewan Mental Health Services Act which is 24(3)(1)(iv), and it goes like this. Part of the earlier part of this is the community treatment order can only be issued if the psychiatrist has probable cause to believe–and this where subsection iv comes in–that the services that the person requires in order to reside in the community so that the person will not be likely to cause harm to himself or herself or to others or to suffer substantial mental or physical deterioration (a) exists in the community (b) are available to the person (c) will be provided to the person.

Then there is subsection (e) which is sort of one guarantee of service. Subsection (e) identifies the names of persons authorized by the regional director who will ensure that the person who is the subject of a community treatment order will receive the services that he or she requires in order to be able to reside in the community. So, again, you have a really clear form of accountability that exists.

Another potential source would be Minnesota–I am trying to remember the name of the legislation–or Wisconsin which talks about some of the services that need to be in place, and they include assessment, diagnosis, identification of persons in need of services, case management, crisis intervention, psychiatric treatment, counselling and psychotherapy, activities of daily living, psychosocial rehabilitation, which may include services provided by day treatment programs, client advocacy, including assistance in applying for any financial support for which the client may be eligible, residential services and recreational activities. These are all built into Wisconsin legislation and the reference is S51421, which specifies the requirement of community support programs.

So you are talking about a marriage of ideas. I would want to return us back to the original thought, which is that what we have, in a way, is the hammer without the other piece, and again the question that goes begging is, if we have the other piece do we need the hammer?

Mr. Chairperson: Thank you very much, Mr. Lauder, for your presentation.

I call the next person, and I am not quite sure how to pronounce this last name. Lucie Pearase? Did I pronounce your name correctly?

Ms. Lucie Pearase (Private Citizen): Well, it is actually Pearase, but Pearce is fine too.

Mr. Chairperson: Have you a written presentation for distribution? Okay, the Clerk will distribute. You may proceed with your presentation.

Ms. Pearase: I am not familiar with the new amendments to the act. I have not seen any of the copies yet. I only learned about these public hearings about a day ago, but I do know that Bill 35, as I understand it, gives police officers the right to pick up a person on a certificate of leave and return them to the hospital and force them to go back on drugs and treatment.

Mr. Chairperson: Could I ask you to bend the mikes a little closer to you, or maybe you could just move up a bit closer.

Ms. Pearase: Is that better?

Mr. Chairperson: That is better.

Ms. Pearase: So, anyway, to the Chairperson and the committee to the amendment to the Mental Health Act, I have a bachelor's degree in social work, and I am also a survivor of severe childhood abuse. Fourteen years ago psychiatrists at the Health Sciences Centre labelled me manic depressive and put me on a drug called lithium. No one in psychiatry ever asked about my history of abuse, and it has never been acknowledged either. In February of 1993, while in university, in counselling to deal with my issues of childhood abuse, I felt the lithium was making me sick, so I decided to stop taking it. I informed Dr. Lander and nurse Elaine Bennett of this, and I was offered no support or follow-up and I was not warned of the consequences either.

Within one month I went into a state of crisis, which I now know to be post-traumatic stress, where I was reliving and remembering the horrific abuse I suffered as a child. Instead of appropriate care and treatment, I was tortured and brutalized by police officers and doctors and nurses at the HSC in the same way that I was tortured and brutalized as a child.

* (1900)

I am also submitting to the committee a copy of a letter I sent to the HSC on May 31, 1998, regarding the gross mistreatment and sexual assault I suffered there in 1993. As I said in that letter, while in crisis from childhood abuse, I was tormented, threatened, brutally assaulted, grossly mistreated, heavily drugged, raped, hog-tied and left to die on a mattress on the floor of a dark, locked room on the locked ward. I know people do not want to believe that, but it actually happened.

I came home from the HSC severely traumatized with bruises to my hands, wrists and hips and suffering excruciating pain in my head, spine and legs. I was forced to take a six-month leave of absence from university and graduated in 1994, only I have not worked since, as I have been trying to heal and recover from the brutality I suffered at the HSC in 1993.

Under The Mental Health Act, which I reviewed, all kinds of offences were committed against me, and the crime of sexual assault was also committed against me, yet no one has ever been held accountable. To this day I have not seen any justice or compensation or even a fair investigation with all of my witnesses heard. I am not a criminal. I am a wounded person, and I certainly did not deserve the gross mistreatment and brutality that I was subjected to. More accountability is definitely needed.

Abuse causes mental illness, and this has now been proven by numerous doctors and other professionals around the world, such as Dr. Charles Whitfield, who wrote this book, Memory and Abuse, Remembering and Healing the Effects of Trauma. Psychiatry's failure to recognize and acknowledge my abuse issues has caused me so much pain and suffering in my life and so many wasted years, and also caused me to be brutally and sexually assaulted at the HSC in 1993 and traumatized even further. Far too many errors are made and far too many people have suffered as a result of those errors. I am not the first woman who has suffered these kinds of assault and brutality–the first survivor of abuse. There has been many more.

When issues of abuse are not dealt with, they keep resurfacing until they are dealt with, which could explain why some people have been in the psychiatric system for years and never get well enough to stay out of the system, or the people who have been in the system for years and suddenly commit murder or suicide. Issues of abuse are never dealt with.

Labelling and drugging survivors of abuse does not help us heal. It only serves to help the psychiatric system maintain the revolving-door syndrome at a high financial and human cost. Institutional psychiatric treatment methods hold little hope of healing for survivors of abuse such as myself. As I pointed out, I was only traumatized further. I will be forever grateful for the healing that began in social work for me and counselling, and so much more of those kinds of treatment methods are needed.

Surviving abuse is a sign of mental strength, not mental illness, and people can heal with appropriate care, treatment and support. I suppose I am a good example. I was first abused as a child in my home, and a Roman Catholic Church, and then again as an adult at the Health Sciences Centre, and I am standing here talking to you today. Yes, I am back on lithium, only I certainly did not deserve the torture and brutality to be put back on the drug. And what if the lithium stops working for me? Will I have to stay on it or some other drug for the rest of my life? Psychiatry has no answers. And if I should be in crisis again, does that mean that I should be subjected to torture and brutality again by police officers and doctors and nurses who do not understand?

If the medical and psychiatric system continues to ignore issues of abuse and trauma, then alternatives must be created. One such alternative, which I wholly support, comes from a therapist who counsels survivors of abuse. That alternative is a facility staffed with knowledgeable and caring professionals from a variety of disciplines who understand issues of abuse and trauma and who have a sincere desire to help people heal.

I hope that all of you might consider all of this as you revise The Mental Health Act. As I was just sitting there, I was thinking to myself, and I almost felt like walking out, because it dawned on me that under the old Mental Health Act, like I say, all kinds of offences were committed against me. What was done about it?

As one lawyer pointed out to me, there is a clause in the act that grants doctors immunity. I do not know if people realize how much power that these kinds of people have over people like me. Doctors and nurses and police officers behind closed doors in a hospital, they can do whatever they want to people just like they did to me. Who is holding them accountable? It is one thing to have a Mental Health Act, but who is holding these people accountable? Thank you.

Mr. Chairperson: Thank you very much for your presentation, Ms. Pearase.

Mr. Chomiak: Thank you for sharing your story with us. All of these stories help if something positive can come from them. My question for you is, at present, if you were to go in--no, I will not put it that way. If someone close to you were to be in crisis, what would you recommend? Where would you recommend they go or what would you recommend that they do if they were to be in a mental health crisis? What would you recommend?

Ms. Pearase: That is just the thing. Just even sitting here listening today, there are so many different situations. Just last week or about a week or two ago in the building where I live, a woman went off her medication and proceeded to set fires in the building, five fires. The fire department came three times to put out the fires. Then finally they figured out who was starting them, and they put cuffs on her and took her away. I mean, every situation is so different. I do not know.

For me personally, I would be terrified if police officers ever came to pick me up again. I would be on the phone right away and calling the top lawyer in Winnipeg. Police officers have no understanding. Obviously even the doctors and the nurses at the Health Sciences Centre had none. They do not want to believe that abuse causes mental illness. It is better just to slap labels on people and drug them. That way, they do not have to listen to their pain. They do not have to try and help them heal.

You know, it is funny. After I was subjected to this torture, I went back to university with a vengeance to get my bachelor's degree, and I did all the research I could possibly do into this topic to figure out what happened to me, what they did to me. I have been in many other groups with women who have been subjected to the same kinds of stuff, and I do not think there is any one answer.

If this Bill 35 is passed, I do not think it should apply to everyone. There have got to be some stricter guidelines in place.

Mr. Chairperson: Thank you very much for your presentation, Ms. Pearase.

Ms. Pearase: You are welcome.

Mr. Chairperson: I call next Murray Waldie. Murray Waldie.

Mr. Murray Waldie (Private Citizen): Even though I have a short presentation, I would like permission to have my wife participate with me in this.

Mr. Chairperson: Absolutely. Could you give us her name, please?

Mr. Murray Waldie: Yes, I will.

Mr. Chairperson: Have you got a presentation for distribution? The Clerk will distribute.

Mr. Murray Waldie: Good evening, Chairman and committee members. My name is Murray Waldie, and this is my wife, Ellen. We are parents of a son who suffers from paranoid schizophrenia. He was diagnosed in April 1991. He received treatment for two years and four months. Then, in July 1993, a Mental Health Review Board ruled that he be treated as a voluntary patient. Since then, he has lived with this illness without any antipsychotic medication nor treatment of any kind.

* (1910)

Mrs. Ellen Waldie (Private Citizen): Hello, I am Ellen Waldie. As his parents, we tried our best to get him help each time the illness flared, but The Mental Health Act, the health system, including psychiatrists and social workers, failed to get him help. Now he has deteriorated to the extent that without any antipsychotic medication he has lost control of his actions and recently pleaded guilty to physical assault and to extensive damage to our home and our property.

Mr. Murray Waldie: As legislators, I implore you to realize that it is much more feasible and less costly to treat a person under a good Mental Health Act and a good mental health system than it is to treat the system's failures under the adversarial system of the Criminal Code of Canada.

Mrs. Waldie: The revised Mental Health Act must be strong enough to treat adequately a wide range of patients, that is, from the mildly ill at one end to those with paranoid schizophrenia at the other end. There are some powerful groups who advocate no treatment against a person's will, regardless of whether the person is capable of making treatment decisions. You as legislators have followed the wishes of that group for 11 years. As a result, the present act and system have failed to treat the noncompliant.

Mr. Murray Waldie: In spite of the wording errors pointed out by Mr. Henteleff and Mr. Peters, I agree generally with the recommendations of the report of The Mental Health Act Review Committee that was presented in January 1997 to our Health minister, but with one major exception. The committee has failed to recommend changes to the process of getting initial treatment for a noncompliant patient. On that basis, our son will not receive any help. You will be allowing the system to wait until some noncompliant persons commit some heinous crime and then letting the Criminal Code take over. Not a very good solution.

Mrs. Waldie: The wording in the act must be tightened so that those incapable of making treatment decisions are, in fact, given therapy and antipsychotic medications on an ongoing basis. Would you please make that change?

Mr. Murray Waldie: I also implore you to put enough money into the system to obtain the services of more competent psychiatrists. Those living with schizophrenia are last on the totem pole. Unless you hire more competent psychiatrists who are willing to treat those with schizophrenia, then there will be many who will continue to live in devastating circumstances. Using the best antipsychotic medications, not just the cheapest, would also help.

Thank you for your patience and consideration. It sure has been a long day.

Mr. Chairperson: Thank you for your indulgence. It certainly has been a long day and especially for those of you who were here first thing in the morning and having to wait till virtually the end of the presentations. We sympathize with the process, but this is the only democratic and public hearing process, quite frankly, in all of Canada that allows for public input into legislation. So we hope you condone the time it took to present here today.

Are there any questions of the Waldies?

Mr. Chomiak: We will follow up with your question about the issue raised on the second page, about your son receiving treatment, when we deal with the legislation. I just want you to comment on–it is the first time I have heard these presentations to these points. I just want your comments on the issue of schizophrenics being last on the totem pole. Secondly, if you can give us an example of the issue of the antipsychotic drugs, not just using the cheapest. I wonder, because you obviously have–it sounds to me like you have experience in that area.

Mr. Murray Waldie: What was the first one you asked?

Mr. Chomiak: About schizophrenic patients being last on the totem pole.

Mr. Murray Waldie: Oh, yes. Well, it is a common fact that psychiatrists generally do not like to deal with schizophrenia because of the unsuccess rate. That is factual. Now, regardless of that, we have far too few psychiatrists here, and with the noncompliant part of it, the doctors are more than busy enough with the compliant, and these noncompliant people have fallen through the cracks. We are not just the only example. There are hundreds, literally hundreds out there, in the same situation.

Now, your second point was on–

Mr. Chomiak: The drugs.

Mr. Murray Waldie: Oh, yes. I have been told that it is policy for psychiatrists in hospitals to treat people on the cheaper drugs first. There is the loss of time and the fact that they get sicker and sicker and sicker. It is very poor spending policy.

In our own son's case, he was on an expensive drug. He was on clozapine, but even though he was on clozapine, it did not work. So he finally lost heart in the system. He finally gave up, that he was not going to get better, and he went off it. But it was evident, as far as I am concerned, that it was not working. There were at least two drugs that may have worked, antipsychotics that may have worked, but he was never tried on them. He quit them, and he has managed to dodge the system ever since. Now he is being dealt with by our Criminal Code, not a good ending. So I hope that answered you.

Mr. Chairperson: Thank you very much for your presentation, Mr. and Mrs. Waldie.

Mr. Murray Waldie: Thank you.

Mr. Chairperson: I call next Phyllis Wayne.

Floor comment: Oh, I am her daughter, and I presented her letter before, but do you want me to read it?

Mr. Chairperson: No, that is fine. If it was here, that is fine. Thank you very much then. I call then Jackie Mauws.

Floor comment: If I may, her presentation–

Mr. Chairperson: Is on the table here, too, as well. Okay, fine. Then I call lastly on Bill 35, except for those who have been dropped to the bottom of the list, Mark Waldie. Mark, do you have a written presentation?

Mr. Mark Waldie (Private Citizen): No, I do not.

Mr. Chairperson: You may proceed then.

Mr. Mark Waldie: Okay, thank you for the opportunity to speak in your considering this act and taking into concern what I think you sincerely believe is a matter of the heart which does not have any necessarily clear-cut answers but must be dealt with. I can address this issue from a few angles. As one with a mental illness, I have depression. As far as I am concerned looking back, I have had it all my life. I am on drugs every day for it, a rather severe case. I have dealt with specialists over the years. I have had long bouts of inability to sleep and had to have drugs to go along with that and severe inflammation such that I was unable to operate my body. I would have to be carried some where, or I would be on the anti-inflammatories and I would freeze up at night so I could not uncover myself, and there was a sense of not being able to breathe and so on. So I know what mental illness is with all the number of implications as far as depression is concerned, and I could go on at length about it.

* (1920)

Anyway, a few things I would like to mention to you, I think, which suggests some solutions to some of the concerns that have been mentioned here. I have experience as a teacher, as a guidance counsellor on a reserve, and I have dealt with some horrendous situations including human inflicted death, suicides, people taking skidoos out into the slush and going for the ice and dying, people taking drugs and going into the depression that comes from the lows of drugs, illicit drugs and then shooting themselves to get out of that chemically induced depression and so on. I have dealt with a number of situations, and this is my experience and observations on reserves. I find it in the regular public school system also. When there is a dealing with drugs, the focus is on illicit drugs, and there should be address to that. I have no criticism of it. What is being done, I agree with. It is what is not being done which I would suggest they could further exercise the good intent which is in place.

People say, well, do not take this drug, do not take that drug, do not take drugs, drugs are bad. Well, what do you do if you are depressed, out of your mind, and so on and so forth? Well, the suggestion is not given. What do I do when I am left hanging? So what I would like to suggest is that you would use your influence and even your directive authority to require in the school system and elsewhere that the good side of drugs be required in the education. In contrast to your friendly or unfriendly neighbourhood drug dealer, there is your good neighbourhood drug dealer called your physician, and there are other ones. He or she can put you in touch with a lot of medications that have significant, positive, essential effects that work, and I can attest to that being a user of antidepression drugs myself. I cannot press that hard enough. There is a gaping void there.

Having said that, I would like to address some issues brought up by some other presenters today. Mr. Henteleff seemed to suggest, as I would understand him, that there is excessive authority perhaps suggested in this legislation that a peace officer, particularly a police officer, who could exercise under this legislation an ability to arrest or take hold of somebody and somehow commit him or her to treatment using a certificate of leave, as I understand it, under what I would consider to be excessively restrictive grounds, that there be a belief that something could happen wrong, there would be injury to that person or other persons. I would suggest that instead of this what I would consider to be excessively restrictive language, the language used in Sections 27 and 494 of The Criminal Code of Canada be adopted instead, and the practised judgments that go along with those two sections, the implications would be recognized, so you would not be going in this blindly.

Section 27 in effect provides that everyone is justified in using such force such as is reasonable to prevent a person from committing an act which is cause for arrest without warrant. The language is actually broader than that. All you have to do is believe the person has committed, or the person has committed, is committing, or you think the person is committing, or is about to commit, or you think that person is about to commit, and that is grounds. No one is suggesting that with the same intent to restrict people's human rights that these two sections be eliminated from the Criminal Code, and therefore also one can be accused of inconsistency likewise.

Section 494 is a companion clause, which provides what popularly is misnomered as citizen's arrest. It is actually broader than that. You do not even have to be a citizen to affect this arrest because it says that everyone is justified in Section 494 to use such force such as is reasonable to arrest a person who has committed an act, which is cause for arrest without warrant so as to deliver him under a peace officer, and likewise provides that all you have to do is see that the person has committed or you think has committed, is committing, you think has committed, is committing, will commit or you think will commit, and that is grounds.

As far as the peace officer is concerned, why is this person supposed to be restricted so that he cannot, or she cannot, exercise the good intent? These are people who go out daily and put themselves in the most dangerous situations in our society and are proven and tested daily as having good self-control and excellent intent. Otherwise, all of Her Majesty's police members would be fired in the country and nobody is suggesting that which, by that gross act of omission, recognizes that there is profound good intent among our police officers and other officers of the peace.

I have experience as a correctional officer in Hamilton-Wentworth Detention Centre. I am an academic. I have about 10 years of university. I am what you would call an assimilator, an academic, as opposed to one who focuses in and does, a converger. I am more of the introverted, and a typically successful correctional officer is an extrovert, recognizes what is going on him immediately, almost without trying, and acts immediately.

I can tell you that some of the comments that have been criticized against the police organizations in this country, including correctional officers, have been made by academics who do not understand the nature of the recommendations and understandings that are brought to the fore to form policies in police forces in this country. I will give you an example.

Just about two years ago, there was an academic from the University of Manitoba who criticized publicly a chief constable of a police force in Canada who recommended that people not be hired who had university degrees. As far as the claim perspective of the academic was concerned, she criticized this police chief as being anti-intellectual, and perhaps even red-neck.

Well, let us consider it from their perspective, and I can because I have lived it. They are not anti-academic. What they are, they do not want to have introverts. They do not know what is going on around them; they can think, but they do not do, they do not react. They are good for thinking, they are not good for reacting. They do not want to have introverts, and I would agree with that chief of police, you want to have extroverts. I can tell you from my experience as an academic, misplaced, because I needed a job, in Hamilton-Wentworth Detention Centre, that these people are profoundly educated in a manner that an academic can never be. They are better than we are.

As a correctional officer in that situation, we get our orders everyday and we are told where to go. One of the places where we are told to go is A and D, Admitting and Discharge. You take the criminals off the street as the police arrest them and give them to you. You can typically work with an experienced officer, and on these long, boring shifts, especially at night, lots of time to discuss lots of things. When somebody comes in, at one glance, in less than a second, the officer beside me, of 16 years experience, 25 years experience and so on, will tell me: this is what this guy is arrested for, this is where he is going to be put, these are the following problems and this is what is going to happen to him, and over the following months, everything happens that way.

These are educated people, and to have such practical hands-on doing expertise from these convergers, in my view, would be well used and exercised in the administration of justice in this province. There is more to education than university, much more, and anybody who does not exercise the humility that is necessary to recognize others' abilities as far as I am concerned does not have any claim to have an honest search for truth. We must be able to say, as I am saying to you, that convergers are better than assimilators; the doers are better than the academics. They do things that I cannot do.

At the same time, I can recognize that I can do things that they cannot do. When it came to red tape, people would typically come to me because I knew how to write. All right, so they need me, I need them, but if we are talking about people who have to make a judgment right now on the street, they are the experts and nobody else is, and I can tell you that from real-world experience. These are educated people.

* (1930)

I think I will restrict my comments to that. I have a number of things I would like to say, and I would like to speak with some people privately. I think the claim made by Mr. Henteleff, I find particularly disturbing that he says, well, you know, an officer really should not have the discretion as suggested in this legislation. In some sense he suggested, well, really, people should be disenfranchised from having a say in what happens to humanity around them. Why? I mean, everybody gets a vote. On what grounds is one considered to be an expert to vote and establish a government? Why are we so good? We are the commoners. Are we to be excluded? I mean, anybody who is human and sees somebody who defecates in his pants and pulls out the defecation and stuffs it in his pockets as I have seen it in jail from the people who are mentally ill, one section of the jail–I do not know what the formal term for it is, but we called it the ward.

These were kind of the mentally ill people. Most of them were made mentally ill by drug abuse. I can tell you some horrible stories. As far as I am concerned, if you want to have a nice 30-second clip on TV to show people why they should not take drugs, just take a shot of 30 seconds of some people herding in the zombies into that section of the jail. Let them see the faces. That is all they need to do, and people ask themselves what happens. You want to stir people to ask questions and to answer them based on facts as they observe it.

Let us not be elitist. Let us not give a new definition to diplomacy in which people are to be excluded and disenfranchised because they are not deemed to be experts by the select few in an ivory tower. All of us count; all of us are human, and we know what it is to have some sense of normalcy in life, and we have some sense to know what is different from that. When there is a need for intervention, people should be allowed to exercise their good intent for the benefit of others, including police officers.

Mr. Chairperson: Thank you very much, Mr. Waldie, for an excellent off-the-cuff presentation. I wish I had your ability. You did an excellent job.

Mr. Mark Waldie: Well, I am looking for a job. I am essentially an underemployed teacher, and that is another issue. In terms of mental health, I can tell you I am not an axe murderer, as some Hollywood films would like to portray people with depression–in fact, quite the opposite.

I can tell you in great part the cure for my continuing depression is having a real job, which we cannot have because of the excesses of the universities making 875 teachers a year no one needs. This is a constructed social injustice, and I would like to ask the government, please, love justice enough to cut back further in education to cause justice, to protect us from the big, bad universities.

Last year, my first job, I was given an unsolicited letter of appreciation from a parent. I was working not only with the nice little kids but the kids who required attending, and I got this letter on a reserve, and I could invite anybody to investigate. I do, but I am not afforded an opportunity to exercise my abilities to work with children because the universities have put me asunder. Please love justice and act against them to protect us from them.

Mr. Praznik: Mr. Chair, I just wanted to thank the presenter, and I wanted to just make the comment, when you are in government and you sit in committees like this as legislators, we often hear so many different complaints about the operations of systems.

Your comments reminded me of a couple of things. One, all systems we create in government or in the community are still human systems, and they are human beings interacting with human beings as imperfectly as all human beings can be at times.

So, although we always strive for perfection, rarely in human history have we ever achieved it, and rarely–I think if we spent all the money we had as a province and then some and put it all into mental health, we would make things better than they are no doubt, but there would still be problems, because it is a human system and there is still that interaction. It is often so easy to be critical of so many parts of that system, and yet it continues to work for many, maybe not for all, but it does do a great amount of good. You reminded us of that I think in your comments with respect to police officers and others, that yes, from time to time things are not necessarily perfect, but there is often a lot more good than we often hear about.

Mr. Mark Waldie: I appreciate your comments. I would like to follow up on a related matter. I had opportunity to exercise Section 27, as I did 494. In relation to The Mental Health Act, Section 27 of the Criminal Code, I used force, and I phoned the police as a follow-up to that. I used it against my brother who is a chronic paranoid schizophrenic, who was severely assaultive against my father who was bleeding from the head and so on, and who smashed all kinds of things in the house. When I did it, I did it with the sense of professional and with, all of its implications, a kind of life suicide in that. As soon as I used that force, I opened myself to my brother accusing me of having used force against him in an assaultive manner. The police investigation established otherwise; however, I acted in the belief that I opened myself to that.

The reason is the previous time I used force against him; when he made such an outburst, I phoned the police. I could not defend myself from him; I was ill at the time in bed. When the police came, I pointed out, here he is. He just said, well, okay, he assaulted me. So I was arrested. I was the one who was beaten up, and I was the one who phoned the police. So, in counter to Mr. Henteleff's claims, here we have somebody who is diagnosed, proven to be mentally ill, and that person has absolute discretion, as, in effect, chief of police, and can order any constable in this city or elsewhere to arrest the person based on a zero tolerance policy.

So, if we are talking about human rights, let us be a little bit broader than what Mr. Henteleff did and let us consider some reality as I have experienced it. It would seem to me from Mr. Henteleff's discussion that he is somewhat removed from reality, and I am right in the middle of it.

Mr. Chairperson: Thank you very much, Mr. Waldie, for your presentation.

I call Dr. Jaye Miles or Darlene Dreilich. [interjection] Yes, we were made aware of that, and we were just wondering whether they had come back. They said if they did not come back, they asked us to distribute a brief, so I was just trying to ascertain whether they had come back. So they are not back, we will then distribute the brief that they had left, if that is the will of the committee. [agreed]

I call then David Smith. David Smith, not being here for the second time, will be dropped off the list. Marlene Vieno. Not seeing her, she will also be dropped off the list. That concludes, by the way, the hearings on this bill, on Bill 35.

Bill 31–The Regulated Health Professions Statutes Amendment Act

Mr. Chairperson: We have one further presentation on Bill 31, Mr. Sanders. Is he here? Mr. Sanders, would you come forward please. Sorry for the long day.

Mr. David M. Sanders (Private Citizen): I apologize for not being here first thing this morning.

Mr. Chairperson: Have you a written presentation for distribution? The Clerk will distribute. You may proceed with your presentation.

Mr. Sanders: Thank you, Mr. Chairman. My name is David Sanders. I am appearing this evening as a private citizen with regard to Bill 31. This is The Regulated Health Professions Statutes Amendment Act. This bill is just one of many pieces of legislation which the Province of Manitoba is enacting for the purpose of ensuring that personal health and other information is kept confidential and made accessible to the persons concerned.

The very limited purpose of Bill 31 is to require that officials of the self-regulated health-related professions preserve the secrecy of all confidential information they may receive and to provide for a fine of up to $50,000 for any official who is found guilty of communicating any such confidential information without proper authorization.

I have asked to appear this evening, first, to commend the overall effort of the government and the Legislature to strengthen and protect the rights of Manitobans with respect to their personal health and other information, and, yet, to suggest some further improvements.

Firstly, I have asked you to note that Bill 31 does not include amendments to the Manitoba Institute of Registered Social Workers incorporation act. I believe that, in all the bills before you dealing with this issue, I have not seen any reference to the social workers. I would suggest that the type of amendments which are contained in this bill should also be made to the MIRSW act since officials of the MIRSW are just as likely to receive confidential personal health and other information as officials of the professions which are included in the bill here before you. So I would suggest that addition.

Secondly, with respect to the matter of enforcement, I am quite concerned that, unless provision is made for prompt, effective investigation and prosecution of offences under this legislation by an independent body and at minimal expense to the individual complainant, then such legislation will really be ineffective and only serve to mislead the public into believing that their confidential information is being protected.

* (1940)

Now, who is to investigate alleged offences under this legislation? Surely not the officials involved, because it is the officials who are mentioned of course as being the possible creators of the offences. The police? I doubt that would be appropriate in cases such as those we are talking about here. I therefore suggest that this committee consider the advisability of amending the bill to provide that complaints about alleged offences under this particular legislation be made to the Ombudsman and dealt with in accordance with the procedures in parts 4 and 5 of The Freedom of Information and Protection of Privacy Act and/or parts 4 and 5 of The Personal Health Information Act.

I might add, I suspect that the lack of such a provision in the bill is probably just an oversight, because the other references in a similar manner are contained within bills which have these procedures. If you will examine it, I think you will find that there is no provision for such investigation and prosecution in these acts unless you make that addition.

The third point I want to make is with respect to the regulation of individual members of these professions. I note that Bill 31 says nothing about the responsibilities of individual members of these professions to preserve the confidentiality of information or to permit a person to have access to his or her records. I do not think any of those acts have much to say on that subject. I believe that all such individual professionals will now be considered trustees of personal health information and will be governed in the future by provisions of The Personal Health Information Act. However, unless the professionals are employed by a "public body," such individual professionals will not be governed by The Freedom of Information and Protection of Privacy Act with respect to their use of other personal information as defined in that act. Since many of these professionals in these groups are in private practice, I believe there will be a serious gap in this overall legislative scheme unless they are made subject to that act or else to similar provisions which could be included in each of these professional statutes by amendments to Bill 31.

Finally, to emphasize my concern about the enforcement of these rights, I would like to tell you about a current case in which I am not the complainant but with which I am very familiar. It involves a registered psychologist who has committed a horrifying breach of confidence and trust. The psychologist treated a patient for over a year without disclosing that the psychologist was a friend and colleague of a third person who was involved in the issues being described by the patient in weekly therapy sessions. More importantly, the psychologist received confidential information from the patient in therapy, and then disclosed it to that third person and through her to a fourth person involved.

The patient finally discovered this highly unethical behaviour in March of this year. The patient immediately terminated the doctor-patient relationship and requested the patient's records. That request was refused outright and for the records in their entirety. The patient filed a formal complaint with the Psychological Association of Manitoba, PAM, early in April of '98, but as of this week, some two and a half months later, the PAM discipline committee has still not considered the complaint, and the chair advises only that the committee may deal with it at its next meeting at the end of June. At best, the committee would only begin its investigation of the complaint after that date.

The patient also filed formal complaints about both access and privacy with the Ombudsman at the end of April, pursuant to the new Personal Health Information Act. I understand that these were the first such complaints received by the Ombudsman under that new legislation. The act gives the Ombudsman a deadline of 45 days to report on complaints about access. On the deadline in mid-June, the Ombudsman advised that the patient's records have been requested from the psychologist but not yet received. The Ombudsman also advised that he anticipated his report on the access complaint would be prepared by mid-September, four and a half months after it was filed. The Ombudsman also advised that he had not yet decided whether to investigate the privacy complaint for which the deadline is 90 days at the end of July.

So today, after three months, the psychologist is still registered and practising, the patient has still been denied access to the records, does not know if PAM will even investigate the complaint filed with it, may not receive the Ombudsman's report on the access complaint for another three months and does not yet know for sure that the privacy complaint will be investigated by the Ombudsman.

Now the patient does understand that the Ombudsman is still getting organized to perform this new function and wants to proceed carefully with the new procedures. Certainly this turns out to be a test case. Nevertheless, committee members who are familiar with the relevant legislation will appreciate that these are only the initial steps and that the final determination of these complaints, likely in court, is probably a very long way off, probably years away. So I have to ask just how effective the present legislation will really be.

Based on PAM, the Psychological Association, the professional organization's performance to date, I have no confidence in their ability to discipline their own members expeditiously and effectively. I am satisfied that the Ombudsman has very good intentions, but so far, after almost two months, no results. So I hope this story may provide committee members with a bit of a reality check as you consider these amendments and the recommendations I have made. Simply putting in the number $50,000 does not produce any protection of confidentiality nor access to records. Thank you.

Mr. Chairperson: Thank you very much, Mr. Sanders, for your presentation.

Hon. Darren Praznik (Minister of Health): Thank you, Mr. Sanders. Just a couple of points that you make. I would like to respond with you here and your information. Chatting with Val Perry, who is one of our legal people on drafting, the reason why the act you refer to is not included in Bill 31 is that this statute deals with public acts. The act you are referring to is a private act, and it has never been the case where penalty or fences were put into a private act. We do not allow private acts, whether they be various associations or golf clubs, to have the power to impose a penalty. They are enabling statutes as opposed to one that calls penalty provisions, whereas the acts listed in Bill 31 are ones that are public bills or public acts of the Legislature creating professional bodies, and they are public acts. That is why the offence penalty is there. So that is the reason why that other act was not included.

The piece about personal health information in the case that you have referenced, if the information that was disclosed was health information, as opposed to personal information, personal information versus personal health information, then it will be covered under The Personal Health Information Act. Now, as you have appreciated, the Ombudsman, who administers that, has been staffed up. This is the first complaint, and he is proceeding, I imagine, cautiously to ensure that if there is a challenge that he will have done his work well. It takes some time, so we appreciate your patience.

I would be most interested to learn whether or not this complaint was dealt with by the professional body and how it was dealt with and what the results of it were. I am sure all of us would be interested in that particular result, because if there is in fact a problem with the periods of time in which these matters are adjudicated, then that is something we would like to know about.

Mr. Sanders: On the first point, I appreciate the explanation why the social workers are not covered in this particular bill. My question is: how do you propose to deal with them? Because the association does have the authority under the act to deal with the discipline of the registered social workers that will involve hearing evidence on these matters. One way or another, I would submit that those individuals should be subject to the same kind of constraints as these other organizations in whatever appropriate way it could be legislated.

Mr. Praznik: You have raised a very interesting area, because social workers are not what one would call a monopoly profession, that anybody, in essence, can become or call themselves a social worker. That particular act is a private act, allows for a group of social workers who come together and are self-regulating. Their discipline is included within the contractual arrangements of their association. Social workers are not, as of yet, in the Province of Manitoba a professionally regulated body by a public statute which prohibits others, restricts the practice of social work to those who are registered under that act, and that has been a point of debate and discussion for some time I know in the Department of Family Services and in other quarters about whether or not that should be an area in which we move.

* (1950)

If a person is a social worker, is working for a public body, which I would imagine most social workers, the vast majority, do, and health information, personal health information comes to them in the course of their work, then they are covered by The Personal Health Information Act. If they are working in a private body, in essence, they are not covered by that. But it does raise the question, and you have a very legitimate point. Are social workers covered? They come in contact with individuals. In order to do that, in essence, you would have to license and regulate in a monopoly way social workers in a restricted piece of legislation, because currently in Manitoba anyone, in essence, can be a social worker. There is not a legal restriction in calling yourself one, as there would be with physicians or dentists or lawyers or others who have regulated professions. That is the difficulty. It is a larger issue.

Mr. Sanders: Although it is the case that the legislation does restrict the use of the term "registered" social worker for those who belong to that organization, you should know that there are registered social workers who are in private practice and who perform services as therapists, and, I submit, are therefore not covered by any of the other legislation unless you find a way of dealing with that.

The other question you referred to, in the case I mentioned, the information in question is personal health information and is therefore subject to The Personal Health Information Act. I believe that when the Ombudsman finishes his review and consultation, he will discover that he must investigate the privacy question.

On your question about respect to how quickly the professional organization deals with it, however they deal with it, I can assure you it will not be as fast as the legislation contemplates, when you submit that the deadline for the Ombudsman is 90 days. The procedures within these professional organizations can never be completed in anything shorter than six months or longer, so they clearly will not be expeditious in the manner that the Legislature intended under the new act and I can assure you will not be dealt with by PAM sooner than the period of time in which the Ombudsman is expected to investigate this, but I would be happy to report.

Mr. Chairperson: Thank you very much, Mr. Sanders, for your presentation. Prior to commencement of this sitting, I have received written submissions on Bill 35. Copies have been made available for committee members and were distributed at the start of the meeting. Is it the will of the committee to have all these submissions appear at the back of the committee transcript prepared for today's meeting? [agreed]

Thank you very much. This concludes then the public hearing on Bills 13, 20, 30, 31, 35, 52 and 57.

Mr. Praznik: Mr. Chair, just on the previous point to understand that, does that mean those presentations that were not delivered personally or in an oral fashion will be attached? It would be a shame to have it in the Hansard and attached. It would be quite a use of a large amount of paper, so I imagine it is just those that were not presented directly.

Mr. Chairperson: That is correct.

One other piece of business, I want to remind all committee members that this committee will again sit on Monday morning at 10 a.m. and will reconvene at 3 p.m on Monday and sit again at 7:30 p.m. on Monday. Then there might be further sitting requirements of bills that are not yet listed, but I would suspect that the House leader will deal with those matters on Monday.

That concludes the order of business for this committee. Committee rise.

COMMITTEE ROSE AT: 7:54 p.m.

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

To: Standing Committee on Law Amendments
Re: Bill 35

I would like to express my reasons why I am against the certificate of leave.

I have a Bachelor of Nursing degree, have worked in various clinical areas, have taught Nursing Education for 29 years. I have confidence in the medical profession, but my experience with psychiatry leaves me with no respect for the psychiatric system as it exists in Manitoba today. Many lives have been lost due to callous professionals who care only about labelling clients as incurable and do not seek ways to help promote human development.

When I sought help for my daughter in the early '70s and realized later the trauma caused by psychiatrists in their wrong diagnoses and treatment, it is unpardonable that she had to go to Ontario and be diagnosed correctly by a general practitioner in a walk-in clinic in the late '80s. Upon returning to Winnipeg as late as 1992 she was abused by a psychiatrist. When she reported this to the College of Physicians and Surgeons, the psychiatrist was sent back to the classroom for remedial and educational training. We do not need this type of system to treat our vulnerable people of society.

I went to Legal Aid for advice concerning another psychiatrist's conduct with my daughter. I told them that if something wasn't done, the way this psychiatrist was misdiagnosing clients, that someday a life would be lost. Within six months this same psychiatrist misdiagnosed a client and did not provide proper treatment, and a life was lost. This is the psychiatrist that the Legal Aid lawyer told me was highly qualified, and they would not listen to me.

Now my daughter is cared for by a family physician on the understanding she is never to be seen by a psychiatrist, because they are incompetent in their field. If my daughter was left in the hands of the psychiatric system I would not have my daughter with us today. The psychiatric system as it is today has too much power over clients who need a different system.

The certificate of leave focuses on keeping clients compliant with taking medications which can do more harm than good and much more is needed. A more holistic, patient-understanding caring system is required, which the present psychiatric system is not able to provide.

The certificate of leave only increases the power to abuse the client. It is the professionals that benefit, not the client.

It is high time we have community mental health walk-in clinics, which are less expensive to operate, considering the high fees paid to psychiatrists.

This certificate of leave is like a noose around a client's neck that acts as a negative force to threaten the rights of the client.

I will be willing to provide data for my above statements should they be requested.

Phyllis Wayne
Winnipeg

* * *

Presentation to the Manitoba Legislature re Bill 35, The Mental Health and Consequential Amendments Act

The Community Coalition on Mental Health is a coalition of organizations and individuals who agree to work together for the betterment of society and the well-being of individuals, families, and communities in Manitoba by the study of issues affecting mental health and through public education and advocacy for improvements in mental health services.

The coalition, in this brief, is restricting its comments to Section 46, Leave certificate. The leave certificate does not clarify adequate safeguards to ensure protection of rights. The coalition wishes to submit the following recommendations:

1) The patient (consumer) must have access to an independent advocate during the development of the leave certificate in order to ensure rights are protected and any power imbalances are addressed.

2) The treatment plan must be a collaborative effort between the treatment team and the patient (consumer) and developed within a partnership framework. The patient (consumer) should have approval over who would comprise the treatment team.

The leave certificate provision appears to rely on a structure of services (in relation to mandated treatment in the community) that does not exist. Clarification regarding the nature and scope of mandated community treatment and the implication for community agencies must be addressed. The leave certificate is to provide for the well-being of individuals within the community and would not be necessary if access to adequate services were available.

The Community Coalition on Mental Health believes that a co-ordinated, comprehensive community-based mental health system should provide the range of services and supports required by an individual, including services which address quality-of-life issues. Currently there are gaps in the system which prevent the availability of the scope of services required.

Darlene Dreilich
Community Coalition on Mental Health

* * *

May 25, 1998

Re: Bill 35

I am writing to request that you support the amended certificate of leave of The Mental Health Act. Too many Manitoba citizens suffering with serious brain disorders are falling through the cracks of a faulty Mental Health Act and, consequently, are not receiving timely and appropriate care and treatment. Please vote yes to amendments to the certificate of leave.

Thank you for considering my urgent request in this matter.

Sincerely,

Mrs. Barbara Gommerman
Winnipeg, Manitoba

* * *

May 21, 1998

Ladies and Gentlemen:

I, Marion Josie Palamar, residing at 243 Kilbride Avenue, Winnipeg, Manitoba (West Kildonan) for almost 20 years, advise you herein, all of the MLAs, that I approve and support the certificate of leave to Bill 35.

I, Marion Josie Palamar, submit the above on my own personal behalf because my blood relative has this terrible disorder, i.e., schizophrenia. In my family, it is genetic, as my mother was diagnosed with same and spent two years at Brandon Mental Hospital in the 1950's. I have all her medical documentation in my possession.

A certificate of leave would provide a less intrusive treatment in the community.

Thank you for all your genuine concern about this long-ignored and misunderstood biochemical disorder; suddenly inflicted without warning on our loved ones, rich and poor. "It does not discriminate."

Yours respectfully,

Marion Josie Palamar

P.S. Because I have just been discharged from the hospital (major surgery), this is being hand-delivered by my friend.

* * *

Re: Bill No. 35

My husband and myself totally support the certificate of leave.

Our son has paranoid schizophrenia. Doctor and patient confidentiality kept us from becoming involved in his treatment and appropriate care.

Repeated stresses, over seven years, proved too much. Our loved one receded into a world of delusion, paranoia, hearing voices, and depression. Without knowledge of what we were dealing with, the primary caregiver (myself) collapsed into severe clinical depression, was hospitalized for two months at PsycHealth Centre. ECT treatments were given; a total of eight, before depression finally lifted.

Public education of mental disease is essential. Schizophrenia is a brain disease like diabetes is a disease of the pancreas. Is there a stigma to multiple sclerosis, Alzheimer's or cancer?

Our son spent one year and three months at PsycHealth. During this time, passes were granted. He would take off and would not return. Without the certificate of leave, the consequences could have been devastating.

The Schizophrenia Society aided us in changing psychiatrists. Progress then started. We were included in the treatment team.

Knowledge obtained from literature from the Schizophrenia Society and Society for Depression and Manic Depression helped to show a light at the end of the tunnel.

When our son filed an appeal for discharge, which is his right, we supported his doctor. Discharge at that time was premature. After a full year at PsycHealth, a long-term facility had to be considered. Refusal to Extended Treatment Unit, Grace Hospital, because of extreme paranoia and delusions, left Selkirk as the last resort.

A bed became available in December '97, after a four-month wait. This presented another problem. We are both in our 70's and unable to drive now. Handi-Transit is our only means of transport.

The end of May '98 finds our loved one one hour's drive away from home. The support of family and friends is paramount. A passage from a newsletter from the Schizophrenia Society is very appropriate. "Don't walk ahead of me, I may not follow. Don't walk behind me, I may not lead. Just walk beside me and be my Friend."

At the present time, our story has no ending in sight. Our son denies having the disease schizophrenia. If and when he is considered for discharge, he will need a 24-hour supervised setting. Is such a place available? How long is the waiting list?

He is presently on long-term disability (CPP). If he has to pay for his medication, he just will not take it. We then have the revolving-door syndrome.

We know schizophrenia is a chronic disease with relapses. Their future is so bleak, it would make anyone of us contemplate suicide, an end to the suffering.

We, as a society, must make their lives more bearable.

Families alone cannot bear this burden.

Sincerely,

Mrs. Dyla McGregor
Winnipeg, Manitoba.

* * *

Attention: Committee Chairperson, Mental Health Act

It has just come to my attention on June 12, 1998, that changes to the Manitoba Mental Health Act are in the process of being passed by the Manitoba Government. CMHA and many consumers in Thompson Region have serious concerns about the proposed certificate of leave provision.

As a consumer of mental health services and a concerned citizen of Manitoba I would like further information on how these changes to The Mental Health Act will affect me. I would also like the opportunity to have hearings in regard to the certificate of leave in our region to voice my concerns in regard to this legislation.

Sincerely,

Yvonne Bloomer, Canadian Mental Health Association, Thompson Region

Kris Cummings, Private Citizen
Armand Manaigre, Private Citizen
Mabel Osborne, Private Citizen
Gerald M. Henry, Private Citizen
Bernice Henry, Private Citizen
Lillian Keam, Private Citizen
Angela Blacksmith, Private Citizen
James G. MacInnis, Private Citizen
Walter Labanowich, Private Citizen
Leonard Crait, Private Citizen